IMPLEMENTATION FACILITATION
TRAINING MANUAL

Using Implementation Facilitation to Improve Care in the Veterans Health Administration

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Implementing evidence-based practices and programs, indeed any complex clinical innovation, is challenging. 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, a multi-faceted process of enabling and supporting individuals, groups and organizations in their efforts to adopt and incorporate clinical innovations into routine practices. Facilitation can incorporate or 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 the processes, and
2) support the development of the skills needed to help organizations implement clinical 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 clinical innovations within Veterans Health Administration (VHA) facilities. Some innovations are more complex and include multiple clinical components. 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 clinical innovations. In addition to this introductory chapter, we have included nine additional chapters in two sections.

Section 1 focuses on providing information about Implementation Facilitation and is divided into four Chapters. In Chapter 1, we provide a brief overview of implementation facilitation (IF), issues to consider when using an IF strategy, conceptual models that can guide the use of the strategy and the current evidence for the effectiveness of using IF. Chapter 2 presents an
overview of the roles that facilitators perform and Chapter 3 provides information about the knowledge, skills, and core competencies that facilitators need to be effective, as well as the characteristics of good facilitators. In Chapter 4, we provide an overview of the phases of the implementation process as a backdrop for Section 2.

Section 2 provides practical guidance for those who may be in a facilitator role; therefore, the five chapters in this section are written in the first person. These chapters focus on conducting implementation facilitation activities and monitoring and improving implementation facilitation processes. Chapter 5 describes the critical tasks facilitators need to perform during the pre-implementation phase in order to lay the foundation for all other implementation facilitation activities. Chapter 6 provides practical information about implementation facilitation activities for helping sites and their stakeholders successfully implement a clinical innovation. Chapter 7 describes activities and resources for sustaining the clinical innovation and Chapter 8 provides guidance for facilitating implementation virtually, i.e., with limited or no in-person contact between facilitators and site personnel. Finally, Chapter 9 discusses methods for evaluating an implementation facilitation strategy through documenting facilitation activities, assessing fidelity to the clinical innovation as well as to the implementation strategy, and assessing outcomes. The appendices include references to additional materials and sample tools and materials.

This manual is a work in progress and will be informed by future findings from implementation facilitation 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 VHA: https://www.queri.research.va.gov/tools/implementation/Facilitation-Manual.pdf
SECTION I

INTRODUCTION TO IMPLEMENTATION FACILITATION
CHAPTER 1
OVERVIEW OF IMPLEMENTATION FACILITATION

The Department of Veterans Affairs (VA) is a forerunner in the development, promotion, and implementation of evidence-based practices (EBPs) through innovative research initiatives, guidelines, quality improvement efforts (e.g., performance monitoring), and programs designed to leverage and advance implementation science. Across the healthcare industry, however, sustainable EBP implementation has emerged as a complex and challenging process. This is particularly true when implementing relatively complex clinical programs (e.g., Primary Care Mental Health Integration (PCMHI), Behavioral Health Interdisciplinary Programs (BHIPs), and Evidence-Based Psychotherapies) which require engagement and support from multiple care specialties and changes in provider attitudes, organizational structures and processes, and clinical practice.\(^1\)\(^-\)\(^3\) Effective implementation typically involves a focus on adopting multi-component clinical innovations or programs tailored to individual settings, application of diverse implementation strategies to support adoption, and involvement of multiple stakeholders.

Implementation facilitation (IF) has been widely used in many healthcare organizations to support clinical innovation implementation. 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 strategy that addresses implementation challenges by incorporating many other implementation activities, including 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 fostering role modeling.\(^4\)\(^,\)\(^6\)\(^-\)\(^8\)

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 a practice.\(^9\)\(^,\)\(^10\) For example, the experiences of a colleague who has successfully used the clinical innovation may be more beneficial 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 EBP or 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. Implementation facilitation provides a mechanism through which factors that impede uptake of the innovation may be addressed whether they are associated with those
receiving the innovation, the context within which the innovation is being implemented or characteristics of the innovation.

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. It 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 to overcome those barriers developed, applied and refined. Implementation facilitation 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.

This manual is designed to help implementation facilitators or those planning an implementation facilitation strategy think about a number of issues.

**Issues to Consider When Planning an Implementation Facilitation Strategy**

**Who will apply facilitation?**

Facilitators can work either internally or externally to the clinical environment. Specifically, an external facilitator is an expert in general implementation strategies and tools and has expertise or credible knowledge about the clinical innovation and its evidence base. An internal facilitator is 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 (VISN) or facility). 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 for future efforts over time. With close mentoring, the external facilitator can transfer understanding of effective implementation activities to the internal facilitator and thus foster introduction and retention of these skills within the local organization.
What will facilitators do?

We’ve already mentioned several activities facilitators can perform, such as providing education and engaging stakeholders. The particular roles that facilitators assume and when they assume them depend upon stakeholder needs during the implementation process.\(^6,7,12,13\) For example, pre-implementation activities focus on engaging leadership support, identifying key stakeholders, and academic detailing. Late-phase implementation focuses on activities to sustain a new EBP or clinical innovation (e.g., establishing ongoing audit and feedback processes and fostering EBP role modeling). Sometimes facilitators are responsible for dual roles. For example, a clinical provider with designated time for implementation facilitation activities may perform both roles. Chapter 2 describes IF roles and Chapters 5-9 describe IF activities in detail.

What knowledge and skills should facilitators have?

Implementation facilitators need a wide range of knowledge and skills.\(^4,6,14\) In addition to core skills, e.g., interpersonal and communication skills, and those related to applying implementation facilitation processes, implementation facilitators need some “content” knowledge about the clinical innovation, its core components and how it should be implemented. They do not have to be experts in the clinical innovation. They can collaborate with experts but without some 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 3 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 site to implement a clinical 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 work of facilitation. The duration of the strategy overall may be pre-determined (e.g., six months) but whenever possible, implementation facilitation should continue until the innovation is well established and/or local change agents take 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 be pre-determined (e.g., through regularly scheduled calls) or interaction may be a mix of scheduled interactions and 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
(QI) teams, who share responsibility for implementation. (See Appendix A-2. Glossary of Terms, pages 113-118, 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 clinical innovation. 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 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 to the facilitator. See Chapter 8 for more information on virtual facilitation.

**Conceptual/Theoretical Underpinnings to Guide IF’s Application**

Although a thorough review of theoretical underpinnings for facilitation is beyond the scope of this manual, there are several conceptual models that may guide thinking about how to apply IF in a particular implementation effort. The integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework\(^\text{15,16}\) suggests that successful implementation results from the facilitation of an innovation with the recipients in their local, organizational and healthcare system context. The i-PARIHS developers conceive of facilitation as an active ingredient with a skilled facilitator who uses the facilitation process to enable recipients to adopt and implement the innovation, tailoring it, as well as implementation efforts, to their own context. The i-PARIHS developers have created a guide for using implementation facilitation.\(^\text{16}\) Though facilitation is frequently associated with the i-PARIHS framework, other conceptual frameworks, such as the Consolidated Framework for Implementation Research (CFIR)\(^\text{17}\) and the U.S. Centers for Disease Control and Prevention’s Replicating Effective Programs (REP) framework\(^\text{18}\) may also be helpful in thinking about how to facilitate implementation of a clinical innovation.
**Evidence for the Effectiveness of Implementation Facilitation**

There is a growing body of evidence that implementation facilitation is effective in improving implementation of clinical innovations. For example, a 2012 systematic review showed that primary care practices receiving practice facilitation were more likely to adopt evidence-based guidelines.\textsuperscript{19} Several studies conducted in the VA have shown that IF improves implementation of complex evidence-based programs. For example, an IF strategy to implement and sustain PCMHI programs at primary clinics with challenging contexts showed that compared to clinics that did not receive IF, primary care patients at IF clinics were significantly more likely to be seen in PCMHI, primary care providers were more likely to refer patients to PCMHI, and a greater proportion of those providers’ patients were referred to PCMHI.\textsuperscript{20} Additionally IF improved PCMHI program uptake, quality and adherence to evidence.\textsuperscript{21} In another study, IF improved uptake of a national VA program to re-engage veterans with serious mental illness in care.\textsuperscript{22} 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.
The goal of implementation facilitation is to understand the culture and unique characteristics of the organization and assist the organization in overcoming obstacles for successful program development, implementation, and sustainability. Many distinct roles and functions fall within the purview of a facilitator. Thus, it is important that the facilitator be flexible, knowledgeable, creative, and adaptable to different techniques that meet the needs of diverse situations. Sometimes, the facilitator functions as an organization leader and, at other times, as a content expert. At still other times, the facilitator serves as a mentor, coach, and change agent. Therefore, it is important that the facilitator be comfortable in diverse roles, be skilled at building relationships and most importantly, be aware of specific nuances within the local organization.

Facilitators can work either internally or externally to the clinical environment and can work in multiple configurations. For example, an external facilitator (EF) who is an expert in general implementation activities and relevant clinical models and their evidence base can work with an internal facilitator who is familiar with facility-level organizational structures, procedures, and culture as well as the clinical processes within the network (VISN) or facility. Alternatively, an EF or internal facilitator can work with a site champion or QI team to implement a new clinical innovation. Below, we describe the potential roles of facilitators and how external facilitators can work with other change agents, i.e., internal facilitators, champions, and/or QI teams.

I. IMPLEMENTATION FACILITATOR ROLES

Facilitators, whether they are internal or external to the clinical environment, are experts in implementation of clinical innovations. In some cases, the expertise of an internal facilitator may emerge over time through mentoring by the external facilitator. Senior leadership support for the facilitator’s involvement in implementing an innovation is critical to ensure that the facilitator’s expertise is recognized. The facilitator’s goals are to help sites create a structure and pathway through which clinical 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),4 “facilitation is more two-way than other implementation strategies, not as prescriptive and more adaptive and respectful of what is in place” (page 7).

Facilitators should support the vision for change. This requires a consistent presence through site visits, telephone conferences, and/or emails. With these contacts, the facilitator can provide the motivational push and intellectual resources that help lead to successful implementation. Below, we briefly describe some of the most important role behaviors of implementation
facilitation. In Chapters 5-9, we focus on how implementation facilitators can operationalize these roles.

Understanding the Setting

Early in the facilitation process, the facilitator should understand the environment within which the clinical innovation is being implemented and work with key stakeholders to identify potential barriers to change as well as ways to overcome these barriers. Additionally, the facilitator should look for enablers of change in the environment and leverage these to benefit the transformation. Each organization has different pathways through which change occurs and processes or people who influence these changes. A facilitator must engage actively with stakeholders and be informed about the political climate\(^i\) of the organization, the unique characteristics of the setting, the demographics of the patient population, and the culture\(^ii\) of the organization. When an EF works in tandem with an internal facilitator, champion or QI team to support clinical innovation implementation, they must communicate with one another to ensure they are aware of these issues. (See Chapter 5, Section IV, “Assessing the Site,” pages 34-39 and Chapter 6, Section VI, “Assessing the Site during the Implementation Phase,” pages 62-63.)

Engaging Stakeholders

Creating an environment that supports a change in practice requires identification and engagement of key stakeholders among leadership, providers, and support staff. While an initial endorsement by network, medical center, and clinic leadership can provide an entryway to the clinical setting, establishing the types of relationships necessary for successful implementation is an essential job for the facilitator. Thus, it is important that the facilitator be able to work and communicate with a variety of personalities and disciplines and feel equally comfortable working with line staff and senior leadership. (See Chapter 5, Section III, “Stakeholder Engagement during the Pre-Implementation Phase,” pages 25-34 and Chapter 6, Section II, “Stakeholder Engagement during the Implementation Phase,” pages 56-58.)

Building Relationships

Once engaged, building and maintaining relationships with key stakeholders is a critical function of implementation facilitation. It is important to establish these relationships early in the implementation process. This may include relationships with leaders and other stakeholders, such as front-line clinicians, nurses, and other clinical staff as well as behind-the-scenes players. Specifically, the facilitator should know who the stakeholders are.

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\(^i\) **Climate:** Concerns the effect of systems on individuals and groups and focuses on organizational members’ perceptions of observable phenomena such as organizational practices and procedures. (See Appendix A2: Glossary of Terms, pages 113-114, for more information.)

\(^ii\) **Culture:** 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.
are, their specific roles in the setting, and how the stakeholders function within the system at large. This information can come from the organizational assessment process, a site champion or QI team or if the facilitator is internal to the clinical setting, their own institutional knowledge. The facilitator should quickly identify the formal and informal leaders and the individuals who strongly influence day-to-day procedures. For example, it is important that a facilitator develop positive working relationships with clinic managers and administrative officers. Without these relationships, it may be difficult to arrange logistics for meetings and guarantee that all key stakeholders will be present, given competing priorities.

The facilitator should also work to create environmental conditions that support and sustain successful organizational change. For example, the facilitator can foster an atmosphere of open and direct communication among stakeholders. It is important to value input from staff at all levels of and roles within the organization. The more stakeholders perceive they are respected and heard, the more likely they are to engage and own the implementation process. To reach group consensus, the facilitator may encourage and support dialogue between multiple stakeholders, guide the discussion, clarify important issues, and move stakeholders to consensus. In this sense, the facilitator may serve as a mediator or neutral party with the primary goal of helping the key stakeholders identify an implementation strategy and successfully implement the innovation.

**Setting Program Goals**

Depending on the experience of site personnel in implementing clinical innovations, setting program goals may be a challenging task. It is important that the facilitator provide structure and guidance that will allow the site staff to develop clinically-meaningful performance improvement goals and related processes that will maximize the potential for success in implementing the innovation.

**Providing Evidence**

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

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**Academic Detailing**: Non-commercial prescriber education (See Appendix A2: Glossary of Terms, page 113, for more information.)
Developing Processes to Inform Implementation

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

Identifying Strengths and Challenges

Facilitators spend a substantial portion of their efforts identifying problems and strengths that can impact implementation. Using data gathered in the implementation process, the facilitator works directly with site personnel, potentially through an internal facilitator, champion or QI team, to identify barriers to implementation and develop feasible solutions for the local context. Working with local site personnel to identify problems and solutions, rather than directly telling them what to do, helps ensure that they apply and maintain implementation skills beyond a particular effort. The facilitator should pay equal attention to factors that can support change. These may be influential and respected people who can lead the mission or have a strong sense of group cohesion. Any identified strengths allow the facilitator to give positive feedback to the group and leverage these strengths for change.

Envisioning Change

The facilitator should help the organization develop its own vision for change, program development, and implementation. Most busy front-line clinicians have little time to reflect on the organization, conceptualize possibilities for change, and consider activities to influence change within the system. At times, stakeholders may have ideas about how a clinical innovation should look but have limited information about how to make change occur. At other times, the stakeholders may not have enough information to understand what changes should be implemented. The facilitator evaluates the site’s readiness for organizational change and provides the resources that are consistent with the site’s receptivity. The facilitator coaches stakeholders through this process and advocates for the innovation.

To help the organization develop a vision related to implementing a clinical innovation, the facilitator leads group discussions that include presentations of the necessary practice or program requirements and provides data on the current stage of implementation at that location, implementation progress and challenges. It should be clear to all stakeholders that the facilitator is there to help them develop and implement a clinical innovation with fidelity that also meets local needs. The facilitator can provide examples of how similar organizations have implemented the innovation as well as what has and has not worked. The facilitator encourages group creativity and explicitly states
that the program will be monitored and adapted accordingly. The key is to guide the stakeholders through the process of envisioning what they would like their program to become and how they would like it to function. While providing guidance and technical assistance, the facilitator must be careful to ensure that the stakeholders, rather than the facilitators, are creating the program, which will foster successful implementation, buy-in, and ownership. This may be difficult when local stakeholders are not actively engaging in the process. The facilitator can make suggestions, provide additional information, and focus on building stakeholder engagement. However, the stakeholders must develop the program to ensure success and sustainability.

**Teaching, Training, Mentoring**

Facilitators can provide implementation assistance to all relevant stakeholders through multiple mechanisms. To be successful, the facilitator must be up-to-date on local initiatives, VA Central Office directives, and relevant current literature. The facilitator can provide education in formal meetings with larger groups or through one-on-one training. The facilitator should work to identify forums and opportunities for continued education, collaboration, and discussions among stakeholders. If these are not already established, the facilitator may need to take the lead in launching them. Forums might include monthly conference calls, weekly team meetings or quarterly educational seminars or trainings to foster growth. Early on, the facilitator identifies gaps in knowledge or skills and helps provide the needed training or resources through direct education or linkage with additional resources. For example, the facilitator may identify and arrange for a guest expert to present information. Through these forums, the internal facilitator not only continues to provide education and consultation but also establishes a forum for programmatic review. This helps create an environment that fosters group discussions and encourages sharing of ideas and resources.

**Supporting Change**

Creating momentum for change within the organization is one of the goals of implementation facilitation. The facilitator identifies and uses systems, leaders, disciplines, programs or groups that have an interest in the desired outcome to help propel the organization toward the desired change. The facilitators partner with stakeholders to create the environment and embed processes that support change. Specifically, the facilitator identifies program champions and early adopters.\(^{iv}\)

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\(^{iv}\) Early Adopters: Early adopters are a more integrated part of the local social system than are innovators. Whereas innovators are cosmopolites, early adopters are localities. This adopter category, more than any other, has the greatest degree of opinion leadership in most systems. Potential adopters
Reinforcing Positive Change

The facilitator fosters growth toward the desired change by communicating positive results across the organization. Facilitators should ask stakeholders to identify a specific set of performance improvement goals to monitor for each clinical innovation they want to implement. The facilitator can then use available data to assist with monitoring progress toward those goals. For such monitoring to inform adaptation of the innovation or program to local site needs and resources, stakeholders should be able to see how their changes have directly influenced programmatic change. This further engages stakeholders and provides positive reinforcement for continued change. It is important to understand that sites implement innovations at different rates and even small accomplishments should be noted and celebrated, particularly at sites having difficulty gaining momentum in the implementation process.

Accordingly, the facilitator should be familiar with any readily-available data that might be useful for monitoring clinical innovation implementation. For example, a facilitator focusing on implementation of telehealth should be knowledgeable about the National Telehealth VSSC data cube which allows one to parse out specific telehealth data by site, clinic, and patient demographics. While additional permissions may need to be obtained in order to access the data cube, a facilitator should be able to refer internal facilitators or site champions to this resource and provide guidance in using the data to improve telehealth implementation.

Leading the Organization Internally

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

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

Look to early adopters for advice and information about the innovation. The early adopter is considered by many as "the individual to check with" before using a new idea." (See Appendix A2: Glossary of Terms, page114, for more information.)
Finally, when working with an EF, the internal facilitator often is the direct organizational link for the EF, developing mechanisms to assess progress and providing regular reports to the EF. Meaningful feedback from stakeholders across the organization is needed for successful implementation. Thus, the internal facilitator maintains dialogue and establishes a feedback loop in which program data and stakeholder feedback is provided to the EF.

**Linking to Outside Resources**

When information is needed about the clinical innovation that goes beyond the knowledge of the facilitator, who may or may not be a content expert for the innovation being implemented, the facilitator also serves as a linkage to other experts or resources. These may include researchers who have developed or studied the innovation or key players who have been successful in their own implementation effort at other sites.

**II. HOW EXTERNAL FACILITATORS CAN WORK WITH INTERNAL FACILITATORS, CHAMPIONS AND QI TEAMS**

The degree and type of interactions that occur between an external and/or internal facilitator, champion and/or QI team will vary across implementation efforts and the implementation phase (see Chapter 4 for a description of the Phases of Implementation).

**During the Pre-implementation Phase**

- The EF serves as a recognized “expert” from outside the local organization, which provides the internal facilitator with a high degree of credibility. We have found this to be a particularly helpful role during the initial engagement of stakeholders, mainly with leadership. Thus, it is incumbent upon the facilitator to be highly knowledgeable about the clinical innovation to be implemented and successful implementation strategies.
  
- The EF takes a more commanding role during early interactions with stakeholders.
  
- In turn, the internal facilitator, champion or QI team is accumulating information on the clinical organization, local culture, history, and interpersonal dynamics at the site.
  
- Following site visits or conference calls with stakeholders, the EF should debrief with others involved in the implementation effort (e.g., internal facilitator, champion, or QI team), with each of them interpreting the significant components that emerged from the meeting/call, identifying the current strengths and weaknesses of the site’s implementation process, and developing a plan to address identified problems and leverage strengths.
During the Implementation Phase

- The facilitator(s) and internal personnel (e.g., internal facilitator, local champion, opinion leader or QI team) should meet regularly to review program implementation progress with the EF 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 VAMCs across the country, each site’s external and internal facilitators met weekly. During these meetings, the facilitators reviewed the status of the program’s implementation and data that documented the implementation process.

- The EF should serve as a mentor to the internal personnel, coaching them on how to address problems and interact with stakeholders.

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

- The EF 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 EF’s level of expertise is needed or when it is felt that the presence of an expert with a high level of credibility is needed to negotiate an impasse or particularly difficult barrier.

- Over the course of the implementation effort the internal personnel progress and begin to lead implementation activities. 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 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 EF for feedback to obtain consultation as needed.

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

- The EF and internal personnel no longer have standing calls or scheduled interactions, though the EF is available on an as needed basis.
• EF and internal personnel interaction is around sustainment and further program development.

• The programs have been implemented and are up and running. With the assistance of the facilitation team, sites have overcome multiple hurdles and have developed successful programs.

Over time, the interactions of the external and internal facilitators evolve, and the roles and functions shift. Above we have outlined a successful process based on our experiences facilitating implementation of PCMHI. This process may vary depending on the exact clinical innovation needs and the skills of the EF and internal personnel. Most importantly, the relationship should be collaborative and supportive and utilize the strengths and skills of all team members in a dynamic process.
Clearly, implementation facilitation is complex. Not only do facilitators need to be able to apply a wide range of implementation interventions, 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 particular clinical innovation. Thus, facilitators require a diverse set of complex skills. This chapter will discuss the essential knowledge, skills, and core competencies of facilitators, as well as some of the attributes of good facilitators.

I. KNOWLEDGE AND SKILLS

In addition to knowledge of implementation facilitation roles and processes, facilitators need some knowledge about the clinical innovation being implemented. In some cases, facilitators are subject matter experts (SMEs); even so, it is important to know other experts, who have a more nuanced understanding of some element(s) of the clinical innovation, to whom facilitators can refer as needed. If the facilitator is not an SME, he or she should know enough about the clinical 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 SMEs in implementation processes 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 clinical innovations.

In addition to knowledge, facilitators should have a range of skills to help organizations implement clinical innovations, including:

- Communication and interpersonal skills\textsuperscript{4,6,14,23,24} to present information (orally, in writing, visually, and over videoconferencing equipment), as well as the ability to effectively advocate for change, ask questions and listen to concerns, develop relationships with stakeholders, foster development of relationships between individuals, and engage stakeholders in participating in the implementation processes.

- Group/team management skills\textsuperscript{6,14,25} to provide leadership, manage complex group dynamics, resolve conflicts, make sure everyone is heard, and help groups stay focused, set goals, and make decisions.

- The ability to rapidly assess the needs and resources of individuals, teams\textsuperscript{26,27} and the organization\textsuperscript{4,26-28} throughout the implementation process and respond to an ever-changing clinical context.
The ability to identify and solve problems\textsuperscript{29} and help others do the same.

Skills related to organizational change management\textsuperscript{30,31} and clinical innovation implementation,\textsuperscript{6,14,28} as well as general administrative and organizational skills.\textsuperscript{14,24}

Strong teaching skills\textsuperscript{14,26,31} to coherently present information about the innovation and/or implementation process when opportunities arise. The facilitator must have the ability to transfer this skill to local champions\textsuperscript{v} so that they too may become experts in the innovation and implementation process.

Marketing\textsuperscript{6,25} skills to ‘sell’ the value and need for change to leaders and other stakeholders as well as motivate others to make the needed changes. To do this, the facilitator needs to develop some credibility with those stakeholders.

Political skills\textsuperscript{6,32} to become aware of the power relations within organizations and facilitate change within diverse, complex political systems.

**II. CORE COMPETENCIES**

The skills facilitators need 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 listed above include both communication and assessment skills. Thus, to develop the skills required for implementation facilitation, it is helpful to think about the core competencies that facilitators need. A recent study identified five implementation facilitation skillsets or core competencies.\textsuperscript{33} Facilitators need to be able 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; and
- Assess people, processes and outcomes and create infrastructure for program monitoring.

\textsuperscript{v}Champion: 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. (See Appendix A2: Glossary of Terms, page 113, for more information.)
III. CHARACTERISTICS OR ATTRIBUTES OF FACILITATORS

In addition to having the requisite knowledge and skills and developing these core competencies, there are some personal traits or characteristics that facilitators need to foster. Perhaps the most important characteristic of a good facilitator is the ability to empathize and understand the needs of others. As noted above, facilitation should occur within an environment of mutual respect. The ability to establish such a relationship requires that the facilitator be genuine and positive. It is important for the facilitator to know when to speak and when to listen. It also is important to 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. Finally, they need to be innovative and resourceful, as well as exhibit energy and enthusiasm.

Training workshops, manuals and resource 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. We encourage implementation facilitators to seek training, mentoring, and/or consultation with others who have some expertise in implementation facilitation.
Implementing an innovation within clinical settings typically involves activities that occur over three phases—pre-implementation, implementation, and sustainability phases.

The **pre-implementation phase** is a time period for designing a customized, local plan for implementing a clinical 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. 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 clinical QI goals defined during the pre-implementation phase.

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

The figure below illustrates these phases and gives examples of related activities. Although the illustration depicts a somewhat linear relationship between the phases, it is actually more appropriate to view them as *dynamic* and *iterative* where one may cycle through the phases multiple times during the course of an implementation effort to achieve the desired change. For example, a facilitator might think that the implementation effort is moving toward the sustainability 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.
4 – Phases of Implementation Facilitation

Phases of Implementation
With Example Activities

Pre-Implementation
• Engage key stakeholders
• Identify determinants of current practice
• Identify potential barriers / facilitators to practice change
• Assess feasibility of proposed implementation strategy(ies)
• Integrate findings into local implementation plan and refine as needed prior to implementation

Implementation
• Assess discrepancies between implementation plan and execution, explore issues of fidelity.
• Understand and document nature and implications of local adaptation
• Monitor impacts and indicators of progress toward performance improvement goals
• Use data to inform need for modifying or refining original strategy
• Provide positive reinforcement to high performers; encouragement and other support to low performers

Sustainability
• Assess usefulness or value of implementation strategies and tools from stakeholder perspective
• Elicit stakeholder recommendations for further refinements to implementation plan
• Identify additional barriers / facilitators to address
• Integrate new strategies or tools into plan to maintain and institutionalize performance improvement

Adapted from: Stetler, et al. (2006)
SECTION II

IMPLEMENTATION FACILITATION ACTIVITIES
I. INTRODUCTION

As mentioned in Chapter 4, the pre-implementation phase is a time period for designing a customized, local plan for implementing a clinical 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 and meeting and initially engaging key stakeholders. 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.

II. 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 clinical innovation. You need to be well versed in any policy documents that support the program or practice that is being implemented, evidence for the clinical 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 in the following areas:

- 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 meet full 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. For example, VHA has a clear mental health strategic and operating plan in the Uniform Mental Health Services Handbook (VHA Handbook 1160.01, recertified in 2013). This handbook and other more specific mental and behavioral health policy documents are available on the VHA intranet at http://vaww.mentalhealth.va.gov/index.asp.

- In addition, you should have thorough knowledge of the evidence that supports the clinical 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 similar to the site.

- You should have a basic understanding of implementation science and knowledge of facilitation activities and processes.

- Finally, you should also have a working understanding of the clinical site where you are implementing the innovation. Each clinical site is unique; you will need to apply a slightly varying set of activities for each site. The needs of each individual site and their readiness to adopt a particular innovation are likely to differ. In addition, individuals who help implement practices and services at the site level will occupy varying positions in their respective organizations and have different relationships with their colleagues, supervisors, and facilities. 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 site.

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 the innovation. The identification of 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. The external facilitator should enlist the help of an internal facilitator, when applicable, or local change agents to identify roles and positions typically held by key stakeholders including:

- Leadership at the network, facility, service, community-based outpatient clinic (CBOC) or other organizational levels who are involved in decision making about the innovation. You may want to start with the Network director, Network Chief Medical Officer (CMO), Network Service Line Leadership (e.g., Network Mental Health (MH) lead), medical center directors, associate directors, executive nurses, chiefs of staff, and chiefs of services (relevant to the change). The leaders’ understanding of the value of the practice/innovation to be implemented and the role of the facilitators will lay the foundation for future efforts. For example, if network-level leaders understand and support efforts, then they can provide an introduction to medical center leadership. You may want to consider an initial meeting with the medical center leadership before engaging other stakeholders at the site. (See Appendix B, page 119, for an outline of the agenda used for the initial call with facility leadership in VA’s Evidence-Based Psychotherapy Facilitation Initiative.) 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 will be supportive of the implementation effort.

- As engagement with Network and/or Medical Center leadership is initiated, it also is important to engage local program leaders, who may have direct responsibility for the program implementing the innovation. This may include a local service line manager or a specific program lead or manager, with an administrative role.

- 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.

- Other stakeholders.
  - Ask (and keep asking) leaders and supervisors about who else needs to be involved in the process.
Other stakeholders to consider including:
- Suicide Prevention Coordinator
- Clinical Applications Coordinator
- MSA or PSA representative
- OEF/OIF/OND Program Manager
- Facility Systems Redesign Lead
- Health Behavior Coordinator
- Evidence-Based Psychotherapy Coordinator
- Facilities Management
- Peer Support Specialist
- Discipline Specific Leads (for social work, psychology, and psychiatry)

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 6 which describes IF 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 challenges.

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 sustainability phase.

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

- Invite leaders to any special events or meetings to lend their support—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 more formal and brief, and provide an executive summary. Link or connect the presentations to executive career field initiatives, performance measures, strategic plans, Under Secretary’s goals, or VHA core values, especially those that are of particular interest or importance to the medical center in which the innovation is being implemented. (See Appendix C-4, page 126, 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.
Levels of Stakeholder Engagement

There are several levels of stakeholder engagement:

**Active engagement**

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

**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 the appropriate times to help facilitate the growth and development of the program. Some stakeholders, including leaders, will remain at the non-engagement level, which makes your task much more difficult. If leaders are not engaged, then engaging them needs to become your primary objective so the implementation process can proceed.

**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 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)\textsuperscript{36-39} 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” (\textsuperscript{36}, p.12), 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 clinical 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 C-4, page 126, 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 to ensure stakeholders who missed the first session due to shift times were included.

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 provide 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 implementation facilitation 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)

Full details on the roles of facilitators may be found above in Chapter 2, “Facilitation Roles.” The points below, however, should be emphasized 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 that you are working closely with an internal facilitator or 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 clinical 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. 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 a clinical innovation embedded and then leaving). Many VA 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 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 aren’t necessarily project saboteurs, but may have competing preferences or priorities for implementation resources or may have genuine, legitimate concerns about the innovation targeted for implementation and its limitations. Listen to those concerns and address them accordingly during the pre-implementation period, trying to win them over to support (or at least not work against) implementation of the targeted program/practice. It is often helpful to watch body language as well as listen to what is (and is not) said during initial meetings. An external and internal facilitator or a facilitator and local change agents 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.

**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 VISN level. One of the important lessons learned among experienced facilitators is when and how often to enlist the help or support of leaders at the site or VISN. 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 forward movement. Use this sparingly and only for items that cannot be otherwise 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 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. As part of your preliminary work, in addition to asking questions, review both inter- and intra-net web sites that offer a "snapshot" of the site. For example, look for information on VISN and facility web sites, the VHA Support Service Center (VSSC) web site, and any other websites containing data related to the innovation you are implementing. 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 C-1, page122.

**Gather information about the clinic**

- **Know the type of clinic:** Community-based Outpatient Clinic (CBOC) vs. Veterans Administration Medical Center (VAMC) clinic. If the facility is a VAMC, identify the facility level of complexity and the types of services provided. If you are working with a CBOC, make sure you also understand the parent VAMC location.

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

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

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

- **Organizational Structure:**

  For most locations, this type of information is available on site-specific web-pages, [http://vaww.va.gov/directory/guide/home.asp](http://vaww.va.gov/directory/guide/home.asp). As further described in Chapter 6, some important information is best obtained through individual conversations or through specific program dashboards.

**Learn about the population**

- Gather demographic information about the population that the innovation or program will serve: ages, urban vs. rural populations, proportion of homeless population, male-to-female ratio, proportion of OEF/OIF Veterans, the proportion of Veterans seen at CBOCs and relevant socio-economic factors that affect the Veteran population and the staff. This information may be obtained from clinical data sources such as the Veterans Health Information Systems and Technology Architecture (VISTA) or a Data Warehouse as well as network- and site-level leadership. You will need to learn about some of the challenges in providing services to meet the needs of their population. For example, proposed services that require telephone land lines when the Veteran population includes a large proportion of homeless Veterans will have obstacles to consider. You may ask key stakeholders about the population and for assistance in obtaining this type of local data.

- 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**

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

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

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

**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 Veteran population, staffing levels, names of key staff members, phone numbers, directions to the site, and any other notes, questions or special issues that need to be addressed. Keeping this document in a folder and frequently updating information will be useful in the future.

One way to maintain information is to keep an Excel workbook with different tabs for different types of information. This will allow efficient updating, use of other spreadsheet features (e.g., graphs, comparative tools) and ability to print only the information needed (see Appendix D. Facilitator’s Clinic Summary Excel Workbook, page 135).

Additional Considerations as You Continue the Assessment Process

- Learn the value system of the organization and get staff input; this is vital! 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, one facility director was very concerned about patient satisfaction rates. Emphasizing the ways the innovation will impact patient satisfaction may be a most effective strategy for engaging and gaining the support of leaders for whom this is important. One facility might be very impressed with data on graphs and charts, and another might be much less impressed with visual data and want to hear more about quality and the Veteran 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. While some assessments will likely be innovation-specific, others may be more generically useful. For example, the Organizational Readiness for Change measure (ORC) 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

- 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 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.

Barriers to obtaining data

- In recent years, with increased emphasis on transparency, there is less reliance on locally obtained data, and you may be able to obtain key data points from readily available national VHA-wide dashboards. It is still important that you discuss how you are using these data and be explicit with local stakeholders that your goal is ongoing innovation quality improvement. 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. Sometimes you have to work on building trust before you can obtain the data you need. It may be helpful if you make an explicit statement about the fact that you are interested in understanding the specific site for innovation implementation and quality improvement and not for evaluative purposes. Remind them that you really are there to help!

- Availability of data may vary from one VAMC to another and from one VISN to another. Some VISNs have consolidated data (‘data warehouses’) that are more readily available than others. In one VISN, there was no consolidation of data, and each facility maintained data in its own manner. Of course, some data is collected nationally and is theoretically "available" if you have the capacity to access it. Some data may be obtained from VISTA.
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 on relevant 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 clinical application coordinators (CACs) 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 VISN 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, such as staff not using the appropriate clinic stop codes, when questioning data.

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

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

- If you find a problem, you might do spot checks or chart reviews to determine what is happening. Although this is time consuming, it is helpful to do this in a limited manner.

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. Interestingly, several locations have asked for 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 without appropriate training to an initiative with no staff at all.

Hiring and Identifying Clinical Innovation Staff

Hiring, training, and mentoring staff to deliver a clinical innovation is a complex process that is important to program sustainability—but begins in the pre-implementation phase. A few fundamental principles will help ensure long-term program success. You should be familiar with these principles and provide consultation to leadership as they identify and hire staff:

1) Prior to identifying or hiring staff, administrators should have a clear understanding of the nature and expectations for successful program functioning.

2) Staff should be matched to program needs.

3) 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:

1. Communicate the above recommendations to program managers and highlight the need to recruit an individual with skills that are well suited for the specific position. If the role being filled is that of the Internal Facilitator, you can refer to Chapter 2, “Facilitation Roles,” to help provide guidance.

2. 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 site, you may provide leadership with sample position descriptions, sample recruitment advertisements, interview questions, and performance plans being used at locations with successful programs. If none are available, assist program managers in developing such materials that are consistent with high functioning programs.

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

**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. The facility-level supervisor should have the responsibility to ensure that appropriate training occurs. However, as a facilitator, you may play a substantial role in the training process. Some general principles are listed below:

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

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

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

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

- If available, recommend attendance at relevant, skill-based training conferences and workshops. Evidence suggests that attendance at a one-to-three-day workshop, with continued follow-up telephone consultation calls, improves provider knowledge and skill acquisition to perform an intervention of brief cognitive-behavioral therapy (CBT) in primary care.⁴³

- Other effective training techniques include implementation of action plans, performance assessments, and ongoing supervisory consultation.⁴⁴,⁴⁵

- Shadowing current, successful providers and ongoing consultation from experts within the field is also recommended.⁴⁶,⁴⁷
• In addition to supporting attendance at relevant workshops, leaders should be involved and encouraged to provide a supportive environment for successful training to occur. You can play a substantial role in the training process.

Mentoring an Internal Facilitator

In Chapter 2, pages 15-17, we described how external facilitators can work with internal facilitators. If you are an EF and the site has a designated, but inexperienced, internal facilitator, you will need to begin training and mentoring the internal facilitator during the pre-implementation phase. The goal of this ongoing process and relationship is to transfer IF knowledge and skills to the internal facilitator so he/she can ultimately lead change efforts at the site. As soon as a local internal facilitator is identified, you should begin meeting with them, assessing their knowledge and skills, and guiding them through IF processes. Typically, as part of mentorship, you should meet with internal facilitator(s) regularly to review implementation progress, discuss next steps, review major actions, and identify additional implementation strategies that may be helpful. Following initial visits or conference calls with stakeholders, you will want to debrief with the internal facilitator, interpreting the major components that emerged from the meeting/call, identifying the current strengths and weaknesses of the site’s implementation process, and developing a plan to address identified problems and leverage strengths. During the pre-implementation phase, you should take the lead in developing possible solutions to problems while the internal facilitator works closely with the sites to obtain their input. You will need to tailor your mentoring efforts to the needs and characteristics of the internal facilitator, building on their strengths and past experiences. You should get to know each other’s work style. Over time, your interactions will evolve, and your roles and functions will shift as the internal facilitator gains implementation facilitation expertise. The degree and type of interactions that occur between an external and internal facilitator will vary across implementation efforts. Most importantly, the relationship should be collaborative and supportive and utilize the strengths and skills of both team members in a dynamic process.

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.
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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 program (to patients, providers, clinics, systems, etc.), the type of services provided, the patients who may benefit from the services, and the ways to link patients to these services. These events may be more formal than other marketing activities. You can schedule them as part of pre-existing meetings or hold them separately. Be sure to have informational handouts available for all who attend. 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, 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.
VII. THE SITE VISIT: PREPARATION FOR TRANSITIONING TO THE IMPLEMENTATION PHASE

Clinical 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 VISN and facility leaders from all applicable departments. As part of a parallel process, it is important to engage departmental and clinic-level leadership and front-line staff. One promising method of implementation involves formal program implementation meetings with all clinic staff and reviewing a previously developed implementation planning guide.48,49 (See Appendix E, pages 139-154, for examples of Implementation Planning Guides from several VA initiatives.)

Thus, one important function of the facilitation team is facilitating program implementation 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 C-3, page 125, and J-1, page 188, 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 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 8.

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 a VISN or facility policy for visiting the site

   If there is a policy, follow those guidelines. For example, in the VA, VISN guidelines may require at least 60 days’ notice to cancel clinics for providers who plan to attend the site visit. Furthermore, some VISNs may require a letter of notification that explains the purpose of the visit and identifies individuals who will be conducting it at least 30 days before the date of the visit.

2. Identify and develop relationships with people who can help

   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:
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- An identified local champion who is stationed at the location 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. Perhaps, the clinic has a regularly-scheduled provider meeting when specific site visit meetings could occur. These contacts can help you navigate through these complicated nuances that vary from location to location.

- 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 C-2, page 124, 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, set up VANTS conferencing lines.

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

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

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

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Basics of Facilitating Meetings

Although the specific techniques and skills used for meeting facilitation will vary, a few general principles should be used as a guide through the process. 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 purpose of the meeting and the objectives to be accomplished. Be flexible and prepared to adjust based on issues brought up in the meeting. Sometimes the group may not be ready to discuss your agenda. In those instances, you may need to back up and provide more education and/or allow alternative points of view to be expressed. A follow-up meeting to address important agenda items may be necessary.

3. **Provide information 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.

6. **Provide structure for the meeting**

   Prepare an agenda for each meeting and solicit items from stakeholders for inclusion.
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 program will be monitored and revised as needed. Remind stakeholders that implementation is a “process,” not an “event.” Thus, the program can continue to be revised and improved as needed to meet organizational goals.

11. **Guide the group to establish an Implementation Plan that meets VHA requirements while considering local needs**

    Facilitators serve as experts in program requirements and have extensive knowledge of how similar locations have successfully implemented programs. However, do not dictate to stakeholders how the program will be implemented at their site. Provide important parameters, program requirements, and information about the evidence base, but let the stakeholders decide about the day-to-day program operations.

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 these programs and what is needed for optimal impact. At times, it may be helpful to gather additional local data to present to the group. You may want to invite a guest speaker who can describe how the program functions elsewhere. (See also “How to Identify and Address Negative Stakeholders” on pages 32-34.)
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 enough 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 C-3, page 125. 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 clinical 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 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, often known as the "Quad," “Quadrad," or “Pentad,” which includes the Medical Center Director, the Associate Medical Center Director, the Chief of Staff, the Associate Director for Patient/Nursing Services, and any other staff required by the Executive Leadership team. You may also invite care line or specific service leaders and program managers to this meeting. For example, if implementing a PCMH 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.

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

**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 clinical 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 40-50 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 clinical innovation, their knowledge of it can allow them to better interface with the clinical 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, such as the Suicide Prevention Coordinator or the OEF/OIF program manager. It is better to err on the side of casting too wide a net, than not to invite the people who should be at the table.

• Typically, this presentation lasts 30 to 40 minutes, allowing ample time for questions and includes a form didactic PowerPoint presentation. See Appendix C-5, Stakeholder Education Overview Presentation (PCMHI), pages 128-132, 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 wide variety of stakeholders basic information about the innovation. 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 characteristics that support implementation
  ▪ What is Implementation Facilitation and how it can help

• While providing this basic education, the facilitation team is 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.

• 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 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 strategy that considers local needs, preferences and resources. Thus, key individuals who should be present include the stakeholders who will be involved in the direct day-to-day operations of the program (i.e., front-line clinicians) and the leaders who will directly oversee the program and the implementation process. Sometimes other stakeholders will be interested and seek
inclusion at this meeting. 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 meeting to ensure a functional working team. It has been found that if too many individuals not directly involved with the innovation are present during the implementation 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 program, why the VHA is implementing the program, and how the program, when well implemented, can positively influence patient care, patient satisfaction, and provider satisfaction. Typically, you need to present this information in a less formal way, which often takes the form of a discussion. The information delivered should be tailored and concise, depending on the stakeholders present and whether they also attended the entrance briefing.

- If possible, provide a Program Implementation Planning Guide for the specific program elements being implemented to structure the remainder of the meeting. (See Section VIII, “Crafting the Implementation Plan: Transitioning to the Implementation Phase,” pages 53-55, and Appendix E, Implementation Planning Guide Examples, pages 139-154.) The guide should include all the program elements required by VA policy. It also allows for variation to meet specific site-level needs. All clinicians review the guide and, through group discussion, reach consensus for the establishment of the required elements, document their decisions and any required actions on the guide, and then translate this guide into a site action plan for program implementation.

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.

Individual meetings

The facilitator or facilitation team (i.e., 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 meetings. The purpose of these meetings will vary as will the specific individuals with whom the facilitation team needs to meet. At times, the purpose may be to further engage stakeholders or to provide more information. At other times, it may be to establish a partnership with a negative stakeholder. The 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 program utilization. You may help the individual problem solve through barriers that may be inappropriate for discussion within a larger group. Perhaps, you will want to have individual meetings with front-line staff to get their perceptions without the presence of supervisors.

**Exit briefing**

The exit briefing is just as important as the entrance briefing. The primary audience for this meeting is top-level leadership. Ideally, the members of the Quadrad and the direct program leadership attend. Additional stakeholders 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 program implementation. Provide information about identified strengths, weaknesses, opportunities, and threats that emerged throughout the site visit. Describe the initial plan to proceed with program 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 to address 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 facilitation team should be prepared to answer questions and provide additional information. However, facilitators should make no decisions based on informal conversation. The facilitation team may learn valuable information that previously may have been unspoken. When conducting site visits, be flexible and adaptive to allow for these impromptu conversations.

**Site visit report**

Upon completion of the initial 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

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**Helpful Tip**

The 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
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 C-6 Site Visit Report Example (PCMHI), pages 133-134.)

VIII. CRAFTING THE IMPLEMENTATION PLAN: TRANSITIONING TO THE IMPLEMENTATION PHASE

Ideally, the site visit will represent a solid launch point to the implementation of your program. Thus, a related task (that may be undertaken immediately before, during, or immediately after the site visit) is to develop a formal Implementation Plan. However, 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. For example, provide details from the Uniform Mental Health Services Handbook for the program being implemented. It is helpful to have examples of similar organizations that have successfully implemented programs, as well as examples of programs that have adapted the design within the confines of the evidence base and achieved the desired outcome. The external and/or internal facilitator should provide a framework that guides the program design phase. At times examples will be readily available. However, at other times, it will be the responsibility of the facilitators to identify and locate this information.

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

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

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

**Provide a Framework for Program Design**

- Provide the tools to design a program that reflects the characteristics of the local organizational culture and meets national VHA requirements. Some of the tools, for example, might include specific sections of the Uniform Mental Health Services Handbook describing program details, relevant VACO, VISN or local policies, research articles (keep to a minimum), handbooks, checklists, fidelity measures, and other relevant resource materials.

- Make sure to have key stakeholders at the table for the program design process. At least one stakeholder from each discipline or staff position that will play a role in the program should have input into its design. This includes leadership, administration, providers of services, clerical staff, allied staff, sources of referrals, and consultative staff. Identify a local champion who will help guide and actively support the process through to completion. See Appendix F, page 155, for Clinical Champion Activities and Characteristics.

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

**Obtain or Create an Implementation Planning Guide**

- The guide includes all required program elements, including for example, the target population, inclusion/exclusion criteria, team composition, activities, services, barriers to look for and guidance on how to resolve them, monitoring activities, protocols and tools (e.g., decision support system, assessment tools, and marketing and training materials). (See Appendix E, pages 139-154 for Implementation Planning Guide Examples.)

- The guide 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 also logs essential administrative steps such as establishing clinic names, forms, procedures, and outcomes that will be monitored.
The final document should contain the required elements of the program and describe the local process for meeting VHA requirements within the context of local resources, processes, and stakeholder needs.

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

Congratulations! Once you have a fully developed and mutually agreed upon Implementation Plan, 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.
CHAPTER 6
IMPLEMENTATION FACILITATION ACTIVITIES
IN THE IMPLEMENTATION PHASE

I. INTRODUCTION TO 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 completion 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.

II. 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. 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 have not been recognized as playing a key role. Once identified, immediately engage with these team members. See Chapter 5, Section III, “Stakeholder Engagement during the Pre-Implementation Phase,” pages 25-34 for more information on this process.
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 regular cycles of updates to which you can attach reports. 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, pages 174-176. (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 information 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 data from the National Telehealth VSSC data cube and through ongoing contact with on-site champions and providers. 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 e.g., 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.

Building Stronger Relationships through Routine Conversations

By this time, you 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. The key is to ensure that they remain invested and actively engaged while they may be faced with many competing priorities.

Overcoming Obstacles through Stakeholder Engagement

Leaders may be instrumental in helping you overcome obstacles. However, the success of this process often depends on the depth and the quality of the relationship. When you point out obstacles, refrain from assigning blame. When enlisting leaders’ help, rather than taking a
negative approach, you can ask them to help convey the information in a non-critical manner. For example, if the objective is to improve patient education in a clinic, you might ask leaders to convey the idea that patients in the clinic should have the necessary tools to make informed decisions about their care. Leaders can ask for suggestions to improve patient education. This empowers staff members to resolve the issues without feeling criticized.

**Dealing with Stakeholder Turnover**

Stakeholder turnover is inevitable and will occur 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.

**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 program or practice. When it becomes institutionalized and part of the training process for new people, you will know you have done your job well.
- Prepare materials to train new staff at every level. For example, the site should include this information in orientations for nurses, other new employees, and residents.
- Identify staff members who can conduct local training and formalize this process throughout the organization.
III. FOSTERING COLLABORATIONS 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 constructs that were previously noted are particularly salient 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. This will help you identify champions for change and understand highly effective methods for influencing organizational and systemic change.

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

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 salient during the implementation phase.

IV. PLANNING IMPLEMENTATION TEAM MEETINGS

Routine ongoing 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 5, Section VIII, pages 53-55, 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 these are established, an important function of the facilitation team is facilitating ongoing, routine innovation implementation team meetings. Ideally, such meetings will have been discussed as part of the implementation plan. 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. 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 meeting but rapidly establishes the expectation to assertively push the initiative forward. As a facilitator, you may need to suggest a recommended frequency.

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

- 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 don’t permit an implementation team meeting.

**V. 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 actually 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. Please note that you should
make sure that someone circulates a written agenda prior to the meeting and provides meeting notes/minutes afterwards.

A well-crafted Implementation Planning Guide 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 needs 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?

- 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 and may have experienced 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 clinical 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. 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. There will be times when you will want to call the team’s attention to these issues. For example, you might say that you noticed some drift from the original plan and ask to take a moment to review the intention. Drift is fine, but you will want to be sure that it is meaningful and purposeful change, rather than an unintended return to previous processes.

- 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.

**VI. 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
Chapter 6 – Implementation Facilitation Activities in the Implementation Phase

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 having challenges implementing 30 minute appointments within
PCMHI, despite education, audit and feedback, and other implementation
strategies, clinicians continued to provide care that was inconsistent with the
model of service delivery. 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.

VII. ASSESSING AND MONITORING INNOVATION IMPLEMENTATION

Another assessment goal of the implementation phase is to establish routine processes for
assessment and data collection 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 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.

Many researchers and facilitators have used theoretical frameworks to guide the selection of metrics. The RE-AIM framework50 is one model that has been widely used for such purposes because it addresses issues related to real-world settings.51 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.

- **Reach** refers to the absolute number, proportion and representativeness of individuals participating in the clinical innovation or program. For example, the site may wish to monitor the number of Veterans who receive or are participating in the innovation and their specific characteristics.

- **Effectiveness** or efficacy refers to 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 Veterans.

- **Adoption** refers to 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 VHA for each area of service delivery. Sites may select these items as the core metrics to monitor. VHA metrics are often linked to facility and leadership performance expectations and ratings. Examples include Strategic Analysis for Improvement and Learning (SAIL) data, which influences both the overall rating of the facility and often the facility director’s performance evaluation, which, in turn, influences the ratings of leadership within each program.
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 guidelines or evidence. Below is a list of data sources.

- **Dashboards**

  In recent years, the VHA has developed multiple nationally available dashboards that can easily be accessed by any VHA 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. Other dashboards include, but are not limited to: the [Mental Health Information System](#), the [Performance Measures Report](#), and [Patient Aligned Care Teams (PACT) COMPASS](#).

- **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 VISN-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, within PCMHI, there are specific measures that have been developed to address provider fidelity, such as the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ), 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.

- **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, Veterans, 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 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 sustainability. 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 facilitation team, 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.

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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.
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. You should be able to use the implementation strategies in the following list; however, this is not an exhaustive list. 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 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 clinical 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 clinical innovation. Next, you should provide educational information about relevant current clinical practice guidelines, the evidence base for the clinical 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 clinical 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.

Marketing

Many specific marketing techniques are described for the pre-implementation phase (see Chapter 5, Section VI, page 42-43). 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.

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 5, Section VI, “Marketing,” pages 42-43), 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 clinical innovation, ongoing mentoring, which will be discussed in the next sub section. There are several issues you need to consider in relationship to ensuring 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 clinical innovation providers for multiple reasons:

- The supervisor must be aware of specific goals for the program and be “onboard” 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.

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**Case Example**

For example, while telehealth has been accepted as standard practice for decades, most providers lack a basic understanding of telehealth. Oftentimes providers lack knowledge or have misconceptions about delivering mental health services via telehealth (i.e., telehealth is a treatment rather than a mode of delivery, only patients who are comfortable with technology are suitable for telehealth, their preexisting clinical skills will not be sufficient over telehealth) which can impede implementation. Additionally, the external facilitator can use training and education to preemptively target previously documented barriers in the implementation of technology-based interventions (i.e., clinical workflow, technology barriers, licensure and credentialing concerns).
Plan who will conduct the training

If you are implementing a program 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. Mentoring typically begins during the pre-implementation phase and continues through the sustainment phase. During the implementation phase, professional development should combine processes and mentoring available at the local, VISN, and national levels. This will ensure an effective and well-functioning program.

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.

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

- Schedule and lead local (e.g., either VISN or region), sharing collaborative calls (see Section X, "Building Learning Collaboratives/Communities of Practice," pages 76-77) with all providers at least monthly
- Monitor program data and provider panel management metrics (see Section VII, "Assessing and Monitoring Innovation Implementation," pages 63-67). 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 174-176 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 national and VISN resources by participating in select calls and related informational/educational opportunities.

**Linking with National/VISN Resources**

In addition to local resources in the VA, there are likely both VISN-level and national 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. For some programs, there are existing national communities or practices, with routine education and consultation offerings. For other programs, there are active VA SharePoint or Pulse site communities that may house resources and educational materials. There are National Program Offices and Centers of Excellence that also can provide a wealth of information (e.g., policy guidance) and
implementation support. There may also be national online forums such as listservs and blogs. 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 into these resources. You may be less familiar with VISN-level resources, unless the innovation is being implemented in the VISN in which you reside. If you are not familiar with these resources, take the time to reach out to key contacts (e.g., VISN leads, VISN level program managers) to identify and familiarize yourself with 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\textsuperscript{56} 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 doing well (however small), you help to create an environment that can support innovation implementation.

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*\textsuperscript{57} 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 PCMHI 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 G, pages 156-173).

Other Key Quality Improvement Processes

There are many other important and effective Quality Improvement (QI) processes. The following are strategies that are often used within VHA. You should, at a minimum, be familiar with these constructs and, ideally, should be able to implement 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

Six Sigma

Six Sigma is a process-based approach to continuous improvement. It uses data and statistical analysis to find process problems that cause a process to be inconsistent. Whenever a process doesn’t work as well or consistently as it should, a “defect” can occur. Six Sigma is a rigorous and disciplined process that focuses on meeting customer needs. Six Sigma methods follow five phases in the following order:

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.


**Spaghetti Diagrams**

A spaghetti diagram is a visual representation using a continuous flow line tracing the path of an item or activity through a process. The continuous flow line enables process teams to identify redundancies in the work flow and opportunities to expedite process flow. See Appendix A-2. Glossary of Terms, page 116, for an example.

**Plan–Do–Study–Act (PDSA) Cycle**

Plan-Do-Study-Act (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.

In addition to the implementation activities described above, other techniques should 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, and
- 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 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.

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

**Establishing VISN-Level Calls**

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

Often, these calls result in stakeholders visiting each other’s sites to learn more. They 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**

For 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.
CHAPTER 7
IMPLEMENTATION FACILITATION ACTIVITIES TO SUPPORT SUSTAINMENT OF THE CLINICAL INNOVATION

I. INTRODUCTION:

One of the seven habits of highly effective people as described by Steven Covey (2004) is to “Begin with the end in mind.”\(^{58}\) The same is true for effective implementation facilitation. Sustaining the successful implementation of a clinical innovation may be harder than the implementation effort itself. We use the term *sustainability* to refer to the continuation of clinical innovations and the delivery of their intended benefits over an extended period of time.\(^{59}\) The indicators that clinical innovations are sustained\(^{60}\) include:

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

It is important to realize that sustainability 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.\(^{61}\) The investment in the implementation of a clinical innovation can only be successful if it is sustained to serve the needs of our Veterans 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.*\(^{62}\)

While the sustainability phase of implementation facilitation focuses on activities and strategies to ensure that the clinical innovation persists over time, many of the activities you perform during the pre-implementation phase and throughout the implementation phase can prepare the site to sustain the innovation. There are some additional activities you can perform toward the end of the implementation phase to prepare the site for the sustainability phase. Because the type and duration of implementation facilitation efforts are widely variable, the work of some facilitators may end during the implementation phase while other facilitators may continue to support site stakeholders during the sustainability 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 sustainability 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 sustainability phase, we provide some suggestions for your role during that phase.

II. EMPOWERING STAFF TO SUSTAIN THE INNOVATION: PRE-IMPLEMENTATION AND IMPLEMENTATION PHASE ACTIVITIES

The following are examples of implementation facilitation activities that will empower staff and support sustainability of the clinical innovation:

- Ensure that the clinical 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 clinical 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 clinical innovation is aligned with agency mission and culture and what resources will support the changes over time.
• Establish an infrastructure for sustainability

**How to establish infrastructure for sustainability:**

- Create an ongoing monitoring system that documents adherence to the clinical innovation;
- Develop policies and standard operating procedures that support the clinical innovation;
- Foster ongoing systems improvements to ensure the integration of the clinical 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.

**III. PREPARING FOR SUSTAINABILITY DURING THE IMPLEMENTATION PHASE**

In addition to empowering site staff to continue the process of monitoring and adapting the innovation, there are some specific activities that can help them assume responsibility for ensuring that the innovation is sustained over time.

**Assessing Site Factors that May Impact Sustainability**

We know that a number of factors, internal and external to a site, can impact sustainability, 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; and

monitoring and evaluation of outcome data associated with implementation activities, including the sharing of activities and outcomes with stakeholders and leadership.

To prepare for sustaining the clinical innovation, it is important that you and the implementation team consider these factors.

Activities become routine when they reflect the collective values and beliefs of staff that implement them. Surveys such as the National Health Service Sustainability Index (SI) or the Program Sustainability Assessment Tool (PSAT) may be used to measure the factors that affect sustainability based on staff reporting (See Appendices I-2, pages 178-181, and I-3, pages 182-187). 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”. Consider using one of these tools to help site stakeholders assess areas that matter specifically to their site. By surveying 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.

Establishing a Sustainability Action Plan (SAP)

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 clinical innovation, especially if you will not be present during the sustainability phase. 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, and
- the resources needed to complete each activity.

A Sustainability Action Plan can supplement the Implementation Planning Guide created in the pre-implementation phase. In essence, the sustainability 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 site leadership to further ensure it gets institutionalized. You should consider writing your SAP using SMART goals (Specific, Measurable, Attainable, Relevant, Time bound). Below are
suggested questions to consider when drafting your goals; a sample SAP with draft goals is provided in Appendix I-1, page 177.

**How will you assess whether the clinical innovation is continuing to deliver benefits to veterans?**

Work with your site to determine what outcomes will show benefits to veterans resulting from the clinical innovation, and consider how these may be measured.

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

This question is related to the ongoing assessment of fidelity to the clinical innovation. How do you assess whether the components are continued? Is there an ongoing monitoring system that documents adherence to the clinical innovation? How will you assess the integration of the clinical 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 clinical 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. 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 clinical 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 program 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 the gain 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 program aren’t 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.
Is there a mechanism through which adherence may be incorporated into performance plans, incentives or rewards? One strategy that has worked well with some VHA implementation initiatives is to connect your site with other VHA sites who have implemented similar clinical 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.

Providing Tools for Getting Back on Track

When developing the Sustainability Action Plan with your site, it’s also important to help them plan for what they will do if adjustments need to be made to sustain the clinical 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 clinical 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 QI and systems redesign tools. (See Chapter 6, pages 70-75).

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](http://ghpc.gsu.edu/sustainability-framework)

- The 2016 Community Tool Box created at Kansas University includes suggestions for sustaining innovations. See [http://ctb.ku.edu/en/sustaining-work-or-initiative](http://ctb.ku.edu/en/sustaining-work-or-initiative).

IV. IMPLEMENTATION FACILITATION ACTIVITIES DURING THE SUSTAINABILITY PHASE

In some implementation facilitation initiatives, the facilitator is present during the sustainability phase. For example, perhaps you are internal to the setting or the innovation was implemented quickly, allowing continued facilitator involvement over time. Once the site has achieved the 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 Sustainability Action Plan during the implementation phase, there are some specific activities implementation facilitators should engage in during the sustainability phase, if you are fortunate enough to 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, especially early in the sustainability phase, whenever you are needed. 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 or site level program champions.

• Routine calls should decrease in frequency and then only occur as needed, per the request of another 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 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.

• 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.
• 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.
CHAPTER 8
VIRTUAL IMPLEMENTATION FACILITATION

Although implementation facilitation efforts generally include a mix of face-to-face 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 clinical innovations. Thus, facilitators have needed to provide implementation facilitation entirely, or almost entirely, through non-face-to-face or virtual modalities, including but not limited to phone, video conferencing, and more complex web-based communication systems (e.g., Microsoft Lync, 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 face-to-face 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 being 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 Lync 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 development is certainly possible via virtual or remote modalities, relationship building 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 such as GoToMeeting or Lync). In some cases, the gains of using advanced technology for facilitation may be outweighed by interrupted video or network connections, 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 VHA National Center for Organization Development.67
### Table 1: Advantages and Disadvantages of Working in Virtual Teams

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>More flexible scheduling for team members.</td>
<td>ADMINISTRATION</td>
</tr>
<tr>
<td></td>
<td>Difficulty scheduling when crossing multiple time zones.</td>
</tr>
<tr>
<td>Improves likelihood of attendance, expands pool of likely participants.</td>
<td>INTERPERSONAL CONNECTIONS</td>
</tr>
<tr>
<td></td>
<td>Networking and interpersonal contact may be stifled.</td>
</tr>
<tr>
<td>Allows off-line work to continue.</td>
<td>ENGAGEMENT</td>
</tr>
<tr>
<td></td>
<td>Participants may become inattentive or absent without face-to-face proximity.</td>
</tr>
<tr>
<td>Reduced cost and low-carbon footprint for meetings.</td>
<td>COST-EFFECTIVENESS</td>
</tr>
<tr>
<td></td>
<td>Requires technological capital.</td>
</tr>
<tr>
<td>Facilitates tracking and archiving of work-activities.</td>
<td>DOCUMENTATION</td>
</tr>
<tr>
<td></td>
<td>Risk of over-monitoring or a culture of surveillance.</td>
</tr>
</tbody>
</table>

Excerpted from the “VA Virtual Teams Handbook”67 (p. 7).

### 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 such as GoToWebinar, Lync, and Adobe Connect are invaluable because they allow participants to read one another’s nonverbal cues; while not on par with face-to-face interactions, video based modalities represent a step up from phone conferencing or text based systems.
Technology, technology, technology

Ensure that technology support is available and present during important virtual meetings.\(^{68}\) 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 support will be present during important virtual meetings to provide support. Establish a back-up plan in case video technology fails.\(^{69}\) Creating a checklist of all items needed to prepare for the virtual visit may be particularly helpful. Please see Appendix J-2, page 191, for an example provided by VA’s Office of Mental Health Operations that was used as a checklist prior to conducting virtual site visits.

- Establish standard conferencing phone lines and be prepared to quickly switch to that format if needed
- Test all equipment and connections before meetings and schedule practice sessions
- 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

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 no opportunity to build relationships as might occur in the context of co-located frequent face-to-face meetings.\(^{70}\) Examples of activities for team building that may be applied in virtual formats may be found in the NCOD handbook (http://vaww.va.gov/NCOD/docs/virtualteamshandbook.PDF).\(^{67}\)

Plan for increased time

 Allow for increased time to complete tasks in addition to the time that would be necessary in face-to-face 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 communications, 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 encourage rapport and trust-building activities.

**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 really 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 media may require an increase in the number or frequency of contacts over the typical time period. 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 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.

**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. It is imperative to understand that the staff at the facility ALWAYS have competing priorities, and they may especially give the pre-implementation process a lower priority. Therefore, be sensitive to their needs and be cognizant of the appropriate timing to take action. 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

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. 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. For example, during a virtual meeting, sending an individual Lync or text message 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 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 handle 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 potentially 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 NCOD available at: http://vaww.va.gov/NCOD/docs/virtualteamshandbook.PDF.

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. 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 check-points 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.70

**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.76 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 visioning exercises, and group activities that help the team develop the aspirational goals of the program as defined by the group of 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 brainstorming process (e.g., use the whiteboard feature of Lync or adobe connect that all members can contribute to 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 staff there 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, understand the organizational structure, 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 implementations 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., in the VA at the VISN and national levels) 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.77 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.73
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.\textsuperscript{70} 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 face-to-face.

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 non-face-to-face 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 face-to-face interactions and allow for asynchronous communication to occur. In addition to the specific nuances described in this chapter, facilitators providing virtual IF must also be well-versed in the strategies described in Chapter 6, “Implementation Facilitation Activities in the Implementation Phase.” Virtual IF may assist sites struggling with implementation challenges when on-site assistance is not feasible or cost-effective. Policymakers, researchers, and those providing IF should understand the potential advantages and disadvantages, and consider recommendations identified by field-based experts to inform application of virtual facilitation.
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 a clinical innovation.

I. DOCUMENTING FACILITATION TIME AND ACTIVITIES

Why Track Facilitation Time and Activities?

There are myriad reasons that it may make 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 effectively spread to other clinics or facilities. In the research setting, such tracking may also be pivotal for informing resource allocation for follow-up studies.

In addition, tracking the particular activities that facilitators engage in throughout the course of implementing a clinical 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 particular activities undertaken by facilitators can also inform the training or education of additional facilitators who may be tasked with scaling up the clinical innovation in question.

Specific Domains to Track

Based on the experiences of facilitators in several healthcare implementation projects, we have developed a templated Facilitation Tracking Tool (Appendix K, page 192) that may be adapted for nearly any facilitation project. We strongly recommend looking over that tracking tool to provide context 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 ten- or 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, 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 clinical 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 clinical innovation being implemented, or problem-solving. 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.

**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” 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 more time-limited intervals is another decision typically left to the discretion of project leaders, dependent on available resources.
II. ASSESSING FIDELITY TO THE CLINICAL INNOVATION

Oftentimes clinical innovations are modified during implementation to accommodate the unique needs of a local site or patient population. As a result, there may be differences between the content and context in which the clinical innovations was originally designed and tested in a controlled research setting, and what is actually implemented. Some changes may have been planned and others may have been unintentional, and it is hard to know whether any of these changes have unintended consequences on outcomes. As a result, it is important to assess the fidelity to the clinical innovation as the alignment between the intervention that was tested in the clinical trial and the intervention that is actually being delivered in your specific site. Fidelity assessment can include adherence to the content (such as changes to program curriculum in terms of additions, deletions or substitutions), as well as the delivery mechanisms including the competence or skill involved in delivery. There may also be changes in the methods that deviate from how a clinical innovation was originally tested. Another consideration if you are implementing a clinical innovation across multiple sites is to assess the frequency and range of adaptation across sites.

What May Be Adapted When Implementing a Clinical Innovation?

The Cancer Prevention and Control Research Network (CPCRN) (http://cpcrn.org/) suggests that there is a continuum for adaptation changes that may be made to the core elements (content, delivery mechanisms, or methods) of a clinical innovation: 1) ‘red light’ changes that should be avoided to maintain fidelity on core components, 2) ‘yellow light’ changes that should be made cautiously, and 3) ‘green light’ changes that are safe to make. See Table below:
Adapting an Evidence-Based Approach

Red Light Adaptations: things that probably cannot be modified

Methods used
- Change theoretical underpinning; mechanisms of change

Content
- Change health topic/behavior addressed
- Add activities that contradict or detract from the original clinical innovation’s goals
- Delete whole sections or major activities
- Reduce duration and dose

Yellow Light Adaptations: things that probably can be changed with caution

Content/Methods
- Alter the length of program activities
- Change the order of sessions or sequence of activities
- Add activities to address other risk factors or behaviors
- Apply the clinical innovation to a different population

Delivery Mechanisms
- Change delivery format/process
- Modify who delivers the program
- Change setting of delivery
- Substitute activities and/or materials

Green Light Adaptations: things that probably can be modified

Minor adaptations to increase reach, receptivity and participation
- Update and/or customize statistics and guidelines
- Customize program materials to fit the priority population, e.g., change names, pictures, wording, etc.
- Change ways to recruit and/or engage priority population

Adapted from CRCRN’s Training slides.

Tools for Planning Adaptations to Clinical Innovations and Assessing Fidelity

While you might not be able to assess how your modifications impact patient or system outcomes, establishing a checklist or guide to consider what is being altered is an important step in assessing fidelity to the clinical innovation, especially if you are implementing across multiple sites. Hill et. al. (2007)\textsuperscript{79} propose that facilitators complete implementation surveys as a feasible method of assessing fidelity which may be used to minimize or standardize adaptations during training and quality assessment.

Ideally you would assess adaptations prior to implementation and carefully assess the acceptability and importance of adaptation. The CPCRN also has a useful Adaptation Planning Tool\textsuperscript{81} for this effort. This tool helps you plan and consider the Adaptation categories of: (1) Program Outcomes and Objectives (2) Determinants and Methods; (3) Delivery Mechanisms; (4) Population and (5) Implementations (capacities, resources). The Adaptation Planning Tool is available at: \url{http://cpcrn.org/wp-content/uploads/2015/02/6bAdaptationPlanningTool.doc}.

Another tool or framework to help you assess modifications to the clinical innovation was developed by Stirman, et. al. (2013).\textsuperscript{82} This was developed to help characterize modifications
made to evidence-based interventions when they are implemented in contexts or with populations that differ from that in which they were originally developed or tested. Their scheme includes classifying modifications based on the following questions:

1. By *whom* are modifications made (administrator, practitioner, researcher)?
2. *What* is modified (content, context, training)?
3. At what *level of delivery* are modifications made (clinic, hospital, system)?
4. *What context modifications* are made (format, setting, personnel or population)?
5. What is the *nature* of content modifications (adding, removing, etc.)?

The tables below contain Stirman, et al.’s lists of the levels at which content modifications occur and the types of content modifications that may be used to document your changes.

### Levels at which content modifications occur

1. Individual recipient level: The intervention is modified for a particular recipient (e.g., simplifying language if a patient has cognitive impairment or if language barriers exist; changes to increase cultural relevance for an individual recipient).
2. Cohort level: The intervention is modified for individuals grouped within the intervention setting into a treatment group, a class, or other type of cohort (e.g., a specific psychotherapy group, grade or classroom).
3. Population level: The intervention is modified for application to a particular cultural, ethnic, clinical or social group (e.g., repetition of intervention components for all patients with cognitive impairments; development of culturally relevant vignettes to be used with all individuals of a particular ethnic identity).
4. Provider/facilitator level: Modifications are made by a clinician/facilitator for all of their participants (e.g., ‘I never set an agenda when I do cognitive therapy’).
5. Unit level: A modification is made by all of the facilitators in a unit (e.g., clinic/department/grade) within a larger organization (e.g., ‘We can only do 60-minute intervention sessions instead of 90-minute sessions in our clinic’).
6. Hospital/Organization level: Modifications are made by an entire organization.
7. Network/Community level: Modifications are applied by an entire network or system of hospitals/clinics/schools (e.g., a Veterans Affairs VISN; school district) or community.

Excerpted from Stirman, et al. (2013)82
Types of content modifications

1. Tailoring/tweaking/refining: This code was assigned to any minor change to the intervention that leaves all of the major intervention principles and techniques intact while making the intervention more appropriate, applicable or acceptable (e.g., modifying language, creating slightly different versions of handouts or homework assignments, cultural adaptations).

2. Adding elements (intervention modules or activities): Additional materials or activities are inserted that are consistent with the fundamentals of the intervention (e.g., adding role play exercises to a unit on assertiveness in a substance abuse prevention intervention).

3. Removing elements (removing/skipping intervention modules or components): Particular elements of the intervention are not included (e.g., leaving out a demonstration on condom use in an HIV prevention intervention for adolescents).

4. Shortening/condensing (pacing/timing): A shorter amount of time than prescribed is used to complete the intervention or intervention sessions (e.g., shorter spacing between sessions, or shortening sessions, offering fewer sessions, or going through particular modules or concepts more quickly without skipping material).

5. Lengthening/extending (pacing/timing): A longer amount of time than prescribed by the manual/protocol is spent to complete intervention or intervention sessions (e.g., greater spacing between sessions, longer sessions, more sessions, or spending more time on one or more modules/activities or concepts).

6. Substituting elements: A module or activity is replaced with something that is different in substance (e.g., replacing a module on condoms with one on abstinence in an HIV prevention program).

7. Re-ordering elements: Modules/activities or concepts are completed in a different order from what is recommended in the manual/protocol. This code would not be applied if the protocol allows flexibility in the order in which specific modules or interventions occur.

8. Integrating another approach into the intervention: The intervention of interest is used as the starting point, but aspects of different therapeutic approaches or interventions are also used (e.g., integrating an ‘empty chair’ exercise into a ‘CBT for Depression’ treatment protocol).

9. Integrating the intervention into another approach: Another intervention is used as the starting point, but elements of the intervention of interest are introduced (e.g., integrating motivational enhancement strategies into a weight loss intervention protocol).

10. Repeating elements: One or more modules, sessions, or activities that are normally prescribed or conducted once during a protocol are used more than once.
Types of content modifications (continued)

11. Loosening structure: Elements intended to structure intervention sessions do not occur as prescribed in the manual/protocol (e.g., the ‘check-in’ at the beginning of a group intervention is less formally structured; clinician does not follow an agenda that was established at the beginning of the session).

12. Departing from the intervention (‘drift’): The intervention is not used in a particular situation or the intervention is stopped, whether this stoppage was for part of a session or a decision to discontinue the intervention altogether (e.g., ‘this client was so upset that I just spent the rest of today’s session letting him talk about it instead of addressing his health behaviors’).

Excerpted from Stirman, et al. (2013)82

In summary, we hope that this information will help you assess where you may have made modifications to the clinical innovation that you are implementing. While modifications are often necessary to improve the fit of the clinical innovation to the Veteran’s needs, modifications should be carefully considered and documented to ensure overall fidelity to the clinical 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. In implementing evidence-based practices or other clinical innovations, it is important to give attention not only to documenting and assuring fidelity to the clinical innovation (as described above), but also to documenting facilitator activities and assessing fidelity to core components of implementation facilitation to support its practical application and dissemination to other settings.35 Within implementation science, there is a diverse portfolio of potential implementation strategies with a range of effectiveness that might be used to support uptake of clinical innovations. Documentation and reporting of fidelity to the implementation strategy will enable implementation scientists and practitioners 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 is woefully underdeveloped and infrequently applied.83

One example of developmental work in this area is an ongoing study to create and pilot a tool for assessing fidelity in use of implementation facilitation strategies.84 As mentioned in the
Introduction, a number of studies have contributed to a growing evidence base for the impact of implementation facilitation strategies for promoting use of a new program or practice in healthcare settings.\textsuperscript{19-22} A scoping literature review of these studies was conducted to document and identify core components of facilitation through a rigorous consensus development process.\textsuperscript{84} Initial results from the review suggest that core components of implementation facilitation may include the following domains: stakeholder engagement, relationship-building, assessment (e.g., understanding context, identifying barriers/facilitators), assisting with preparation/planning, providing education/training, performance monitoring (e.g., monitoring adherence to implementation plan and clinical performance data (audit/feedback)), problem-solving, and adapting/refining the implementation plan as needed to meet goals. After vetting with an expert panel, these results will be used to develop a prototype tool to assess implementation facilitation fidelity for testing and refinement.

IV. ASSESSING OUTCOMES

When assessing the impact of an implementation facilitation 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.

Assessing the Clinical Innovation

Clinical innovation outcomes will of course depend on the program that you are implementing and the target of the clinical innovation. The RE-AIM evaluation framework\textsuperscript{50} provides a helpful tool by which outcomes of the clinical innovation may be assessed. As noted in Chapter 7, RE-AIM promotes use of measures to assess the reach, effectiveness, adoption, implementation and maintenance or sustainability of the clinical innovation over time.

- \textit{Reach} refers to the measurement of participation or exposure to the clinical innovation by targeted providers and/or patients.
- \textit{Effectiveness} concerns the effect of an intervention on particular process-of-care (e.g., recommended prescriptions or lab orders, visit frequency) or clinical outcomes (e.g., symptoms, functioning).
- \textit{Adoption} refers to measures of the proportion and representativeness of users of the clinical intervention, and whether they meet some established threshold that would indicate routine use of the clinical innovation.
- \textit{Implementation} refers to measurement of fidelity to the clinical intervention, the extent to which an implementation strategy or plan is executed as planned and/or assessment of costs associated with implementation.
- \textit{Maintenance} is an indication of how long a facility sustains an intervention or institutionalizes into care delivery.
According to the RE-AIM framework, an intervention can only affect a population if clinics and providers first *adopt* it, *reach* a large proportion of the target population, *implement* it with fidelity, *effectively* improve outcomes and maintain the intervention after researchers withdraw.

### 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 implementation and/or those that 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 in section I of 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.\(^8^5\) 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.\(^8^6\)
• 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.

This chapter provides brief, general information on processes, measures and tools that may be useful in documenting and evaluating the impact of an implementation facilitation strategy. However, specific measures and tools used for evaluation across different projects may vary considerably, depending on the nature and intensity of the implementation facilitation strategy deployed, the characteristics of the clinical innovation being implemented, available resources and other factors. Accordingly, users of this manual should exercise their discretion in determining which of the processes, tools and measures described are appropriate or feasible to be applied within their own project.
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## APPENDIX A. GLOSSARIES

### Appendix A-1. Glossary of Acronyms

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>CAC(s)</td>
<td>Clinical Application Coordinators</td>
</tr>
<tr>
<td>CBOC</td>
<td>Community-Based Outpatient Clinic</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive-Behavioral Therapy</td>
</tr>
<tr>
<td>CFIR</td>
<td>Consolidated Framework for Implementation Research</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CPCRN</td>
<td>Cancer Prevention and Control Research Network</td>
</tr>
<tr>
<td>EBP(s)</td>
<td>Evidence-Based Practice(s)</td>
</tr>
<tr>
<td>EF</td>
<td>External Facilitator</td>
</tr>
<tr>
<td>i-PARIHS</td>
<td>integrated Promoting Action on Research Implementation in Health Services</td>
</tr>
<tr>
<td>IF</td>
<td>Implementation Facilitation</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MI</td>
<td>Motivational Interviewing</td>
</tr>
<tr>
<td>NCOD</td>
<td>National Center for Organization Development</td>
</tr>
<tr>
<td>OEF/OIF</td>
<td>Operation Enduring Freedom/Operation Iraqi Freedom</td>
</tr>
<tr>
<td>ORC</td>
<td>Organizational Readiness for Change</td>
</tr>
<tr>
<td>PACT</td>
<td>Patient-Aligned Care Teams</td>
</tr>
<tr>
<td>PCMHI</td>
<td>Primary Care-Mental Health Integration</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan – Do – Study - Act</td>
</tr>
<tr>
<td>PSAT</td>
<td>Program Sustainability Assessment Tool</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RE-AIM</td>
<td>Reach, Effectiveness, Adoption, Implementation, Maintenance</td>
</tr>
<tr>
<td>REP</td>
<td>Replicating Effective Programs</td>
</tr>
<tr>
<td>SAIL</td>
<td>Strategic Analysis for Improvement and Learning</td>
</tr>
<tr>
<td>SAP</td>
<td>Sustainability Action Plan</td>
</tr>
<tr>
<td>SI</td>
<td>Sustainability Index</td>
</tr>
<tr>
<td>SME(s)</td>
<td>Subject Matter Expert(s)</td>
</tr>
<tr>
<td>VA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>VACO</td>
<td>VA Central Office</td>
</tr>
<tr>
<td>VAMC</td>
<td>Veterans Affairs Medical Center</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td>VANTS</td>
<td>VA Nationwide Teleconferencing System</td>
</tr>
<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
</tr>
<tr>
<td>VISN</td>
<td>Veterans Integrated Service Network</td>
</tr>
<tr>
<td>VISTA</td>
<td>Veterans Health Information Systems and Technology Architecture</td>
</tr>
<tr>
<td>VSSC</td>
<td>VHA Support Service Center</td>
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Appendix A-2. Glossary of Terms

Academic Detailing¹
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 Practice²-⁴
- 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.

Champions⁵-⁸
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 Agent⁵
Individuals who are affiliated with an outside entity and formally influence or facilitate intervention decisions in a desirable direction.

Climate⁵
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) Climate⁵
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**

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.

**Clinical innovations**

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

**Culture**

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**

“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.

Implementation facilitator\textsuperscript{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 clinical 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.

Opinion Leader\textsuperscript{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


Testimonial:
A brief, spoken statement by a referring provider extolling the virtues of the program. This could include, but is not limited to, describing how the program had a positive impact by improving patient outcomes or by improving provider job satisfaction.

Formal definition: A written or spoken statement, sometimes from a person figure, sometimes from a private citizen, extolling the virtue of some product.

References


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

Part of Site Recruitment Process  
OMHO Evidence-Base Psychotherapies 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 PC-MHI implementation. The model was developed by implementation science experts at MH-QUERI and was successfully piloted in three VISNs. The results will be coming out in publication soon. This is an evidence-based model.
  - Because of the success observed with assisting sites with PC-MHI implementation and our observation from the OMHO site visits that EBP implementation is an area of potential growth at many sites, OMHO 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 IF. Would you agree or would you have any concerns about this?

Following the EBP visit, we would schedule calls with the IF 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 IF 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 C. Site Visit Resources

Appendix C-1. Pre-Site Visit Facility Assessment Call
OMHO Evidence-Base Psychotherapies 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 Quadrad/Pentad 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 with consultative resources – initially weekly or bi-weekly, then progressing to monthly as the IF 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.
Appendix C-1. Pre-Site Visit Facility Assessment Call

How many provider FTEE do you have in specialty mental health? Do you feel that you are appropriately staffed?

Do you have a PC-MHI 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 VISN?

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?

   OMHO will pay for our travel.
Appendix C-2. Preparation for Site Visit – Pre-Meeting Checklist

Meeting Space

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

Technology

4) ___ Is the necessary technology available?
   i) ___ Computers
   ii) ___ Projector
   iii) ___ Access to presentations (including multiple back-ups)
   iv) ___ Video Conferencing
   v) ___ Speaker Phones
   vi) Other________________________

5) ___ Is there a plan B if technology does not work?
6) ___ Is there someone onsite, who is a "go-to" person to help if things go wrong?
7) Plan B:____________________________________________________________
8) ___ Are VANTS lines or video conferencing set up?

Stakeholders

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

Arrangements with Facility

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

Items to Remember

___ Agenda  ___ AV Equipment (if not provided by site)
___ Handouts  ___ List of Attendees  ___ Directions to Site
___ Issues to Address  ___ Phone numbers  ___ Notes
___ Laptop
# Appendix C-3. Facilitation Site Visit Agenda

OMHO Evidence-Based Psychotherapies Facilitation Initiative

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Meeting</th>
<th>Suggested Attendees*</th>
</tr>
</thead>
</table>
| 8:30 – 9:00 a.m.   | Entrance Briefing | • Entrance Briefing                                                    | • Facility Leadership  
|                    |          | • Mental Health Leadership                                              |                      |
| 9:00 – 9:15 a.m.   | Break – set up for next session | • 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 | • 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     | • Break                                                                |                      |
| 10:45 a.m. – 12:00 p.m. | Implementation Meeting | • Implementation Meeting                                                | • Mental Health Leadership  
|                    |          | • Review and complete the implementation checklist.                     |                      |
|                    |          | • Develop plan for full implementation.                                |                      |
| 12:00 – 1:30 p.m.  | Lunch and facilitation team preparation for afternoon sessions.       | • Lunch and facilitation team preparation for afternoon sessions.      | • OMHO Facilitation Team  |
| 1:30 – 2:30 p.m.   | Implementation Meeting (Continued from the morning session)           | • Implementation Meeting (Continued from the morning session)          | • Same suggested Attendees as Implementation Meeting – morning session  |
|                    |          | • Review and complete the implementation checklist.                     |                      |
|                    |          | • Develop plan for full implementation.                                |                      |
| 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 | • Exit Briefing                                                        | • Facility Leadership  
|                    |          | • Mental Health Leadership                                              |                      |
Appendix C-4. Site Visit Entrance Briefing Slides
OMHO Evidence-Base Psychotherapies Facilitation Initiative

Slide 1
Evidence-Based Psychotherapy Implementation
Claire Collie, Ph.D.
National Project Director, Local EBP Coordinator Program
OMHO Mental Health Technical Assistance Specialist
JoAnn Kirchner, M.D.
Director, Mental Health Quality Enhancement Research Initiative

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.
Appendix C-4. Site Visit Entrance Briefing Slides

**Slide 7**

### Change in PCL Scores for Cognitive Processing Therapy Completers

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>VA</th>
<th>Civilian</th>
<th>Persian Gulf</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL 1st Session</td>
<td>64.1</td>
<td>64.7</td>
<td>45.2</td>
<td>62.3</td>
</tr>
<tr>
<td>PCL Final Session</td>
<td>45.5</td>
<td>47.7</td>
<td>64.1</td>
<td>43.4</td>
</tr>
</tbody>
</table>


**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** (Turk 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** (Pears 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 C-5. Stakeholder Education Overview Presentation (PCMHI)

Slide 1

Primary Care - Mental Health Integration
Katherine Dollar, PhD
Patricia Dumas, RN, MPH

Slide 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 a.m.</td>
<td>Director's Boardroom</td>
<td>Entrance Briefing&lt;br&gt;• Provide overview of PC-MHI and the facilitation process to facility leadership</td>
</tr>
<tr>
<td>9:00 – 10:00 a.m.</td>
<td>M9-280</td>
<td>Overview of PC-MHI and Facilitation&lt;br&gt;• Opportunity to educate staff with general overview and national data&lt;br&gt;• Explain facilitation process</td>
</tr>
<tr>
<td>10:30 – 10:45 a.m.</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>11:00 – 12:00 p.m.</td>
<td>M9-280</td>
<td>Implementation Meeting&lt;br&gt;• Review and complete the implementation checklist&lt;br&gt;• Develop plan for full implementation</td>
</tr>
<tr>
<td>12:00 p.m. – 1:00 p.m.</td>
<td>Lunch and prep for afternoon</td>
<td></td>
</tr>
<tr>
<td>1:00 – 2:00 p.m.</td>
<td>M9-280</td>
<td>Overview of PC-MHI and Facilitation (repeat of morning session)</td>
</tr>
<tr>
<td>2:00 – 3:00 p.m.</td>
<td>M9-280</td>
<td>Tour of primary care clinics</td>
</tr>
<tr>
<td>3:00 – 4:00 p.m.</td>
<td>M9-280</td>
<td>Individual Meetings (if requested)&lt;br&gt;• If no requests for individual meetings, prep for exit briefing</td>
</tr>
<tr>
<td>4:00 – 5:00 p.m.</td>
<td>Director's Boardroom</td>
<td>Exit Briefing</td>
</tr>
</tbody>
</table>

Slide 3

Overview of Presentation

• Introduction
• Integrated care (PC-MHI) and PACT
• Evidence base for PC-MHI
• Requirements for PC-MHI services
• Description of Implementation Facilitation strategy

Slide 4

Why ARE WE Here?

Slide 5

Today's Health Care Realities

• Traditional practice (in both medicine and mental health) assumes the mind and the body function independently. In reality, mental and physical health are interconnected:
  − 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
• Up to 70% of Primary Care medical appointments have a psychosocial component:
  − Psychosocial concerns covering the full spectrum of psychiatric disorders, from subclinical distress to serious mental health concerns
  − Behavioral concerns ranging from insomnia, treatment adherence, and pain management
  − Lifestyle issues such as exercise, tobacco use, and reducing alcohol intake

Slide 6

Today's Health Care Realities (con’t)

• Distressed patients use twice the healthcare services
• Most psychotropic medications are written by Primary Care Providers (PCP)
• Primary Care has become the nexus of our outpatient health care delivery system
• PCPs often lack time and training to address the large number of patients with behavioral health concerns
Slide 7

“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

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.

Slide 10

PC-MHI is an Integral Part of PACT

- 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

Slide 11

The Role of Population Based Integrated Care

- Improved identification
- Improved access

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 (Fomerantz et al., 2008)
Appendix C-5. Stakeholder Education Overview Presentation (PCMHI)

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 (Lawes et al., 2004)
  - 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-Bryne et al., 2001)
  - Higher patient perceptions of quality of care (Katon et al., 1999)

Slide 14
Integrated Care Evidence Base

• **Improved identification**
  - Improved identification of depression, psychiatric comorbidities 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)

Slide 15
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., 2003; Gilbody et al., 2000; Hurford et al., 2006; Katon et al., 2002; Roy-Bryne et al., 2001; Katon et al., 1999)
  - Similar remission rates and symptom reduction for depression compared to enhanced specialty referral (Krish et al., 2004)
  - Decreased 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; Hurford et al., 2006; Chen et al., 2006; Areán et al., 2002; Unützer et al., 2002

Slide 16
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

Slide 17
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
Appendix C-5. Stakeholder Education Overview Presentation (PCMHI)

Slide 19

<table>
<thead>
<tr>
<th>Co-located Collaborative MH Care</th>
<th>Mental Health Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>On site, embedded in the primary care clinic</td>
</tr>
<tr>
<td></td>
<td>A different floor, a different building</td>
</tr>
<tr>
<td>Population</td>
<td>Most are healthy, mild to moderate symptoms, behaviorally influenced problems.</td>
</tr>
<tr>
<td></td>
<td>Most have mental health diagnoses, including serious mental illness</td>
</tr>
<tr>
<td>Provider Communication</td>
<td>Collaborative &amp; on-going consultations via PCP’s method of choice (phone, note, conversation), focus within PACT.</td>
</tr>
<tr>
<td></td>
<td>Consult requests, CPRS notes, focus within mental health treatment team.</td>
</tr>
<tr>
<td>Service Delivery Structure</td>
<td>Brief (30-60 min.) or limited number of encounters (avg. 2-3), same-day as PC visit.</td>
</tr>
<tr>
<td></td>
<td>Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic assessment, psychotherapy and psychopharmacological, individual or group, recovery-oriented care. Broad scope that varies by diagnosis.</td>
</tr>
</tbody>
</table>

Slide 20

- Co-located care only
- Long-term psychotherapy
- Open ended
- 30-60 minute appointments
- Lengthy diagnostic assessments
- Inpatient for specialty MH
- Primary Mental Health ED
- Medication management only
- Co-located MH services only
- Extensive documentation

Slide 21

- 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

Slide 22

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

Slide 23

- 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

Slide 24

- Identification
  - Screening in primary care
  - Pharmacy antidepressant initiation reports
  - Patient request for treatment
- Assessment and triage to appropriate level of service
  - 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
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
  - Uncomplicated depression = PCP prescribes antidepressant, mental health care manager monitors, activates, and educates
  - Complex depression = specialty mental health care
  - Imminent risk of suicide = emergency department or 911

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!

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

PC-MHI Resources

- PC-MHI SharePoint
  - 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.Antinger@va.gov to join
- Behavioral Health in PACT listserv
  - e-mail nicole.mattila2@va.gov to join
- PC-MHI group on Yammer
  - Sign up with your @va.gov e-mail address at www.yammer.com

Questions
Appendix C-6. Site Visit Report for PCMHI

Date: [Date]

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

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

2. Teleconference to identify how new program design can ensure key components of IC are in place (Care Management, open access to brief, focused interventions for alcohol use disorders, depression, anxiety and behavioral medicine services to address broader behavioral health concerns).

3. Facilitation team to join conference calls of established [name of facility/clinic] integration committee.
4. Facilitation team to provide literature describing efficacy and implementation of specific care management programs, including the specific references and requirements presented in the Uniform Mental Health Services Handbook and the Mental Health Strategic Plan, and links to VA sponsored sites where care management is fully implemented with successful outcomes.

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

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

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

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

9. Consult with local and regional leadership to identify how best to provide care management (inclusion in the role of integrated care provider, through additional site personnel, or through network level providers).
APPENDIX D. FACILITATOR’S CLINIC SUMMARY EXCEL WORKBOOK

CLINIC SUMMARY EXCEL WORKBOOK  DIAGNOSIS TAB

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>274</td>
<td>162</td>
<td>168</td>
<td>181</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>127</td>
<td>101</td>
<td>37</td>
<td>97</td>
</tr>
<tr>
<td>Anxiety</td>
<td>113</td>
<td>71</td>
<td>65</td>
<td>86</td>
</tr>
<tr>
<td>PTSD</td>
<td>106</td>
<td>93</td>
<td>78</td>
<td>131</td>
</tr>
</tbody>
</table>

Diagnosis in PCMH FYXX to Date ([Date] through [Date])

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>219</td>
<td>64</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>27</td>
<td>5</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety</td>
<td>87</td>
<td>28</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>PTSD</td>
<td>64</td>
<td>46</td>
<td>31</td>
<td>9</td>
</tr>
</tbody>
</table>

Diagnosis In MH FFYXX to Date ([Date] through [Date])

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>651</td>
<td>302</td>
<td>223</td>
<td>339</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>187</td>
<td>226</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>Anxiety</td>
<td>219</td>
<td>95</td>
<td>32</td>
<td>122</td>
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<tr>
<td>PTSD</td>
<td>437</td>
<td>249</td>
<td>328</td>
<td>242</td>
</tr>
</tbody>
</table>
Appendix D. Facilitator’s Clinic Summary Excel Workbook

CLINIC SUMMARY EXCEL WORKBOOK - UNIQUES TAB

<table>
<thead>
<tr>
<th>SITE</th>
<th>Uniques in PC</th>
<th>Uniques in PCMH</th>
<th>Uniques in MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>9224</td>
<td>471</td>
<td>1775</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>5632</td>
<td>146</td>
<td>1772</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>4025</td>
<td>86</td>
<td>715</td>
</tr>
<tr>
<td>Clinic 4</td>
<td>5654</td>
<td>71</td>
<td>904</td>
</tr>
</tbody>
</table>

UNIQUES BY SITE

LOCATION OF SPECIALTY MENTAL HEALTH PROGRAMS

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>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.</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>MH specialty services in upstairs, while PC clinic is downstairs. Mental health providers are scheduled to move into offices in PC on [Date].</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>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.</td>
</tr>
<tr>
<td>Clinic 4</td>
<td>Square shaped building with all parts connected. PC is referred to as &quot;Dr.’s Corridor&quot;. 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.</td>
</tr>
</tbody>
</table>
### CLINIC SUMMARY EXCEL WORKBOOK - DIAGNOSIS BY PERCENT TAB

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>PTSD</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>46%</td>
<td>44%</td>
<td>20%</td>
<td>51%</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>6%</td>
<td>3%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>18%</td>
<td>19%</td>
<td>9%</td>
<td>24%</td>
</tr>
<tr>
<td>PTSD</td>
<td>14%</td>
<td>32%</td>
<td>36%</td>
<td>13%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>37%</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>11%</td>
<td>13%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>12%</td>
<td>5%</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>PTSD</td>
<td>25%</td>
<td>14%</td>
<td>46%</td>
<td>27%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Clinic 1</th>
<th>Clinic 2</th>
<th>Clinic 3</th>
<th>Clinic 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>PTSD</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## CLINIC SUMMARY EXCEL WORKBOOK - STAFFING TAB

<table>
<thead>
<tr>
<th>SITE</th>
<th>PC PROVIDERS</th>
<th>SP MH PROVIDERS</th>
<th>IC MHP</th>
<th>NURSES</th>
<th>CLERKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>16 (4 are NP)</td>
<td>3 MD, 1 NP, 5 Ph.D, 1 Ph.D (Neuropsy), 3 CSW, 2 RN</td>
<td>1 MD, 1 LCSW, 1 NP</td>
<td>7 LPN (PC), 4 RN (PC)</td>
<td>2 MH, 4 PC</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>12</td>
<td>3MD, 4 Ph.D., 1 Ph.D (Neuropsy), 3 CSW</td>
<td>1 MD, 1 LCSW</td>
<td>15 PC</td>
<td>2 MH, 3 PC</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>8 (PC)</td>
<td>5 PC, 1 MHS</td>
</tr>
<tr>
<td>Clinic 4</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>
## APPENDIX E. IMPLEMENTATION PLANNING GUIDES

### Appendix E1. PCMHI Implementation Planning Guide: Steps for Implementing Collaborative Care Models

<table>
<thead>
<tr>
<th>Implementation Step</th>
<th>Decision</th>
<th>Action Item</th>
</tr>
</thead>
</table>
| **Specify possible target patients and identification procedures:** | • Referral to integrated provider will be based on PCPs need, using warm handoffs.  
• Referrals will be based primarily on level of severity (i.e., stable, with mild to moderate symptoms) rather than by specific diagnosis.  
• Referrals should include, but are not limited to, assessment support, depression monitoring, brief interventions for depression, anxiety, substance misuse, PTSD, and behavioral medicine interventions (e.g., sleep hygiene, coping with chronic illness). | • Integrated Care Provider (ICP) to receive additional training in Care Management.  
• Continued education/marketing to PCPs about use of warm hand-off and care management service will be provided by [name] and ICP.  
• Facilitation team will monitor PC-MHI no-show rate. |
| **Identify possible exclusion criteria and method for assessing criteria:** | • Level of severity, rather than specific diagnosis will be exclusion criteria,- pts. who are not stable with severe symptoms will be referred to specialty MH care.  
• Patients currently enrolled in specialty mental health should be seen by their usual provider and nursing team. [Name] will facilitate this linkage. Specialty mental health will also provide urgent access to prescribers.  
• If initiating antipsychotics or patient is not stable, the patient should be referred for same-day evaluation by psychiatric prescribers.  
• OEF/OIF veterans, experiencing potential PTSD symptoms or other severe | |
| **Step 1** | **Step 2** | |
| • Patients referred by PCP(warm handoffs)  
  o Patients referred for brief interventions (approximately 1-4 sessions) for stress management, tobacco and alcohol misuse, chronic pain, sleep hygiene, lifestyle changes and coping with chronic illness  
  o Patients referred for brief interventions for anxiety and depression  
  o Patients referred for skill building (relaxation training, goal setting)  
• Patients screening positive for one or more of the following conditions, e.g., depression, alcohol dependence, anxiety and PTSD  
• Patients with target condition  
• Patients targeted by performance measures  
• Other | • 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  
• Other | |

---

**Note:** The table continues with similar entries for subsequent steps in the implementation planning process.
Appendix E-1. Implementation Planning Guide (PCMHI)

<table>
<thead>
<tr>
<th>Step</th>
<th>Specify collaborative care team members:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>• Behavioral health provider (e.g., psychologist, master’s level social worker, licensed counselor)</td>
</tr>
<tr>
<td></td>
<td>• Primary care providers (physician, physician assistant, nurse practitioner)</td>
</tr>
<tr>
<td></td>
<td>• Care manager (e.g., nurse, social worker)</td>
</tr>
<tr>
<td></td>
<td>• Co-located Prescribing Provider</td>
</tr>
<tr>
<td></td>
<td>• Clinical supervisor (e.g., psychiatrist)</td>
</tr>
<tr>
<td></td>
<td>• OEF/OIF Care Coordinator</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
<tr>
<td></td>
<td>• [Name], ICP, is the integrated behavioral health provider and provides the care management function.</td>
</tr>
<tr>
<td></td>
<td>• Call Center can be consulted by either PCPs or the ICP for additional comprehensive assessments.</td>
</tr>
<tr>
<td></td>
<td>• [Name] and [Name] are identified as medical IC champions.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Clinical supervisor for IC staff is [name].</td>
</tr>
<tr>
<td>4</td>
<td>• Specify clinical activities of collaborative care team members:</td>
</tr>
<tr>
<td></td>
<td>• Behavioral health providers</td>
</tr>
<tr>
<td></td>
<td>o Functional assessment</td>
</tr>
<tr>
<td></td>
<td>o Triage and consultation</td>
</tr>
<tr>
<td></td>
<td>o Brief interventions (e.g., 1-4 sessions for multiple concerns)</td>
</tr>
<tr>
<td></td>
<td>o Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management)</td>
</tr>
<tr>
<td></td>
<td>o Stress management</td>
</tr>
<tr>
<td></td>
<td>o Sleep hygiene</td>
</tr>
<tr>
<td></td>
<td>o Behavioral interventions for chronic pain</td>
</tr>
<tr>
<td></td>
<td>o Lifestyle interventions for chronic conditions (e.g., diabetes)</td>
</tr>
<tr>
<td></td>
<td>o Relaxation training</td>
</tr>
<tr>
<td></td>
<td>o Other</td>
</tr>
<tr>
<td></td>
<td>• Primary Care Providers:</td>
</tr>
<tr>
<td></td>
<td>o Screen for target condition</td>
</tr>
<tr>
<td></td>
<td>o Diagnose target condition</td>
</tr>
<tr>
<td></td>
<td>o Prescribe medication</td>
</tr>
<tr>
<td></td>
<td>o Refer to collaborative care team</td>
</tr>
<tr>
<td></td>
<td>o Refer to specialty mental health</td>
</tr>
<tr>
<td></td>
<td>o Educate PCPs</td>
</tr>
<tr>
<td></td>
<td>• [Name], ICP, will conduct functional assessments.</td>
</tr>
<tr>
<td></td>
<td>o Triage and consultation</td>
</tr>
<tr>
<td></td>
<td>o Brief interventions (e.g., 1-4 sessions for multiple concerns)</td>
</tr>
<tr>
<td></td>
<td>o Behavioral medicine interventions (e.g., tobacco cessation, alcohol misuse, weight management)</td>
</tr>
<tr>
<td></td>
<td>o Stress management</td>
</tr>
<tr>
<td></td>
<td>o Sleep hygiene</td>
</tr>
<tr>
<td></td>
<td>o Relaxation training</td>
</tr>
<tr>
<td></td>
<td>o Other</td>
</tr>
<tr>
<td></td>
<td>• Primary Care Providers:</td>
</tr>
<tr>
<td></td>
<td>o Screen for target condition</td>
</tr>
<tr>
<td></td>
<td>o Diagnose target condition</td>
</tr>
<tr>
<td></td>
<td>o Prescribe medication</td>
</tr>
<tr>
<td></td>
<td>o Refer to collaborative care team, including co-located provider</td>
</tr>
<tr>
<td></td>
<td>o Refer to specialty mental health</td>
</tr>
<tr>
<td></td>
<td>o Educate PCPs</td>
</tr>
<tr>
<td></td>
<td>• Integrated care provider to receive additional training from [names] for behavioral medicine interventions.</td>
</tr>
<tr>
<td></td>
<td>• In service to be provided for PCPs about psychiatric medication in PC.</td>
</tr>
<tr>
<td></td>
<td>• [Names] to provide presentations to PC staff on quarterly basis.</td>
</tr>
<tr>
<td></td>
<td>• MH specialty care to have an &quot;on-call&quot; urgent access provider scheduled for every day.</td>
</tr>
<tr>
<td></td>
<td>• MH to provide this schedule to PC, so that PCPs know who they should contact.</td>
</tr>
</tbody>
</table>

Symptoms should be linked with the OEF/OIF care coordinator rather than with the ICP.
- 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
    - 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

- 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.
### 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
  - 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

### 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
- Establish clinic names and codes
- Standards for assigning diagnoses, CPT codes, etc.
- Consult forms/procedures
- Other

- 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].
- 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
- 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.
## Appendix E2. Implementation Planning Guide: Steps for Implementing Evidence-Based Psychotherapies

<table>
<thead>
<tr>
<th>Implementation Step</th>
<th>Decision</th>
<th>Action Item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Determine overarching program structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Create a separate EBP clinic with EBPs targeting multiple conditions coordinated with a separate point of entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incorporate EBPs into existing clinic structure, providing other treatments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Both a stand-alone EBP program and EBPs embedded in existing clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop local consultation options to support EBP therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Step 2** Identify starting target population(s):       |          |             |
| • Disorder specific or not                               |          |             |
| o Symptom assessment of target population                |          |             |
| o 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 |          |             |
### 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 PC-MHI
- 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
- 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
  - 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
- 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

### Scheduling

#### Step 8
- **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

### Communication with other providers while Veteran is engaged in EBP:

#### Step 9
- **Targeted Providers:**
  - Mental Health Treatment Coordinator (will EBP provider become MHTC?)
  - Primary Care provider
  - PC-MHI providers
  - Group therapists
  - Prescribing Provider
  - Other
- **Communication method:**
  - Cosigned notes
  - Team meetings
  - Coordination with Vet Centers
  - Other
<table>
<thead>
<tr>
<th>Step 10</th>
<th>Process for transferring Veterans who have completed EBP episode of care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Referral to PC – obtain and review Service Agreement between MH and PC</td>
</tr>
<tr>
<td></td>
<td>• Referral to specialty mental health for medication maintenance</td>
</tr>
<tr>
<td></td>
<td>• EBP after care groups?</td>
</tr>
<tr>
<td></td>
<td>• Referral to Vet Center</td>
</tr>
<tr>
<td></td>
<td>• Referral to Peer Support</td>
</tr>
<tr>
<td></td>
<td>• What will be the re-entry procedures for Veterans who need an additional EBP episode of care?</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 11</th>
<th>Specify options to increase EBP capacity through panel management:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Referral to EBP</td>
</tr>
<tr>
<td></td>
<td>• Referral to non-EBP preparatory group</td>
</tr>
<tr>
<td></td>
<td>• Referral to peer support group</td>
</tr>
<tr>
<td></td>
<td>• Refer to community resources</td>
</tr>
<tr>
<td></td>
<td>• Refer to Vet Centers</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Step 13</th>
<th>Education:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Audience</td>
</tr>
<tr>
<td></td>
<td>o Veterans</td>
</tr>
<tr>
<td></td>
<td>o Family Members</td>
</tr>
<tr>
<td></td>
<td>o Veteran Service Organizations</td>
</tr>
<tr>
<td>o Community</td>
<td></td>
</tr>
<tr>
<td>o Mental Health and Other Services – e.g., Primary Care</td>
<td></td>
</tr>
<tr>
<td>(What you are doing with EBPs and why? Help promote understanding about any exclusion criteria and episodes of care model)</td>
<td></td>
</tr>
<tr>
<td>o Press</td>
<td></td>
</tr>
<tr>
<td>o Others</td>
<td></td>
</tr>
<tr>
<td>• Type of education products</td>
<td></td>
</tr>
<tr>
<td>o Marketing products</td>
<td></td>
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<tr>
<td>o Brochures</td>
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<tr>
<td>o Posters</td>
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<tr>
<td>o Presentations</td>
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<td>o Videos</td>
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<tr>
<td>o Other</td>
<td></td>
</tr>
<tr>
<td>• Education Location</td>
<td></td>
</tr>
<tr>
<td>o PC Clinics</td>
<td></td>
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<tr>
<td>o MH Clinics</td>
<td></td>
</tr>
<tr>
<td>o Other</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E3. Implementation Planning Guide: Measurement Based Care

Site: ____________________________________________
Identified Lead: _________________________________

<table>
<thead>
<tr>
<th>Roles/Tasks</th>
<th>Actionable Items/Examples*</th>
<th>Plan (including timeframe)</th>
<th>Who’s in Charge?</th>
<th>Potential Barriers/Notes</th>
</tr>
</thead>
</table>
| A. Identify Setting and Participating Staff | • Identify setting(s): PCMHI, GMH, BHIP, Residential, etc.  
• Identify Local Lead  
  o See supporting document on choosing a Local Lead aka Internal Champion  
• Determine staff to participate: e.g., LCSWs, Psychiatrists, Psychologists, Addiction Therapists, trainees, admin support staff, etc.  
  o We strongly encourage (but do not require) participation of as many providers as possible | | | |
| Clinic(s)/Team(s)  
Local Lead  
Participating Providers | | | | |
| B. Engage & Train Staff | • Engage all staff through meetings and communications.  
• Ensure all staff complete all MBC training as needed.  
• Determine which staff will be involved in Implementation Planning process (a meeting to complete the rest of this sheet)  
  o Recommend as many participating staff participate in implementation planning as possible | | | |
### C. Determine Additional Ways Leadership can Support Participants

- Leadership will have already signed off on participation
- Examples of additional support:
  - Provide recognition for participating providers.
  - Consider 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, tablets, etc.).
  - Provide opportunities for participants to present to local leadership on progress.

### D. Determine Who to be Assessed

- Identify Veteran population to receive MBC
  - All patients 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.)

- Recommend initiating MBC with Veterans engaged in a new episode of care since changes in outcomes are more likely to occur and be reflected in outcome measures
  - Other__________________

### E. Determine Measures & Frequency

- Select Measures
  - PHQ-9
  - GAD-7
  - PCL-5
  - BAM-R
  - Other__________________

*We require a minimum of one of the identified...*
measures administered at two time points within six months.*

Consider whether all Veterans will get same measures & how will be determined (e.g., one PCMHI clinic determined that Veterans screening positive on 4 item PTSD screen would receive PCL-5).*

- Determine timing of measurement:
  - Intake into clinic?
  - Post treatment? Mid-treatment?
  - Every relevant MH encounter?
  - Clinical judgment?
  - As recommended by a particular rollout that clinic has been involved in?
  - Other predetermined intervals?
    - If so, document__________

F. Determine Method of Administration & Who Administers

- Determine method to administer measures
  - Paper survey
  - Kiosk
  - Tablet
  - Veteran at computer (Secure Desktop)
  - Provider reading aloud (e.g. from MHA)
  - Other ________________

We do not have approval for system-wide use of tablets or other mobile devices for instrument administration at this time. If a site has mobile devices that can be used on the network, we will support their use to administer instruments through one of our identified software applications such as BHL.

- Determine who administers (this may
### G. Determine Method of Documentation within MHA and Who Documents

- Establish method to ensure that data are entered in MHA
  - MHA entry is required
- 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 within 24 hours of the data collection when assessments are weekly and with 7 days if assessments are monthly.*

### H. Determine Clinical use of MBC

- Based on data collection method, determine if scores can be available at time of visit
- How will providers make use of data to promote shared decision-making and
<table>
<thead>
<tr>
<th>I. Decide how to Engage Veterans</th>
<th>- Identify how clinic/team will collect and incorporate Veteran input/feedback on implementation of MBC. (e.g., Random selection of Veterans to complete a satisfaction survey on the MBC process).</th>
</tr>
</thead>
<tbody>
<tr>
<td>J. Defining MBC Success</td>
<td>- Identify why this is important; what are your clinic/team’s goals and how would you define success?</td>
</tr>
</tbody>
</table>
| K. Develop implementation support plan | - Identify frequency/format of meetings for clinic implementation team to self-assess progress, navigate any barriers, celebrate successes (e.g., MBC implementation becomes a boilerplate agenda item on team meetings).  
- Identify how participating staff can make use of Pulse Site to support shared goals.  
- Determine which staff will join support conference calls/coaching calls (Local Lead, others?). |
<table>
<thead>
<tr>
<th>L. Determine MBC Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify start date for MBC</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M. Determine how to Sustain MBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop Standard Operating Procedures (SOP) for MBC (=this document as it evolves)</td>
</tr>
<tr>
<td>• Recognize high MBC providers</td>
</tr>
<tr>
<td>• Celebrate implementation of MBC.</td>
</tr>
</tbody>
</table>
During the project, the site’s clinical champion helps lead local implementation efforts and communicates regularly with the external facilitator 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 15-20 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 G. 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 PCMH)? 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.
Flow Map Example: Positive Depression Screen Future State

Positive Depression Screen (PACT LPN)

PCP Conducts Follow-Up Depression Reminder

Positive Follow-Up?

No

Depression Education per PCP

Yes

Referral for PC-MHI Assessment

PC-MHI Disposition

Mild—Moderate: Medication or Patient Declining Specialty MH

Mild—Moderate: Psychotherapy

Moderate-Severe: Medication

Moderate-Severe: Psychotherapy

PC-MHI Care Management

PC-MHI Psychotherapy

MH Clinic Medication

MH Clinic Psychotherapy
## 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).

<table>
<thead>
<tr>
<th>Tool</th>
<th>Symbol</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oval</td>
<td><img src="image" alt="Oval" /></td>
<td>Start and stop points of the flow map</td>
</tr>
</tbody>
</table>
| Square/rectangle | ![Square/rectangle](image) | Process step  
- A single, discrete step within the process  
- Usually has only one arrow pointing toward and away from the square |
| Diamond   | ![Diamond](image) | 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    | ![Arrows](image) | Direction of flow                                                   |
| Cloud     | ![Cloud](image) | Highlights ideas/solutions (note that these are separated from the process and can be placed anywhere on the process map) |
| Kapowie   | ![Kapowie](image) | 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)) |
### Appendix G. Flow Mapping Guide

<table>
<thead>
<tr>
<th>Color</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear</td>
<td>Non-value adding step, but <strong>still necessary</strong></td>
</tr>
<tr>
<td>Green</td>
<td>Value – <strong>adding</strong> step (e.g., from the perspective of the patient)</td>
</tr>
<tr>
<td>Red</td>
<td>Non-value adding and likely <strong>unnecessary step</strong>. Can also be used for Kapowies.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Step</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine what process will be targeted</td>
<td>PACT and MHSL PI/PC-MHI/leadership meeting to identify MH clinical reminder performance measure improvement areas</td>
</tr>
<tr>
<td>Review relevant SOPs, procedure guides, existing flow maps, etc.</td>
<td>Materials reviewed: MHSL to Medicine Service Line Agreement, Depression Reminder Completion SOP, recent performance measure completion data, flow mapping guide</td>
</tr>
<tr>
<td>Determine flow mapping team; ask identified team members if there are others they would suggest including.</td>
<td>Team: MHSL PI Lead PC-MHI Representative MHSL Leader PACT Leader BHIP/MH Clinic Representative MH Intake Representative</td>
</tr>
<tr>
<td>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</td>
<td>Share Flow Mapping resources with mapping team, discuss goal of mapping effort.</td>
</tr>
<tr>
<td>As a team, determine from what viewpoint the process will be mapped (e.g., bird’s eye, ground-level, veteran, PCP, therapist, MSA)</td>
<td>Viewpoint: Perspective of PACT and MHSL clinicians</td>
</tr>
<tr>
<td>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)</td>
<td>Utilization of Microsoft Word and Flow Mapping Tools Guide</td>
</tr>
<tr>
<td>Team titles the process map</td>
<td>“Positive Depression Screen Current State”</td>
</tr>
<tr>
<td>Team identifies the beginning (start) and end (stop) points of the process (represented by ovals)</td>
<td>Beginning: Positive Depression Screen End: Follow-up Reminder Completion and MH Disposition Adherence</td>
</tr>
</tbody>
</table>
**Appendix G. Flow Mapping Guide**

<table>
<thead>
<tr>
<th>Step</th>
<th>Example</th>
</tr>
</thead>
</table>
| 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 PC-MHI)                                                                 |
| 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 PC-MHI 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 (IF) 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 IF 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 PCMH 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 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.

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Current State, map what is ACTUALLY happening</td>
<td>For Current State, don’t map how the process “should or could” flow</td>
</tr>
<tr>
<td>Ask questions</td>
<td>Assume you know the answers</td>
</tr>
<tr>
<td>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).</td>
<td>Allow mapping efforts to delve into significant detail at the outset or begin without clearly determine the process to be mapped.</td>
</tr>
<tr>
<td>Involve the people who are involved in the process. Different levels of involvement will highlight different aspects of process.</td>
<td>Limit mapping team members to those in leadership or those on the frontline. It should ideally include representatives from all levels.</td>
</tr>
<tr>
<td>Actively facilitate the mapping process with focus maintained on process.</td>
<td>Let the mapping effort become bogged down in minutia, with arguments or blaming.</td>
</tr>
<tr>
<td>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.</td>
<td>Assume that the current process is the same as what is written in an SOP or other materials.</td>
</tr>
<tr>
<td>Draw map as it is being described by the team and clarify uncertainties.</td>
<td>Translate what the team is telling you into what you think they mean.</td>
</tr>
<tr>
<td>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.</td>
<td>Attempt to create a perfectly formatted map from the start.</td>
</tr>
<tr>
<td>Ensure Current State is captured before Future State is drafted.</td>
<td>Jump into Future State mapping before the Current State is verified.</td>
</tr>
<tr>
<td>Orient the mapping team to the purpose of the mapping effort, and provide a symbol key to the mapping team.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 (IF), as well as relevant front line staff knowledgeable about the current process flow, serve as the local process experts. Process flow mapping may start with the EF and IF 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 IF 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
Appendix G. Flow Mapping Guide

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oval</td>
<td>Start/stop</td>
</tr>
<tr>
<td>Square/Rectangle</td>
<td>Process Step</td>
</tr>
<tr>
<td>Small Square attached to Process Square/Rectangle</td>
<td>Used to show data if needed (e.g., #s, duration until appt)</td>
</tr>
<tr>
<td>Lines with Arrows</td>
<td>Direction of flow</td>
</tr>
<tr>
<td>Diamond</td>
<td>Decision step (yes and no inserted above direction lines to show decision flow)</td>
</tr>
<tr>
<td>Cloud</td>
<td>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</td>
</tr>
<tr>
<td>Kapowee</td>
<td>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</td>
</tr>
</tbody>
</table>

**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

Appendix G. Flow Mapping Guide
Future State Flow Map Example: PC-MHI ID’s Need for Specialty MH Psychiatry Evaluation

PC-MHI identifies need for specialty MH psychiatry evaluation

Has patient seen a specialty MH provider within the past 1 year and willing to follow-up with that provider?

Y

Schedule Appointment into MH Provider’s Clinic

N

Warm Hand-off to MH Intake Center

Intake team refers to appropriate BHIP Team (Mental Health Clinic) or Subspecialty MH for Review

Patient Scheduled into appropriate Specialty MH Clinic
## APPENDIX H. PROGRAM REPORT EXAMPLES

### Appendix H-1. PCMHI Program Implementation Quarterly Report

Facility: _______________________________ Facilitator: _______________________________

Date of Site Visit: _______________________________

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

<table>
<thead>
<tr>
<th>Measure 1: High Antipsychotic Doses</th>
<th>FACILITY NAME</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Veterans prescribed AP doses above 125% of recommended range:</td>
<td>7.5</td>
<td>25</td>
</tr>
<tr>
<td>Veterans who received APs (total):</td>
<td>7.4</td>
<td>24</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Doses within and above range by medication*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication and Dose Range</td>
</tr>
<tr>
<td>Above 125% of Range</td>
</tr>
<tr>
<td>Above Range</td>
</tr>
<tr>
<td>Within Range</td>
</tr>
<tr>
<td>Below Range</td>
</tr>
<tr>
<td>Total N</td>
</tr>
</tbody>
</table>

* 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 VHA Clinical Practice Guideline for Psychoses.

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

† 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).
### Appendix I-1. Sample Sustainability Action Plan (SAP)

<table>
<thead>
<tr>
<th>Sustainment Activity</th>
<th>Who is responsible?</th>
<th>Frequency and due dates</th>
<th>What metrics will you use to track progress?</th>
<th>Resources needed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Continue to deliver benefits to veterans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess relevant data: service utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess relevant data: clinical outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 2: Continue the components of the original innovation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review program components yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review process data review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 3: Maintain partnerships with stakeholders to continue to deliver the innovation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan for communicating and sharing progress: With leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Veterans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 4: Maintain new practices, procedures and policies established during the implementation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review and update Implementation Planning Guide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 5: Sustain attention to the innovation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review status of program in staff meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check on availability of resources for continuing the innovation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I-2. National Health Service Sustainability Index

NHS Sustainability Model

Authors
Lynne Maher1  David Gustafson2  Alyson Evans3

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 John’s House, East Street, Leicester LE1 6NB
2 - University of Wisconsin, Rm 1190 WABF Building, 610 Walnut Street, University of Wisconsin Madison 53705.
Appendix I-2. National Health Service Sustainability Index

<table>
<thead>
<tr>
<th>Process</th>
<th>Factor</th>
<th>Score</th>
<th>Factor Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits beyond helping patients</td>
<td></td>
<td></td>
<td>The change improves efficiency and makes jobs easier</td>
</tr>
<tr>
<td>Credibility of the benefits</td>
<td></td>
<td></td>
<td>The change improves efficiency but does not make jobs easier</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The change does not improve efficiency but does make jobs easier</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The change neither improves efficiency nor makes jobs easier</td>
</tr>
<tr>
<td>Adaptability of improved process</td>
<td></td>
<td></td>
<td>Benefits of the change are immediately obvious supported by evidence and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>believed by stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benefits of the change are not immediately obvious even though they are</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>supported by evidence and believed by stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benefits of the change are not immediately obvious even though they are</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>supported by evidence. They are not believed by stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benefits of the change are neither immediately obvious supported by evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>nor believed by stakeholders</td>
</tr>
<tr>
<td>Effectiveness of the system to monitor</td>
<td></td>
<td></td>
<td>The process can be adapted to other organisational changes and there is a</td>
</tr>
<tr>
<td>process</td>
<td></td>
<td></td>
<td>system for continually improving the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The process can be adapted to other organisational changes but there is no</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>system for continually improving the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The process is not able to adapt to other organisational changes and there</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>is no system for continually improving the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is a system in place to identify evidence of progress, monitor progress,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>act on it and communicate results</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is a system in place to identify evidence of progress and act on it,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>but the results are not communicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is a system in place to identify evidence and monitor progress. The</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>results are communicated but no one acts on them</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is no system in place to identify evidence of progress or to monitor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>progress nor act or communicate it</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Assessment</td>
<td>Date</td>
</tr>
<tr>
<td>2nd Assessment</td>
<td>Date</td>
</tr>
<tr>
<td>3rd Assessment</td>
<td>Date</td>
</tr>
</tbody>
</table>

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Appendix I-2. National Health Service Sustainability Index

Staff

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff involvement and training to sustain the process</td>
<td>Staff have been involved from the beginning of the change and adequately trained to sustain the improved process</td>
</tr>
<tr>
<td>Staff attitudes toward sustaining the change</td>
<td>Staff feel empowered as part of the change process and believe the improvement will be sustained</td>
</tr>
<tr>
<td>Senior leadership engagement</td>
<td>Organizational leaders take responsibility for efforts to sustain the change process and staff generally share information with and actively seek advice from the leader</td>
</tr>
<tr>
<td>Clinical leadership engagement</td>
<td>Clinical leaders take responsibility for efforts to sustain the change process and staff generally share information with and actively seek advice from the leader</td>
</tr>
</tbody>
</table>

Staff Total Score

<table>
<thead>
<tr>
<th>1st Assessment</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Assessment</td>
<td>Date</td>
</tr>
<tr>
<td>3rd Assessment</td>
<td>Date</td>
</tr>
</tbody>
</table>
Appendix I-2. National Health Service Sustainability Index

**Organisation**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Choose the **Factor Level** that comes closest to your situation and circle the **Score** to the left of it.

- **Factor Level**
  - There is a history of successful sustainability improvement goals are consistent with the organisation's strategic aims.
  - There is no history of successful sustainability but the 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 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 level 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.

**Organisation Total Score**

<table>
<thead>
<tr>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
</table>

**Staff Total Score**

<table>
<thead>
<tr>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
</table>

**Process Total Score**

<table>
<thead>
<tr>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
</table>

**Sustainability Total Score**

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 I-3. Program Sustainability Assessment Tool (PSAT)

The Program Sustainability Assessment Tool is a 40-item self-assessment that can be used by staff and stakeholders to assess the sustainability capacity of a program. The tool includes 40 multiple choice questions allowing you to "rate the sustainability capacity of your program across a range of factors." You can complete the tool online (at: https://sustaintool.org), immediately get results, and save a copy of the report. We have also included a copy on the following pages in this appendix.

The sustaintool.org website was designed to help implementers 1) “understand the factors that influence a program’s capacity for sustainability;” 2) use the PSAT to “assess your program’s capacity for sustainability;” 3) review the results of your assessment; and 4) “develop an action plan to increase the likelihood of sustainability.”

Read more about the development of the Program Sustainability Framework:

Read more about the reliability testing of the Program Sustainability Assessment Tool:

Read more about how to use results from the Program Sustainability Assessment Tool to engage in sustainability planning:
Program Sustainability Assessment Tool v2

What is program sustainability capacity?
We define program sustainability capacity as the ability to maintain programming and its benefits over time.

Why is program sustainability capacity important?
Programs at all levels and settings struggle with their sustainability capacity. Unfortunately, when programs are forced to shut down, hard won improvements in public health, clinical care, or social service outcomes can dissolve. To maintain these benefits to society, stakeholders must understand all of the factors that contribute to program sustainability. With knowledge of these critical factors, stakeholders can build program capacity for sustainability and position their efforts for long term success.

What is the purpose of this tool?
This tool will enable you to assess your program’s current capacity for sustainability across a range of specific organizational and contextual factors. Your responses will identify sustainability strengths and challenges. You can then use results to guide sustainability action planning for your program.

Helpful definitions
This tool has been designed for use with a wide variety of programs, both large and small, across different settings. Given this flexibility, it is important for you to think through how you are defining your program, organization, and community before starting the assessment.

Below are a few definitions of terms that are frequently used throughout the tool.

- **Program** refers to the set of formal organized activities that you want to sustain over time. Such activities could occur at the local, state, national, or international level and in a variety of settings.
- **Organization** encompasses all the parent organizations or agencies in which the program is housed. Depending on your program, the organization may refer to a national, state, or local department, a nonprofit organization, a hospital, etc.
- **Community** refers to the stakeholders who may benefit from or who may guide the program. This could include local residents, organizational leaders, decision-makers, etc. Community does not refer to a specific town or neighborhood.

Copyright 2013. The Program Sustainability Assessment Tool v2 is a copyrighted instrument of Washington University, St Louis, MO. All rights reserved. If you would like more information about the framework or our sustainability assessment tool, visit [http://www.sustaintool.org](http://www.sustaintool.org).
Program Sustainability Assessment Tool v2

The name of the program or set of activities I am assessing is:

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select “NA.” For each statement, circle the number that best indicates the extent to which your program has or does the following things.

**Environmental Support:** Having a supportive internal and external climate for your program

<table>
<thead>
<tr>
<th></th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Champions exist who strongly support the program.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program has strong champions with the ability to garner resources.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program has leadership support from within the larger organization.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The program has leadership support from outside of the organization.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program has strong public support.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Funding Stability:** Establishing a consistent financial base for your program

<table>
<thead>
<tr>
<th></th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program exists in a supportive state economic climate.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program implements policies to help ensure sustained funding.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program is funded through a variety of sources.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The program has a combination of stable and flexible funding.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program has sustained funding.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Program Sustainability Assessment Tool v2**

For each statement, circle the number that best indicates the extent to which your program has or does the following things.

### Partnerships: Cultivating connections between your program and its stakeholders

<table>
<thead>
<tr>
<th></th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diverse community organizations are invested in the success of the program.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program communicates with community leaders.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Community leaders are involved with the program.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Community members are passionately committed to the program.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The community is engaged in the development of program goals.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Organizational Capacity: Having the internal support and resources needed to effectively manage your program and its activities

<table>
<thead>
<tr>
<th></th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program is well integrated into the operations of the organization.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Organizational systems are in place to support the various program needs.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Leadership effectively articulates the vision of the program to external partners.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Leadership efficiently manages staff and other resources.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program has adequate staff to complete the program’s goals.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For each statement, circle the number that best indicates the extent to which your program has or does the following things.

### Program Evaluation: Assessing your program to inform planning and document results

<table>
<thead>
<tr>
<th>Statement</th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program has the capacity for quality program evaluation.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program reports short term and intermediate outcomes.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evaluation results inform program planning and implementation.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Program evaluation results are used to demonstrate successes to funders and other key stakeholders.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program provides strong evidence to the public that the program works.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Program Adaptation: Taking actions that adapt your program to ensure its ongoing effectiveness

<table>
<thead>
<tr>
<th>Statement</th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program periodically reviews the evidence base.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program adapts strategies as needed.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program adapts to new science.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The program proactively adapts to changes in the environment.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program makes decisions about which components are ineffective and should not continue.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Program Sustainability Assessment Tool v2

For each statement, circle the number that best indicates the extent to which your program has or does the following things.

Communications: Strategic communication with stakeholders and the public about your program

<table>
<thead>
<tr>
<th>Statement</th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program has communication strategies to secure and maintain public support.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Program staff communicate the need for the program to the public.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program is marketed in a way that generates interest.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The program increases community awareness of the issue.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program demonstrates its value to the public.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic Planning: Using processes that guide your program's direction, goals, and strategies

<table>
<thead>
<tr>
<th>Statement</th>
<th>To little or no extent</th>
<th>To a very great extent</th>
<th>Not able to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program plans for future resource needs.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The program has a long-term financial plan.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The program has a sustainability plan.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The program's goals are understood by all stakeholders.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The program clearly outlines roles and responsibilities for all stakeholders.</td>
<td>1 2 3 4 5 6 7 NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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.

<table>
<thead>
<tr>
<th>Meeting and brief description</th>
<th>Time Needed</th>
<th>Location</th>
<th>Suggested Attendees (Will vary by facility)</th>
</tr>
</thead>
</table>
| 1. **Entrance Conference:** Need a 30 minute time frame with the QUAD. Ideally this meeting will happen first. Quad 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 (Quad +AOs)  
• PC Leadership  
• MH leadership |
| 2. **Overview of PC-MHI 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 minute | V-tel | • PC Leadership MH Leadership  
• PC-MHI staff  
• Key Stakeholders  
• Clinic set-up and scheduling Staff |
<table>
<thead>
<tr>
<th>Meeting and brief description</th>
<th>Time Needed</th>
<th>Location</th>
<th>Suggested Attendees (Will vary by facility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>identified gaps\n  • Review and discuss Clinical services and initial assessment from functional tool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Implementation Meeting Part II</strong>\n  • Continue review and discussion of Functional Tool: Clinical services, Clinical services, assessment and patient identification\n  • Identify gaps and steps for full implementation</td>
<td>90-120 minutes</td>
<td>V-tel</td>
<td>Same as Implementation Meeting Part I</td>
</tr>
<tr>
<td><strong>5. Implementation Meeting Part III</strong>\n  • Continue review and discussion of functional tool: Clinical services, Clinical services, assessment and patient identification\n  • Develop plan for full implementation</td>
<td>90-120 minutes</td>
<td>V-tel</td>
<td>Same as Implementation Meeting Part I</td>
</tr>
<tr>
<td><strong>6. Virtual Tour of PC and PCMHI Space:</strong>\n  • Review floor plans,\n  • Describe space\n  • Share pictures\n  • Consider pre-recorded tour with facility permission</td>
<td>30-45 minutes</td>
<td>V-tel</td>
<td>• PC Leadership\n  • MH Leadership\n  • PC-MHI staff</td>
</tr>
<tr>
<td>Meeting and brief description</td>
<td>Time Needed</td>
<td>Location</td>
<td>Suggested Attendees (Will vary by facility)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Consider real-time tour via Video with facility permission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Exit Conference:</td>
<td>30 minutes</td>
<td>V-tel</td>
<td>• Facility Leadership (Quad +AOS) PC Leadership  MH leadership</td>
</tr>
<tr>
<td>• After implementation checklist is completed and initial plan is</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>developed, but prior to release of formal report, a verbal update</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to the QUAD is provided</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8. Individual meetings                                            | 45-90 minutes | Phone or V-tel | • PCMHI Staff  
• Leadership  
• Other stakeholders  
• Anyone wishing to speak with the facilitators individually. |
| • Questions, comments, and concurs                              |             |          |                                                                                                          |
| • Available throughout the process as needed                     |             |          |                                                                                                          |
| 9. On-going Implementation meetings                              | 45-60 minutes | Phone and v-tel | • Implementation committee and others as needed                                                          |
| • 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                         |             |          |                                                                                                          |
| 10. Facility Leadership updates                                  | 30 minutes  | V-tel    | • Quad  
• MH leaderships  
• PACT leadership                                                             |
| • Updates to be provided to facility leadership at midpoint and   |             |          |                                                                                                          |
| then at the finalization of facilitation.                        |             |          |                                                                                                          |
Appendix J-2. Preparation for Virtual Site Visit: Pre-Meeting Checklist vi

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 VISN 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. __________

Video conferencing using Jabber:

☐ With MH POC, determine how many sites/rooms will need to join Video Conferencing: at Facility, VISN, 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. __________

vi 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 K. IMPLEMENTATION FACILITATION TRACKING LOG & DEFINITIONS

**SITE NAME:**

<table>
<thead>
<tr>
<th>Name of person completing sheet:</th>
<th>Role of person completing sheet:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Type</th>
<th>Mode of Communication</th>
<th>Primary person with whom you interacted</th>
<th>Time</th>
<th>Facilitation Activity Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1=prep time</td>
<td>2=site on-one 3=group 4=site visit 5=other 6=not applicable (eg, prep time)</td>
<td>1=Provider(s) 2=Leadership - service level 3=Leadership - society level 4=Leadership - VISION level 5=Leadership - national level 6=External facilitator 7=Internal facilitator 8=Client or admin support 9=Team member(s) 10=Other</td>
<td>1</td>
<td>1=Assessment 2=Preparation/piloting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>3=Stakeholder engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>4=Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>5=Ongoing process monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>6=Program adaptation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>7=Problem identification and problem solving</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8=Data audit/feedback and evaluation of implementation outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
<td>9=Program marketing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>10=Network development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td>11=Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Activity (use numbers from box to the right)</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
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. Facilitation Activities Definitions

1. **Assessment** involves gathering information about the site, its clinicians and/or targeted patient population (typically prior to implementation) to help guide or inform implementation planning and execution. Activities may include:
   - Working with stakeholders to identify current local resources and practices to support deployment of *the clinical innovation*.
   - Assessing organizational context/environment (including resources, data capture systems, culture, leadership, etc.), needs, barriers and facilitators to implementation
   - Reviewing on-line resources to learn more about the clinical site or patient population served.
2. **Preparation/planning** involves efforts conducted in isolation or in partnership with stakeholders to help the site prepare and plan for implementation. Activities may include:
   - Help clinics identify local change agents (e.g., champions, opinion leaders)
   - Based on assessment activities, facilitating [clinical innovation staff] role development and training that will best meet patient and/or clinic needs or preferences.
   - Assisting sites with goal-setting.
   - Assisting sites with developing a local implementation plan, or adapting an existing implementation plan, to meet project goals.
   - Assisting sites with establishment of clinics, note templates or other resources or mechanisms that may be needed to support local implementation.
   - Adapting templated documents for use with a particular site.
   - Developing meeting agendas or other documents in preparation for a call or meeting with site personnel.
   - Typing up notes or other debriefing documents after a call or meeting with site personnel (as these will likely inform subsequent contact with the site).

3. **Stakeholder engagement** includes efforts to develop relationships and lines of communication with key local stakeholders to facilitate their active involvement in implementation planning and execution. Activities may include:
   - Engaging regional and medical center managers directly through product and service line meeting presentations about [the clinical innovation]
   - Engaging local management and providers through briefings and individual meetings during site visits
   - Incorporating process feedback from the implementation effort into existing leadership meetings and information dissemination mechanisms
   - Being available and providing consultation on [clinical innovation] implementation progress to regional and local leadership as needed and/or as requested by local stakeholders

4. **Education** involves efforts to inform stakeholders about (a) the evidence base for a clinical program or practice, and/or (b) distinct implementation strategies and how they may be utilized to help the site achieve project goals. Activities may include:
   - Providing briefings to medical center management to ensure they are aware and supportive
   - Educating staff about the clinical innovation program and how it will affect them
   - Providing local champions with educational tools that can facilitate implementation.
   - Coordinating regional and clinic level educational efforts
   - Providing [clinical innovation] staff with educational briefings about other [clinical innovation] sites
   - Educating staff on the interpretation of performance feedback reports

5. **Ongoing progress monitoring** involves efforts to track how the site is progressing in terms of executing the implementation plan and meeting implementation milestones or goals. Activities may include:
   - Developing, assigning and monitoring action items to reach goals
   - Conducting structured telephone consultation on progress toward goals
   - Encouraging sites to progress toward goals
   - Providing ongoing implementation process information to staff and site level
Appendix K. Implementation Facilitation Tracking Log & Definitions

leadership

6. **Program adaptation** involves efforts with local stakeholders and program content experts to adapt the program or practice targeted for implementation to enhance fit with local resources, preferences or other contextual factors while also maintaining fidelity. Activities may include:
   - Meeting with key stakeholders during site visits to adapt or fit the program to the local context, needs and resources while ensuring fidelity, involving content experts as necessary
   - Conducting telephone or site visit consultation on adaptation as clinic personnel or program needs change
   - Maintaining awareness and contact with other potentially related initiatives to ensure that the program is adapted to work synergistically with these initiatives

7. **Problem identification and problem solving** involves efforts with stakeholders to identify and address challenges or problems that arise during implementation that may prevent the site from achieving project goals. Activities may include:
   - During implementation, helping sites to identify possible barriers to implementation and address them
   - Reviewing implementation process outcomes and identifying implementation barriers during monthly program specific implementation teleconferences with site personnel
   - Assisting sites in problem resolution by communicating with senior leadership as appropriate.
   - Assisting sites in problem resolution by communicating with other local services.

8. **Data audit/feedback and evaluation of implementation outcomes** involves efforts to facilitate development of data reports that can be used to monitor program impacts on key processes of care and/or patient outcomes. Activities may include:
   - Working with local Office of Information Technology (OIT) or VISN experts on pulling administrative data
   - Discussing monthly performance feedback reports with site participants
   - Discussing development of monthly workload reports
   - At pre-defined intervals, providing program outcomes summaries to document impacts and support leadership decisions regarding continued program implementation, sustainability and spread

9. **Program marketing** involves efforts to promote local buy-in and support among leadership, clinicians and/or patients for adopting and continuing the targeted clinical program or practice. Activities may include:
   - Supporting marketing activities at clinics
   - Providing support for sites to conduct brief face-to-face meetings with local change agents and providers
   - Identifying ongoing marketing opportunities and strategies

10. **Network development** involves efforts to facilitate connections between stakeholders within-site or among stakeholders across multiple sites to enable information-sharing on their experience in implementing the new clinical program or practice, what works and does not work, new local resources or practices developed to support implementation, etc. Activities may include:
• Discuss learning and networking ‘community of practice’ opportunities among clinics implementing [the clinical innovation]
• Encourage attendance at program-specific teleconferences
• Using successful sites as educators in regional and local educational ‘communities of practice’
• Supporting clinic personnel’s use of the ‘community of practice’ as a resource to enable and empower them to address implementation barriers and identify innovative facilitators.
• Encouraging and supporting sharing their own experiences and networking within the ‘community of practice’ for problem solving and education
• Using the ‘community of practice’ to identify educational needs for local staff

11. Other refers to facilitator activities not described above. If using this column, please describe the activity in the “Notes” section of the tracking log.
APPENDIX L. RECOMMENDED READINGS


