Using Implementation Facilitation to Improve Healthcare

IMPLEMENTATION FACILITATION TRAINING MANUAL

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FOREWORD

Our ability to translate the latest research findings into practice in a timely manner can be discouraging. Further we face challenges of how to apply the rigidly controlled environments of randomized-controlled trials with their related successes to the real-life environments of clinical practices. Focused efforts must be implemented in order to see the fruition of our labors into real clinic settings to ensure our patients receive the best treatments possible. These efforts must also support implementation in a variety of unique environments – each health care system, clinic, and individual with whom we work may need different types of support. Simply writing and issuing a national policy to implement a new strategy will be insufficient to see the fruits of our labor.

Perhaps that is why I am so enthusiastic about the publication of this updated Implementation Facilitation (IF) Training Manual. IF has been critical to the success of multiple national efforts within the VHA system – measurement-based care, primary care-mental health integration, and evidence-based psychotherapy initiatives, to name a few. The beauty of IF lies in its strong foundation in implementation science principles combined with the practical applications needed to support administrators, clinicians, stakeholders, and patients in rolling out evidence-based interventions. IF hears the voices of all these individuals and helps to make research-based strategies practically supportable in the real world setting in which we all practice. It is patient and provider centered in its approach, in true support of our Quadruple Aim mission.

The Manual was originally developed to support implementation of evidence-based practices and programs and other clinical innovations in the VA and has been used, along with an IF Training Program developed by the VA Behavioral Health (BH) Quality Enhancement Research Initiative (QUERI), to support a multitude of national clinical initiatives. This version of the Manual reflects the latest IF research and theory, as well as the experiences of IF experts. It is a practical resource for those who are new to implementation facilitation and those who have been applying it for years. The Manual was developed by IF experts who are affiliated with VA BH QUERI and have substantial experience and expertise in applying and testing the impact of IF strategies to support implementation of evidence-based practices and programs and other clinical innovations. Over the past 8+ years, they have systematically worked to transfer this knowledge to national VA leaders, frontline clinical managers, other QUERI/VA researchers, and non-VA researchers through development and ongoing refinement of an IF Training Program. Not only are these among the most brilliant minds in implementation science I have encountered, they are also individuals who care deeply about bringing evidence-based practices to patients, while also caring for and supporting the people ensuring its implementation.

Those who choose to utilize this resource and receive training from these partners will find their ability to implement best practices to be tremendously strengthened, even at sites facing the greatest challenges. I am indebted to each of these individuals for their strong support of so many efforts for us in VA nationally over the years and I am thrilled to see their work translated in such a manner to have even broader reach to each of you and the systems and individuals you serve.

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INTRODUCTION TO THE TRAINING MANUAL

Implementing evidence-based practices and programs, or any complex innovation, is challenging. Implementation Facilitation is a strategy with proven success in supporting implementation efforts. Facilitation has been widely used in many fields (e.g., management, education, social work, community development, mediation, as well as healthcare). Typically, we think about facilitation as a process of working with groups to support participatory ways of doing things. Group facilitators are generally experts in the process of helping groups, e.g., make decisions and identify and solve problems. Although group facilitation may be used to support implementation efforts, it may not be sufficient to help complex healthcare organizations make the changes needed for improved clinical practice. This manual focuses on *implementation facilitation* (IF), a multi-faceted process of enabling and supporting individuals, groups and organizations in their efforts to adopt and incorporate innovations into routine practices. IF may often include many other implementation strategies, e.g., audit and feedback, education and training, and stakeholder engagement.

The purpose of this manual is to:

1) provide information and resources for individuals seeking to understand and apply implementation facilitation, and
2) support the development of the skills facilitators need to help organizations implement innovations.

The manual incorporates *implementation science* and clinical operations expertise and includes practical recommendations for applying evidence-based implementation strategies that can improve uptake of evidence-based clinical practices by targeting barriers at the provider or health care organization levels. Although there are other publicly available materials that serve the same purpose, this manual also provides practical guidance for supporting implementation of innovations within Department of Veterans Affairs (VA), Veterans Health Administration facilities. Some innovations are more complex and include multiple components (e.g., changes in provider behaviors and workflow processes). The word, "program" in this manual refers to this type of innovation. The manual was designed to be one component of a facilitation training program, but it can also be used by any individual wishing to obtain information and/or hone skills needed to help healthcare organizations implement innovations. For example, practice facilitators working with Practice Based Research Networks, coaches, and quality improvement leaders may also find this Manual helpful.

Program
a complex innovation that includes multiple components

This Training Manual consists of ten chapters. The first two provide general information about IF. In Chapter 1, we provide a brief overview of IF, issues to consider when using an IF strategy, conceptual models that can guide the use of the strategy, the current evidence for the

effectiveness of using IF, and some discussion about when IF should be applied. Chapter 2 provides information about the characteristics of good facilitators; the knowledge, skills, and core competencies that facilitators need to be effective; and how to learn IF skills and develop competencies. In Chapter 3, we discuss different models of IF, provide an overview of the phases of the implementation process, and how change agents (including external and internal facilitators) work together across phases of implementation.

The next four chapters provide practical guidance for those who may be in a facilitator role; therefore, they are written in the first person. These chapters focus on conducting IF activities and monitoring and improving IF processes. Chapter 4 describes the critical tasks facilitators need to perform during the pre-implementation phase in order to lay the foundation for all other IF activities. Chapter 5 provides practical information about IF activities for helping sites and their stakeholders successfully implement an innovation. Chapter 6 describes activities and resources for sustaining the innovation and Chapter 7 provides guidance for facilitating implementation virtually, i.e., with limited or no in-person contact between facilitators and site personnel.

In Chapter 8, we provide some special applications of IF for implementing virtual technology, e.g., Video Telehealth to Home, to deliver innovations. Chapter 9 discusses methods for evaluating an IF strategy through documenting facilitation activities, assessing fidelity to the innovation as well as to the implementation strategy, and assessing outcomes. Finally, Chapter 10 discusses strategies facilitators can apply to support their own wellbeing and thereby enhance their effectiveness. The appendices include references to additional materials and sample tools and materials to reinforce and advance facilitators' skill development.

Additionally, this version of the IF Manual incorporates, for the first time, cutting edge knowledge, suggestions, and resources for using IF to reduce disparities in healthcare implementation and to promote health equity for all people. We have much to learn and study about overcoming implementation barriers leading to disparities, such as structural racism or heterosexism. We showcase our commitment to humble reflection, learning, and action to promote health equity in a more socially just society by beginning to explicitly consider and address implementation disparities in this new version of the manual.

This manual is a work in progress and will be informed by future findings from IF studies as well as possibly your own experiences. We invite you to provide us with feedback and materials or resources that may be helpful to others who are embarking on this journey. We encourage you to share this manual or the link to it with others, both in and outside of VA: https://www.queri.research.va.gov/tools/implementation/Facilitation-Manual.pdf

CHAPTER 1
OVERVIEW OF IMPLEMENTATION FACILITATION

Although implementing and sustaining evidence-based practices and programs (EBPPs) can improve the quality of healthcare and the outcomes patients experience, the processes involved can be challenging. This is particularly true when implementing relatively complex clinical programs (e.g., Integrated Primary Care), Evidence-Based Psychotherapies). Such programs require significant stakeholder engagement, support from multiple care specialties, and changes in provider attitudes, organizational structures and processes, and clinical practice.[1-3] Effective implementation of clinical and organizational practices and programs involves tailoring them to individual settings, applying diverse implementation strategies to support adoption, and involving multiple stakeholders. Although the Department of Veterans Affairs (VA) is a forerunner in the development, promotion, and implementation of EBPPs through innovative research initiatives, guidelines, quality improvement efforts (e.g., performance monitoring), and programs designed to leverage and advance implementation science, many VA clinical settings struggle with implementing EBPPs and other clinical initiatives. In this Manual, we primarily focus on the application of implementation facilitation to support adoption of EBPPs in VA clinical settings; however, we have found that previous versions of this Manual were applicable to non-VA settings as well. Because healthcare organizations frequently implement new practices, programs, and initiatives, evidence-based or not, in this Manual we will call WHAT is being implemented, the "innovation," and WHERE the innovation is being implemented, the "setting" or "site."

INNOVATION = WHAT

EBPPs or any clinical or organizational practice, program, or initiative being implemented

SETTING/SITE = WHERE

Location (e.g., organization, clinic, facility) where the innovation is being implemented

Implementation facilitation (IF) has been widely used in many healthcare organizations to support implementation of innovations. In its simplest form, IF is a process of interactive problem-solving and support that occurs in the context of a recognized need for improvement and a supportive interpersonal relationship.[4,5] However, IF can also be a very complex, multifaceted implementation strategy that addresses challenges or barriers by incorporating many other implementation activities. These include but are not limited to identification and engagement of key stakeholders at all organizational levels, problem identification and resolution, provision of local technical support, creation of learning collaboratives, academic detailing (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 role modeling.[4,6-9] IF can be applied in any healthcare setting but a great deal

IMPLEMENTATION STRATEGY

What you do (or someone else does) to help the setting implement the innovation

has been written about a specific type of IF, called *practice facilitation*, which is primarily applied in primary care settings.[7,10] Practice facilitation has also been used to bridge clinics and communities in some studies and is increasingly used to link payers and health systems/clinics. There are currently no clear distinctions between IF and practice facilitation, although IF focuses on the implementation of innovations, when in some cases practice facilitation has been utilized to improve existing healthcare processes.

Although facilitation has been used in many disciplines, the tenets of IF in healthcare arose from the education and nursing disciplines and acknowledge the fact that, while research evidence supporting a given program or practice is important, clinical experience and professional knowledge provide additional evidence that directly affects the adoption of an innovation.[11,12] For example, learning about the experiences of a colleague who has successfully used the innovation may be more compelling evidence to a provider than a journal article. In addition, factors within the implementation setting or context influence innovation adoption. For example, organizational structure, leadership support, prior experience in new practice implementation, and methods of communication directly influence implementation efforts. Finally, characteristics of the innovation being implemented influence uptake. As mentioned earlier, highly complex innovations such as the integration of mental health services into primary care settings may be more difficult to implement than a less complex innovation such as prescribing a new medication that has just been approved. Implementation facilitation provides a process through which factors that impede uptake of the innovation may be addressed whether such factors are associated with those receiving the innovation (i.e., the recipients), the context within which the innovation is being implemented, or characteristics of the innovation. For additional information on the influence of evidence, context, and innovation characteristics on implementation, see discussion of the 'integrated – Promoting Action on Research Implementation in Health Services' (i-PARIHS) framework on page 7.

Implementation facilitation involves helping rather than telling.[12,13] Establishing a partnership based on mutual respect with stakeholders at the implementation setting is *critical* to successful implementation. IF is not a process of providing resources and stepping back or simply telling someone what to do. Rather, it requires the creation of a supportive environment within which knowledge may be exchanged, barriers to implementation identified, and processes or solutions to overcome those barriers developed, applied, and refined.[8,14] IF also involves both doing and enabling. At times, facilitation involves doing something for the organization or its stakeholders. For example, facilitators may provide education or monitor uptake of the innovation through audit of electronic clinical data and feeding this information back to clinical providers (audit and feedback). At other times, they may help and enable clinical providers to provide education or feedback to others. Although facilitation of each implementation effort has its own purpose and goals, ultimately, the overall purpose of facilitation is to provide the help and support needed to improve clinical care and patient outcomes.

Implementation facilitation involves helping rather than telling. Establishing a partnership based on mutual respect with stakeholders at the implementation setting is critical to successful facilitation activities.

This manual is designed to help implementation facilitators or those planning an IF process think about a number of factors.

Issues to Consider When Planning an Implementation Facilitation Strategy

Will the facilitator be internal or external to the setting?

Facilitators can work either externally or internally to the setting. For example, an external facilitator may be an expert in general implementation strategies and tools and have expertise or credible knowledge about the innovation and its evidence base. An internal facilitator may be familiar with facility-level organizational structures, procedures, and culture as well as, if needed, the clinical processes within the healthcare network (e.g., the Veterans Integrated Services Network) as applicable. A particular implementation effort can include an internal facilitator, an external facilitator, or both. Although external facilitation is frequently applied in settings in which local staff lack implementation knowledge and skills, combining external and internal facilitation can support the current effort as well as build capacity and knowledge that may be applied by the internal facilitator in future implementation efforts.

What will facilitators do?

We've already mentioned several activities facilitators can perform, such as engaging stakeholders, problem-solving, and providing education. The particular activities that facilitators engage in and when they do them depend upon stakeholder needs during the implementation process.[6,15,16] For example, pre-implementation activities focus on engaging leadership support, identifying key stakeholders, and academic detailing. Late-phase implementation focuses on activities to sustain an innovation (e.g., establishing ongoing audit and feedback processes and fostering EBPP role modeling). Sometimes facilitators are responsible for dual roles. For example, a clinical provider with designated time for IF activities may serve as an internal facilitator in addition to performing their clinical duties. Chapters 4-8 describe IF activities in detail.

What knowledge and skills should facilitators have?

Implementation facilitators need a wide range of knowledge and skills.[17-19] In addition to core skills, e.g., interpersonal and communication skills, and those related to applying IF processes, implementation facilitators need some "content" knowledge about the innovation, its core components and how it should be implemented. They do not have to be experts in the innovation. They can consult or collaborate with experts as needed, but without their own credible knowledge of the particular innovation, facilitators will have difficulty performing facilitation activities such as assessing the organization's readiness for change, needs, resources, and barriers and facilitators to change. Chapter 2 will provide detailed information about the knowledge and skills that facilitators need to be successful in the role.

How long and how often should facilitation be provided?

Facilitators need to consider how long they will work with a setting to support implementation of an innovation. Many factors should be considered when making this decision, e.g., the complexity of the innovation, the organization's size, characteristics and resources for implementation, as well as the resources available to support the efforts of the facilitator. The duration of the strategy overall may, in some cases, be pre-determined (e.g., six months) but whenever possible, IF should continue until the innovation is well established within the clinical setting(s) and/or local change agents take full responsibility for supporting implementation or sustaining the innovation. Facilitators also need to decide how frequently they will interact with site stakeholders. The frequency of interaction may also be pre-determined (e.g., through weekly, bi-weekly, or monthly calls) or be scheduled based on the needs and characteristics of the site. In either scenario, interaction may be a mix of regularly scheduled interactions and other ad hoc interactions as needed.

Will facilitators work with other change agents to effect change?

Implementation is likely to be more successful when internal change agents are engaged in supporting implementation. Facilitators can engage and work with local change agents, such as clinical champions, opinion leaders, and/or quality improvement/implementation teams, who share responsibility for implementation. (See Appendix A-2. Glossary of Terms, pages 140-144, for definitions of these terms).

Which stakeholders will implementation facilitators target?

Facilitators need to target all individuals and groups of stakeholders who can impact implementation of the innovation and/or will be directly affected by the implementation effort. Some of those stakeholders may be the providers of the innovation, other providers and staff who refer patients to innovation providers, or the patients themselves. Facilitators also need to target organizational leaders who can support implementation efforts, as well as frontline clinicians and other staff members who must be involved for successful organizational and clinical practice change.

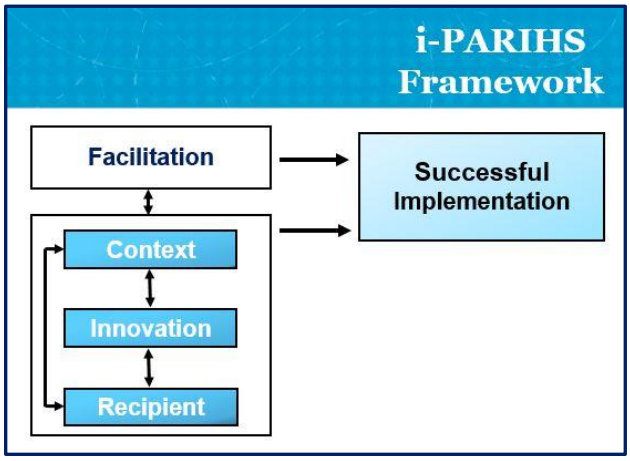
What medium will implementation facilitators use?

Facilitators can use any medium of interaction that is available to them and effective. In-person meetings are always valuable for assessing sites and engaging stakeholders but may not be feasible for every interaction. Facilitating implementation virtually through phone conferencing, videoconferencing, webinars, and other technology-based mediums may be necessary if resources for travel are not available or in other circumstances where in-person interactions would not be recommended (e.g., COVID-19 pandemic). See Chapter 7 for more information on virtual IF.

Conceptual/Theoretical Frameworks for Guiding IF's Application

Scholars agree that it is important to use implementation science frameworks/models to understand and guide the implementation process, as well as to identify and address factors that hinder and support it.[20-22] Although using a conceptual framework is valuable, discussion about the many available frameworks, how to select those tailored to a particular innovation and context, and how to apply them is beyond the scope of this Manual. For that reason, here we discuss briefly one framework (i-PARIHS) that is particularly well-suited to the use of an IF strategy, and then we mention a couple of other frameworks that may be of interest as well.

Figure 1: i-PARIHS Framework



The integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework, which was informed by other theories, models, and frameworks and the extensive experience of its developers, proposes that implementation is influenced by four domains and the dynamic interaction between them.[14,23] Specifically, i-PARIHS proposes that implementation is influenced by characteristics of the *innovation* being implemented, the people who help implement or who receive the innovation (*recipients*), and the organizational *context* in which the innovation is implemented. A fourth influencer, *facilitation*, is the active ingredient needed for successful implementation. Facilitation can address the challenges and leverage the positive influences related to the innovation, recipients, and context. Thus, the i-PARIHS framework is ideally suited to guide the facilitation process.[14]

Though IF is frequently associated with the i-PARIHS framework, other conceptual frameworks, such as the Consolidated Framework for Implementation Research (CFIR)[24] and the U.S. Centers for Disease Control and Prevention's Replicating Effective Programs (REP) framework[25] may also be helpful in thinking about how to facilitate implementation of an innovation. Nilsen (2015) provides more information about different types of implementation theories, models, and frameworks.[21]

Evidence for the Effectiveness of Implementation Facilitation

There is a growing body of evidence that IF is effective in improving implementation of innovations. For example, in VA treatment settings, IF strategies have been used to: implement Primary Care Mental Health Integration programs with improved uptake, quality, and adherence to evidence;[26,27] improve uptake of a national program to re-engage Veterans with serious mental illness into care;[28] improve adoption of brief cognitive behavioral therapy in primary care;[29] improve metabolic side effect monitoring for patients taking antipsychotic medications;[30] and increase enrollment in a quality improvement initiative to improve transitions of care for patients with heart failure.[31] In non-VA settings, IF strategies have supported implementation of patient-centered medical homes in primary care[31] and improved diabetes care,[32] preventive

care[33], and pediatric hospital care.[34] In addition, a systematic review found that primary care practices were almost three times more likely to adopt evidence-based guidelines through the use of IF,[10] and another review found beneficial effects of IF on outcomes of four major chronic diseases in primary care: asthma, cancer, cardiovascular disease, and diabetes.[35] Clearly, evidence for the impact of IF in supporting implementation of effective clinical programs and practices is robust across diverse clinical settings, including under-resourced, late-adopter locations.[26] Since this Manual is focused on how to apply IF strategies, those interested in learning more about the evidence base for IF are encouraged to review the cited references for more information.

Is Facilitation the Implementation Strategy to Use in All Situations?

As described above, IF has been shown to be particularly effective in supporting implementation of highly complex innovations such as those that require integrating new providers into a clinical setting, new roles for clinical staff and/or new clinical processes, even in under-resourced, late-adopter sites. However, it is important to note that IF can require considerable resources in terms of the facilitator's time as well as the time of the clinical leaders/stakeholders with whom they engage. For innovations that are not as complex, such as making providers aware of a newly approved medication that may benefit their patients, consider using an alternative, less resource-intensive strategy like training/education (including academic detailing) and/or technical assistance. Essentially, for innovations of low complexity, it is certainly appropriate in terms of efficiency to give consideration to whether another strategy requiring fewer resources may offer similar chances for implementation success.

Another consideration is whether some settings may not be the best 'candidates' for receiving IF (e.g., chaotic sites with ineffective leadership and/or high rates of provider/staff turnover, sites that are overtly antagonistic to implementing the innovation). Given the resources involved in applying IF, you may want to be selective in choosing which sites to work with and avoid those that are either not ready for an IF strategy or not receptive.

As we have pointed out in this chapter, implementation facilitation is a complex, evidence-based implementation strategy. If you are using or plan to use IF, there are multiple issues you need to consider in order to maximize the potential for successful implementation. We also recommend that you select a conceptual framework that can guide the facilitation process.

CHAPTER 2
CHARACTERISTICS, KNOWLEDGE, SKILLS, AND CORE COMPETENCIES OF FACILITATORS

Not everyone can facilitate change. Literature suggests that facilitators need a diverse range of personal attributes and skills to be effective. Implementation facilitation (IF) is complex. Not only do facilitators need to be able to apply a wide range of implementation strategies, they need to be able to assess what should be done, who should be involved, when they should intervene to facilitate change, and what might impede or enhance implementation of the innovation. This chapter will discuss some of the attributes of good facilitators, the knowledge, skills, and core competencies they need, and how facilitators can develop IF skills.

I. CHARACTERISTICS OR ATTRIBUTES OF FACILITATORS

There are likely personal characteristics that may predispose facilitators to choosing this role and/or make it easier to assume. Merriam-Webster defines a characteristic as "a distinguishing trait, quality, or property." Below we list characteristics of facilitators that are more commonly mentioned in literature.

- Because facilitation needs to occur within an environment of mutual respect, perhaps the most important characteristic of a good facilitator is the *ability to empathize and understand the needs of others*.

- The facilitator needs to *be genuine and positive* in order to establish such relationships.

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

- It is important for the facilitator to know *when to speak, when to listen, and how to handle criticism*.

- It also is important to develop a pattern of *responding to stakeholder feedback and suggestions in a timely manner* to achieve implementation goals.

- Facilitators need to *be flexible* so that they can adapt their efforts and respond to local context, including needs and resources.

- They need to be *self-confident*, *innovative and resourceful*, as well as *exhibit energy and enthusiasm.*

- Finally, they need to be *credible, approachable, and accessible.*

See Elledge, et al. 2019 for additional characteristics.[36] Although having such characteristics is important, facilitators also need the appropriate knowledge and skills to support implementation.

II. KNOWLEDGE FACILITATORS NEED

In addition to knowledge of IF roles and processes, facilitators need credible knowledge about the innovation being implemented. In some cases, facilitators are subject matter experts; even so, it is important to know other experts who have a more nuanced understanding of some element(s) of the innovation to whom facilitators can refer as needed. If the facilitator is not an expert in the clinical or organizational innovation being implemented, he or she should know enough about the innovation and how it works to be able to help the site implement it and embed it within the organization so that it will be sustained. However, the facilitator may also engage one or more innovation subject matter experts to ensure that site stakeholders have access to that expertise. Additionally, facilitators require some knowledge of implementation science, quality improvement, and organizational change processes, as well as the organizational policies, structures, and contexts that can affect implementation of innovations. We will discuss knowledge facilitators need in Chapters 4 and 5.

III. IMPLEMENTATION FACILITATION SKILLS AND CORE COMPETENCIES

However, knowing about the innovation, facilitation, and implementation is not sufficient. Facilitators also need to develop a wide range of complex skills to help organizations implement innovations. Ritchie et al. documented five core competencies consisting of twenty-two skills/skillsets.[18] Core competencies facilitators need to develop include abilities to:

- Build relationships with and between others and create a supportive environment for change
- Help change the system of care and the structure and processes that support it
- Transfer knowledge and skills and create infrastructure support for ongoing learning
- Plan and lead change efforts
- Assess people, processes, and outcomes and create infrastructure for program monitoring

Skills facilitators need to develop these competencies are both complex and overlapping. For example, assessment skills include communication skills (i.e., the ability to listen and ask questions). In fact, many of the skills facilitators need include both communication and assessment skills. Although facilitators need a wide range of skills, the types of skills they need may depend on the innovation being implemented and the organizational context for change.

Below is a list of IF skills for each of the core competencies. All five competencies require communication skills.

Table 1. Implementation Facilitation Skills (Adapted from Ritchie et al. 2020)[18]

Communication skills	Interacting with individuals and groups, orally or in writing, to share information, e.g., through formal presentations, less formal conversations, emails, messages, and reports; listening to stakeholders; and asking questions to understand their needs and concerns
Competency 1 **Building relationships and creating a supportive environment**	
Interpersonal skills	Interacting with stakeholders in positive ways, e.g., listening to stakeholders and ensuring they have opportunities to express their opinions, deferring to them when appropriate, working around their schedules, assessing and addressing their needs and concerns, and knowing when and how to be assertive and still be supportive
Stakeholder engagement	Involving stakeholders (individuals/teams that can affect or will be affected by the innovation) and fostering participation in planning and implementation processes, as well as tailoring interactions to their needs
Motivating/building confidence	Praising stakeholders for participation and implementation progress and encouraging them to assess their own efforts, share their successes, solve problems, and create their own strategies
Political skills	Assessing, understanding, navigating, and leveraging the political dynamics of the setting
Interacting and working with leaders	Combining and applying all of the skills in this group to obtain the support and involvement of leaders, includes being comfortable with leadership at all levels, adopting a power stance when appropriate, and being respectful of leaders' time and supportive of their decisions
Competency 2 **Changing the system of care and structures and processes that support it**	
Helping to design/adapt an innovation to meet local needs	Helping stakeholders plan an innovation that fits with local needs and available resources and further adapt the innovation based on implementation progress and outcomes data and emerging barriers and enablers
Problem identification and solving skills	Identifying and addressing problems and helping stakeholders identify and address problems, e.g., lack of space, implementation resources, leadership support, and stakeholder participation
Presenting/using data to improve the innovation	Reviewing, interpreting, and presenting qualitative and quantitative information and using this information, e.g., to support and

	encourage stakeholder efforts, plan interventions to improve implementation, and support problem identification
Helping integrate the innovation into other programs/services	Identifying and collaborating with leaders/staff of programs whose patients might need the innovation, who may provide additional services for patients receiving the innovation, or who may benefit from knowledge of the innovation to support sustainability after active implementation
Competency 3 **Transferring knowledge and skills and creating infrastructure support for ongoing learning**	
Education/marketing skills	Persuasively presenting and discussing the innovation, how it works, and the evidence for it; the innovation's value, benefits, and outcomes and how to implement it, including how to address implementation challenges, as well as tailoring content and process to stakeholder needs and concerns
Training, mentoring, and coaching skills	Using training, mentoring, and coaching techniques to transfer skills to clinicians and leaders for providing/conducting the innovation
Learning and fostering learning skills	Applying learning strategies (e.g., learning from experts, others similar to yourself, and from past experiences) to fill in gaps in knowledge and build on existing knowledge and skills; and fostering stakeholder use of these strategies
Building learning collaboratives	Building a learning collaborative for innovation providers to support implementation by encouraging participation, facilitating meetings/calls, and encouraging members to share their own experiences and problems, work on solutions, and develop best practices
Competency 4 **Planning and leading change efforts**	
Administrative and project management skills	Performing technical tasks, e.g., working with sites to plan and schedule site visits and conference calls and disseminating materials and site visit reports, and pushing implementation forward when stakeholders/sites are not responding, or implementation processes are stalled
Meeting facilities and individuals where they are	Accepting and working with site and stakeholder limitations, building on their strengths, and helping them be as successful as possible
Leading/managing team processes	Facilitating communication and managing conflict/disruptive behavior; guiding team processes, e.g., by sharing ideas, affirming stakeholder input, fostering team self-management; and leading task-oriented processes, e.g., goal setting, innovation design and adaptation, decision-making, and problem identification and solving

Thinking strategically and planning	Thinking through what is currently happening at sites, what needs to happen for successful implementation, and how facilitators can help; planning/preparing for implementation events; and diagnosing/evaluating sites and implementation processes
Pulling back and disengaging	Gaging when stakeholders are ready to assume responsibility for implementation efforts and refraining from acting as the expert, deferring decision-making to leaders, helping stakeholders explore options and come to consensus, and saying good-bye
Competency 5 **Assessing people, processes, and outcomes and creating infrastructure for monitoring**	
Organizational and individual assessment skills	Gathering information about and assessing the organizational context, including demographics, current practices, leadership structure/support, and relevant policies and procedures that can influence implementation, and assessing stakeholders, interpersonal and group dynamics, and other factors
Developing an innovation monitoring system	Helping sites identify measures for assessing/monitoring provider productivity, innovation utilization, and outcomes; identifying, accessing and obtaining data from existing databases; and developing/preparing feedback reports for monitoring, adapting and improving the innovation
Monitoring innovation implementation status	Continually observing implementation progress by reading and interpreting data in feedback reports; assessing innovation fidelity to the evidence-base, fit with organizational context, and implementation barriers/enablers

IV. HOW TO LEARN IF SKILLS AND DEVELOP CORE COMPETENCIES

Facilitators learn their skills in a variety of ways. Some attend training workshops and/or receive ongoing mentoring. Others assume the role of facilitator but receive no formal training and have to learn by trial and error. Publicly available training manuals, such as this one, and other materials may be helpful to new, or even more experienced implementation facilitators, but they are not sufficient for developing such a large number of complex skills and core competencies and adapting their application to local needs, resources, and other contextual characteristics. Training workshops, particularly if they are interactive, are helpful in laying a foundation. Having personal characteristics that are facilitative help, as does having good communication and interpersonal skills. However, even individuals with preexisting good communication and interpersonal skills have to learn how to use those skills in the interest of helping others implement innovations.[37] Scholars agree and our own experience confirms that new facilitators need some ongoing support, i.e., mentoring, coaching, and/or consultation, to develop these skills.

How facilitators can obtain ongoing support is also variable. In their 2015 revision of the PARIHS Framework, Harvey and Kitson describe one model of the pathway from novice to

experienced and expert facilitator.[14] They propose that novice facilitators are best able to support local, focused implementation projects under the direction and guidance of more experienced facilitators who can help them learn the basic skills of facilitation. As novices gain facilitation knowledge and skills (specifically around organizational change, team dynamics, and system change) they move into the role of the experienced facilitator who, under the supervision of an expert facilitator, are able to focus their work at a larger contextual level and assume responsibility for helping to mentor and support novice facilitators. Finally, expert facilitators are able to work within and across health systems to support and evaluate implementation in multiple contexts and across innovations. Thus, the "expert's role is one of coordination, leadership, and the provision of high-level expertise" around facilitation, the innovation, recipients, and context, i.e., the four dimensions of i-PARIHS.[14] This type of structured approach to training and facilitation knowledge acquisition can provide an established process within healthcare systems through which facilitators can be trained, mentored and vetted as well as a career trajectory in this emerging field. Unfortunately, many projects and initiatives lack capacity for using this model. In many initiatives and projects, an expert or group of experts provide training and support or consultation to novice facilitators who conduct their work at multiple levels of a health care organization and across multiple organizations as needed.

Finally, for some IF efforts, novice facilitators lack training and/or ongoing support. **We strongly encourage novice and even experienced implementation facilitators to seek training, mentoring, and/or consultation with others who have some expertise in IF.** Implementation facilitation is a complex strategy; it is easy for facilitators to become overwhelmed when they lack a person or community with whom they can discuss challenging situations and barriers. We address this topic in Chapter 10.

Even when formal mechanisms for mentoring or consultation are not available, facilitators can take several steps to develop the skills they need:

- Seek out experts or even peers in other systems that have more experience than you. There are methods that experts use to transfer IF skills.[37] Understanding these methods can inform your efforts to seek consultation from more experienced facilitators. For example, ask them to model how to perform facilitation activities you are learning and then explain why they did what they did. You might ask them to give you examples or tell you stories about similar situations and how they handled them. Ask them to coach you on how to perform particular activities and/or shadow you while you do them, providing feedback on your efforts. You could also ask them to let you reflect on what you think you should do and provide feedback.

- Establish a learning collaborative or community of practice with facilitators in other healthcare settings to share lessons learned and provide a venue for seeking consultation.

- Of course, finding an IF expert who can act as a mentor and provide regular ongoing support is ideal but not always available.

This chapter explored some of the attributes of good facilitators, the knowledge, skills, and core competencies they need, and how facilitators can develop the wide range of complex skills needed to help organizations implement innovations. Although facilitators can learn about IF and develop these skills through formal training or by trial and error, it is best done with the support of a more experienced facilitator.

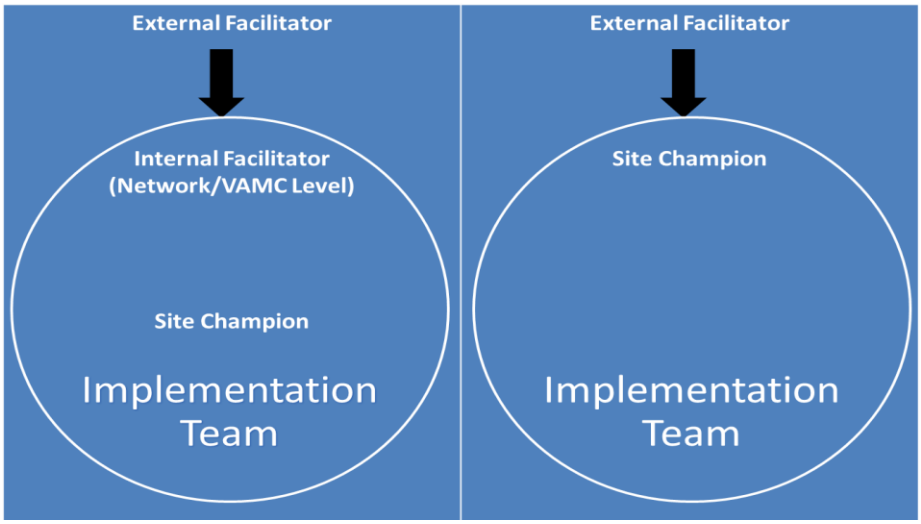
CHAPTER 3
MODELS OF IMPLEMENTATION FACILITATION AND THE IMPLEMENTATION PROCESS

As previously discussed, facilitation is both a role that individuals assume and a strategy focused on helping stakeholders to implement innovations in their setting. In this chapter, we provide information on different models of the facilitation role in relationship to the setting, the implementation process which consists of three phases, and how facilitation models play out across the phases of implementation.

I. MODELS OF IMPLEMENTATION FACILITATION

Facilitators can be located either internally or externally to the organization or setting in which the innovation is being implemented. Additionally, there are different models or configurations of facilitation depending on where facilitators are located (i.e., external or internal to the setting) and whether they enlist the help of other change agents in the setting to support implementation processes. For example, an external facilitator who is an expert in general implementation activities and relevant clinical or organizational innovations and their evidence base can work with an internal facilitator who is familiar with organizational structures, procedures, and culture as well as the clinical processes within a healthcare region or facility. In such models, the external facilitator typically augments their own implementation support activities with mentoring efforts to transfer implementation knowledge/skills to the internal facilitator so they can be applied not only in the current implementation effort, but also in future efforts when the external facilitator is no longer available. The internal facilitator typically carries the greater share of the burden in supporting the implementation efforts of stakeholders at the local level. Alternatively, in another model, an external facilitator can work directly with a *local site champion* and/or *implementation team* (i.e., without an internal facilitator) to support innovation implementation (See Figure 2). This implementation team (sometimes referred to as a quality improvement team) is typically comprised of stakeholders that have specific knowledge or expertise that will inform innovation implementation. The external facilitator assists local leadership and site champions in identifying which stakeholders should be included on the local implementation team, based on their knowledge of innovation requirements and site assessment (See Chapter 4).

Figure 2. Examples of External Facilitation Models



An alternative to having an external facilitator is that of an internal facilitator working on a specific initiative or embedded within an organization, as is common in many Canadian healthcare settings.[38] For example, in this structure (see Figure 3) a facilitator may provide direct implementation support to a clinic or practice within which they are located or affiliated or, similar to the external facilitation models, the internal facilitator may enlist the assistance of other change agents, i.e., a local site champion or an Implementation Team. These internal facilitators may use a variety of organizational development, project management, quality improvement, and practice improvement approaches to build the internal capacity of a clinic to help it engage in improvement activities over time and support it in reaching incremental and transformative implementation goals.

Figure 3. Example of Internal Facilitation Model

Facilitators, whether they are internal or external to the clinical environment, are experts in implementation of innovations. In some cases, the expertise of an internal facilitator may develop over time through mentoring by an external facilitator or through their own acquisition of knowledge. Senior leadership support for the facilitator's involvement in implementing an innovation is critical to ensure that the facilitator's expertise is recognized and reinforced. The facilitator's goals are to help sites create a structure and pathway through which innovations may be successfully implemented. First, and foremost, the facilitator must create a positive working relationship with key stakeholders. As noted by Stetler et al., 2006, p. 7,[4] "facilitation is more two-way than other implementation strategies, not as prescriptive and more adaptive and

respectful of what is in place." Facilitators should support the vision for change. This requires a consistent presence through site visits, telephone conferences, emails, and/or other forms of communication. With these contacts, the facilitator can provide the motivational push and intellectual resources that help lead to successful implementation within a specific context. The strategies applied by a facilitator will likely vary based on the needs of a specific setting and the phase of the implementation process.

II. PHASES OF THE IMPLEMENTATION PROCESS

Implementing an innovation within clinical settings typically involves activities that occur over three phases—*pre-implementation*, *implementation*, and *sustainment* phases.

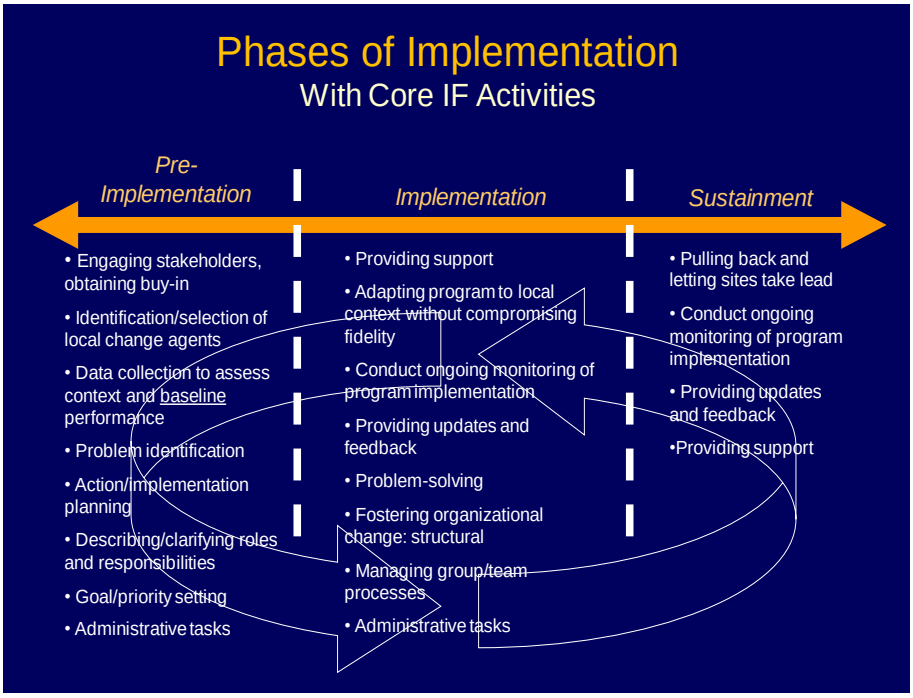
The ***pre-implementation phase*** is a time period for designing a customized, local plan for implementing an innovation and conducting other activities that need to occur PRIOR to implementation. Aarons and colleagues (2011) divide pre-implementation into *exploration* and *adoption decision/preparation* phases.[39] During the exploration phase, the focus is on becoming aware of issues that need attention or improved methods for addressing challenges. In the adoption decision/preparation phase, the questions of interest include factors that support the decision to implement the innovation and the selection of strategies to support implementation. Given the amount of time and effort that may be necessary to engage sites in implementation activities, there is strength in this type of categorization. Yet, since this manual focuses on facilitation, we collapse these two categories into a single pre-implementation phase.

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

The ***sustainment phase*** focuses on activities and strategies to ensure that performance or quality improvement goals are achieved and changes in the structure or processes that produced that improvement are sustained 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 back to another phase or through the phases multiple times during the course of an implementation effort* to achieve the desired change. For example, a facilitator might think that the implementation effort is moving toward the sustainment phase when staff turnover or leadership change requires a return to conducting activities (i.e., stakeholder engagement) that are more common in the pre-implementation phase.

Figure 4: Phases of Implementation* and Core IF Activities**



*Adapted from Stetler et al. 2006[40] **Excerpted from Smith et al. 2020[41]

III. HOW EXTERNAL FACILITATORS, INTERNAL FACILITATORS, CHAMPIONS, AND IMPLEMENTATION TEAMS WORK TOGETHER

The degree and type of interactions that occur between an external and/or internal facilitator, champion and/or implementation team will vary across implementation efforts and the implementation phase. While the facilitator can be internal or external to the clinical setting, our experience and knowledge has largely been gained through the application of an External Facilitator (EF) model (Figure 2). Therefore, we frame much of the information provided below through that lens.

During the Pre-implementation Phase

- In an EF model, the facilitator serves as a recognized “expert” from outside the local organization, which provides the internal facilitator (if present) 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.

- Regardless of whether the facilitator is external or internal to the clinical setting it is incumbent upon the facilitator to be highly knowledgeable about the innovation to be implemented and successful implementation strategies.

- The facilitator takes a more commanding role during early interactions with stakeholders. For more information about how facilitators engage stakeholders during this phase, see Chapter 4, pages 27-36.

- In turn, the internal personnel (e.g., internal facilitator (if present), champion, or implementation team) is accumulating and sharing information on the clinical organization, local culture, history, and interpersonal dynamics at the site to inform implementation planning.

Following site visits or conference calls with stakeholders, the facilitator should debrief with others involved in the implementation effort (e.g., internal facilitator (if present), champion, or implementation team) to interpret and confirm the significant components and action items that emerged from the meetings/calls. This debrief should focus on identifying the current strengths and weaknesses of the site's implementation process and developing a plan to address identified problems and leverage strengths.

During the Implementation Phase

- The facilitator and internal personnel (e.g., internal facilitator (if present), local champion, opinion leader, or implementation team) should meet regularly to review program implementation progress, with the facilitator and the internal personnel jointly interpreting data that reflect the implementation process and developing strategies to address implementation barriers. For example, for an implementation project aimed at enhancing the delivery of outpatient general mental health care in nine medical centers across the country,[2] each site's external and internal facilitators met weekly. During these meetings, the facilitators reviewed the status of the program's implementation progress and data that documented the implementation process.

- The external facilitator should serve as a mentor to the internal personnel, coaching them on how to address problems and interact with stakeholders. Over time, the external facilitator works to transfer these roles/activities to the internal personnel (e.g., internal facilitator (if present), site champion, or implementation team).

- Over time, the internal personnel begin to concentrate more on site level activities ("nuts and bolts") of implementation, interacting regularly to establish an implementation measurement system (milestones and metrics), developing plans to address barriers to the innovation implementation, and executing the implementation plan.

- The external facilitator continues to be a consultant on developing strategies to address barriers to implementing the innovation and should be called into site level discussions or visits when the external facilitator'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.

- Over the course of the implementation effort, the internal personnel (e.g., internal facilitator (if present), site champion, or implementation team) progress and begin to lead implementation activities more independently. This is important so that the sites can be sufficiently independent to sustain the practice.

The End of the Implementation Phase

- Meetings to review the site's implementation processes should decrease over time and may become briefer. As internal personnel (e.g., internal facilitator (if present), site champion, or implementation team) develop implementation skills, they should increasingly assume responsibility for interpreting data, identifying barriers to implementation, and developing ways to overcome these barriers. They can review their efforts with the external facilitator for feedback to obtain consultation, as needed.

- External facilitator and internal personnel roles begin to shift with internal personnel assuming roles formerly filled by the facilitator. The external facilitator should rarely be needed for site interactions.

- As implementation moves toward the sustainment phase, activities include a formal meeting to address the tasks needed to ensure that the program is fully incorporated into setting operations (institutionalized). We recommend that this is done through the development of a sustainability action plan (see Chapter 6, pages 87-89). The development of this Plan should be led by site personnel with the external facilitator serving as a consultant.

The Sustainment Phase

As the implementation phase winds down, it is critical that the external facilitator and internal personnel (e.g., internal facilitator (if present), site champion, or implementation team) turn their collective attention to sustainment. While in some implementation efforts, time and resource limitations may not allow the external facilitator to be involved in the sustainment phase. Below we address the relationship between the external facilitator and internal personnel when the facilitator maintains involvement (the sustainment phase is fully addressed in Chapter 6):

- The external facilitator and internal personnel no longer have standing calls or scheduled interactions, though the facilitator is available on an as needed basis.

- The external facilitator and internal personnel's interaction are focused on sustainment and further program development.

- The innovation or program has been implemented and is fully up and running. With the assistance of the external and/or internal facilitator(s), sites have overcome multiple hurdles and have developed successful programs.

Over time, the interactions of the external facilitator and internal personnel (e.g., internal facilitator (if present), site champion, or implementation team) evolve and the roles and functions shift. Above we have outlined a successful process based on our experiences facilitating implementation of several initiatives. This process may vary depending on the exact innovation needs and the skills of the external facilitator and internal personnel. Most importantly, throughout implementation, the relationship should be collaborative and supportive and utilize the strengths and skills of all team members in a dynamic process.

CHAPTER 4
IMPLEMENTATION FACILITATION ACTIVITIES IN THE PRE-IMPLEMENTATION PHASE

As mentioned in Chapter 3, the ***pre-implementation phase*** is a time period for designing a customized, local plan for implementing an innovation and conducting other activities that occur PRIOR to implementation. The work occurring during this phase provides the framework and foundation for all implementation activities. Thus, it is critical to spend sufficient time in pre-implementation activities, engaging in preparation and planning, prior to beginning the work of implementation. Developing a solid foundation during pre-implementation will ensure that you are well-prepared for implementation. *The length of this chapter reflects the amount of work that needs to be done during this phase.* Essential pre-implementation tasks described in this chapter include site assessment, meeting and initially engaging key stakeholders, and considering adaptations to the innovation for the local environment. Activities may include hiring and training staff and marketing the innovation or program. Final pre-implementation tasks include an initial site visit and working with the team to develop an implementation plan. Once an implementation plan is established, you will be ready to move to the implementation phase. We also note that much of the material in this section was developed based on work conducted within the VA but is applicable to implementation projects outside of VA settings as well.

Program
a complex innovation that includes multiple clinical components

I. CRITICAL KNOWLEDGE PRIOR TO IMPLEMENTATION

As a facilitator, an essential pre-implementation task is to ensure you have the knowledge you need to facilitate implementation of the innovation. You need to be well versed in any policy documents that support the program or practice that is being implemented, evidence for the innovation, key strategies and interventions that can support implementation, and an understanding of the clinical setting. You may need to read additional documents or seek additional training/consultation to ensure expertise.

For example, there may be specific guidelines and national policies, memos, and directives related to the innovation that you are implementing. In addition to formal policies, there may be highly recommended national guidelines or strong practices that have been identified. National directives should be combined with any existing or planned, regional, or local practice expectations. It is important that the facilitator know these national and local policies, otherwise you may implement a program that does not fully meet policy expectations. Understanding the requirements that relate to the specific program being implemented provides the framework within which the implementation process should reside. In short, it is important to know the

"Three P's"—policies, priorities, and programs—that may impact how your specific program is implemented.

Three P's that may impact implementation:
- ***Policies***
- ***Priorities***
- ***Programs***

The facilitator should have knowledge of the following key areas:

- Implementation Science: You should have a basic understanding of implementation science and knowledge of facilitation activities and processes. Knowledge of quality improvement techniques (e.g. Six Sigma)[42] may also be useful for helping sites implement specific clinical processes and make changes to how they deliver care.[43]

- Context of Local Setting: In addition, you should have a working understanding of the clinical setting in which you are implementing the innovation. Each clinical setting is unique; you will need to apply a slightly varying set of implementation activities for each setting. The needs of each individual setting and their readiness to adopt a particular innovation are likely to differ. In addition, individuals who help implement practices and services at the setting level will occupy varying positions in their respective organizations and have different relationships with their colleagues, supervisors, and facilities. Because of this, individuals will have differing spheres of influence within the organization. To adapt to the particular circumstances of each facility, you will select from a broad range of activities (described below) based on your understanding of the particular clinical setting.

  SETTING = WHERE
  Location (e.g., organization, clinic, facility) where the innovation is being implemented

- Evidence for the Innovation: You should also have thorough knowledge of the evidence that supports the innovation or program. This evidence should not be limited to traditional research findings such as randomized controlled trials or effectiveness studies, but should also include other forms of evidence, such as information on budget impact of the program (costs), patient testimonials, provider experiences, and the impact of implementing the program in other settings. When collecting this knowledge, it is important to consider the clinical setting where the innovation is being implemented: in general, people are more likely to be convinced by evidence that is derived from settings and populations that are similar to their own.

- Health Disparities: Finally, it is important to determine the extent to which there is a disparity in the access to, delivery of, or quality of the innovation to be implemented. Health disparities are clinically and statistically significant differences in health or health care between two or more groups. Groups that experience worse health or health care might be categorized by race, ethnicity, sexual orientation, gender identity, socioeconomic status, functional limitation, or other characteristics.[44,45] These groups often have experienced social, economic, and/or environmental disadvantage that

usually accompanies health care disparities. For example, children of color with autism spectrum disorder are less likely to have their condition diagnosed or treated than white children.[46,47] Similarly, African American US military Veterans are less likely to receive compensation for posttraumatic stress disorder (PTSD) than are their white counterparts.[48] Implementation efforts that do not take such disparities into account (in these cases, related to autism and PTSD screening, respectively) may end up inadvertently perpetuating them – these are implementation disparities. Health and healthcare disparities inhibit health equity, which occurs when there is a just opportunity for the well-being of all people.[49] See Table 2 for health equity factors, along with guidance for addressing those issues in the pre-implementation phase and beyond.[50]

Table 2. Health Equity Factors with Relevance to Healthcare Implementation.

	Cultural Factors of Recipients	**Clinical Encounter/ Point-of-Care**	**Societal Context**
Health Equity Factor Relevant to Healthcare Implementation	Recipient (patients, providers, and staff) factors, i.e., medical mistrust, demographics, or implicit/unconscious bias[51-54]	What occurs or is perceived during the actual clinical encounter or patient-provider interaction in which the innovation is delivered or offered, such as discrimination or bias[55-57]	Societal influences including physical structures, economies, and social and political forces such as structural racism, insurance, or discriminatory policies[58-60] May include social determinants of health, such as food insecurity
How to Assess the Status of Each Factor	Ask experts in the innovation if there are documented disparities in prevalence of health condition or healthcare treatment (presence of either suggests implementation disparities are more probable)		
	As you meet stakeholders, ask whether any groups are more impacted by the health condition or lack of treatment than others		
	Use existing or administrative data to assess disparities in implementation for a current innovation that needs to be implemented with better quality or higher rates		

How to Assess the Status of Each Factor (Cont'd)	Collect new data using qualitative interviews or quantitative surveys on any factors that seem like they may inhibit equitable implementation (e.g., social determinants of health; https://www.phenxtoolkit.org).[61]

II. OBTAIN OR CREATE AN IMPLEMENTATION PLANNING GUIDE TEMPLATE

Prior to implementing an innovation, it is important that you begin to develop or adapt an Implementation Planning Guide (sometimes referred to as an implementation 'blueprint,' 'playbook,' 'checklist,' or 'worksheet'). This type of document can be crucial for ensuring that: key stakeholders are identified and recruited; action items and their follow-through are documented; and target schedules are communicated and followed.

An Implementation Planning Guide can be crucial for ensuring that: key stakeholders are identified and recruited; action items and their follow-through are documented; and target schedules are communicated and followed.

Creating this guide first requires developing a template that can be populated with relevant information during the pre-implementation phase. Although there are various formats that can be used when developing an Implementation Planning Guide Template, it may be most usefully designed as a worksheet, deliberately including columns for implementation teams to document local decisions, action items, time frame, and responsible parties.

- The Implementation Planning Guide Template will be used to guide your initial implementation planning meeting and will be completed with the stakeholders at the site (see section below entitled "Crafting the implementation plan"). This template, once completed with the local site, will become your local implementation plan. See Appendix B-2 and B-3 for blank example planning guide templates, and Appendix B-4 for an example of a completed implementation planning guide.

- Although implementation planning guide templates have been developed for some programs, the facilitator may need to create an Implementation Planning Guide Template for the specific innovation (the "What" you are implementing). Ultimately, those who are experienced and knowledgeable about the program requirements should develop this planning guide template.

- A document describing how to create an Implementation Planning Guide Template is available in Appendix B-1 How to Create an Implementation Planning Guide.

- A well-developed planning guide template includes all required program elements, 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).

- It is critical that the facilitator know which steps or elements in the Implementation Planning Guide Template can be adapted or modified to meet the needs of the setting and which must remain constant to ensure fidelity to the evidence base for the innovation. It is important that facilitators understand which features of the innovation can be adapted before engaging in an implementation process. Therefore, it is important that facilitators are familiar with each step in the Implementation Planning Guide Template developed for their innovation.

- The Implementation Planning Guide Template 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 guide directs the process of program design and leads stakeholders through essential decision points in designing the implementation strategy. The guide can also log essential administrative steps such as establishing clinic names, forms, procedures, and outcomes that will be monitored.

III. STAKEHOLDER ENGAGEMENT DURING THE PRE-IMPLEMENTATION PHASE

How to Identify Stakeholders

As a facilitator, you will need to identify potential key stakeholders whom the innovation will affect, and whose work will affect implementation of the innovation. Identifying these stakeholders during the pre-implementation phase is crucial for several reasons. First, you will need to gather information from them about the hospital or clinic in which your innovation is being implemented. Second, you will need to provide information to them about the innovation and the planned implementation thereof. Third, the stakeholders identified during the pre-implementation phase are typically the ones with whom the facilitator(s) will be working most closely to actually implement the innovation during the implementation phase. You should document stakeholders' preferred names, roles, and contact information as you meet or learn about them. See Appendix C for an example of a stakeholder tracking tool.

If you are an external facilitator, you should enlist the help of those internal to the site (e.g., an internal facilitator (when applicable), leadership, or other local change agents) to identify roles and positions typically held by key stakeholders, including:

- Leadership at the network (regional), facility, service, or other organizational levels who are involved in decision making about the innovation. You may want to start with the regional or network director, medical center directors, associate directors, executive nurses, chiefs of staff, and chiefs of the disciplines or services that will be directly involved in, or affected by, the implementation process. The leaders' understanding of

the value of the innovation to be implemented and the role of the facilitators will lay the foundation for future efforts. For example, if regional- or network-level leaders understand and support your 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. See Appendix D, pages 170-172 for an example of a call agenda used to introduce medical center leadership to an innovation). Leadership at every level can help pave the way for success, since they are the ones who are ultimately responsible for the organization. It is essential that you ensure that leadership is well informed and supportive of the implementation effort.

- As engagement with higher-level (i.e., regional, network, or medical center) leadership is initiated, it also is important to engage local leaders who may have direct responsibility for the program, discipline, or service implementing the innovation. Note that clinical and administrative leaders may both be pivotal in ensuring implementation success, depending on the particular setting and innovation being implemented.[62]

- The "doers" can help identify process steps and potential problems. For example, you should involve front-line clinicians, nursing, clerical staff, administrators, and other allied staff, as applicable. These relationships are extremely important. If the front-line team is not adequately engaged and actively involved in developing the implementation plan, the process is likely to suffer. Everyone who will play a part in the program, or whose work will be affected by the program's implementation, should be identified as a stakeholder.

- Those with Information Technology (IT) specialties should also be considered key stakeholders and you should actively work to engage them. For example, if video conferencing will be needed, it is important to begin working with these team members during pre-implementation.

- Engaging patients, or consumers of healthcare, may be particularly relevant for an implementation disparity problem. Existing research on engaging consumers in the implementation process is limited, and is also known as co-created integrated knowledge translation,[63,64] participatory implementation science,[65] or community engaged dissemination and implementation.[66] The limited work on this topic shows preliminary benefits: a better intervention fit for the patient population,[67] systems redesign that is more patient-centered,[68] greater use of effective healthcare interventions in community settings,[69] improved patient health behaviors and outcomes,[70] and increased sustainment of an intervention.[71] Recruiting patients to work on an implementation effort, especially those actually representative of patients served, and retaining those patients in an implementation effort, will be challenging. However, these efforts can help maximize the chances of implementation success.

- Other stakeholders to consider:

  - 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.
- When speaking to stakeholders, it can also be helpful to employ a "snowball sampling" approach by asking them to name additional stakeholders.
- Look for and include people who are "centers of influence" but do not have an official title. For example, clerical staff may not have supervisory responsibility on paper, but may nonetheless serve as the "glue" that holds a clinic together, especially if they have been serving in that role for many years.

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, some of which will be described in more detail in Chapter 5 which describes implementation facilitation activities during the implementation phase. An overarching theme of stakeholder engagement is to 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.

Create an atmosphere that is open, non-critical, and goal-oriented. You need to convey that you are embarking on a journey with the stakeholders and will help them work through challenges.

Engage leadership

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

Ask leaders if there are any regular cycles of updates to which you can attach reports

- Invite leaders to any special events or meetings to lend their support—especially kickoff meetings or initial site visits that occur during the pre-implementation phase.

Remember that many hospital leaders have schedules that are tightly packed so inviting them to such events should be done well in advance of the event.

Tailor presentations to the type of stakeholder you are trying to engage

- To engage leadership, ensure that leaders understand your role and position, conduct presentations that are brief and more formal, and provide an executive summary. Link or connect the presentations to metrics that matter to them (e.g., performance measures, strategic plans, or regional directives), especially those that are of particular interest or importance to the medical center in which the innovation is being implemented. (See Appendix E-4, pages 178-179, for an example of Site Visit Entrance Briefing Slides.) Include some brief background information, scientific evidence, and data and create the vision of what the innovation 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.

Engaging Patients

- Facilitators may recruit one or more patients to assess important elements of an effort. This can frequently be accomplished through groups such as patient or community advisory boards in which facilitators engage patients in some component of implementation planning or usability testing or development of a tool for the implementation effort. Patients may also provide feedback on presentations, outreach components, implementation planning, or interpretation of data.

- Patients may also be more actively or directly involved with the design and implementation planning. For example, patients might become part of the implementation team, be trained as facilitators, or become co-investigators on an implementation study—consistent with the principles of community-based participatory research.[72] In addition, facilitators might form a relationship with a relevant community group who shares ownership of the implementation effort, are compensated for their time and knowledge, and whose input informs many stages of implementation. These individuals might be the stakeholders who “own” the innovation after facilitation ends. More intensive engagement requires more training of patient stakeholders and policies and funding mechanisms that allow for equitable compensation.

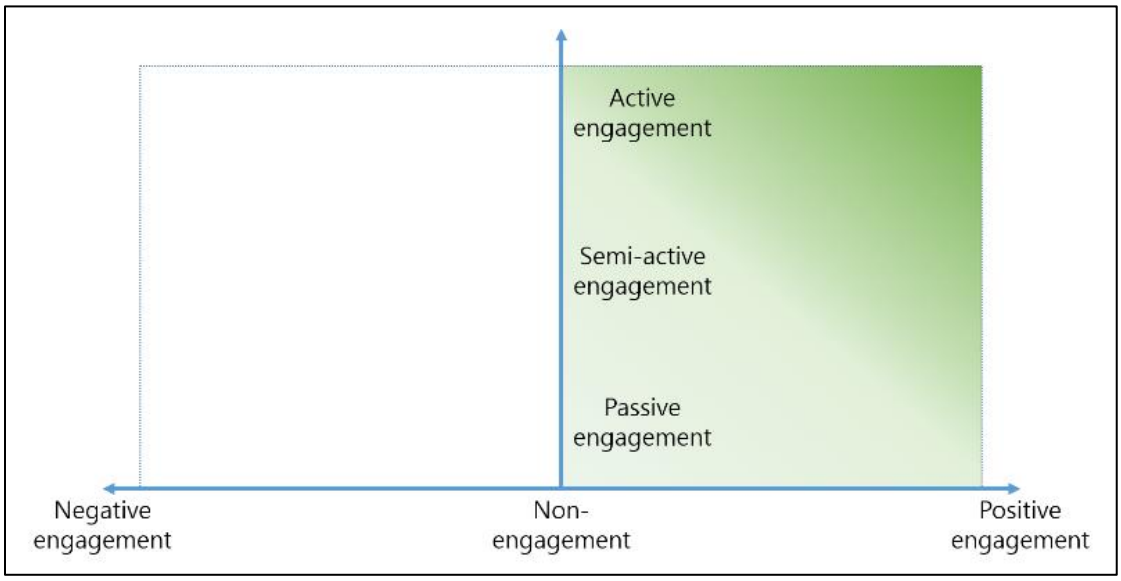
Levels of Stakeholder Engagement

There are several levels of stakeholder engagement described below and illustrated in Figure 5:

> ***Active engagement.*** Stakeholders take an active part in the change process (e.g., 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 innovation in their day-to-day functions. They perform the work of the process to achieve the desired outcome.
>
> ***Semi-active engagement.*** Stakeholders value the desired outcome of the change process and publicly 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.
>
> ***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.
>
> ***Non-engagement.*** Stakeholders are not involved at any level in the change process.
>
> ***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 “How to Roll with Resistance” 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 critical 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.

Figure 5. Levels of Stakeholder Engagement (Green indicates ideal engagement)



How to Roll with Resistance

- In the pre-implementation phase, some stakeholders may express skepticism, negativity, or resistance to the innovation you will be implementing or to your role as a facilitator. This is quite normal, and depending on the previous change initiatives that have been attempted at that medical center, such skepticism may in fact be healthy! Thus, encouraging stakeholders to be honest from the beginning about potential problems can have two positive effects: it can help establish your credibility as someone who is genuinely interested in people's concerns, and it can help minimize the chances that the implementation process runs into foreseeable roadblocks.

- Generally, you can deal with initial resistance 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 as implementation continues. Sometimes leaders may appear to be negative stakeholders at first but may simply be responding to other pressures within the organization and may need to work them out. Give everyone an

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

opportunity to shine and when positive movement occurs, however slight, reward it and highlight it profusely.

- In some cases, the communication approach of Motivational Interviewing (MI)[73-76] may be useful for more actively engaging ambivalent stakeholders. This approach is rooted in an empathic interpersonal style and calls for the facilitator to draw out and strengthen the respondent's motivation for change with the aim of resolving ambivalence about making the change. Although frequently used as a clinical technique, MI's creators define it as a "collaborative conversation style,"[73] making it an ideal set of tools for the context of implementation. By encouraging stakeholders to verbalize the problems with the status quo and the possible benefits of making changes to the way care is currently delivered, the MI approach may help ambivalent stakeholders to more seriously consider the innovation you are trying to implement. Caution is warranted; however, many clinicians have been trained in MI and may resent having a technique often used in clinical settings (originally developed to encourage problem drinkers to increase their motivation for sobriety) "used against them." Nonetheless, the core concept of MI—to roll with resistance by encouraging the respondent to voice their own reasons that change might be desirable—is a sound one to employ when working with reluctant stakeholders.

How to Educate Stakeholders about Your Innovation

During the pre-implementation phase, expect curiosity from stakeholders regarding the nature of the innovation you are preparing to implement. A goal of the pre-implementation phase should be to provide the evidence (research, clinical, patient and provider testimonials, cost and resource) that supports the innovation. All stakeholders should receive some level of education about the innovation. This may occur during the site visit or prior to the site visit via teleconference. Be sure to tailor the information and how you present it to the specific group of stakeholders. For example, to facility leadership and other key stakeholders, you should present, in 15 minutes or less, basic information about the innovation, focusing on important outcomes, critical needs, and costs, but NOT on nuanced details of how to provide the innovation. (See Appendix E-4, pages 178-179, for an example of Site Visit Entrance Briefing Slides.)

Case example

In an initiative to implement Tobacco Treatment in Substance Use Disorder (SUD) Residential Programs, the facilitator was a health psychologist with extensive experience in tobacco cessation and treatment of tobacco use disorders who was very effective at providing education on these topics. Additionally, she provided resources, posters, flyers, handouts, and other information for the clinicians and patients and suggested site stakeholders distribute the educational materials to all clinicians and post them on the unit. During one initial site visit the facilitator arranged an extra early morning educational session for stakeholders who missed the first session due to shift times.

It may be necessary to present more detailed information to team members providing the innovation or directly supervising them. This type of education should be much more detailed and tailored to ensure they can competently deliver the innovation. If possible, provide continuing medical education credit for participation in these training activities.

How to Introduce Stakeholders to Implementation Facilitation

In addition to engaging stakeholders and educating them about the innovation, introducing the site personnel to the implementation facilitation strategy is an important pre-implementation step. Conducting this introduction early-on will help ensure that key stakeholders in the change process understand facilitation, have clear expectations, and can minimize the chances of future misunderstandings and miscommunication. Often this information is also provided during the initial visit or teleconferences that occur prior to the visit during the pre-implementation phase.

Communicate facilitator role(s)

Emphasize the points below during the pre-implementation phase:

- For many stakeholders, the term **External Facilitator** may conjure up negative stereotypes of a distant consultant making sweeping changes without having a true knowledge of how things truly work at that site. To combat this, if you are an EF, you should be clear that you are providing expertise on the process of implementation and a particular innovation and that you are working closely with an internal facilitator, champion, and/or other local change agents who have a greater awareness of local conditions.

- If an internal facilitator is involved, describe the **Internal Facilitator** role and its importance in sharing local knowledge and the capacity to forge partnerships among local stakeholders who are involved in, or affected by, the innovation implementation.

Communicate goals and timing of implementation facilitation

- During the pre-implementation phase, it is helpful to communicate clearly the **goals** of the facilitation effort—namely, the establishment of your particular innovation at that site. It is worth emphasizing, however—as spelled out in Chapter 1, “An Overview of Implementation Facilitation”—that facilitation is a multi-faceted process that involves helping rather than telling.[12] Communicating this clearly reinforces the idea that you are looking for true participation from stakeholders in the change process.

- The **timing** and duration of implementation facilitation also deserves emphasis during the pre-implementation phase. In many cases, this will mean letting stakeholders know that you are “in it for the long haul” (i.e., are not simply spending a few weeks getting an innovation embedded and then leaving). Many clinics may have had bad experiences with external change agents who came and went before real change could be firmly established, so it will be helpful to make it clear that

facilitation is a process to which the facilitators are committed for the duration. If there is a set period for the facilitation process, be sure that this time period is relayed to all key stakeholders.

How to Identify and Address Negative Stakeholders

Recognizing negative stakeholders is another process that begins in pre-implementation and continues throughout the implementation process itself. *Do not confuse negative engagement with initial healthy skepticism or 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 innovation 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 are not *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 during the pre-implementation period, trying to win them over to support (or at least not work against) implementation. It is often helpful to watch body language as well as listen to what is (and is not) said during initial meetings. An external and internal facilitator, or a facilitator and other local change agents (e.g., champion), working together often will be able to identify potential negative stakeholders. Most of the time, you can expect at least one negative stakeholder in every implementation effort.

Helpful Tips

Tips for managing negative stakeholders:

- *As a general rule, address negative stakeholders as soon as you identify them. Do not wait and hope that they will change. One exception to this rule may occur if you know that a negative stakeholder is about to retire or transfer to a different department. In that case, you will need to balance the pros and cons of addressing them given their time-limited involvement.*
- *Deal with any negativity in meetings in a direct but positive manner. It often helps to use humor.*
- *Do not allow negative stakeholders 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 convert 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.*

Ultimately, managing or working around negative stakeholders may require enlisting the help of leaders or managers at the site or even the regional or network level. One of the important lessons learned among experienced facilitators is when and how often to enlist help at these higher leadership levels. Although you may frequently informally seek consultation and input from leaders as part of maintaining their engagement, only in rare circumstances should you actively enlist their help for the management of negative stakeholders or other concerns. In the ideal situation, you would never have to resort to this action. Innovations tend to work best when developed and implemented by those who are closest to the clinical services. Know that enlisting the help of other leaders is essentially calling in the "big guns." However, there are times when this extreme action may be necessary to continue moving forward. Use this sparingly and only for items that cannot otherwise be resolved and are important to the initiative. Be sure that you have actively tried many techniques before resorting to this last strategy. If you frequently call in the big guns, it devalues both your power and influence as well as theirs.

Case Example

When facilitating the implementation of Primary Care Mental Health Integration (PCMHI) per the request of network leadership, a local level primary care lead was a negative stakeholder. He came to meetings late, if at all, and when present, sat in the corner and wrote notes instead of engaging in the process. The rest of the implementation team did all that they could to engage him in the process and to implement despite his behavior.

The facilitation team used multiple strategies to engage him. However, after several months, it became clear that the initiative could not progress further without his active investment, involvement, and support. With no other options left, the facilitators approached the network leadership, (AKA the "big guns") who had requested the assistance of implementation facilitators. The facilitators had to describe the stakeholder's behavior as one of the barriers to implementation and asked for network support to address the challenge.

Please note that this was done only after much deliberation and consultation among other expert facilitators. In taking this step, there are many risks, including losing the progress made thus far, as well as the relationship with network leadership. In this situation, it was handled delicately; the network leadership addressed the concerns and the behavior improved, allowing implementation to move forward.

IV. ASSESSING THE SITE

Site Assessment is a critical activity that needs to be conducted throughout the implementation facilitation process. There are many types of data and information that you should obtain. This includes formal administrative data as well as informal data about context. During the pre-implementation phase, beginning with a preliminary site assessment, you should seek to obtain

a broad overview of the system and context, the types of services provided, as well as an initial understanding of day-to-day operations and administrative data.

Conduct a Preliminary Site Assessment

Get to know some basic information about a site, even before visiting; this is an important pre-implementation step. This preliminary "homework" about the site will help you prepare for the initial site visit, and the fact that you did some preparation to get to know the site will establish credibility with staff. You should work to identify basic information about the organization, the clinic (e.g., type, size, setting), and the population served, as well as other important contextual information. You will also want to identify administrative data relevant to the innovation being implemented, if such data are available. Tracking down such data sources may require engaging stakeholders who are far removed from frontline clinical care such as data support specialists or medical record administrators. We recommend that you develop a set of questions and query stakeholders to learn about each site while fostering engagement. An example of a Pre-Site Visit Facility Assessment Call interview from the Evidence-based Psychotherapy Facilitation Initiative can be found in Appendix E-1, pages 173-174.

Gather information about the clinic

- Know the type of clinic: Will you be working with a primary medical center, or a smaller community-based satellite office? If the latter, make sure you understand its relationship to any larger affiliated medical center(s).

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

- Setting: Gather some information about the community and any special considerations that may affect success. This type of data is often obtained through conversations with key stakeholders. For example, if a facility is located in a community with high unemployment, homelessness, or crime, these factors may be relevant to the innovation's success. For example, 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, ultimately leading to an increase in the number of people without health insurance seeking services at local clinics.

- Academic Affiliation: 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.

Helpful Tips

Assess site characteristics:

- Type of Clinic
- Size
- Setting
- Academic Affiliation
- Patient Population
- Organizational Structure

- Organizational Structure: Do what you can to develop a clear sense of how the organization is structured and who reports to whom (e.g., via an organizational chart). It may be particularly important to identify whether the organizational structure is such that staff report to multiple supervisors. For example, it is possible that clinicians on an outpatient mental health team may report to their team leader as well as to discipline-specific supervisors (e.g., Chief of Psychology, Chief of Psychiatry). In those cases, buy-in from all relevant leaders will likely be important to successful implementation.

Learn about the population

- Gather data on the type of patient population typically served by the clinic (e.g., insurance status, typical age range, gender, ethnicity, and common comorbid conditions). You will need to learn about some of the challenges in providing services to meet the needs of their population. For example, implementation of telehealth services may be more difficult if a large proportion of the patient population lacks access to reliable cellular or wi-fi service. These data may be obtained either quantitatively (from medical record data, dashboards, or patient registries) or qualitatively (from discussions with frontline staff, administrators, and support personnel).

- It is important that you also gather diagnostic information about the population that the program will serve. For example, in implementing a depression care management program, it would be essential 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

- Collect names of key staff members as well as formal and informal leaders. Confirm correct spelling of names, preferred pronouns, and academic degrees. Misspelling names or listing incorrect titles for key staff (e.g., using “Ms.” Instead of “Dr.”) can create real problems for an implementation effort, as these mistakes may be interpreted as disrespect or sloppiness on the part of the facilitator.

- Identify organizational and leadership structures, as well as relevant measures of organizational performance (e.g., patient satisfaction scores and relevant performance measures).

Document what you learn

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 patient 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 frequently updating information will be useful in the future. Especially if you are going to be working with the same sites or clinics on multiple projects over time, it may be useful to save these data in a contact tracking database so that future projects need not collect the same data again.

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

- One way to maintain information is to keep a workbook with different tabs for different types of information. This will allow efficient updating, use of other spreadsheet features (e.g., graphs, comparative tools), and ability to print only the information needed (for an example, see Appendix F. Clinic Summary Excel Workbook).

Additional Considerations as You Continue the Assessment Process

- Learn the value system of the organization and get staff input! Understanding the value system will help you 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, if you learn that a facility director is very concerned about patient satisfaction, then you can emphasize the ways the innovation will impact this metric. Organizational values may also reflect viewpoints regarding what types of data are most compelling; for example, managers at one facility might be very impressed with data on graphs and charts, while managers at another facility might be much less impressed with visual data and want to hear more about quality and the patient experience.

- Be observant for stakeholders who appear to support the innovation 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.

- Structured assessments may also help you develop a better sense of the relative strengths—or areas of concern—for staff at the site in question. The Agency for Healthcare Research and Quality has compiled guidance on this topic that may be of interest.[77] While some assessments will likely be innovation-specific, others may be more generically useful. For example, the Organizational Readiness for Change

measure (ORC)[78,79] is a self-report measure that may be completed by staff at the site. Scores on the ORC indicate the extent to which the working environment is perceived to be friendly toward process improvement activities. The ORC is available at: https://ibr.tcu.edu/wp-content/uploads/2016/01/ORC-S-pdf.pdf. Generally, a formal assessment is not sufficient to capture the nuanced dynamics captured in the processes described above.

- Assessment is an ongoing process without an end. Initially, 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.

Obtaining Administrative Data

Data may be a powerful tool. Often decisions are made based on administrative data, and innovation implementation success or failure may be determined based on outcomes obtained from administrative data. Thus, it is essential that implementation facilitators know how to obtain and interpret relevant data. If you do not have these skills for the innovation you are implementing, seek additional consultation immediately. If administrative data are not readily available—as is the case in many healthcare systems[80,81] —then other strategies (e.g. conducting rapid chart reviews, or conducting direct observations of clinical processes) may be needed.

Barriers to obtaining data

- Recent years have seen an increased emphasis on transparency within some medical systems. If you are working in such a system, there may be opportunities to obtain national or regional data rather than obtaining local data from each site or clinic that is implementing a given innovation. In these cases, it is still important that you discuss how you are using these data and be explicit with local stakeholders that your goal is ongoing quality improvement related to the innovation. For some innovations, you may still need to rely on local data only.

- You may have difficulty getting permission to access local data because some leaders and managers may be suspicious about your wanting to obtain "their data." They may feel that you will try to use data to criticize them—and they may have had experiences in the past where facilitators or consultants did exactly that! Sometimes you have to build trust before you can obtain the data you need; it may be helpful if you state explicitly that you are interested in understanding the site for innovation implementation and quality improvement and not for evaluative purposes. Remind them that you really are there to help, and then prove it by being careful about how you frame the results of whatever analyses you complete!

How to get data

- Depending on the innovation being implemented, you may be able to obtain all the data that is needed from national dashboards. Additional information about the type of data available from administrative dashboards is available in the next chapter.

- Gaining local access to data involves finding the right people who can provide the needed data. Developing relationships with administrative officers and data support specialists is essential. Ideally, they can either provide access to the data or the tools to gain access.

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

Verify the accuracy of data 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. For example, apparent differences in suicide rates between sites may reflect different data collection methods rather than "true" findings.

- 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 may be helpful to do this in a limited manner.

- If possible, it may be useful to enlist the help of a data support specialist (e.g., see https://www.corhio.org/blogs/expertise/2018/3/21/what-in-the-world-is-a-chita) with expertise in pulling, aggregating, and verifying administrative data.

V. HIRING AND TRAINING STAFF

The timing of hiring and training of staff is highly variable and could happen during any of the phases of implementation facilitation. The extent of input that facilitators may have in hiring and training is also highly variable. However, these are critical factors that can make or break an implementation initiative. Prior to implementing a program, it is essential that key staff are identified (either hired or otherwise assigned to the program) and appropriately trained. In our experience, it is common for sites to request facilitation support without having identified staff to provide the program. In these situations, hiring and training staff becomes a primary pre-

implementation task. As a facilitator, be prepared to find a range of situations from an initiative that is fully staffed (with or without appropriate training) to an initiative with no staff at all.

Hiring and Identifying Innovation Staff

Hiring, training, and mentoring staff to deliver an innovation is a complex process that is important to sustainability—but begins in the pre-implementation phase. We note that there may be significant variability from system to system (and from program to program) regarding whether, and to what extent, facilitators are involved in hiring decisions. If you have the opportunity to provide feedback or consultation related to hiring, we recommend familiarizing yourself with the following principles:

- Prior to identifying or hiring staff, administrators should have a clear understanding of the nature and expectations for successful program functioning.
- Staff should be matched to program needs.
- It is important to employ or select 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. 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. 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:

- 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. If the role being filled is that of the Internal Facilitator, you can refer to Chapter 3, pages 16-22 to help provide guidance.
- Help administrators and program managers with identifying program needs, specific skill sets, and characteristics that will be essential for program success. For example, depending on the needs of the setting, 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.
- 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 if desired by leadership.

Training Clinical Innovation Staff

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

- New providers should be familiar with the setting and the practice expectations of the innovation/program. Reading core texts and research manuscripts as well as additional resources recommended by the clinic 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.
- Other effective training techniques include implementation of action plans, performance assessments, and ongoing supervisory consultation.[82,83]
- Shadowing current, successful providers and ongoing consultation from experts within the field is also recommended.[84,85]
- In addition to supporting attendance at relevant workshops, leaders should be involved and encouraged to provide a supportive environment for successful training to occur.[83] You can play a substantial role in the training process.

Helpful Tips

- You can facilitate formal training opportunities for clinical staff charged with implementing the innovation by either hosting a training event or providing an educational series.
- You can provide training experiences if you are a content expert. You can also offer presentations and training events hosted by external experts.

VI. MARKETING

Appropriate marketing of the innovation you are trying to implement can increase stakeholder engagement throughout the implementation process. More will be said about this in the next chapter. During the pre-implementation process, some of your marketing efforts may focus on increasing awareness of the implementation process itself and your role in it. The following marketing strategies in the pre-implementation phase may be especially helpful for launching a program.

Presentations

The goal of formal marketing events is to describe the benefits of the innovation (to patients, providers, clinics, systems, etc.), the type of services provided, the patients who may benefit from the innovation, 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, or plan to distribute them electronically if meetings are held virtually. Furthermore, do not forget to include materials about yourself and the implementation process during such presentations. For example, be sure to describe your specific role in the process as a facilitator, the timeline for implementation, the names of local leaders who have invited you to be involved, and other details so that attendees are not confused by your involvement.

Emails

Use emails to describe specific topics of interest within the program. Make them brief and include bulleted or numbered information, as well as your contact information to ensure that staff members can reach out to you with questions.

Flyers

Similar to emails, 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.

Newsletters

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

Patient-Facing Marketing

The health promotion field has many examples and research on marketing directly to patient or consumer groups. This may create demand or “pull” for an innovation. All marketing materials should be checked for health literacy (ability to interpret written or audio health information) or health numeracy (ability to interpret medical statistics). Patient difficulties with health literacy and numeracy can contribute to unjust disparities

in healthcare delivery. The literacy or numeracy levels should be suited to patient stakeholders through processes such as:

- Checking and adjusting reading levels using word processing software
- Consulting with an institutional center for health literacy
- Surveying a subsample of target patients for the innovation using one empirically validated question to assess health literacy[86,87]
- Having a patient stakeholder read and discuss written documents with facilitators before circulating to all patient stakeholders—the discussion would focus on what is clear/unclear, what needs to be defined further, or what may be presented a different way

Some currently known examples of patient-facing marketing are advertising for the innovation through mass media,[88] community organizations and other service providers, or hosting outreach events to educate potential recipient consumers of the innovation (e.g., patients, caregivers, families) on information about the health condition or the innovation.[89]

VII. THE SITE VISIT: PREPARATION FOR TRANSITIONING TO THE IMPLEMENTATION PHASE

Innovation 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 implementation activities.

As part of the implementation plan, it is important to engage top-level network and/or 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 previously developed implementation planning guide.[90,91] (See Appendix B, pages 145-167, for examples of previously developed Implementation Planning Guides.)

Thus, one important function of the facilitator(s) is facilitating program implementation planning meetings. While crucial details to keep in mind for any implementation meeting are included in the next chapter, in this section we discuss core elements of the first set of implementation meetings, which are often consolidated into an in-person or virtual site visit. (See Appendices E-3, pages 176-177, and K-1, pages 217-219, for examples of in-person and virtual facilitation site visit agendas.) Realistically, this may be the first time that all of the invested stakeholders have come together to discuss the program. While in-person meetings have obvious benefits over virtual approaches, budget limitations, space constraints, travel restrictions, or other factors (e.g., COVID-19 pandemic) may mean that the site visit must be conducted over telephone or video teleconferencing equipment. Specific best practices for such virtual site visits may be found in Chapter 7.

Meeting Logistics

It is easy to underestimate the amount of time that it will take to schedule, organize, and prepare for the site visit. Surprisingly, this may be one of the most frustrating and time-consuming processes.

1) **Check for network or facility policy for visiting the site**

   Actively seek out existing guidelines for scheduling site visits, especially if you plan to involve frontline clinical staff in the site visit activities. For example, in the VA, local or regional guidelines may require at least a 60-day notice to cancel clinics for providers who plan to attend the site visit. Being aware of these guidelines ahead of time can help you avoid logistical issues (such as key staff being unable to attend site visit activities), while also demonstrating to staff at the site that you are committed to understanding the local context.

2) **Identify and develop relationships with people who can help**

   You may organize and schedule many of the meetings. However, if you are not located at the clinic where a program is being implemented and do not have knowledge of the clinic layout and meeting spaces:

   - An identified local champion at that site can serve as a primary contact.
   - Identify critical contacts who can describe the clinic layout and are familiar with the set-up of meeting locations and the process for reserving rooms. For example, it may be easiest to build the site visit schedule around a regularly scheduled, recurring staff or provider meeting. These contacts can help you navigate through these complicated nuances that vary from site to site.
   - Establish rapport and build a relationship with the clinical manager and the lead administrative officer. If at all possible, start 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.

3) **Make the meeting arrangements**

   - Consider creating a pre-meeting checklist to ensure that everything is arranged and brought to the meeting (see Appendix E-2, page 175, for an example of a Pre-Meeting Checklist).

- Determine which tasks you will complete to decrease as much additional work for clinic staff as possible. For example, you may be able to set up tele- or video-conferencing sessions rather than asking local staff.

- 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 equipment.

- Create a master guest list that includes those who have indicated they will attend and their contact information.

- 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, and no one can find the speaker phone after repeated assurances that it would be available. These things happen. Be prepared to roll with the punches and problem solve on your feet.

> ***Expect the unexpected. Be flexible and ready to problem-solve. 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, and no one can find the speaker phone.***

Basics of Facilitating Meetings

Although the specific techniques and skills used for facilitating meetings will vary, a few general principles should be used as a guide through the process. Note that these apply to site visit meetings as well as the repeated meetings that occur during the implementation phase discussed in the next chapter.

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 slide presentation or will they find formalities off-putting and prefer a more low-key discussion with handouts?

2) Know the purpose and goals of the meeting

The specific techniques and strategies you should use in a meeting will depend on the overarching purpose and specific goals of the meeting. 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 and correct misinformation

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 feedback

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 ensure you are incorporating them into the program design and adaptation. Consider the power differential that may exist between different stakeholder groups based on social positions, hierarchies, or historical context (e.g., patients and nurses). Then, adapt meeting arrangements to enhance likelihood of participation by stakeholders who may have or perceive they have less power than other stakeholders.

6) Provide structure for the meeting

Prepare an agenda for each meeting and solicit items from stakeholders for inclusion. Note that most people tend to underestimate (rather than overestimate) the amount of time that will be required to cover a given topic in group meetings. To avoid needing to truncate discussions, we recommend building extra time into the agenda to accommodate this.

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

Not all communication is verbal. Pay attention to facial expressions and body language.

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 major 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 implementation plan will be monitored and revised as needed. Remind stakeholders that implementation is a "process," not an "event." Thus, the plan can continue to be revised and improved as needed to meet organizational goals.

11) Guide the group to establish an Implementation Plan that meets the overall goals of the implementation effort while considering local needs

Facilitators serve as experts in program requirements and have extensive knowledge of how similar locations have successfully implemented innovations. However, do not dictate to stakeholders how the innovation 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.

12) Respond appropriately when stakeholders disagree

Stakeholders will disagree at times. There are many techniques you can use 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 the innovation 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 "How to Identify and Address Negative Stakeholders" on pages 35-36.)

13) Provide written documentation

After each meeting, ensure that there is written documentation of the meeting. This may take the form of a site visit report after the initial meeting (as described further below) or as minutes or notes from follow-up meetings. It is important that these documents include a record of who was in attendance, important items discussed, decisions that were made, resulting follow-up action items, responsible individuals, and specific time frames for completion. Documentation should be brief but sufficient to provide an overview of the meeting for anyone who was not able to attend and to provide documentation of major items, which may be helpful to review at a later point in time.

Individual Components of the Site Visit

The site visit typically consists of a series of interconnected meetings. Each meeting has a unique purpose and involves different stakeholders. Below we provide information about the structure, purpose, attendees, and goals for each of the typical component meetings of an initial

site visit. An example facilitation site visit agenda can be found in Appendix E-3, pages 176-177. It is important to keep in mind that the material described in this section is meant to be illustrative but not set in stone; specific site visit procedures and agenda will of course need to be tailored to your individual program needs, as well as the needs of the sites in which the innovation is being implemented. Regardless, 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 (see below) and provide early feedback to the site.

Entrance briefing (overview with leadership):

- Ideally, this meeting will be the first in a series and include the facility leadership. You may also invite care line or specific service leaders and program managers to this meeting. For example, if implementing a PCMHI 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.

- The main purpose of this meeting is to:

  - engage leaders,

  - provide them with information about the program,

  - establish support for the program,

  - convey to all stakeholders that leaders are invested in this process and implementation of the innovation, and

  - gather information about key areas of interest to leaders (e.g., any metrics, or process improvements) that are relevant to the innovation in order to develop shared goals to support implementation.

- This meeting should be relatively brief. Approximately 15 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 (of no more than 10 minutes), 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.

Stakeholder innovation education overview presentation

- The stakeholder education overview presentation will typically be the largest meeting of the day. This meeting provides the opportunity to educate the broadest group of stakeholders about the innovation and the facilitation process. Be inclusive in the invitation and work to invite anyone who may interface with the innovation. In previous initiatives, the education overview presentation included up to fifty participants. For example, when facilitating the implementation of evidence-based psychotherapies, some locations invited all general and specialty mental health providers to attend. Although many providers and staff may not be directly engaged in the innovation, their knowledge of it can allow them to better interface with the innovation providers and support sustainability.

- Consider inviting facility leaders who should be aware of the program but may not be involved in day-to-day functioning. It is better to err on the side of casting too wide a net than to not invite people who should be at the table.

- Typically, this presentation lasts 30 to 40 minutes, allowing ample time for questions and includes a formal didactic PowerPoint presentation. (See Appendix E-5, Stakeholder Education Overview Presentation (PCMHI), pages 180-184, for an example.)

- Ensure that the space reserved for this meeting is large enough to accommodate the number of stakeholders invited.

- The goal of this presentation is to provide a basic information about the innovation to a wide variety of stakeholders. At the end of the presentation, stakeholders should be able to understand the following objectives:

    - What are the basic components of the innovation
    - Why it is important
    - What are the policy requirements or known strong practices
    - How it can improve care
    - How/where it fits within the continuum of services currently being provided
    - What is the supporting evidence for the innovation
    - Common implementation challenges or concerns
    - Common site resources or characteristics that support implementation
    - What is Implementation Facilitation and how it can help

- While providing this basic education, the facilitator(s) are also engaging in marketing. One of the goals of this presentation is to bolster enthusiasm about the innovation and increase system-wide support for implementation. Thus, it is important that this presentation is brief and engaging and that it emphasizes how the innovation can improve services or the process of care for patients.

- Remember that this presentation is not intended to provide in-depth training to those who will be providing the innovation. Rather it is intended to provide basic education about the innovation and the implementation initiative to a wide group of stakeholders. Thus, specific nuanced education and training about providing the critical components should not be included in this introductory overview.

Program implementation planning meeting

- After the entrance briefing and stakeholder education overview presentation, have a meeting that focuses on reviewing the program requirements in greater detail and designing an implementation plan 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. Although it is recommended that a diverse group of stakeholders be included and those interested in participating should be invited to attend, there may be times when you need to limit the number of stakeholders who participate in the implementation planning meeting to ensure a functional working team. If too many individuals not directly involved with the innovation are present during the meeting, a great deal of time may be spent in orienting them to the innovation, decreasing the time available to develop an implementation plan.

- This meeting should begin with another review of the program requirements, the evidence base for the innovation, why the innovation is being implemented, and how the innovation, 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 overview presentation.

- Use a Program Implementation Planning Guide Template, described previously, (see pages 26-27 above and Appendices B-2 and B-3), for the specific program elements being implemented to structure the remainder of the meeting. (See Section IX, "Completing the Implementation Planning Guide: Transitioning to the Implementation Phase," pages 54-57 and Appendix B-4, Implementation Planning Guide Example, pages 162-167.) The guide should allow for variation to meet specific site-level needs, preferences, or priorities. Stakeholders participating in the implementation process should review the Guide and use it to develop a customized site action plan

for program implementation. See “Provide a Framework for Program Implementation Planning” on pages 55-56 for more information.

Tour clinics

The facilitator(s) 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. If the meeting is being conducted virtually, a video-based “virtual tour” may still be possible.

Individual meetings

The facilitator or facilitation team (e.g., an external and internal facilitator working together) may opt for a series of individual meetings with various stakeholders. This may occur at any point in the facilitation process and may or may not occur the same day as the larger implementation planning meetings. The purpose of these individual meetings will vary as will the specific individuals with whom the facilitator(s) need 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 facilitator(s) 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 innovation utilization. You may help the individual problem solve through barriers that may be inappropriate for discussion within a larger group. You may also want to have individual meetings with front-line staff to get their perceptions without the presence of supervisors.

Exit briefing

The exit briefing is just as important as the entrance briefing. The primary audience for this meeting is top-level leadership. Ideally, both facility and direct program leadership attend. Additional stakeholders may 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 implementation. Provide information about identified strengths, weakness, opportunities, and threats that emerged throughout the site visit. Describe the initial plan to proceed with innovation implementation. This meeting provides the opportunity to identify specific barriers that leadership can address to ensure successful implementation. For example, during your site visit, you may have identified a specific IT or staffing barrier that needs senior leadership input to fully address. This is your chance to state the need and for leadership’s assistance in addressing it.

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 facilitator(s) should be prepared to answer questions and provide additional information. However, facilitators should make no decisions based on informal conversation. The facilitator(s) may learn valuable information that was previously unspoken. When conducting site visits, be flexible and adaptive to allow for these impromptu conversations.

Site visit report

Upon completion of the site visit, facilitators should provide a brief written document summarizing the visit. This document is intended to provide a written record of the visit, including the stakeholders in attendance and the important implementation decisions that were made. Ideally, this follow-up report should be succinct, easily readable, and no longer than 3-5 pages. Provide leadership an opportunity to review the report and make edits prior to distribution. This will ensure accuracy as well as potentially identify any points of inconsistency or misunderstandings about either the innovation, the implementation plan, or current processes at the facility. (See Appendix E-6 Site Visit Report Example, pages 185-186.)

Helpful Tips

The site visit report should include:

- A brief overview of innovation and current operational status
- Items that were reviewed during exit briefing, i.e., identified strengths, weaknesses, opportunities, and threats that emerged during the site visit
- A description of the initial plan to proceed with program implementation

VIII. COMPLETING THE IMPLEMENTATION PLANNING GUIDE: TRANSITIONING TO THE IMPLEMENTATION PHASE

As described in Section III above, an early goal of the pre-implementation phase is to develop an Implementation Planning Guide Template for the program or innovation being implemented. Ideally, the site visit will allow you to complete this template, representing a solid launch point to the implementation of your program. An example of a completed Implementation Planning Guide can be found in Appendix B-4. As part of this process, you will also need to create a vision for the program and provide a framework for program design.

Create the Vision First

- In order to create a vision for the program, provide an orientation so that all stakeholders understand the required program components. It is helpful to have examples of similar organizations that have successfully implemented programs as well as examples of programs that may have adapted the design within the confines of the evidence base and achieved the desired outcome. The external and/or internal facilitator should provide a framework that guides the program implementation planning 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. ***It is helpful to elicit leaders' vision for program implementation and provide them an opportunity to articulate that vision to their staff in program implementation planning meetings.*** For implementation planning 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, strategic plans, and goals of the organization and individual stakeholders. For example, if one of the organization's core values is patient satisfaction, the stakeholders should have an understanding of how the program will improve patients' experiences of care.

- Everyone involved in program implementation planning must be motivated to make the changes. They need to see the benefits to their patient population and their organization. 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 patient population and their organization.***

Provide a Framework for Program Implementation Planning

- Provide the tools to design an implementation plan that reflects the characteristics of the local organizational culture and effectively lays the groundwork to successfully implement the innovation in question. Some of the tools, for example, might include relevant clinic policies, research articles (keep to a minimum), handbooks, checklists, fidelity measures, and other resources.

- Make sure to have key stakeholders at the table for the program implementation planning 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. See Appendix G, page 191, for Clinical Champion Activities and Characteristics.

- When there are changes in leadership or key staff, review with them the decisions made during the implementation planning process to obtain buy-in for the innovation design by those in positions of power.

- Together, discuss the steps in the Implementation Planning Guide Template, and use the template as a worksheet to document the decisions made, any action items, who is responsible for specific steps, and expected timeframes. Once the template has been completed, it becomes the local Implementation Planning Guide.

Consider Adaptations to the Innovation

Adaptation is an important step in implementation facilitation to ensure an innovation is compatible with the needs of your priority population and local conditions. To guide these decisions and ensure that your adaptations don't interfere with implementing with fidelity, the Cancer Prevention and Control Research Network (CPCRN) adapted work by Lesesne, et al.[92] to create an Adaptation Guidance Tool[93] (see below) which provides general guidance on things that can and cannot be changed from the original innovation to maintain fidelity.

In choosing an evidence-based intervention you may have to make changes to increase fit or compatibility with your audience and/or community. Here is general guidance in terms of things that can and cannot be changed from the original intervention. Remember to refer to any adaptation suggestions from the original developer(s) or vet adaptation decisions with subject matter experts in making these adaptation decisions.

Ideally, adaptations to innovations will enhance their "fit" with the population and context in which they are being implemented – while maintaining fidelity to the core components of the innovation.

Figure 6. Adaptation Guidance Tool[93]

Adaptation Guidance
Green = Things that CAN be changed: • Names of health care centers or systems • Pictures of people and places and quotes • Hard-to-read words that affect reading level • Wording to be appropriate to audience • Cultural indicators based on population • Ways to reach and recruit your audience • Incentives for participation • Timeline (based on adaptation guides)
Yellow = Things that can be changed <u>with caution</u>: • Substituting activities and/or adding new activities • Changing the order of the curriculum or steps (sequence) • Altering the length of program activities • Shifting or expanding the primary audience • Varying delivery format/process steps • Modifying who delivers the program • Adding activities to address other risk factors or behaviors
Red = Things that CANNOT be changed: • The health communication model or theory • The health topic/behavior • Deleting core components or whole sections of the program • Reduction of program • Timeline • Dosage (e.g., activities, time/session) • Putting in more strategies that detract from the core components

In addition, the Iterative Decision-making for Evaluating Adaptations (IDEA)[94] may be useful for planning adaptations. It presents a series of decision points to help guide administrators, clinicians, facilitators, and other stakeholders in considering and deciding upon what adaptations may be helpful as an innovation is rolled out. For those interested in documenting modifications, several tracking frameworks may be used (e.g., The FRAME[95]).

Congratulations! Once you have a fully developed and mutually agreed upon local Implementation Planning Guide, you are ready to transition to the next phase: Implementation. The vision is created, and you have an implementation framework ready to go. These key pre-implementation activities have provided the necessary foundation for successful implementation.

IX. CORE ACTIVITIES ACROSS THE PRE-IMPLEMENTATION PHASE

Recent work has aimed to determine what core facilitation activities are essential across implementation phases. A literature review and modified Delphi process suggests that the activities below should be considered core during the pre-implementation phase[41] (see Appendix L-1, pages 222-224, for definitions for each of the core facilitation activities listed below). You will note that much of the material above is focused on helping to ensure that each of these core activities are pursued during the pre-implementation phase. For example, Section III in this chapter focuses on engaging stakeholders; Section IV focuses on site assessment, including data collection to assess context and baseline performance and to identify problems; and Sections VII and VIII focus on facilitation activities to assist sites with action/implementation planning and goal/priority setting. While we describe the list below as core activities, we also note that your particular implementation project may require additional activities that don't fall neatly into one of these categories. More detail on the evaluation of implementation facilitation—including assessment of the extent to which each of these core activities are completed during the pre-implementation phase—can be found in Chapter 9:

- Engaging stakeholders, obtaining buy-in
- Identification/selection of local change agents
- Data collection to assess context and baseline performance
- Problem identification
- Action/implementation planning
- Describing/clarifying roles and responsibilities
- Goal/priority setting
- Administrative tasks

The goal of the material in this chapter is to prepare you to successfully navigate the pre-implementation phase of an implementation project. Such pre-implementation preparation represents the foundation for achieving implementation of a clinical innovation, and as we stated above, *the length of this chapter reflects the amount of work that needs to be done during this phase*. Completing the steps outlined above should leave you prepared for the next step: the implementation phase itself.

CHAPTER 5
IMPLEMENTATION FACILITATION ACTIVITIES IN THE IMPLEMENTATION PHASE

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 quality improvement (QI) goals defined during the pre-implementation phase. The activities of the facilitator should all be geared toward assisting the site in the actual work of implementation. Typically, this phase begins after development of the implementation plan and focuses on providing necessary supports for implementation activities. During this phase, facilitators apply many different implementation strategies to support the uptake of an innovation, tailoring their efforts to the specific innovation, the needs of the site, and the stakeholders with whom the facilitators are working. Some implementation facilitation activities, such as helping sites establish systems for monitoring implementation progress, are unique to this phase, while others are conducted across all phases with variation or nuances specific to the implementation phase. For example, although the facilitator initiates processes for supporting communication and relationship building during pre-implementation, during the implementation phase, the facilitator works to deepen relationships and routinize communication processes. This chapter provides practical information about facilitation strategies and activities for the implementation phase.

IMPLEMENTATION STRATEGY

What you do (or someone else does) to help the setting implement the innovation

I. PLANNING IMPLEMENTATION TEAM MEETINGS

Routine implementation team meetings are a critical aspect of the implementation process. By the time you are in the active implementation phase, the site should already have a well-developed implementation plan and an active implementation team (see Chapter 4, pages 54-57, for information about development of an implementation plan through use of an Implementation Planning Guide). If these two tasks have not been completed, pause active implementation until a plan can be developed and agreed upon by all stakeholders and a team established.

Once the team and implementation plan are established, an important function of the facilitator(s) is facilitating ongoing, routine innovation implementation team meetings. Ideally, such meetings will have been discussed as part of developing the local implementation plan in the pre-implementation phase. However, it is possible that this planning may not have occurred and planning the ongoing implementation team calls may be a critical first step in facilitating execution of the implementation plan. If this is the case:

- It is essential that you make sure these meetings are **pre-scheduled** with a set date and time that is mutually agreeable to all stakeholders.

- It is also essential that you make sure these meetings are scheduled on a recurring and routine basis.

- Although the implementation team should decide the frequency and duration of meetings, let the team know that successful implementation teams tend to meet more frequently early in the active implementation phase. For example, the team should consider having weekly or bi-weekly meetings initially to ensure momentum continues. This not only capitalizes on energy created from the initial implementation planning meeting but rapidly establishes the expectation to assertively push the initiative forward. As a facilitator, you may need to recommend meeting frequency.

- As the process progresses and implementation occurs, make sure the team revisits the frequency and duration of meetings in later stages.

- Because it is wise to schedule meetings in advance, be sure that someone sends a recurring calendar invite to all team members. It is far better to have future meetings scheduled and find that they are not needed than to scramble to fit in meetings and, at worst, lose momentum because schedules do not permit an implementation team meeting.

- If engaging patient stakeholders throughout the implementation phase, consider and ask about their needs, other demands, and preferences for meeting regularly to ensure they can participate. Here are some sample solutions from others who have engaged patients in implementation:
    - Meetings with patient stakeholders might occur with less frequency than all healthcare professional meetings to reduce burden
    - Schedule meetings far in advance to allow patient stakeholders to arrange transportation and coverage for other commitments
    - Agendas and other materials should be sent for review before the actual meeting
    - Use existing funds or ask for additional funds to pay for honorariums, childcare, transportation, and other costs to allow patient stakeholders to participate

II. FACILITATING IMPLEMENTATION MEETINGS

Now that the implementation plan, implementation team, and routine implementation meetings have been established, it is time to jump into the active phase of implementation work. It is through the routine implementation meetings that the implementation plan is executed, monitored, and refined to meet the defined performance or clinical QI goals. Review the general skills and principles for facilitating meetings described in the previous chapter prior to running implementation meetings.

Although the exact tasks that you complete during routine implementation team meetings will vary depending on the needs of the site and the specific innovation being implemented, the following represent a few essential areas that you should address. You should make sure that someone circulates a written agenda prior to the meeting and provides meeting notes/minutes afterwards. (Note: this may be you, especially at first, until an internal facilitator, leader, or champion can take responsibility.)

A well-crafted Implementation Planning Guide (see Chapter 4, Section VIII, pages 54-57) may be used to structure these meetings. It may be helpful to walk-through this document during each meeting. This provides a clear structure to the meetings, ensures that each item on the implementation plan is being attended to, highlights areas that need additional refinement, and creates a process to identify clear next steps for each team member to move implementation forward. Below are some suggestions for helping the site 'walk-through' the plan:

- **Monitor the implementation plan**. Review the implementation plan at each meeting. This should include a review of the key metrics and targets selected by the site, progress, timeframes, barriers, necessary refinements, and next steps.

- **Discuss and document progress**. This review and discussion should include the documentation of progress on both qualitative and quantitative data. In addition to key metrics, for each action item, document whether progress is being made, whether the item is on hold, or whether the item is not progressing. Seek to understand stakeholders' perceptions in addition to the key metrics. How are providers responding to the changes? How has the innovation started to change care?

Helpful Tips

Summary of how you can help sites during implementation planning team meetings:

- Monitor the Implementation Plan
- Discuss and document progress
- Identify and understand barriers
- Help to problem-solve and identify solutions
- Modify or adapt the Implementation Plan as appropriate
- Watch for drift
- Provide positive reinforcement
- Provide support, encouragement, and other forms of assistance when there are challenges or bumps in the road

- **Identify and understand barriers**. For each item that is not progressing, take time to stop and identify barriers and understand why that item is not progressing. Data should be used to inform the need for modifying or revising the implementation plan.

- **Help to problem-solve and identify solutions**. As barriers or challenges emerge, or if items are not progressing, help the team to engage in a positive problem-solving process. Brainstorm and/or present potential solutions. Recommend strong practices that have been successful in other locations. Link stakeholders to additional subject matter experts, resources, or other similar sites that have been successful despite similar challenges. Help them to generate reasonable alternatives. Provide them with additional education, if needed. Apply other discrete implementation strategies,

described in the next section, as appropriate to the challenge/barrier they are experiencing. If these are outside your expertise, ensure that you link the site with experts who can engage in these activities to support the site's implementation.

- **Modify or adapt the implementation plan as appropriate**. Once potential solutions are identified, work with stakeholders to develop a plan to address identified problems and leverage strengths. Remember that the implementation plan is not set in stone and should be adapted throughout the process to ensure, not only a solid implementation plan, but also a successful and complete implementation of the innovation. Make changes as needed, but ensure input from all stakeholders is considered, that all stakeholders are informed of suggested adaptations, and that consensus is achieved before formally modifying the plan.

- **Watch for drift**. While adaptations may be useful, drift (defined as gradual return to previous processes and abandonment of the innovation in question)[96] can easily derail an implementation effort. As an outsider, you may be better able to recognize drift from the plan, changes in momentum, or decreases in energy than those within the organization. It is critical that you pay attention to these features and be ready to call the implementation team's attention to these issues.

- **Provide positive reinforcement**. Be sure to celebrate the success of the team and note even small accomplishments.

- **Provide support, encouragement, and other forms of assistance as appropriate when the team faces challenges or bumps in the road**. Be clear that these are expected and that there has never been an implementation initiative that went exactly as planned. Let them know that you are there to help and that together you can overcome this challenge.

III. STAKEHOLDER ENGAGEMENT DURING THE IMPLEMENTATION PHASE

The work of stakeholder engagement, just like any relationship, is never finished and evolves over time. By this time in the process, key stakeholders should already be identified and initially engaged. Thus, the primary task becomes building stronger relationships and ensuring that engagement is maintained over time. Your activities in the implementation phase will vary based on the type of stakeholder and the previously established level of stakeholder engagement (see Levels of Stakeholder Engagement, pages 31-32). However, it is possible no one identified or adequately engaged essential stakeholders during the pre-implementation phase. Perhaps they were on leave and were not able to attend prior meetings, or they may not have been recognized as playing a key role. Once identified, immediately engage with these team members. See Chapter 4, "Stakeholder Engagement during the Pre-Implementation Phase," pages 27-36 for more information on this process.

As mentioned in Chapter 4, when engaging with patient stakeholders in groups with healthcare professionals, consider power differentials between different groups based on social positions given historical or current hierarchies, paradigms, or oppression. Adapt meeting arrangements to enhance likelihood of participation by stakeholders who may have, or perceive they have, less power than other stakeholders. For example, when meeting with medical assistants and medical directors, ask people to send questions to you prior to the meeting. You could then respond to them in the meeting without indicating who submitted them. You might also consider specifically asking the medical assistants to provide their input first.

Building Stronger Relationships through Routine Reporting

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 existing processes for regular updates on which your project can be included. For example, some leaders may want monthly reports; others may want quarterly reports. Providing routine data and opportunities to discuss and review may be one way to continue to enhance engagement throughout the active implementation phase. This act of routine reporting not only includes assessment and monitoring, but also has a strong engagement component. Examples of program reports that were designed to meet specific stakeholder requests can be found in Appendix H-1 and H-2, pages 192-194 (See below for additional information about creation of baseline/routine reports and audit and feedback).

Case Example

In a project in which facilitators were helping implement telehealth, stakeholders 1) differed in the specific data they initially wanted to monitor and improve, 2) changed what they wanted to monitor and improve over time, and 3) changed the frequency with which they wanted feedback. Facilitators responded to differing and changing stakeholder needs by pulling relevant data from national dashboards. For example, leadership was initially more interested in the number of clinicians and staff trained in telehealth. As the project proceeded, they largely shifted their attention to increased spread and penetration of telehealth services; and facilitators provided them feedback on, for example, the number of clinicians providing mental health services via telehealth, the number of unique patients served via telehealth, and the total number of telehealth encounters. By focusing on the data that were most relevant to stakeholders, the facilitators were able to maintain stakeholder interest and commitment throughout the project. This implementation effort laid groundwork that later helped the medical center further shift toward telehealth during the COVID-19 pandemic.

Building Stronger Relationships through Routine Conversations

By this time, you likely will have established an initial relationship with your stakeholders. To continue to nurture the process of engagement, it may be important to reach out to them outside the routine, scheduled meetings, and reporting structure. Consider sending quick emails with good news reports or from time to time calling them out of the blue for a brief phone contact. Consider sending them an informal instant message just to check in from time to time. The key is to ensure that they remain invested and actively engaged while they may be faced with many competing priorities. You may want to take the time to get to know stakeholders as individuals. What interests outside of work do they have? What are they passionate about (e.g., grandchildren, pets, coaching). Getting to know individuals at this personal level, helps to establish rapport and strengthen the relationship.

To sustain partnerships with patient and other stakeholders over time, one solution would be ongoing partnership meetings or events. These regular engagement opportunities to update on implementation progress or seek feedback may avoid consulting stakeholders too late to change anything. This regular engagement can also build trust and rapport with stakeholders.[89]

Dealing with Stakeholder Turnover

Stakeholder turnover is inevitable and will occur across the phases, including during the implementation phase. In fact, it may happen several times during the implementation process. 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! For example, in one implementation facilitation initiative, multiple changes occurred among key stakeholders, including two changes in clinicians (one retired and one resigned), the unfortunate death of a program manager, and the promotion of a network leader to a central office position. There are a number of ways you can deal with this issue so that the impact on your implementation plan is minimized—see the “Helpful Tips” box below for examples.

Helpful Tips

Tips for dealing with stakeholder turnover:

- 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 innovation. 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 document archiving sites.
- Identify staff members who can conduct local training and formalize this process throughout the organization.
- Develop formal succession plans to ensure continuity of roles and institutional memory when turnover occurs.

In addition to addressing stakeholder turnover among staff, it is also important to consider turnover among stakeholders who are patients. Solutions to turnover of patient stakeholders should include action to prevent loss or to ensure there are enough patient stakeholders for engagement to continue should turnover occur. To retain patients, especially those with significant societal or health burdens, facilitators might maintain responsibility for managing logistics as much as possible to minimize administrative burden on patients. Having a group of patients, versus one or two, can ensure engagement continues when natural turnover or patient dropout occurs. Regular communication strategies that occur through multiple pathways (e.g., using a combination of e-mails, phone calls, text messages) will also enhance chances patient stakeholders are updated in a manner suited to their needs, keeping in mind their communication streams might be different from other stakeholders (e.g., leadership).[89]

IV. FOSTERING COLLABORATIONS AND PARTNERSHIPS DURING THE IMPLEMENTATION PHASE

Although the skills associated with fostering collaborations were described in the pre-implementation phase, these important facilitation activities will continue through the implementation phase as well. For example, as you develop a deeper understanding of the site and build stronger relationships, you will likely identify both additional needs that may be enhanced through fostering collaborations as well as institutional supports/initiatives that you may not have been aware of during pre-implementation. Thus, two important activities that were previously noted are particularity relevant during the implementation phase:

1) **Identify existing partnerships and practices.** Find the existing positive energy and work with it to build momentum for the program or practice being implemented. To identify existing positive energy, speak with leadership, including program managers, discipline leads, and medical center directors to identify ongoing QI 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 will also identify individuals who are interested in system change to provide the best patient care possible.

2) **Once you identify existing QI initiatives, become actively involved in them by forming collaborations and partnerships 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.

Prior to the implementation phase, you may not be able to effectively identify these initiatives, have the time to discuss them with leadership, and form collaborations with them. Thus, the main concepts and skills involved in fostering collaborations are important to consider across all phases of implementation facilitation but may be most relevant during the implementation phase.

It is also critically important to engage consumers or patient representatives as stakeholders throughout the process of implementation. There are several different ways that this can be accomplished within the implementation phase, with various levels of engagement and involvement. For example, some projects have included a patient as a required member of the site implementation planning teams. In this scenario, the patient is considered a key stakeholder and is actively involved in on-going, routine implementation team meetings and processes. Other facilitation efforts have engaged patient advisory boards throughout the process, which often involves attending board meetings and routinely presenting materials and incorporating feedback from these stakeholders. Another option is to engage a group of local patients at the site that is implementing the innovation and seek their input and ask about their experiences of care both before and after the implementation process. Although the extent to which the consumer is engaged will vary based on the specific project, it is important that facilitators ensure they actively find ways to engage representative end-users (patients, in this case) throughout the process.

V. ASSESSING THE SITE DURING THE IMPLEMENTATION PHASE

Site assessment is an essential implementation facilitation activity that occurs across all phases of the facilitation process. However, the exact nature and focus of the assessment will shift over time. During the implementation phase, the focus of site assessment moves away from preliminary assessment focused on site-level characteristics and shifts towards development of a complex and nuanced understanding of the site that builds upon the knowledge and data obtained from the pre-implementation phase. As you build trust with key stakeholders, they may be more forthcoming with important information about how the site operates. You should consider this to be important data.

You can gather much of this information through active listening and well-placed questions, rather than formal assessment. During the implementation phase, you need to gain a thorough understanding of the site and its organizational context. Some of this information will become evident to you simply through your ongoing interactions with the site. As you gain familiarity with the key players, personalities, and preferences, you will develop a complex conceptualization of the site's culture, climate, and ability to change. Seek to learn about the informal leaders, the personalities of key team members, alliances and conflicts, as well as organizational history that influence program implementation. Continue to ask questions. Watch for patterns in behavior and recurring themes. Pay attention to who is repeatedly absent or late, as well as who is quiet or not. This will provide valuable information to enhance your understanding of the context of the site. Listen for comments that may indicate barriers or facilitators for change.

Case Example

At one site implementing 30-minute appointments within PCMHI, clinicians continued to provide care that was inconsistent with the model of service delivery despite education, audit/feedback, and other implementation strategies. Although a thorough site assessment had been completed, it was well into the implementation phase before the facilitator understood the true challenge. There had been a high-profile suicide and clinicians were concerned about patient lethality, increased scrutiny of their work, and leadership support in a perceived hostile work environment. These complex themes did not emerge until key site team members fully trusted the facilitator and only because the facilitator was listening closely to comments made in an implementation meeting and asked supportive follow-up questions. Important contextual and institutional information influencing implementation may not always be immediately apparent. Be prepared to continue site assessment throughout the facilitation process.

If the innovation may differ by rate of delivery, uptake, quality, or outcome between patient groups (i.e., healthcare / implementation disparity), continue assessing (formally or informally) the three factors that may contribute to this:

- Cultural factors of recipients, such as medical mistrust, demographics, or biases of patients, providers, and other staff;
- Clinical encounter or patient-provider interaction in which the innovation is delivered or offered; and
- Societal influences including physical structures, economies, and social and political forces such as linguistic competency of signs and forms, structural racism, insurance, or discriminatory policies. For formal measures of these factors, see Woodward et al. (especially Table 1).[50]

VI. ASSESSING AND MONITORING INNOVATION IMPLEMENTATION

Another assessment goal of the implementation phase is to establish routine processes for data collection and monitoring that the site will ultimately be able to continue once the facilitation process is finished. To address this goal, you will need to help site stakeholders identify both key metrics for monitoring implementation and relevant data sources. (See Appendix H-1 and H-2, pages 192-194, for examples of program monitoring reports.) You will also need to help develop routine reports for monitoring these metrics, processes for reviewing them with site stakeholders, and processes for helping stakeholders assess this information and use it to improve innovation implementation.

Identify Key Metrics and Data Sources

As you enter the implementation phase, ensure that you, in collaboration with the implementation team, identify all the important metrics that are relevant to the specific innovation and implementation plan, as well as data sources for their measurement. In addition to helping the team identify important metrics, ask stakeholders about additional data that they would like to monitor. You can use these metrics to establish routine reporting and monitor implementation progress.

Selection of metrics

Many facilitators have found it helpful to use a framework to guide the selection of metrics. The RE-AIM framework[97] is one model that has been widely used for such purposes because it addresses issues related to real-world settings.[97] You can use data collected for each of the five RE-AIM dimensions (reach, effectiveness, adoption, implementation, and maintenance) to monitor implementation and assess the innovation's overall effect. Below we list each of the dimensions and examples of metrics for them. See also Chapter 9 or www.re-aim.org.

Dimensions	Definitions
Reach	The absolute number, proportion, and representativeness of individuals participating in the innovation or program. For example, the site may wish to monitor the number of patients who receive or are participating in the innovation and their specific characteristics.
Effectiveness or efficacy	The impact of an innovation on important outcomes, including specific patient-level outcomes, potential negative effects, quality of life, and economic outcomes. For example, if a site is implementing a tobacco cessation program, site stakeholders might want to collect data on and monitor quit rates and the program's impact on other important health variables for enrolled patients.
Adoption	The absolute number, proportion, and representativeness of users (settings and/or staff) of the innovation. For example, a measure of adoption might be the number of clinical providers who are delivering the innovation.
Implementation	refers to innovation fidelity or the extent to which a site implements the innovation as planned. For example, many evidence-based programs have core components, and measures of implementation might assess how well each of those core components was actually implemented.
Maintenance	refers to the sustainment of the innovation and is often assessed by repeating measures of reach, effectiveness, adoption, and implementation over time.

In addition to metrics identified by site stakeholders, there are often specific program goals and benchmarks established by health care systems, i.e., Veterans Health Administration in VA, for each area of service delivery. Sites may select these items as the core metrics to monitor. In VA, metrics are often linked to facility and leadership performance expectations and ratings.

Selection of data sources

There are a number of sources of data you can use to monitor innovation implementation. In addition to accessing these yourself, to sustain the innovation, it will be important that you help site personnel learn how to collect and use this data to continue to monitor the innovation and maintain fidelity to clinical practice guidelines or the evidence base for a given innovation. Below is a list of data sources:

- **Dashboards**. In recent years, the VA has developed multiple nationally available dashboards that can easily be accessed by any VA employee. The availability of these resources will depend on the specific innovation being implemented. Typically, these systems include relevant administrative data. However, due to challenges in rolling up administrative data nationally, you should obtain direct provider feedback and verification to ensure their accuracy. There are many national program-specific dashboards available. For example, there is a PCMHI Same-Day Access dashboard and there is a dashboard specific to suicide prevention efforts in the emergency department. The nature and type of data available depends on the specific program. Many dashboards now allow you to drill down to both the individual patient and the provider levels. You will need to be familiar with all dashboards that are relevant to the innovation you are implementing. These dashboards are primarily used for administrative program review. Thus, you may be working with site-level personnel who are not familiar with these resources and it is critical that you have the knowledge and expertise to not only utilize these tools, but to demonstrate and share that knowledge with individuals at the site.

- **Locally available administrative data.** Often sites opt to monitor and improve implementation based on locally available data. You should fully support this process, and work with the team to ensure team members collaborate with stakeholders who have access to these data and identify ways to incorporate into routine reporting and audit and feedback processes.

- **Observations**. If possible, make direct observations of what is happening at the clinic. A network-level team member or leader can assist with this process by making site visits and observing direct interactions between stakeholders, including those between patients and clinical staff.

- **Innovation fidelity measures (if available).** Some innovations will have specific measures or metrics that have been developed to assess implementation fidelity, while other innovations may not. For example, for PCMHI, there are specific measures that have been developed to address provider fidelity, such as the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ),[98] and specific metrics (e.g., the percentage of patients who are seen in PCMHI the same day as a primary care appointment). If fidelity measures are available for the innovation being implemented, it is extremely helpful to include them as additional tools and sources of information to monitor implementation. In cases where established innovation fidelity measures are

not available, consult with innovation developers and/or subject matter experts to identify some program elements or measures that may be used for fidelity monitoring

- **Chart reviews.** A review of patient charts can check for provider competency with administrative and documentation skills. This information may be used as feedback to providers 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.** The site implementation team may want to gather information from supervisors, clinicians, patients, and other clinical staff about the innovation, its impact, and ways implementation might be improved.

Establish Baseline and Routine Reports

By selecting metrics and gathering data from the sources above, you can easily monitor innovation implementation through the baseline and routine reports. (See Appendix H-1 and H-2 for examples of program monitoring reports.) To create these reports, you will need to work with site stakeholders to:

- Establish goals and targets for success based on the data being tracked. For some data, there may be system-wide or national targets or goals that may direct these expectations.

- Develop the structure, format, and content of reports for data being tracked.

- Develop routine processes for monitoring and reporting the data.

- Ensure the site understands the data included in the metrics and how the data are collected, reported, and interpreted.

Helpful Tips

Report contents should:

- Be brief (typically one page of relevant data), be easily interpreted, and include a legend
- Depict areas of both strength and weakness
- Meet the needs of leadership (make sure before finalizing and routinizing report contents)

To develop reports:

- Work with the local team to develop a data report template (some locations will prefer Spreadsheet files and others will prefer word processing files).
- Review the data for accuracy and coding errors with key stakeholders

To sustain the process:

- Transfer skills for creating reports and, if needed, obtaining and interpreting data to local team members

Once the initial report is established, determine the frequency for routine reporting. This may vary depending on how frequently updates are made to the data sources and the needs of your stakeholders. This could be weekly, monthly, or quarterly. The essential feature is consistency. Decide with the team the frequency for the reports and ensure that a process is established and implemented for routine reporting.

Monitor Implementation

Systematic monitoring of data and timely feedback to leadership and providers is an important element of program monitoring, improvement of innovation implementation, and sustainment. To start this process, you should ensure that all key stakeholders are aware of baseline data for metrics being assessed so that everyone has an understanding of the starting place prior to the implementation facilitation process. You should then monitor these data points, sharing the routine reports with stakeholders throughout the implementation process to track change. This process should include ongoing discussions among providers, the facilitator(s), and local supervisors rather than limited to formal annual or semi-annual evaluations.

At implementation team meetings, you should review and discuss data and revise action plans for areas that are not making progress within an appropriate and expected timeframe and are determined to need additional attention. It is critical that you discuss these data with providers in a direct but nonthreatening way and get their perceptions. You may want to use more formal processes, such as audit and feedback or academic detailing to inform the review of data and improve innovation implementation.

Case example

The VA Tobacco MHRRTP Dashboard became a key feature in facilitating implementation of Tobacco Treatment in Substance Disorder (SUD) Residential Programs. The dashboard contained information relevant to the progress the programs were making in several areas, including prescribing practices, diagnoses, and counseling. One of the leaders was especially motivated by data and used the reports to improve the program. In addition to using dashboard data, facilitators used an Action Plan feedback report in the dashboard format. The Action Plan listed the program goals developed by stakeholders and provided feedback on their status in meeting the goals. Status categories included: “completed,” “in progress,” and “no progress.” It was helpful to have the “no progress” goals displayed in red; this motivated one program to make changes. The facilitators suggested stakeholders limit the number of program goals they identified and ensured that goals were attainable. The goals that were not attainable in the time allotted were listed as “on hold” and did not count against their progress.

VII. CONTINUOUS QUALITY IMPROVEMENT

Part of the facilitation process that occurs during implementation is establishing a culture of continuous quality improvement. To do this well, one must engage in ongoing program/innovation monitoring, thoughtful review of the data, and purposeful program adaptation when data indicate areas for improvement. Essentially, as a facilitator you are guiding the site through multiple Plan-Do-Study-Act (PDSA) cycles.

PDSA is an iterative and cyclical, four-step problem-solving model used for continuously improving a process or implementing process change. PDSA cycles consist of small-scale tests of planned changes by temporarily trialing the change, evaluating its impact, and improving the initial plan before carrying it out across the board. This will give everyone involved the opportunity to see if the proposed change will work and to maximize the potential for success. If the initial change does not create the desired outcomes, the cycle begins again as additional slight modifications are made, trialed, and evaluated. This cycle continues until the desired outcomes are achieved.

As part of this process, it is important to remember that the initial implementation plan may need to be adapted over time if the initial decisions have not been implemented or have not created the desired outcomes. Thus, your approach to developing the plan, monitoring the outcomes, and revising should be flexible and adaptable from the beginning. This approach allows for continued adaptation over time, with ongoing monitoring, until the desired outcomes are achieved and sustained.

The entire facilitation process, but specifically within the implementation phase, should embrace a continuous quality improvement mindset. Thus, if the initial plan or facilitation strategies are not achieving the desired outcomes, remember the importance of making small adaptations until acceptable outcomes are achieved. For more information about PDSA cycles visit the Institute for Healthcare Improvement (IHI) Website, available at IHI: How to Improve.

VIII. IMPROVING INNOVATION IMPLEMENTATION

In addition to the implementation strategies discussed previously, there are many other strategies that facilitators can apply, based on the results of site and implementation assessments, to improve innovation implementation. Thus, the facilitator must be aware of and able to employ these strategies throughout the implementation phase as needed. Further, remember that all the specific strategies should be applied within the context of a supportive interpersonal relationship. You should be able to use the implementation strategies in the following list; however, this is not an exhaustive list. For the purposes of this manual we focus on academic detailing, marketing, education, mentoring, linking with national or regional resources, capitalizing on strengths, audit and feedback, process mapping, problem identification and resolution, and building learning collaboratives or communities of practice. If you do not have experience with these activities, you may want to seek consultation, additional training and learning experiences for yourself, or bring in other experts to consult with the site.

Academic Detailing

Academic detailing[99-101] typically includes providing a review of the research and clinical evidence that supports the program implementation or practice change and sharing it with key stakeholders. It is an educational service that may better align current practices with the scientific evidence. Academic detailing highlights gaps between the evidence base and actual practices at the site and encourages adoption of best practices and clinical practice guidelines, ultimately enhancing the quality of the services provided.

Academic detailing is used to present the evidence and guidelines that support the innovation. Typically, academic detailing involves interactions between the implementation facilitators and frontline clinical providers at the site. To conduct academic detailing, first, you will need to investigate site stakeholders' baseline knowledge and motivation for current practices. Essentially, you will want to understand providers' current practices as well as their understanding and perceptions of the innovation. Next, you should provide educational information about relevant current clinical practice guidelines, the evidence base for the innovation and/or best practices to clinicians. Some providers may already be using the best practices that are fully aligned with clinical practice guidelines or the evidence base, while others may not. If gaps between current practices and guidelines or evidence emerge, you should seek to understand what beliefs the clinician has about the innovation as well as other barriers that may be influencing less than ideal care. Provide clear behavioral objectives through the repetition of essential educational messages and the provision of positive feedback for improved clinical practices. Academic detailing, as part of implementation facilitation, frequently occurs late in the pre-implementation phase or early in the implementation phase. Depending on the project design, implementation facilitators, may be able to invite regional or national experts to provide or support academic detailing exercises. Therefore, it may not always be the facilitator providing the academic detailing directly.

Marketing

Many specific marketing techniques are described for the pre-implementation phase (see Chapter 4, Section VI, page 44-45). You should continue marketing activities across all phases of implementation. However, the specific content of marketing messages, audiences, and the marketing strategies used will vary depending on the needs of the site at any given point in time. The goal of marketing shifts from launching the program to improving the program and reinforcing prior messages. Below are some descriptions of and recommendations for marketing activities during the implementation phase:

Repeating the same message over and over again reinforces the message and should not cause frustration. Just as the advertising 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 tend to revert to previous practice patterns without repeated marketing of the innovation. You should continue marketing after the innovation has been fully implemented and well beyond. View it as one component of an ongoing dialogue between those highly invested in the innovation and additional stakeholders.

Providers have a tendency to revert to previous practice patterns without repeated marketing of the innovation.

During this phase, the focus of marketing techniques needs to shift. Your goal is no longer to provide initial education about the innovation but to reinforce prior marketing efforts and provide more complex/advanced messages as the site makes progress. During this phase, you may rely more on informal processes, such as curbside consultation or informal conversations as part of

team meetings (see Chapter 4, Section VI, “Marketing,” pages 44-45), based on the degree of engagement and relationship with the stakeholders.

Marketing messages should include data that demonstrates implementation progress and can thus be used to celebrate the site’s achievements. Messages can also be tailored to the specific interests of stakeholders. You can use data obtained for monitoring implementation progress to inform marketing practices. The data you collect during continuous monitoring processes should pinpoint any changes in utilization of the innovation after a targeted marketing intervention. For example, a marketing effort to support PCMHI implementation may consist of informing primary care providers of a specific intervention for a specific target condition. Ideally, soon after initiating the marketing effort, your data should show an increase in PCMHI referrals for that specific condition.

It is important that someone, such as a local champion, continue to provide more formal marketing, such as flyers, email blasts, or presentations, but they should also reinforce prior messages, build on previous content, and continue to advance implementation of the innovation.

Educating and Training Innovation Providers

As you proceed with the implementation plan, you may find that one of the implementation barriers is actually clinical providers’ lack of knowledge about the innovation or specific skills needed to deliver the innovation. You will need to provide this sort of knowledge and help them develop skills.

To ensure that innovation providers have the appropriate knowledge and skills, they need education and training, and, depending on the complexity of the innovation, ongoing mentoring, which will be discussed in the next sub section. There are several issues you need to consider in relationships to ensure that providers receive the training they need:

Consider the role of the primary supervisor

Throughout the implementation facilitation process, you must maintain consistent communication with the primary supervisor of innovation providers for multiple reasons:

- The supervisor must be aware of specific goals for the program and be “on board” for specific training objectives.
- The innovation provider’s supervisor is ultimately responsible for the innovation, while the facilitation team members are expert consultants tasked with supporting innovation implementation.
- Ultimately, it is the supervisor’s program and the supervisor’s staff. Thus, you need to inform and obtain approval from the primary supervisor regarding any data monitoring and the nature and function of any contacts with staff.

It is important that you and the primary supervisor represent a united front, which will minimize any potential difficulties, conflicts, or confusion with 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. In the context of matrixed organizations (i.e., organizations in which frontline clinicians report to more than one supervisor, such as a team lead and a discipline chief), it is important to ensure that all supervisors support the implementation effort.

Plan who will conduct the training

If you are implementing an innovation in which you have subject matter expertise, you may provide some education yourself. This may be especially true for programs that are focused heavily on implementing specific clinical procedures. For example, implementation facilitators for a program meant to increase the use of evidence-based psychotherapies may be experts in those psychotherapies themselves. However, you may be implementing an innovation for which you are not a subject matter expert. In that situation, you should provide connections to subject matter experts and help arrange educational opportunities to ensure that providers receive training to address the gaps in knowledge and skills.

Plan how the training will be provided

This education could be provided in multiple formats, perhaps including, but not limited to, consultation with subject matter experts, online courses, webinars, or other training events.

Essential implementation facilitation tasks for training include the following:

- Ensure that all 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 the new skills. By watching someone whose skills are more advanced, providers can learn how to deliver the innovation with fidelity more quickly.
- After training, you or the supervisor should consider observing the new providers in action and provide supportive and constructive feedback.

Mentoring Innovation Providers

In addition to education and training, new innovation providers will benefit from mentoring throughout the implementation facilitation process. Mentoring is defined as a dynamic learning partnership in which an individual with greater expertise supports, guides, coaches, and generally helps an individual with less expertise learn a set of skills and/or develop professionally.

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

It is likely that you may become either a formal or informal mentor to not only the frontline staff delivering the innovation, but also to leaders and supervisors. Ultimately, during the implementation phase, you will be transferring much of your knowledge to local team members at the site and much of this process will occur through mentoring processes. It is likely that the supervisor responsible for the innovation will come to view you as a valued mentor and colleague.

Helpful Tips

Ongoing mentoring and supervision tasks to consider during the Implementation Phase:

- Schedule and lead local sharing collaborative calls (see Section X, "Building Learning Collaboratives/Communities of Practice," pages 80-81) with all providers at least monthly.
- Monitor program data and provider panel management metrics (see Section VII, "Assessing and Monitoring Innovation Implementation," pages 67-71). Provide benchmarks and help individual providers set goals for innovation implementation.
- Review individual provider metrics monthly. You can present data in de-identified reports and lead group discussion about program QI (see Appendix H, pages 192-194 for examples of program reports).
- Conduct monthly, individual discussions with providers whose data consistently fall below expectations to suggest adequate utilization rates or adequate innovation 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 additional resources by participating in select calls and related informational/educational opportunities if they are available.

Linking with Regional or National Resources

In addition to local resources within sites, there may be additional resources that can help support implementation of the innovation. Although these will vary by specific program content, typically these resources bring together experts from around the country to teach staff the concepts and skills vital to the specific program. There may also be national online forums, such as listservs, and blogs or organizations that offer lower intensity technical assistance to support

implementation. As a facilitator, you should be informed about the relevant resources for the innovation that you are implementing and know when and how to help the site link in these resources.

Capitalizing on Strengths to Motivate Change

When working with site stakeholders to help them implement changes, it is natural to notice what they are not doing yet, or doing poorly, and point it out. However, site stakeholders can get discouraged if the focus of implementation facilitation is on challenges and failure to meet them. It is important that, as often as possible, you build stakeholder confidence and motivate change by focusing on what they are doing right. One organizational change management and action research approach, called appreciative inquiry,[102] suggests that we should focus on discovering organizational elements and factors that have enabled the organization to be successful, help organizational stakeholders to envision what might be in the future, and help them build on their strengths. The idea is that you maximize or leverage existing strengths to create change. By affirming what is positive about the organization and what it is going well (however small), you help to create an environment that can support innovation implementation.

Site stakeholders can get discouraged if the focus is on challenges and failure to meet them. It is important that, as often as possible, you build stakeholder confidence and motivate change by focusing on what they are doing right.

Capitalizing on the existing strengths of the organization is an important construct that should be considered throughout the implementation facilitation process. As noted elsewhere in this manual, it is important to find the positive energy and understand the areas in which the organization is exceling. Understanding these strengths will help you to conceptualize the context and identify processes to which site stakeholders will be receptive.

Providing Audit and Feedback

Audit and feedback[103] is a broad term used to describe the review of clinical performance data from a specified time period that is provided to the clinical team members and then discussed with them. Often, the review of clinical performance data is provided in a written document, including graphs, that is discussed through a mutually respectful dialogue. Many of the activities described in the implementation section of this manual fall within the broad category of audit and feedback, including any routine processes established for site assessment and for monitoring both the program overall and progress on the implementation plan.

Process or Flow Mapping

Flow or process mapping is a means to identify and create a visual representation of all the steps in a specific process (e.g., referral from primary care to general mental health). Essentially, the team looks at the process with “fresh eyes” by listing or drawing all the steps in the process, people involved in the process, and any bottlenecks or problem areas. There are many benefits of process mapping, including capturing and examining an

accurate visual representation of a process, diagnosing barriers and problems that keep a process from working effectively, ensuring that all members of a team have an accurate and shared understanding of the process, and shifting conceptualization of problems from people to processes. By doing the latter, you can help create a psychologically safer environment for process improvement efforts. (See the helpful Flow Mapping Guide in Appendix I, pages 195-210.)

Other Key Quality Improvement Processes

There are many other important and effective Quality Improvement (QI) processes. You should, at a minimum, be familiar with these constructs and, ideally, should be able to apply these strategies when appropriate for the specific context in which you are working. To be competent in executing these processes, you may require additional training or certification. Many of these processes may be being used at implementation sites for other initiatives, or have local champions (e.g., systems redesign champions); and it may be helpful to identify and partner with these change initiatives and leaders.

Lean Management

Lean is a process improvement method derived from the study of the principles of the Toyota Production System. 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.

Six Sigma

Six Sigma is a process-based approach to continuous improvement. It uses data and statistical analysis to find 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:

1) Define the project/problem
2) Measure the factors aligned with the process
3) Analyze the process to find root causes
4) Improve the process by testing solutions
5) Control the process after evaluating the improvements

More information available at the South Texas Veterans Health Care System – Lean Management Center: http://vasthcs.med.va.gov/lean/faq.htm.

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 workflow and opportunities to expedite process flow. See Appendix A-2. Glossary of Terms, page 142, for an example.

In addition to the implementation activities described above, other techniques may be employed throughout the implementation process. These include, but are not limited to:

- Identifying and engaging stakeholders at all organizational levels
- Identifying problems and resolving them
- Providing assistance with technical issues
- Developing information exchange networks
- Training staff members
- Providing patient education
- Engaging in formative evaluation
- Engaging opinion leaders and clinical champions
- Fostering role modeling

IX. PROBLEM IDENTIFICATION AND RESOLUTION

During the implementation phase, there will be bumps along the way. It would be unrealistic to expect an entirely smooth process. Remember that this is difficult work, and you should expect challenges. As a facilitator, your role includes helping site stakeholders recognize when there is a problem, identify and concretely define the problem, and work to collaboratively identify potential solutions until an effective resolution can be achieved. Implementation facilitation activities you will need to conduct include:

- Identifying barriers, obstacles or gaps in resources. These barriers may negatively impact innovation implementation throughout the process and require involving 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.

- Guiding, teaching, coaching, encouraging, and problem-solving. 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 should expect them. Remain positive, listen to concerns, and suggest possible solutions. Encourage and recognize positive actions of stakeholders. Remain available for consultation when difficulties arise and stay in regular contact with key stakeholders.

- Once you and the local implementation team have collaboratively identified potential solutions, consider engaging in a specific PDSA cycle, described above. In this scenario, the planning team would select one potential solution to the specific problem that the group thinks has a high likelihood of success, implement the solution as a small scale trial, and then evaluate the outcomes. The process should be continued with small adaptations until a successful solution has been identified with consensus across stakeholders.

X. BUILDING LEARNING COLLABORATIVES/COMMUNITIES OF PRACTICE

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 QI. The purpose of a learning collaborative is to support sustainability, encourage ownership, underscore progress, spread innovative problem-solving, and provide emotional support.

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 continue trying new things. 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.

Types of Learning Collaboratives

A number of formats foster both learning and collaboration. For example, you can schedule conference calls on a regular basis (e.g., monthly or quarterly). You can form large email groups to send out information or request input from all involved or establish websites, annual video conferences, or large learning collaborative conferences (whether virtual or in-person). Be sure

to identify and highlight successful programs and persuade stakeholders to share implementation lessons and best practices with each other.

Often, these contacts can result in stakeholders visiting each other's sites to learn more. They may share process information, templates, and resources. They build trusting relationships with each other and feel comfortable bouncing questions off each other. Even those who are new to the process often have good ideas to share.

Case Example

In a recent PCMHI 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.

XI. CORE ACTIVITIES ACROSS THE IMPLEMENTATION PHASE

Because, by definition, facilitation is a flexible approach that bundles a set of implementation techniques, the above techniques are not an exhaustive list of those that might be used in an implementation facilitation initiative. For example, over 70 potential implementation strategies have been identified and defined.[5,7]

Further, while all of these strategies are important, in a recent study[41] the activities listed below were identified by facilitation subject matter experts as **core activities** for monitoring fidelity to implementation facilitation as part of the implementation phase (see Appendix L-1, pages 222-224, for definitions for each of the below core facilitation activities). You will note that much of the material above is focused on helping to ensure that each of these core activities are pursued during the implementation phase. For example, Section II in this chapter discusses activities of facilitators in implementation meetings with sites to provide support, provide regular updates and feedback, and manage group/team processes; Section VI focuses on assessing and conducting ongoing monitoring of innovation implementation; and Section IX focuses on facilitation activities to assist sites in problem-solving.

- Providing support
- Adapting program to local context without compromising fidelity
- Conduct ongoing monitoring of program implementation
- Providing updates and feedback
- Problem-solving

- Fostering organizational change: structural
- Managing group/team processes
- Administrative tasks

Additional details about tools for monitoring fidelity to the implementation facilitation process can be found in chapter 9, pages 112-113.

Regardless of the specific strategies that are being used, it is important that they are selected for a specific reason, and the decision to apply a specific activity is based on thoughtful consideration of multiple strategies, and then purposefully matching the activity to the barrier or obstacle that is being addressed. The process further highlights the need for continuous monitoring. If the expected outcomes are not being achieved, the facilitator should reconsider potential implementation activities and select additional activities to apply.

In summary, the implementation phase is an active phase that moves the innovation into active practice. The goals and activities that facilitators engage in build on the tasks completed in pre-implementation and prepare the site for sustainability. The implementation phase often begins after the local implementation planning guide is developed and marks the actual work of implementation. It involves monitoring and ensuring that the steps of the implementation plan are completed and that the components are implemented with fidelity. During this phase, relationships deepen as facilitators work more closely with the sites and trust is fully established. Facilitators engage in multiple implementation support strategies, based on the needs of the site. Typically, the implementation phase transitions into sustainability once the innovation has fully been implemented with fidelity, all steps in the planning guide complete, and the site is achieving (or making progress towards) the outcomes they expected.

CHAPTER 6
IMPLEMENTATION FACILITATION ACTIVITIES TO SUPPORT SUSTAINMENT OF THE INNOVATION

"Don't Leave Your Change to Chance" Dave Shavel (Community Anti-drug Coalitions of America (CADCA))

Sustaining the successful implementation of an innovation may be harder than the implementation effort itself. Change that is not sustained wastes precious resources, limits credibility to mobilize change in the future, and diminishes efforts to serve those in need. We use the term *sustainment* to refer to the continuation of innovations and the delivery of their intended benefits over an extended period of time.[104] The indicators[105] that innovations are sustained include:

- *Maintenance* or the ability to continuously deliver the benefits achieved when the innovation was first implemented
- *Institutionalization* or the integration of the innovation within the organizational culture through policy and practice
- *Capacity building activities* or activities that build the infrastructure and long-term resources that will support the continued delivery of the innovation

Sustainment is a dynamic process, changing over time. It is important to realize that sustainment goes beyond maintaining the changes accomplished during the implementation phase to include adapting the innovation to situations in your specific setting that change over time.[106] The investment in the implementation of an innovation can only be successful if it is sustained to serve the needs of patients well past the implementation phase.

> *Sustainability has evolved from being considered as the endgame of a translational research process to a suggested 'adaptation phase' that integrates and institutionalizes interventions within local organizational and cultural contexts.*[107]

While the sustainment phase of implementation facilitation focuses on activities and strategies to ensure that the innovation persists over time, many of the activities you perform during the pre-implementation phase and throughout the implementation phase prepares the site to sustain the innovation. There are additional activities you can perform toward the end of the implementation phase to prepare the site for the sustainment phase. Because the type and duration of implementation facilitation efforts are widely variable, **the work of some facilitators (e.g., external facilitators) may end during the implementation phase while other facilitators (e.g., internal facilitators) may continue to support site stakeholders during the sustainment phase.** For example, some facilitation efforts may be limited to a specific

amount of time or a specific amount of funding. In those situations, the facilitator may need to finalize interactions with the site prior to the sustainment phase.

This chapter is intended to provide information and practical tools to guide your efforts to help site personnel prepare for and support sustainment of the innovation. First, we explore how you can empower site personnel to sustain the innovation through previously described activities during the pre-implementation and implementation phases. Next, we describe additional implementation facilitation activities you can conduct toward the end of the implementation phase that focus specifically on preparing site stakeholders for their role in sustaining the innovation. Finally, for those facilitators who will continue to support stakeholders during the sustainment phase, we provide some suggestions for your role during that phase.

I. PRE-IMPLEMENTATION AND IMPLEMENTATION PHASE SUSTAINABILITY PLANNING

Assessing Site Factors that May Impact Sustainability

We know that a number of factors, internal and external to a site, can impact sustainability,[108,109] including:

- Relevance of the innovation to address a need and fit of the innovation with organizational and professional missions, strategies, and procedures
- Leadership factors such as presence and influence of a champion and involvement/actions of leadership/management
- Organizational and resource factors such as the relationships among stakeholders, project management structures, resources, and systems to support the innovation
- Staff training and education related to the innovation
- Monitoring and evaluation of outcome data associated with implementation activities, including the sharing of activities and outcomes with stakeholders and leadership

During the pre-implementation phase, discuss these factors and ask the implementation team to consider what would be required for the site for sustainability in the pre-implementation phase.

There are also systematic surveys that outline the factors associated with sustainment. These include the National Health Service Sustainability Index (SI) and the Program Sustainability Assessment Tool (PSAT) which may be used to measure presence or absence of those factors affecting sustainability, based on staff reporting (See Appendices J-2, pages 212-215, and J-3, page 216).[109] The Sustainability Index measures ten factors across organization, staff, and process dimensions that affect the likelihood of sustainment. It has been used in VA to assess variability in sustainability of a national mental health system redesign initiative [110]. The PSAT authors propose using their tool to prioritize sustainability action planning to more “holistically

address the internal and external challenges and pressures associated with sustaining a program".[111] The domains of the PSAT are described in Table 3.

Table 3. Program Sustainability Framework Domains and Definitions;[111] (www.sustaintool.org)

Domain	Definition
Political Support (now called Environmental Support)	Having a supportive internal and external climate for your program
Funding Stability	Establishing a consistent financial base for your program
Partnerships	Cultivating connections between your program and its stakeholders
Organizational Capacity	Having the internal support and resources needed to effectively manage your program
Program Evaluation	Assessing your program to inform planning and document results
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness
Communications	Strategic communication with stakeholders and the public about your program
Strategic Planning	Using processes that guide your program's directions, goals, and strategies

Consider using one of these tools to help site stakeholders assess areas that matter specifically to their site. If you decide to systematically survey staff involved in the implementation, you can gain insight on the site's sustainability capacity and identify actionable targets on which to focus their efforts.

Empowering Staff to Sustain the Innovation

Activities become routine when they reflect the collective values and beliefs of staff that implement them.[108] Using knowledge about the factors that may impact sustainability, the following are examples of implementation facilitation activities that will empower staff and support sustainability of the innovation:

- Ensure that the innovation is integrated into existing clinical programs and services. An innovation that has been integrated with other existing services and processes is more likely to be sustained. For example, in implementing team-based general mental health care, it is important to incorporate transitions to and from primary care clinics.

- Establish a system for ongoing training of stakeholders, including new providers/staff, as well as boosters for staff already participating. Training should not just focus on the innovation itself but also include time for engaging staff, obtaining their buy-in, and reducing resistance to change through empowerment while communicating how the innovation may benefit patients, staff, and the organization as a whole.

- Plan to engage clinical and senior leadership throughout all phases, using communications about ways the innovation is aligned with agency mission and culture and what resources will support the changes over time.

- Establish an infrastructure for sustainability.

Helpful Tips

How to establish infrastructure for sustainability:

- Create an ongoing monitoring system that documents adherence to the innovation;
- Develop policies and standard operating procedures (SOPs) that support the innovation;
- Foster ongoing systems improvements to ensure the integration of the innovation into care processes; and
- Create a mechanism through which adherence may be incorporated into performance plans, incentives or rewards.

- Ensure that the staff members feel empowered to continue the process once the active phase of implementation facilitation has ended. Throughout the implementation phase, ensure that they are involved in every decision, feel a sense of ownership, and have the skills to engage in ongoing monitoring processes without your routine assistance. Essentially, prepare the site to no longer need you. As the implementation process comes to a close, your role should become less active. When problems arise, rather than jumping in immediately, you should wait to see if they can problem-solve and identify solutions without your input.

II. PREPARING A SUSTAINABILITY ACTION PLAN (SAP) DURING THE IMPLEMENTATION PHASE

Helping your implementation team create a **Sustainability Action Plan (SAP)** can go a long way in leaving your site with the confidence and structure to sustain the innovation, especially if you will not be present during the sustainment phase.[112] To develop the SAP, you will need to help the team identify goals for sustaining the innovation. For each of the SAP's goals, help the team decide and list the *activities* the site will perform to ensure that the changes stay in place and prevent slippage back to the old way of doing things. Also, make sure that the SAP includes:

- The identified *leader(s)* for each activity
- The *frequency* with which the activity will be conducted
- The criteria for *monitoring/measuring* the activity
- The *resources* needed to complete each activity (with weblinks embedded in the plan document for easy access

A SAP can supplement the Implementation Planning Guide created in the pre-implementation phase. In essence, the sustainment phase concentrates on continuing the elements of the implementation plan necessary to sustain change and converting them into "the way we do things here." The SAP may be reviewed at your last meeting with the implementation team and shared with site leadership to further ensure it gets institutionalized. Consider also including a patient or community representative in developing a SAP. You should consider writing your SAP using SMART goals (Specific, Measurable, Attainable, Relevant, Time bound).[113]

Questions to Consider When Drafting Goals

Below are suggested questions to consider when drafting your goals; a sample SAP with draft goals is provided in Appendix J-1, page 211.

How will you assess if the innovation is reaching the intended patient population?

> Collaborate with the site to collect data to understand if the patients receiving or being offered the innovation are actually the ones in highest need of the innovation. In other words, is the innovation equitably reaching all patient populations? Who is not reached by the innovation? Determine which patient subgroups have highest rates or burden of the health problem, and who has less access, use of, or worse outcomes of the innovation being implemented. Patient subgroups might be defined by certain social dimensions (e.g., race, income, rural residence) or social determinants of health (e.g., food insecurity). Asking these questions highlights any disparities in who is reached by the innovation and can naturally lead to sites figuring out how they can better reach those who are not receiving the innovation (especially patients who experience disparities related to social dimensions and social determinants of health).[114]

How will you assess whether the innovation is continuing to deliver benefits to patients?

Work with your site to determine what outcomes will show benefits to patients resulting from the innovation and consider how these may be measured. Consider again whether there are disparities or inequities in outcomes for some patient subgroups, such as people of color or women. Are there unique challenges for some patients to access the innovation? How could the site adapt to overcome those unique challenges?

How will you assess whether the components of the original innovation continue?

This question is related to the ongoing assessment of fidelity to the innovation. How do you assess whether the core components are continued? Is there an ongoing monitoring system that documents adherence to the innovation? How will you assess the integration of the innovation into routine processes? Your SAP can establish a system for ongoing training of new providers/staff as well as boosters for staff already participating on skills and knowledge related to the innovation.

What is your plan to ensure that partnerships among stakeholders are maintained to continue to deliver the innovation?

Engaging with stakeholders and integrating their feedback and recommendations into the SAP is vital in planning for sustainability. Help the site establish a mechanism through which subsequent communications can occur with leadership, other relevant clinical services, and patient or community groups. Although the formal facilitation process may be completed, it is important that stakeholders and champions continue to communicate with each other. Your SAP can include an activity for your site to continue to engage clinical and senior leadership including language about how the innovation is aligned with agency mission and culture and what resources will support the changes over time.

How will you ensure that new practices, procedures, and policies (infrastructure) established during the implementation are maintained?

Help your site assess what clinical and oversight processes assure continuation. In some cases, having staff conduct a periodic program assessment like that used in the pre-implementation phase can help them assess what aspects of the innovation are still in place. Help the site ensure that the SAP includes consideration of the need for additional organizational and/or operational structures to hold what has been gained in the future.

How will you ensure that the innovation continues to be the "way we do things" here?

In preparing the SAP, work with your site to determine who will be responsible for keeping maintenance of the innovation on stakeholders' radar. How will they tell if some aspects of the innovation are not continuing? Have you identified any barriers to sustaining the innovation? Help them establish a way to check in about whether the

innovation continues to fit with their site's mission and culture over time. If patient and community stakeholders were involved in pre-implementation and implementation phases, they may also offer accountability to evolving sustainment, perhaps through their ongoing presence in the implementation effort or organized community events.

Is there a mechanism through which adherence may be incorporated into performance plans, incentives, or rewards? One strategy that has worked well with some VA implementation initiatives is to connect your site with other VA sites who have implemented similar innovations after the facilitation phase is over. This provides an ongoing way of comparing notes, sharing best practices, and discussing strategies for barriers with others working on a similar endeavor.

When Monitoring Reveals the Need for Adjustments: Tools for Getting Back on Track

When developing the SAP with your site, it is also important to help them plan for what they will do if adjustments need to be made to sustain the innovation that they implemented. At some point, there will likely be a need to intervene to assure it continues to result in a high quality and equitable intervention. This is the time to review the process improvement and/or systems redesign tools you may have employed during the implementation phase. You can train change agents (e.g., local champion or internal facilitator) who will be there after your facilitation role has ended to use quality improvement and systems redesign tools. (See Chapter 5, pages 59-82). You may need to connect local change agents to subject matter experts internal to their organization as other individuals they may go to for expertise or advice, perhaps on topics related to equity, social determinants of health, or quality improvement.

Additional Resources

In addition to resources mentioned in "Assessing Site Factors that Support Sustainability," there are some websites that contain information that may be helpful for sustainability work:

- The Georgia Health Policy Center Sustainability Framework includes fundamental characteristics and capacities associated with long-term viability and lasting community impact based on extensive field testing. See http://ghpc.gsu.edu/sustainability-framework

- The 2016 Community Tool Box created at Kansas University includes 18 sections on planning for sustainability in communities. This comprehensive set of resources and tools focuses extensively on different tactics for financial sustainability, as well as case examples in diverse settings. See https://ctb.ku.edu/en/sustaining-work-or-initiative.
- Evidence Based Sustainment Strategies: a systematic review of evidence supporting sustainment strategies for public health innovations and facilitating and hindering factors of sustainment, such as funding and/or contracting for continued services, alignment of agency priorities and the innovation, monitoring effectiveness, etc.[115]

III. IMPLEMENTATION FACILITATION ACTIVITIES DURING THE SUSTAINMENT PHASE

In some implementation facilitation initiatives, the facilitator is present during the sustainment phase. This is likely to be the case when the facilitator is internal to the setting in which the innovation is being implemented. In some circumstances, an external facilitator may continue to provide support during this phase, for example, when the innovation was implemented relatively quickly, allowing continued facilitator involvement over time. Whether you are internal or external to the setting, once the site has achieved its implementation goals, your role will soon begin to shift. As noted previously, much of the work to ensure sustainability occurs during the pre-implementation and implementation phases. In addition to creating the SAP during the implementation phase, there are some specific activities implementation facilitators should engage in during the sustainment phase, if you remain involved with the site during this phase.

- Although you remain present in the organization, you will have a much less active role; the bulk of your work has been completed. It is important that you recognize this shift while it is occurring and allow it to happen naturally. You may need to consciously decrease your involvement and presence, allowing other team members to step up. You have been seen as the expert and now you may need to ensure that others do not automatically turn to you when they could potentially successfully continue the process without you.

- You may need to purposefully decrease your presence in specific clinic areas if there is the potential for others to rely too heavily on your expertise.

- It is critical that you remain engaged with key stakeholders, although from a further distance. You should continue to be available whenever you are needed, especially early in the sustainment phase. You want to be sure stakeholders don't feel abandoned. Much like parenting, you will need to find the delicate balance between stepping back and allowing others to continue the process while still being available to provide support as needed.

- As you exit the clinical setting, establish a mechanism through which subsequent communications can occur with leadership, site level program champions, and patient or community stakeholders.

- Routine calls should decrease in frequency and then only occur as needed, per the request of a stakeholder. The focus of these calls should be on consultation and ongoing mentorship.

- When challenges emerge, hold back from initially solving them even though you may be quickly able to do so. This will allow others to proceed as if you were no longer available as a facilitator.

- When you do jump in, encourage activities (such as reviewing the sustainability action plan) that support team members in identifying solutions on their own.
- Encourage review of already developed SOPs to reinforce the institutionalization of the innovation.
- Encourage team members to continue to track data and monitor the program. This should no longer be part of your routine activities, but you should encourage other stakeholders, and those providing the innovation, to continue these activities. How do outcome monitoring, performance monitoring, and/or quality measurement systems inform how things may be changing over time?
- Likewise, teach them to pay attention to changes in the environment that may affect the effectiveness of the innovation: (1) are there organizational or societal changes happening; (2) changes in providers' level of expertise or cultural competence; (3) changes in patient populations and patient needs, etc. They may be able to "take the pulse" on some of these more sensitive matters if they have ongoing engagement and feedback from important patient subgroups (e.g., community groups, or patient representatives from a population in high need of the innovation).
- Encourage the team to continue to present data and progress demonstrating sustainability to leadership through ongoing reports. Again, you should not be creating or presenting this information. Your role has shifted to a coach or mentor providing consultative support as needed.
- Celebrate and reinforce continued progress.
- Encourage the team to refer to the SAP periodically and to update it annually or as needed.
- Finally, ensure that team members 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 the innovation is one way that you can communicate your continued availability if the need arises.

As a facilitator, seeing the fruits of your efforts implemented and maintained in routine practice is extremely rewarding. All activities across pre-implementation and implementation are ultimately working towards this goal.

IV. CORE ACTIVITIES DURING THE SUSTAINMENT PHASE

While all of the activities described above to support sustainability are important, the following below activities were identified by facilitation subject matter experts as *core* activities for monitoring fidelity to implementation facilitation as part of the sustainment phase[41] (see Chapter

9 for information on IF fidelity monitoring and Appendix L-1, pages 221 for definitions for each of the below core facilitation activities). You will note that much of the material above is focused on ensuring that each of these core activities are pursued during the sustainment phase. For example, Section III in this chapter discusses activities of facilitators to continue providing support when needed (though at a lower level of intensity) and, over time, pulling back and letting sites take the lead in carrying forward the implementation process.

- Pulling back and letting sites take lead
- Conduct ongoing monitoring of program implementation
- Providing updates & feedback
- Providing support

The facilitator's efforts to ensure innovation sustainment begin long before the sustainment phase of implementation. During the pre-implementation and implementation phases, facilitators can help stakeholders assess factors that might impact sustainability, empower them to establish processes and systems that will support sustainability, and prepare a formal action plan for the sustainability phase. Although the work of some facilitators ends with the implementation phase, those who are available during the sustainment phase will have a less active role than during the previous phases but can continue to support stakeholder efforts to sustain the innovation.

CHAPTER 7
VIRTUAL IMPLEMENTATION FACILITATION

Although implementation facilitation efforts generally include a mix of in-person and virtual interactions, reductions in spending for travel and advancements in technology infrastructure have resulted in implementation facilitation initiatives with limited or no opportunities for facilitators to travel to sites implementing innovations. In some cases, natural disasters or pandemics – like COVID-19 – may require the majority of interactions to occur virtually. Thus, facilitators have needed to provide implementation facilitation entirely, or almost entirely, through virtual modalities, including but not limited to phone, instant messaging, video conferencing, and more complex web-based communication systems (e.g., Microsoft Teams, WebEx, Adobe Connect). These developments have spawned questions about what it takes to conduct successful implementation facilitation with minimal or no in-person interaction with the site implementing the innovation. Although there is ample evidence that virtual learning may be as effective as in-person learning, few studies have described virtual facilitation methods. Thus, the contents of this chapter were developed by field-based facilitators who convened to identify advantages, challenges, concerns, best practices, and recommendations for conducting implementation facilitation virtually.

I. DEFINITION OF VIRTUAL IMPLEMENTATION FACILITATION

Virtual Implementation Facilitation may be defined as implementation facilitation conducted with limited or no in-person contact between the facilitator and the site implementing the innovation, although the proportion of virtual to in-person interactions can exist across a continuum. For example, some implementation facilitation initiatives may be fully virtual, while others may include both in-person and remote interactions (e.g., an initial in-person site visit, combined with the subsequent facilitation components provided virtually). Virtual implementation facilitation may be provided through a variety of technological platforms, ranging from basic remote technologies such as individual or group telephone calls and video teleconferencing, to more advanced technologies that allow for combined audio, video, and viewing/creation of shared documents (e.g., Microsoft Teams, WebEx, or Adobe Connect).

II. POTENTIAL ADVANTAGES AND DISADVANTAGES OF VIRTUAL FACILITATION

As with any innovation, we can anticipate both advantages and disadvantages to using only virtual implementation facilitation. Advantages include decreased cost associated with travel,

and increased flexibility for scheduling which in turn allows for additional stakeholder participation while minimizing clinic disruption. Virtual facilitation may also allow for greater access to facilitator time. Virtual facilitation has the potential for more timely initiation of implementation facilitation, as travel approval and planning can result in delays. Combined, these factors may allow some facilities to participate and receive implementation facilitation that may have been unable to do so otherwise.

Despite potential advantages, there are also some potential disadvantages to using only virtual implementation facilitation. For example, virtual facilitation is not a panacea for addressing cost concerns, as outcomes may not be equivalent to in-person processes. However, this remains largely unknown. Additionally, some facilitators are concerned that use of virtual interactions alone may impair their ability to engage stakeholders and establish trust and rapport. While relationship building is certainly possible via virtual or remote modalities, it may take longer. Furthermore, important nuances of communication (i.e., nonverbal cues) may be lost when conducted over non-visual virtual modalities.

It is also important to recognize and be aware of the challenges related to using technology. Stakeholders may not have access to relevant hardware (e.g., cameras, high-quality microphones) or software (e.g., the correct versions of virtual platforms). In some cases, the gains of using advanced technology for facilitation may be outweighed by poor video or audio connectivity, periodic network slowdowns, and other disruptions. These technological issues may be exacerbated in certain settings (such as VA) with strict electronic security systems or network firewalls.

Although not specific to implementation facilitation, additional advantages and disadvantages of working in virtual teams are documented in the “VA Virtual Teams Handbook” developed by the VA National Center for Organization Development.[116]

Table 4: Advantages and Disadvantages of Working in Virtual Teams*

	Advantages	**Disadvantages**
Administration	More flexible scheduling for team members.	Difficulty scheduling when crossing multiple time zones.
Interpersonal Connections	Improves likelihood of attendance, expands pool of likely participants.	Networking and interpersonal contact may be stifled.
Engagement	Allows off-line work to continue.	Participants may become inattentive or absent without in-person proximity.
Cost-effectiveness	Reduced cost and low-carbon footprint for meetings.	Requires technological capital.
Documentation	Facilitates tracking and archiving of work activities.	Risk of over-monitoring or a culture of surveillance.

*Adapted from the “VA Virtual Teams Handbook,” p. 7.[116]

III. BEST PRACTICES AND RECOMMENDATIONS

The following are recommendations for enhancing the success of virtual implementation facilitation and overcoming the disadvantages listed above.

Using Technology

Use video-based technology whenever feasible

Include some form of video-based conferencing technology early in the process and as frequently as possible. Platforms with video capability are invaluable because they allow participants to read one another's nonverbal cues as opposed to phone conferencing or text-based systems.

However, if you find yourself providing virtual implementation facilitation and either you or the site do not have the capabilities/functionality to use video technology, consider the following recommendations:

- Ask for pictures and consider creating a PowerPoint with everyone's picture to be used during introductions
- During early meetings ask everyone to include a picture, as part of their user icon/profile associated with the platform being used

Technology, technology, technology

Ensure that technology support is available and present during important virtual meetings.[117] For example, you might require that in order to receive virtual facilitation, the site must identify an IT contact who will be able to assist throughout the facilitation efforts, with the specific expectation that IT will be present during important virtual meetings to provide support. Establish a back-up plan in case video technology fails.[118] Creating a checklist of all items needed to prepare for the virtual visit may be particularly helpful. Please see Appendix K-2, page 220, for an example provided by VA's Office of Mental Health Operations that was used as a checklist prior to conducting virtual site visits.

Although many recent advancements have been made within VA regarding approval, use, and implementation of sophisticated virtual capabilities, do

Helpful Tips

- Establish standard conferencing phone lines as a back-up in case more sophisticated technology fails and be prepared to quickly switch to that format if needed
- Test all equipment and connections before meetings and schedule practice sessions with staff to work out any problems in advance
- Establish someone (e.g., an IT person with video teleconferencing experience) to be present to begin each session to ensure equipment is turned on and working
- Always have an emergency contact number (e.g., a cell phone) to reach support personnel in case equipment stops working

not automatically assume that most stakeholders at any given location are familiar with or know how to use these platforms. Do not overestimate their technical savvy. This has been a common mistake made by facilitators resulting in delays within virtual meetings which has slowed down the overall implementation process. Make sure to discuss proposed platforms in advance of sessions to confirm that attendees are familiar with and comfortable navigating the selected technology; if they have not used a platform before, encourage attendees to try loading the platform and schedule a practice session prior to your scheduled meeting.

The virtual site visit tour

Facilitators may wonder how they can replicate the tour of clinical space that often occurs as part of the site visit through a virtual platform. Consider requesting an interactive virtual tour. As part of this, request to see floorplans and maps while having the site describe the space to you. Ask what it looks like. Is it newly renovated? What kind of furnishings are present? Some locations have obtained approval and sent facilitators either pictures or videos of the space. One program was able to have a guided virtual tour from a phone camera. Consider creative solutions and allow the technology to support and enhance rather than hinder this process.

Security and Confidentiality

It is also important to ensure that the platform you are using is approved by your healthcare system and meets all security and confidentiality requirements, especially if you are part of an initiative that requires review and use of protected information.

Practice

Practice using the technology and test the equipment

We have found that it is critical to practice, especially when using video or other complex interactive technology. We recommend scheduling a brief practice session with those at the site you're working with the day prior to meetings. Even if you have used the technology routinely and believe that the team at the site has strong technological skills, it is important to test the equipment, connections, and bandwidth prior to the meetings.

Be prepared that technology may fail and have plan B ready

Even with the best planned efforts and despite multiple practice sessions, be prepared that things may not work according to plan. For example, consider scenarios of power failures, server failures, failures within the selected platform (e.g., national VA outages for unknown reasons) and be prepared to adjust accordingly in real time. Facilitators have experienced all of these situations. Thus, it is important to have back-up communication and file sharing processes pre-established. For example, consider either having hard copies of materials available or sending materials to all participants via e-mail prior to the meeting. It can also be helpful to have a built in back-up meeting

platform. For example, if you are using video-conferencing, also set up a phone line as a back-up.

Building Relationships

Allow & schedule time for informal interactions

Build in time for informal interactions and strategically set aside time for relationship building. This may be most important early in the process as relationships are forming and trust is being built. As part of this process, plan and engage in activities that help the team members to get to know each other better. While this is important for all implementation facilitation initiatives, it is especially crucial for virtual facilitation because participants will otherwise have limited opportunities to build relationships that might occur in the context of co-located frequent in-person meetings.[119] Examples of activities for team building that may be applied in virtual formats may be found in the Virtual Teams Handbook developed by VA's National Center for Organization Development available at http://vaww.va.gov/NCOD/docs/virtualteamshandbook.PDF.

Plan for increased time

Allow for increased time to complete tasks in addition to the time that would be necessary during in-person interactions. When operating in a virtual format, it is important to adjust your agenda to allow additional time. For example, you may need to decrease the number of agenda items for each meeting to ensure that each item is adequately covered. Without being able to rely on non-verbal forms of communication, it may take longer to check in with each participant and to establish consensus. There may be delays resulting from technology connections, and it takes time to establish rapport and build trust. Consider using technology to actively rather than passively engage participants. For example, you might have them respond to poll questions, or ask them to post comments and questions in the chat box.

Pay attention to time zone differences

When scheduling meetings on remote platforms, pay attention to time zone differences and use scheduling options that are within normal business hours for all participants. This may be challenging when working across multiple time zones and may limit the number of available options. However, even highly invested stakeholders may be reluctant to engage in a process that requires meetings when they are typically away from work.

Establish frequent contact early

Building relationships via virtual modalities may require an increase in the number or frequency of contacts over the typical time period.[119] More specifically, the facilitator may want to establish routine calls during the pre-implementation phase, rather than waiting for the implementation phase. The facilitator may also want to establish a pattern of

regularly calling individual key stakeholders during the pre-implementation phase, or as soon as the site has expressed interest in participating in implementation facilitation.

Enhance efforts to engage leadership

Leadership engagement is an essential feature of any implementation facilitation initiative. However, as with any relationship, efforts to enhance leadership engagement may be more challenging when done remotely and will need additional attention. It may be more important to reach out to leadership for individual phone calls, even if brief, to build your relationship. Specifically ask leadership to share their vision and how it relates to their facility, both to you individually as well as within larger group meetings. Often, one of the primary tasks of an initial site visit is to engage leadership and time is spent meeting with them both informally and formally. Although challenging, you may need to supplement activities with additional contacts to ensure that these functions are achieved through remote communication. More specifically, consider having fewer formal meetings with leadership, but increasing the frequency of routine, informal interactions, such as a quick good news update or a brief “hello” over instant messaging. These informal interactions can continue to enhance engagement with leadership while minimizing time demands. In addition to using instant messaging or “chat” features, some initiatives have been successful texting, but only after ensuring that all participants either have business cell phones or are comfortable using personal cell phones for those purposes.

Attend to levels of investment and competing priorities

Carefully attend to different levels of investment at each site and take the time to build relationships, especially with key stakeholders.[120] It is imperative to understand that facility staff ALWAYS have competing priorities, and they may especially give the pre-implementation process a lower priority.[121] Therefore, be sensitive to their needs and be cognizant of the appropriate timing to take action.[122] When proceeding in a virtual format, it is possible that these competing priorities may not be as obvious as they would be to a facilitator at the site, or they may not be identified as early in the process as would be ideal. The facilitator will need to take active steps to be sure they are aware of other potentially competing demands. Throughout the process, the facilitators should informally and formally ask the site about other local initiatives and site-specific concerns, while being aware of other national issues that may be high priority.

Conducting Virtual Meetings

Ask about preferred platform

It is important to ask the site about which platforms they are most comfortable with and accustomed to using. It is recommended that you gather this information early, potentially during one of your first contacts with either the local champion, internal facilitator, or leadership. If there is a platform that they are used to using, we recommend

that you proceed using this platform, rather than asking them to learn a new platform while also taking on the implementation of a new innovation.

Solicit input frequently

Be sure to verbally check-in with all team members during meetings, especially if they are being quiet, and provide opportunities for all team members to give input.[117] This may require additional process and content check-ins with the team.

Have a plan for back-channel communication

Some facilitators found that checking in with leadership and key stakeholders informally improved processes.[123] For example, during a virtual meeting, sending an instant message or text to a key player can help improve the process and allow you to better understand the energy in the room that you may not be able to pick up on over the virtual connection. Consider asking how they think the meeting is going or asking if they have any concerns that have not been addressed.

Establish rules for virtual meetings early

It will be important to take the time to explicitly discuss the rules of conduct and process[117] for interaction during virtual meetings and ideally these should be established and discussed in advance of the meeting. For example, how will interruptions be handled? How will the group manage situations where multiple people are talking at once? In the absence of visual cues, it may be difficult to know when somebody wants to speak. This can further be complicated by technological delays experienced in some of the web-based platforms. How will you ensure that less assertive individuals have the opportunity to speak? It is important to be aware of these challenges and develop a specific plan to address them. Some suggestions are provided in the Virtual Teams Handbook developed by VA's National Center for Organization Development available at http://vaww.va.gov/NCOD/docs/virtualteamshandbook.PDF.

One of the potential disadvantages of providing facilitation virtually is that participants may often be at their typical, individual workstations rather than in a conference room or other meeting location and the temptation to multitask is noteworthy. Busy stakeholders may find themselves distracted as e-mails come in or colleagues send them instant messages. To address this concern, some recent facilitation initiatives have directly asked participants to turn off any potential distractions (e.g., e-mail) for the duration of the meeting. Facilitators have found that starting the meetings with this request has helped to establish a culture of focused rather than divided attention.

Promoting Shared Understanding

Clarify purpose and roles of implementation facilitation early

Explaining the role of the virtual implementation facilitator (Internal or External) is essential to ensuring fidelity to the role and a smooth implementation process.[117,124] The potential for confusion about purpose and roles is magnified when relying solely on remote communications. In the absence of non-verbal cues, it may be difficult to determine if stakeholders are fully comprehending information you are trying to communicate. Build in checkpoints early in the process to summarize information, provide opportunities for questions, and ask stakeholders to describe their understanding of the purpose and goals. Initially, facilitators may need to establish frequent contacts to listen and learn about what the site is doing and collect information about successes and challenges.[119]

Promote a common sense of purpose

One of the tasks of implementation facilitation is to promote a common sense of purpose as you are working to engage all stakeholders.[125] This may be challenging without having the opportunity to be physically present at the location. It will be important that you include essential tasks with the goal of creating this common sense of purpose. For example, you may want to include group activities that help the team develop aspirational goals of the program as defined by stakeholders. To do this effectively in virtual formats, consider using on-line technology that allows for screen sharing and provides the capability to capture a group brain-storming process (e.g., use the whiteboard features that allow all members to contribute and view).

Establish understanding of context and organizational structure early

While understanding the context in which your innovation is being implemented is a core part of any facilitation effort, this task is especially challenging—and yet especially important—for virtual facilitation. There may be some aspects of the context and organizational structure at a given facilitation site that are obvious to local staff but completely invisible to remote facilitators. Examples of this might include the physical space of the office or clinic, the extent to which clinic leaders are visible to frontline staff, or the characteristics of the “typical” patient treated in that clinic. At the facility level, understanding the organizational structure is critical, including both the formal structure as described in organizational charts and the informal structure of who people go to when they need support from other parts of the hierarchy. These steps are crucial to evaluate the level of authority needed to support the implementation process and who has the power to institute needed changes. Frequent check-ins may expedite the process. It is also important to be aware of issues and policies occurring at higher organizational levels (e.g., at the network and national levels within VA) and in the larger healthcare context to understand outside competing influences.

Using Supportive Behavior

Pursue increased flexibility

Although implementation facilitation overall is a highly flexible and adaptable implementation strategy, all aspects of virtual facilitation may require further enhanced flexibility.[126] For example, although it is recommended that all interactions have an agenda, be prepared to alter the agenda as needed in terms of both content and process.[122]

Listen actively

The role of active listening in virtual facilitation is essential. It will be important for virtual facilitators to have strong active listening skills and to pay attention to nuances in language used.[119] This is particularly important when relying solely on remote communication. Virtual facilitators must consistently follow up on any statements that are not fully clear, double check intended meanings, and ask additional questions that might not be needed when interacting in person.

Exhibit energy and enthusiasm

At the initial virtual contact sessions, being prepared to inject energy is always vital. Energy may be difficult to convey over remote technologies. Facilitators have found that their energy and enthusiasm may not be as evident in virtual formats as it is in person. Facilitators must be aware that they may need to intentionally do more and take active steps to communicate their enthusiasm than they might in person.

In summary, it is important to remember that facilitation that relies on virtual interactions appears to occur along a continuum, with some programs having no in-person contact, and others having minimal. Further, standard implementation facilitation may use virtual technologies throughout the process as well to supplement in-person interactions and allow for asynchronous communication to occur. In addition to the specific nuances described in this chapter, facilitators providing virtual implementation facilitation must also be well-versed in the strategies described in Chapter 5, “Implementation Facilitation Activities in the Implementation Phase.” Virtual implementation facilitation may assist sites struggling with implementation challenges when on-site assistance is not feasible or cost-effective. Policymakers, researchers, and those providing implementation facilitation should understand the potential advantages and disadvantages, and consider recommendations identified by field-based experts to inform application of virtual facilitation.

CHAPTER 8
SPECIAL APPLICATIONS OF IMPLEMENTATION FACILITATION

In this chapter, we discuss the use of IF for supporting implementation of technology-based delivery models.

I. IMPLEMENTING VIDEO TELEHEALTH TO HOME

Implementing video telehealth to home (VTH) presents unique challenges due to constantly evolving technology, variable equipment and infrastructure, and oftentimes complicated guidelines and best practices. Although any practice change can be difficult to implement, technology-based interventions, including VTH, may be more likely to evoke skepticism or anxiety from providers. This process can be made doubly complicated if the facilitator is tasked with implementing a new practice (e.g., an evidence-based therapy) and a new mode of delivering that practice (e.g., VTH) at the same time. Given the inherent complexities of this modality, use of a specific VTH implementation approach can be helpful (e.g., Personalized Implementation of Video Telehealth (PIVOT)),[127] with additional considerations for implementing VTH at rural or under-resourced sites (e.g., Personalized Implementation of Video Telehealth for Rural Veterans (PIVOT-R)).[128] Some of the key components of this approach are outlined below.

Lessons Learned for Improving the Implementation Process

Engaging providers

It is crucial to engage frontline providers as national goals and top-down expectations are rarely sufficient to substantially advance implementation of VTH. Technology can be intimidating or off-putting to many, contributing to questions and concerns about necessary expertise for use or ability to build rapport via video. Providers may also be skeptical or uninformed about the logistics, capabilities, or policies related to VTH. It is critical to be aware of current VTH guidance at the institution, state, and national level in order to engage in effective education, marketing, and outreach to increase interest and motivation for adoption. Thoughtfully and directly addressing providers' concerns can help improve engagement and trust. For example, acknowledging that VTH *can* feel daunting when unfamiliar while highlighting the available resources and your willingness to help them get comfortable can reduce resistance.

Importance of logistics

Ensuring a successful VTH session is a multi-step process that requires a significant amount of advanced planning and organization. VTH logistical procedures should be established during the pre-implementation phase, including the following:

- Identifying who will obtain the necessary VTH equipment for both patients and providers.
- Testing VTH platform(s), from both patient and provider perspectives, on different devices, operating systems, and web browsers. For example, VA's VTH platform, VA Video Connect, requires patients to download a free app on iOS devices (iPhone or iPad), and is optimized on Google Chrome.
- Understanding all scheduling procedures, including processes for requesting VTH appointments/links, sending appointment reminders, and avoiding double-booking VTH and in-office visits.
- Clarifying VTH documentation requirements including consent for treatment via VTH, note templates, and inclusion of additional relevant information (e.g., patient's physical address, emergency contact information).
- Confirming how VTH appointments will count towards workload credit and any special procedures for billing and insurance.
- Establishing backup procedures in the case of remote access disconnection, power or internet/cellular outages, and equipment failure. Creating guides and troubleshooting tips ahead of time can minimize frustration and increase willingness to try VTH.

Cross training

As discussed, VTH entails a complicated constellation of logistical concerns that make cross-training necessary for successful implementation. It is important to have more than one person trained for each aspect of VTH to ensure continuous operation when staff are unavailable due to position vacancies, illness, vacation, or other personal issues. Depending on staff size and specialization, it is also helpful for individuals to be knowledgeable about multiple aspects of VTH. COVID-19 highlighted the importance of cross-training as many sites have experienced staffing problems while individuals await test results or remain in quarantine due to the pandemic.

Recommendations for VTH Implementation

Track implementation training and activities

Tracking training and implementation activities can help maximize efficiency, reduce duplication of effort, identify successful strategies, and refine the implementation approach. Sites or clinics where VTH is being implemented need to identify who is responsible for maintaining a record of the providers who have completed training and are ready to deliver care via VTH. The specific training and competencies will be determined by the approved VTH platform and the providers' discipline or patient interactions; some providers may need to demonstrate competence using VTH for group appointments while others will only use VTH for individual appointments. Keeping a record of providers trained in VTH can help monitor progress towards implementation goals (i.e., XX% of providers trained), identify patterns in VTH adoption (i.e., by discipline or clinic), and determine points of intervention. For example, as VTH implementation progresses, facilitators may want to engage providers who have completed VTH training but have conducted zero or very few VTH appointments to date.

As provider comfort with VTH has been found to increase with experience,[129] it is critical to assess concerns, troubleshoot problems, and offer additional support to help encourage use.

It is also helpful to keep a log of implementation and outreach efforts, particularly if implementing VTH at multiple sites or clinics. Information might include the date, location/site, name and position/title of people present, method of communication (e.g., email, phone call, presentation, team meeting), and outcome. This record will enable you to keep track of who you have approached about VTH and serve as useful reminders for future contact or follow-up. Additionally, this record can offer an overview of which clinics or disciplines have adopted VTH and help you determine which implementation strategies are most successful, allowing real-time adaptations to the implementation approach.

Identify champions and early adopters

Technology-based innovations, including VTH, inevitably attract early adopters and champion providers. These individuals may be more technologically savvy, excited about flexibility, or motivated by improved access for their patients. Regardless of their motivation, champions and early adopters should be identified and nurtured with personalized, “concierge” facilitation to maximize their engagement. They can help to pilot and refine procedures and identify workflow issues prior to expanding efforts to the larger team. Additionally, VTH champions and early adopters offer an opportunity to spread positive messages about VTH to colleagues on a peer-to-peer basis, which can be more compelling than messaging from leadership or external facilitators.

Be organized and flexible

The complicated and constantly changing nature of VTH means that organization and flexibility are critical for successful implementation. It is important to be informed about the current state of VTH; guidance can shift rapidly, as is particularly evident during the COVID-19 pandemic. Guidelines, memos, best practices, and ethics related to VTH should be closely monitored at the site, state, and national levels. Ongoing assessment will enable you to quickly identify and adapt to any VTH changes as well as national or site level expectations. While it is important to have a plan, willingness and readiness to capitalize on organic demand can advance VTH implementation goals. Unexpected events in the region or the world can increase patient and provider interest in VTH. In extreme situations, events can contribute to significant changes to policies and best practices. During Hurricane Harvey, over 30,000 people were displaced from their homes with even more left without power. The VA deployed mental health providers to temporary shelters to help Veterans connect to their VA providers via VTH. Previously reluctant mental health (MH) providers began using VTH and continued doing so after their Veteran patients returned home. The COVID-19 pandemic precipitated an unprecedented transition to telework and VTH delivered care, coupled with the relaxation of regulations surrounding use of HIPAA-compliant platforms and increased

insurance coverage of VTH appointments. While these policy changes may be temporary, they offer a unique opportunity to engage providers and promote implementation of VTH.

Assess multiple outcomes

Although successful VTH implementation often focuses on the number of VTH patients and encounters, assessing multiple outcomes can offer a nuanced understanding of the impact and identify points of intervention. High numbers of VTH patients and encounters could imply widespread adoption of VTH but may instead reflect a few dedicated VTH providers. If the goal is to offer VTH across a variety of services and to many patients, outcomes must go beyond tallies of patients and encounters. Relevant outcomes might include the number of VTH sessions per provider, the overall percentage of mental health visits delivered via VTH, and which clinics or disciplines are offering VTH. These additional outcomes highlight the breadth and depth of implementation success.

II. IMPLEMENTING TELEHEALTH-ENHANCED PRIMARY CARE MENTAL HEALTH INTEGRATION (PCMHI)

In VA, the integration of mental health interventions into primary care settings (Primary Care Mental Health Integration; PCMHI) is an evidence-based approach to managing common mental health concerns in primary care without a separate referral to specialty mental health. PCMHI involves co-located collaborative care and telephone care management. Co-located collaborative care was designed to be staffed by on-site behavioral health providers; however, this is not always feasible in small and/or rural clinics. These features can be harder to execute when not in-person and need to be adapted for provision through tele-health.

To support this adaptation, the Toolkit for Implementing Telehealth- Enhanced PCMHI was developed as part of a larger VA study to assess the effectiveness of adding PCMHI providers to clinics via video tele-health technology (tele-PCMHI). Tele-health technology refers to non-face-to-face care using video and telephone visits. The toolkit provides instruction on necessary steps, procedures, and considerations when the behavioral health PCMHI provider delivers services to an outpatient clinic remotely.

While care management services are a core component of PCMHI, and often already provided via telephone, we did not focus on care management for this toolkit. Care management via telephone can and should supplement collaborative care provided as part of tele-PCMHI. This toolkit contains information about how to deliver PCMHI behavioral health services (i.e., collaborative care) remotely via tele-health, relying primarily on video visits and supplementing with telephone visits when necessary. Tools should be customized to fit sites' unique priorities, circumstances, and needs.

Intended users include providers, staff, managers, and administrators at community-based outpatient clinics and VA Medical Centers wanting to implement co-located collaborative care

(i.e., behavioral health providers) in PCMHI to clinics via video tele-health technology (tele-PCMHI). We refer to these individuals as tele-PCMHI champions in these tools and suggest forming a small tele-PCMHI implementation team composed of 2 to 5 individuals who will do detailed planning, carry out required tasks, and eventually, evaluate how well tele-PCMHI is going.

Tool development was supported by the “Adapting and Implementing the Blended Collaborative Care Model in CBOCs” study (CRE 12-310) funded by the VA Health Services Research & Development (HSR&D) program.

CHAPTER 9
EVALUATION OF THE IMPLEMENTATION FACILITATION STRATEGY

This chapter provides general information on processes, measures and tools that may be useful in documenting and evaluating the impact of an implementation facilitation strategy when applied to support use of an innovation. Chapters 4 and 5 discuss activities facilitators use to support implementation, including assessing the local site, identifying metrics and data sources for assessing implementation, and monitoring ongoing implementation progress. In this chapter we discuss ways that the IF strategy can be evaluated. Evaluation processes can be conducted by whoever is responsible for the facilitation effort (in the case of a clinical initiative or program), facilitators who are also members of a research team conducting the evaluation, or investigator(s) for a research study/evaluation process that is conducted independent of the implementation effort. Regardless of who is responsible for leading evaluation activities, evaluators will need input, e.g., documentation or data, from the facilitator(s) who supported implementation.

I. DOCUMENTING FACILITATION TIME AND ACTIVITIES

Why Track Facilitation Time and Activities?

There are myriad reasons why it makes sense to track, in detail, the time and effort being invested in a particular implementation project. From a practical perspective, tracking facilitation time may be crucial to conducting cost analyses, informing hiring decisions, or determining whether a facilitation project may be feasibly spread to other clinics or facilities. In the research setting, such tracking may also be pivotal for informing resource allocation for follow-up studies. For example, careful documentation of facilitator time has been used to estimate costs of integrating mental health care into primary care clinics[130] and enhancing teamwork in outpatient general mental health clinics.[131]

In addition, tracking the particular activities that facilitators engage in throughout the course of implementing an innovation may be valuable. For example, such activity-tracking may reveal a dearth of planning and preparation leading to large amounts of rework or problem-solving later in the implementation process. Furthermore, tracking the specific activities undertaken by facilitators can also inform the training or education of additional facilitators who may be tasked with scaling up the innovation in question.

Programs for Tracking

Tracking facilitation time can be labor intensive and burdensome. We suggest that you select a program or platform for documenting time that fits with your needs, the resources you have for collecting and analyzing time data, and the skills of the facilitators who will use the program/platform. Excel spreadsheets are one option. Based on the experiences of facilitators in several healthcare implementation projects, we developed a templated Implementation

Facilitation Time Tracking Log in Excel (Appendix L-1, page 221) that may be adapted for nearly any facilitation project.[130] We have also developed Access databases that allowed facilitators to select options from drop-down boxes rather than typing answers into a spreadsheet. See Appendix L-2, page 225 for a sample Access database form.

Specific Domains to Track

You will need to decide which domains you want to document. The Implementation Facilitation Time Tracking Log (see Appendix L-1, page 222) we developed provides context and definitions for the list of facilitation domains we indicate below.

Date and time spent

While fairly self-explanatory, it is important to note the date and amount of time spent on any facilitation activity being tracked. To minimize measurement burden on facilitators that may be associated with more precise time documentation, it may make sense in some cases to round off “time spent” to fifteen-minute increments. Nonetheless, decisions on the precision of time documentation are typically left to the discretion of project leaders and facilitators.

Event type

In our experience, it may be useful to know whether each facilitation activity was being conducted by the facilitator alone, in a one-on-one setting, or with a larger group (such as a site visit or group conference call).

Communication type

Facilitating is all about communication, which can include email, phone, video teleconferencing, interactions through other virtual platforms (e.g., Microsoft Teams, WebEx), or face-to-face modalities. Ratings for this domain would not apply, of course, for time spent by the facilitator alone (e.g., formatting documents for distribution).

People with whom the facilitator is interacting

The characteristics or details of the particular innovation targeted for implementation will affect how much granularity is required for this domain. Some type of rough indicator, however, of the primary personnel involved (e.g., a clinical team, facility leadership, or another facilitator) will be useful for getting a picture of how the facilitation progressed and which stakeholders may have been integral to the process.

Facilitation activity

What were the objectives, exactly, of each facilitation activity being tracked? Examples might include assessing aspects of care being delivered at the site, educating staff about the innovation being implemented, or problem-solving. Activities listed in the Implementation Facilitation Time Tracking Log and defined in Appendix L-1 (pages 221-

224) were identified using a rigorous literature review and Delphi process.[41] Some facilitation activities may be more important during certain implementation phases than others—for example, identifying problems or roadblocks may be particularly important during the pre-implementation phase, while problem-solving activities are likely to take place during the implementation phase.[41] Once again, the amount of specificity required in this domain will vary widely from project to project, and we recognize that many of the tasks undertaken by facilitators may fulfill multiple objectives. In those situations, it may nonetheless be helpful to identify the primary activity being pursued for any given block of facilitator time.

Timing of Facilitation Tracking

Tracking facilitation time and activities can itself be a time-intensive process, especially for facilitators who may be working with multiple sites or clinics simultaneously. Nevertheless, in some projects, facilitators are asked to document all of their activities on a continuous basis throughout. However, for other projects, it may make sense to track all facilitation activities taking place in "thin slices" or specific time-limited intervals across the project. For example, you may track the time spent in facilitation for one-week intervals every two months for the duration of the facilitation effort and use those data to estimate the total time spent on specific facilitation activities across the entire process. Whether to track facilitation activities on a continuous basis throughout, or instead, in time-limited intervals is another decision typically left to the discretion of project leaders, dependent on available resources.

II. ASSESSING FIDELITY TO THE INNOVATION

Oftentimes innovations are modified during implementation to accommodate the unique needs and/or preferences of a local site or patient population. As a result, when the innovation is actually implemented, there may be differences between the content of the modified version of the innovation and/or the context in which it was originally designed and tested in a controlled research setting.[132] This may be particularly true when the innovation is complex. Some changes may have been planned and others may have been unintentional, and it is difficult to know whether any of these changes may have unintended consequences on outcomes.[133] As a result, it is important to assess *the fidelity* to the innovation to ensure that its core components are actually delivered in your specific site(s).[105] Fidelity assessment can include review of: (1) adherence to the content (such as changes to program curriculum in terms of additions, deletions, substitutions and/or customizations); and/or (2) the delivery mechanisms including the competence or skill involved in training. There may also be changes in the methods that deviate from how an innovation was originally tested such as the length of, or change in, the order of innovation activities. Another consideration if you are implementing an innovation across multiple sites is to assess the frequency and range of adaptation across sites.

INNOVATION = WHAT

EBPPs or any clinical or organizational practice, program, or initiative being implemented

Tools for Planning Adaptations to Innovations and Assessing Fidelity

As described in Chapter 4, adaptation is an important step in implementation facilitation to make an innovation compatible to the needs of the target patient population and local conditions. Pages 56-57 present general guidance from the Adaptation Guidance Tool of things that can and cannot be changed from the original innovation to maintain fidelity.

This stage is a good time to refer back to the Program Adaptation Guidance Tool recommended in Chapter 4. Whether or not you established a checklist of modifications earlier, documenting what was done is an important step in assessing fidelity to the innovation, especially if you are implementing across multiple sites. For use in reviewing your earlier documentation or documenting adaptations at a later stage, the Program Adaptation Checklist is available at: https://rtips.cancer.gov/rtips/assets/rtips/reference/adaptation_guidelines.pdf

Information to guide your documentation and consideration of fidelity can also be found in a framework to help you assess modifications to the innovation developed and revised by Stirman, et. al..[95,96] The Framework for Reporting Adaptations and Modifications – Expanded (FRAME)[95] was developed to help characterize modifications made to evidence-based interventions when they are implemented in contexts or with patient populations that differ from that in which they were originally developed or tested. FRAME posits that there are multiple forms of modifications and considerations for making those modifications, including:

- When and how in the implementation process the modification was made
- Whether the modification was planned/proactive or unplanned/reactive
- Who determined that the modification should be made
- What was modified
- At what level of delivery the modification was made
- Type or nature of context or content-level modifications
- Extent to which the modification is fidelity-consistent
- Reasons for modification (intent, goals, and influences)

Figure 7 below outlines types of content modifications that may be used to document changes. Stirman et al. emphasize that these modifications may occur at different levels such as the individual recipient level, population level (e.g., a particular cultural, ethnic, clinical, or social group), provider organization level (clinic, hospital, etc.), etc.

Figure 7. Excerpted from Stirman, et al. (2019)[95]

Types of content modifications

- Tailoring/tweaking/refining
- Changes in packaging or materials
- Adding elements (intervention modules or activities)
- Removing elements (removing/skipping intervention modules or components)
- Shortening/condensing (pacing/timing)
- Lengthening/extending (pacing/timing)
- Substituting elements
- Re-ordering of intervention modules or segments
- Spreading (breaking up session content over multiple sessions)
- Integrating another approach into the intervention
- Integrating the intervention into another approach
- Repeating elements
- Loosening structure
- Departing from the intervention ('drift') (either followed by a return to protocol within the encounter or without returning)

Another important succinct guide is a fact sheet based on SAMHSA's Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence developed by the Nathan Kline Institute for Psychiatric Research.[134] This fact sheet, "Modifying Evidence-Based Practices to Increase Cultural Competence: An Overview," provides guidance on why adapting innovations for different cultural groups is important and how to consider changes that maintain the integrity of the innovation and produce predictable outcomes. It can be found at: Fact Sheet.

For additional information on adaptation in implementation science, and thinking about sources of adaptations of innovations, we recommend: The Adaptome: Advancing the Science of Intervention Adaptation.[135]

In summary, we hope that this information will help you assess where you may have made modifications to the innovation that you are implementing, and any implications for fidelity. While modifications are often necessary to improve the fit and compatibility of the innovation to the needs and/or preferences of a local site or patient population, modifications should be carefully considered and documented to ensure overall fidelity to the innovation, which may also be useful in assessing its sustainability.

III. ASSESSING FIDELITY TO THE IMPLEMENTATION FACILITATION STRATEGY

To help ensure appropriate application and spread of successful implementation strategies, it is important whenever possible to use tools and processes to measure and support fidelity to the core components of a given strategy.[136] In implementing evidence-based practices or other innovations, it is important to give attention not only to documenting and assuring fidelity to the *innovation* (as described above) but also to documenting facilitator activities and assessing fidelity to the core activities of *implementation facilitation (IF)* to support its practical application and dissemination to other settings.[40] Within implementation science, there is a diverse portfolio of implementation strategies with a range of effectiveness that might be used to support uptake of innovations. Documentation and reporting of fidelity to the implementation strategy will enable implementation practitioners and scientists to assess the extent to which implementation success is influenced by adherence to core components of the strategy or strategies used. Fidelity assessment will also support more accurate replication of these strategies by others if shown to be successful. Unfortunately, this aspect of implementation science and practice has been relatively underdeveloped and infrequently applied.[137]

Implementation Strategy
What you do (or someone else does) to help the setting implement the innovation

As mentioned in the Introduction, a number of studies have contributed to a growing evidence base for the impact of IF strategies for promoting use of a new program or practice in healthcare settings.[10,26,27,138] Based on a comprehensive scoping literature review of IF studies published from 1996-2015 (94 studies, 135 articles) followed by a rigorous consensus development process with an expert panel,[41] core IF activities for fidelity monitoring were identified for each of the three phases of implementation: 8 core IF activities for the Pre-Implementation Phase, 8 core IF activities for the Implementation Phase, and 4 core IF activities for the Sustainment Phase (see Table 5). Definitions for the core IF activities are provided in Appendix L-1.

Table 5. Core Implementation Facilitation Activities

Pre-Implementation Phase	Implementation Phase	Sustainment Phase
Engaging stakeholders/ obtaining buy-in	Providing support	Providing support
Identification/selection of local change agents	Adapting program to local context without compromising fidelity	Pulling back and letting sites take lead
Data collection to assess context and baseline performance	Conduct ongoing monitoring of program implementation	Conduct ongoing monitoring of program implementation

Pre-Implementation Phase	Implementation Phase	Sustainment Phase
Problem identification	Providing updates & feedback	Providing updates & feedback
Action/implementation planning	Problem-solving	
Describing/clarifying roles and responsibilities	Fostering organizational change: structural	
Goal/priority setting	Managing group/team processes	
Administrative tasks	Administrative tasks	

The consistent inclusion of an IF fidelity measure in future studies could help document and characterize empirical relationships between IF fidelity and implementation outcomes, enhancing what may be learned from such research. There are several ways that IF Fidelity might be monitored:

- For IF fidelity monitoring, use of core IF activities can be documented by facilitators on a regular basis (e.g., weekly, biweekly) on the IF Time Tracking Log described earlier in this chapter (see pages 108-109). For quantitative IF fidelity analyses in an evaluation, one might assess: (a) to what extent facilitators applied ALL of the core IF activities in the site(s) they worked with for each phase of implementation; (b) how *frequently* facilitators applied the different core IF activities in their contacts with sites; and (c) whether/how any of the IF fidelity measures were associated with implementation outcomes.

- Facilitators' use of core IF activities may also be examined in qualitative debriefing interviews by evaluators assessing their activities with sites to support implementation of a given program or practice. For example, Iverson et al. are conducting in-depth follow-up qualitative interviews with facilitators to assess fidelity to the 16 core implementation facilitation activities as part of an ongoing trial.[139]

- Finally, in cases where facilitators may choose not to document their time and activities on an IF Time Tracking Log (to minimize facilitator reporting burden), we have developed and are currently piloting prototype IF fidelity tools that could be completed by facilitators for periodic IF fidelity monitoring.[140] These IF fidelity tool prototypes are designed as 'stand-alone' self-report fidelity assessments that facilitators can complete to document their use of core IF activities at a given site. They are intended to serve as a self-assessment for facilitators to monitor their use of core IF activities within the different phases of implementation and to assess frequency and intensity of their use of the core IF activities. These IF Fidelity Tool prototypes are not currently available; they will be added to this Manual once initial testing and refinement is completed.

IV. ASSESSING OUTCOMES

When assessing the impact of an implementation facilitation (IF) strategy, there are two general categories of outcomes to consider: clinical outcomes from the innovation being implemented and implementation outcomes of the IF strategy itself. In selecting the outcomes to focus on, it is important to involve key stakeholders (e.g., operational partners, implementation recipients), so that there is a shared understanding of the impact that the IF strategy is targeting to make. There also are additional considerations for assessing outcomes, stemming from how (i) IF often employs multiple implementation strategies as a bundle and (ii) successful implementation is being increasingly seen as a path to health equity.

Assessing the Innovation

Innovation outcomes will of course depend on the program that you are implementing and the target of the innovation. The RE-AIM evaluation framework[97] provides a helpful tool by which outcomes of the innovation may be assessed. As noted in Chapter 5, RE-AIM promotes use of measures to assess the reach, effectiveness, adoption, implementation, and maintenance or sustainability of the innovation over time.

Dimensions	Definitions
Reach	The absolute number, proportion, and representativeness of individuals participating in the innovation or program. For example, the site may wish to monitor the number of patients who receive or are participating in the innovation and their specific characteristics.
Effectiveness or efficacy	The impact of an innovation on important outcomes, including specific patient-level outcomes, potential negative effects, quality of life, and economic outcomes. For example, if a site is implementing a tobacco cessation program, site stakeholders might want to collect data on and monitor quit rates and the program's impact on other important health variables for enrolled patients.
Adoption	The absolute number, proportion, and representativeness of users (settings and/or staff) of the innovation. For example, a measure of adoption might be the number of clinical providers who are delivering the innovation.
Implementation	refers to innovation fidelity or the extent to which a site implements the innovation as planned. For example, many evidence-based programs have core components, and measures of implementation might assess how well each of those core components was actually implemented.
Maintenance	refers to the sustainment of the innovation and is often assessed by repeating measures of reach, effectiveness, adoption, and implementation over time.

According to the RE-AIM framework, an innovation can only affect a population if clinics and providers first adopt it, reach a large proportion of the target patient population, implement it with fidelity, effectively improve outcomes, and maintain the innovation after researchers withdraw.

There are related outcomes that depict the innovation's compatibility with the implementation context. These include acceptability, appropriateness, and feasibility:[141]

- *Acceptability* refers to the extent to which stakeholders find the innovation palatable, given their knowledge of and experience with it. (Note that this is distinct from the acceptability of the IF strategy, which is discussed under the section below on Assessing the Implementation Process).

- *Appropriateness* refers to the extent to which the innovation addresses the need of the population that the implementation is targeting. For instance, an innovation that has been shown to increase the rate of guideline-concordant cancer screening would be appropriate for a clinic looking to improve their screening rate.

- *Feasibility* refers to the extent to which it is practical for the innovation to be carried out within a setting. This practicality is often driven by the availability of resources needed for carrying out the innovation. For instance, an innovation that requires new equipment to be purchased may not be feasible for a clinic with limited financial resources on hand.

These assessments of the compatibility between the innovation and the implementation context may render different results depending on whose perspectives the assessments examine and when the assessments are conducted. To accurately capture multiple perspectives and how they change over time, it is recommended that the assessments (1) involve stakeholders at various organizational levels (e.g., leadership, front-line staff) and with diverse relationships to the innovation (e.g., payer, consumer) and (2) are conducted across distinct phases of implementation.

Assessing the Implementation Process

The second category of outcomes to consider includes those associated with the implementation process itself. Some have embedded the assessment of these outcomes under implementation fidelity within the 'Implementation' dimension of the RE-AIM framework, while others have considered it as a distinctly different area. While the degree to which an innovation is implemented as planned is one component of assessing facilitation outcomes there are other factors to consider. These include:

- *Acceptability of the implementation facilitation strategy.* When assessing acceptability, it is important to target key stakeholders such as site level leadership, those that champion local implementation and/or others who are closely involved in the implementation process. This assessment is frequently done through interviews conducted by someone other than the facilitator (to minimize social desirability bias), though this may be done less formally through a brief set of questions. What is important is to be able to document the experiences of those participating in the implementation process so that future IF activities may be improved.

- *Cost of the IF strategy.* Documenting the cost of the facilitation process continues to be an important component of implementation. As described previously in this chapter, *Documenting Facilitation Time and Activities*, understanding the cost of the implementation activity allows for clinical and operational leadership to determine the degree to which the IF strategy can feasibly be incorporated into large scale spread initiatives. Costs can vary greatly across different models of IF, with one of the primary drivers of IF costs being the facilitators' time.

Case Example

For example, in a project to re-engage Veterans with severe mental illness that had been lost to care back into treatment, a virtual "light touch", low intensity IF model was applied over a six-month period. This model required on average 7.3 hours of facilitator time per site.[28] In contrast, an intensive external and internal facilitation model applied over 27 months to implement Primary Care Mental Health integration at clinics with particularly challenging organizational contexts required on average 55 hours of external facilitator time and 426 hours of internal facilitator time per site. Approximately forty percent of external facilitation time was devoted to travel.[130]

- *Implementation process outcomes.* These outcomes refer to the degree to which sites achieve the implementation milestones that are set during implementation planning and may be collected by frequent review of the implementation plan or in consultation calls with the sites. It is important to remember that the implementation plan is a "living document" and that making informed changes in the plan over the course of the implementation process to increase chances for success does not reflect failure but rather close attention to the needs of the site and appropriate execution of the Plan-Do-Study-Act cycle.

Case Example

For example, in a project to implement the Collaborative Chronic Care Model (CCM) into interdisciplinary team-based care at multiple outpatient general mental health clinics, an external-internal facilitation model was applied over 12 months per site.[142] Implementation process outcomes assessed included (i) team function and (ii) concordance of team processes with core CCM elements. Team function was assessed using the Team Development Measure,[143] a team member survey, administered at the start of implementation and during the second six months of implementation. CCM concordance was assessed by reviewing the extent to which the team had established and documented 27 care processes deemed consistent with the CCM. The review assigned a consensus rating of "not completed," "partially consistent," or "fully consistent" for each process.

Selecting Outcome Measures

Among these multiple outcomes that can be considered for assessing the impact of an implementation facilitation strategy, their availability and relative priority depends on the context of implementation. Health care systems may already have predetermined outcomes (or performance measures) that align to their organizational priorities, which they desire to improve through a particular implementation effort (e.g., increase in access to health care services, enhanced employee satisfaction). Even within a single health care system, stakeholders at different organizational levels may be interested in different outcomes; for instance, front-line providers may consider frequent check-ins with existing patients on their panel to be their priority, while their clinic leadership may view increasing access to new patients in need of services to be essential. Furthermore, implementation projects may have their own benchmarks for assessing implementation success across multiple systems that they work with (e.g., proportion of employees trained in the new innovation, fidelity with which the innovation is implemented), which may or may not be seen as critical by their operational partners at the health care systems.

It is thus important for an implementation project to make clear to its operational partners and other key stakeholders at different organizational levels, based on its knowledge of the innovation's evidence base, which outcomes are reasonable to target within the timeframe of implementation. It is also important for the implementation project to learn from its operational partners about outcomes that are already routinely being measured by the health care system, so that outcomes data collection and reporting can be planned accordingly. For the different stakeholders involved in this discussion to select the implementation project's relevant outcome measures, they may differ in how frequently and in what format they wish to stay informed about changes in those outcomes. It this therefore recommended that the implementation project establishes expectations early on regarding when, to whom, and how its implementation outcomes will be presented.

Case Example

To pilot implementation of a suicide prevention intervention in emergency departments, experts in the innovation (Caring Contacts), research design, and implementation practice worked with medical center emergency department and mental health leadership to identify both sources of data that were available and metrics that medical center leadership prioritized.[140] Following the pilot, outcomes were revised based on continued input from this group of experts, including the clinical leaders who remained on the pilot advisory board. This pilot ultimately led to support for implementation of Caring Contacts in 28 sites across the health care system.

Additional Considerations for Assessing Outcomes

IF often employs multiple implementation strategies as a bundle. There is a growing emphasis on identifying which strategies, and which combination of strategies, lead to better implementation outcomes.[144,145] These recent developments are both strengthening and further specifying the evidence base of IF as an implementation strategy. Such expanded evidence will enable future IF efforts to better predict which outcomes are most reasonable to target, based on which IF model a project decides to employ (e.g., whether involving a learning collaborative or not; whether conducting a site visit or not). Importantly, this will directly inform the selection of outcome measures that implementation projects carry out in collaboration with their operational partners and stakeholders, as discussed under the section above on Selecting Outcome Measures.

Another consideration for assessing outcomes is that successful implementation is being increasingly seen as a path to health equity.[146,147] Health care disparities that inhibit or prevent health equity can be recognized as a special case of implementation failure, in which the implementation effort is not able to increase the uptake of an evidence-based innovation into routine practice for certain populations who need them most. Accordingly, implementation efforts are beginning to more explicitly consider the relevance of societal context on implementing an innovation. These societal influences include the various physical structures in the built environment, economies, policies, and social forces within which implementation contexts and recipients reside. When assessing potential and resulting impacts of an IF strategy, consideration of these influences can critically inform how the strategy can be tailored to meet the needs of diverse contexts and recipients, and also what outcomes are reasonable to target for which implementation contexts and recipients.

Facilitators conduct many assessment activities to support innovation implementation, e.g., they assess organizational progress and outcomes of innovation implementation. However, this chapter explores methods for evaluating the IF strategy itself. Such evaluation may include documentation of facilitators' time and activities; assessment of whether the core components of the innovation were implemented with fidelity; assessment of whether the IF strategy was applied as originally planned (including use of core IF activities); and assessment of the overall outcomes of the IF process, including innovation outcomes and outcomes of the implementation process itself. Conducting such evaluation activities can help facilitators improve their efforts to support implementation and ultimately improve innovation outcomes.

CHAPTER 10
SUPPORTING FACILITATOR WELLBEING AND EFFECTIVENESS

However skilled they may be, implementation facilitators cannot implement change alone. Successful facilitation relies on effective collaboration between facilitators and the individuals, teams, and organizations they support. The process of establishing collaboration is dynamic and can be challenging, particularly for novice facilitators and/or when facilitation does not proceed as planned. This is because facilitators not only *do* the work of facilitation, they also *experience* it emotionally, physically, and mentally. To remain effective, facilitators need to pay close attention to their own wellbeing throughout the facilitation process, by reflecting, adapting, and seeking support as necessary. This chapter will discuss facilitator wellbeing and present three strategies to support facilitator wellbeing and effectiveness.

I. FACILITATOR WELLBEING

Facilitation Intensity

During all phases of implementation (pre-implementation, implementation, and sustainment), facilitators use different degrees of effort to respond to facilitation challenges and to bring about implementation successes. As a result, facilitators experience a range of emotions related to their facilitation efforts. These emotions can impact how the facilitators feel about themselves, their facilitation, and the implementation process. We call this ***facilitation intensity*** and define it as:

> "A measure of both the facilitation tasks and activities needed to engage and motivate implementation, and the psychological impact on the facilitator of delivering the facilitation tasks and activities."[148]

The intensity with which individual facilitators experience the facilitation process can vary from encounter to encounter (e.g., facilitation meeting/call), from project to project, and from facilitator to facilitator (e.g., novice facilitator, expert facilitator). A task that is very intense for one facilitator may go emotionally unacknowledged by another facilitator. These differences in facilitation intensity have important implications for facilitator wellbeing and for implementation success.

Facilitator Morale

Facilitation can be extremely rewarding. Accomplishing even simple tasks through a team effort and effective facilitation can be satisfying and can bring renewed energy for all involved. However, less successful facilitation experiences can be just as impactful and taxing for the facilitator. This is due, in part, to the inevitable setbacks associated with pursuing implementation goals. As facilitators work through failures and challenges to achieve successes, fatigue may be unavoidable, even when success is achieved. As a result, facilitators

should anticipate challenges and be prepared to address them to minimize impacts on their own morale.

Facilitators for a quality improvement initiative to improve patients' experience of care coordination in primary care identified the following challenges they experienced.[148] They typically experienced these often-interrelated challenges simultaneously.

- Lack of progress or follow-through from the implementation team on key project metrics
- Changes to the implementation team due to staffing reassignments or loss of interest
- Emotion/frustration directed at the facilitator by the implementation team
- Mismatched expectations between the facilitator and the implementation team
- Supporting the implementation team with and generating buy-in for quality improvement/implementation methods and data collection
- Managing team dynamics
- Promoting effective communication between the implementation team and the facilitator and within the team
- Documenting implementation and facilitation progress

Facilitator Burnout

Facilitation is complex and often occurs in dynamic (and sometimes dysfunctional) settings. As a result, facilitators risk experiencing the same symptoms of work-related burnout – exhaustion, cynicism, loss of confidence in their skills/training – as the people they support.[149] Although all facilitation can be challenging, facilitation that involves multiple encounters per week, over extended periods of time, and across teams and/or organizations can be especially challenging since the potential for burnout associated with facilitation is greater. Recognizing and addressing burnout, as well as preventing it whenever possible, is important for facilitators to maintain their wellbeing and effectiveness (see Section II below for strategies to support facilitator wellbeing and effectiveness).

Facilitator Resilience

In addition to coping internally with the fluctuating intensity of the facilitation process, facilitators must also learn to regulate their outward displays of emotion when interacting with the individuals and teams they facilitate. By regulating their own emotions, facilitators are able to encourage others to continue working toward successful implementation even when they

themselves are experiencing fatigue or stress. We call this coping and self-regulation ***facilitator resilience*** and define it as:[150]

> "The facilitator's ability to cope and adapt to the complexities of facilitation to effectively engage and motivate recipients in implementation, while nurturing and sustaining hope, self-efficacy, and adaptive coping behaviors in themselves."

Facilitators use their personal and professional skills, both learned and natural, to support and enable implementation. For example, they may use their *personal skills* to listen sympathetically to individuals on implementation teams who are frustrated with the barriers to implementation they are experiencing (e.g., resistance from leadership, lack of buy-in from colleagues), while using their *professional skills* to actively seek clues in the conversation to identify strategies that might help address the barriers to implementation.

Facilitators' ability to cope with and adapt to the complexity of facilitation cannot be separated from the facilitation process itself and can positively and negatively impact the effectiveness of their facilitation. Facilitators who are better able or better supported to cope may be more effective than facilitators who are less able or less supported.

II. SUPPORTING FACILITATOR WELLBEING AND EFFECTIVENESS

Facilitators need to be supported with a variety of resources to better cope with facilitation intensity, strengthen their resilience, and improve their effectiveness. This can be done by providing time for facilitators to reflect, debrief, and self-reflect after each facilitation encounter.

Continuous Feedback

Soliciting feedback from others about their facilitation is an important way that facilitators can improve their facilitation effectiveness. Feedback can be collected formally (e.g., via interview, survey) and informally (e.g., via constructive discussion during a meeting). Feedback can come from the individuals and teams being facilitated, from other facilitators, from supervisors, and from the facilitators themselves through self-reflection. Facilitators can check in periodically with the implementation teams they support to gauge their satisfaction with the facilitation process and to identify areas for improvement.

Debrief Sessions

Debrief sessions are a second strategy facilitators can use to work through implementation challenges, especially those that require high intensity. Debrief sessions can be formal (e.g., scheduled after each facilitation encounter) or informal (e.g., held as needed) and can range in length from a few minutes to 30-60 minutes or more depending on the topic being discussed.

Debrief sessions are most helpful when held with other facilitators (when available) or individuals who understand the challenges of facilitation and can help address both the technical and the emotional aspects of facilitation. The sessions allow facilitators to step back

emotionally and mentally from the facilitation process by relying on the feedback of others to help facilitators process their own emotions and to brainstorm how to address challenges. Debrief sessions can be very cathartic.

Self-Reflection

Reflective writing has been used in psychotherapy training programs to promote expertise development, improve stress management, avoid burnout, and increase effectiveness in therapists.[151] Facilitators may experience similar benefits by writing about their facilitation process in an open-ended or templated way, to capture specific information about their wellbeing and effectiveness. These self-reflections can be brief and can be completed in a systematic way (e.g., after each facilitation encounter) or on an “as needed” basis. Reflective writing can be cathartic for facilitators since it provides an outlet to process emotions associated with facilitation, as well as a way to assess, refine, and improve facilitation skills.

Facilitation is relational in nature and often occurs in complex and dynamic environments. Facilitator wellbeing and facilitator effectiveness can be impacted by the intensity of the facilitation process. To remain effective, facilitators should be watchful of their own morale and burnout and seek support when necessary. Continuous feedback, debrief sessions, and reflective writing are three strategies that can help support facilitator wellbeing and effectiveness on an ongoing basis throughout the facilitation process.

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APPENDIX A. GLOSSARIES

Appendix A-1. Glossary of Acronyms

EBP(s)	Evidence-Based Psychotherapies
EBPP(s)	Evidence-Based Practice(s) and Program(s)
EF	External Facilitator
i-PARIHS	integrated Promoting Action on Research Implementation in Health Services
IF	Implementation Facilitation
IT	Information Technology
MH	Mental Health
MI	Motivational Interviewing
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom
OMHSP	Office of Mental Health & Suicide Prevention
ORC	Organizational Readiness for Change
PACT	Patient-Aligned Care Teams
PCMHI	Primary Care-Mental Health Integration
PDSA	Plan – Do – Study – Act
PSAT	Program Sustainability Assessment Tool
QI	Quality Improvement
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
SAP	Sustainability Action Plan
VA	Department of Veterans Affairs
VACO	VA Central Office
VANTS	VA Nationwide Teleconferencing System
VTH	Video Telehealth to Home

Appendix A-2. 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 important clinical actions or processes.

Champions[5-8]

A champion is an individual who exhibits strong support and campaigns for or drives through an intervention or practice change within his/her organization, overcoming the status quo and resistance, willing to risk informal status or reputation in the process. Effective champions build support from those in authority and/or a broad coalition of support. Having a champion may be necessary (though not sufficient) for successful implementation.

Change Agent[5]

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

Climate[5]

Concerns the effect of systems on individuals and groups and focuses on organizational members’ perceptions of observable phenomena such as organizational practices and procedures.

(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.

Culture[5]

Norms, values, and basic assumptions of a given organization. Organizational culture concerns system evolution and involves an in depth exploration of underlying assumptions not readily apparent to outside observers.

Early Adopters[5,9]

"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 an innovation. The early adopter is considered by many as 'the individual to check with' before adopting 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. Early adopters help trigger the critical mass when they adopt an innovation.

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. In one sense, early adopters put their stamp of approval on a new idea by adopting it."

Taken from *Diffusion of Innovations*, Everett M. Rogers, fifth edition, page 283.

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.

Implementation facilitator[10-14]

An implementation facilitator is an individual in an appointed role that helps and supports individuals, teams and organizations to enable them to implement innovations, e.g., evidence-based practices and programs. Implementation facilitators may be external or internal to the

setting in which an innovation is being implemented. They use a range of techniques and approaches, tailored to organizational needs and resources, to develop supportive relationships and, help stakeholders to leverage strengths and address context-specific challenges inherent in implementing innovations.

Innovation (What is being implemented)

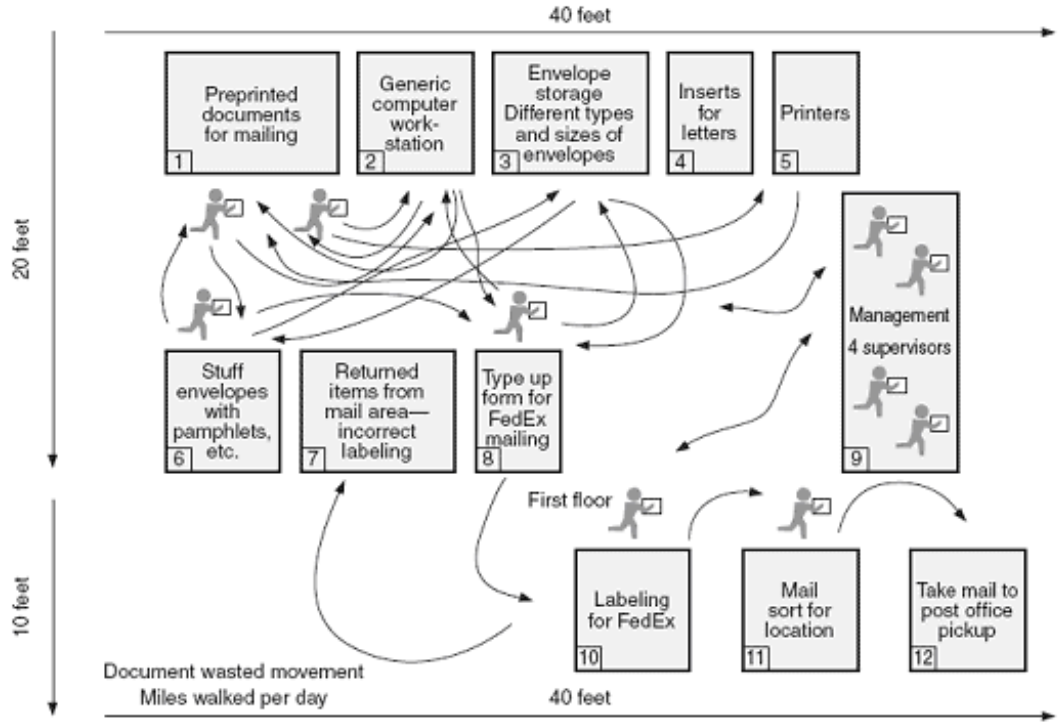
Evidence-based practices and programs or any clinical or organization practice, program, or initiative being implemented, as well as any changes intended to improve clinical care that are new to the organization making that change.

Opinion Leader[5,6,9,15-18]

An opinion leader is an individual in an organization who 1) possess attributes of authority, representativeness and credibility, 2) have informal influence on the attitudes and beliefs of their colleagues, and 3) are seen as respected sources of information which enables them to exert influence on others' decision making in ways that support an intended change or push back against it via word-of-mouth and/or face-to-face communication. Opinion leaders may be "experts" who exert their influence via authority and status or "peers" who exert their opinions through representativeness and credibility.

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: August 30, 2020.

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.

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APPENDIX B. IMPLEMENTATION PLANNING GUIDE RESOURCES

Appendix B-1. How to Create an Implementation Planning Guide

Frontline clinical providers and managers have called for tools and/or organized processes that can be used to guide key decisions in planning for the implementation of innovations and practices.[1] Providing this guidance is a core component of implementation facilitation as it has been applied within and outside of VA. There are several methods through which these plans or guides can be created, piloted and maintained. Below is a sequence of steps that we have applied across several clinical quality improvement and research initiatives.

Detail the core components of the innovation

Fixsen and colleagues have defined core components as the most essential and indispensable components of an intervention practice or program ("core intervention components") or the most essential and indispensable components of an implementation practice or program ("core implementation components").[2] There are several sources from which core components can be identified. In the case of highly evidence-based innovations (e.g., care management for depression), core components of the innovation may be clearly delineated in the reports of randomized controlled trials, literature syntheses, and/or clinical policy. If you are lucky enough to have these types of sources, use them to clearly define the innovation's core components and let that inform the development of your implementation planning guide.

Frequently, facilitators are faced with less rigorous sources of data while still charged with the need to implement the innovation. We may be charged with supporting implementation of a new program or practice that is poorly defined or has not been rigorously evaluated to identify the core components that are essential to achieving clinically meaningful outcomes. If this is the case, consider using other means (as described below) to identify other sources for this information.

Identify source/s of expertise in the innovation

Identify the individuals that originally developed the innovation, or who may have championed its use in earlier stages of development and application. These are the people who may have the most empirical and/or experiential knowledge about core components of the innovation. If you are implementing a program or practice that builds upon an existing innovation you may want to identify the developers, champions and users of the existing innovation and convene an expert panel to discuss which elements are adaptable and how best to adapt it to the new target population, setting, or delivery system. This approach is frequently applied as we take highly evidence-based practices and adapt them for use through new technologies such as apps or telemedicine.

The process of identifying core components may take several steps during which you start with key informant interviews to gain the experts' thoughts on what they believe are

core components of the innovation, with further distillation and refinement of those key elements through use of surveys or other methods. It may be necessary to have the informants rank the core components and then convene the group together to discuss the rankings and reach consensus, potentially through a modified Delphi process.[3] The number of steps needed will differ based on the complexity of the innovation and the existing evidence supporting and experiences with its use.

Describe the steps necessary to successfully implement the innovation

While you can certainly use the experts identified above to help you think through the steps of implementing the innovation, your best source may be those that have already incorporated the innovation into their own clinic or practice. You can identify these "early adopters" through administrative data, clinical and operational leadership, or perhaps even by self-identification in listservs. Site or clinic level leadership at these 'exemplar' sites can help you identify the person that was most involved in the implementation process. Ask for about an hour of their time and conduct a semi-structured interview. Examples of questions you may consider using are provided at the end of this document. If possible, conduct this work in diverse sites so that you can get a broad sense of implementation challenges that may be encountered. Usually, five sites are sufficient to provide the variability needed to develop a strong implementation planning document.

Provide key decision points along with options/choices for adaptation (as appropriate) that can be made to tailor the innovation to the context within which it is being implemented, while maintaining fidelity to the innovation's core components

Now that you have identified the core components to be implemented and the recommended steps that should be taken in implementing them, summarize this information in an Implementation Planning Guide (sometimes referred to as an implementation 'checklist' or 'blueprint'). When site level adaptation is possible for a given step, you may want to consider including choices made at the sites from your key informant interviews. Providing options or examples helps sites that have not implemented the innovation have a model or structure that can be used as a basis for making their own decisions.

Pilot the Implementation Planning Guide

If possible, prior to applying the implementation planning guide, pilot it with the types of stakeholders that will be using it when you begin the planning process. Sites that you have used to inform the development of the planning guide may be willing to review the guide or even conduct a mock implementation planning session. If this is not possible, at the very least sit with someone who is naive to the planning guide and work through each of the steps. This will help you determine if the steps are in the correct order, comprehensive and clearly understandable.

Revise the Implementation Planning Guide as new knowledge is gained during the implementation process

View the guide as a "living document." As you apply it at different sites and actually execute the implementation process, use the knowledge gained to update, modify or refine earlier decisions documented in the guide.

Examples of implementation planning guide templates can be found in Appendix B2 and B3. A completed implementation planning guide can be found in Appendix B4.

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Implementation Interview Guide
(Examples of questions for identifying steps)

Name of Site/Clinic:

Name of Informant:

We contacted you because an analysis of administrative data (or other method you used to identify the informant) suggested that your site has been actively using [name of innovation] as part of clinical care. Is this correct?

1. Which program(s) at your facility are actively using [name of innovation]?
2. Which one of these is most active in using [name of innovation] (or in which clinic setting are you most familiar with the implementation process)?
3. For how long have you been utilizing [name of innovation] in clinical care?
4. What were the motivators behind implementing [name of innovation]?
5. In what setting/s (both clinic type and what level of care) has [name of innovation] been implemented?

6. Do you have a standard protocol for using [name of innovation]? If so, could you share that with us?
7. What proportion of clinicians are using [name of innovation] in those settings?
8. How many patients have been served by [name of innovation]?
9. Tell me about the steps you went through to implement [name of innovation]?
10. What barriers did you experience when implementing [name of innovation]? What did you do to address those barriers?
11. What helped you get [name of innovation] implemented? Were there local processes or resources that were particularly useful in implementing [name of innovation]? What types of staff or providers were involved in the planning and implementation of [name of innovation]?
12. Any lessons learned from the implementation process? What were the most important things you did to help ensure success in implementing [name of innovation]? If you were implementing [name of innovation] again what, if anything, would you do differently?
13. For clinics that are starting to implement [name of innovation], what would you say were the most important steps or factors to consider in successfully implementing the program?
14. Is there anything else you would like to tell me that I did not ask?

Appendix B-2. Implementation Planning Guide Template for MBC

MBC Implementation Planning Guide Template*
Quick Start Guide

- As a reminder, the basic requirements for implementation of Measurement Based Care (MBC) are:). As a reminder:
  - **Collect**: Veterans complete reliable, validated, clinically appropriate measures **at regular intervals** as part of *routine care.*
  - **Share**: Clinical information is shared with the **Veteran** and **other clinicians involved in the Veteran's care** to *inform* clinical care and *shared decision-making.*
  - **Act**: Together, clinicians and Veterans **use that information to make decisions** about care thereby *individualizing* ongoing treatment and improving results.
- Your implementation plan should clearly address all three of these requirements. Beyond that, you and your site/clinic get to decide who/what/where/why/when/how to implement MBC in a way that fits for your setting.
- Many sites have found that working through the document below helps them to brainstorm different decision points and create a plan towards successful MBC implementation.
- It is best to fill out the plan with input from everyone on the team who will be involved in MBC. The best way to do that is to complete it collaboratively during staff meetings, but it also can be shared via email using edits made using track changes.
- The plan works best when it is reviewed regularly in team meetings and revised as needed. You should consider it to be a "living document" that changes over time as you learn more about what works for your setting.
- Get help with these challenges by posting to Pulse, attending monthly Community of Practice calls, contacting an MBC Subject Matter Expert or by emailing MBCinformation@va.gov
- **Don't forget to establish a Sustainability Action Plan:** The investment in the implementation of MBC can only be successful if it is sustained to serve the needs of our Veterans well past the implementation phase. A Sustainability Action Plan (SAP) can supplement this Implementation Planning Guide. During planning and implementation, we will be working with you to develop your SAP to ensure MBC is successfully sustained after facilitation ends.

**This MBC Implementation Planning Guide Template was adapted for the Behavioral Health QUERI MBC Project [Laura O. Wray, PhD, & Dave Oslin, MD; PIs; November 7, 2018] from the Guide developed by the VA Office of Mental Health and Suicide Prevention for the National MBC Initiative.*

MBC in PCMHI Implementation Planning Guide Template

Site:
Identified Lead:

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
A. Identify Participating Staff • Local Lead • Participating Providers	• Identify Local Lead (if not the PCMHI Lead) • *See supporting document on choosing a Local Lead aka Internal Champion* • Determine staff to participate: e.g., primary care providers LCSWs, Psychiatrists, Psychologists, Addiction Therapists, trainees, admin support staff, etc. *We strongly encourage participation of as many providers as possible*				
B. Decide how to Engage Veterans and other stakeholders	• Identify how your implementation team will collect and incorporate Veteran input/feedback on implementation of MBC in addition to the input provided by a Veteran member of the team. (e.g., Random selection of Veterans to complete a satisfaction survey on the MBC process, coordination with Veterans MH Councils, consultation with advisory boards and other stakeholder groups).	*Optimally you have a Veteran on your implementation team so you will have some input from the start of planning. You should develop a plan to seek additional Veteran input as soon as it makes sense based on your implementation plan.*			
C. Determine MBC Start Date	Identify start date for the implementation of this plan. • It is ok change the start date after it was selected due to kinks in the plan. *Some sites with several barriers or more complex implementation plans have opted for a phased approach- starting with a more "bare bones" implementation plan for the first few months and then adding more measures, etc. later on.*	*We recommend doing this ASAP after beginning to develop your plan.*			

Appendix B-2. Implementation Planning Guide Template for MBC

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
D. Engage & Train Staff	• Engage all staff through meetings and communications. • Continue to engage and educate leadership • Determine how leadership can best support - *Provide recognition for participating providers.* - *Allocate site-specific resources that may be available to support implementation (e.g., admin support, dedicated time for local champion during initial implementation phase, budget support for MBC support materials, e.g. color printers, clipboards, etc.).* - *Provide opportunities for participants to present to local leadership on progress.* • Ensure all staff completes all MBC training as needed. Training includes basic MBC concepts, **(Collect, Share, Act)** clinical interpretation of, selected measures, and local SOPs. • How will you know that all providers have competency to use the selected measures? • Determine which staff will be involved in Implementation Planning process (a meeting to complete the rest of this sheet) *It is recommended to have as many participating staff participate in implementation planning as possible*	*We recommend that staff is trained up within 30 days of your start date.*			

Appendix B-2. Implementation Planning Guide Template for MBC

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
E. COLLECT: Determine Who to be Assessed	• Identify Veteran population to receive MBC ○ All Veterans served by participating providers/programs or clinics ○ Subset of Veterans (e.g., those engaged in new episodes of care, group tx, individual tx, those who screen positive for specific diagnoses, etc.) ○ Other_____ *It is recommended to initiate MBC with Veterans engaged in a new episodes of care since changes in outcomes are more likely to occur and be reflected in outcome measures earlier in treatment*	*We recommend doing this within 30 days of beginning to develop your plan.*			
F. COLLECT: Determine Measures & Frequency	• Select Measures ○ PHQ-9 ○ GAD-7 ○ PCL-5 ○ BAM-R ○ Other_____ • Determine timing of measurement (*encouraged to be at least every 30 days)* ○ Every relevant PCMHI MH encounter? ○ Every 2 weeks? ○ Other predetermined intervals? If so, document_____	*We recommend doing this within 30 days of beginning to develop your plan.*			

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
G. COLLECT: Determine Method of Administration & Who Administers	• Determine method to administer measures ○ Paper survey ○ Veteran at computer (Secure Desktop) ○ Provider reading aloud (e.g. from MHA, this is not recommended) ○ Other _____ • Determine who administers (this may be redundant depending on response to previous question) ○ Provider ○ Other staff (e.g. admin support, trainees) ○ Other _____ • Determine timing of when administration happens during visit: ○ Lobby, before session ○ In session with provider ○ Different at intake/first visit than subsequent visits? ○ Other _____	*We recommend doing this within 45 days of beginning to develop your plan.*			
H. COLLECT: Determine Method of Documentation within MHA and Who Documents	• Data must pass through to the MH VistA files. For most programs that will require the use of MHA (Mental Health Assistant) or BHL (Behavioral Health Lab). • If administration method is paper/pencil or otherwise not directly linked to MHA, identify who will enter data into MHA: ○ Provider ○ Other clinical staff ○ Administrative support ○ Other_____ • When will MHA entry happen? ○ At time of administration ○ Other _____ *In cases where the data is collected via paper/pencil, the timing of the data entry is crucial. Optimally data entry will occur within 24 hours of the data collection.*	*We recommend doing this within 45 days of beginning to develop your plan.*			

Appendix B-2. Implementation Planning Guide Template for MBC

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
I. SHARE: Determine Clinical use of MBC	Sharing with Veterans • Based on data collection method, determine if scores can be available at time of visit • How will providers share data with the Veteran in session? • How will you ensure that providers know how to and are comfortable sharing this information? • **How will sharing the data be documented in the chart?** Sharing Across the Care Team • What other members of the care team may benefit from this information? - How will you discuss changes in the data with them? - Have you provided adequate training to the other members of the team? How will you ensure that team members understand this information? • If measures are being collected by team members who are not LIPs, create standard operating procedures (SOPs) to ensure that Veterans receive appropriate follow-up care with LIPs and/or urgent care when results from measures indicate that care is needed outside the provider's scope of practice - How will you ensure that all providers are trained on clinically appropriate follow-up when scores/items require intervention?	*We recommend doing this within 45 days of beginning to develop your plan.*			

Roles/Tasks	Actionable Items/Examples*	PLAN (INCLUDING TIMEFRAME)	Who's in Charge?	Current Status/Potential Barriers/Notes	Metrics and How you define success for each item
J. ACT: Determine Clinical use of MBC	• After sharing with the Veteran, how will providers use data to promote shared decision-making and individualize treatment in this particular setting? (e.g. reviewing graphs, motivational enhancement discussions, adaptive treatment planning, linking to other sources of clinical data, discussing symptom change in context of Veteran's identified goals, facilitating discussions about level of care decisions, etc.) • **How will shared decision making be documented in the chart to reflect the Veteran's understanding of the scores and how these data influenced treatment planning?**	*We recommend doing this within 45 days of beginning to develop your plan.*			
H. PROGRAM EVALUATION: Determine how data will be aggregated and how aggregate data will be used	How will you **use** MBC to evaluation your PCMHI program? • Determine what measures will be aggregated and what time points will be reviewed (e.g., baseline, during treatment, discharge, post discharge). • Determine how data will be extracted and aggregated. What tools are available to support aggregating data? • How frequently will aggregate data be reviewed? • At what level will aggregate data be reviewed and shared (team, clinic program, facility, VISN)? • What staff will participate in review of aggregate data? • What role will data play in quality improvement efforts?	*We recommend doing this within 60 days of beginning to develop your plan, but you may want to return to this item after implementation starts and you get a better sense of the potential benefits of MBC for your program.*			

please see the MBC SharePoint for all additional resources

Appendix B-3. Implementation Planning Guide Template for EBPs
Steps for Implementing Evidence-Based Psychotherapies (EBPs)

Implementation Step		Decision	Action Item
Step 1	**Determine overarching program structure** • Create a separate EBP clinic with EBPs targeting multiple conditions coordinated with a separate point of entry • Incorporate EBPs into existing clinic structure, providing other treatments • Both a stand-alone EBP program and EBPs embedded in existing clinics • Determine selection criteria for clinicians to receive EBP training to maximize EBP implementation (e.g., select providers who are interested in participating in EBP training/consultation and who spend a significant proportion of their time providing psychotherapy to the patient population targeted by the EBP, e.g., at least 50%; etc.) • Develop local consultation options to support EBP therapists • Develop flow map of the current patient flow related to EBPs if one is not available, and determine an ideal flow map if it is determined that changes are needed. • Other		

Step 2	**Identify starting target population(s):**
	• Disorder specific or not
	  ○ Symptom assessment of target population
	  ○ Focus on EBPs for certain conditions only (e.g., PTSD, Depression, SMI, etc.)
	• Other EBPs offered (Family therapy, SUD, insomnia, etc.)
	• Patients targeted by performance measures, OEF/OIF/OND, patients on waiting lists, etc.
	• Patients new to MH based on target population
	• Existing MH patients who have requested EBPs
	Note: Ensure that EBPs are not denied to Veterans who request them, even if they are not in the targeted starting population		

Implementation Step		Decision	Action Item
Step 3	**Identify possible exclusion criteria and method for assessing criteria (Based on the target starting population, are there any exclusion criteria you are going to consider?):** • Co morbidities • Sub-threshold disorders • Acute or high risk suicidal or homicidal ideation • No exclusion for initial consultation and triage visit • Other		
Step 4	**Specify how patients are referred:** • Referred by PCP • Referred by PCMHI • Referred by specialty mental health • Patients currently enrolled in specialty care programs • After completion of psychotherapy preparation • Through an intake and education program • Consult process that meets the new consult requirements • Referral process within the same Clinic (consult not required, will one be used?) • Other		

Step 5	**Education for Referral Sources:**
	• Education process
	  ○ Written materials
	  ○ In service presentations
	  ○ Team meetings
	  ○ Other
	• Information provided
	  ○ Description of EBPs offered
	  ○ Target populations
	  ○ Exclusion criteria
	  ○ Referral process
	  ○ Communication plan
	  ○ Appropriateness of referral (shaping)
	  ○ Treatment results
	  ○ Other		

Step 6	**Intake Process:** • Previous provider diagnosis		

Implementation Step		Decision	Action Item
	• Chart review • Intake evaluation • None • Process for screening and managing inappropriate referrals • Other		

Step 7	**Specify treatment process:**
	• EBP orientation process? (How will you ensure this process meaningfully engages Veterans in care and does not become merely a "warehouse" for referrals if access is backed up?)
	  ○ Psychoeducational/Motivational Group
	  ○ Individual
	  ○ Include family members?
	  ○ Number of sessions?
	  ○ Required or optional and method for deciding
	• Specify EBP(s) provided
	  ○ Cognitive Behavioral Therapy (CBT)- Depression
	  ○ ACT for Depression
	  ○ IPT
	  ○ PE
	  ○ CPT
	  ○ Social Skills Training
	  ○ Other
	• Format for provision of EBPs
	  ○ Individual
	  ○ Group
	  ○ Combined
	  ○ Tele Mental Health
	• Clinical assessment tools:
	  ○ Symptom severity for target condition
	  ○ Suicide risk
	  ○ Psychiatric comorbidity
	  ○ Adherence
	  ○ Side-effects
	  ○ Quality of life indicators
	  ○ Other
	• Guidelines for completing EBPs:
	  ○ Length of time enrolled
	  ○ Patient preference
	  ○ Provider assessment		

Implementation Step		Decision	Action Item
	○ Treatment response and how measured? (e.g., PCL, BDI-II, PHQ-9, etc.) ○ Non-response to treatment (how will this be defined?) ○ Maximal improvement reached (how will this be defined?) ○ Other		
Step 8	**Scheduling** • Frequency ○ Weekly ○ Other? • Who controls scheduling ○ Provider ○ Other? • Scheduling Process ○ 30 minute default increments to allow for 30-120 minute sessions? ○ Schedule entire course of weekly EBP sessions prior to initiating treatment? ○ Other		
Step 9	**Communication with other providers while Veteran is engaged in EBP:** • Targeted Providers: ○ Mental Health Treatment Coordinator (will EBP provider become MHTC?) ○ Primary Care provider ○ PCMHI providers ○ Group therapists ○ Prescribing Provider ○ Other • Communication method: ○ Cosigned notes ○ Team meetings ○ Coordination with Vet Centers ○ Other		
Step 10	**Process for transferring Veterans who have completed EBP episode of care:** • Referral to PC – obtain and review Service Agreement between MH and PC • Referral to specialty mental health for medication maintenance		

Implementation Step		Decision	Action Item
	• EBP after care groups? • Referral to Vet Center • Referral to Peer Support • What will be the re-entry procedures for Veterans who need an additional EBP episode of care? • Other		
Step 11	**Specify options to increase EBP capacity through panel management:** • Referral to EBP • Referral to non-EBP preparatory group • Referral to peer support group • Refer to community resources • Refer to Vet Centers • Other		

Step 12	**Identify or develop implementation tools:**
	• Person responsible for monitoring implementation:
	  ○ Local EBP Coordinator
	  ○ Other
	• Measuring utilization of EBPs (e.g., local tracking tools, CPRS EBP templates)
	• Reporting implementation outcomes -
	• Content (MH utilization, number of patients served, clinical outcomes, performance measures, patient satisfaction, etc.)
	• Identify EBP champions (by Clinic or EBP) to assist with education and implementation
	• Other		

Step 13	**Education:**
	• Audience
	  ○ Veterans
	  ○ Family Members
	  ○ Veteran Service Organizations
	  ○ Community
	  ○ Mental Health and Other Services – e.g., Primary Care (What you are doing with EBPs and why? Help promote understanding about any exclusion criteria and episodes of care model)
	  ○ Press
	  ○ Others
	• Type of education products		

Implementation Step		Decision	Action Item
	○ Marketing products ○ Brochures ○ Posters ○ Presentations ○ Videos ○ Other • Education Location ○ PC Clinics ○ MH Clinics ○ Other		

Appendix B-4. PCMHI Implementation Planning Guide Example - Steps for Implementing Collaborative Care Models

Implementation Step		Decision	Action Item

Step 1	**Specify possible target patients and identification procedures:**
	• Patients referred by PCP(warm hand offs)
	  ○ 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
	  ○ Patients referred for brief interventions for anxiety and depression
	  ○ 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 PCMHI 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 ongoing services	• 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.	

Implementation Step		Decision	Action Item
	• Other	• 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.	
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
	  ○ Functional assessment
	  ○ Triage and consultation
	  ○ Brief interventions (e.g., 1-4 sessions for multiple concerns)
	  ○ Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management)
	  ○ Stress management
	  ○ Sleep hygiene
		• [Name], ICP, will conduct functional assessments.
		  ○ Triage and consultation
		  ○ Brief interventions (e.g., 1-4 sessions for multiple concerns)
		  ○ Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management)
		  ○ Stress management
		  ○ Sleep hygiene
		  ○ Relaxation training
		  ○ Other
		• Primary Care Providers:
			• 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.

Implementation Step		Decision	Action Item
	○ Behavioral interventions for chronic pain ○ Lifestyle interventions for chronic conditions (e.g., diabetes) ○ Relaxation training ○ Other • Primary Care Providers: ○ Screen for target condition ○ Diagnose target condition ○ Prescribe medication ○ Refer to collaborative care team ○ Refer to specialty mental health ○ Educate PCPs ○ Participate in education activities ○ Other • Care Managers: ○ Symptom assessment of target condition ○ Education and activation ○ Treatment preference assessment ○ Treatment barriers assessment ○ Psychosocial assessment ○ Self-management goal and activity setting ○ Brief counseling (e.g., problem-solving therapy) ○ Psychiatric comorbidity assessment: – Schizophrenia – Bipolar Disorder – Substance misuse – PTSD – Panic Disorder – Generalized Anxiety Disorder – Sleep Disorders – Pain	○ Screen for target condition ○ Diagnose target condition ○ Prescribe medication ○ Refer to collaborative care team, including co-located provider ○ Refer to specialty mental health ○ Educate PCPs ○ Participate in education • [Name], ICP, to provide care management function. • 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.	• MH to provide this schedule to PC, so that PCPs know who they should contact.

Implementation Step		Decision	Action Item
	– Other ○ Management of comorbid conditions: – Substance misuse (mild, moderate) – PTSD (mild, moderate) – Panic Disorder – Generalized Anxiety Disorder – Sleep Disorders – Pain – Other • Symptom monitoring for target conditions • Medication adherence monitoring ○ Side-effects monitoring ○ Counseling adherence monitoring ○ Self-management monitoring ○ Other • Care Manager Psychiatric Supervisor: ○ Train collaborative care team ○ Supervise collaborative care team ○ Educate PCPs ○ Assess difficult cases presented by collaborative care manager ○ Provide treatment recommendations to PCPs ○ Provide consultations (by appointment and/or curbside) ○ Accepts referrals ○ Other		
Step 5	**Specify treatment guidelines:** • Specify protocols for stepping up the intensity of care for patients failing treatment. • Guidelines for referral to specialty mental health: ○ Patient preference	• Co-located, collaborative providers will see patients for ~5 sessions and then will refer to specialty care, as treatment needs are above and beyond scope for ICP.	• Copy of service agreement to be provided by [name].

Implementation Step		Decision	Action Item
	○ Treatment resistant ○ Severity of illness ○ Suicide risk ○ Psychiatric comorbidity ○ Non-response ○ Non-adherence • Guidelines for dis-enrolling patients: ○ Length of time enrolled ○ Number of failed trials ○ Increases in symptom severity or comorbidity ○ Treatment response • Medication management algorithm (formulary adjustments)		
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: ○ Symptom severity for target condition ○ Suicide risk ○ Psychiatric comorbidity ○ Adherence ○ Side-effects • PCP brochures & educational materials • Brochures and educational materials for patients • Training materials for collaborative care team • Job descriptions and scope of practices for depression care team members	• 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.

Implementation Step		Decision	Action Item
	• Establish clinic names and codes • Standards for assigning diagnoses, CPT codes, etc. • Consult forms/procedures • Other		

APPENDIX C. STAKEHOLDER TRACKING TOOL EXAMPLE

[Project Name]: Who's Who?

Facilitator: [Name] [phone number] [phone type: cell/office]

Stakeholders	[Name of clinic] [Facility Location (if different)]	Name of clinic] [Facility Location (if different]
Facility (VAMC) Telehealth Coordinator (FTC)	[Contact Name]: [Contact Phone Number]: [Contact Email] [Role/Duties] [Notes]	[Contact Name] [Contact Phone Number] [Contact Email] [Role/Duties] [Notes]
Telehealth Clinical Technician (TCT)		
VAMC Chief of MH		
CBOC Medical Director over Mental Health		
Business Office Chief		
Medical Support Assistant (MSA) Supervisor for Primary Care		
MSA supervisor for Mental Health		
MSAs		
Clinical Champion		
Other CBOC Point of Contact		
VISN Leadership		
Primary Care Leadership		
Union Reps		

Stakeholders	[Name of clinic] [Facility Location (if different)]	Name of clinic] [Facility Location (if different]
Specialty Mental Health		
PCMHI Team		
Other Support		

Instructions: The purpose of this tool is to keep track of stakeholder roles, names, and contact information. This is especially useful for projects with many stakeholders and/or many sites. As you learn about or meet stakeholders, track them in your tool to remember "Who's who" – you might find a digital application or spreadsheet is easier for you to track this information. You should track any other relevant information about their preferences for contact or upcoming changes in "Notes," such as if someone is retiring soon or shares their personal cell phone number with you to be used only for urgent issues. This tool can become a staple for facilitators, ensures the right people are involved and not missed, and also supports a dual facilitator team or effort should one facilitator need to transfer facilitation to a new facilitator.

APPENDIX D. OUTLINE OF INITIAL FACILITATION CALL WITH MENTAL HEALTH LEADERSHIP

Part of Site Recruitment Process
VA Office of Mental Health & Suicide Prevention (OMHSP)
Evidence-Base Psychotherapies (EBPs) Facilitation Initiative

- Thank the site for their interest.
- Facilitation is evidence-based.
  - Facilitation represents an intensive service to provide support for site level implementation of complex and challenging programs.
  - Often, directives and education are not sufficient for program implementation to be successful.
  - The challenge is how to not only implement the program at a bare minimum level, but how to do so in a way that works for the site and results in true improvement. The goal is to make things better for your site, not make it worse.
  - Facilitation was first developed to assist sites with PCMHI implementation. The model was developed by implementation science experts at MH-QUERI and was successfully piloted in three networks. The results will be coming out in publication soon. This is an evidence-based model.
  - Because of the success observed with assisting sites with PCMHI implementation and our observation from the OMHSP site visits that EBP implementation is an area of potential growth at many sites, OMHSP adapted the facilitation model to assist sites with EBP implementation.
  - We want to acknowledge that this is a relatively new program; however, we have piloted it with three sites and are receiving positive feedback and observing really good outcomes.
- Facilitation Process
  - Your site would receive assistance from an EBP implementation expert trained in the facilitation process for a period of up to 6 months.
  - The process begins with discussions and data gathering that help us understand your site as a whole, your EBP implementation goals and challenges, and what has already been working well for your site in this area.
  - We will schedule a one-day site visit. This is not an evaluative visit that will lead to required action plans. Our goal would be to gain a thorough understanding of what your site already has in place and what are the challenges that need to be addressed in order for your site to reach your implementation goals.
  - During the visit, we would meet with Facility Leadership, MH and Program Leadership, and frontline staff involved with EBP implementation. We will provide education and also involve multiple stakeholders in a dialog that will begin the process of your facility developing your EBP implementation plan.

  - Following the visit, we will provide a brief report to you and your leadership that summarizes the visit, our observations, and broadly outlines the steps for moving forward with implementation.
  - The facilitation expert will work with an internal facilitator at your site as the individual who will guide the implementation process at your site. This should be an individual with inside knowledge who can also assist with logistics (e.g., reserving rooms for the meetings). The facilitation process requires some dedicated time in order to be able to do it well, including time to plan and execute the implementation activities, as well as monitor and lead the overall implementation effort. We estimate this would require about 10% effort.
  - For EBP implementation, we are suggesting that the Local EBP Coordinator who is already in this role at your facility, be the internal facilitator. Would you agree or would you have any concerns about this?
  - Following the EBP visit, we would schedule calls with the internal facilitator to assist with monitoring the implementation plan progress, assist with development of outcome measures, and help problem solve around any barriers that are encountered. Initially, these calls will occur weekly or bi-weekly but over time, the EF will mentor and coach the internal facilitator to take more and more of the lead, and as implementation progresses the calls may be reduced to monthly.
  - Any questions and concerns about the process?

- Acknowledge this is a relatively new program and we will ask for their feedback and suggestions about how we can make this program as helpful as possible to their site and other sites.

- Initial data gathering:

  - Do they have a Local EBP Coordinator? Does that person have the dedicated .3 FTE and will they be able to fully participate in the facilitation process?
  - What does their capacity look like in terms of trained staff?
  - Their general perceptions about their EBP implementation – things that have gone well and challenges?
  - What are their goals for EBP implementation?
  - Is there anything else we need to know about before starting the next phase?

[If indicate interest]

- We know that you are very busy. What would be the best way for us to reach you?

- The next step will be for our Office to email your facility Director with an official offer of the facilitation assistance. We will be able to start the process with you once we get an affirmative response.

  - Would you like to discuss with your facility Director first and then let us know when we should send that communication? Feel free to share the Facilitation Fact Sheet we sent you.

- Once we hear back from your Director, we will contact you to schedule a call with you and the Local EBP Coordinator, as well as anyone else you would like to include, to get more information about your site and EBP implementation goals and needs. [If LEBPC not on this first call – acknowledge that we may need to repeat some of the information about the facilitation process to bring them up to speed]

APPENDIX E. SITE VISIT RESOURCES

Appendix E-1. Pre-Site Visit Facility Assessment Call OMHSP Evidence-Base Psychotherapies (EBPs) Facilitation Initiative

Site Visit _____

Introductions

** Who's on the call and brief introduction (if needed).

** Thank the facility for their willingness and interest.

** Purpose of the call today: For us to get a better understanding of where you are in implementing EBPs. Also, what needs do you have and how can we help you improve the functioning of those programs?

Explain the facilitation process:

We will come to do a site visit (previously sent a draft agenda and will work with you to finalize it – we can modify it to meet your needs), it is a one-day visit. We start by meeting with your facility leadership to tell them about EBPs and needs for implementation. Then meet with MH Managers and program staff that might be involved in or affected by EBP implementation to educate them about the same issues around EBPs. If you feel it would be helpful for us to have separate educational sessions for management and staff, we can arrange that. Then we have a lengthier meeting with a group consisting of MH Leadership, Program Leads, clinicians doing EBPs, etc. and go through an implementation checklist. As a group, we will work through some of the different decisions that might help make the program more efficient. The questions are based on interviews with key informant sites that have high functioning EBPs programs. They are designed to help you determine what you would like your program to look like. We work with you to create an action plan based on your goals and decisions and will continue to follow up with the Internal Facilitator by phone to see how it is going and to continue providing ongoing assistance and connect in you with consultative resources – initially weekly or bi-weekly, then progressing to monthly as the internal facilitator takes an increasingly active role. We will be working closely with your Local EBP Coordinator who is already in the role of supporting EBP implementation at your facility. This process usually lasts for up to 6 months, depending on how quickly you are progressing towards meeting your goals.

Questions:

- How many unique Veterans does it serve?
- How many unique Veterans are engaged in specialty mental health care?
- How is your specialty mental health care organized (e.g., Service Line, Disciplines, etc.)? Request that they send a copy of their current org chart.

- How many provider FTEE do you have in specialty mental health? Do you feel that you are appropriately staffed?
- Do you have a PCMHI program? How is it staffed?
- Do you refer to Vet Center(s)? If so, what kinds of services are typically available at the Vet Center and when would you refer?
- Any academic affiliations?
- How patient flow is organized in MH across the system?
  - What is the general treatment model (e.g., long-term vs. short term, group vs. individual)?
  - Where are EBPs placed in that flow?
  - Do they have a patient flow map and if so, could they send it? [if they don't have one, we could help them develop one as part of the facilitation if that would be helpful]
- Could ask Local EBP Coordinator to email later:
  - Which EBPs are available?
  - To what degree are EBP trained providers able to provide those EBPs?
  - Approximately how many patients are seen in EBPs per week?
  - How many fully trained EBP providers (including completing consultation) do you have on staff?
  - Do you have any EBP trainers available at your facility and/or the network?
- How are Veterans educated about EBPs and how are referrals made?
- What is the process for clinicians to schedule EBP visits?
- Who have been your strongest advocates, either leadership or providers, for EBPs?
- What have been your experiences in implementing EBPs thus far?
  - Barriers
  - Facilitators
- What are your goals for your EBP program?
- What do you already have in place that is working well?

Discuss EBP Visit Logistics:

- Target date for the visit (or confirm if already established) [Start by discussing the general time frames you would be available and ask the site about preferences. Also be sure to communicate that our program will be as flexible as we can to accommodate their scheduling preferences if these times are not good for them]
- POC from the facility to coordinate details for the visit?

Appendix E-2. Preparation for Site Visit – Pre-Meeting Checklist

Meeting Space (if meeting is taking place in-person)

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?

   ___Computers

   ___Projector

   ___Access to presentations (including multiple back-ups)

   ___Video Conferencing

   ___Speaker Phones

   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 ___AV Equipment (if not provided by site)

___Handouts ___List of Attendees ___Directions to Site

___Issues to Address ___Phone numbers ___Notes

___Laptop

Appendix E-3. Facilitation Site Visit Agenda

OMHSP Evidence-Base Psychotherapies Facilitation Initiative

Time	Location	Meeting	Suggested Attendees*
8:30 – 9:00 a.m.		Entrance Briefing	• Facility Leadership • Mental Health Leadership
9:00 – 9:15 a.m.		Break – set up for next session	
9:15 – 10:30 a.m.		Overview of Evidence-Based Psychotherapies in VA and the Facilitation Process for Leadership and Staff	• Mental Health Leadership • Clinic Leadership • Local EBP Coordinator • EBP clinical staff • Other Stakeholders
10:30 – 10:45 a.m.		Break	
10:45 a.m. – 12:00 p.m.		Implementation Meeting • Review and complete the implementation checklist.	• Mental Health Leadership • Local EBP Coordinator • Key Stakeholders (Mental Health AO, Leads or Managers of Clinics involved with EBP delivery, Clinical Staff delivering EBPs, etc.) • Clinic set-up and scheduling Staff (e.g., Clinic scheduling staff) • Other Stakeholders
12:00 – 1:30 p.m.		Lunch and facilitation team preparation for afternoon sessions	• OMHSP Facilitation Team

Time	Location	Meeting	Suggested Attendees*
1:30 – 2:30 p.m.		Implementation Meeting (Continued from the morning session) • Review and complete the implementation checklist. • Develop plan for full implementation.	• Same suggested Attendees as Implementation Meeting – morning session
2:30 – 3:30 p.m.			• If requested, individuals may follow up with the Facilitator for consultation or to discuss additional implementation issues. Otherwise, the Facilitator will prepare for the exit briefing.
3:30 – 4:00 p.m.		Exit Briefing	• Facility Leadership • Mental Health Leadership

Appendix E-4. Site Visit Entrance Briefing Slides
OMHSP Evidence-Base Psychotherapies Facilitation Initiative

Slide 1

Evidence-Based Psychotherapy Implementation

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Slide 2

Evidence-Based Psychotherapies Help Veterans Recover

- The EBPs currently being disseminated in VA address a number of the mental and behavioral health concerns experienced by Veterans.
- Supported by efficacy and effectiveness studies including those conducted in VA populations, whenever possible.
- In 2007, VACO Mental Health Services launched an EBP dissemination and training program which was one of the largest ever organization-wide EBP implementation efforts and it continues to grow.

Slide 3

EBP Implementation and Quality of Mental Health Care

- Effective clinical outcomes.
- Enhances continuity of care by ensuring Veterans receive an effective dose of psychotherapy.
- Veterans report significant satisfaction with reduction in symptoms and enhanced quality of life following EBP treatment.
- Enhances clinician satisfaction and reduces burnout.

Slide 4

Dissemination and Implementation of EBPs in VA

- As of the end of FY14, over 10,700 VA clinicians have been trained in one or more EBPs.
- Clinician training includes an intensive 2 – 4 day workshop, after which the clinician provides the therapy while receiving weekly consultation from an expert.

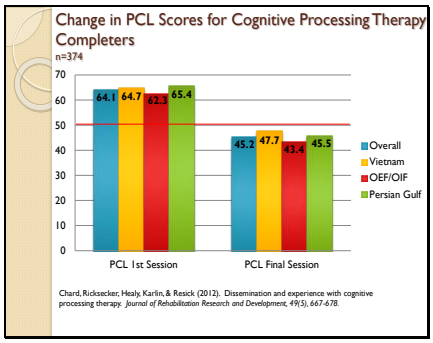
Slide 5

EBP Implementation Requirements and Measurement in VA

- Uniform Mental Health Services Handbook requires that all Veterans with PTSD, depression, or serious mental illness should be offered the option of receiving EBPs for the following target conditions and must have access to these EBPs, if desired.
- Mandatory CPRS progress note templates to document EBP delivery have been deployed nationally to improve local and centralized measurement of EBP delivery.
- A national EBP template utilization dashboard is currently available and features continue to be added.

Slide 6

Slide 7



Slide 8

EBPs Can Change Veterans' Lives

- "Quite frankly it's one of the best things that I could have put myself through."
- "I used to go through life just going through the motions, now I'm getting a chance to experience life."
- "I have hope again."

Slide 9

Evidence-Based Psychotherapies are Cost Effective

- Prolonged Exposure Therapy (Tuerk et al., 2012)
  - 45% reduction in subsequent mental health service utilization in Veterans who completed Prolonged Exposure Therapy for PTSD
- Cognitive Processing Therapy or Prolonged Exposure Therapy (Meyers et al., 2013)
  - 32% reduction in mental health utilization during the year following treatment, compared with the year prior to treatment.
  - 39% reduction in cost/Veteran, with an average of $5,173 in the year prior to treatment compared with $3,133 in the year following treatment.

Slide 10

Evidence-Based Psychotherapies Can Increase Access

- Clinician A sees 4 unique Veterans for monthly supportive therapy in the same weekly appointment slot. The same Veterans are seen for years.
- Clinician B sees one Veteran weekly for EBP sessions. A new Veteran is seen in the appointment slot when the Veteran completes the EBP. Each year, 3 – 4 unique Veterans are seen in the same weekly appointment slot.
- During 3 years, Clinician A will see the same 4 unique Veterans. Clinician B will see 9 – 16 unique Veterans in the same appointment slot.

Slide 11

EBPs are Challenging to Implement

- Full implementation of EBPs can require a significant system redesign in order to create capacity.
- EBP delivery represents a significant shift in approach to treatment for some clinicians, Clinics, and Veterans.
- Access to EBPs (a time-limited but intensive treatment) must be balanced with initial access for mental health evaluation for an increasing number of Veterans seeking services.

Slide 12

Facilitation

- Acknowledges that while research evidence is important, clinical experience and professional knowledge directly affect adoption.
- 6 month process
- Bundles an integrated set of interventions
  - Which intervention is applied varies based on the needs of the facility
  - Builds upon program/practice educational efforts

Slide 13

Facilitation of EBPs

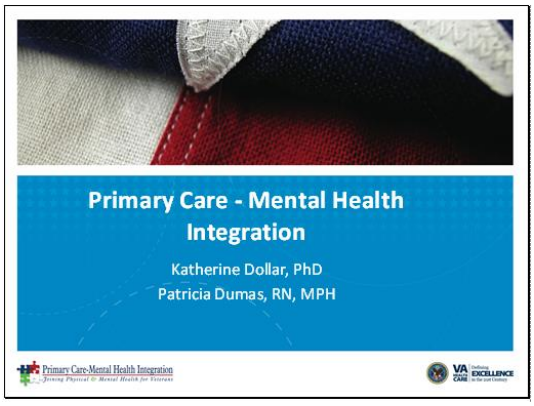
- Includes the involvement of multiple stakeholders in the design of the EBP program
- Provides support from a facilitator that is expert in EBPs and the implementation process with direct linkage to the Local EBP Coordinator
- Provides ongoing support through the implementation process to identify barriers and help develop solutions to overcoming them

Slide 14

- Questions?

Appendix E-5. Stakeholder Education Overview Presentation (PCMHI)

Slide 1

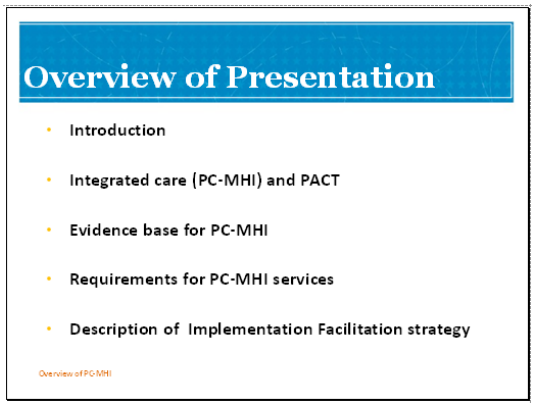


Slide 2

Site Visit Agenda

Time	Location	Meeting
08:30 – 9:00 a.m.	Director's Boardroom	Entrance Briefing • Provide overview of PC-MHI and the facilitation process to facility leadership
9:00 – 10:00 a.m.	M9-280	Overview of PC-MHI and Facilitation • Opportunity to educate staff with general overview and national data • Explain facilitation process
10:00 – 10:15 a.m.		Break
10:15-12:00	M9-280	Implementation Meeting • Review and complete the implementation checklist • Develop plan for full implementation
12:00 p.m. -1:00 p.m.		Lunch and prep for afternoon
1:00-2:00 p.m.	M9-280	Overview of PC-MHI and Facilitation (repeat of morning session)
2:00 – 2:30 p.m.		Tour of primary care clinics
2:30 – 4:00 p.m.	M9-280	Individual Meetings (if requested) • If no requests for individual meetings, prep for exit briefing
4:00 – 4:30 p.m.	Director's Boardroom	Exit Briefing

Slide 3



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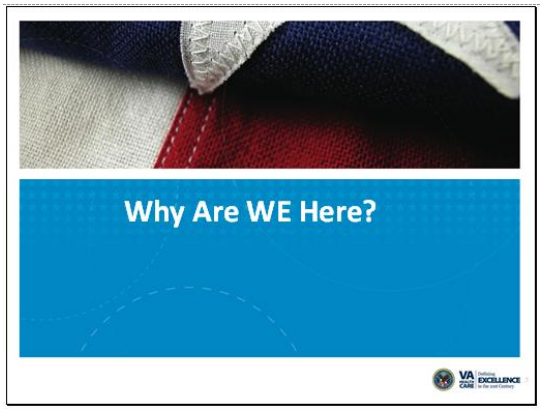

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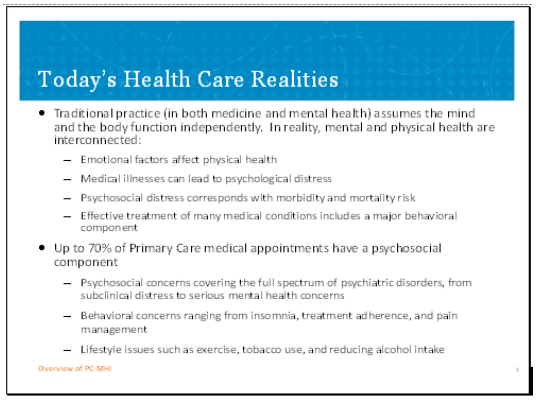

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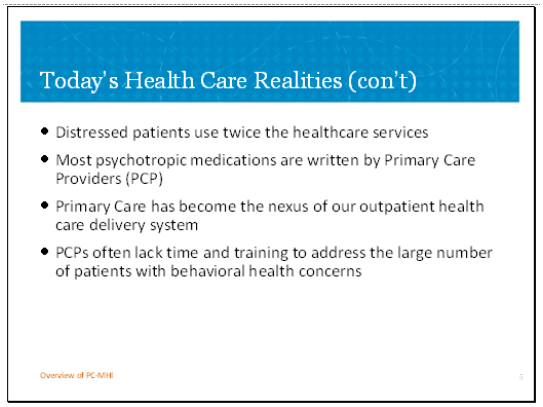

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"Primary care practitioners are a critical link in identifying and addressing mental disorders... Opportunities are missed to improve mental health and general medical outcomes when mental illness is under-recognized and under-treated in primary care settings."

-Former Surgeon General David Satcher

"The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated."

-Plato

Slide 8

What to do? Integrated Primary Care

- Traditional practice (in both medicine and mental health) assumes the mind and body function independently
- In reality, they are interconnected and we need to be, too:
  - Emotional factors affect physical health
  - Medical illnesses can lead to psychological distress
  - Psychosocial distress corresponds with morbidity and mortality risk
  - Effective treatment of many medical conditions includes a major behavioral component

Overview of PC-MHI

Slide 9

What is Integrated Care?

Integrated Primary Care (known as **Primary Care-Mental Health Integration or PC-MHI** in VHA) is an overarching term conceptually defined as,

A form of care where mental/behavioral health and primary care providers interact in a systematic manner to meet the health needs of their patients.

Integrated Care staff are part of the interdisciplinary PACT and work collaboratively with the PC team to identify and treat patients with common mental and/or behavioral health needs in the PC setting. They function as a key member of the PC team, providing brief assessment, triage, brief interventions, and collaborative management of PC patients.

Overview of PC-MHI

Slide 10

PC-MHI is an Integral Part of PACT

"... the Patient Centered Medical Home will not reach its full potential without adequately addressing patients' mental health needs. Doing so, however, will likely shift responsibility for the delivery of much mental health care from the mental health sector into primary care..."

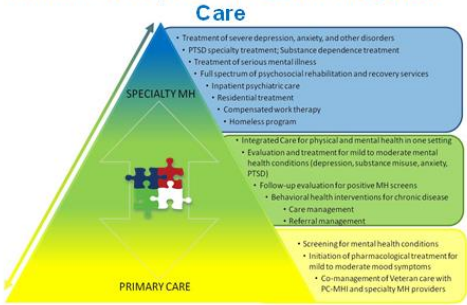
Cioglia TW, Brown JD. Integrating Mental Health Treatment into the Patient Centered Medical Home. AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality, June 2010.

- ✓ Provides support and education for the PACT
- ✓ Supports PCP/teamlet (provide assistance, not a separate plan of care))
- ✓ Provides patient centered, open access, brief treatment
- ✓ Offers a range of services within Primary Care (including brief treatments & care management)
- ✓ Serves as a bridge to specialty mental health services for those who need/want additional treatment

Overview of PC-MHI

Slide 11

The Role of Population Based Integrated Care



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Slide 12

Integrated Care Evidence Base

- Improved **identification**
  - Improved identification of depression, psychiatric co-morbidities and substance misuse (Oslin et al., 2006)
  - Improved identification of depression (Watts et al., 2007)
- Improved **access**
  - Increased rates of treatment (Alexopoulos et al., 2009; Watts et al., 2007; Bartels et al., 2004; Hedrick et al., 2003; Liu et al. 2003; Unützer et al., 2002)
  - Reduced wait times (Pomerantz et al., 2008)

Overview of PC-MHI

Slide 13

Integrated Care Evidence Base

- Improved **engagement** and **adherence**
  - Improved engagement in mental health treatment (Zanjani et al., 2008)
  - Improved engagement and adherence in treatment for depression and at-risk alcohol use (Bartels et al., 2004)
  - Greater antidepressant adherence (Hunkeler et al., 2006; Katon et al., 1999, 2002)
  - Improved no-show rates (Pomerantz et al., 2008; Zanjani et al., 2008; Guck et al., 2007)
- Higher **quality care**
  - Increased probability of receiving guideline-concordant treatment (Watts et al., 2007; Roy-Byrne et al., 2001)
  - Higher patient perceptions of quality of care (Katon et al., 1999)

Overview of PC-MHI 12

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Integrated Care Evidence Base

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  - Improved identification of depression (Watts et al., 2007)
- Improved **access**
  - Increased rates of treatment (Alexopoulos et al., 2009; Watts et al., 2007; Bartels et al., 2004; Hedrick et al., 2003; Liu et al. 2003; Unützer et al., 2002)
  - Reduced wait times (Pomerantz et al., 2008)

Overview of PC-MHI 11

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Integrated Care Evidence Base

- Better **clinical and functional outcomes**
  - Improved short and long term clinical (remission; symptom reduction) and functional outcomes compared to standard care for depression (Alexopoulos et al., 2009; Gilbody et al., 2006; Hunkeler et al., 2006; Katon et al., 2002; Unützer et al., 2002; Roy-Byrne et al., 2001; Katon et al., 1999)
  - Similar remission rates and symptom reduction for depression compared to enhanced specialty referral (Krahn et al., 2006)
  - Decrease in at-risk alcohol use comparable to enhanced specialty referral (Oslin et al., 2006)
  - More rapid clinical response (Alexopoulos et al., 2009; Hedrick et al., 2003)
  - Higher fidelity to integrated care model resulted in better patient response and remission rates (Oxman et al., 2006)
- Increased **patient satisfaction**
  - Pomerantz et al., 2008; Hunkeler et al., 2006; Chen et al., 2006; Areán et al., 2002; Unützer et al., 2002

Overview of PC-MHI 13

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Integrated Care Requirements (per VHA Handbook 1160.01)

- **Two Required PC-MHI Components:**
  - Co-located Collaborative Care:
    - Embedded MH providers working collaboratively with PC team to provide brief interventions and education
  - Care Management
    - Evidence based, algorithmic, longitudinal monitoring, education, and activation for MH conditions (TIDES, BHL)
- **Focus on common conditions:**
  - Depression, anxiety, alcohol misuse, PTSD evaluation

Overview of PC-MHI

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Integrated Care Requirements (per VHA Handbook 1160.01)

- **VAMCs & very large CBOCs (>10K uniques)** need full-time availability of both co-located collaborative services & care management
- **Large CBOCs (5K-10K uniques)** need co-located collaborative services & care management, availability as appropriate
- **Medium-sized CBOCs (1.5K-5K uniques)** need on-site MH services, configured (integrated vs. MH clinic) as appropriate
- **Small CBOCs** need to provide access to MH services

Overview of PC-MHI

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Facility Summary
PC-MH Integration

PC-MHI SERVICE UTILIZATION	FY09	FY10	FY11	FY12	FY13
PC-MHI Uniques	239	635	387	74	14
PC-MHI Encounters	390	938	434	75	15
Individual Encounters (534)	390	938	434	75	15
PC-MHI Average Encounters/ Uniques	1.63	1.48	1.12	1.01	1.07
New PC-MHI Patients	239	625	355	71	14
PC-MHI Penetration	1.0 %	2.7 %	1.6 %	0.3 %	0.1 %
PC-MHI Penetration Numerator	239	635	387	74	14
PC-MHI Penetration Denominator	24,530	23,334	24,926	26,461	24,586

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CCC Compared to Mental Health Specialty Care

	Co-Located Collaborative MH Care	Mental Health Specialty Care
Location	On site, embedded in the primary care clinic	A different floor, a different building
Population	Most are healthy, mild to moderate symptoms, behaviorally influenced problems.	Most have mental health diagnoses, including serious mental illness
Provider Communication	Collaborative & on-going consultations via PCP's method of choice (phone, note, conversation). Focus within PACT.	Consult requests, CPRS notes, Focus within mental health treatment team.
Service Delivery Structure	Brief (20-40 min.) visits, limited number of encounters (avg. 2-3), same-day as PC visit.	Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.
Approach	Problem-focused, solution oriented, functional assessment. Focused on PCP question/concern and enhancing PCP care plan. Population health model.	Diagnostic assessment, psychotherapy and psychopharmacological, individual or group, recovery-oriented care. Broad scope that varies by diagnosis.

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CCC is and includes...
- PACT based
- Joint treatment planning/consultation
- Patient-centered
- Brief encounters (< 30 minutes)
- Measurement-based screening (identification) and assessment (PHQ)
- Time limited, longitudinal care episodes
- Intervention for common mental health conditions (depression)
- Goal-focused
- Focused, targeted documentation
- Crisis intervention

CCC can be...
- Triage and referral management
- Bridge to more intensive services
- Group/Shared visits
- Health behavior interventions
- Telephone contacts
- Patient education and activation

CCC is not...
- Co-located care only
- Long-term psychotherapy
- Open ended
- 50-90 minute appointments
- Lengthy diagnostic assessments
- Intake clinic for specialty MH
- Primary Mental health ED
- Medication management only
- Co-located MH services only
- Extensive documentation

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What is PC-MHI Care Management?

- Evidence-based, algorithmically driven, disease specific services for common MH conditions in PC (including depression, anxiety, and ETOH misuse)
- Provided in collaboration with the PCP and under the supervision of a prescribing mental health provider
- Provided via Translating Initiatives for Depression into Effective Solutions (TIDES), the Behavioral Health Laboratory (BHL), or other evidence-based models approved by the Office of Mental Health Services

Overview of PC-MHI

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PC-MHI Care Management Services

PC-MHI Care Management delivers a **package** of disease-specific services, including:
- Evaluation and triage, usually telephone-based
- Algorithmic, protocol-based treatment support
- Patient activation, education for self-management
- Telephone follow-up including on-going assessment and monitoring of adherence to medication, treatment plan, behavioral activation, problem solving

Overview of PC-MHI

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Principles of Integrated Care in VA

- Open or advanced access
- Problem-focused assessment and treatment: tend to what the Veteran wants tended to
- On-site clinicians in primary care
- Stepped care
- Measurement-based care
- Care management
- Referral management when needed

VETERANS HEALTH ADMINISTRATION

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Examples of Integrated Care Processes

- **Identification**
  - Screening in primary care
  - Pharmacy antidepressant initiation reports
  - Patient request for treatment
- **Assessment and triage to appropriate level of service**

  Possible scenarios:
  - Uncomplicated depression = PCP prescribes antidepressant, mental health care manager monitors, activates, and educates
  - Diagnostic and/or pharmacologic question = co-located collaborative care provider curbside consultation
  - Complicated depression = specialty mental health care
  - Imminent risk of suicide = emergency department or 911

VETERANS HEALTH ADMINISTRATION

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Where Do We Begin?

- Talk about the elephants in the room – CHANGE is hard for everyone!
- Build relationships – break down silos, get to know each other, involve everyone in developing an implementation plan
- Provide education – these are new concepts and for many a new way of providing care
- Work together to develop an implementation plan!

Overview of PC-MHI

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Blended Facilitation

- Process of enabling site level personnel to implement and sustain PC-MHI
- Supported by internal and external facilitators
- Intensive 6 month* program assistance approach

*timeline can be flexible

Overview of PC-MHI

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PC-MHI Resources

- PC-MHI SharePoint
  https://vawww.portal.va.gov/sites/pcmhihub/PCMHI/Pages/default.aspx
  - Links to other Integrated Care resources
  - Announcements & Calendar of Events
  - PC-MHI Document Library
  - PC-MHI Community List & Document Library
- PC-MHI e-mail group
  - e-mail Maureen.Metzger@va.gov to join
- Behavioral Health in PACT listserv
  - email *nicole.mattila2@va.gov* to join
- PC-MHI group on Yammer
  - Sign-up with your @va.gov e-mail address at www.yammer.com

Overview of PC-MHI

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Questions

Overview of PC-MHI

Appendix E-6. Site Visit Report Example (PCMHI)

Date: [Date]

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

Visit Summary: Facilitation Team provided an overview of Primary Care-Mental Health Integration (PCMHI) and discussed current practices as well as plans for upcoming restructuring of PCMHI. 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 ongoing 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.

- 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).

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

- 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.

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

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

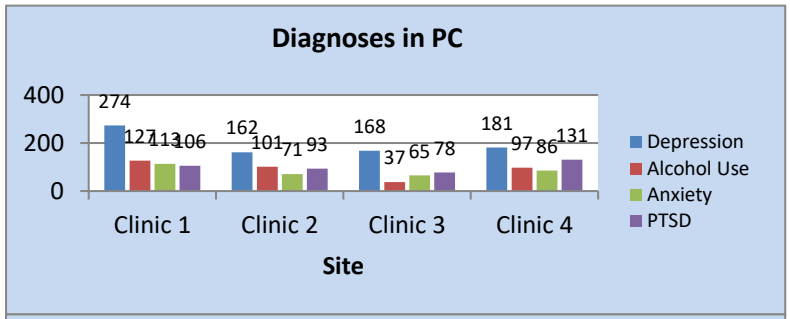
- Internal Facilitator [name] to present outcomes of integrated care at primary care education day [date], with input from External Facilitator [name].

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

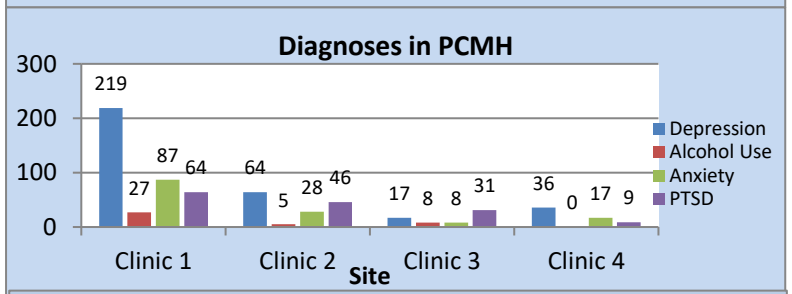
- Consult with local and regional leadership to identify how best to provide care management (inclusion in the role of integrated care provider, through additional site personnel, or through network level providers).

CLINIC SUMMARY EXCEL WORKBOOK - DIAGNOSIS TAB

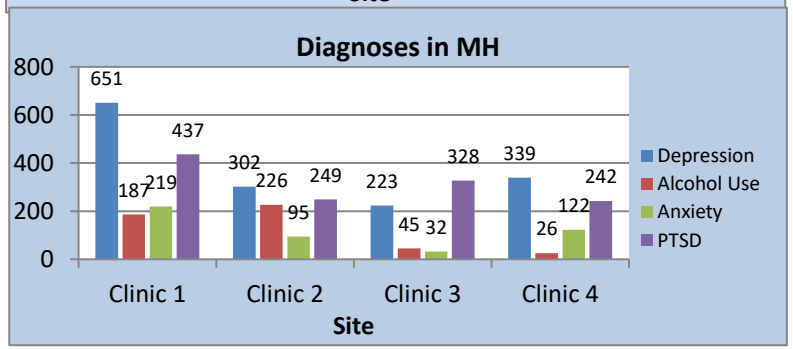
	Diagnosis in **PC** FYXX to Date ([Date] through [Date])			
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	274	162	168	181
Alcohol Use	127	101	37	97
Anxiety	113	71	65	86
PTSD	106	93	78	131



	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



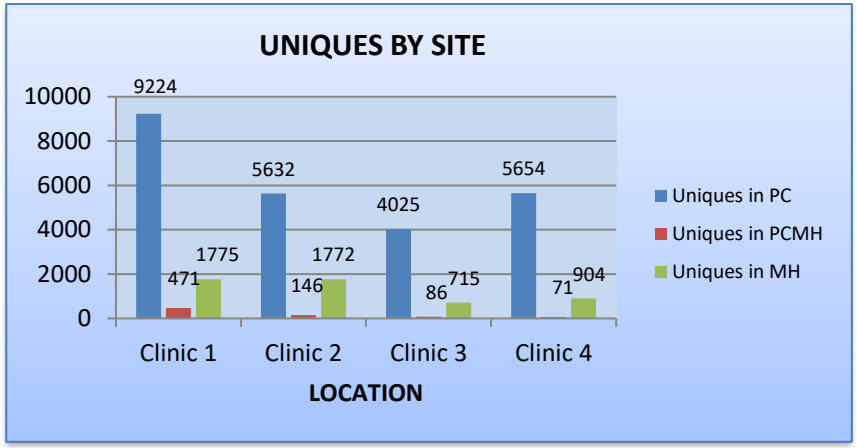
	Diagnosis In **MH** FFYXX to Date ([Date] through [Date])			
Site	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Depression	651	302	223	339
Alcohol Use	187	226	45	26
Anxiety	219	95	32	122
PTSD	437	249	328	242



CLINIC SUMMARY EXCEL WORKBOOK - Uniques Tab

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



CLINIC SUMMARY EXCEL WORKBOOK - STAFF TAB

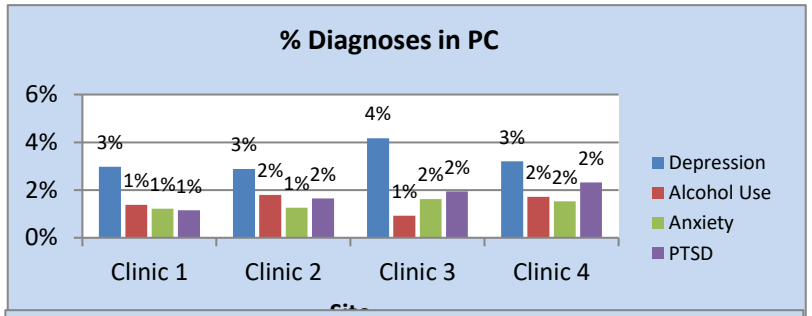
LOCATION OF SPECIALTY MENTAL HEALTH PROGRAMS

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.

CLINIC SUMMARY EXCEL WORKBOOK - DIAGNOSIS BY PERCENT TAB

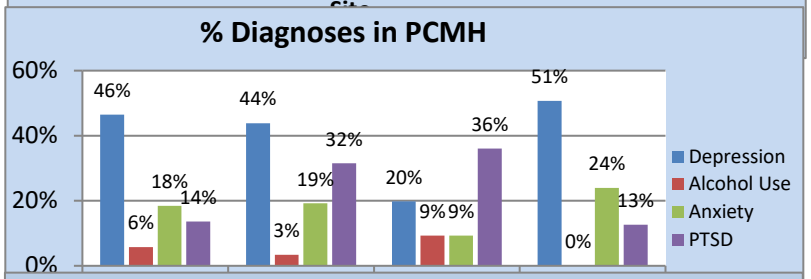
Diagnosis in **PC** FYXX to Date ([Date] through [Date])

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%



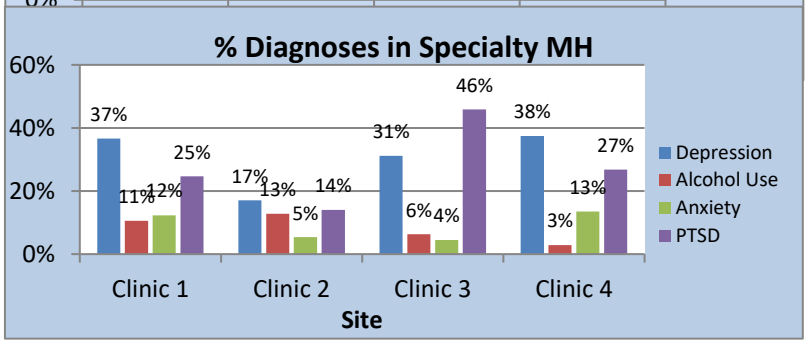
Diagnosis in **PCMH** FY09 to Date ([Date] through [Date])

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%



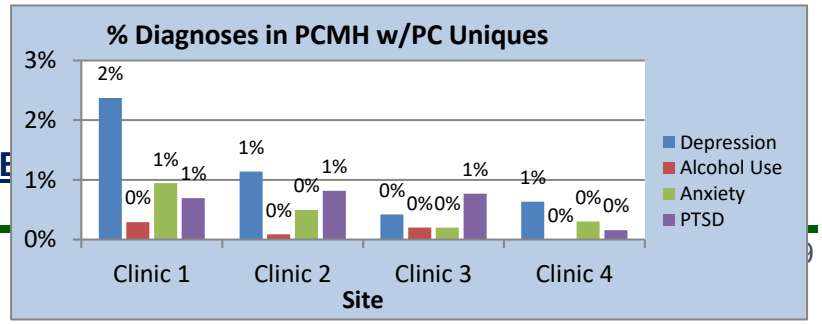
Diagnosis In **Specialty MH** ([Date] through [Date])

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%



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 G. CLINICAL CHAMPION ACTIVITIES AND CHARACTERISTICS

During the project, the site's clinical champion helps lead local implementation efforts and communicates regularly with the external and/or internal facilitator(s) for monitoring of progress and impact of implementation, problem-solving, and adaptation of implementation strategies/tools as needed to maximize potential for success. In carrying out this role, the champion typically will participate on biweekly 30 to 60-minute calls with the facilitator for the first 2-3 months of implementation, and then monthly thereafter until the facilitation intervention ends at 6 months. Characteristics of successful clinical champions would typically include:

- Enthusiastic about leading local efforts to implement the new program or practice, with support of local leadership (leadership support of the champion's efforts is critical to success)
- Well-respected by colleagues and perceived as influential and knowledgeable about the new program/practice and/or clinical treatment of the targeted MH condition
- Resides within the clinical structure of the site or clinic; familiar with the clinic's organizational structure, climate, culture (individuals who are well-established in the organization would usually be strongly preferred over someone relatively new to the organization)
- May have led successful quality improvement or practice change efforts in the clinic in the recent past
- Persistent; goal-oriented; problem-solver

APPENDIX H. PROGRAM REPORT EXAMPLES

Appendix H-1. PCMHI Program Implementation Quarterly Report

Facility: _____ Facilitator: _____

Date of Site Visit: _____

Metric/Source	Location	Baseline (Date)	Q1 (Date)	Q2 (Date)	Q3 (Date)	Q4- Current (Date)
PCMHI Functional Tool: (-Focus on functions not achieving basic level)	Locally Completed as part of Pre-work	-Gaps in Care Management , Same day access, and in PACT team functioning	In progress	Same day access improving	Care management program implemented	All elements met at Basic Level, and some at optimal and desirable
% Recommendations on Implementation plan complete	Locally Completed	All in Progress	25%	25%	50%	75%
PACT 15 (quarterly)	PCMHI Dashboard	4.31%	4.8%	5%%	5.7%	6.8%
% Same Day (quarterly)	Same day Dashboard	12%	12%	15%	22%	27%
# of encounters (quarterly)	PCMHI Dashboard	283	297	311	329	380
Current uniques (quarterly)	PCMHI Dashboard	711	815	820	824	879
Other Improvements (qualitative)	Local Goals		Team Huddles Began	PACT Exam room spaced obtained	Care Management program initiated!	Continue to work on maintenance, program fidelity, and access

Appendix H-2. ASSIST Performance Measures Summary Report

A STUDY OF STRATEGIES TO IMPROVE SCHIZOPHRENIA TREATMENT (ASSIST)
Performance Measures Summary Report
<FACILITY NAME HERE>
<MONTH & YEAR HERE>

Measure 1: High Antipsychotic Doses	**FACILITY NAME**		**Baseline**	
	%	**N**	**%**	**N**
Veterans prescribed AP doses above 125% of recommended range:	7.5	25	7.4	24
Veterans who received APs (total):		333		323

Historical **% of Veterans prescribed AP doses above 125% of recommended range from December 2005 – November 2006:**	11.7% (69/592)

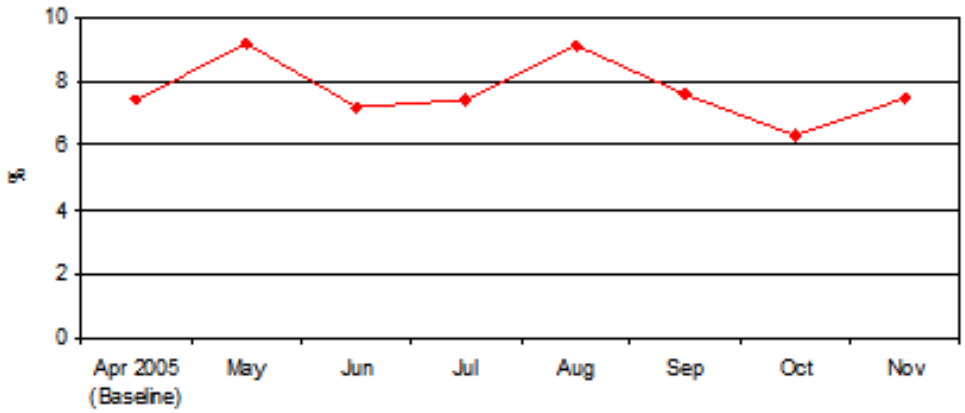
Doses within and above range by medication*:

Medication and Dose Range	aripiprazole 10-30mg	chlorpromazine [illegible]	clozapine 150-600	fluphenazine 2-20	haloperidol 2-20	loxapine 60-100	molindone 50-225	olanzapine 5-25	perphenazine [illegible]	quetiapine 200-800	risperidone 2-8	thiothixene 4-30	trifluoperazine [illegible]	ziprasidone 40-160mg	Totals
Above 125% of Range	1	0	5	0	5	3	0	2	0	0	4	0	4	1	25
Above Range	0	0	6	0	0	0	0	6	0	1	0	0	0	1	14
Within Range	23	9	20	7	23	2	1	55	2	51	96	1	3	24	317
Below Range	1	5	0	1	1	0	0	0	1	9	7	1	0	0	26
Total N	25	14	31	8	29	5	1	63	3	61	107	2	7	26	382

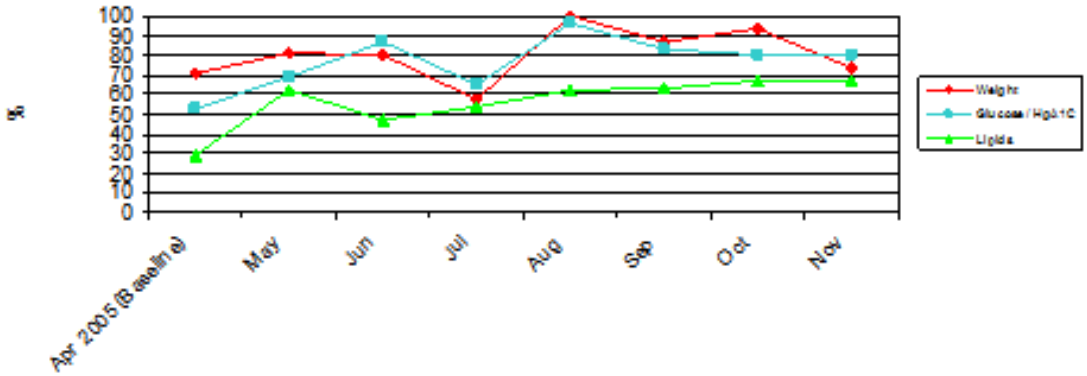
* This table provides information on filled antipsychotic prescriptions during the last month. The N (382) of AP fills is greater than the number of Veterans who received antipsychotics during the month (N=333) because some Veterans received more than one antipsychotic medication. Recommended dose ranges are from VA Clinical Practice Guideline for Psychoses.

Measure 2: Side Effect Monitoring for Veterans Started on New Antipsychotics†	**FACILITY NAME**		**% Change from Baseline**
	%	**N**	
Veterans on new antipsychotic in previous month (total):		30	•
Assessment Window: 30 days before to 30 days after starting a new AP (-30 to +30 days)			
Veterans with ***weight*** recorded:	73.3	22	+2.7
Veterans with ***glucose*** or ***hemoglobin A1C*** recorded:	80.0	24	+27.1
Veterans with ***lipid profile*** recorded:	66.7	20	+37.3
Assessment Window: 90 days before to 30 days after starting a new AP (-90 to +30 days)			
Veterans with ***weight*** recorded:	80.0	24	+3.5
Veterans with ***glucose*** or ***hemoglobin A1C*** recorded:	86.7	26	+16.1
Veterans with ***lipid profile*** recorded:	83.3	25	+30.4

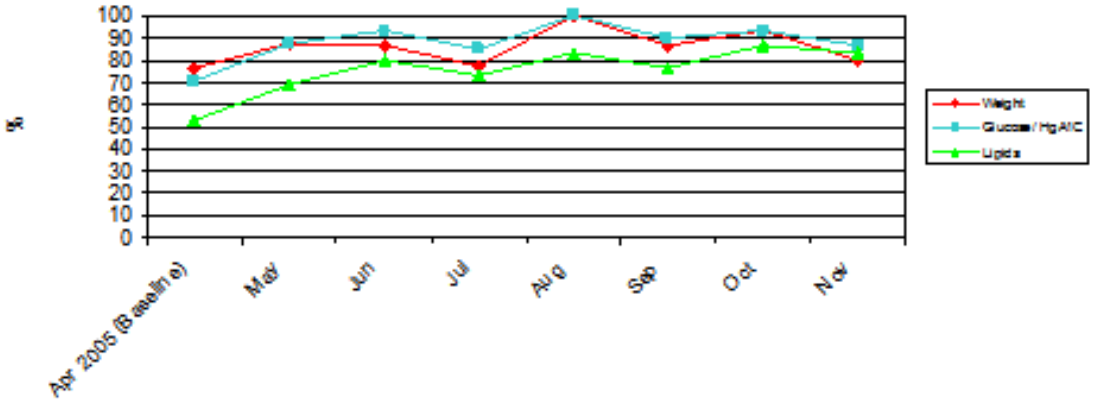
† ASSIST's primary performance measure for assessing completion of side effect monitoring is 30 days before to 30 days after starting a new antipsychotic medication (-/+ 30 days).



Patients with schizophrenia on AP doses >125% of recommended range



Side effect monitoring completed for patients started on new antipsychotics (-30 to +30 day window)



Side effect monitoring completed for patients started on new antipsychotics (-90 to +30 day window)

APPENDIX I. FLOW MAPPING GUIDE

Office of Mental Health Operations

Authors: Jennifer Patterson, Ph.D.; Jessica Gifford, Ph.D.; Erin Zerth, Ph.D.; Matthew Yoder, Ph.D.

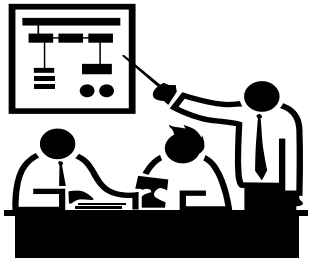
1 PROCESS MAPPING BASICS

"Knowledge is a process of piling up facts; Wisdom lies in their simplification." (Martin H. Fisher)

1.1 What is Flow Mapping?

A flow map is a visual representation of a process and its associated steps.

1.2 Why Flow Map?



Flow mapping is one of many tools used to inform process improvement efforts. Flow mapping helps to:

- capture an accurate visual representation of a process,
- examine a process that may not be meeting expectations,
- examine a process that is exceeding expectations,
- diagnose the barriers and problems that keep a process from working effectively,
- differentiate system “noise” from value-added steps within a process,
- identify areas to target for improvement,
- design improved processes to improve efficiency and program effectiveness,
- ensure that all members of a team have an accurate and shared understanding of the process being targeted,
- shift conceptualization of problems from people to processes instead (as doing so can help create a psychologically safer environment for process improvement efforts).

1.3 Scope

The start and stop points of a flow map are dictated by the process being targeted, and the level of detail needed to support the process improvement effort. For example, is the process being targeted the patient flow within a program (e.g., patient flow within PCMHI)? Or between programs (e.g., referrals from multiple MH programs to EBPs)? Or is it a specific procedure used within a program (e.g., incorporating recovery principles within inpatient groups)?

Additionally, viewpoint should also be considered. For example, a macro level mapping effort may be most appropriate if there is a need to clarify how programs within a service overlap. In that example, the mapping would not include a significant number of details, but would show a general flow and illustrate any major areas of redundancy. The viewpoint would be a “bird’s eye view,” as opposed to a ground-level view.

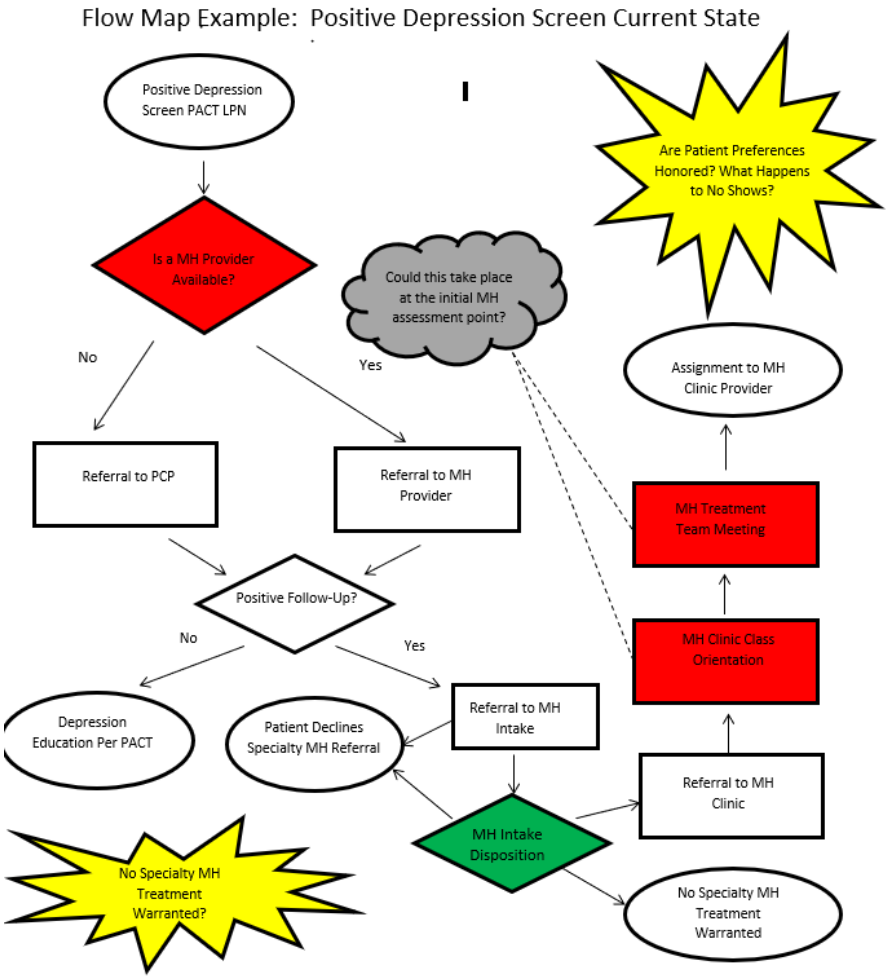
Aim to map at a level of detail that will be sufficient for capturing inefficiencies and highlighting efficiencies. And remember, the point of flow mapping is to inform the process improvement effort (not to become the process improvement effort itself).

1.4 Current State

How well can someone plot a course to a destination when they don't really know where they're starting from? The person could head in a general direction, but that would be inefficient. To have the best chance of reaching a destination in a timely, cost-effective manner, it is best to know where you are now and where you want to eventually arrive.

The "Current State" is the "You Are Here" part of the mapping process. It depicts a process as it is actually or truly operating right now. Accurately capturing the current state of a process

- allows for accurate analyses,
- increases validity and utility of pre- and post- comparisons,
- facilitates a shared understanding of the process by those involved and is the foundation from which change plans can be developed.



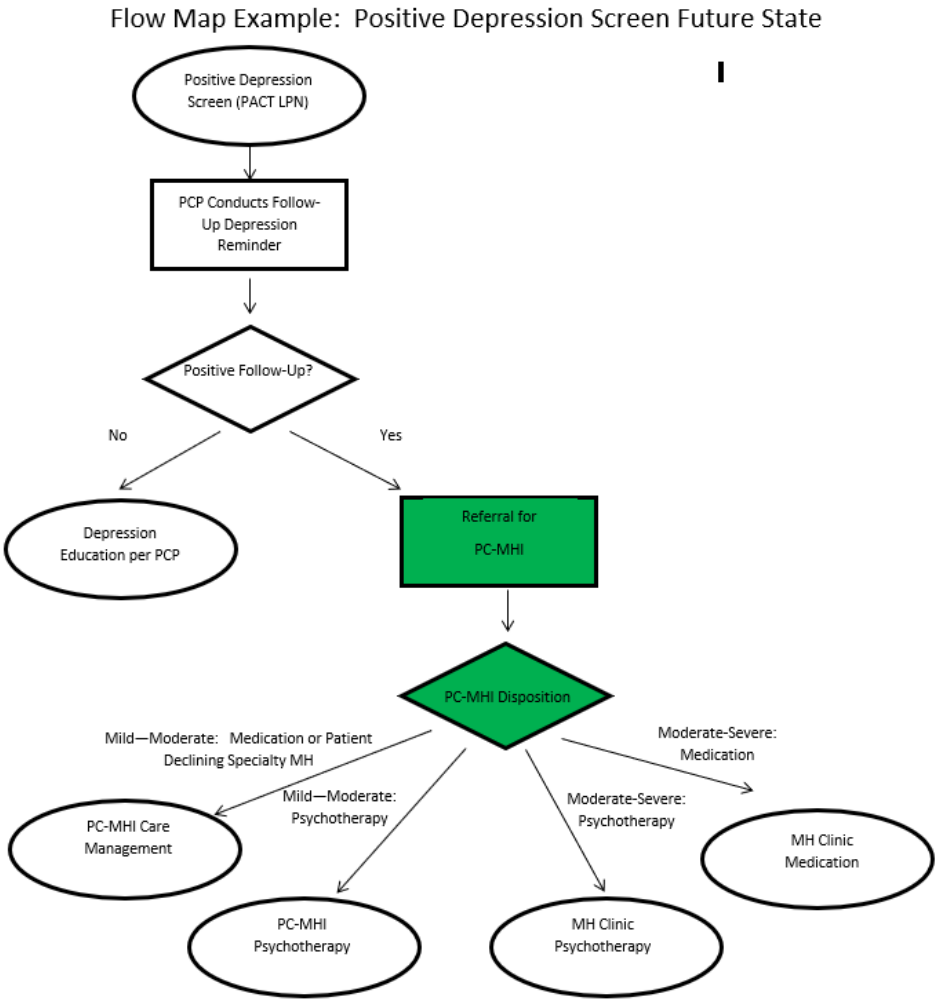
1.5 Future State

The "Future State" flow map represents the ideal process flow. This is the "X marks the spot" portion of the mapping process. It is the treasure being pursued! "Ideal" will mean something different depending on the site, but it is a process state in which identified areas of waste, redundancy or barriers are minimized or eliminated.

To inform the development of a Future State map, review the Current State map for any of the following:

- Unnecessary steps
- Redundancy
- Delays
- Areas in the flow map that are "muddy" or were not easily determined (this can be a hint about what might need to be better defined)
- Loops that do not move the process forward ("re-work loops")
- Ambiguity
- Areas of change that would result in the biggest benefit (often found near start point)
- Complexity that could be simplified
- Underutilization and overutilization of resources
- Mismatched supply and demand (e.g., over staffed clinics with low demand, understaffed clinics with high demand)
- Decision steps (diamonds) that could be removed to facilitate more continuous flow
- Absolutes (steps that cannot be changed even if doing so would greatly impact flow)

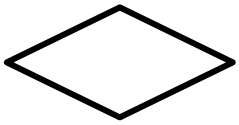
The Future State map is established based on the analysis of Current State, and also in consideration of the program requirements and unique features of the site. An example of a large-scale change that improved flow for Veteran care was the co-location of behavioral health within primary care. This improved access to mental and behavioral health care across the nation because (in part) it reduced the number of steps required to connect Veterans with that care.



2 COMPONENTS OF PROCESS MAPPING

The following symbols and colors comprise the basic flow mapping toolkit. A summary of these tools is included in the appendix (Appendix 7.1).

Oval		Start and stop points of the flow map
Square/rectangle		Process step - A single, discrete step within the process - Usually has only one arrow pointing toward and away from the square

Tool	Symbol	Use
Diamond		Decision step - A point in the process when a decision must be made - Usually has at least 2 arrows pointing away from the diamond - Each arrow pointing away from the diamond represents a unique decision outcome (e.g., yes, no)
Arrows		Direction of flow
Cloud		Highlights ideas/solutions (note that these are separated from the process and can be placed anywhere on the process map
Kapowie		Ka-Bam! This shape highlights possible obstacles, barriers, challenges and waste (these are also depicted separate from the flow and are generally placed close to the step(s) in question).

Color	Use
Clear	**Non-value** adding step, but **still necessary**
Green	**Value – adding** step (e.g., from the perspective of the patient)
Red	**Non-value** adding and likely **unnecessary step**. Can also be used for Kapowies.

3 PUTTING THE PIECES TOGETHER

While flow mapping is by no means a linear process, the following steps provide general guidance in approaching this task. Inevitably, the flow mapping route will be based on individual site needs, culture, and willingness.

"Putting it all together" should involve "all putting it together" whenever possible. This should be a collaborative process.

Here is the step by step process used to create the CURRENT state map and FUTURE state map included above.

Step	Example
Determine what process will be targeted	PACT and MHSL PI/PCMHI/leadership meeting to identify MH clinical reminder performance measure improvement areas
Review relevant SOPs, procedure guides, existing flow maps, etc.	Materials reviewed: MHSL to Medicine Service Line Agreement, Depression Reminder Completion SOP, recent performance measure completion data, flow mapping guide
Determine flow mapping team; ask identified team members if there are others they would suggest including.	Team: MHSL PI Lead PCMHI Representative MHSL Leader PACT Leader BHIP/MH Clinic Representative MH Intake Representative
Make sure the team members are working with the same tools (e.g., symbols, colors) and are aware of the goal(s) of the mapping effort	Share Flow Mapping resources with mapping team, discuss goal of mapping effort.
As a team, determine from what viewpoint the process will be mapped (e.g., bird's eye, ground-level, Veteran, PCP, therapist, MSA)	Viewpoint: Perspective of PACT and MHSL clinicians
Team decides on method for initial mapping effort (e.g., whiteboard, wall, computer) and make sure supplies are on hand (e.g., markers, post-its)	Utilization of Microsoft Word and Flow Mapping Tools Guide
Team titles the process map	"Positive Depression Screen Current State"
Team identifies the beginning (start) and end (stop) points of the process (represented by ovals)	Beginning: Positive Depression Screen End: Follow-up Reminder Completion and MH Disposition Adherence

Step	Example
Team brainstorms process and decision steps that occur between the start and stop points	Rectangles – process steps (e.g., referral to ILP for follow-up assessment, referral to specialty MH) Diamonds – decision steps (e.g., who will conduct positive follow-up reminder, what is appropriate MH Intake disposition for positive reminders)
Once team is satisfied that all process and decision steps are accounted for, draw arrows	Process steps have one arrow pointing toward the rectangle, and one arrow leaving the rectangle. Decision steps should have more than one arrow flowing from the diamond.
Team ensures all loops are closed.	✓
Team reviews the process map for areas of waste, barriers, redundancy, re-work loops etc.	Examples: Are patient preferences honored? What happens to no-shows? What about utilization of watchful waiting or psychoeducational protocols for patients declining specialty MH?
Any steps that represent possible waste, barriers, redundancy etc. are highlighted using RED.	Relevant symbols are filled in with RED (e.g., seeking if a MH provider is available to conduct follow-up depression screen).
KAPOWIE (S) can be used to highlight a factor that could be improved.	KAPOWIE(S) are inserted to highlight a factor that can be improved (e.g., re-work loop).
Color any steps that are of VALUE to the user/consumer (i.e., meeting attendee) in GREEN.	Relevant shapes are filled in with GREEN (e.g., one streamlined mental health brief assessment and disposition via PCMHI)
If the mapping team has ideas for how the process can be improved, insert a CLOUD with the idea highlighted.	CLOUDS are inserted to capture ideas for process improvement (e.g., could MH Clinic orientation and treatment team meetings be streamlined and take place earlier in the process?).
Re-work map based on analysis of CURRENT STATE to create FUTURE STATE map.	Re-work loops eliminated via utilization of PCP for depression follow-up reminders and utilization of PCMHI to assist with initial MH triage.

Additional flow map examples are provided in Appendix 7.2.

4 FACILITATING THE MAPPING PROCESS

The mapping process affords an excellent opportunity to employ facilitation skills.

4.1 The Right Team

The mapping process may start with the Internal Facilitator and External Facilitator (EF), but should be expanded to include other relevant stakeholders (i.e., M.H. leadership, subspecialty clinic directors, frontline clinical staff and supervisors, clerical staff, etc.). Keep the team a manageable size and comprised of consistent players, regardless of whether the mapping effort takes place in-person or electronically.

4.2 Laying the Foundation

Conceptualizing “Mental Health” as a system through which patients flow is usually not a novel idea for sites. The multitude of benefits associated with flow mapping and mapping both the Current and Future State, however, may be a somewhat new approach to the age-old task of “flow charting”. Facilitators are encouraged to talk with the stakeholders, listen to their needs and concerns, and tailor the rationale for mapping to their needs. Discuss the benefits associated with flow mapping and how it will help them address their needs. The facilitator can also then tailor the mapping process itself to the culture and needs of the site.

4.3 Brainstorming

Brainstorming helps free ideas when done in a well-facilitated and “safe” environment. When brainstorming (e.g., to identify processes to be mapped, or to develop a future state map), the facilitator should encourage “outside the box” thinking, write down all ideas that are shared, and actively redirect the discussion if it strays into problem-solving or judgments. Brainstorming can be used at multiple points throughout the site’s Facilitation process. For example, during pre-visit coordination, the internal facilitator and EF may spend time brainstorming about what processes to target. And/or, the Facilitator(s) may decide brainstorming could fuel small group discussions and mapping efforts during the site visit.

4.4 Observation and Experience

Eliciting ideas from the site’s staff during the brainstorming process is often very helpful. Drawing a map based on their observations and experience is useful as well. Additionally, first-hand observation or experience is an informative method for verifying mapping results and getting a more solid picture of what the frontline staff contend with on a day to day basis. For example, it may be useful to do a tracer for a patient seen that day/week. Visiting the clinic in which the program operates can also shed light on the flow. For example, if a PCP has to walk down a hallway and make 5 turns to get to a PCMHI provider, warm handoffs may be a rarity and thus impact flow.

4.5 Review of Materials

Reviewing SOPs, procedures, site visit reports, MHIS data and so forth provides valuable information. Discrepancies amongst such materials can highlight areas of flow that may need clarification, or modification in pursuit of ideal flow state. It is also useful for Facilitator(s) to have an understanding of the Uniform Mental Health Services Handbook, as well as the Facilitation Guide, as this knowledge can help with addressing stuck points (red squares or "kapowies") with the sites.

4.6 Useful Questions

Useful questions for guiding and diagramming the flow mapping process:

- Distinguishing between current and ideal patient flow. Both are important.
- How do patients get into the system or what is the front door?
- How to patients exit the system or what is the back door?
- What are the options for patients once they are in the system?
- How do you know when you need to (specify action)? For example, "How do you know when you need to refer a patient to general Mental Health or PCT?"

Useful Questions when reviewing the Current State and considering the ideal flow:

- Is there a problem with current performance? Do you need better results?
- Have you been skipping any critical steps?
- Are all steps necessary? Are there areas of unnecessary duplication or redundancy?
- How often do you have to do each step?
- Are there areas that rely on an individual to "remember" to do something? Any process that relies on memory is prone to error.
- What happens if the process breaks down? Do you need a fail-safe mechanism?
- Can some steps be done simultaneously?
- Is there a more logical way to sequence the steps?
- What skills are necessary to perform each step?
    - If more skills are required, can current staff be trained or do duties need to be shifted to more qualified staff?
    - Could someone with fewer skills perform this step? Would they need training or support?
    - Could someone be hired to perform this step?
    - Could this step be outsourced?
- Is there any technology that would make this process more efficient or easier to do?
- Are you thinking outside the box? Is there an entirely different way to get this done?
- Who do you know that handles this task very well (an exemplar)? Can you study their workflow?

4.7 Stay Flexible

Flow mapping can be a fluid process. You will undoubtedly need to re-arrange the map components as the team discusses the process. As such, it is often best to start with markers and a whiteboard, post-its and a wall, or plain old-fashioned pencil and paper. Get the key steps

sketched out first, then fill in others. It's best to wait until the steps are decided on before trying to add arrows. If you need more than one arrow coming from a symbol, it is likely a decision point (diamond).

4.8 Capture Ideas

During the mapping process, if ideas for improving the process are put forth, write or post them on a separate section of the board (away from the current state map being developed). Once the current state map is finalized (i.e., arrows are inserted, team agrees it is accurate), then insert the ideas as clouds at the relevant places on the map.

4.9 Get Creative

Consider having the mapping team stand at a white board or wall to share in the process, rather than sitting around a table. The former provides a more active context for the mapping and helps with team cohesion. This strategy encourages involvement; anyone can put up a post-it or draw on the board.

4.10 Verify

The team should review the flow map to ensure it is as accurate as possible. This can include walking through the process multiple times. The Facilitator can assist both the process of creating and verifying the map using questions such as those noted above. As the map is reviewed, ensure that all loops are closed, decision steps have more than one arrow originating from them, and process steps have one arrow pointing toward and away from the symbol.

Also, sites may have flow charts representing different programs, or a flow chart of overall service flow. These may be provided to you with the expectation that the charts will serve as the flow map for the Facilitation process. Review all the information provided, and respectfully address whether additional mapping efforts would be beneficial. For example, the flow chart(s) provided may have been developed by one individual (as opposed to a team) and therefore are inherently less accurate at capturing key factors in the process flow. The charts may also illustrate a more idealized version of the current state of flow than is being implemented on the front lines. These charts can help inform the creation of a Future State map, but an accurate Current State map is needed to begin the process.

4.11 System Redesign

Consider inquiring as to whether any mapping team members have completed system redesign training (at any level). Such staff may be valuable resources for the site and the facilitation process as they embark on their process improvement efforts. Relatedly, local System Redesign leadership may be available to offer helpful suggestions and tips. They may have recommendations or identify staff that could lead a flow or process mapping effort onsite and be a local consultant for redesign efforts. Note that Systems Redesign is in varying stages of implementation across the VA, so not all resources will be available at all sites.

5 TIPS AND HINTS

During the flow mapping effort, the following should be kept in mind:

- Flow mapping is a tool and should not take up too much time in the facilitation process.
- Find a balance between offering suggestions and encouraging a site to develop a map on of their own.
- Be careful not to overwhelm the site with too many decision points too quickly in the mapping process. Start broad and get more detailed later if needed.
- Make sure to run the ideal patient flow map (future state) by relevant stakeholders at the site for input so the result is not seen as too top-down (or bottom up!).

Here are a few additional tips and hints:

Do	Don't
For Current State, map what is ACTUALLY happening	For Current State, don't map how the process "should or could" flow
Ask questions	Assume you know the answers
Start mapping at a macro level, and only after the team has decided what will be mapped and the boundaries of the map (start/stop points).	Allow mapping efforts to delve into significant detail at the outset or begin without clearly determine the process to be mapped.
Involve the people who are involved in the process. Different levels of involvement will highlight different aspects of process.	Limit mapping team members to those in leadership or those on the frontline. It should ideally include representatives from all levels.
Actively facilitate the mapping process with focus maintained on process.	Let the mapping effort become bogged down in minutia, with arguments or blaming.
Verify the map through asking questions, doing a "mock walk through", etc. If it possible, use the "go see" approach, and view the process in action and/or the setting of the process.	Assume that the current process is the same as what is written in an SOP or other materials.
Draw map as it is being described by the team and clarify uncertainties.	Translate what the team is telling you into what you think they mean.
Use pencil, post-its, erasable whiteboard, flip charts for the initial mapping session so that steps can be easily rearranged. Draw arrows in once the steps are in place	Attempt to create a perfectly formatted map from the start.
Ensure Current State is captured before Future State is drafted.	Jump into Future State mapping before the Current State is verified.
Orient the mapping team to the purpose of the mapping effort and provide a symbol key to the mapping team.	Assume everyone knows how to flow map and jump into the process without ensuring all team members are on the same page, with the same resources.

6 FLOW MAPPING AND THE FACILITATION PROCESS

YOU ARE HERE
"Current State" process flow mapping can be a useful tool early in the facilitation process and is recommended prior to initiating the Implementation Checklist.

- This facilitates a shared understanding of the scope of the process by those involved, can assist in the identification of key site-specific outcome variables, and may highlight potential leverage for points of change.
- The External Facilitator (EF) serves as the flow mapping guide when illustrating the current state of the process. The EF may involve local system redesign experts when available.
- The Internal Facilitator, as well as relevant frontline staff knowledgeable about the current process flow, serve as the local process experts. Process flow mapping may start with the EF and internal facilitator but should be expanded to other relevant players to ensure accuracy.
- Flow mapping teams should take note of barriers, challenges and waste as well as ideas and solutions.
- Be sure to save an electronic copy of the current state flow map (formal diagram or photo of white board mapping, etc.) for reference later in the facilitation process.
- Reminder, the point of flow mapping is to inform the process improvement effort from a "bird's eye view" and should not become the process improvement effort itself.

DESTINATION

"Future State" process flow mapping represents the ideal process flow. It can be helpful to outline key steps prior to initiating the Implementation Checklist at the facility but you will undoubtedly need to re-arrange the map components as the team discusses the process.

- This includes the removal of unclear or unnecessary decision points or process redundancies.
- The EF often serves as the flow mapping and subject matter guide when highlighting key steps in the future state process, but the internal facilitator and relevant stakeholders will be key players throughout the process.
- Consider inquiring as to whether any facilitation team members have completed system redesign trainings or if local system redesign leadership may be available to offer suggestions and tips.
- Remember to stay flexible and fine-tune the map throughout the facilitation process. Revisit the future state throughout the actual implementation to refine processes as needed.

7 APPENDIX

7.1 Reference Tool

7.2 Additional Example Flow Maps

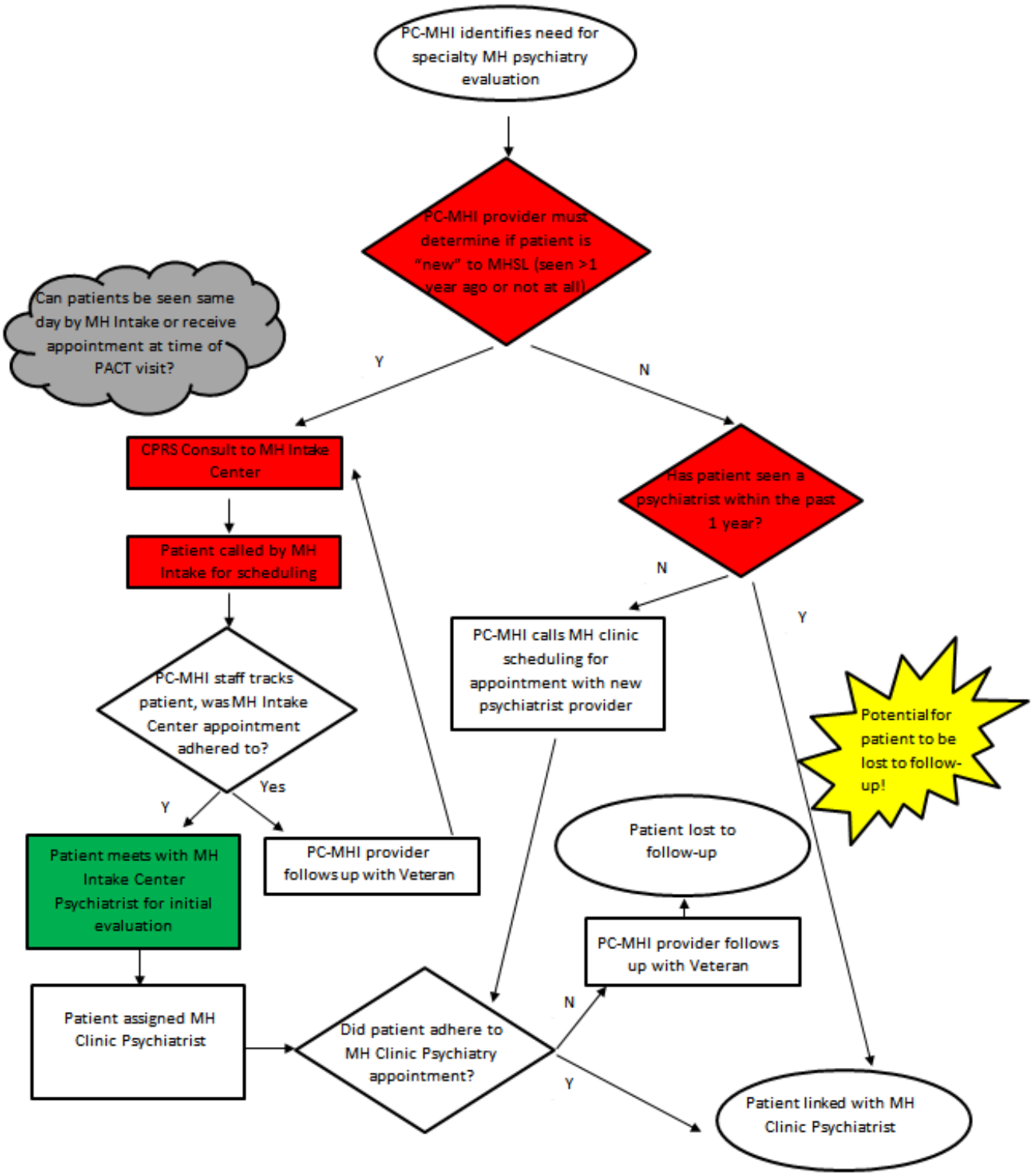
7.3 Additional Resources

Symbol	Definition
Oval	Start/stop
Square/Rectangle	Process Step
Small Square attached to Process Square/ Rectangle	Used to show data if needed (e.g., #s, duration until appt)
Lines with Arrows	Direction of flow
Diamond	Decision step (yes and no inserted above direction lines to show decision flow)
Cloud	Highlights solutions/ideas: separate than the process flow; can be placed anywhere on the map when you have you may want to address or look into
Kapowee	Highlights possible obstacles barriers or waste: separate than the process flow; can be placed anywhere on the map when you identifies an obstacle, barrier or waste in your process

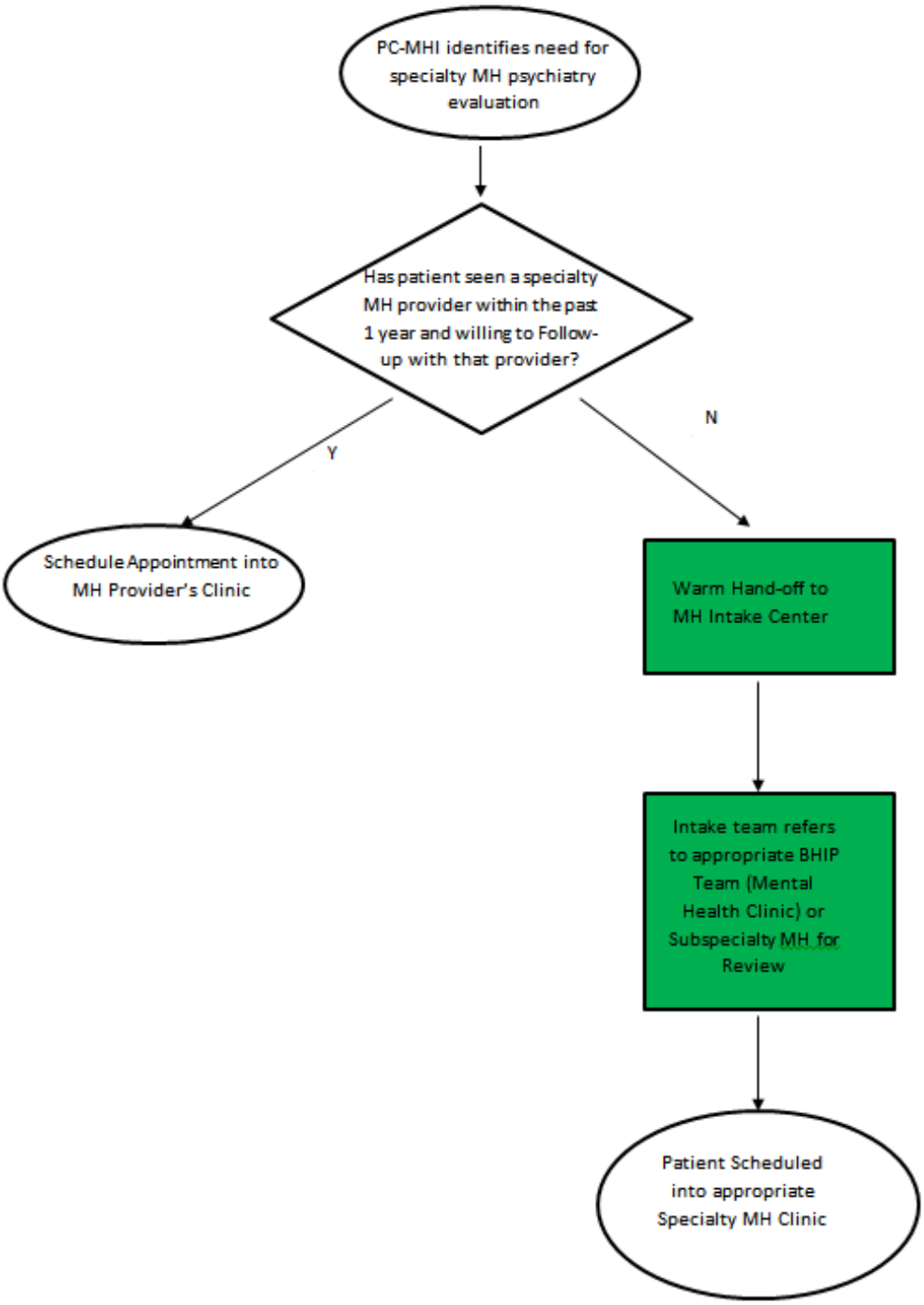
Colors: used to represent value within the process

Red	Non-value adding, and likely unnecessary, step
Green	Value adding step (typically from the perspective of a veteran who is going through the process)
Clear	Non value adding, but necessary, step

Current State Flow Map Example: PC-MHI ID's Need for Specialty MH Psychiatry Evaluation



Future State Flow Map Example: PC-MHI ID's Need for Specialty MH Psychiatry Evaluation



Appendix J-1. Sample Sustainability Action Plan (SAP)

Sustainment Activity *What will you do to make sure you meet the goals?*	**Who is responsible?**	**Frequency and due dates**	**What metrics will you use to track progress?**	**Resources needed**
Goal 1: Continue to deliver benefits to patients				
Assess relevant data: service utilization by relevant patient subgroups (i.e., assessing disparities)				
Assess relevant data: clinical outcomes by relevant patient subgroups (i.e., assessing disparities)				
Goal 2: Continue the components of the original innovation				
Train staff				
Review program components yearly				
Review data and discuss with staff				
Goal 3: Maintain partnerships with stakeholders to continue to deliver the innovation				
Plan for communicating and sharing progress: With leadership				
With providers				
With Veterans or community groups				
Goal 4: Maintain new practices, procedures and policies established during the implementation				
Review and update Implementation Planning Guide				
Goal 5: Sustain attention to the innovation				
Review status of program in staff meetings				
Check on availability of resources for continuing the innovation				

Appendix J-2. National Health Service Sustainability Index

NHS Sustain**ability** Model

Authors

Lynne Maher[1] David Gustafson[2] Alyson Evans[2]

Directions

Read through the model.
Select the level of each factor that best describes your situation.
Circle or mark your score.
Add the scores from each factor level that you selected and enter into the assessment panel at the bottom.

Scores

Preliminary evidence suggests; a score of 55 or higher offers reason for optimism while a score of 45 or lower suggests that you need to take some action to increase the likelihood that your improvement initiative will sustain.

Look initially at the factors that you scored with lower marks. You will find some useful information in the corresponding section of this guide which will help you to devise an action plan for improvement.

You will find it helpful to continue to use the model over time and we suggest reviews at periods of three to six months.

We are continuing to assess the use and impact of the sustainability model. We would be pleased to receive any thoughts or comments that you have for improvement.

1 - Modernisation Agency of the British National Health Service, 4th Floor, St Johns House. East Street, Leicester LE1 6NB
2 - University of Wisconsin, Rm 1119 WARF Building, 610 Walnut Street, University of Wisconsin Madison 53705

Process

Choose the **Factor Level** that comes closest to your situation and circle the **Score** to the left of it

Factor	Score	Factor Level
Benefits beyond helping patients		The change improves efficiency and makes jobs easier
		The change improves efficiency but does not make jobs easier
		The change does not improve efficiency but does make jobs easier
		The change neither improves efficiency nor makes jobs easier
Credibility of the benefits		Benefits of the change are immediately obvious supported by evidence and believed by stakeholders
		Benefits of the change are not immediately obvious even though they are supported by evidence and believed by stakeholders
		Benefits of the change are not immediately obvious even though they are supported by evidence. They are not believed by stakeholders
		Benefits of the change are neither immediately obvious supported by evidence nor believed by stakeholders
Adaptability of improved process		The process can be adapted to other organisational changes and there is a system for continually improving the process
		The process can be adapted to other organisational changes but there is no system for continually improving the process
		The process is not able to adapt to other organisational changes but there is a system for continually improving the process
		The process is not able to adapt to other organisational changes and there is no system for continually improving the process
Effectiveness of the system to monitor progress		There is a system in place to identify evidence of progress, monitor progress, act on it and communicate results.
		There is a system in place to identify evidence of progress and act on it, but the results are not communicated
		There is a system in place to identify evidence and monitor progress. The results are communicated but no one acts on them
		There is no system in place to identify evidence of progress or to monitor progress nor act or communicate it

Process Total Score						
	1st Assessment	Date	2nd Assessment	Date	3rd Assessment	Date

Staff

Choose the **Factor Level** that comes closest to your situation and circle the **Score** to the left of it

Factor	Score	Factor Level
Staff involvement and training to sustain the process		Staff have been involved from the beginning of the change and adequately trained to sustain the improved process
		Staff have been involved from the beginning of the change but not adequately trained to sustain the improved process
		Staff have not been involved from the beginning of the change but they have been adequately trained to sustain the improved process
		Staff have neither been involved from the beginning nor adequately trained to sustain the improved process
Staff attitudes toward sustaining the change		Staff feel empowered as part of the change process and believe the improvement will be sustained
		Staff feel empowered as part of the change process but don't believe the improvement will be sustained
		Staff don't feel empowered by the change process but believe the improvement will be sustained
		Staff don't feel empowered by the change process or believe the improvement will be sustained
Senior leadership engagement		Organisational leaders take responsibility for efforts to sustain the change process and staff generally share information with and actively seek advice from the leader
		Organisational leaders don't take responsibility for efforts to sustain the change process but staff generally share information with and seek advice from the leader
		Organisational leaders take responsibility for efforts to sustain the change process but staff typically don't share information with or seek advice from the leader
		Organisational leaders don't take responsibility for efforts to sustain the change process and staff typically do not share information with or seek advice from the leader
Clinical leadership engagement		Clinical leaders take responsibility for efforts to sustain the change process and staff generally share information with and actively seek advice from the leader
		Clinical leaders don't take responsibility for efforts to sustain the change process but staff generally share information with and actively seek advice from the leader
		Clinical leaders take responsibility for the efforts to sustain the change process but staff typically do not share information with or actively seek advice from the leader
		Clinical leaders don't take responsibility for efforts to sustain the change process and staff typically do not share information with or actively seek advice from the leader

Staff Total Score						
	1st Assessment	Date	2nd Assessment	Date	3rd Assessment	Date

Organisation

Choose the **Factor Level** that comes closest to your situation and circle the **Score** to the left of it

Factor	Score	Factor Level
Fit with the organisation's strategic aims and culture		There is a history of successful sustainability improvement goals are consistent with the organisation's strategic aims
		There is a history of successful sustainability but the improvement and organisation is strategic aims are inconsistent
		There is no history of successful sustainability but the improvement goals are consistent with the organisation's strategic aims
		There is no history of successful sustainability and the improvement goals are inconsistent with the organisation's strategic aims
Infrastructure for sustainability		Staff, facilities and equipment, job descriptions, policies, procedures and communication systems are appropriate for sustaining the improved process
		There is an appropriate level of staff, facilities and equipment, but inadequate job descriptions, policies, procedures and communication systems for sustaining the change
		The levels of staff, facilities and equipment to sustain the change are not appropriate although job descriptions, policies, procedures and communication systems are adequate
		The staff, facilities and equipment, job descriptions, policies and procedures and communication systems are all not appropriate for sustaining the change

	1st	2nd	3rd
Organisation Total Score			
+			
Staff Total Score			
+			
Process Total Score			
=			
Sustainability Total Score			
	1st Assessment / Date	2nd Assessment / Date	3rd Assessment / Date

How to calculate your score

Add the **Process**, **Staff** and **Organisation** scores together and place in the **Sustainability Total Score** box.

The closer your score is to 100, the better chance of successful sustainability.

55 or higher offers reason for optimism

45 or lower suggests reason for concern

Appendix J-3. Sustainability Assessment Tools

The **Program Sustainability Assessment Tool** (https://sustaintool.org/psat/) is a 40 question self-assessment. Both program staff and stakeholders can take the assessment to evaluate the sustainability capacity of a program. When you take the assessment online you will receive a summary report of your overall sustainability. You can use these results to help with sustainability planning.

- The assessment is made up of 40 multiple choice questions. You will rate your program/coalition/set of activities across 8 sustainability domains
- The assessment takes about 10-15 minutes to finish
- The assessment can be used by programs at community, state, and national levels
- The assessment can be taken as an individual or group
- The assessment is used by various programs; public health, social services, clinical care, and educational programs have all found the assessment to be very relevant to their work

The **Clinical Sustainability Assessment Tool (CSAT) (**https://sustaintool.org/csat/) is a 35 question self-assessment. Both clinical staff and stakeholders can take the assessment to evaluate the sustainability capacity of a clinical practice. When you take the assessment online you will receive a summary report of your overall sustainability. You can use these results to help with sustainability planning.

- The assessment is made up of 35 multiple choice questions. You will rate your practice activities across 7 sustainability domains.
- The assessment takes about 10-15 minutes to finish
- The assessment can be used in a wide variety of clinical practice settings (e.g., hospital systems, clinics, pharmacies, community health centers, long-term care facilities, and home healthcare).
- The assessment can be taken as an individual or group.

Read more about the development of the Program Sustainability Framework:

> Schell SF, Luke DA, Schooley MW, et al. Public health program capacity for sustainability: a new framework. Implement Sci. 2013;8(1):15. https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-8-15.ris

Read more about the reliability testing of the Program Sustainability Assessment Tool:

> Luke DA, Calhoun A, Robichaux CB, Elliott MB, Moreland-Russell S. The Program Sustainability Assessment Tool: a new instrument for public health programs. Prev Chronic Dis. 2014;11:E12. https://doi.org/10.5888/pcd11.130184

Read more about how to use results from the Program Sustainability Assessment Tool to engage in sustainability planning:

> Calhoun A, Mainor A, Moreland-Russell S, Maier RC, Brossart L, Luke DA. Using the Program Sustainability Assessment Tool to assess and plan for sustainability. Prev Chronic Dis. 2014;11:E11. https://doi.org/10.5888/pcd11.139185

APPENDIX K. VIRTUAL FACILITATION RESOURCES

Appendix K-1. Virtual Facilitation Meeting Agenda (PCMHI)

Primary Care-Mental Health Integration Facilitation Virtual Agenda

List Facility – Date

Please note that this agenda is transforming what was previously a 1-1.5 day in person visit and condensing it into a virtual format. To accomplish the same tasks in virtual platforms several meetings are requested, but can occur over a series of days if needed.

Meeting and brief description	Time Needed	Location	Suggested Attendees (Will vary by facility)
1. Entrance Conference: Need a 30 minute time frame with the top leadership. Ideally this meeting will happen first. Top leadership needs to be aware of process and purpose of engagement with this site	30 minutes	Must have either V-tel or Jabber with projecting capabilities	• Facility Leadership • PC Leadership • MH leadership
2. Overview of PCMHI and Facilitation: • Opportunity to educate staff with general overview and national data • Explain facilitation process	45-90 minutes, depending on requests for educational content	Need a large room to accommodate many staff members with V-tel	• Anyone that can benefit from learning about PCMHI • MH Leadership • Program Managers • All PCMHI staff Key Stakeholders • Stakeholders in specialty MH and PACT
3. Implementation Meeting Part 1: • Optional flow mapping meeting • Review Functional Tool Responses (Completed in Pre-work) focus on	90-120 minutes	V-tel	• PC Leadership MH Leadership • PCMHI staff • Key Stakeholders • Clinic set-up and scheduling Staff

Meeting and brief description	Time Needed	Location	Suggested Attendees (Will vary by facility)
identified gaps • Review and discuss Clinical services and initial assessment from functional tool			
4. Implementation Meeting Part II • Continue review and discussion of Functional Tool: Clinical services, Clinical services, assessment and patient identification • Identify gaps and steps for full implementation	90-120 minutes	V-tel	Same as Implementation Meeting Part I
5. Implementation Meeting Part III • Continue review and discussion of functional tool: Clinical services, Clinical services, assessment and patient identification • Develop plan for full implementation	90-120 minutes	V-tel	Same as Implementation Meeting Part I
6. Virtual Tour of PC and PCMHI Space: • Review floor plans • Describe space • Share pictures • Consider pre-recorded tour with facility permission • Consider real-time tour via Video with facility permission	30-45 minutes.	V-tel. May require other options if Selected by the facility	• PC Leadership • MH Leadership • PCMHI staff

Meeting and brief description	Time Needed	Location	Suggested Attendees (Will vary by facility)
7. Exit Conference: • After implementation checklist is completed and initial plan is developed, but prior to release of formal report, a verbal update to the Facility Leadership is provided	30 minutes	V-tel	• Facility Leadership • PC Leadership • MH leadership
8. Individual meetings • Questions, comments, and concurs • Available throughout the process as needed	45-90 minutes	Phone or V-tel	• PCMHI Staff • Leadership • Other stakeholders • Anyone wishing to speak with the facilitators individually
Additional Meetings			
9. On-going Implementation meetings • Regular meetings to address all items on implementation plan. Initially meet 2X a month but may reduce to 1X as progress is made • Proceed until facilitation is completed	45-60 minutes	Phone and V-tel	• Implementation committee and others as needed
10. Facility Leadership updates • Updates to be provided to facility leadership at midpoint and then at the finalization of facilitation	30 minutes	V-tel	• Quad • MH leaderships • PACT leadership

Appendix K-2. Preparation for Virtual Site Visit - Pre-Meeting Checklist[1]

Instructions: Check the box after completing the task and add the date by clicking on the line and using the drop-down arrow to the calendar.

☐ Discuss with Facility MH Lead whether this will be conducted using **only** Lync or a **combination** of Lync and Jabber (for video) _____

If using Jabber:

☐ Coordinate with Facility POC Jabber addresses; have Facility POC set up V-tel bridge if you will be working with more than one location. _____

NOTE: If facility-end is participating via VTEL, all jabber participants can be automatically dialed from the host (facility) at meeting times. If anyone misses the auto dialed call; they can dial in to the VTEL call-in number provided by the facility.)

☐ Day before the meeting, test all equipment (Jabber and VTEL) with the site.

_____

☐ If using Lync only, send out meeting invite to Facility and Network MH Leadership and ask them to forward to all anticipated participants. As a back-up, set up a VANTS Line in case of Lync failure during the meeting. _____

☐ Ensure site has an appropriate conference room for sharing screens (projector connected to a computer on VA network); as well as speakers for clear audio. _____

<u>Video conferencing using Jabber:</u>

☐ With MH POC, determine how many sites/rooms will need to join Video Conferencing: at Facility, Network, other locations. _____

☐ Ask MH POC to reach out to local IT staff to assist with set up of Video Conferencing; provide your Jabber account information _____

☐ Obtain dial-in numbers once established and update meeting invite; include VANTS backup and cell phone numbers (yours & MH POC at minimum) _____

☐ Test out equipment the day before the visit. _____

[1] *This example was provided by the Office of Mental Health Operations and was used as a checklist for conducting virtual site visits. Please note these visits were not within the context of implementation facilitation, but were site reviews of mental health programs. Nonetheless, the initial visits were in-person and were then transitioned to a virtual format, which led to the creation of this checklist.*

APPENDIX L. IMPLEMENTATION FACILITATION TIME TRACKING RESOURCES

Appendix L-1. Implementation Facilitation Time Tracking Log and Definitions

SITE NAME:

Name of facilitator:

Date	Event Type **1**=prep time (facilitator alone) **2**=one-on-one **3**=group **4**=site visit **5**=other	Mode of Communication 1=phone 2=email 3=V-Tel 4=in-person 5=other 6=not applicable (eg, prep time)	Personnel Codes **1**=Provider(s) **2**=Leadership - service level **3**=Leadership - facility level **4**=Leadership - VISN level **5**=Leadership - national level **6**=External facilitator **7**=Internal facilitator **8**=Clerk or admin support **9**=Team Member(s) **10**=Clinic Supervisor(s) **11**=Other (Check box(es) for personnel with whom you interacted)											Time		Primary Activity (use numbers from box to the right)	Facilitation Activity Codes **1**=Action/implementation planning **2**=Adapting program to local cintext without compromising fidelity **3**=Administrative tasks **4**=Conduct ongoing monitoring of program implementation **5**=Data collection to assess context/baseline performance **6**=Describing/clarifying roles and responsibilities **7**=Engaging stakeholders, obtaining buy-in **8**=Fostering organizational change: structural **9**=Goal/priority setting **10**=Identification/selection of local change agents **11**=Managing group/team processes **12**=Problem identification **13**=Problem-solving **14**=Providing support **15**=Providing updates and feedback **16**=Pulling back and letting sites lead Note: Check boxes for all activities you conducted; then select the primary activity and enter that number in the Primary Activity column **to the right.**															Notes:
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Hour**	**Min**		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	

Definitions for Time Tracking Log

I. Event Type Definitions

1. **Prep time** refers to tasks/activities done by a facilitator in isolation (i.e., no one else is involved) for preparation or planning (see example activities listed under "Preparation/planning" in the "Facilitation Activities Definitions" section below).

2. **One-on-One interaction refers to a call or meeting with one person at a particular site.**

3. **Group interaction** refers to a call or meeting with a group of individuals at a particular site.

4. **Site Visit** refers to a facilitator in-person visit to a site.

5. **Other** refers to additional types of interaction(s) with sites not captured above.

II. Mode of Communication Definitions

1. **Phone** activities refer to contact with site personnel that is conducted over the telephone.

2. **Email** activities refer to time spent in email correspondence with site personnel.

3. **V-Tel** activities refer to contact with site personnel that is conducted over v-tel, Skype, or videoconferencing equipment.

4. **In-person** activities refer to time spent in face-to-face contact with site personnel.

5. **Other** activities refer to other modes of contact with site personnel not captured above.

6. **Not applicable** refers to solitary activities performed by a facilitator (e.g., prep time).

III. Core Facilitation Activities and Definitions

1. **Action / implementation planning**
   Assisting with the development and refinement of Action Plans / Implementation Plans, including formal action items, short-term plans and long-term plans; assisting sites with an implementation checklist.

2. **Adapting program to local context without compromising fidelity**
   Help to adapt to and create synergy with local context, including local structure, staffing, culture and other initiatives.

3. **Administrative tasks**
   Set up site visits; scheduling and inviting stakeholders to calls and meetings; organizing meetings; emailing announcements and reminders; setting up monthly innovation provider calls; creating and sending out meeting minutes; preparing and disseminating reports and materials; scheduling/arranging speakers for monthly calls; making arrangements for innovation provider training (e.g., sending innovation providers to other clinics to shadow another innovation provider) (Note that only the *arrangement part* is administrative, not actual *provision* of training); preparing PowerPoint slides. *Does not include organizing regional or national meetings.*

4. **Conduct ongoing monitoring of program implementation**
   Monitoring/tracking/collecting data/information on progress, problems/barriers, enablers (facilitators), fidelity to evidence, performance, and innovation activities and linking implementation to outcomes. Includes quantitative and qualitative data, observations, etc.

5. **Data collection to assess context and <u>baseline</u> performance**
   Collecting/reviewing quantitative/qualitative diagnostic information/data to understand the local context, baseline performance, determinants of current practice (barriers and enablers (facilitators)).

6. **Describing/clarifying roles and responsibilities**
   Describing purpose and process of innovation, facilitation, what will occur, establishing/clarifying and allocating roles and responsibilities.

7. **Engaging stakeholders, obtaining buy-in**
   Engaging relevant stakeholders and seeking their participation/buy-in; building relationships with stakeholders; helping stakeholders 'own' the change.

8. **Fostering organizational change: structural**
   Promoting structural change required for implementation (e.g., staffing changes, reporting structure changes, office assignment changes, methods for referring patients, how patients move through the system [e.g., physically get to innovation providers, get from innovation providers to front desk] etc.).

9. **Goal/priority setting**
   Assisting in setting clear, realistic goals; setting priorities. Includes assisting with the selection of an area for change and developing/refining specific clinical practice questions.

10. **Identification/selection of local change agents**
    Helping identify/select, and/or hire local change agents, e.g., internal facilitators, opinion leaders, champions, and quality improvement (QI) team members.

11. Managing group/team processes
Includes managing group dynamics, running effective meetings, keeping group focused, establishing team structure, membership, roles and ground rules, creating atmosphere of mutual respect, enhancing communication, building relationships among (not with) team members, empowering group members, fostering democratic/participatory process.

12. Problem identification
Assisting with problem identification, awareness and clarification, including understanding current ways of working and thinking, identifying gaps and barriers in current context.

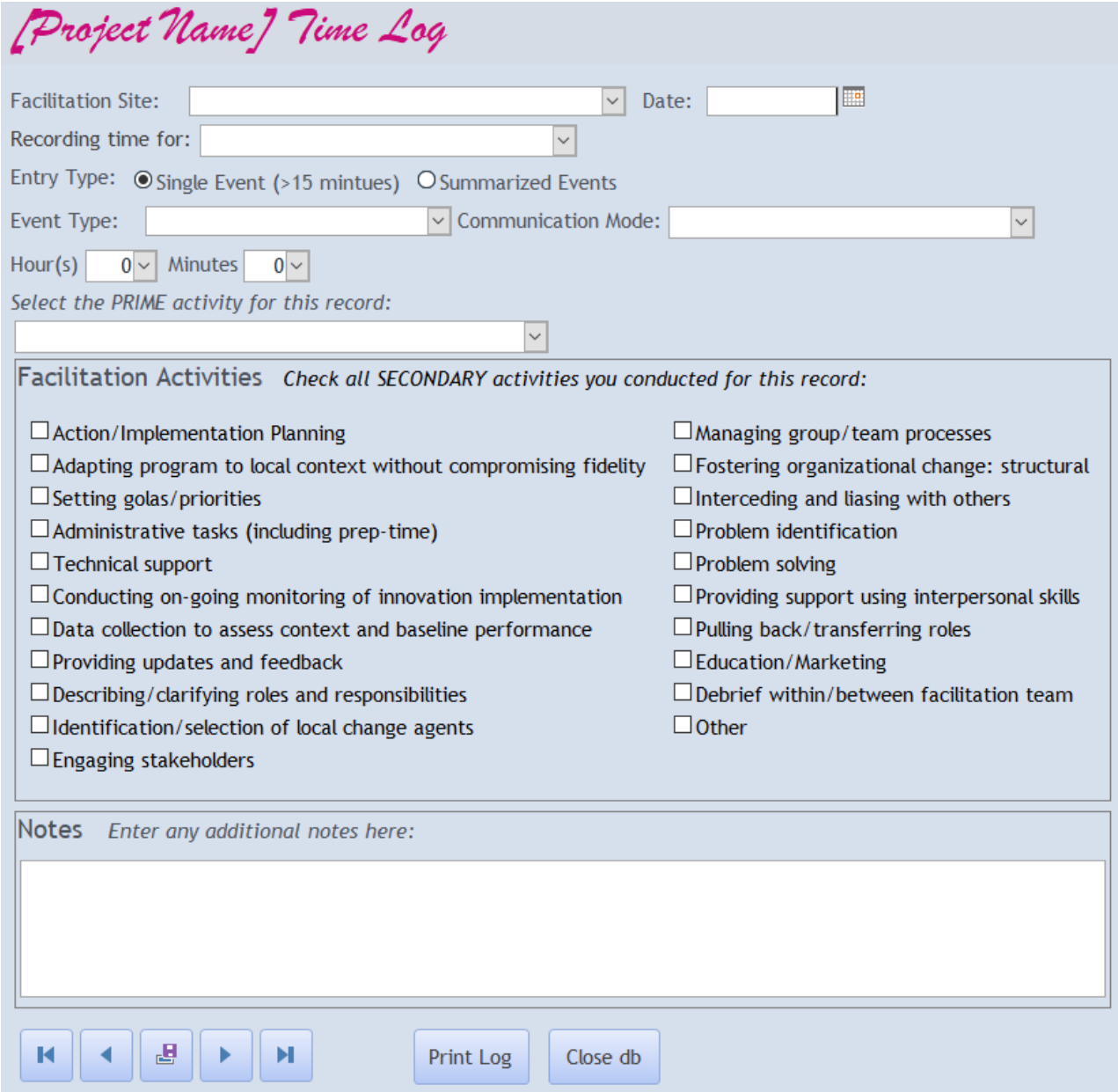
13. Problem-solving
Assistance with problem solving, brain storming solutions.

14. Providing support
Being generally helpful and available; communicating regularly; being available for questions; providing encouragement; doing things in a warm, encouraging, and empathetic way rather than hypercritical, punishing way; demonstrating “people skills”; using carrots rather than sticks; acknowledging ideas and efforts and celebrating achievements/success; maintaining momentum and enthusiasm; creating an open, supportive, and trusting environment conducive to change; providing ongoing support/reassurance and constructive feedback. May also include self-disclosure (sharing personal insights or experiences), interjecting humor.

15. Providing updates and feedback
Providing updates on implementation, including providing feedback on data, PDSA cycles (CQI), innovation provider activities, facilitator activities, relevant professional or system-level information (e.g., availability of new guidelines, tools, awareness of new administrative/clinical policy, etc.). Includes interpretation of data for stakeholders.

16. Pulling back and letting sites take lead
Pulling back and letting sites take lead in implementation / sustainability.

Appendix L-2. Implementation Facilitation Time Tracking Access Database Form



[Project Name] Time Log

Facilitation Site: Date:

Recording time for:

Entry Type: Single Event (>15 mintues) Summarized Events

Event Type: Communication Mode:

Hour(s) 0 Minutes 0

Select the PRIME activity for this record:

Facilitation Activities *Check all SECONDARY activities you conducted for this record:*

- Action/Implementation Planning
- Adapting program to local context without compromising fidelity
- Setting golas/priorities
- Administrative tasks (including prep-time)
- Technical support
- Conducting on-going monitoring of innovation implementation
- Data collection to assess context and baseline performance
- Providing updates and feedback
- Describing/clarifying roles and responsibilities
- Identification/selection of local change agents
- Engaging stakeholders
- Managing group/team processes
- Fostering organizational change: structural
- Interceding and liasing with others
- Problem identification
- Problem solving
- Providing support using interpersonal skills
- Pulling back/transferring roles
- Education/Marketing
- Debrief within/between facilitation team
- Other

Notes *Enter any additional notes here:*

Print Log Close db

APPENDIX M. RECOMMENDED READINGS

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