Implementation Facilitation Training Manual

Using External and Internal Facilitation to Improve Care in the Veterans Health Administration

Version 1

MENTAL HEALTH QUERI
Quality Enhancement Research Initiative

The development of these materials was supported by Mental Health Quality Enhancement Research Initiative

Introduction

Implementing evidence-based practices and programs, indeed any complex clinical program, is challenging. Facilitation is a strategy with proven success in program implementation. This manual is one component of a facilitation training program. It defines an external and internal facilitation strategy for implementing new programs or practices, describes the specific roles associated with this strategy, and illustrates activities in which facilitators may engage during the implementation process. In this strategy, facilitators can work either internally or externally to the clinical environment. Specifically, an external facilitator (EF) is an expert in general implementation activities and relevant clinical models and their evidence base. An internal facilitator (IF) is familiar with facility-level organizational structures, procedures, and culture as well as the clinical processes within the Veterans Integrated Services Network (VISN) or facility. Over time, and with close mentoring, the EF transfers understanding of effective implementation activities to the IF and thus fosters introduction and retention of these skills within the local organization. Although facilitators' roles are described in Section II, much of the manual describes the facilitation strategy generally rather than assigning roles and tasks to either the EF or the IF because their individual responsibilities will change over time and depend upon the IF's abilities and local site characteristics. The manual specifically identifies the EF or the IF when one of them should conduct a task.

This manual is based on the experiences of external and internal facilitators associated with the implementation of the VHA Primary Care Mental Health Integration Initiative with input from external facilitators who worked to implement programs or practices for patients with severe mental illness and substance use disorders, as well as the literature related to facilitation and evidence based implementation strategies (see References, pp. 60 – 68). Throughout the manual, we use examples from this Initiative to illustrate points.

This manual was developed by: JoAnn E. Kirchner, MD, Mona Ritchie, MSW, PhD(c), Katherine Dollar, PhD, Patricia Gundlach, MSSW, and Jeffrey Smith, PhD(c). Special thanks to the following external reviewers: Geoffrey Curran, PhD, Lisa Kearney, PhD, Lawrence Daily, MSW, and Amy Cohen, PhD, and to Valorie Shue, BA, and Amanda Lunsford, MA, technical writers.

Note: It is important for the reader to understand that this manual is a work in progress and will be informed by future findings from the "Blended Facilitation to Enhance PCMH Program Implementation" study as well as possibly your own experiences.

Version 1

Table of Contents

I. Brief Overview of Facilitation 3

II. Facilitation Roles 6

III. Phases of Implementation 15

IV. Pre-Implementation Phase: Critical Knowledge Prior to Implementation 16

V. Stakeholder Engagement 17

VI. Site Assessment 23

VII. Facilitating Program Implementation Meetings 28

VIII. Program Design 37

IX. Program Adaption 41

X. Hiring, Training and Mentoring Staff 44

XI. Academic Detailing 47

XII. Marketing 48

XIII. Collaboration 51

XIV. Building Learning Collaboratives 53

XV. Monitoring and Improving the Program 55

XVI. Factors that Support Sustainability 58

Appendices 62

I. Brief Overview of Facilitation

A. Purpose of Facilitation

The Department of Veterans Affairs (VA) has been a forerunner in the development, promotion, and implementation of evidence-based practices (EBPs) through innovative research initiatives, guidelines, programs designed to develop implementation science, and quality improvement efforts (e.g., performance monitoring). Across the healthcare industry, however, sustainable EBP implementation has emerged as a complex and challenging process. This is particularly true when implementing relatively complex clinical programs, such as Primary Care Mental Health Integration (PC-MHI), which require engagement and support from multiple care specialties and changes in provider attitudes, organizational structures and processes, and clinical practice.[1] Effective implementation typically entails multi-component programs tailored to individual settings, diverse implementation strategies, and involvement of multiple stakeholders.

Facilitation is one strategy to improve implementation of EBPs. The tenets of facilitation arose from the education and nursing disciplines and acknowledge the fact that, while research evidence supporting a practice is important, clinical experience and professional knowledge provide additional evidence that directly affects the adoption of a practice.[2, 3] For example, the experiences of a colleague who has successfully used the program or practice may be more important to a provider than a journal manuscript. In addition, factors within the implementation setting or context influence practice adoption. For example, the organizational structure, leadership support, prior experience in new practice implementation, and methods of communication directly influence implementation efforts.

Facilitation is a multi-faceted process and involves helping rather than telling.[3] Based on VA experience, Stetler et al. has defined facilitation as a process of interactive problem solving and support that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship. Establishing a partnership based on mutual respect with stakeholders at the implementation setting is critical to successful facilitation activities. It is not a process of providing resources and stepping back[4] or simply telling someone what to do. Rather, it requires the creation of a supportive environment within which knowledge can be exchanged,[4] barriers to implementation identified, and processes to overcome those barriers developed.

Facilitation is a multi-faceted process and involves helping rather than telling… Establishing a partnership based on mutual respect with stakeholders at the implementation setting is critical to successful facilitation activities.

Facilitation for implementing EBPs bundles an integrated set of interventions.[5] These include identifying and engaging key stakeholders at all organizational levels, problem identification and resolution, assistance with technical issues, developing information exchange networks, academic detailing (face-to-face presentation of the evidence that supports a practice or program), marketing, staff training, patient education, formative evaluation, audit and

feedback, engagement of opinion leaders and clinical champions, and fostering role modeling.[5-8] The particular roles that facilitators assume and when they assume them depend upon stakeholder needs during the implementation process.[6, 7, 9, 10] For example, pre-implementation activities focus on engaging leadership support, identifying key stakeholders, and academic detailing. Late-phase implementation focuses on activities to sustain a new EBP (e.g., establishing ongoing audit and feedback processes and fostering EBP role modeling).

B. Characteristics of A Good Facilitator

To assume facilitation roles in a way that is responsive to organizations' needs over time, facilitators must have strong communication and interpersonal skills as well as an understanding of the need for flexibility in identifying and refining implementation processes to achieve performance goals.[6, 11] Perhaps the most important characteristic of a good facilitator is the ability to empathize and understand the needs of others. As noted above, facilitation should occur within an environment of mutual respect. The ability to establish such a relationship requires that the facilitator be genuine and positive. It is important for the facilitator to know when to speak and when to listen. It also is important to understand the value and credibility established in responding to stakeholder feedback and suggestions *in a timely manner* to achieve implementation goals.

Perhaps the most important characteristic of a good facilitator is the ability to empathize and understand the needs of others.

Frequently, the facilitator is required to 'sell' the value and need for change to leaders and other stakeholders as well as motivate others to make the needed changes. To do this, the facilitator needs to develop some credibility with the audience. It is important to provide positive feedback when organizations make even small movements toward the desired change and provide negative feedback in an encouraging manner to those not progressing toward the desired change, for example by saying things such as "other sites have faced similar situations" and offering an array of options for problem solving. In addition, it is important that facilitators are reflective listeners and engage stakeholders in problem solving, recognizing that *stakeholders are the experts in their site's context and culture*.

The facilitator role does not come with a set of clearly-identified steps that one simply walks through with stakeholders. Rather, the facilitator must rapidly assess the skills and resources of an organization throughout the implementation process and respond to an ever-changing clinical context. The facilitator should have strong teaching skills to coherently present information about the practice or implementation process when opportunities arise. The facilitator must have the ability to transfer this skill to champions[i] so that they too can become

[i] *Champions: "Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation]," overcoming indifference or resistance that the intervention may provoke in an organization. (See Appendix A 2. Glossary of Terms.)*

experts in the subject matter. Finally, it is critical that facilitators possess the ability to analyze and interpret data and teach that skill to stakeholders to self-evaluate and refine the implementation process as needed to reach performance goals.

II. Facilitation Roles

Facilitators can work either internally or externally to the clinical environment. Specifically, an external facilitator (EF) is an expert in general implementation activities and relevant clinical models and their evidence base. The internal facilitator (IF) is familiar with facility-level organizational structures, procedures, and culture as well as the clinical processes within the network (VISN) or facility. Over time, and with close mentoring, the EF transfers understanding of effective implementation activities to the IF and thus fosters introduction and retention of these skills within the local organization. Below, we describe the specific roles of the two types of facilitators: external and internal.

A. External Facilitators

External facilitators are experts in practice/program implementation. Support for the EF's involvement in facilitating practice/program implementation should come from senior leadership to ensure that the EF's expertise is recognized. The EF's goals are to help sites create a structure and pathway through which practice/program changes can be successfully implemented. First, and foremost, the EF must create a positive working relationship with key stakeholders. As noted, "facilitation is more two-way than other implementation strategies, not as prescriptive and more adaptive and respectful of what is in place (page 7)." [5]
External facilitators should support the vision for change. The EF must maintain an external expectation for implementing the practice. This requires a consistent presence through site visits, telephone conferences, and/or emails. With these contacts, the EF can provide the motivational push and intellectual resources that help lead to successful implementation. Below, we briefly describe some of the most important aspects of external facilitation. Additional information on these topics is provided in subsequent sections of the manual.

> ***Understanding the setting.*** Early in the facilitation process, the EF should understand the environment within which the practice or program is being implemented and work with key stakeholders to identify potential barriers to change as well as ways to overcome these barriers. Additionally, the EF should look for facilitators of change and leverage these to benefit the transformation. Identifying and working with barriers and facilitators is an iterative process during which the EF must engage actively with stakeholders and be a keen observer to stay informed about the political climate[ii] of the organization, the unique characteristics of the setting, the demographics of the Veteran population, and the culture[iii] of the organization. Each organization has different pathways through which change occurs and processes or people who influence these changes. When the EF works in tandem with an IF to support practice/program

[ii] *Difference between Culture & Climate: Organizational culture concerns system evolution and involves an in depth exploration of underlying assumptions not readily apparent to outside observers. Organizational climate, on the other hand, concerns the effect of systems on individuals and groups and focuses on organizational members' perceptions of observable phenomena such as organizational practices and procedures. (See Appendix A 2. Glossary of Terms.)*

[iii] *Culture: Norms, values, and basic assumptions of a given organization. (See Appendix A 2. Glossary of Terms.)*

implementation, they must communicate with one another to ensure they are aware of these issues. (See "VI. Site Assessment," page 23.)

Engaging Stakeholders. Creating an environment that supports a practice change requires identification and engagement of key stakeholders among leadership, providers, and support staff. While an initial endorsement by network, medical center, and clinic leadership can provide an entrée to the clinical setting, establishing the types of relationships necessary for successful implementation is a job for the EF. Thus, it is critical that the EF be able to work and communicate with a variety of personalities and disciplines and feel equally comfortable working with line staff and senior leadership. (See "V. Stakeholder Engagement," page 17.)

Setting Program Goals. Depending on the site's experience implementing EBPs, setting program goals may be a challenging task. It is important that the EF provide structure and guidance that will allow the site to develop clinically-meaningful performance improvement goals and related processes that will maximize the potential for success in implementing the program or practice.

Providing Evidence. In working with key stakeholders to develop a pathway to change that fits the characteristics of the organization, the EF provides resources and information to help answer critical questions. Academic Detailing[iv] is an important component of facilitation that most frequently occurs early in the implementation process. While this includes a review of the research and clinical evidence that supports the program implementation or practice change, it is important to provide additional evidence such as examples of how similar settings have adapted the program, patient or provider satisfaction with it, and efficiencies or organizational benefits (e.g., improvement in a performance monitor) that result from successful implementation. It is important to realize that different audiences may value different types of evidence. (See "XI. Academic Detailing," page 47.)

Developing Processes to Inform Implementation. The EF helps sites identify data elements that allow them to monitor the implementation process and progress toward performance improvement goals. While some of these data elements are common across sites or even standardized nationally, many sites have specific, locally-developed indicators or measures that inform their ability to fully implement the practice/program. As these measures are developed and obtained, in an iterative process, the EF works with sites to interpret findings, identify and implement interventions that could improve the process, and monitor the impact of these interventions.

[iv] *Academic Detailing: Non-commercial prescriber education (academic detailing) removes the profit motive and replaces carefully crafted sales messages with objective, educational messages based on the most up-to-date and complete scientific evidence available. This approach represents an important service to prescribers because it helps them get the unbiased information they need to make the best possible prescribing decisions for their patients. (See Appendix A 2. Glossary of Terms.)*

Identifying Problems and Strengths. These efforts are a prominent portion of external facilitation. Using data gathered in the implementation process, the EF works directly with the IF and site personnel to identify barriers to implementation and develop feasible solutions for the local context. Working with the IF and local site personnel to identify problems and solutions, rather than directly telling them what to do, helps ensure that they apply and maintain implementation skills beyond a particular effort. The EF should pay equal attention to facilitators of change. These may be influential and respected people who can lead the mission or have a strong sense of group cohesion. Any identified strengths allow the IF to give positive feedback to the group and leverage that for change.

Linking to Outside Resources. When information is needed about the program or practice that goes beyond the knowledge of the EF, the EF also serves as a linkage to other experts or resources. These may include researchers who have developed or studied the program or practice or key players who have been successful in their own implementation effort at other sites.

B. Internal Facilitators

The goal of internal facilitation is to understand the culture and unique characteristics of the organization and assist the organization in overcoming obstacles for successful program development, implementation, and sustainability. Many distinct roles and functions fall within the purview of an IF. Thus, it is important that the IF be flexible, knowledgeable, creative, and adaptable to different techniques that meet the needs of diverse situations. Sometimes, the IF functions as an organization leader and, at other times, as a content expert. At still other times, the IF serves as a mentor, coach, and change agent.[v] Therefore, it is important that the IF be comfortable in diverse roles, be skilled at building relationships, and, most importantly, be aware of specific nuances within the local organization. The following paragraphs summarize some of the roles that are consistent with internal facilitation.

Internal Organizational Leader: By definition, the IF is an identified leader within the local organization. The IF is a *local* expert (i.e., someone internal to the local system). This individual has "insider" information about the organization. An individual external to the local setting (e.g., the EF) would be unfamiliar with the nuances or complexities of the organization. The IF knows or can easily find out how "we do things here" and understands how the system and current practices have evolved. For example, an IF knows the institutional history, the overall internal structure, and the workflow of the organization.

[v] *Change Agent: Individuals who are affiliated with an outside entity and formally influence or facilitate intervention decisions in a desirable direction. (See Appendix A 2. Glossary of Terms.)*

II. Facilitation Roles

Organizational stakeholders should view the IF as a leader with direct links to the VISN and medical center supervisory chain of command. Although the IF may or may not directly supervise, it is important that others view him or her as an influential and authoritative individual with the capacity to establish work expectations and influence program performance. Stakeholders should view the IF as an extension of the mental health VISN lead tasked with implementing program requirements to meet national expectations.
Ideally, an IF has a high level of achievement within the organization and the knowledge and resources to implement meaningful change. This person is "known" to stakeholders as an individual with an established local track record and is well-respected within the organization.

Relationship Builder: One critical function of internal facilitation is building and maintaining relationships with key stakeholders. The IF identifies key stakeholders and establishes relationships with them early in the program or practice implementation process. These can include leaders and other stakeholders, such as front-line clinicians, nurses, and other clinical staff as well as behind-the-scenes players. Specifically, the IF knows who the stakeholders are, their specific roles in the setting, and how the stakeholders function within the system at large. The IF quickly identifies the formal and informal leaders and the individuals who strongly influence day-to-day procedures. For example, it is critical that the IF develop positive working relationships with clinic managers and administrative officers. Without these relationships, it may be difficult to arrange logistics for meetings and guarantee that all key stakeholders will be present, given competing priorities.

The IF also works to create environmental conditions that support and sustain successful organizational change. For example, the IF fosters an atmosphere of open and direct communication among stakeholders. To reach group consensus, the IF encourages and supports dialogue between multiple stakeholders, guides the discussion, clarifies key issues, and moves stakeholders to consensus. In this sense, the IF may serve as a mediator or neutral party with the primary goal of helping the key stakeholders identify an implementation strategy and successfully implement the program.

Teacher, Trainer, Mentor: Internal facilitators provide direct technical assistance pertaining to program implementation to all relevant stakeholders through multiple mechanisms. To be successful, the IF must be up-to-date on local initiatives, Central Office directives, and relevant current literature. The IF can give technical assistance by providing education in formal meetings with larger groups or through one-on-one training. Optimally, the IF should be considered a resource and link to regional and national expertise, including the EF, who can supplement information provided by the IF. The IF has a working knowledge of the available resources both internal and external to the organization. This individual is familiar with best practices and clinical practice

guidelines, provides information about them to the organization, and links the organization to additional content experts.

The IF works to identify forums and opportunities for continued education, collaboration, and discussions among stakeholders. If these are not already established, the IF takes the lead in launching them. Forums might include monthly conference calls, weekly team meetings or quarterly educational seminars or trainings to foster growth. Early on, the IF identifies gaps in knowledge or skills and helps provide the needed training or resources through direct technical assistance or linkage with additional resources. For example, the IF may identify and arrange for a guest expert to present information. Through these forums, the IF not only continues to provide education and consultation but also establishes a forum for programmatic review. This helps create an environment that fosters group discussions and encourages sharing of ideas and resources.

Visionary: Even though the IF is considered a local leader, he or she helps the organization develop its own vision for change, program development, and implementation. Most busy front-line clinicians have little time to reflect on the organization, conceptualize possibilities for change, and consider activities to influence change within the system. At times, stakeholders may have ideas about how their program should look but have limited information about how to make change occur. At other times, the stakeholders may not have enough information to understand what changes should be implemented. The IF evaluates the site's readiness for organizational change and provides the resources that are consistent with the site's receptivity. The IF coaches stakeholders through this process and advocates for the program.

To help the organization develop a vision related to implementing a new program or practice, the IF leads group discussions that include presentations of the necessary practice or program requirements and provides data on the current stage of implementation at that location. The IF conducts group discussions about implementation progress and challenges. It should be clear to all stakeholders that the IF is there to help them develop and implement a program that meets Uniform Mental Health Service Handbook (VHA Handbook 1160.01) requirements *and* local needs. The IF provides examples of how similar organizations have implemented the practice/program as well as what has and has not worked. If this information is not readily available, the IF should work with the EF to identify additional resources and experts. The IF encourages group creativity and explicitly states that the program will be monitored and adapted accordingly. The key is to guide the stakeholders through the process of envisioning what they would like their

While providing guidance and technical assistance, the IF must be careful to ensure that the stakeholders, rather than the facilitators, are creating the program, which will foster successful implementation, buy-in, and ownership.

program to become and how they would like it to function. While providing guidance and technical assistance, the IF must be careful to ensure that the stakeholders, rather than the facilitators, are creating the program, which will foster successful implementation, buy-in, and ownership. This can be difficult when local stakeholders are not actively engaging in the process. The IF can make suggestions, provide additional information, and focus on building stakeholder engagement. However, the stakeholders must develop the program to insure success and sustainability.

Change Creator: One goal of internal facilitation is to create momentum for change within the organization. The IF identifies and uses systems, leaders, disciplines, programs or groups that have an interest in the desired outcome to help propel the organization toward the desired change. The IF partners with stakeholders to create the environment and embed processes that support change. Specifically, the IF identifies program champions and early adopters.[vi]

Reinforcer of Positive Change: The IF facilitates growth toward the desired change by communicating positive results across the organization. Facilitators should ask stakeholders to identify a specific set of performance improvement goals to monitor for each practice or program they want to implement. The IF can then use available data to assist with monitoring progress toward those goals. For program monitoring to be meaningful, feedback from stakeholders across the organization is needed. Thus, the IF maintains dialogue and establishes a feedback loop in which program data and stakeholder feedback inform program adaptation. Stakeholders should be able to see how their changes have directly influenced programmatic change. This further engages stakeholders and provides positive reinforcement for continued change.

Accordingly, the IF should be familiar with any readily-available data that might be useful for monitoring practice/program implementation. For example, the national PC-MHI program office has an intranet-based dashboard that contains program data, which can be sorted into site-specific details. The IF focusing on PC-MHI program implementation should be familiar with this resource and be able to guide stakeholders

---

[vi] *Early Adopters: Early adopters are a more integrated part of the local social system than are innovators. Whereas innovators are cosmopolites, early adopters are localities. This adopter category, more than any other, has the greatest degree of opinion leadership in most systems. Potential adopters look to early adopters for advice and information about the innovation. The early adopter is considered by many as "the individual to check with" before using a new idea. This adopter category is generally sought by change agents as a local missionary for speeding the diffusion process. Because early adopters are not too far ahead of the average individual in innovativeness, they serve as a role model for many other members of a social system.*

The early adopter is respected by his or her peer, and is the embodiment of successful, discrete use of new ideas. The early adopter knows that to continue to earn this esteem of colleagues and to maintain a central position in the communication networks of the system, he or she must make judicious innovation-decisions. The early adopter decreases uncertainty about a new idea by adopting it, and then conveying a subjective evaluation of the innovation to near-peers through interpersonal networks."
(See Appendix A 2. Glossary of Terms.)

to it, help them interpret the data, and use it to improve practice/program implementation. It is not expected that a potential IF already have this knowledge. The IF will learn much of this information as part of the training process and in collaboration with the EF after the specific program for implementation has been identified. However, the IF should have this knowledge prior to engaging the sites and initiating the facilitation process.

Finally, the IF often is the direct organizational link to the EF, developing mechanisms to assess progress and providing regular reports to the EF.

C. How External and Internal Facilitators Work Together

The degree and type of interactions that occur between an external and internal facilitator will vary across implementation efforts. In our work to date (largely focused on the implementation of PC-MHI programs), we can divide this into four 6-month periods. We use these 6-month periods as a framework realizing that actual time frames will vary based on the complexity of the intervention and the skills of the facilitators.

During the first 6 months

- The EF serves as a recognized "expert" from outside the local organization, which provides the IF with a high degree of credibility. We have found this to be a particularly helpful role during the initial engagement of stakeholders, mainly with leadership. Thus, it is incumbent upon the EF to be highly knowledgeable about the program or practice to be implemented and successful implementation strategies.

- Thus, the EF takes a more commanding role during early interactions with stakeholders.

- In turn, the IF is accumulating information on the clinical organization, local culture, history, and interpersonal dynamics at the site.

- Following site visits or conference calls with stakeholders, the EF and IF debrief, with each of them interpreting the key components that emerged from the meeting/call, identifying the current strengths and weaknesses of the site's implementation process, and developing a plan to address identified problems and leverage strengths.

- The EF and IF(s) meet regularly to review program implementation progress. For PC-MHI implementation, the EF and IFs from two networks involved in the facilitation program met twice monthly. It was particularly important to have joint meetings including both IFs since the experiences in one setting could inform facilitation activities in another setting. During these meetings, the IF would review the status of the program's implementation and data (both quantitative and qualitative) that documented the implementation process.

- The EF takes the lead in developing possible solutions to problems while the IF works closely with the sites to obtain their input.

- Early on, the EF sets the pace for the implementation process.

- The facilitators get to know each other's work style, and the EF determines the IF's communication skills and current understanding of implementation activities.

During the second 6 months

- Meetings to review each site's implementation process continue to include IF(s) and occur twice monthly with the EF and IF jointly interpreting data that reflect the implementation process and developing strategies to address implementation barriers.

- The EF continues to serve as a mentor to the IF(s), coaching them on how to address problems and interact with stakeholders.

- The IF begins to concentrate more on site level activities ("nuts and bolts") of implementation, interacting regularly with the sites to establish an implementation measurement system, developing plans to address barriers to the program or practice implementation, and executing the implementation plan.

- The EF continues to be a consultant on developing strategies to address barriers to implementing the program or practice and should be called into site level discussions or visits when the EF's level of expertise is needed or when it is felt that the presence of an expert with a high level of credibility is needed to negotiate an impasse or particularly difficult barrier.

During the third 6 months

- Meetings to review the sites' implementation processes decrease to monthly and occur individually with each IF. For PC-MHI implementation, these interactions became more brief (20-30 minutes in length) and were more a presentation of site status by the IF, who had already interpreted the data that documented the implementation status, identified barriers to implementation, and developed ways to overcome those barriers.

- EF and IF roles begin to shift. For PC-MHI implementation, there was a role shift at the site level where the IF took on the role of the credible expert and the EF was rarely needed for stakeholder interactions.

II. Facilitation Roles

During the fourth 6 months

- The IF has progressed through a developmental process and now is conducting the implementation activities.
- The EF and IF no longer have standing calls or scheduled interactions, though the EF is available on an as needed basis.
- The EF and IF may still work together on supportive activities such as educational conferences
- EF and IF interaction is around sustainment and further program development.
- The programs have been implemented and are up and running. With the assistance of the facilitation team, sites have overcome multiple hurdles and have developed successful programs. Sites are beginning to wave goodbye to the IF as well; however, they still want the IF available for consultation on an as needed basis.

Over time, the interactions of the external and internal facilitators evolve, and the roles and functions shift. Above we have outlined a successful process within the context of implementing PC-MHI. This process and time frame may vary depending on the exact program needs and the skills of both the EF and IF. Most importantly, the relationship should be collaborative and supportive and utilize the strengths and skills of both team members in a dynamic process.

III. Phases of Implementation

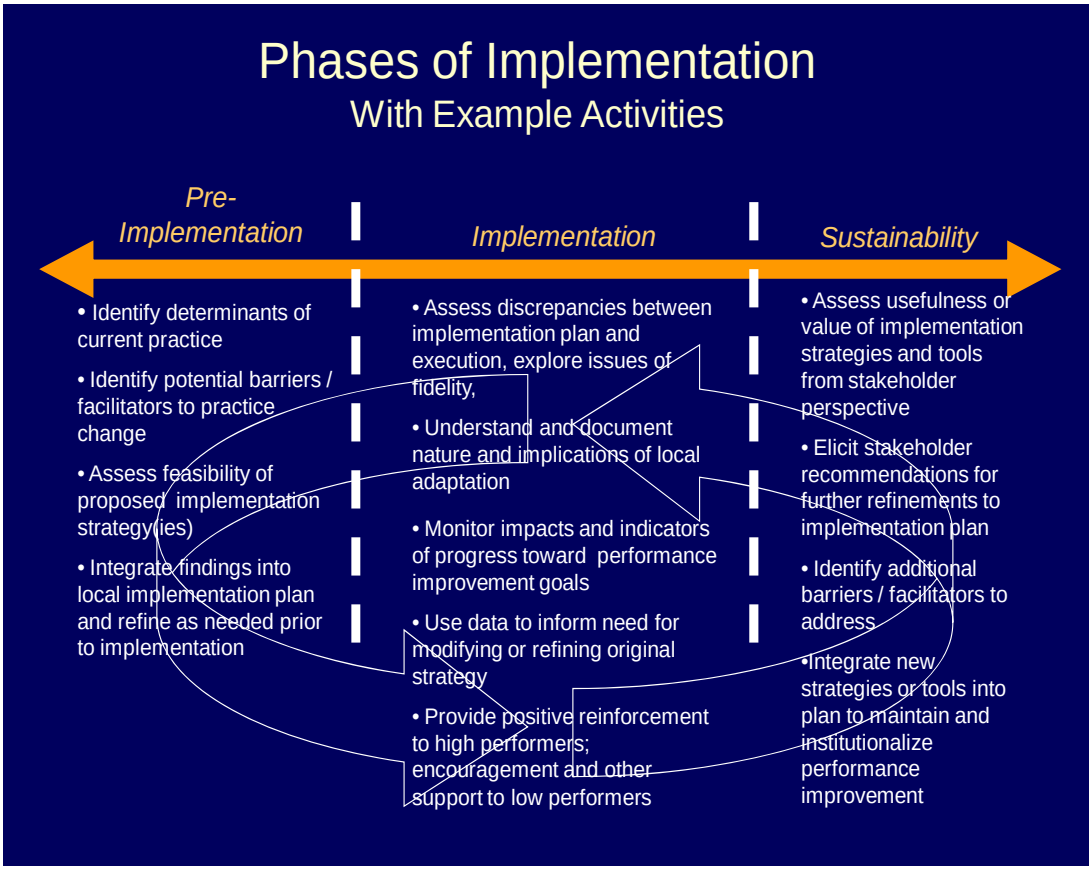
Implementing a new program or practice within clinical settings typically involves activities that occur over three phases—*pre-implementation*, *implementation*, and *sustainability* phases.

The ***pre-implementation phase*** is a time period for designing a customized, local plan for implementing a new program or practice involving activities that occur PRIOR to implementation.

The ***implementation phase*** is the time period during which the local implementation plan is actually executed, monitored and refined to meet the performance or clinical QI goals defined during the pre-implementation phase.

The ***sustainability phase*** focuses on activities and strategies to ensure that performance or clinical QI goals are achieved, and changes in clinical structure or processes that produced that improvement persist over time.

The figure below illustrates these phases and gives examples of related activities. Although the illustration depicts a somewhat linear relationship between the phases, it is actually more appropriate to view them as *dynamic* and *iterative* where one may cycle through the phases multiple times during the course of an implementation effort to achieve the desired change.



Adapted from: Stetler CB, Legro MW, Wallace CM, Bowman C, Guihan M, Hagedorn H et al. The role of formative evaluation in implementation research and the QUERI experience. Journal of General Internal Medicine 2006; 21(s2): S1-S8.

IV. Pre-Implementation Phase

Critical Knowledge Prior to Implementation:

Prior to engaging with a clinical site, as a facilitator, you should be well versed in the documents that support the program or practice that is being implemented as well as implementation strategies and interventions.

- First, VHA has a clear mental health strategic and operating plan in the Uniform Mental Health Services Handbook (VHA Handbook 1160.01) and the FY11-13 Mental Health Initiative Operating Plan. Understanding the requirements that relate to the specific program being implemented provides the framework within which the implementation process should reside. This should be combined with any existing or planned national, regional or local practice measures, or related or interdependent programs that may interface with the target implementation program.

- Second, you should have thorough knowledge of the evidence that supports the practice. This evidence should not be limited to traditional research findings such as randomized controlled trials or effectiveness studies, but should also include any information on budget impact of the program (costs), if applicable, patient testimonials, provider experiences, and the impact of implementing the program in other settings similar to the site.

- Finally, you should have a basic understanding of implementation science and knowledge of facilitation activities and processes.

Facilitators need to apply a slightly varying set of activities by site. First, individual site's needs and their readiness to adopt a particular innovation are likely to differ. In addition, individuals who help implement practices and services at the site level will occupy varying positions in their respective organizations and have different relationships with their colleagues, supervisors, and facilities… meaning they will have differing spheres of influence within the organization. To adapt to each facility's particular circumstances, you will select from a broad range of activities (described below) based upon an assessment of each site's needs, preferences, barriers, facilitators, and resources.

V. Stakeholder Engagement

A. How to Identify Stakeholders

As a facilitator you will need to identify potential key stakeholders whom the program will affect. The EF may help the IF to identify critical roles and positions typically held by key stakeholders, but the IF will need to identify the local individuals including:

1. Leadership at the network, facility, service, community-based outpatient clinic (CBOC) or other organizational levels who are involved in decision making about the program. You may want to start with the Network director, Network chief medical officer (CMO), medical center directors, associate directors, executive nurses, chiefs of staff, and chiefs of services (relevant to the change). Leaders' understanding of the value of the practice/program to be implemented and the role of the facilitators will lay the foundation for future efforts. For example, if network-level leaders understand and support efforts, then they can provide an introduction to medical center leadership. You may want to consider an initial meeting with the medical center leadership before engaging other stakeholders at the site. Leadership at every level can help pave the way for success. They are the ones who are ultimately responsible for the organization. Thus, ensuring that they will be informed and supportive of the implementation effort is essential.

2. The "doers" can help identify process steps and potential problems. For example, you should involve front-line clinicians, nursing, clerical staff, administrators, social workers, and other allied staff, as applicable. Those with information technology (IT) specialties or other consultants also can be helpful to the program's success. Everyone who will play a part in the program should be identified as a stakeholder.

3. Other stakeholders.

    - Ask (and keep asking) leaders and supervisors about who else needs to be involved in the process.

    - Review organizational charts (if available) or the organization's structure for helpful information.

    - Be aware of people who are "centers of influence" but do not have an official title. For example, during PC-MHI implementation, in one clinic everyone relied on the receptionist, an excellent communicator, who kept everyone moving in the right direction. She had been employed there for many years and was the "glue" that held everything together. It would have been a mistake to omit her as a stakeholder.

V. Stakeholder Engagement

B. How to Engage Stakeholders

Stakeholder engagement is the process of stimulating action or system change through the work of members of an organization; you will need to rely on these relationships throughout the change process.

There are many ways to engage stakeholders:

- Create an atmosphere that is open, non-critical and goal-oriented. Stakeholders need to feel comfortable talking about problems and obstacles with you. They need to feel that you are trustworthy and diplomatic, non-blaming, responsive and helpful to them. You need to convey that you are embarking on a journey with the stakeholders and will help them work through problem areas.

- When stakeholders bring problems and issues to you, you can:
  - Ask if they have any suggestions for resolving the problems or issues.
  - Give them examples of options and let them choose what will work for them. For example, rather than lecturing on a solution, you might say, "Here is what one site did to solve that problem. Do you think that would work for you?"
  - Engage them in brainstorming other possibilities and potential solutions.
  - Normalize problems and obstacles as part of the growing pains of change and say they are expected and "just part of the process."
  - Use positive reinforcement any time a stakeholder suggests a workable solution or moves toward the desired results. Positive reinforcement is much more effective than criticism. ENCOURAGE, DO NOT CRITICIZE.

Engage Leadership at All Phases of Implementation

Leadership engagement is an ongoing process that starts in the pre-implementation phase and continues throughout each phase of implementation including the sustainability phase.

- Once you begin to engage leaders, it is important to keep them updated on the progress, obstacles, relevant data, impact on the organization, and, particularly, any successes. Discuss and establish a reporting process with leaders; ask them if there are any regular cycles of updates to which you can attach reports. For example, some leaders may want monthly reports; others may want quarterly reports.

- Invite leaders to any special events or meetings to lend their support.

- Leaders can be instrumental in helping you overcome obstacles. When you point out obstacles, refrain from assigning blame. When enlisting leaders' help, rather than taking a negative approach, you can ask leaders to help convey the information in a non-critical manner. For example, if the objective is to improve patient

education in a clinic, you might ask leaders to convey the idea that patients in the clinic should have the necessary tools to make informed decisions about their care. Leaders can ask for suggestions to improve patient education. This empowers staff members to resolve the issues without feeling criticized.

Tailor Presentations to the Type of Stakeholder You are Trying to Engage

- To engage leadership, ensure that leadership understands your role and position, make presentations that are more formal and brief, and provide an executive summary. Link or connect the presentations to any executive career field initiatives, performance measures, strategic plans or VHA core values. Include some brief background information, scientific evidence, and data and create the vision of what the program will accomplish. Ask leadership what types of information they would like to see and what information would best meet their needs (e.g., types of patients seen, performance measures, outcomes, etc.).

- To engage stakeholders who are "doers," make presentations that are more detailed and include more process information.

- Allow time for all stakeholders to ask questions or clarify information.

Roll with Resistance

- In the beginning phases of implementing something new, some stakeholders may express skepticism, negativity or resistance. This is quite normal.

- Generally, you can deal with it by offering additional education, reviewing the evidence, coaching, and providing examples of how it might work. Negative stakeholders will often say things like, "That will never work here."

- You will need to spend time understanding why they feel it will not work, answering their questions, and helping them to develop a realistic vision of the desired outcome (i.e., improvement… not perfection).

- It is not unusual for stakeholders with initial skepticism or even those who set up initial obstacles to become some of the strongest supporters. Sometimes leaders may appear to be negative stakeholders but may be responding to other pressures within the organization and may need to work them out. Give everyone an opportunity to shine and when positive movement occurs,

It is not unusual for stakeholders with initial skepticism or even those who set up initial obstacles to become some of the strongest supporters.

however slight, reward it and highlight it profusely. Some stakeholders will remain elusive. Continue to invite their input, involvement, and support. They may be focused on other areas, but keep them informed and do not give up on them. These stakeholders might be quite helpful when they are able to participate.

C. Levels of Stakeholder Engagement

There are several levels of stakeholder engagement:

1. ***Active Engagement:*** Stakeholders take an active part in the change process (i.e., participate in or lead meetings, set goals, help resolve problems or overcome obstacles, and set expectations for change in supervision of others). They incorporate the change process or program in their day-to-day functions. They perform the work of the process to achieve the desired outcome.

2. ***Semi-Active Engagement:*** Stakeholders value the desired outcome of the change process and publically express their support. They may include progress updates in their meetings, ask relevant questions or help lay the groundwork for change. They may not incorporate the change process or program in their daily functions but will take some actions to enhance the desired outcomes.

3. ***Passive Engagement:*** Stakeholders want to proceed with the change process but are not likely to take any action themselves. They will not interfere with the change process but may take little or no action to encourage or enhance it.

4. ***Non-Engagement:*** Stakeholders are not involved at any level in the change process.

5. ***Negative Engagement:*** Stakeholders take an active or semi-active role in working against the change process. They may appear to support it but work against it or actively express their objections about it. (See Special Issues section below.)

Almost every stakeholder begins at the non-engagement level. You will need to work to move key stakeholders into active, semi-active or passive engagement. High-level leaders may be at the passive or semi-active engagement level but render sufficient support at the appropriate times to help facilitate the growth and development of the program. Some stakeholders, including leaders, will remain at the non-engagement level, which makes your task much more difficult. If leaders are not engaged, then engaging them needs to become your primary objective so the implementation process can proceed.

D. Special Issues in Engaging Stakeholders

1. Identify and address negative stakeholders

Recognize negative stakeholders. Do not confuse negative engagement with initial resistance (see description above). A true negative stakeholder works in a strategic manner to block progress and may be operating with another agenda or view the program as interfering with other goals or objectives. Negative stakeholders may not be immediately identifiable and may appear to be supportive or say little in meetings. They may withhold information, resources, and tools or influence the process negatively. It is important to acknowledge that negative stakeholders aren't *necessarily* project saboteurs, but may have competing preferences or priorities for implementation resources or may have genuine, legitimate concerns about the innovation targeted for implementation and its limitations. Listen to those concerns and address them accordingly, trying to win them over to support (or at least not work against) implementation of the targeted program/practice. It is often helpful to watch body language as well as listen to what is (and is not) said during meetings. The EF and IF working together often will be able to identify potential negative stakeholders. Most of the time, you can expect one negative stakeholder in every implementation effort.

Address negative stakeholders as soon as you identify them. Do not wait and hope that they will change.

- Deal with any negativity in meetings in a direct but positive manner. It often helps to use humor.
- Do not allow them to dominate meetings or conversations but address any underlying concerns and move forward. Sometimes you can say, "Let's talk more about your concerns later."
- Have a "heart-to-heart discussion" with them; it may help address and neutralize their concerns.
- Work to move negative stakeholders into non-engagers or passive engagers.
- Seek guidance from others; many times organizations already know their negative stakeholders and how to work around them.

2. Deal with stakeholder turnover

Stakeholder turnover is inevitable. This will often be a source of frustration for you because just when someone is an active stakeholder and is functioning well in the process, there is a change! There are a number of ways you can deal with this issue:

- As the program grows, anticipate stakeholder turnover and identify more than one person to fill a role. Encourage cross-training of local staff on skills, tasks and activities relevant to program implementation.

- Prepare to meet with new stakeholders again and again, particularly when they hold leadership positions.

- Better yet, ensure that the organization has a process in place to provide an orientation for new stakeholders about the program or practice. When it becomes institutionalized and part of the training process for new people, you will know you have done your job well.

- Prepare materials to train new staff at every level. For example, the site should include this information in orientations for nurses, other new employees, and residents.

- Prepare materials for ready access on web pages and SharePoint sites.

- Identify staff members who can conduct local training and formalize this process throughout the organization.

VI. Site Assessment

A. Conduct a Preliminary Site Assessment

Get to know some basic information about a site, even before visiting; this is an important first step. This preliminary "homework" about the site will help you prepare for the visit and the fact that you did some preparation to get to know the site will provide credibility with staff. As part of your preliminary work, in addition to asking questions, review both inter- and intra-net web sites that offer a "snapshot" of the site. For example, look for information on VISN and facility web sites, the VHA Support Service Center (VSSC) web site, and any other websites containing program-specific data.

Assess the Site
Clinic Characteristics

- *CBOC/VAMC*
- *Size*
- *Setting*
- *Academic Affiliation*
- *Patient Population*
- *Organizational Structure*

Gather information about the clinic:

- Know the type of clinic: Community-based Outpatient Clinic (CBOC) vs. Veterans Administration Medical Center (VAMC) clinic.

- Determine the number of unique Veterans who obtain services at the location by identifying the number of unique patients and encounters over the past fiscal year.

- Gather some information about the community and any special considerations that may affect success. For example, if a facility or CBOC is located in a community with high unemployment, homelessness or crime, these factors may be relevant to the program's success. When General Motors closed an automobile manufacturing plant in one community, it economically devastated that community and the surrounding area. The very high unemployment rate had a domino effect on businesses. It increased the number of Veterans seeking services at small CBOCs. At another CBOC, a large influx of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans after the end of a large deployment of National Guard members raised the number of Veterans seeking care for mental health issues.

- Find out if it is a teaching facility and if the staff members have academic affiliations, have conducted relevant research or have published articles. For example, in one project a key leader at a participating facility had written a number of journal articles that took an alternative view to the focus of the project.

VI. Site Assessment

Learn about the population:

- Gather demographic information about the population that the practice/program will serve: ages, urban vs. rural populations, proportion of homeless population, male-to-female ratio, proportion of OEF/OIF Veterans, the proportion of Veterans seen at CBOCs and relevant socio-economic factors that affect the Veteran population and the staff. This information can be obtained from clinical data sources such as VISTA or a Data Warehouse as well as network- and site-level leadership. You will need to learn about some of the challenges in providing services to meet their populations' "needs." For example, proposed services that require telephone land lines when the Veteran population includes a large proportion of homeless Veterans will have obstacles to consider.

- It is important that you also gather diagnostic information about the population that the practice/program will serve. For example, in implementing a depression care management program, it would be critical to know the number of individuals who have depression and are receiving care at the location. This information should include special populations served.

Learn about the organization:

- Staffing and names of key staff members (and the correct spelling of names)

- Leaders (formal and informal), correct spelling of their names and information about leadership

- Organizational structure and relevant measures of organizational performance, e.g., patient satisfaction scores and relevant performance measures

When gathering information on a number of sites, there are several ways you can document the information so that it is readily available:

- You may want to summarize data for each site in a one-page document for easy reference. This reference document might contain demographic information on the Veteran population, staffing levels, names of key staff members, phone numbers, directions to the site, and any other notes, questions or special issues that need to be addressed. Keeping this document in a folder and updating information will be useful in the future.

- One way to maintain information is to keep an Excel workbook with different tabs for different types of information. This will allow efficient updating, use of

Document what you learn about sites so that it is readily available (e.g., in a one-page summary or an Excel workbook).

other spreadsheet features (e.g., graphs, comparative tools) and ability to print only the information needed (Please see Example #1: Clinic Summary Excel Workbook in Appendix B).

B. Additional Considerations as You Continue the Assessment Process

1. Learn the value system of the organization and get staff input; this is critical! This is how you will know what data to collect and present. How the organization collects and uses data for evaluation or performance monitoring may reflect some of the viewpoints of leadership. For example, one facility director was very concerned about patient satisfaction rates. Stressing how the program will impact patient satisfaction can be a most effective strategy for engaging and gaining the support of leaders for whom this is important. One facility might be very impressed with data on graphs and charts, and another might be much less impressed and want to hear more about quality and the Veteran experience.

2. Be observant for stakeholders who appear to support the program but may actually have another agenda. Sometimes, things that are not said are as important as things that are said in a meeting. Who is the "power person" at a meeting? Who is not saying anything? Who appears to agree but then takes an action that may not be supportive? This is all quite normal and expected in the change process. You must remain positive and address any negatives immediately.

3. Assessment is an on-going process without an end. At first, the information you collect will be just a snapshot. You will continue to learn more details about the organization as the process continues. As you learn more about the organization and its people, you will discover their specific challenges, strengths, and goals. Additionally, changes in staff and leadership, shifting and competing priorities, and budget constraints require attention, and you will need to assess their effects on implementation.

C. Obtaining Administrative Data

Data can be a powerful tool. Learn how to access and use data (See “XV. Monitoring and Improving the Program,” page 55)

1. **Barriers to obtaining data:**

   - You may have difficulty getting permission to access data because some leaders and managers can be suspicious about your wanting to obtain "their data." They may feel that you will try to use data to criticize them. Sometimes you have to work on building trust before you can obtain the data you need. It may be helpful if you make an explicit statement about the fact that you are interested in understanding

the specific site for program implementation and quality improvement and not for evaluative purposes.

- Availability of data may vary from VAMC to VAMC and from VISN to VISN. Some VISNs have consolidated data ('data warehouses') that are more readily available than others. In one VISN, there was no consolidation of data, and each facility maintained data in its own manner. Of course, some data is collected nationally and is theoretically "available" if you have the capacity to access it. Some data can be obtained from VISTA.

2. How to get data:

- Gaining access involves finding the right people who can provide the needed data. Developing relationships with administrative officers and clinical application coordinators is critical. Ideally, they can either provide access to the data or the tools to gain access.

- It might be helpful if you establish regularly-scheduled reports (on a weekly or monthly basis, for example) for which you can "pull" the needed data and then provide data to stakeholders. (See Example 2: Sample Program Reports in Appendix B.) At some sites, these reports can be automated. (See Example 3: Instructions for Obtaining Unique and Encounter Data in Appendix B.) At other sites, you will need to rely upon staff to run these reports. Some facilities have staff who can write programs to get the needed data and at other sites this is more difficult.

- You will need to find out about the site's resources and utilize them. This information can be obtained during your site visit or during your early discussions with VISN and site level leadership.

3. Verify the accuracy of data that you obtain. "The devil is in the details!"

- Review the reports and question any data that appear to be inaccurate. You will often find systemic problems, such as staff not using the appropriate clinic stop codes, when questioning data.

- Make sure the data are collected in the same manner and are actually measuring the desired data (see below). One clinic that does not have the appropriate stop code attached to it can skew the data.

- Ask clinic staff to review their data to make sure they appear accurate to them. Encourage their feedback and listen carefully to the information they provide. A comment such as, "I know I had more phone calls than that this month," may indicate a problem that needs to be resolved.

- If you find a problem, you might do spot checks or chart reviews to determine what is happening. Although this is time consuming, it is helpful to do this in a limited manner. Sometimes flow-mapping the steps is helpful in resolving a problem. Flow mapping involves identifying all of the steps in the process, listing them in a sequential order, and then diagramming the process creating a visual depiction of the process. This may be used to trace a patient's process through a clinic from the time of check-in to check-out. This provides an illustration of the process (or clinic flow) from start to finish.

VII. Facilitating Program Implementation Meetings

Program implementation should use a theoretically-driven, purposeful, and well-constructed implementation plan. All too frequently, programs are developed and staff is hired with very little planning or time given to program implementation.

Implementation scientists have repeatedly demonstrated that top-down initiatives, even when supplemented with academic detailing and training, are alone often not sufficient to implement sustained clinical practice change.

Implementation scientists have repeatedly demonstrated that top down initiatives, even when supplemented with academic detailing and training, are alone often not sufficient to implement sustained clinical practice change.[12-15] This is particularly true when implementing complex programs that require engagement and support from multiple care specialties and changes in provider attitudes, organizational structures, and clinical processes.[1]

As part of the implementation plan, it is important to engage top-level VISN and facility leaders from all applicable departments. As part of a parallel process, it is important to engage departmental and clinic-level leadership and front-line staff. One promising method of implementation involves formal program implementation meetings with all clinic staff and reviewing a program implementation checklist.[16, 17]

Thus, one critical function of the facilitation team is facilitating program implementation meetings. Within an overarching framework and set of guidelines, you have a lot of flexibility, and each meeting should be tailored to the needs and culture of the site. Creating a forum to facilitate discussion and overall communication among multiple stakeholders, at times, may be more critical than the specific content. Realistically, this may be the first time that all of the invested stakeholders have come together to discuss the program. Creating a forum, to host an on-going dialogue among all stakeholders, is one of the most important roles of facilitation.

A. Organizing and Scheduling the Meetings: The Logistics

It is easy for the IF to underestimate the amount of time that it will take to schedule, organize, and prepare for program implementation meetings. Surprisingly, this can be one of the most frustrating and time-consuming processes.

1. **Check for a VISN or facility policy for visiting the site**. If there is a policy, follow those guidelines. For example, one VISN policy requires a letter of notification that explains the purpose of the visit and identifies individuals who will be conducting it at least 30 days before the date of the visit.

2. **Identify and develop relationships with people who can help.** The IF will organize and schedule many of the meetings. However, there will be times when the IF is not located at the clinic where a program is being implemented and will not have knowledge of the clinic layout and meeting spaces.

- First, an identified local champion who is stationed at the location can serve as a primary contact. Identify critical contacts, (i.e., individuals who can problem solve, can describe the clinic layout, and are familiar with the set-up of meeting locations and conference rooms). Ideally, they can provide insider information. For example, some locations may require a specific amount of lead time (e.g., 60 days' notice) to allow clinicians to have their schedules blocked. Perhaps, the clinic has a regularly-scheduled provider meeting when the program implementation meeting could occur. On the other hand, this might be a bad time to hold the implementation meeting at other clinics. These contacts can help facilitators navigate through these complicated nuances that vary from location to location.

- Second, establish rapport and build a relationship with the clinical manager and the lead administrative officer. If at all possible, the IF starts to engage these individuals and build these relationships prior to scheduling initial meetings. Facilitators are more likely to have support and assistance from individuals with whom they already have a working relationship. The clinic staff members need to understand the facilitator's role and purpose of the visit. If this relationship is already established, the process of scheduling will be much smoother.

- Ask contacts about the best people to approach to complete specific tasks.

3. **Make the meeting arrangements.**

- Consider creating a pre-meeting checklist to ensure that everything is arranged and brought (See Example 4: Sample Pre-Meeting Checklist in Appendix B).

- Determine which tasks you will complete to decrease as much additional work for clinic staff as possible. For example, the facilitator may be the one who sets up VANTS conferencing lines.

- Work with contacts to comply with local norms and avoid accidently stepping on someone's toes. Ask who typically blocks provider clinic schedules to ensure their availability for the meeting. Also ask who has the ability and knowledge to schedule conference rooms and reserve video or conferencing technologies.

- Create a master guest list that contains those who have indicated they will attend and their phone numbers.

- Despite best efforts, things often do not go according to plan. Expect the unexpected. Be flexible and prepared to problem-solve. You may get to a location and a key stakeholder or leader has called in sick, the power has been knocked out by a storm, the clinic has a fire code called during the meeting, no one can find the speaker phone after repeated assurances that it would be available or Joint Commission arrives unannounced. These things happen. Be prepared to roll with the punches and problem solve on your feet.

> ***You may get to a location and a key stakeholder has called in sick, the power has been knocked out, the clinic has a fire code called during the meeting, no one can find the speaker phone or Joint Commission arrives unannounced.***

B. Program Implementation Meetings

Once meeting details have been finalized and all logistics appear to be falling into place, a new facilitator may be wondering what happens next. How does one facilitate a meeting? What is the role of the facilitator and what specific tasks should be completed? As part of the program implementation process, facilitators will conduct multiple meetings. Ideally, the first program implementation visit will consist of a series of meetings. Each meeting will have a different purpose, which will determine the specific individuals who should attend and dictate the focus and the content of the meeting. It is critical to have the correct stakeholders at the right meetings.

As noted above, prior to engaging the site, it is important to have VISN-level leadership support. Although they might not attend the implementation meetings, it is important to have discussed the program with VISN leaders, addressed their concerns, and understood their vision for the fully implemented program. When you are scheduling site visit meetings with individual VAMCs, you should inform the VISN-level leader when these meetings will occur.

1. The First Program Implementation Site Visit

Program implementation is a multi-faceted process involving a series of stakeholder meetings with various purposes. The following provides an example of how an initial series of program implementation meetings might be conducted. This is an example that has worked well in multiple locations, but facilitators will need to adapt it to meet their specific needs. (See page 33.)

- ***Entrance briefing: (Overview with leadership and stakeholders)***
  - Ideally, this meeting will be the first in a series and include the facility leadership, often known as the "Quad", which includes the Medical Center Director, the Associate Medical Center Director, the Chief of Staff, the Associate Director for Patient/Nursing Services, and any other staff required by the Quadrad. Also

invite care line or specific service leaders and program managers to this meeting. For example, if implementing a PC-MHI program, leaders from both primary care and mental health should attend. Different facilities will have different administrative and leadership structures, and the titles and distinct roles of those who should be involved in this meeting will vary from location to location. Consider inviting facility leaders who should be aware of the program, but may not be involved in day-to-day functioning, such as the Suicide Prevention Coordinator or the OEF/OIF program manager. It is better to err on the side of casting too wide a net, than not to invite the people who should be at the table.

- The main purpose of this meeting is to engage leaders, provide them with information about the program, establish support for the program, and convey to all stakeholders that leaders are invested in this process and program implementation. This meeting should be relatively brief. Approximately 30 minutes may be sufficient. These individuals have busy schedules and part of engaging them is being respectful of their time limitations. This meeting may be the most formal. Consider creating a formal professional presentation, briefly describing the program requirements, the evidence base, and any known outcome data describing how having this particular program, when successfully implemented, may positively influence clinical care in areas of concerns to top leadership. These may include program impact on performance measures, improvement in patient health outcomes and satisfaction rates, provider satisfaction, and cost. Throughout the visit, you will be gathering information about the site. It is important that you listen to the perspectives of multiple stakeholders. Throughout the day, you may want to take notes structured by identified strengths, weakness, opportunities, and threats that emerge throughout the visit. This will prepare you to conduct the exit briefing and provide early feedback to the site.

- If a CBOC is the primary location for program implementation, engage leadership at the primary supporting VAMC. In this situation, the initial entrance briefing may take place at the parent facility with all the other meetings occurring at the clinic location.

- ***Program implementation meeting***

  - After the entrance briefing, have a meeting that focuses on reviewing the program requirements in greater detail and designing an implementation strategy that considers local needs, preferences and resources. Thus, key individuals who should be present include the stakeholders who will be involved in the direct day-to-day operations of the program (i.e., front-line clinicians) and the leaders who will directly oversee the program and the implementation process. Sometimes other stakeholders will be interested and seek inclusion at this meeting.

- This meeting should begin with another review of the program requirements, the evidence base for the program, why the VHA is implementing the program, and how the program, when well implemented, can positively influence patient care, patient satisfaction, and provider satisfaction. Typically, you need to present this information in a less formal way, which often takes the form of a discussion. The information delivered should be tailored and concise, depending on the stakeholders present and whether they also attended the entrance briefing.

- If possible, provide a program implementation checklist for the specific program elements being implemented to structure the remainder of the meeting. (See "Program Design" section and Appendix B, Example 5: Sample Implementation Checklist originally described in Fortney and colleagues [2009][16, 17] and Kirchner et al. [2010],[17] as developed for PC-MHI program implementation.) The checklist should include all the program elements required by the Uniform Mental Health Services Handbook. It also allows for variation to meet specific site-level needs. All clinicians review the checklist and, through group discussion, reach consensus for the establishment of the required elements. Document their decisions and any required actions on the checklist and then translate this checklist into a site action plan for program implementation.

- ***Tour clinics***

  Both the EF and IF should tour the clinic space along with program staff for feedback. The physical and geographical location influences provider and patient interactions and team functioning and provides valuable information about clinic flow and current space allocation.

- ***Individual Meetings***

  The facilitation team (i.e., the EF and the IF working together) may opt for a series of individual meetings with various stakeholders. This can occur at any point in the facilitation process and may or may not occur the same day as the larger implementation meetings. The purpose of these meetings will vary as will the specific individuals with whom the facilitation team needs to meet. At times, the purpose may be to further engage stakeholders or to provide more information. At other times, it may be to establish a partnership with a negative stakeholder. The facilitation team may request a meeting to discuss program implementation concerns with only the direct program manager. At this meeting, the objective may be to provide and discuss data about program utilization. You may help the individual problem solve through barriers that may be inappropriate for discussion within a larger group. Perhaps, you will want to have individual meetings with front-line staff to get their perceptions without the presence of supervisors.

VII. Facilitating Program Implementation Meetings

- ***Exit briefing***

  The exit briefing is just as important as the entrance briefing. The primary audience for this meeting is top-level leadership. Ideally, the members of the Quadrad and the direct program leadership attend. Additional stakeholders can be present, but it is not necessary. This meeting also should be brief, ideally less than 30 minutes. The goal is to provide a summative overview of all the information gathered. Briefly re-state the goals of the program and describe the current status of implementation at the location and the necessary changes for successful program implementation. Provide information about identified strengths, weakness, opportunities, and threats that emerged throughout the site visit. Describe the initial plan to proceed with program implementation. This information will be followed-up with a written report (See Appendix B for Example #6: Sample Site Visit Report), which includes an action plan.

- ***Sample Agenda for One-Day Site Visit***

TIME	EVENT	ROOM
9:00-9:30	Entrance Briefing (Leadership)	M204
9:30-11:00	Program Implementation Meeting with Managers, Staff, and stakeholders	M204
11:00-11:30	Tour Facilities and Clinics	M204
11:30-1:00	Lunch and afternoon prep	M204
1:00-3:00	Individual meetings (Other Stakeholders; e.g.,)	M204
3:30	Exit Briefing	

- ***The after meeting***

  At times, conversations may continue after the official meeting has ended. A few stakeholders may feel more comfortable continuing the conversation with the facilitators in a less formal situation. When this occurs, the facilitation team should be prepared to answer questions and provide additional information. However, facilitators should make no decisions based on informal conversation. The facilitation team may learn valuable information that previously may have been unspoken. When conducting site visits, be flexible and adaptive to allow for these impromptu conversations.

- ***After the meeting***

  The specific decisions and any required actions are documented on the checklist. The checklist is then translated into a site visit report and action plan for program implementation. This plan will directly reflect not only the specific steps, but also the specific information provided to leadership at the exit interview, including identified strengths, weaknesses, opportunities, and threats. The documentation should include specific time frames, if determined, and assignments. Provide this report to leadership and widely circulate it to all stakeholders who were invited to attend the initial meetings. Ask for input, additions, and modifications from all who were present, prior to finalizing the site report. Incorporate this information into the report and re-send it to all stakeholders. The next step of the facilitation process will be to ensure implementation of the action plan.

2. **Follow-up program implementation meetings**

   The initial action plan should be monitored and revised as necessary throughout the implementation process. The EF and IF should review the action plan during their bi-weekly meetings and follow-up with specific stakeholders to ensure that the initial items are being addressed. The time frame for follow-up will vary based on site needs and stakeholders' preferences. In fact, it may take several meetings to work through an implementation checklist and establish an action plan. Thus, flexibility is needed in determining the exact timing for follow-up meetings. Ideally, all stakeholders should review, update and revise the plan as needed at formal meetings at approximately eight to ten months and again two years after initial development. If problems are identified, additional stakeholder meetings should be scheduled.

C. How to Facilitate Meetings

Although the specific techniques and skills used for meeting facilitation will vary, a few general principles should be used as a guide through the process.

1. **Know the audience.**
   Use different techniques and presentation styles depending on the stakeholder group. If possible, you should be informed about the culture of the clinic. Are the individuals more likely to be impressed by a formal didactic PowerPoint presentation or will they find formalities off-putting and prefer a more low-key discussion with handouts?

2. **Know the purpose and the goals of the meeting.**
   The specific techniques and strategies you should use in a meeting will depend on the purpose of the meeting and the objectives to be accomplished. Be flexible and prepared to adjust based on issues brought up in the meeting. Sometimes the group may not be ready to discuss your agenda. In those instances, you may need to back up and provide

more education and/or allow alternative points of view to be expressed. A follow-up meeting to address important agenda items may be necessary.

3. **Provide information.**
   Providing information is often the best way to start the meetings. The specific content, details, and extent of information will vary depending on the purpose of the meeting and the stakeholders present. Typically, provide information about the specific program requirements, the evidence base, local site characteristics, and your role (and boundaries of your role) as an external or internal facilitator.

4. **Get stakeholder information.**
   As part of facilitation, always seek information from multiple stakeholders. At times, the facilitation team will need to ask for stakeholders' perceptions about what is going well with the program, what areas need improvement, and where change is needed.

5. **Create an environment conducive to open discussion.**
   Elicit input from the group frequently. Ask for their opinions and insure you are incorporating them into the program design and adaptation.

6. **Provide structure for the meeting.**
   Prepare an agenda for the meeting and provide documentation after the meeting that describes the action plan. (See Appendix B for Example 6: Sample Site Visit Report.)

7. **Re-focus the group when needed.**
   Group discussions can at times diverge from issues related to the program. When this happens, acknowledge it and suggest to the group that, due to time constraints, you want to re-focus the discussion on the program and its implementation.

8. **Pay attention to verbal and nonverbal information.**

9. **Listen and reflect.**
   When someone makes a comment that is particularly salient, you may want to repeat it back, perhaps rephrasing it. This will communicate that you heard the comment and thought it was important. By re-stating it, you will also emphasize this point to the larger group.

10. **Ensure that all stakeholders are heard during the meeting.**
    Listen to all stakeholders at the table, ensuring that everyone has a chance to be heard, and repeat key points so that all stakeholders understand the various perspectives. Then guide the process for reaching consensus. Just like any consensus-building effort, this may involve some negotiation. Make it explicitly clear that the program will be monitored and revised as needed. Remind stakeholders that implementation is a "process," not an "event." Thus, the program can continue to be revised and improved as needed to meet organizational goals.

11. **Correct any misinformation.**

12. **Guide the group to establish an implementation plan that meets VHA requirements while considering local needs.**
    Facilitators serve as experts in program requirements and have extensive knowledge of how similar locations have successfully implemented programs. However, do not dictate to stakeholders how the program will be implemented at their site. Provide important parameters, program requirements, and information about the evidence base, but let the stakeholders decide about the day-to-day program operations.

13. **What to do when stakeholders disagree**
    Stakeholders will disagree at times. Many techniques can be used when stakeholders are deadlocked on an issue. First, review the program requirements with the group and ensure that the plan under discussion is within the scope of those requirements. Second, review the evidence base. Explain "what we know" about these programs and what is needed for optimal impact. At times, it may be helpful to gather additional local data to present to the group. You may want to invite a guest speaker who can describe how the program functions elsewhere. (See also “Identify and Address Negative Stakeholders” on page 21.)

VIII. Program Design

1. Create the Vision First

- In order to create a vision for the program, provide an orientation to it so that all stakeholders understand the required program components. Provide details from the Uniform Mental Health Services Handbook for the program being implemented. It is helpful to have examples of similar organizations that have successfully implemented programs, as well as examples of programs that have adapted the design within the confines of the evidence base and achieved the desired outcome. The EF and IF should provide a framework that guides the program design phase. At times examples will be readily available. However, at other times, it will be the responsibility of the facilitators to identify and locate this information.

- Ensure that stakeholders have a vision of the program's goals and an initial understanding of their role in accomplishing the major objectives. ***In particular, it is helpful to elicit leaders' vision for program implementation and provide them an opportunity to articulate that vision to their staff in program design meetings.*** For program design to succeed, all key stakeholders at the local level need to have a good understanding of the desired outcome.

- Clarify and resolve questions, concerns, and misconceptions that arise to create a shared vision, which optimally should fit the needs of the organization and align with core values of the VA, strategic plans, and goals of the organization and individual stakeholders. For example, if one of the organization's core values is Veteran satisfaction, the stakeholders should have an understanding of how the program will impact Veteran satisfaction.

- Everyone involved in program design must be motivated to make the changes. They need to see the benefits to their Veteran population, their organization, and the VHA. They must perceive that their efforts and contributions are valued particularly when working through obstacles and overcoming resistance to change. Their ability to articulate the value of the change and its benefits is vital.

Everyone involved in program design must be motivated to make the changes. They need to see benefits to their Veteran population, their organization, and the VHA.

2. Provide a Framework for Program Design

- Provide the tools to design a program that reflects the characteristics of the local organizational culture and meets national VHA requirements. Some of the tools include specific sections of the Uniform Mental Health Services Handbook describing program

details, relevant VACO, VISN or local policies, research articles (keep to a minimum), handbooks, checklists, fidelity measures, and other relevant resource materials.

- Make sure to have key stakeholders at the table for the program design process. At least one stakeholder from each discipline or staff position that will play a role in the program should have input into its design. This includes leadership, administration, providers of services, clerical staff, allied staff, sources of referrals, and consultative staff. Identify a local champion who will help guide and actively support the process through to completion.

- When leadership or key staff changes, review the design process to obtain buy-in for the program design by those in positions of power.

- Obtain or create an *Implementation Checklist*. (See Appendix B, Example 5: Sample Implementation Checklist.)

  - The checklist includes all required program elements, including for example, the target population, inclusion/exclusion criteria, team composition, activities, services, barriers to look for and guidance on how to resolve them, monitoring activities, protocols and tools (e.g., decision support system, assessment tools, and marketing and training materials).

  - The checklist allows stakeholders to think through each step of implementing the program, establish major decision points, identify who should take responsibility for each step, and detect any unresolved action items. The checklist guides the process of program design and leads stakeholders through key decision points in designing the implementation strategy.

  - The checklist also logs essential administrative steps such as establishing clinic names, forms, procedures, and outcomes that will be monitored.

  - The final document should contain the required elements of the program and describe the local process for meeting VHA requirements within the context of local resources, processes, and stakeholder needs.

  - Although implementation checklists have been developed for some programs, the EF may need to create an implementation checklist for the specific program. The structure and guiding principles will remain the same, but the details of the program requirements and specific options for local adaptations will vary. Ultimately, those who are experienced and knowledgeable about the program requirements should develop this checklist.

VIII. Program Design

3. Program Design Process

The program design process is not linear but is an ongoing, cyclic process that responds to changes within the organization and the external environment. It does not occur in a specific number of steps or a limited time frame but involves a process of initial program design, monitoring and obtaining feedback, and then re-designing to make needed updates or corrections. Key tasks include the following:

> ***The program design process is not linear but is an ongoing, cyclic process that responds to changes within the organization and the external environment.***

- Regularly review outcomes, fidelity measures, and checklists to ensure the program does not drift from the intended goals or program requirements. You can establish initial timelines and priorities to track progress and identify and address problems early. It is normal, and should be expected, for some degree of drift to occur. Plan to minimize this barrier by establishing review processes and timelines early in the process.

- Consult with local or VISN Six Sigma[vii] experts, those involved in Systems Re-design,[viii] quality improvement or performance improvement processes. You can flow-map[ix] the

---

[vii] *Six Sigma: Six sigma is a process-based approach to continuous improvement. It uses data and statistical analysis to find process problems that cause a process to be inconsistent. Whenever a process doesn't work as well or consistently as it should, a "defect" can occur. Six sigma is a rigorous and disciplined process that focuses on meeting customer needs. Six sigma methods follow five phases in the following order: Define the project/problem; Measure the factors aligned with the process; Analyze the process to find root causes; Improve the process by testing solutions; Control the process after evaluating the improvements. (See Appendix A 2. Glossary of Terms.)*

[viii] *Systems Redesign: Systems redesign is intended to embody the capacity for an organization to improve and meaningfully redesign the system. This means working smarter. It is the combination of enlightened leadership strategically driving change AND exceptional facilitator staff teaching, leading, facilitating, promoting, organizing, arranging, prodding, measuring and doing whatever it takes to engage the front line staff in productive meaningful improvement of systems that matter in improving care to our patients. Past systematic improvement efforts were sometimes staffed with one or two people and aligned inside of one department. The efforts may not have involved significant numbers of front line staff. VHA is passionate about changing this. Change means increasing our improvement capability in a way that is dramatically more effective than the past. (See Appendix A 2. Glossary of Terms.)*

[ix] *Flow mapping is a means to identify all the steps in a current process. Essentially, one looks at the process with "fresh eyes" by listing all the steps in the process, people involved in the process, and any bottlenecks or problem areas. When trying to implement a new process, it is helpful to flow-map the proposed process. This helps in staff training and testing out the process to make sure that it works as expected. Often, it takes several versions of re-working the process so that it becomes efficient and adopted by all the stakeholders. Getting input with each new revision helps to make it successful. In this process, one sees things in a new way that helps improve the implementation process. (See Appendix A 2. Glossary of Terms.)*

process, obtain data, and, when making a change to the process, continue to measure and re-measure outcomes to determine if the process is effective in achieving the desired results. (See "XIII. Collaboration" for more information, page 51).

- Guide, teach, coach, encourage, and problem solve. Local champions and key stakeholders must take responsibility for program design and the resulting activities, efforts, and outcomes. It is not unusual for participants to start the process with enthusiasm but over time express skepticism or outright negativity. Anticipate these reactions as a normal part of the process. Also, tell stakeholders that challenges are likely to occur… they are to be expected. Remain positive, listen to concerns, and suggest possible solutions. Encourage and recognize stakeholders' positive actions. Remain available for consultation when difficulties arise and stay in regular contact with key stakeholders.

- Help identify barriers, obstacles or gaps in resources to program implementation at the beginning of the process and involve key stakeholders in brainstorming solutions. Your perspective or view from a distance will be useful to those within the organization. For example, resources may be reallocated or reorganized (as feasible) in a manner that changes availability and eliminates the gap.

- Understand the local organizational culture and encourage creativity. Generally, there are multiple solutions or pathways to a desired outcome. Help participants generate options to resolve identified barriers or problems and partner with them in selecting the most promising solutions.

IX. Program Adaptation

When implementing new programs, you and the stakeholders should use creativity to work out the implementation details to make the program come alive. Rarely, if ever, will the same resources be available at every site or will stakeholders adopt the model in exactly the same manner. As long as everyone adheres to basic guidelines or fidelity criteria, innovation and creativity should be encouraged. "One size does *not* fit all."

A. What Might Need to Be Adapted?

- *Program adaptation means using the staff and resources available to produce the desired outcome.* Often, new program models will recommend "ideal" staffing levels, resources needed, and guidelines for program elements. Typically, ideal situations do not exist. Sometimes it is possible to hire the staff, but for some this is a luxury. To use a sports metaphor, "you have to play the game with the team you have". You may not have the depth of talent you really want or need to win, but you have to work with what you have. If you are weak in one area, use the strength in another to compensate.

- Sometimes the unique characteristics of a facility will drive program adaptation. For example, large urban areas may have problems of homelessness, substance abuse, and poverty. Program adaptation may mean making some changes to the model to adapt to the needs of a population. For example, a program that involves telephone-based interventions may not be able to reach homeless Veterans who do not have phones. These Veterans may need more outreach activities or pre-paid telephone cards to make phone calls. In implementing PC-MHI interventions, we found that facilities with large geriatric populations needed to adapt the pace and type of interventions to the population served. What works well at one site may not work at all at another. For example, you may need to adapt services to reach rural populations through tele-health, phone, web sites, mail or other methods. You may need to extend services into remote areas to reach Veterans or address transportation problems. While specific clinic and population needs must be considered for successful program implementation and adaptations may be necessary, it is important to ensure fidelity to the evidence base that supports the practice or program.

B. Facilitating Adaptation Processes

- One useful exercise is to have someone play the role of a Veteran or family member and evaluate the process from their eyes. You may want to enlist the help of some Veterans to make the program more Veteran- and family-friendly. One facility that had a large Native American population did this quite successfully. All of the materials for the program were written with Native American values and concepts in mind. Adaption can make programs appealing to the local Veteran populations.

- Often, you and the local champions need to brainstorm together about potential options for adaptation. Some of the obstacles or problems will be in areas that need

program adaptation. For example, if space limitations are a problem, then walk through the area "with fresh eyes" to help identify potential options. It may mean using space a little differently and negotiating some compromises.

- A good time to discuss adaptation is while going through the Implementation Checklist (See "VIII. Program Design," page 37). The Implementation Checklist often outlines some of the options for program adaptation. For example, program exclusions, services offered, and the types of staff who deliver services may differ. Much of that can be outlined in the discussions of the Implementation Checklist. For example, if the program model recommends that a social worker complete a function, a nurse or psychologist might be able to perform the function instead. If a psychiatrist is recommended but not available, a nurse practitioner, resident or fellow might be able to perform some of the functions instead, provided the function falls within their scope of practice.

- Sometimes program adaptation will occur as a result of trial and error or pilot programs. Giving stakeholders permission to try something new or innovative for a pilot will often generate ideas for program adaptation. Getting people out of the "status quo" for a time frees them to think about new options. It is not unusual for a first attempt to fail, but then better ideas can be generated. For example, when space was a problem at one facility, a succession of options was tried. Input was obtained from stakeholders, and, finally, all agreed upon a solution. It would not have been possible to get all stakeholders to agree until the early options were tried and failed.

- Sometimes it is helpful to involve Six Sigma experts or those experienced at Lean Thinking to help with program adaptation. They can help figure out how to make the most of resources by using flow charts or spaghetti diagrams[x] to obtain desired results and eliminate or reduce unnecessary steps in processes.

[x] *Spaghetti diagram: a visual representation using a continuous flow line tracing the path of an item or activity through a process. The continuous flow line enables process teams to identify redundancies in the work flow and opportunities to expedite process flow. (See Appendix A 2. Glossary of Terms.)*

IX. Program Adaptation

C. Be Careful about "drift" from program Models

If too much adaptation occurs, stakeholders may unintentionally move away from the evidence-based models. It is useful to review fidelity criteria, the Implementation Checklist and/or program outcomes to determine if too much adaptation has occurred and how to get back to delivering what the model prescribes.

If too much adaption occurs, stakeholders may unintentionally move away from the evidence-based models.

D. Program Adaptation Never Ends

Review relevant data such as patient satisfaction on a regular basis. Measure and review implementation and, if available, patient outcomes. Services always will be in the process of improvement. Change is constant. There will always be staff turnover, budget constraints, and other challenges. The program needs to be flexible enough and sufficiently institutionalized to endure. Reading relevant research, visiting other sites with similar services, and attending conferences or other educational opportunities can give you new ideas for improvement.

X. Hiring, Training and Mentoring Staff

A. Hiring and Identifying Program Staff

Hiring, training, and mentoring program staff is a complex process that is critical to program sustainability. A few key principles will help ensure long-term program success by employing highly-competent and skilled personnel invested in the continued implementation and sustainability of the program. For many programs, it will not be necessary or possible to hire new staff. *However, you should be familiar with these principles and provide consultation to leadership as they identify and hire staff.* Unfortunately, high staff turnover tends to occur without careful selection and matching to program needs. This is costly for training and team functioning and can decrease reciprocal trust with other providers.

Overlooking important considerations during the hiring process, or rushing to fill a position quickly, may have a negative impact on the successful implementation of an effective program. Prior to identifying or hiring staff, administrators should have a clear understanding of the nature and expectations for successful program functioning. As a facilitator, there are additional resources that you can provide (e.g., documented skills needed for optimal program functioning) and tasks you can complete to help with this process:

1. Communicate the above recommendations to program managers and highlight the need to recruit an individual with skills that are well suited for the specific position.

2. Help administrators and program managers identify program needs, specific skill sets, and characteristics that will be critical for program success. For example, depending on the needs of the site, you may provide leadership with sample position descriptions, sample recruitment advertisements, interview questions, and performance plans being used at locations with successful programs. If none are available, assist program managers in developing such materials that are consistent with high functioning programs.

3. Tailor your involvement in the hiring process to the site.
   Depending on the site, and your relationship with leadership, you may be asked to have an active and substantial role in this process. At other locations, local leadership will prefer that your role be purely consultative. You may be asked to assist in the selection process by reviewing candidates and developing interview questions. Remember that you are a consultant informing the process and ultimately the leadership will make all decisions. Be prepared to provide information about the hiring practices at successful sites and to offer suggestions to supplement their current efforts. Offer to assist in the process, but recognize that some locations may only need or desire consultative support.

X. Hiring, Training and Mentoring Staff

B. New Provider Training

Although ideal, it is rare to find a provider who has been trained and worked in a similar program. Most will require training. The facility-level supervisor should have the responsibility to ensure that appropriate training occurs. However, as a facilitator, you may play a substantial role in the training process. Some general principles are highlighted below.

- New providers should be familiar with the setting and the practice expectations of the program. Reading core texts and research manuscripts as well as additional resources recommended by VA leadership will help them with this process.

- Training should be structured around attainment of the core competencies for the position.

- The supervisor, with your assistance, should ensure that adequate time for orientation and training is scheduled before the provider begins performing clinical services. Taking the time to construct an appropriate training process will increase the likelihood of program success and sustainability and decrease turnover by supporting provider confidence and satisfaction.

- Ideally, someone who is an expert and has experience training others to operate well within the model should conduct the training.

- If available, recommend attendance at relevant, skill-based training conferences and workshops. Evidence suggests that attendance at a one-to-three-day workshop, with continued follow-up telephone consultation calls, improves provider knowledge and skill acquisition to perform an intervention of brief cognitive-behavioral therapy (CBT) in primary care.[18]

- Other effective training techniques include implementation of action plans, performance assessments, and ongoing supervisory consultation.[19, 20]

- Shadowing current, successful providers and ongoing consultation from experts within the field is also recommended. [21, 22]

- In addition to supporting attendance at relevant workshops, leaders should be involved and encouraged to provide a supportive environment for successful training to occur. [20] You can play a substantial role in the training process.

  - You can facilitate formal training opportunities by either hosting a training event or providing an educational series.
  - You can provide training experiences if you are a content expert or offer presentations and training events hosted by external experts.

C. Mentoring

Mentoring new providers is an on-going process that occurs at regular intervals. To ensure an effective, well-functioning program, professional development should combine processes and mentoring available at the local, VISN, and national levels.

Typically, the local supervisor will have the most direct and meaningful authority and responsibility for front-line providers. Therefore, the process of ongoing mentoring and supervision at this level is a critical element for program effectiveness and sustainability. The administrative supervisor may be a local trainer, but this is not always the case. If the administrative supervisor does not have the expertise, time, or interest necessary to provide appropriate training, support, and supervision, identify a local trainer. At times, the IF may serve in this role. The IF may conduct ongoing training and mentoring via conference calls, video conferencing, and/or live meetings if the IF is not located on site.

XI. Academic Detailing

Academic detailing typically includes a review of the research and clinical evidence that supports the program implementation or practice change and is shared with key stakeholders. It is an educational service that can better align practices with the scientific evidence. One use of academic detailing is to highlight gaps between the evidence-based and actual practices and encourages uptake of clinical practice guidelines.

Typically, academic detailing involves interactions between providers and either the EF or IF. Academic detailing includes investigating the baseline knowledge and motivation for current practices and then provides clear behavioral objectives through the repetition of educational essential messages and the provision of positive feedback for improved clinical practices. Academic detailing, as part of either external or internal facilitation, frequently occurs during the initial interactions with the site. It is used to present the evidence and guidelines that support the program or practice. In our experience, academic detailing also may be used when presenting the program or practice to providers who may interact with the implementation effort.

XII. Marketing

Appropriate marketing can increase referrals to the new program or practice, as well as the likelihood of *appropriate* referrals.

A. Basic Elements of Marketing Strategies

1. Know the audience and understand what information is most likely to capture attention and maintain interest in the program. One simple technique, which is often overlooked, is to directly discuss the program with stakeholders through formal or informal interactions. Part of understanding the audience is to know what kind of methodologies to use for communication and marketing. For example, busy health care providers quickly become frustrated when asked to sit through lengthy presentations or complete long surveys. For them, use brief discussions or one-page questionnaires.

2. Decide whether the approach to marketing will be direct, indirect, or a combination of both. A direct approach involves providing formal educational information to stakeholders about the program, such as describing the evidence base, how providers refer patients to the program, and which patients may or may not benefit from the program. This may occur at formal marketing or educational events or via flyers and e-mail. Using this approach, stakeholders typically realize that you are marketing the program. An indirect approach is more subtle and may involve informal or curbside discussions. For example, you may provide an anecdotal story of how the program helped a patient or how the program could help a specific patient a provider is concerned about. Both direct and indirect marketing strategies should be used and may be used in combination to describe the evidence behind the program in a way that is both educational and motivational.

3. Marketing is an on-going process. Repeating the same message over and over again reinforces the message and should not cause frustration. Just as the advertisement industry ensures that we will hear and see a given commercial multiple times on many channels, you may need the same tenacity in repeating messages across an array of modalities. Providers have a tendency to revert to previous referral practice patterns without repeated marketing of a new program or practice. You should continue marketing after the program has been fully implemented and well beyond. View it as one component of an ongoing dialogue between those highly invested in the program and additional stakeholders.

4. Perform program monitoring to inform marketing practices. For example, continuous monitoring should pinpoint a change in program utilization after a target marketing intervention. Within PC-MHI, a marketing effort may consist of informing primary care providers of a specific intervention for a specific target condition. Ideally, soon after initiating the marketing initiative, you will identify an increase of program referrals for that specific condition in program monitoring.

B. Marketing Strategies

The following marketing strategies may be helpful for launching a program.

- ***Presentations***
  The goal of formal marketing events is to describe the benefits of the program (to patients, providers, clinics, systems, etc.), the type of services provided, the patients who may benefit from the services, and the ways to link patients to these services. These events may be more formal than other marketing activities. You can schedule them as part of pre-existing meetings or hold them separately. Be sure to have informational handouts available for all who attend.

- ***Stakeholder meetings and team huddles***
  Repeatedly discuss the program at meetings and in huddles.[xi] For example, during a Patient-Aligned Care Team (PACT) huddle, a PC-MHI provider can market services by providing a testimonial[xii] on how a particular patient has benefitted (or could benefit) from the program's services.

- ***Phone calls or web-based live meetings***
  These approaches can be useful after an initial meeting to address follow-up questions or to provide additional information about the program.

- ***E-mails***
  Use emails to describe specific topics of interest within the program. Make them brief and include bulleted or numbered information.

- ***Flyers***
  Similar to e-mails, use flyers to provide brief information on the new program or practice and place them strategically. For example, post flyers that contain program contact information in exam rooms. Make them brief one-page informational sheets focused on a specific topic. Monitor flyer distribution areas and replenish supplies as needed.

[xi] *Huddles: brief staff gatherings (<5 minutes) held at the beginning of each shift and are meant to discuss safety or unit issues. (See Appendix A2. Glossary of Terms.)*

[xii] *Testimonial: a brief, spoken statement by a referring provider extolling the virtues of the program. This could include, but is not limited to, describing how the program had a positive impact by improving patient outcomes or by improving provider job satisfaction.*
Formal definition: A written or spoken statement, sometimes from a person figure, sometimes from a private citizen, extolling the virtue of some product. (See Appendix A 2. Glossary of Terms.)

XII. Marketing

- ***Newsletters***
  Newsletters can be useful for providing updates about the program, staffing, current services, and success stories to stakeholders.

- ***Data***
  Celebrate successful or promising changes that emerge from data monitoring. Provide this information and data to all stakeholders. Sharing data that support program success, patient satisfaction, and best practices will reinforce use of the program.

- ***Surveys***
  Use informal surveys to gather information about satisfaction with the overall program and with individual program elements. These surveys also could ask about services stakeholders would like for the program to provide. List several items that stakeholders can either rank order or circle based on level of priority.

- ***Individual discussions***
  These are powerful. If program use is low, speak to individual providers about the barriers to program referral. You can ask how the program could be enhanced to be more helpful to them and about which services their patients need and would like.

XIII. Collaboration

One critical component of successful facilitation is the ability to develop and capitalize upon powerful collaborations. This includes forming collaborations as well as identifying and joining existing, highly-functioning collaborative initiatives. Existing infrastructure and processes at your facilities may help you push your program forward without recreating the wheel.

1. Identify existing partnerships and practices; this is an important skill to develop. Find the existing positive energy and work with this energy to build momentum for the program or practice being implemented. In order to identify existing positive energy, speak with leadership, including program managers, discipline leads, and medical center directors to identify existing quality improvement initiatives with which you can partner. Ask program leads to help you identify local individuals who might be valuable partners and collaborators. It is highly likely that through these processes you also will identify individuals who are interested in system change to provide the best patient care possible. This will help you identify champions for change and understand highly effective methods for influencing organizational and systemic change.

2. Once identified, become actively involved in existing VA change initiatives by forming collaborations with leaders of these initiatives. You may be able to leverage resources from related initiatives to help promote the development and implementation of your program or practice.

3. In addition to collaborations with *existing* groups, structures, and processes, it is critical that you *develop* strategic relationships and collaborations with multiple stakeholders to maximize chances for successful program development and implementation.

4. The following are potential processes for developing collaborations and system change in the VHA. You may want to initiate one of these processes as part of your program implementation or integrate your effort into existing organizational change processes. A change process may be in place for a program that is similar to the one you are developing or that may directly interface with your program.

    - *Systems Re-Design, Lean Management*[xiii] *and Six Sigma projects:* These are process-based approaches to continuous quality improvement. They use data and statistical analysis to identify problems that cause a process to be inconsistent. These are rigorous and disciplined processes that focus on improving care, customer needs, and systemic functioning. These programs also may incorporate facilitation or technical assistance for successful implementation. More information about these

[xiii] *Lean is a process improvement method derived from the study of the principles of the Toyota Production System (TPS). Lean is a way of thinking about how a product or service moves through a work system in the most efficient manner possible. Lean is a strategy that creates "flow" through that work system by the elimination of waste, variation and work imbalance. Along the way, each activity or step in the work system must create value from the perspective of the customer. (See Appendix A 2. Glossary of Terms.)*

processes, specific training, and tools for using them can be found at the following VA websites:

- Systems Re-Design: https://srd.vssc.med.va.gov/Pages/default.aspx
- Lean Management: http://vaww.vasthcs.med.va.gov/lean/Default.htm
- Six Sigma: http://vaww.vasthcs.med.va.gov/lean/faq.htm

- *Leadership programs:* The VA has many leadership training initiatives. These are usually competitive and require an application and approval to attend. They can help you develop skills and meet other leaders with whom you may want to collaborate and may be beneficial for both the EF and IF. The goal of these programs is to create a continuum of leadership development consistent with the VHA Succession & Workforce Development Strategic Plan. These programs emphasize mentoring, developing individual plans for growth, and multiple learning opportunities through diverse modalities. These programs include the Executive Career Field Candidate Development Program (ECFCDP), The Health Care Leadership Development Program (HCLDP), LEAD program, and Health Care Executive Fellows (HCEF) Program. It is important that you develop and enhance your leadership skills to ensure that organizational stakeholders view you as a leader. These programs may help you develop collaborations while providing additional training and mentoring in leadership and the organizational structure of the VA. Additional information about these and other VA leadership programs can be found at http://vaww.vasthcs.med.va.gov/Education/EducationResources.htm.

XIV. Building Learning Collaboratives

A. Purpose of Learning Collaboratives

Learning collaboratives give stakeholders the opportunity to share what they have learned with others in a manner that promotes an understanding that "we learn from each other and help each other progress." Learning collaboratives are quite different from expert lecturing or teaching in that they promote learning through "home-grown" experts. Who better to talk about overcoming an obstacle than someone who just did it? When facilitators build learning collaboratives, they can help promote, highlight, and reward successful quality improvement. The purpose of a learning collaboratives is to support sustainability, encourage ownership, underscore progress, spread innovative problem solving, and provide emotional support.

Learning collaboratives are quite different from expert lecturing or teaching in that they promote learning through "home-grown" experts. Who better to talk about overcoming an obstacle than someone who just did it?

Once this process of shared learning begins, you can create momentum for implementation that will be self-rewarding and ongoing and produce an atmosphere of willingness to try something new. Being able to share missteps and ineffective endeavors is all part of the process and promotes a powerful opportunity for learning. A learning collaborative can help stakeholders share strategies for success, best practices, and suggestions to help each other.

B. Types of Learning Collaboratives

A number of formats foster both learning and collaboration. For example, you can schedule VISN or local conference calls on a regular basis (i.e., monthly or quarterly). Facilities can, in turn, schedule small, face-to-face meetings and include CBOCs. You can form large e-mail groups to send out information or request input from all involved or establish SharePoint sites, annual tele-video conferences or large learning collaborative conferences. Be sure to identify and highlight successful programs and persuade stakeholders to share implementation lessons with each other.

C. Establish VISN-level Calls

Initially, you can establish VISN-level conference calls on a monthly basis. Duplication of national conference calls that offer more didactic learning and less interaction is less helpful. Each facility and CBOC can select a representative to participate in the calls. Establish the agenda with the expectation that each site will provide brief updates on their progress. During the call, participants have the opportunity to talk to each other. Refrain from lecturing and ask relevant questions to encourage information sharing. Stakeholders enjoy this interactive and dynamic process and learn quickly from each other.

Often, these calls result in stakeholders visiting each other's sites to learn more. They share process information, templates, and resources. They build trusting relationships with each other and feel comfortable bouncing questions off each other. For example, in a recent PC-MHI program, one clinic was further along in implementation than others. This clinic often hosted others who were interested in learning from them. Clinicians visited for the day, shadowed the host, and learned how things worked. Both the host and the visiting stakeholders learned from each other. Even those who are new to the process often have good ideas to share.

D. Planning Large Learning Collaborative Conferences

Large conferences can be helpful in establishing regional or facility-wide learning collaborative but planning them can be complex and time-consuming. Detailed information on how to plan such a conference is provided in Appendix C on page 91.

All the work spent in planning can result in a well-organized and thought-out program.

XV. Monitoring and Improving the Program

Systematic monitoring of program data and timely feedback to leadership and providers is an important element of program monitoring and sustainability. The feedback process should be an ongoing discussion among the providers, the facilitation team, and local supervisors rather than limited to formal annual or semi-annual evaluations.

A. Program Monitoring Tools

By using a combination of the following methods, you can readily identify areas for improvement and create reports that depict areas of strength and weakness. Create action plans for areas needing additional attention.

- ***Observations***
  If possible, make direct clinic observations. A VISN-level IF can assist with this process by making site visits and observing direct interactions with patients and clinical staff.

- ***Program fidelity measures (if available)***

- ***Dashboards***
  Monitor individual program provider's patient management trends, including the number of unique patients seen, the total number of encounters, the number of encounters per unique patient, the number of encounters per day, average session length, and most common diagnoses seen. View this information in relationship to the overall clinic population. These data, however, remain meaningless without direct provider feedback.

- ***Chart reviews***
  Review a few patient charts to check for provider competency with administrative and documentation skills. This information can be fed back to providers and used to help them improve their skills. Also, there may be times when it is appropriate to share this information with supervisors, for example when the provider needs additional training or monitoring or to ensure appropriate clinical care is delivered.

- ***Input from other team members***
  Gather information from supervisors, clinicians, and other clinical staff about the program and its impact and how it might be improved.

XV. Monitoring and Improving the Program

B. Ongoing Mentoring and Supervision

The IF, an invested supervisor or a local trainer/champion also should consider the following tasks for ongoing mentoring and supervision:

- Ensure that new providers receive adequate training to support attainment of all relevant competencies (i.e., clinical skills, practice management, consultation, documentation, teamwork and administrative skills).

- Ensure that providers have the opportunity to observe someone using these skills. After training, you or the supervisor should consider observing the new providers in action and provide supportive and constructive feedback.

- Schedule and lead local (e.g., either VISN or region) sharing collaborative calls with all providers at least monthly.

- Monitor program data and provider panel management metrics (see above). Provide bench marks and help individual providers set goals for program implementation.

- Review individual provider metrics monthly. You can present data in de-identified reports and lead group discussion about program quality improvement. (See Appendix B #1 Clinic Summary Excel Workbook.)

- Conduct monthly, individual discussions with providers whose data consistently fail to suggest adequate utilization rates or adequate program implementation.

- Develop and implement action plans for areas of identified difficulty.

- Meet at least quarterly with local leadership or supervisors to ensure ongoing problem solving and collaborative communications.

- Link with national and VISN resources by attending select calls and related informational/educational opportunities.

C. Interface with primary supervisors of the clinicians

Throughout this process, the facilitation team, and especially the IF, must maintain consistent communication with the primary supervisor for many reasons. First, the supervisor must be aware of the specific goals for the program and be "on-board" for the specific training objectives. The supervisor is ultimately responsible for the program while the facilitation team members are expert consultants tasked with program implementation. Ultimately, it is the supervisor's program and the supervisor's staff. Thus, inform and obtain approval from the primary supervisor regarding any data monitoring and the nature and function of any contacts with staff. Also, provide progress reports.

It is important that you and primary supervisors represent a united front, which will minimize any potential difficulties, conflicts or confusion with the front-line providers. View yourself as an extension of the supervisor and, in ambiguous circumstances, defer to the supervisor's authority. We recommend scheduled monthly contacts to create a forum of continued dialogue and provide an update on program and provider performance.

D. National Resources

In addition to local and VISN-level resources, national resources and training can supplement the supervision process and facilitate training and continued education. Although these will vary by specific program content, typically these training events bring together experts to teach staff from around the country the concepts and skills critical to the specific program.

XVI. Factors that Support Sustainability

The ***sustainability phase*** of an implementation effort focuses on activities and strategies to ensure that performance or clinical QI goals are achieved and changes in clinical structure or processes that produced that improvement persist over time. During the implementation phase there are key facilitation activities that will support sustainability of the program or practice. These include:

- Ensuring that the program or practice has been integrated into existing clinical programs and services. For example, in implementing PC-MHI programs, it was important to incorporate transitions from OEF/OIF clinics.

- Establishing a system for ongoing training of key stakeholders including new providers/staff.

- Reviewing existing policies and processes to ensure that they support the program or practice and will not emerge as barriers to sustainability.

- Establishing an ongoing monitoring system that documents adherence to the program or practice as well as a mechanism through which adherence can be incorporated into performance plans, incentives or rewards.

- Identifying a local champion or leader who is the "go to" person for questions, program advocacy, and program monitoring.

One of your key activities in the sustainability phase will be to remain engaged with stakeholders to obtain their feedback on the critical elements of the implementation plan that need to be retained or "institutionalized" to sustain performance improvements going forward. In essence, the sustainability phase concentrates on identifying those key elements of the implementation plan necessary to sustain change and converting them into "the way we do things here." Engaging with stakeholders across all phases of implementation and integrating their feedback and recommendations into designing and refining the implementation plan to achieve and maintain performance improvement is absolutely vital in 'planning for sustainability.' In this phase, you will need to obtain stakeholder perspectives on the usefulness or value of individual elements of the implementation plan, additional barriers or facilitators, and recommendations for how implementation strategies or tools may need further refinement (or new strategies and tools may need to be introduced) to maintain or enhance performance improvement. Finally, as you exit the clinical setting it is important that you establish a mechanism through which subsequent communications can occur with leadership or site level program champions. Although the formal facilitation process may be completed, it is important that stakeholders

In essence, the sustainability phase concentrates on identifying those key elements of the implementation plan necessary to sustain change and converting them into 'the way we do things here.'

and champions are aware of your continued availability for consultation. Provide information to them about your availability and preferences for future discussions. Occasionally checking in with the site to see if they have encountered any changes in implementing the program or practice is one way that you can communicate your continued availability if the need arises.

XVII. References

1. Kilbourne AM, Schulberg HC, Post EP, Rollman BL, Belnap BH, Pincus HA. Translating evidence-based depression management services to community-based primary care practices. *Milbank Q*. 2004;82(4): 631-659.

2. Kitson A, Harvey G, McCormack B. Enabling the implementation of evidence based practice: A conceptual framework. *Quality in Health Care*. 1998;7(3): 149-158.

3. Rycroft-Malone J, Kitson A, Harvey G et al. Ingredients for change: Revisiting a conceptual framework. *Quality and Safety in Health Care*. 2002;11(174-180.

4. Burrows DE. Facilitation: a concept analysis. *J Adv Nurs*. 1997;25(2): 396-404.

5. Stetler, C. B., Legro, M. W., Rycroft-Malone, J., Bowman, C., Curran, G., Guihan, M., Hagedorn, H., Pineros, S., and Wallace, C. M. Role of external facilitation in implementation of research findings: A qualitative evaluation of facilitation experiences in the Veterans Health Administration. Implementation Science 1[23]. 10-18-2006.

6. Harvey G, Loftus-Hills A, Rycroft-Malone J et al. Getting evidence into practice: The role and function of facilitation. *J Adv Nurs*. 2002;37(6): 577-588.

7. Hayden, P., Frederick, L., Smith, B. J., and Broudy, A. Developmental Facilitation: Helping Teams Promote Systems Change. Collaborative Planning Project for Planning Comprehensive Early Childhood Systems. 2-21. 2001. Center for Collaborative Educational Leadership, Denver CO 80204.

8. Nagykaldi Z, Mold JW, Aspy CB. Practice facilitators: A review of the literature. *Family Medicine*. 2005;37(8): 581-588.

9. Heron J. *Dimensions of Facilitator Style*. Guildford: University of Surrey; 1977.

10. Thompson GN, Estabrooks C, Degner LF. Clarifying the concepts in knowledge transfer: A literature review. *J Adv Nurs*. 2006;53(6): 691-701.

11. Cheater FM, Hearnshaw H., Baker R., Keane M. Can a facilitated programme promote effective multidisciplinary audit in secondary care teams? An exploratory trial. *International Journal of Nursing Studies*. 2005;42(7): 779-791.

12. Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*. 2004;82(4): 581-629.

13. Grol R, Wensing M, Eccles M. *Improving Patient Care: The Implementation of Change in Clinical Practice*. London: Elsevier; 2005.

14. Parker LE, dePillis E, Altschuler A, Rubenstein LV, Meredith LS. Balancing participation and expertise: A comparison of locally and centrally managed health care quality improvement within primary care practices. *Qual Health Res*. 2007;17(9): 1268-1279.

15. Shekelle PG, Kravitz RL, Beart J, Marger M, Wang M, Lee M. Are nonspecific practice guidelines potentially harmful? A randomized comparison of the effect of nonspecific versus specific guidelines on physician decision making. *Health Services Research*. 2000;34(7): 1429-1448.

16. Fortney JC, Pyne JM, Smith JL et al. Steps for implementing collaborative care programs for depression. *Population Health Management*. 2009;12(2): 69-79.

17. Kirchner JE, Parker LE, Bonner LM, Fickel JJ, Yano EM, Ritchie MJ. Roles of managers, frontline staff and local champions, in implementing quality improvement: stakeholders' perspectives. *Journal of Evaluation in Clinical Practice*. 2010;no numbers.

18. Cully JA, Teten AL, Benge JF, Sorocco KH, Kauth MR. Multidisciplinary Cognitive-Behavioral Therapy Training for the Veterans Affairs Primary Care Setting. *Prim Care Companion J Clin Psychiatry*. 2010;12(3).

19. Borrelli B, Lee C, Novak S. Is provider training effective? Changes in attitudes towards smoking cessation counseling and counseling behaviors of home health care nurses. *Preventive Medicine*. 2008;46(4): 358-363.

20. Martin HJ. Improving training impact through effective follow-up: Techniques and their application. *Journal of Management Development*. 2010;29(6): 520-534.

21. Robinson P, Reiter J. *Behavioral consultation and primary care: a guide to integrating services*. New York: Springer Science-Media; 2007.

22. Hunter CL, Goodie JL, Oordt MS, Dobmeyer AC. *Integrated behavioral health in primary care: step-by-step guidance for assessment and intervention*. Washington, D.C.: American Psychological Association; 2009.

Additional Supporting Literature Not Cited

Aarons GA. Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). Mental Health Services Research 2004; 6(2): 61-74.

Adams RD, Benjamin ML. Innovative approaches to mental health service delivery in rural areas. Journal of Rural Community Psychology 1988; 9: 41-50.

Armenakis AA, Harris SG, Mossholder KW. Creating readiness for organizational change. Human Relations 1993; 46(6): 681-703.

Auster E, Wylie K, Valente M. Strategic organizational change: Building change capabilities in your organization. New York, New York: Palgrave Macmillan. 2005.

Austin JR, Bartunek JM. Theories and practices of organizational development. In: Weiner IB, ed, Handbook of Psychology, Volume 12. Hoboken, New Jersery: John Wiley. 2003; 309-32.

Backer TE. Assessing and enhancing readiness for change: implications for technology transfer. NIDA Research Monograph 1995; 155: 21-41.

Badamgarav E, Weingarten SR, Henning JM, Knight K, Hasselblad V, Gano A, Ofman JJ. Effectiveness of disease management programs in depression: A systematic review. American Journal of Psychiatry 2003; 160(12): 2080-90.

XVII. References

Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Arean PA et al. Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. American Journal of Psychiatry 2004; 161(8): 1455-62.

Bero LA, Grilli R, Grimshaw JM, Harvey E, Oxman AD, Thomson MA. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. British Medical Journal 1998; 317: 465-8.

Berwick DM. Continuous improvement as an ideal in health care. The New England Journal of Medicine 1989; 320(1): 53-6.

Berwick DM. The science of improvement. Journal of American Medical Association 2008; 299: 1182-4.

Brook RH. Practice guidelines and practicing medicine: Are they compatible? The Journal of the American Medical Association 1989; 262(21): 3027-30.

Chen H, Coakley E, Cheal K, Maxwell J, Costantino G, Krahn D et al. Satisfaction with mental health services in older primary care patients. American Journal of Geriatric Psychiatry 2006; 14(4): 371-9.

Cockburn J. Adoption of evidence into practice: Can change be sustainable? Medical Journal of Australia 2004; 180(6 Suppl): S66-S67.

Crossan MM, Land HW, White RE. An organizational learning framework: From intuition to institution. Academy of Management Review 1999; 24(3): 522-37.

Cunningham CE, Woodward C, Shannon HS, MacIntosh J, Lendrum B, Rosenbloom D, Brown J. Readiness for organizational change: A longitudinal study of workplace psychological and behavioural correlates. Journal of Occupational and Organizational Psychology 2002; 75(4): 377-92.

Curran G, Mukherjee S, Allee E, Owen R. A process for developing an implementation intervention: QUERI Series. Implementation Science 2008; 3(1): 17.

Curran GM, Thrush CR, Smith JL, Owen RR, Ritchie M, Chadwick D. Implementing research findings into practice using clinical opinion leaders: Barriers and lessons learned. Joint Commission Journal on Quality and Patient Safety 2005; 31(12): 700-7.

Davis D. Does CME work? An analysis of the effect of educational activities on physician performance or health care outcomes. International Journal of Psychiatry in Medicine 1998; 28(1): 21-39.

Davis DA, Taylor-Vaisey A. Translating guidelines into practice. A systematic review of theoretic conceps, practical experience and research evidence in the adoption of clinical practice guidelines. Canadian Medical Association Journal 1997; 157(4): 408-16.

Dearing JW. Evolution of diffusion and dissemination theory. Journal of Public Health Management and Practice 2008; 14(2): 99-108.

Demakis JG, McQueen L, Kizer KW, Feussner JR. Quality Enhancement Research Initiative (QUERI): A collaboration between research and clinical practice. Medical Care 2000; 38(6 (Supplement 1)): I-17-I-25.

XVII. References

Deming WE. Out of the Crisis. The MIT Press. 2000.

Denison DR. What is the difference between organizational culture and organizational culture and organizational climate? A native's point of view on a decade of paradigm wars. Academy of Management Review 1996; 21(3): 619-54.

Department of Veterans Affairs. Uniform Mental Health Services in VA Medical Centers and Clinics. Veterans Health Administration Handbook 1160.01. Septemer 11,2008.

Ellis I, Howard P, Larson A, Robertson J. From workshop to work practice: An exploration of context and facilitation in the development of evidence-based practice. Worldviews Evidence Based Nursing 2005; 2(2): 84-93.

Elwyn G, Hocking P. Organisational development in general practice: Lessons from practice and professional development plans (PPDPs). BMC Family Practice 2000; 1: 2.

Emery F. The Second Design Principle: Participation and the democratization of work. In: Trist E, Murray J, eds, The Social Engagement of Social Science: A Tavistock Anthology, Vol 2: The Socio-technical perspective. Innovations in Organization Series. Philadelphia: University of Pennsylvania Press. 1993; 214-33.

Feifer C, Fifield J, Ornstein S, Karson AS, Bates DW, Jones KR, Vargas PA. From research to daily clinical practice: What are the challenges in "translation"? Joint Commission Journal on Quality and Safety 2004; 30(5): 235-45.

Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: A framework for change. Milbank Quarterly 2001; 79(2): 281-315.

Fickel JJ, Parker LE, Yano EM, Kirchner JE. Primary care - mental health collaboration: An example of assessing usual practice and potential barriers. Journal of Interprofessional Care 2007; 21(2): 207-16.

Fiol CM, Lyles MA. Organizational learning. Academy of Management Review 1985; 10(4): 803-13.

Fixsen DL, Naoom S, Blase KA, Friedman RM, Wallace F. Implementation Research: A Synthesis of the Literature. 2005. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. National Implementation Research Network.

Gallo J, Zubritsky C, Maxwell J, Nazar M, Bogner H, Quijano L et al. Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (PRISM-E). Annals of Family Medicine 2004; 2(4): 305-9.

Ghosh AK. On the challenges of using evidence-based information: The role of clinical uncertainty. Journal of Laboratory and Clinical Medicine 2004; 144(8): 60-4.

Gilbody S, Whitty P, Grimshaw J, Thomas R. Educational and organizational interventions to improve the management of depression in primary care. A systematic review. Journal of American Medical Association 2003; 289(23): 3145-51.

XVII. References

Gilbody S, Bower P, Whitty P. Costs and consequences of enhanced primary care for depression: Systematic review of randomised economic evaluations. Bulletin of the Menninger Clinic 2006; 189: 297-308.

Ginsburg LR, Lewis S, Zackheim L, Casebeer A. Revisiting interaction in knowledge translation. Implement Sci 2007; 2: 34.

Greenhalgh T, Worrall JG. From EBM to CSM: The evolution of context-sensitive medicine. Journal of Evaluation in Clinical Practice 1997; 3(2): 105-8.

Greenhalgh T. Narrative-based medicine in an evidence-based world. British Medical Journal 1999; 318: 323-5.

Greenhalgh T. Intuition and evidence-uneasy bedfellows? British Journal of General Practice 2002; 52(478): 395-400.

Grimshaw J, Eccles M, Tetroe J. Implementing clinical guidelines: Current evidence and future implications. Journal of Continuing Education in the Health Professions 2004; 24(Suppl 1): S31-S37.

Grimshaw JM, Shirran L, Thomas R, Mowatt G, Fraser C, Bero L et al. Changing provider behavior: An overview of systematic reviews of interventions. Medical Care 2001; 39(8 Suppl 2): II-2-II-45.

Grimshaw J, Eccles M, Thomas R, Maclennan G, Ramsay C, Fraser C, Vale L. Toward evidence-based quality improvement: Evidence (and its limitations) of the effectiveness of guideline dissemination and implementation strategies 1966-1998. Journal of General Internal Medicine 2006; 21(s2): S14-S20.

Grol R, Dalhuijsen J, Thomas S, Veld C, Rutten G, Mokkink H. Attributes of clinical guidelines that influence use of guidelines in general practice: Observational study. British Medical Journal 1998; 317: 858-61.

Grol R, Grimshaw J. Evidence-based implementation of evidence-based medicine. Joint Commission Journal on Quality Improvement 1999; 25(10): 503-13.

Haynes RB. What kind of evidence is it that evidence-based medicine advocates want health care providers and consumers to pay attention to? BMC Health Services Research 2, 3. 2002.

Hroscikiski MC, Solberg LI, Sperl-Hillen JM, Harper PG, McGrail MP, Crabtree BF. Challenges of change: A qualitative study of chronic care model implementation. Annals of Family Medicine 2006; 4(4): 317-26.

Hulscher ME, Wensing M, Grol RP, van der Weijden T, van Weel C. Interventions to improve the delivery of preventive services in primary care. American Journal of Public Health 1999; 89(5): 737-46.

Hynes DM, Perrin RA, Rappaport S, Stevens JM, Demakis JG. Informatics resources to support health care quality improvement in the Veterans Health Administration. Journal of the American Medical Informatics Association 2004; 11(5): 344-50.

Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press. 2001.

XVII. References

Jenicek M. The hard art of soft science: Evidence-based medicine, reasoned medicine or both? Journal of Evaluation in Clinical Practice 2006; 12(4): 410-9.

Jones LR, Badger LW, Ficken RP, Leeper JD, Anderson RL. Inside the hidden mental health network. Examining mental health care delivery of primary care physicians. General Hospital Psychiatry 1987; 9(4): 287-93.

Jones L, Wells K. Strategies for Academic and Clinician Engagement in Community-Participatory Partnered Research. Journal of American Medical Association 2007; 297(4): 407-10.

Katon W, Robinson P, Von Korff M, Lin E, Bush T, Ludman E et al. A multifaceted intervention to improve treatment of depression in primary care. Archives of General Psychiatry 1996; 53(10): 924-32.

Kirchmeyer C, Cohen A. Multicultural groups: Their performance and reactions with constructive conflict. Group and Organization Management 1992; 17(2): 153-70.

Kirchner J, Edlund CN, Henderson K, Daily L, Parker LE, Fortney JC. Using a multi-level approach to implement a primary care mental health (PCMH) program. Families, Systems & Health 2010; 28(2): 161-74.

Kirchner JE, Parker LE, Yano EM, Bonner LM, Hollis D, Ritchie MJ. Implementation Manual: Local Champions - Translating Initiatives for Depression into Effective Solutions. 2007.

Kitson AL, Rycroft-Malone J, Harvey G, McCormack B, Seers K, Titchen A. Evaluating the successful implementation of evidence into practice using the PARiHS framework: Theoretical and practical challenges. Implementation Science 3[1], 1-12. 2008.

Kizer KW, Demakis JG, Feussner JR. Reinventing VA health care: Systematizing quality improvement and quality innovation. Medical Care 2000; 38(6 Supplement I): I-7-I-16.

Kochevar LK, Yano EM. Understanding health care organization needs and context. Beyond performance gaps. Journal of General Internal Medicine 2006; 21(Supplement 2): S25-S29.

Landry MD, Sibbald WJ. Changing physician behavior: A review of patient safety in critical care medicine. Journal of Critical Care 2002; 17(2): 138-45.

Langer EJ. The psychology of control. Beverly Hills, CA: Sage. 1983.

Lefcourt HM. Personality and locus of control. In: Garber J, Seligman EP, eds, Human Helplessness: Theory and applications. New York: Academic Press. 1980; 245-59.

Lepper MR, Greene D. Over justification research and beyond: Toward a means-ends analysis of intrinsic and extrinsic motivation. In: Lepper MR, Greene D, eds, The hidden costs of reward: New perspectives on the psychology of motivation. Hillsdale, New Jersey: Lawrence Erlbaum Associates. 1978; 109-48.

Liu CF, Rubenstein LV, Kirchner JE, Fortney JC, Perkins MW, Ober SK et al. Organizational cost of quality improvement for depression care. Health Services Research 2009; 44(1): 225-44.

Locock L, Dopson S, Chambers D, Gabbay J. Understanding the role of opinion leaders in improving clinical effectiveness. Social Science and Medicine 2001; 53: 745-57.

XVII. References

MaGPle Research Group. General practitioners' perceptions of barriers to their provision of mental healthcare: A report on Mental Health and General Practice Investigation. New Zealand Medical Journal 2005; 118(1222).

Margolis PA, Lannon CM, Stuart JM, Fried BJ, Keyes-Elstein L, Moore DE, Jr. Practice based education to improve delivery systems for prevention in primary care: randomised trial. British Medical Journal 2004; 328(7436): 388.

National Advisory Mental Health Council Services Research and Clinical Epidemiology Workgroup. The Road Ahead: Research Partnerships to Transform Services. 2006. Washington, D.C., Department of Health and Human Services and National Institutes of Health.

Neumeyer-Gromen A, Lampert T, Stark K, Kallischnigg G. Disease management programs for depression. A systematic review and meta-analysis of randomized controlled trials. Medical Care 2004; 42(12): 1211-21.

Oslin D, Ross J, Sayers S, Murphy J, Kane V, Katz I. Screening, assessment, and management of depression in VA primary care clinics. The Behavioral Health Laboratory. Journal of General Internal Medicine 2006; 21(1): 46-50.

Parker LE. When to fix it and when to leave: Relationships among perceived control, self-efficacy, dissent, and exit. Journal of Applied Psychology 1993; 78: 949-59.

Parker LE, Kirchner JE, Bonner LM, Yano EM, Fickel JJ, Ritchie MJ, Simons CE. Creating a quality improvement dialogue: Utilizing knowledge from frontline staff, managers, and experts to foster health care quality improvement. Qualitative Health Research 2009; 19(2): 229-42.

Perlin JB, Kolodner RM, Roswell RH. The Veterans Health Administration: Quality, value, accountability, and information as transforming strategies for patient-centered care. The American Journal of Managed Care 2004; 10(Part 2): 828-36.

Pomerantz A. Improving treatment engagement and integrated care for veterans. The primary mental health care clinic at the White River Junction VA Medical Center, Vermont 2005 APA Gold Award. Psychiatric Services 2005; 56(10): 1306-8.

Porta M. Is there life after evidence-based medicine? Journal of Evaluation in Clinical Practice 2004; 10(2): 147-52.

Rogers EM. Diffusion of Innovations. Fourth ed. New York: Free Press. 1995.

Rosenheck RA. Organizational process: A missing link between research and practice. Psychiatric Services 2001; 52(12): 1607-12.

Rost K, Humphrey J, Kelleher K. Physician management preferences and barriers to care for rural patients with depression. Archives of Family Medicine 1994; 3(5): 409-14.

Rost K, Smith R, Matthews DB, Guise B. The deliberate misdiagnosis of major depression in primary care. Archives of Family Medicine 1994; 3(4): 333-7.

XVII. References

Rubenstein LV, Parker LE, Meredith LS, Altschuler A, dePillis E, Hernandez J, Gordon NP. Understanding team-based quality improvement for depression in primary care. Health Services Research 2002; 37(4): 1009-29.

Rubenstein LV, Pugh J. Strategies for promoting organizational and practice change by advancing implementation research. Journal of General Internal Medicine 2006; 21(S2): S58-S64.

Rubenstein L, Meredith L, Parker L, Gordon N, Hickey S, Oken C, Lee M. Impacts of evidence-based quality improvement on depression in primary care: A randomized experiment. Journal of General Internal Medicine 2006; 21(10): 1027-35.

Rycroft-Malone J, Harvey G, Seers K, Kitson A, McCormack B, Titchen A. An exploration of the factors that influence the implementation of evidence into practice. Journal of Clinical Nursing 2004; 13(8): 913-24.

Rycroft-Malone J. The PARIHS Framework-A framework for guiding the implementation of evidence-based practice. Journal of Nursing Care Quality 2004; 19(4): 297-304.

Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence-based medicine: What it is and what it isn't. British Medical Journal 1996; 312(7023): 71-2.

Sales A, Smith J, Curran G, Kochevar L. Models, strategies, and tools. Theory in implementing evidence-based findings into health care practice. Journal of General Internal Medicine 2006; 21(s2): S43-S49.

Schoonhoven CB. Sociotechnical considerations for the development of the space station: Autonomy and the human element in space. The Journal of Applied Behavioral Science 1986; 22(3): 276-186.

Sharp ND, Pineros SL, Hsu C, Starks H, Sales AE. A qualitative study to identify barriers and facilitators to implementation of pilot interventions in the Veterans Health Administration (VHA) Northwest Network. Worldviews Evidence Based Nursing 2004; 1(2): 129-39.

Sherman S, Fotiades J, Rubenstein L, Gilman S, Vivell S, Chaney E et al. Teaching system-based practice to primary care physicians to foster routine implementation of evidence-based depression care. Academic Medicine 2007; 82(2): 168-75.

Shortell SM, Bennett CL, Byck GR. Assessing the impact of continuous quality improvement on clinical practice: What it will take to accelerate progress. The Milbank Quarterly 1998; 76(4): 593-624.

Soumerai SB, Avorn J. Principles of educational outreach ('Academic Detailing') to improve clinical decision making. Journal of the American Medical Association 1990; 263(4): 549-56.

Soumerai SB. Principles and uses of academic detailing to improve the management of psychiatric disorders. International Journal of Psychiatry in Medicine 1998; 28(1): 81-96.

South SF. The secret to successful change: "The three Ds". Clinical Leadership & Management Review 2000; 14(5): 216-8.

Stetler CB, Legro MW, Wallace CM, Bowman C, Guihan M, Hagedorn H et al. The role of formative evaluation in implementation research and the QUERI experience. Journal of General Internal Medicine 2006; 21(s2): S1-S8.

XVII. References

Stetler CB, Mittman BS, Francis J. Overview of the VA Quality Enhancement Research Initiative (QUERI) and QUERI theme articles: QUERI Series. Implementation Science 2008; 3(8).

Stetler CB, McQueen L, Demakis J, Mittman B. An organizational framework and strategic implementation for system-level change to enhance research-based practice: QUERI Series. Implementation Science 2008; 3(30).

Stockdale SE, Mendel P, Jones L, Arroyo W, Gilmore J. Assessing organizational readiness and change in community intervention research: framework for participatory evaluation. Ethnicity and Disease 2006; 16(1 Suppl 1): S136-S145.

Sullivan G, Duan N, Mukherjee S, Kirchner J, Perry D, Henderson K. The role of services researchers in facilitating intervention research. Psychiatric Services 2005; 56(5): 537-42.

Sullivan G, Blevins D, Kauth MR. Translating clinical training into practice in complex mental health systems: Toward opening the 'Black Box' of implementation. Implementation Science 3, 33. 2008.

The National Child Traumatic Stress Network. Learning Collaborative Information Packet. Retrieved from: http://www.nctsnet.org/nctsn_assets/pdfs/LC_info_packet_ 3-22-07.pdf . 2007.

Tracy CS, Dantas GC, Upshur REG. Evidence-based medicine in primary care: Qualitative study of family physicians. BMC Family Practice 4[6], Epub. 2003.

Vera D, Crossan M. Strategic leadership and organizational learning. Academy of Management Review 2004; 29(2): 222-40.

Weber V, Joshi MS. Effecting and leading change in health care organizations. Joint Commission Journal on Quality Improvement 2000; 26(7): 388-99.

Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging Community Intervention and Mental Health Services Research. American Journal of Psychiatry 2004; 161(6): 955-63.

White DB. Instituting organizational learning for quality improvement through strategic planning nominal group processes. Journal for Healthcare Quality 2000; 22(5): 13-8.

Williams JW, Jr., Gerrity M, Holsinger T, Dobscha S, Gaynes B, Dietrich A. Systematic review of multifaceted interventions to improve depression care. General Hospital Psychiatry 2007; 29(2): 91-116.

Woodman RW, Sawyer JE, Griffin RW. Toward a theory of organizational creativity. The Academy of Management Review 1993; 18(2): 293-321.

Zanjani F, Miller B, Turiano N, Ross J, Oslin D. Effectiveness of telephone-based referral-care management, a brief intervention designed to improve psychiatric treatment engagement. Psychiatric Services 2008; 59(7): 776-81.

Appendices: Table of Contents

Appendix A: Glossary of Acronyms 63

Appendix A: Glossary of Terms 64

Appendix B: Example 1 - Clinic Summary Excel Workbook 70

Appendix B: Example 2 - Sample Program Reports 75

Appendix B: Example 3 - Instructions for Obtaining Unique and Encounter Data 76

Appendix B: Example 4 - Pre-Meeting Checklist 83

Appendix B: Example 5 - Implementation Checklist 84

Appendix B: Example 6 - Sample Site Visit Report 89

Appendix C: How to Plan Large Collaborative Conferences 91

Appendix D: Recommended Readings 95

Appendix A: Glossary of Acronyms

ACRP	Ambulatory Care Reporting Program
CBOC	Community-Based Outpatient Clinic
CBT	Cognitive-behavioral therapy
CMO	Chief Medical Officer
EBP(s)	Evidence-based practice(s)
EBQI	Evidence-based quality improvement
ECFCDP	Executive Career Field Candidate Development Program
EF	External facilitator
HCEF	Health Care Executive Fellow(s)
HCLDP	Health Care Leadership Development Program
IF	Internal facilitator
LEAD	Leadership, Effectiveness, Accountability, Development
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom
OMHS	Office of Mental Health Services
PACT	Patient-Aligned Care Teams
PCMH	Primary Care Mental Health
PC-MHI	Primary Care-Mental Health Integration
PCP	Primary Care Provider
QI	Quality Improvement
VA	Department of Veterans Affairs
VACO	VA Central Office
VAMC	Veterans Affairs Medical Center
VANTS	VA Nationwide Teleconferencing System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VISTA	Veterans Health Information Systems and Technology Architecture
VSSC	VHA Support Service Center

Appendix A: Glossary of Terms

Academic Detailing:[1]

Non-commercial prescriber education (academic detailing) removes the profit motive and replaces carefully crafted sales messages with objective, educational messages based on the most up-to-date and complete scientific evidence available. This approach represents an important service to prescribers because it helps them get the unbiased information they need to make the best possible prescribing decisions for their patients.

Best Practice:[2-4]

- Evidence-based findings regarding an appropriate diagnostic approach, therapeutic treatment/regimen, or delivery system.

- Findings should be well established to be "best practice" and may be found within more general evidence-based guidelines but focus on a more limited set of key clinical actions or processes.

Champions:[5]

"Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation]"[6] (p.182), overcoming indifference or resistance that the intervention may provoke in an organization.

Change Agent:[5]

Individuals who are affiliated with an outside entity and formally influence or facilitate intervention decisions in a desirable direction.

Difference between Culture & Climate:[7]

Organizational culture concerns system evolution and involves an indepth exploration of underlying assumptions not readily apparent to outside observers. Organizational climate, on the other hand, concerns the effect of systems on individuals and groups and focuses on organizational members' perceptions of observable phenomena such as organizational practices and procedures.

Culture:[5]

Norms, values, and basic assumptions of a given organization.

(Learning) Climate:[5]

A climate in which: a) leaders express their own fallibility and need for team members' assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.

(Implementation) Climate:[5]

The absorptive capacity for change, shared receptivity of involved individuals to an intervention and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.

Early Adopters:[8]

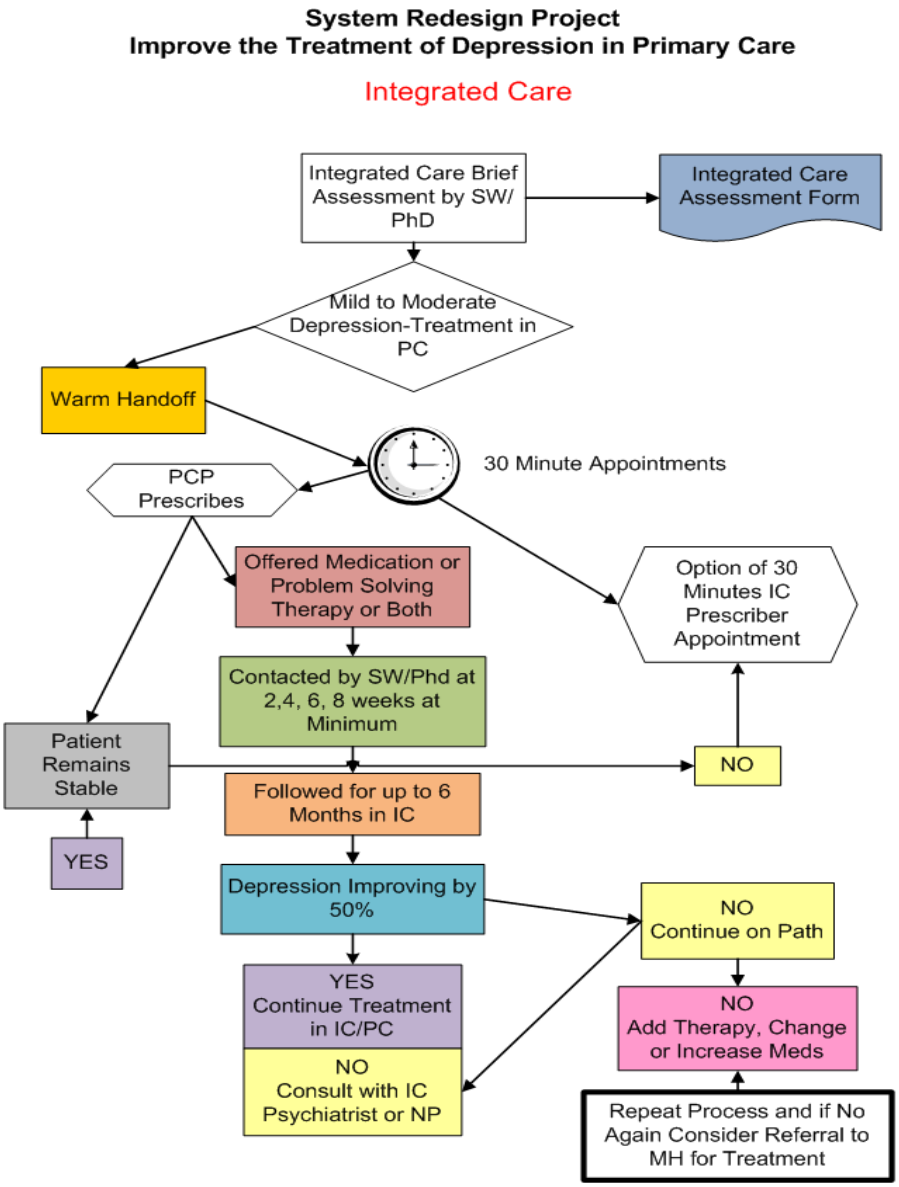
"Early adopters are a more integrated part of the local social system than are innovators. Whereas innovators are cosmopolites, early adopters are localites. This adopter category, more than any other, has the greatest degree of opinion leadership in most systems. Potential adopters look to early adopters for advice and information about the innovation. The early adopter is considered by many as "the individual to check with" before using a new idea. This adopter category is generally sought by change agents as a local missionary for speeding the diffusion process. Because early adopters are not too far ahead of the average individual in innovativeness, they serve as a role model for many other members of a social system.
The early adopter is respected by his or her peers, and is the embodiment of successful, discrete use of new ideas. The early adopter knows that to continue to earn this esteem of colleagues and to maintain a central position in the communication networks of the system, he or she must make judicious innovation-decisions. The early adopter decreases uncertainty about a new idea by adopting it, and then conveying a subjective evaluation of the innovation to near-peers through interpersonal networks."
Taken from *Diffusion of Innovations*, Everett M. Rogers, fourth edition, page 264.

Flow Mapping & Diagram:

Flow mapping is a means to identify all the steps in a current process. Essentially, one looks at the process with "fresh eyes" by listing all the steps in the process, people involved in the process, and any bottlenecks or problem areas. When trying to implement a new process, it is helpful to flow-map the proposed process. This helps in staff training and testing out the process to make sure that it works as expected. Often, it takes several versions of re-working the process so that it becomes efficient and adopted by all the stakeholders. Getting input with each new revision helps to make it successful. In this process, one sees things in a new way that helps improve the implementation process. (See example below.)

Appendix A: Glossary of Terms

Flow Map Example



Huddles:

These are brief staff gatherings (<5 minutes) held at the beginning of each shift and are meant to discuss safety or unit issues.
Available at: http://vaww.tampa.med.va.gov/resources/tcab/toolkits.php. Accessed: 9/29/2011.

Appendix A: Glossary of Terms

Lean management:

Lean is a process improvement method derived from the study of the principles of the Toyota Production System (TPS). Lean is a way of thinking about how a product or service moves through a work system in the most efficient manner possible. Lean is a strategy that creates "flow" through that work system by the elimination of waste, variation, and work imbalance. Along the way, each activity or step in the work system must create value from the perspective of the customer.
Available at: South Texas Veterans Health Care System – Lean Management Center http://vaww.vasthcs.med.va.gov/lean/Default.htm. Accessed 9-28-2011.

Six Sigma:

Six sigma is a process-based approach to continuous improvement. It uses data and statistical analysis to find process problems that cause a process to be inconsistent. Whenever a process doesn't work as well or consistently as it should, a "defect" can occur. Six sigma is a rigorous and disciplined process that focuses on meeting customer needs. Six sigma methods follow five phases in the following order: Define the project/problem; Measure the factors aligned with the process; Analyze the process to find root causes; Improve the process by testing solutions; Control the process after evaluating the improvements.
Available at: South Texas Veterans Health Care System – Lean Management Center http://vasthcs.med.va.gov/lean/faq.htm. Accessed: 9-27-2011.

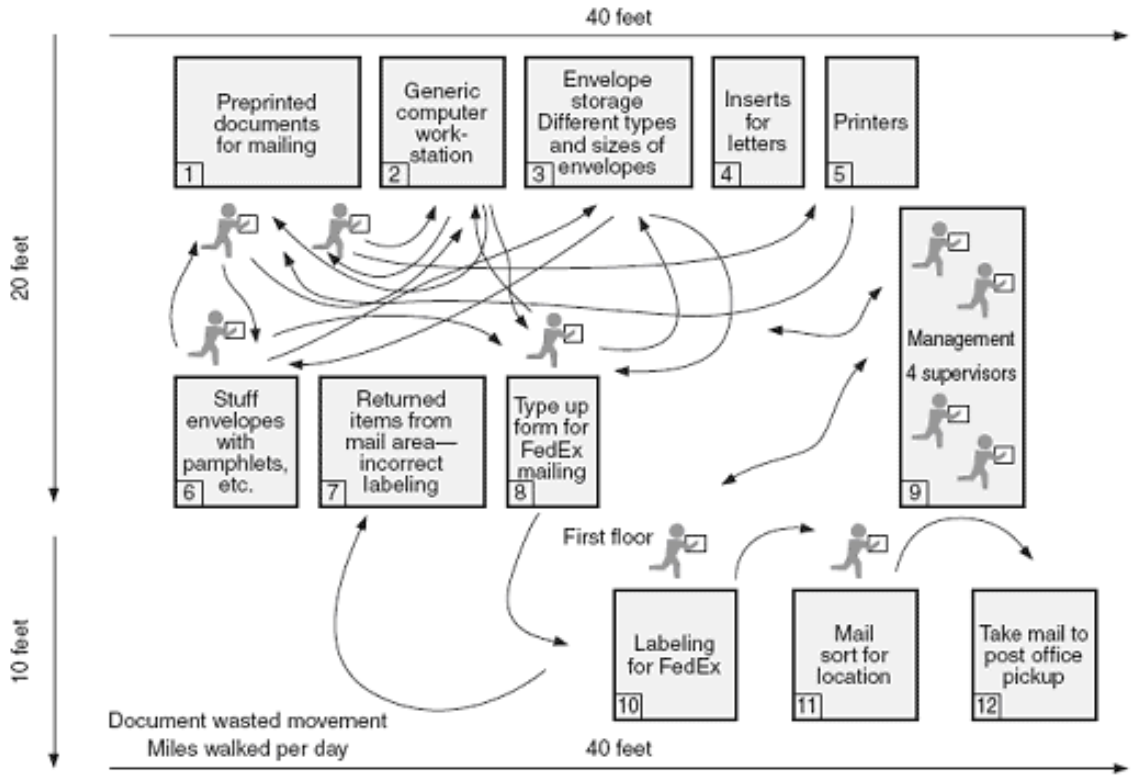
Spaghetti diagrams:

A spaghetti diagram is a visual representation using a continuous flow line tracing the path of an item or activity through a process. The continuous flow line enables process teams to identify redundancies in the work flow and opportunities to expedite process flow. This diagram illustrates a study that a health department administrative health office did to identify ways to shorten the walking time from one activity to another for tasks that staff did frequently.[9]

Appendix A: Glossary of Terms

Spaghetti Diagram Example:

Health Department Administrative Office Flow



Excerpted from Ron Bialek, Grace L. Duffy, and John W. Moran, *The Public Health Quality Improvement Handbook* (Milwaukee, WI: ASQ Quality Press, 2009), page 220. Available at: http://asq.org/learn-about-quality/process-analysis-tools/overview/spaghetti-diagram.html. Accessed: 9/27/2011.

System Redesign:

Systems redesign is intended to embody the capacity for an organization to improve and meaningfully redesign the system. This means working smarter. It is the combination of enlightened leadership strategically driving change AND exceptional facilitator staff teaching, leading, facilitating, promoting, organizing, arranging, prodding, measuring and doing whatever it takes to engage the front line staff in productive meaningful improvement of systems that matter in improving care to our patients. Past systematic improvement efforts were sometimes staffed with one or two people and aligned inside of one department. The efforts may not have involved significant numbers of front line staff. VHA is passionate about changing this. Change means increasing our improvement capability in a way that is dramatically more effective than the past.

Taken from "What is System Redesign V3" fact sheet by Mike Davies. Available at http://srd.vssc.med.va.gov/Topics/Tools/Pages/default.aspx. Accessed: 9-29-2011.

Appendix A: Glossary of Terms

Testimonial:

A brief, spoken statement by a referring provider extolling the virtues of the program. This could include, but is not limited to, describing how the program had a positive impact by improving patient outcomes or by improving provider job satisfaction.
Formal definition: A written or spoken statement, sometimes from a person figure, sometimes from a private citizen, extolling the virtue of some product.

REFERENCES

1. Reck, J. and Prescription Policy Choice's Academic Detailing Planning Initiative. A Template for Establishing and Administering Prescriber Support and Education Programs: A collaborative, service-based approach for achieving maximum impact. 2008. Hallowell, ME, Prescription Policy Choices.

2. Feussner JR, Kizer KW, Demakis JG. The Quality Enhancement Research Initiative (QUERI): From evidence to action. *Medical Care*. 2000;38(6 [Supplement I]): I-1-I-6.

3. NHS Centre for Reviews and Dissemination. Getting evidence into practice. *Effective Health Care*. 1999;5: 1-15.

4. Stetler CB, Mittman BS, Francis J. Overview of the VA Quality Enhancement Research Initiative (QUERI) and QUERI theme articles: QUERI Series. *Implementation Science*. 2008;3(8).

5. Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., and Lowery, J. C. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science.* 2009 4(50).

6. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., MacFarlane, F., and Peacock, R. How to spread good ideas: a systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation. 1-456. 2004. London, National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO).

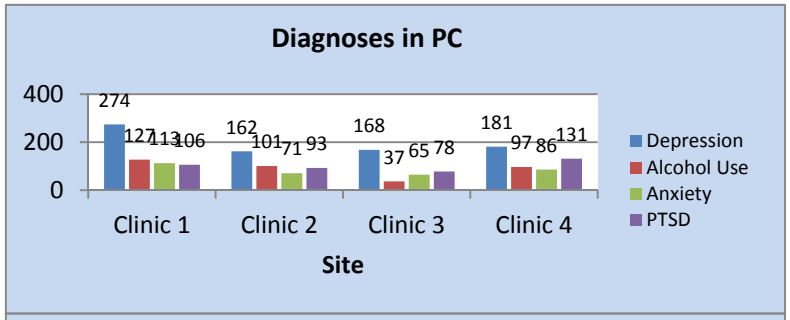
7. Denison DR. What is the difference between organizational culture and organizational culture and organizational climate? A native's point of view on a decade of paradigm wars. *Academy of Management Review*. 1996;21(3): 619-654.

8. Rogers EM. *Diffusion of Innovations*. New York: Free Press; 1995.

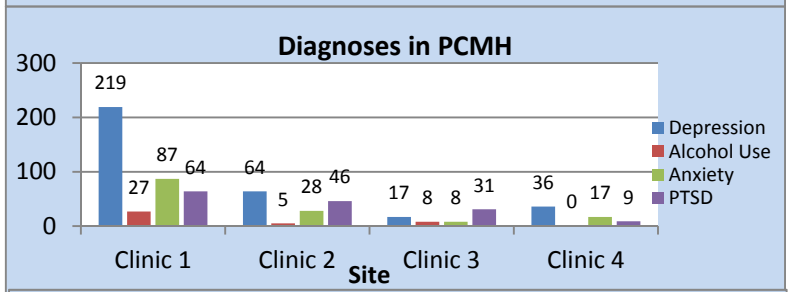
9. Bialek R, Duffy GL, Moran JW. *The Public Health Quality Improvement Handbook*. Milwaukee, WI: ASQ Quality Press; 2009.

EXAMPLE 1: CLINIC SUMMARY EXCEL WORKBOOK DIAGNOSIS TAB

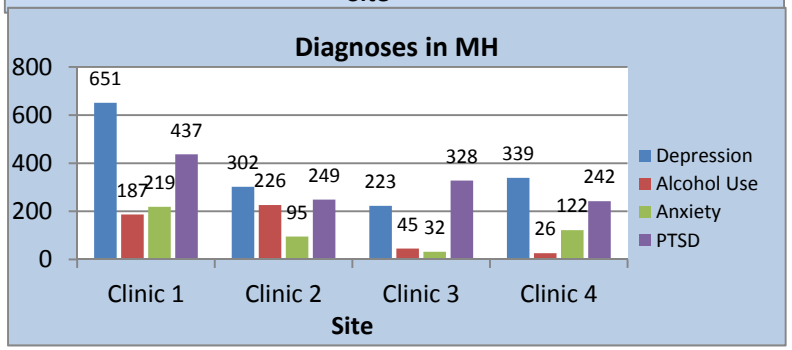
	Diagnosis in **PC** FYXX to Date ([Date] through [Date])			
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	274	162	168	181
Alcohol Use	127	101	37	97
Anxiety	113	71	65	86
PTSD	106	93	78	131



	Diagnosis in **PCMH** FYXX to Date ([Date] through [Date])			
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	219	64	17	36
Alcohol Use	27	5	8	0
Anxiety	87	28	8	17
PTSD	64	46	31	9



	Diagnosis In **MH** FFYXX to Date ([Date] through [Date])			
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	651	302	223	339
Alcohol Use	187	226	45	26
Anxiety	219	95	32	122
PTSD	437	249	328	242

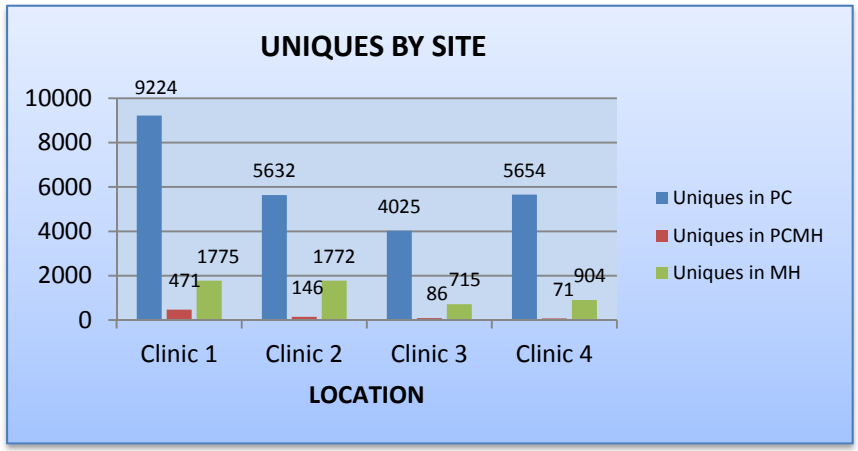


Appendix B: Clinic Summary Excel Workbook

EXAMPLE 1: CLINIC SUMMARY EXCEL WORKBOOK <u>UNIQUES TAB</u>

Clinic Data FYxx to Date ([Date] through [Date])

SITE	Uniques in PC	Uniques in PCMH	Uniques in MH
Clinic 1	9224	471	1775
Clinic 2	5632	146	1772
Clinic 3	4025	86	715
Clinic 4	5654	71	904



Appendix B: Clinic Summary Excel Workbook

EXAMPLE 1: CLINIC SUMMARY EXCEL WORKBOOK STAFF TAB

LOCATION OF SPECIALTY MENTAL HEALTH PROGRAMS

Clinic 1	Larger clinic with distinct separation between PC and specialty mental health. Specialty mental health is in separate part of building. IC MHP offices are in PC.
Clinic 2	MH specialty services in upstairs, while PC clinic is downstairs. Mental health providers are scheduled to move into offices in PC on [Date].
Clinic 3	Reports small clinic, with two main hallways. One is circular and contains PC and IC MH provider. Separate hallway has other specialty services. IC MH provider has office in center of PC circular unit. Specialty mental health care is about 10 steps away from PC hallway, separate hallway.
Clinic 4	Square shaped building with all parts connected. PC is referred to as "Dr.'s Corridor". This is one long hallway. IC MHP office is at the end of the Dr.'s Corridor. Specialty MH is next to PC, but down different hallway. Reports that all are very close physically and in terms of working together.

Appendix B: Clinic Summary Excel Workbook

EXAMPLE 1: CLINIC SUMMARY EXCEL WORKBOOK <u>DIAGNOSIS BY PERCENT TAB</u>

Diagnosis in **PC** FYXX to Date ([Date] through [Date])

Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	3%	3%	4%	3%
Alcohol Use	1%	2%	1%	2%
Anxiety	1%	1%	2%	2%
PTSD	1%	2%	2%	2%

Diagnosis in **PCMH** FY09 to Date ([Date] through [Date])

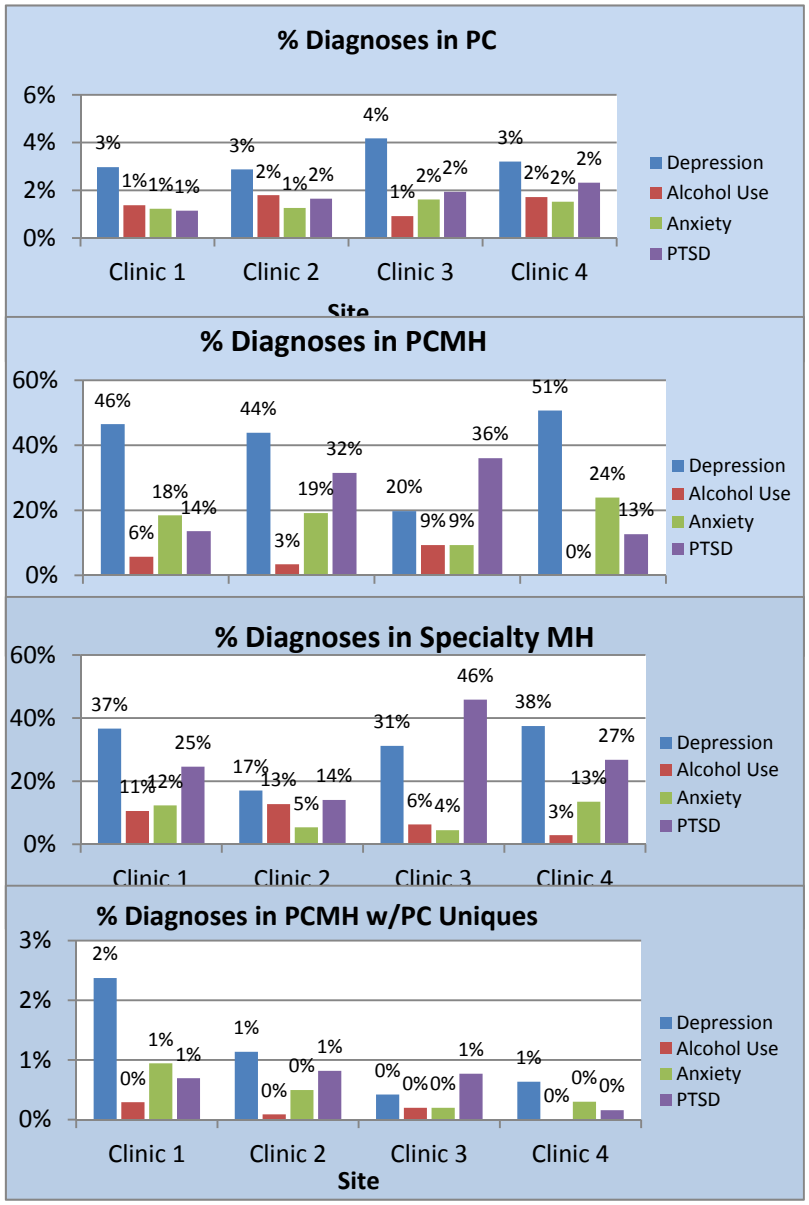
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	46%	44%	20%	51%
Alcohol Use	6%	3%	9%	0%
Anxiety	18%	19%	9%	24%
PTSD	14%	32%	36%	13%

Diagnosis In **Specialty MH** ([Date] through [Date])

Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	37%	17%	31%	38%
Alcohol Use	11%	13%	6%	3%
Anxiety	12%	5%	4%	13%
PTSD	25%	14%	46%	27%

Dx In **PCMH with PC Uniques** ([Date] through [Date])

Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	2%	1%	0%	1%
Alcohol Use	0%	0%	0%	0%
Anxiety	1%	0%	0%	0%
PTSD	1%	1%	1%	0%



Appendix B: Clinic Summary Excel Workbook

EXAMPLE 1: CLINIC SUMMARY EXCEL WORKBOOK STAFFING TAB

SITE	PC PROVIDERS	SP MH PROVIDERS	IC MHP	NURSES	CLERKS
Clinic 1	16 (4 are NP)	3 MD, 1NP, 5 Ph.D, 1 Ph.D (Neuropsy), 3 CSW, 2 RN	1 MD, 1 LCSW, 1 NP	7 LPN (PC) , 4 RN (PC)	2 MH, 4PC
Clinic 2	12	3MD, 4 Ph.D., 1 Ph.D (Neuropsy), 3 CSW	1 MD, 1 LCSW	15 PC	2 MH, 3PC
Clinic 3	7	5	1	8 (PC)	5 PC, 1 MHS
Clinic 4	7	6	1	6	5

Appendix B: Sample Program Reports

EXAMPLE 2: SAMPLE PROGRAM REPORTS

Sample 1

Primary Care Mental Health Provider Report: [month] 2011 (23 possible workdays)

Provider	Provider Type	Work Days/mo	Uniques	Encs	Enc/Pt	Enc/Day		Tele Uniq	Tele Enc	TOTAL ENC/DAY
a	Social Worker	16	25	38	1.52	2.38		3	5	2.69
b	Social Worker	6	37	38	1.03	6.33		0	0	6.33
c	Social Worker	14	48	73	1.52	5.21		4	5	5.57
d	Social Worker	19	12	13	1.08	0.68		0	0	0.68
e	Social Worker	19	30	43	1.43	2.26		18	24	3.53

Time period of report : [date] through [date]

** data pulled [date]*

Sample 2

VISN A PRIMARY CARE MENTAL HEALTH PROVIDER REPORT

Stop Code 534

Facility	Provider	Hrs/Mo	Diff/Hr	Act Hrs	Days/Mo	Uniq	Encs	Enc/Pt	Enc/Day	Care Mgmt Calls
[Facility Name]										
1	a	160	8	152	19	30	43	1.43	2.26	**6**
2	b	160	49.5	110.5	14	48	73	1.52	5.29	
3	c	160	11	149	19	12	13	1.08	0.70	
					32	**60**	**86**	**2.60**	**5.98**	**15**

data pulled [date]

+this is raw unvalidated data and is not fully accurate
++ days/qtr, and leave taken each month at each clinic required

**difficulty determining hours*

Time period of report : [date] through [date]

EXAMPLE 3: Instructions for Obtaining Unique and Encounter Data

The following procedures are a step-by-step guide to obtain uniques and encounters from the ACRP menu within VISTA for individual providers.

In order to complete this process, access to the Ambulatory Care Reporting Menu [SCDX AMBCAR REPORTING] is required.

Once access to this menu is granted, the following steps should be completed.

Step 1: First, access the ACRP Menu by entering **^**ACRP. The following options will appear.

```
1    ACRP Ad Hoc Report Menu  [SCRPW AD HOC RPT MENU]
2    ACRP Ad Hoc Report  [SCRPW AD HOC REPORT]
3    ACRP Reports Menu  [SCRPW ACRP REPORTS MENU]
```

Step 2: Chose option *1.* *(1 ACRP Ad Hoc Report Menu)*

The following menu options will appear.

```
AAH    ACRP Ad Hoc Report
DRT    Delete an Ad Hoc Report Template
DTP    Display Ad Hoc Report Template Parameters
PAH    Print from Ad Hoc Template
```

Step 3: *Select AAH here*. The following text will appear.

```
ACRP Ad Hoc Report Menu Option: aah  ACRP Ad Hoc Report;

-------------------- A C R P   A d   H o c   R e p o r t --------------------
          This report can be used to produce information from the ACRP
          databases in a variety of ways.  Parameter selection will
          determine how to count and screen the information.

          The report user is prompted for report parameters in the
          following categories:

          FORMAT - determines the style of report to be printed.

          PERSPECTIVE - the element that the report will be organized
          and sub-totaled by.

          LIMITATIONS - elements that can be used to narrow the scope
          of the report to only include (or exclude) specified data.

          OUTPUT ORDER, PRINT FIELDS - determines the order of output;
          allows selection of print fields for detailed patient lists.
```

At the end of the text, you will be asked the following question:

Step 4:

```
Would you like to use parameters from an existing template?
```

In order to set up a new template, say *"No"* at this prompt. (Once you have templates established you would enter the name of it here.) If no is entered, the next screen appears as follows.

```
-------------------- A C R P   A d   H o c   R e p o r t ------------------
     Select one of the following:

          D         DETAILED
          S         SUMMARY
```

Step 5:

```
Select report format: SUMMARY// d  DETAILED
```

Step 6:

```
Select one of the following: (select E)

          E         ENCOUNTER/VISIT/UNIQUE LIST
          D         DIAGNOSIS/PROCEDURE RANKING
          B         BOTH ACTIVITY & DX/PROC. LISTS
-------------------------- R E P O R T   F O R M A T ------------------------
Select type of detail: e  ENCOUNTER/VISIT/UNIQUE LIST

     Select one of the following: (select E again)

          E         ENCOUNTER
          V         VISIT
          U         UNIQUE
```

Step 7:

```
List activity by: e  ENCOUNTER

     Select one of the following: (select D)

          F         FORMATTED TEXT
          D         DELIMITED VALUES FOR EXPORT TO SPREADSHEET
```

Step 8:

```
Produce output as: FORMATTED TEXT// d  DELIMITED VALUES FOR EXPORT TO
SPREADSHEET
--------------------------- Report format selection -------------------------
Report format parameters determine the appearance of the report.

-------------------- R E P O R T   P E R S P E C T I V E ------------------
```

```
     Select one of the following: (select CL for clinic)

          CL        CLINIC
          SC        STOP CODE
          PR        PROVIDER
          DX        DIAGNOSIS
          AP        AMBULATORY PROCEDURE
          VF        V FILE ELEMENT
          PD        PATIENT DEMOGRAPHICS
          PE        PATIENT ELIGIBILITY
          PC        PRIMARY CARE
          EH        ENROLLMENT (HISTORICAL)
          EC        ENROLLMENT (CURRENT)
          OE        OUTPATIENT ENCOUNTER
          PM        PERF MONITOR
```

Step 9:

```
Select report perspective: cl  CLINIC

--------------------- R E P O R T   P E R S P E C T I V E -------------------
     Select one of the following: (CN for clinic name)

          CN        CLINIC NAME
          CG        CLINIC GROUP
          CS        CLINIC SERVICE
```

Step 10:

```
Select CLINIC category: cn  CLINIC NAME

     Select one of the following:

          L         LIST
          N         NULL (NO DATA VALUE)
```

Step 11:

```
Limit this factor by: l  LIST


                         *** Item List Selection ***
```

Step 12:

```
Select HOSPITAL LOCATION NAME:
```

At this point enter the names of the clinic you want included in the report. Once you have entered all of the clinic names hit return and the following menu will appear.

Step 13:

```
Then enter the dates you are looking for.
------------------------- Report perspective selection ----------------------
The element selected for this parameter will determine how the statistics
will be organized and sub-totaled.
```

```
                          *** Date Range Selection ***
Beginning date: 7/1/11  (JUL 01, 2011)

   Ending date: 7/3/11  (JUL 03, 2011)

Select additional output limiting factor:  (optional)

     Select one of the following:

          CL        CLINIC
          SC        STOP CODE
          PR        PROVIDER
          DX        DIAGNOSIS
          AP        AMBULATORY PROCEDURE
          VF        V FILE ELEMENT
          PD        PATIENT DEMOGRAPHICS
          PE        PATIENT ELIGIBILITY
          PC        PRIMARY CARE
          EH        ENROLLMENT (HISTORICAL)
          EC        ENROLLMENT (CURRENT)
          OE        OUTPATIENT ENCOUNTER
          PM        PERF MONITOR
```

Step 14:

```
Select limiting factor: pr  PROVIDER


     Select one of the following:

          PP        PRIMARY PROVIDER
          SP        SECONDARY PROVIDER
          AP        ALL PROVIDERS
          PC        PRIMARY PROVIDER PERSON CLASS
          SC        SECONDARY PROVIDER PERSON CLASS
          AC        ALL PROVIDERS PERSON CLASS
```

Step 15:

```
Select PROVIDER category: pp  PRIMARY PROVIDER


    Select one of the following:

          L         LIST
          R         RANGE
          N         NULL (NO DATA VALUE)
```

Step 16:

```
Limit this factor by: l  LIST

                          *** Item List Selection ***
```

Step 17:

```
Select NEW PERSON NAME: - Enter the names of providers that you are looking
for in those specific clinics.


     Select one of the following:

          I         INCLUDE
          E         EXCLUDE
```

Step 18:

```
Include or exclude records in this category: i  INCLUDE

               Select another output limiting factor:  (optional)
--------------------- R E P O R T   L I M I T A T I O N S -------------------
     Select one of the following:

          CL        CLINIC
          SC        STOP CODE
          PR        PROVIDER
          DX        DIAGNOSIS
          AP        AMBULATORY PROCEDURE
          VF        V FILE ELEMENT
          PD        PATIENT DEMOGRAPHICS
          PE        PATIENT ELIGIBILITY
          PC        PRIMARY CARE
          EH        ENROLLMENT (HISTORICAL)
          EC        ENROLLMENT (CURRENT)
          OE        OUTPATIENT ENCOUNTER
          PM        PERF MONITOR
```

Step 19:

```
Select limiting factor: - hit return/enter at this point, then A for
alphabetic

-------------------------- Report limitation selection -----------------------
Limiting factors determine which encounter records to count.  Multiple
limiting factors can be chosen and specified to only include (or exclude)
specific data.


-------------------- R E P O R T   P R I N T   O R D E R -------------------
     Select one of the following:

          A         ALPHABETIC
          E         ENCOUNTER TOTAL
          V         VISIT TOTAL
          U         UNIQUE TOTAL
```

Step 20:

```
Select report print order: ALPHABETIC// a  ALPHABETIC
```

Step 21:

```
Report descriptive title (optional): Give it a brief descriptive name here.
It will then show you the parameters you entered for the template. If you
want to change anything you can do so at this point.  Otherwise return
through to end.

------------------------- Report print order selection ----------------------
This parameter determines the order in which the report will be printed.
          Select additional print fields for patient detail:  (optional)
---------------- A D D I T I O N A L   P R I N T   F I E L D S --------------
     Select one of the following:

          CL        CLINIC
          SC        STOP CODE
          PR        PROVIDER
          DX        DIAGNOSIS
          AP        AMBULATORY PROCEDURE
          VF        V FILE ELEMENT
          PD        PATIENT DEMOGRAPHICS
          PE        PATIENT ELIGIBILITY
          PC        PRIMARY CARE
          EH        ENROLLMENT (HISTORICAL)
          EC        ENROLLMENT (CURRENT)
          OE        OUTPATIENT ENCOUNTER
          PM        PERF MONITOR

Specify additional print field:

------------------------ Additional print field selection --------------------
Additional print fields that are selected will be included in the output of
encounter, visit, or unique patient detail lists,

--------------------------  R E P O R T   F O R M A T  ----------------------

                Report output format: DETAILED
                      Type of detail: ENCOUNTER/VISIT/UNIQUE LIST
             List activity detail by: ENCOUNTER
                   Produce output as: DELIMITED VALUES FOR EXPORT TO
SPREADSHEET
---------------------  R E P O R T   P E R S P E C T I V E  ----------------

                Perspective category: CLINIC
            Perspective sub-category: CLINIC NAME
                         Detail list:

--------------------  R E P O R T   L I M I T A T I O N S  ----------------

                       Starting date: JUL 1,2011
                         Ending date: JUL 3,2011

           Addl. limitation category: PROVIDER
       Addl. limitation sub-category: PRIMARY PROVIDER
                        Include list:
```

```
--------------------- R E P O R T   P R I N T   O R D E R ----------------
------------- S e l e c t e d   R e p o r t   P a r a m e t e r s -----------

                        Output order: ALPHABETIC
            Report descriptive title: provider workload

-----------------------------------------------------------------------------
                                 Report action

     Select one of the following:

          C         CONTINUE
          E         EDIT PARAMETERS
          R         RE-DISPLAY PARAMETERS
          P         PRINT PARAMETERS
          Q         QUIT
```

Step 22:
Select report action: CONTINUE// **If you would like to make any changes, select E for Edit Parameters, otherwise return.**

Step 23:
Save in ACRP REPORT TEMPLATE: This is where you name your report and save it. It is highly recommended that you use your initials at the beginning of the name so that it is easier to locate (AAA-NAME OF TEMPLATE) when you go back to use it again.

Step 24:
Output MUST be QUEUED
DEVICE: HOME// queue to device to print or spool. Some institutions require this report to be run during non-business hours.

Appendix B: Pre-Meeting Checklist

EXAMPLE 4: Pre-Meeting Checklist

Meeting Space

1) ___ Is the meeting space reserved?
2) ___ Does the space have enough technological capacity?
3) ___ Does the space have enough seating capacity?

Technology

4) ___Is the necessary technology available?
   i) ___Computers
   ii) ___Projector
   iii) ___Access to presentations (including multiple back-ups)
   iv) ___Video Conferencing
   v) ___Speaker Phones
   vi) Other_____

5) ___Is there a plan B if technology does not work?
6) ___Is there someone onsite, who is a "go-to" person to help if things go wrong?
7) Plan B:_____

_____

8) ___Are VANTS lines or video conferencing set up?

Stakeholders

9) ___Have all stakeholders been invited?
10) ___Have stakeholders responded to the invitation?

Arrangements with Facility

11) ___Have clinic schedules been closed during the meeting time?
12) ___Has the facilitator notified leadership and administration that s/he will be on site?

Items to Remember

___Agenda
___Handouts
___Directions to Site
___Phone numbers
___Laptop
___AV Equipment (if not provided by site)
___List of Attendees
___Issues to Address
___Notes

Appendix B: Implementation Check List

EXAMPLE 5:
Implementation Check List
Steps for Implementing Collaborative Care Models
VISN A

Implementation Step		Decision	Action Item

Step 1	**Specify possible target patients and identification procedures:**
	• Patients referred by PCP(warm hand offs)
	  o Patients referred for brief interventions (approximately 1-4 sessions) for stress management, tobacco and alcohol misuse, chronic pain, sleep hygiene, lifestyle changes and coping with chronic illness
	  o Patients referred for brief interventions for anxiety and depression
	  o Patients referred for skill building (relaxation training, goal setting)
	• Patients screening positive for one or more of the following conditions, e.g., depression, alcohol dependence, anxiety and PTSD
	• Patients with target condition
	• Patients targeted by performance measures
	• Other
		• Referral to integrated provider will be based on PCPs need, using warm handoffs.
		• Referrals will be based primarily on level of severity (i.e., stable, with mild to moderate symptoms) rather than by specific diagnosis.
		• Referrals should include, but are not limited to, assessment support, depression monitoring, brief interventions for depression, anxiety, substance misuse, PTSD, and behavioral medicine interventions (e.g., sleep hygiene, coping with chronic illness).
			• Integrated Care Provider (ICP) to receive additional training in Care Management.
			• Continued education/marketing to PCPs about use of warm hand-off and care management service will be provided by [name] and ICP.
			• Facilitation team will monitor PC-MHI no-show rate.

Step 2	**Identify possible exclusion criteria and method for assessing criteria:** • Patients currently enrolled in specialty mental health • Schizophrenia • Bipolar Disorder • Severe substance misuse • Severe anxiety • Severe PTSD • High risk suicide ideation • No exclusion for initial consultation and triage visit or skill building and coping with chronic disease interventions but ultimately will not see the following for on-going services • Other	• Level of severity, rather than specific diagnosis will be exclusion criteria,- pts. who are not stable with severe symptoms will be referred to specialty MH care. • Patients currently enrolled in specialty mental health should be seen by their usual provider and nursing team. [Name] will facilitate this linkage. Specialty mental health will also provide urgent access to prescribers. • If initiating antipsychotics or patient is not stable, the patient should be referred for same-day evaluation by psychiatric prescribers. • OEF/OIF veterans, experiencing potential PTSD symptoms or other severe symptoms should be linked with the OEF/OIF care coordinator rather than with the ICP.	

Implementation Step		Decision	Action Item
Step 3	**Specify collaborative care team members:** • Behavioral health provider (e.g., psychologist, master's level social worker, licensed counselor) • Primary care providers (physician, physician assistant, nurse practitioner) • Care manager (e.g., nurse, social worker) • Co-located Prescribing Provider • Clinical supervisor (e.g., psychiatrist) • OEF/OIF Care Coordinator • Other	• [Name], ICP, is the integrated behavioral health provider and provides the care management function. • Call Center can be consulted by either PCPs or the ICP for additional comprehensive assessments. • [Name] and [Name] are identified as medical IC champions. • Psychiatrists [Name] and [Name] will remain located in primary care to provide curbside psychiatric consultation to PCPs. These providers are not considered part of IC, but part of specialty mental health and will be retained in stop code 502. [Name] will only be accepting patients new to behavioral health. • Clinical supervisor for IC staff is [name].	• Facilitation team to provide staff with comprehensive list of available assessments. • [Name of MD] will serve as PC contact if PCPs have trouble accessing psychiatry. • [Name of Psychiatrist] to serve as MH contact for issues/concerns with linkage to psychiatry. • In order to maintain availability of psychiatric prescribers, patient panels will be monitored through quarterly reports and PCPs' reports of access to psychiatric prescribers will be monitored. • If access becomes a problem, current plan will be revised.
Step 4	**Specify clinical activities of collaborative care team members:** • Behavioral health providers o Functional assessment o Triage and consultation o Brief interventions (e.g., 1-4 sessions for multiple concerns) o Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management) o Stress management o Sleep hygiene o Behavioral interventions for chronic pain o Lifestyle interventions for chronic conditions (e.g., diabetes) o Relaxation training o Other • Primary Care Providers: o Screen for target condition o Diagnose target condition o Prescribe medication o Refer to collaborative care team o Refer to specialty mental health o Educate PCPs o Participate in education activities o Other • Care Managers:	• [Name], ICP, will conduct functional assessments. o Triage and consultation o Brief interventions (e.g., 1-4 sessions for multiple concerns) o Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management) o Stress management o Sleep hygiene o Relaxation training o Other • Primary Care Providers: o Screen for target condition o Diagnose target condition o Prescribe medication o Refer to collaborative care team, including co-located provider o Refer to specialty mental health o Educate PCPs o Participate in education • [Name}, ICP, to provide care management function.	• Integrated care provider to receive additional training from [names] for behavioral medicine interventions. • In service to be provided for PCPs about psychiatric medication in PC. • [Names] to provide presentations to PC staff on quarterly basis. • MH specialty care to have an "on-call" urgent access provider scheduled for every day. • MH to provide this schedule to PC, so that PCPs know who they should contact.

Implementation Step		Decision	Action Item
	o Symptom assessment of target condition o Education and activation o Treatment preference assessment o Treatment barriers assessment o Psychosocial assessment o Self-management goal and activity setting o Brief counseling (e.g., problem solving therapy) o Psychiatric comorbidity assessment: - Schizophrenia - Bipolar Disorder - Substance misuse - PTSD - Panic Disorder - Generalized Anxiety Disorder - Sleep Disorders - Pain - Other o Management of comorbid conditions: - Substance misuse (mild, moderate) - PTSD (mild, moderate) - Panic Disorder - Generalized Anxiety Disorder - Sleep Disorders - Pain - Other o Symptom monitoring for target conditions o Medication adherence monitoring o Side-effects monitoring o Counseling adherence monitoring o Self-management monitoring o Other • Care Manager Psychiatric Supervisor: o Train collaborative care team o Supervise collaborative care team o Educate PCPs o Assess difficult cases presented by collaborative care manager o Provide treatment recommendations to PCPs o Provide consultations (by appointment and/or curbside) o Accepts referrals o Other	• MH specialty care to have an "on-call" urgent access provider scheduled for every day. MH to provide this schedule to PC, so that PCPs know who they should contact. • [Name], ICP, to be referral for patients needing short-term services.	
Step 5	**Specify treatment guidelines:** • Specify protocols for stepping up the intensity of care for patients failing treatment. • Guidelines for referral to specialty mental	• Co-located, collaborative providers will see patients for ~5 sessions and then will refer to specialty care, as treatment needs are above	• Copy of service agreement to be provided by [name].

Implementation Step		Decision	Action Item
	health: o Patient preference o Treatment resistant o Severity of illness o Suicide risk o Psychiatric comorbidity o Non-response o Non-adherence • Guidelines for disenrolling patients: o Length of time enrolled o Number of failed trials o Increases in symptom severity or comorbidity o Treatment response • Medication management algorithm (formulary adjustments)	and beyond scope for ICP.	
Step 6	**Specify suicide protocol:** • Protocol for assessing suicide risk • Protocol for ensuring safety of high risk patients	• Process and document in place with specific algorithm.	• Existing protocol to be sent to facilitation team, which will be embedded in final document. • Protocol will be reviewed at staff educational meetings
Step 7	**Identify or develop implementation tools:** • Decision support system • Clinical assessment tools: o Symptom severity for target condition o Suicide risk o Psychiatric comorbidity o Adherence o Side-effects • Brochures and educational materials for PCPs • Brochures and educational materials for patients • Training materials for collaborative care team • Job descriptions and scope of practices for depression care team members • Establish clinic names and codes • Standards for assigning diagnoses, CPT codes, etc. • Consult forms/procedures • Other	• Education presentations to MH and PC staff.	• Facilitation team to provide MH Care Line Manager with contact from National evaluation team concerning cost analysis of program. • Education for PCP to be provided at quarterly in-service. • Education for MH staff to be provided at team meetings.

EXAMPLE 6
Primary Care-Mental Health Integration

Date: [Date]

Attendees: [Names, credentials (e.g., John Doe, MD)]

Visit Summary: Facilitation Team provided an overview of Primary Care-Mental Health Integration (PC-MHI) and discussed current practices as well as plans for upcoming restructuring of PC-MHI. This site has a unique plan for full integration of health care, including embedding a mental health team in PC and integrating primary care providers within specialty mental health services. [Name of facility/clinic] plans to have a psychiatrist, with an established panel and limited open access slots, co-located in PC. A clinical social worker will serve as the co-located, integrated care provider and will not have a full panel but will have open access slots. This provider will also engage in care management activities. Continued facilitated discussion will identify how new program design can ensure key components of integrated care are in place and will ensure on-going collaborative processes between PC and MH are established.

Elements Facilitating Integration Process:

- Primary care leadership is invested in integrated care
- Administrative leadership is supportive of the integrated care
- Availability of specialty care providers
- Willingness of organization to change for better patient care
- Existing infrastructure that could support mental health and primary care collaboration
- Positive experiences by primary care of integrated model
- Physical co-location with psychiatrists
- Infrastructure is in place at the network level that would support assessment piece of care management

Potential Integration Obstacles:

- Upcoming change in integrated care mental health provider
- New integrated care provider with limited experience in integrated care
- Lack of care management component in existing or planned program
- Despite co-location, limited availability of prescribing mental health provider in support of primary care in open access model
- Upcoming relocation of providers will necessitate careful monitoring to ensure that key components of the integrated care program are retained

Initial Plan:

1. PC and MH leadership and integration committee are to review facilitation team assessment.

2. Teleconference to identify how new program design can ensure key components of IC are in place (Care Management, open access to brief, focused interventions for alcohol

use disorders, depression, anxiety and behavioral medicine services to address broader behavioral health concerns).

3. Facilitation team to join conference calls of established [name of facility/clinic] integration committee.

4. Facilitation team to provide literature describing efficacy and implementation of specific care management programs, including the specific references and requirements presented in the Uniform Mental Health Services Handbook and the Mental Health Strategic Plan, and links to VA sponsored sites where care management is fully implemented with successful outcomes.

5. Review of implementation check-list through a teleconference to be scheduled by internal facilitator [name] with assistance from facilitation program assistant in 3-4 weeks.

6. Facilitation team to provide literature describing outcomes and implementation of integrated care.

7. Internal Facilitator [name] to present outcomes of integrated care at primary care education day [date], with input from External Facilitator [name].

8. Integrated care provider to attend training at [location] [dates].

9. Consult with local and regional leadership to identify how best to provide care management (inclusion in the role of integrated care provider, through additional site personnel, or through network level providers).

Appendix C: Planning Large Collaborative Conferences

How to Plan Large Learning Collaborative Conferences

A. Initial Steps

1. Start the approval process with VISN or Facility Education Departments once you have leadership support. This process normally starts in October-January but check with your VISN or Facility Education Department for their schedules and deadlines. This is only required if you need funding support. Get on their agenda to discuss the idea. This is a competition! Programs will be competing for dollars. If the program wins, another loses. The departments will help by giving suggestions for accomplishing goals. Be flexible and receptive to their suggestions. Sometimes their financial support will go to what they perceive as other more pressing priorities, but be persistent. For example, a proposal for a large, in-person learning collaborative did not receive funding one year, but the Education Committee made suggestions for and funded a smaller educational program, which was quite successful. The following year, the facilitator returned with a proposal for a large conference, and the Education Committee approved it.

2. Explicitly state to leaders what the benefit will be to the organization. Why should the organization spend valuable resources on it? Strengthen the proposal by tying it to other organizational goals, values, executive career initiatives, strategic plans or performance measures.

3. Establish funding mechanisms. Financial considerations may determine the type and size of conference planned. You should consider factors such as the availability of funds to provide travel for speakers, per diem and travel for participants, and honorariums for non-VA speakers. The availability of funds also will determine the location of the conference. Will there be funds to hold it at a conference center or hotel or will a VA facility be available and provide the optimal learning environment?

4. Clarify the source of funds and the responsible party for payment early in the planning stages. Generally, if the conference is approved for funding at the appropriate level, funding is provided for the faculty and conference site. Facilities or programs may need to provide the funds for participants. Clarify this at the outset because it will be a determining factor in whether you are able to get the speakers you want and if participants will have funding to attend. If the conference is small enough to hold at a VA facility and does not involve any over-night travel, you may not have to consider this.

5. Consult with your finance or education office to determine what, if any, funds will be needed and identify which fund control point will cover any needed funds.

6. Consult with Employee Education Services (EES) if your plan for a conference is approved. Usually, a member of EES will be assigned to assist with the project. If not, request the help. They are experts at making these arrangements. They will help with logistical details, planning, and conducting the conference. For example, they can

arrange for contracting with hotels, any needed audio-visual equipment, and break-out rooms. They will guide you through the planning process. They often have access to staff who will design registration brochures, establish registration links, and format surveys. They will help formalize goals and objectives and think about all the details needed to conduct the conference. In some cases, they will even provide staff for the registration table and help during the conference.

7. In planning a large learning collaborative conference, develop objectives and S.M.A.R.T. (specific, measurable, achievable, relevant and timely) goals. Decide what you want participants to accomplish from the conference. These goals help everyone stay on track.

8. Identify the intended audience. Who should attend the conference? Why do they need this information? What would motivate them to attend? In the VA, the intended audience usually is health professionals or support staff members. However, any invested stakeholders may want to attend. When designing the conference, keep in mind the educational and technical levels of the intended audience. Will the audience be heterogeneous, homogeneous or a mix of levels of expertise? If there will be a mixed audience, design materials that are comprehensible and interesting to all attendees.

9. Consult with peers, supervisors, and leadership for their ideas. Also, develop a marketing plan that you can fine-tune with the initial responses from consultants. When you have your initial ideas for the conference, goals and objectives, desired format, intended audience, and any budget requirements, you can begin to discuss them with leadership to obtain their support and input.

10. Decide on the format. The format of the conference may be informal or formal. It may be in-person, occur via conference calls or use other distance technology such as tele-video conferences or Live Meetings. Each has advantages and disadvantages.

11. Select the optimal learning environment to accomplish the goals within budgetary constraints. The advantage of an in-person meeting is the opportunity for networking and sharing of ideas. The disadvantages are the expense of bringing people together if travel funds are involved and the requirement that someone else must assume the responsibilities of participants during their absence. Large plenary sessions provide the opportunity for many participants to hear the same message. However, this environment does not usually enhance the opportunity for discussion and input. Small groups are much more conducive to obtaining input, accomplishing a task or asking questions. Distance technology such as tele-video conferences or Live Meetings may work well for didactic presentations and are cost-effective but don't enhance networking opportunities or discussion. If you choose to use distance technology, you must ensure that technical assistance is readily available to promptly resolve any issues that may arise. Always have a back-up plan should technology fail. For example,

arrange for a VANTS line in addition to the tele-video conference so that participants can make a conference call to listen-in if technology fails.

B. Planning Process

- Establish an initial meeting or conference call with the Education Office representative and Employee Education Office to determine some general time lines.

- Set the date of the conference to allow for sufficient planning time. We recommend at least four months planning time or longer for a major learning collaborative. Avoid planning an in-person meeting during seasons that are likely to interrupt travel plans and negatively influence the conference. For example, a conference in Minneapolis in January or one in Florida during hurricane season may limit attendance or minimize interest. Sometimes, you must schedule conferences at inopportune times. Be prepared with a back-up plan.

- Once you have established the date, work backwards with the time lines. Some of the deadlines on the timeline will include the following:

  - Establish a planning committee
  - Finalize goals and objectives for learning
  - Develop draft agenda
  - Obtain keynote speakers
  - Develop marketing plan
  - Deadlines for registration
  - Deadlines for Power-Point Presentations
  - Deadlines for Hand-out

- Form a planning committee that includes representatives from the major stakeholder groups to help guide the planning process. When recruiting members, explain the responsibilities of committee members, including participation in weekly conference calls, helping to establish goals and objectives, marketing the conference, assisting with obtaining speakers, serving as moderators for panels or conducting workshops. Keep leadership informed on progress and include them in the planning when possible.

- Develop a draft agenda, desired topics, and lengths of presentations that include a mix of learning opportunities consisting of plenary sessions and smaller workshops whenever possible.

- The committee can help recruit speakers and provide input on the agenda as well as help conduct the conference. The draft agenda will likely change during the planning process. Allow for as much lead time as possible when recruiting speakers. A back-up plan will help should a main speaker be unavailable due to weather delays or other

problems. Discuss the goals of the conference with speakers so they are clear about the message you want to convey. Check back with speakers on a regular basis to ensure that they understand your expectations and to answer questions. Confirm the agenda a month in advance with all speakers before finalizing it.

C. Follow-up After Learning Collaborative Events

- Follow-up with participants to assess whether the goals and objectives were met or more needs to be done.

- Conduct follow-ups by visiting or calling sites and talking with stakeholders to determine if they learned any new ideas or adopted goals and objectives for implementation. Help consolidate the learning to advance the implementation process.

Appendix D: Recommended Readings

Curran G, Mukherjee S, Allee E, Owen R. A process for developing an implementation intervention: QUERI Series. Implementation Science 2008; 3(1): 17.

Harvey G, Loftus-Hills A, Rycroft-Malone J, Titchen A, Kitson A, McCormack B, Seers K. Getting evidence into practice: the role and function of facilitation. J Adv Nurs 2002; 37(6): 577-88.

Kirchner J, Edlund CN, Henderson K, Daily L, Parker LE, Fortney JC. Using a multi-level approach to implement a primary care mental health (PCMH) program. Families, Systems & Health 2010; 28(2): 161-74.

Stetler CB, Damschroder LJ, Helfrich CD, Hagedorn HJ. A Guide for applying a revised version of the PARIHS framework for implementation. Implement Science 2011; 6(1): 99.

Stetler CB, Legro MW, Rycroft-Malone J, Bowman C, Curran G, Guihan M et al. Role of "external facilitation" in implementation of research findings: a qualitative evaluation of facilitation experiences in the Veterans Health Administration. Implementation Science 2006; 1: 23.