

# Facilitation: An Evidence-Based implementation Strategy

CyberSeminar  
April 7, 2016

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# Poll Question

What is your primary role in VA?

1. Clinician
2. Researcher
3. Student, fellow or trainee
4. Policy Maker or Manager
5. Other

# CyberSeminar Overview

- Background
- Implementation Facilitation Strategy
- Overview of Evaluation/Methods
- Quantitative Methods, Results
- Qualitative Methods, Results, and Discussion

# Poll Question

Have you used a facilitation strategy to support implementation of an evidence-based practice or program in a research project or clinical initiative?

1. Yes
2. No

# Background

- Implementing new programs and practices is challenging
- Both top down mandates, and bottom up approaches, have limitations
- Many clinical settings
  - Lack capacity for implementation activities and quality improvement efforts
  - Experience significant contextual barriers
- Facilitation strategies have shown promise in implementing programs and practices

# Background

- Implementation Facilitation (IF) strategies
  - Focus on building relationships
  - Help and enable as opposed to tell
  - Partner with sites
- Bundle evidence-based implementation interventions
- Facilitators use particular activities and techniques
- We developed and applied an IF strategy within the context of a national Primary Care-Mental Health Integration (PC-MHI) clinical initiative

# The Implementation Facilitation Strategy

# The Implementation Strategy

## External Facilitator (EF)

- National expert in IF techniques and PC-MHI
- Linked to other experts and implementation resources
- Trained/mentored internal regional facilitator

## Internal Regional Facilitator (IRF)

- Embedded within clinical organization at regional level
- Familiar with local and regional organizational structures, procedures, culture and clinical processes
- Worked directly with site level personnel
- Allowed the institutional knowledge gained from the implementation process to remain within clinical network

# The Implementation Strategy

## Pre-implementation activities focused on:

- Engaging leadership support
- Identifying key stakeholders
- Conducting formative evaluation activities
- Providing academic detailing

## Design Phase

- Initiated when sites hired PC-MHI staff
- Design phase initiation and length varied
- Concluded with a comprehensive implementation plan

# The Implementation Strategy

## Early Implementation

- Facilitators continued to engage and partner with stakeholders at all levels
- Helped refine and implement plan, assess and address barriers, monitor progress, audit and feedback
- Facilitators also established regional learning collaboratives for PC-MHI providers

# The Implementation Strategy

## Late Phase

- Facilitators and stakeholders continued to partner to sustain PC-MHI
- Continued audit and feedback, problem identification and resolution
- Integrating PC-MHI into organizational systems and processes

## Maintenance Phase

- Partner with stakeholders to Identify key elements of the implementation plan necessary to sustain change and help them establish mechanisms to convert those elements into **‘the way we do things here’**

# Evaluation Methods

# Evaluation of the IF Strategy

- Independent evaluation

- Study Aim

Test the effectiveness of the IF strategy versus standard national support alone, on extent of clinic-level outcomes, provider behavior change, and changes in Veterans' service utilization

# Evaluation of the IF Strategy

- Independent evaluation

- Study Aim

Test the effectiveness of the IF strategy versus standard national support alone, on extent of clinic-level outcomes, provider behavior change, and changes in Veterans' service utilization *at sites unable to implement the program without assistance.*

# Evaluation of the IF Strategy

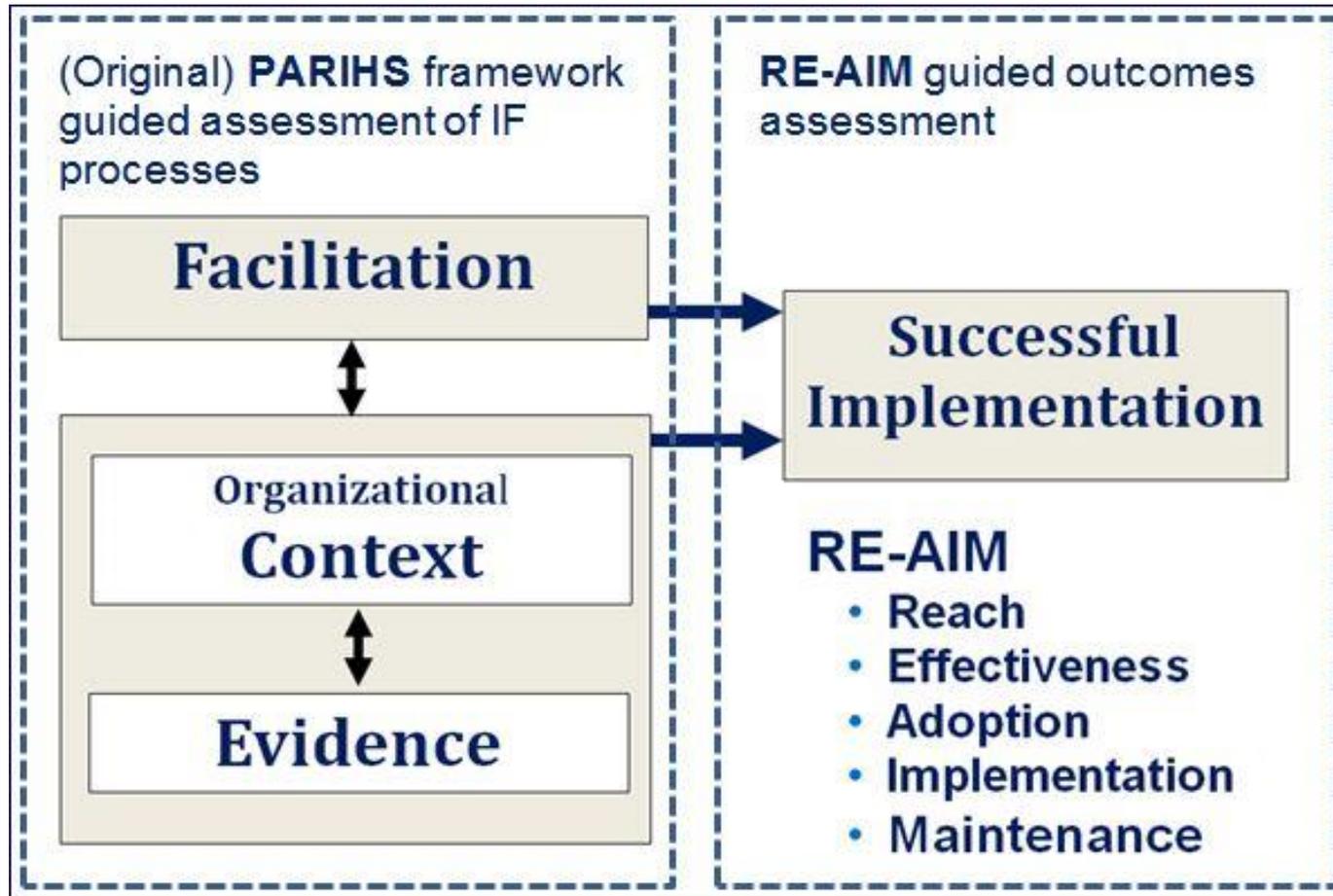
- Quasi-experimental, Hybrid Type III Design and mixed methods
- 16 PC Clinics implementing PC-MHI
  - Network MH Directors identified clinics unable to implement PC-MHI without help
  - 8 IF and 8 matched comparison VA PC clinics
- Consensus matching approach
  - Networks matched on organizational structure and support for PC-MHI
  - Clinics matched on size, location, perceived need, perception of evidence, general clinic innovativeness, academic affiliation

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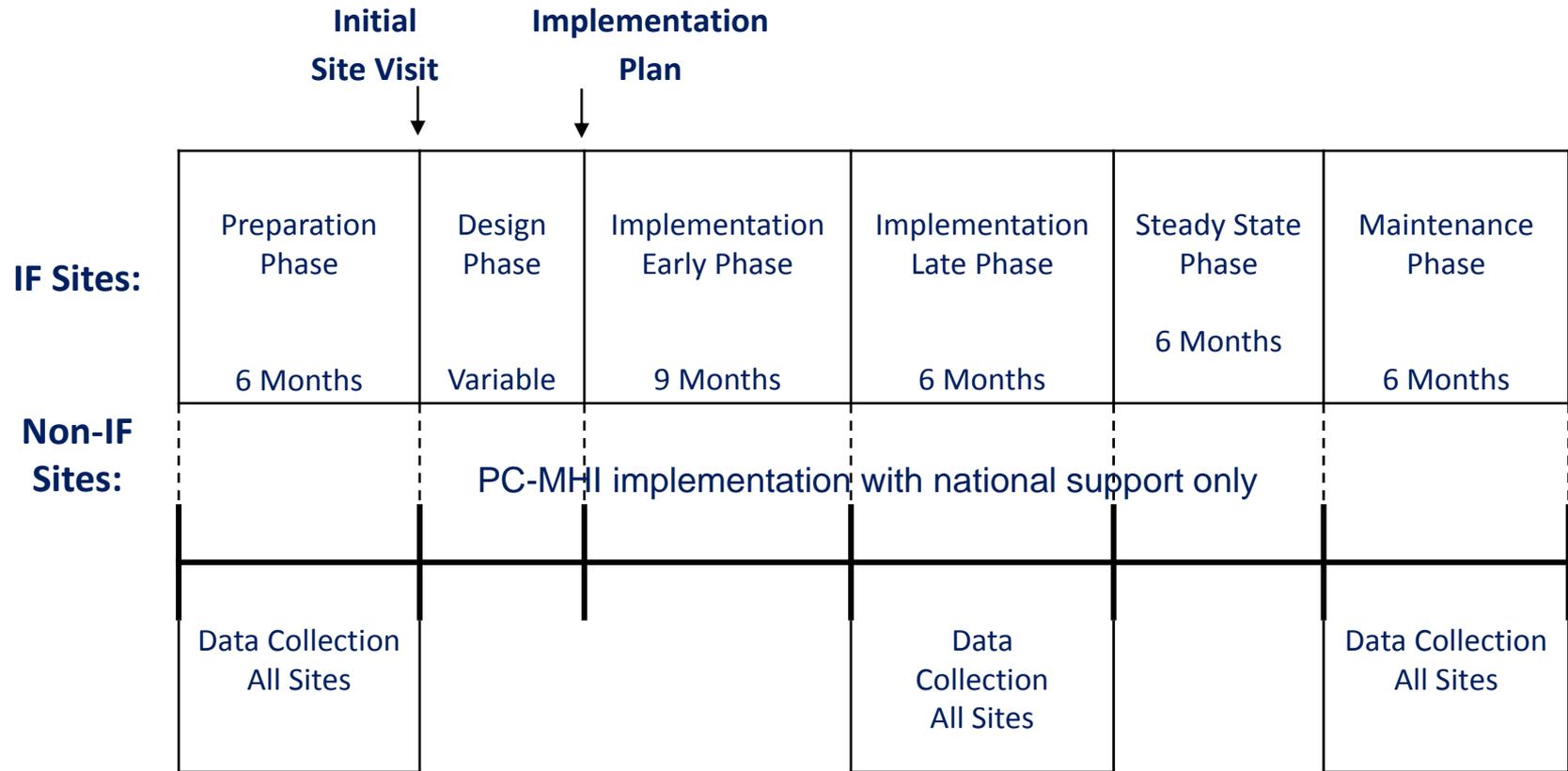


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# Conceptual Frameworks



# Methods



## Study Periods

(Liu et al. 2009)

# Quantitative Methods and Results

# RE-AIM Measures

## Reach

- Percentage of patients seen in PC with a PC-MHI encounter

## Effectiveness

- Percentage of PC patients with an initial visit to specialty care

## Adoption

- Percentage of *PC providers referring* at least 1 patient to PC-MHI
- Proportion of PC providers' *patients referred* to PC-MHI

## Implementation

- Percentage of patients referred to PC-MHI that were seen on the same day (open access)

## Maintenance

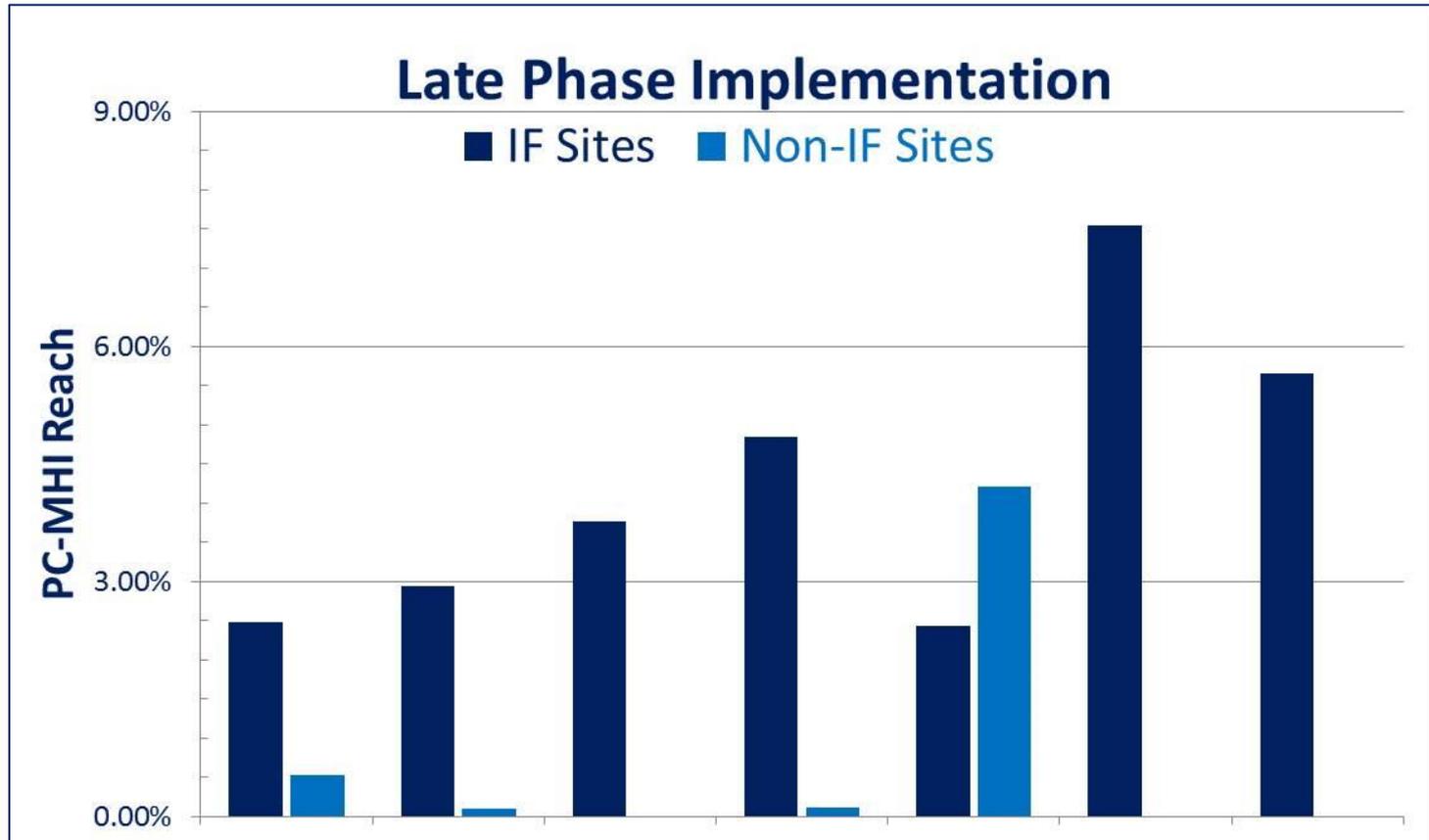
- A re-assessment of each measure during maintenance

# Methods

- Compared 7 of 8 VA primary care (PC) clinics receiving IF and national support **with** 7 of 8 matched comparison clinics receiving national support only
- Data Sources
  - VHA Medical SAS Outpatient data (patient data)
  - VHA Primary Care Management Module (PCMM) data set (provider data)
- Controlled for clustering using generalized estimating equations (GEE)



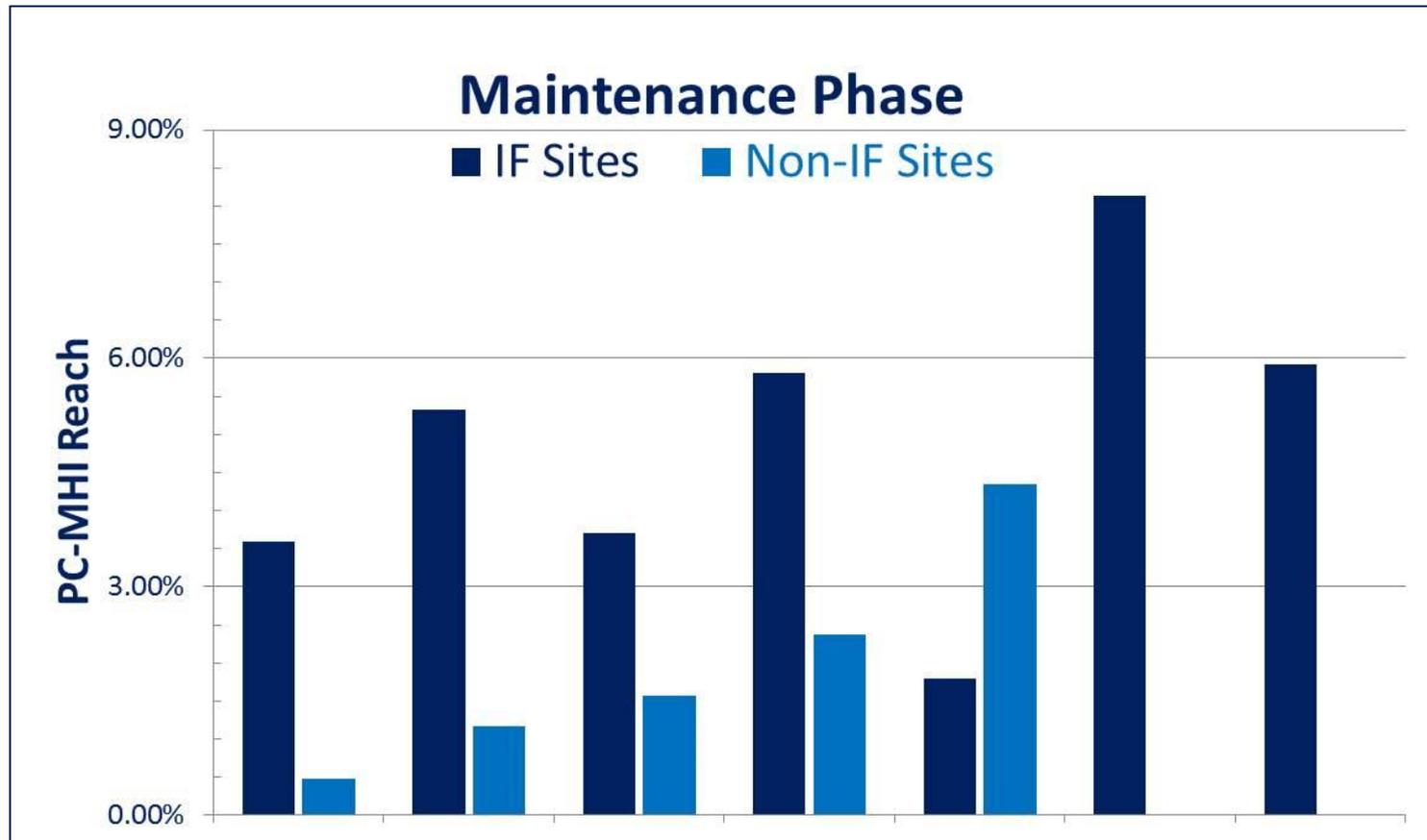
# Results: Reach



**OR = 8.93 (2.99,26.61),  $p < 0.001$**



# Results: Reach



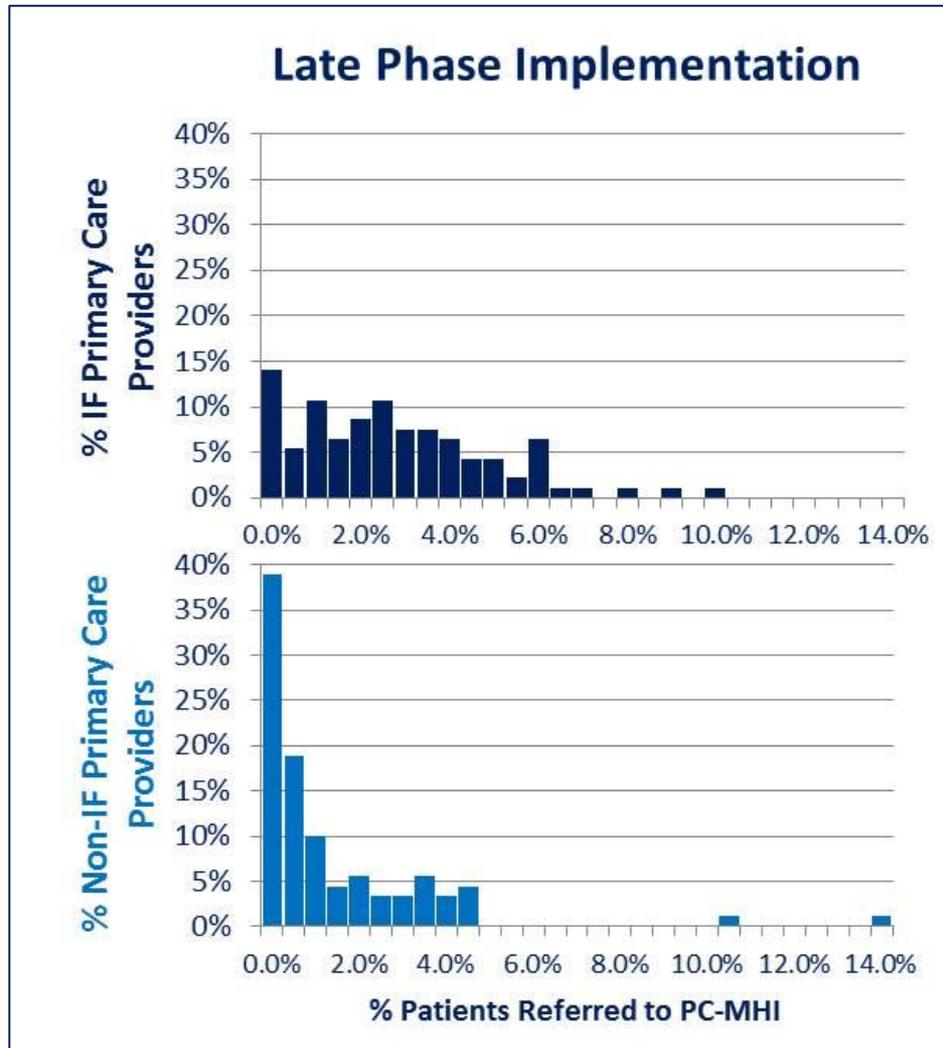
OR = 4.30 (1.90, 9.73),  $p < 0.001$

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# Results: Adoption



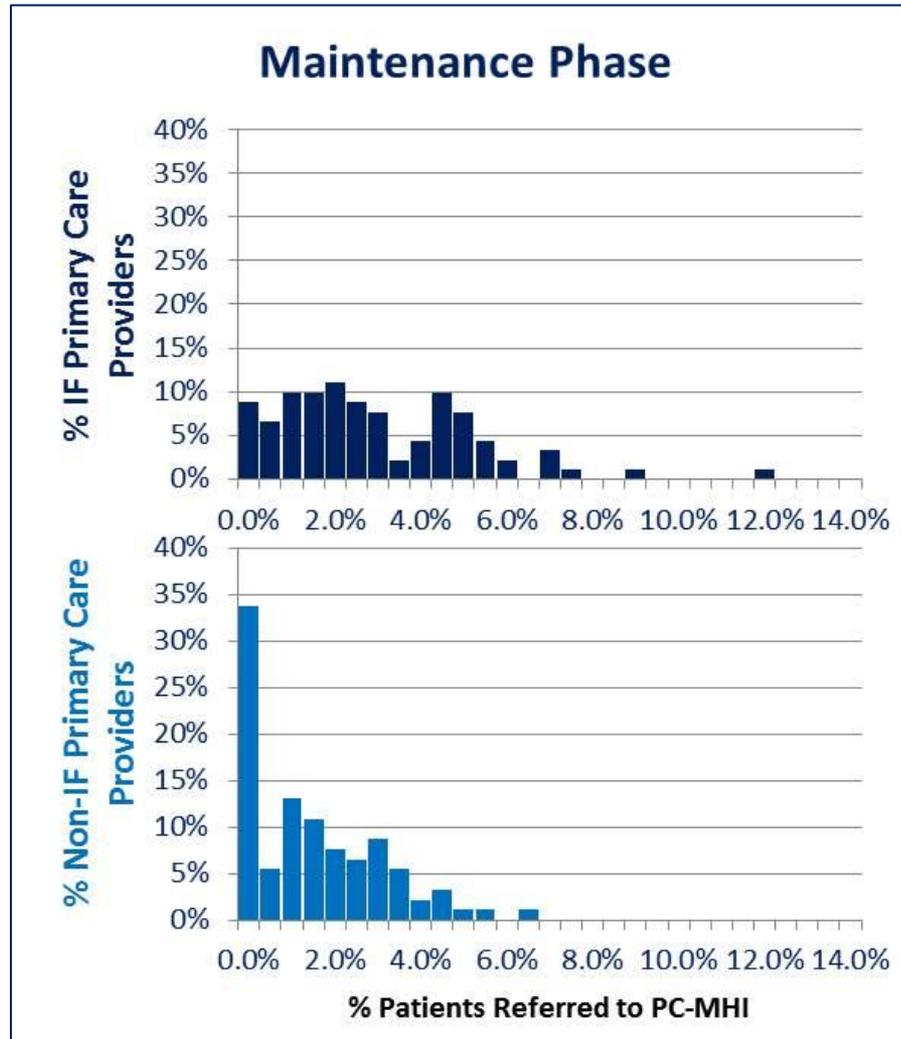
% Providers OR = 7.12 (1.22, 41.57),  $p < 0.05$

% Patients  $\beta = 0.027$  (0.012, 0.014),  $p < 0.001$



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# Results: Adoption



% Providers OR = 9.73 (1.95, 48.56),  $p < 0.05$

% Patients  $\beta = 0.022$  (0.008, 0.037),  $p < 0.05$

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# Principal Findings

In Late and Maintenance phases, facilitation clinics had:

- **Greater Reach**  
Percentage of *patients with PC-MHI encounters*:
- **Greater Adoption**  
Percentage of *providers referring*  
Percentage of *patients referred*
- **No Differences in Effectiveness or Implementation Fidelity**

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# Summary

- Addition of this strategy resulted *in significant differences* in PC-MHI reach and adoption of the intervention that were *sustained*
  - IF strategy was developed and implemented through clinical-research partnerships
  - Stakeholders at all levels helped adapt the program and address barriers
  - The IRF continued to provide support after the EF ‘pulled away’



# Limitations

- Although a primary aim was to determine effectiveness of the IF strategy
  - We were unable to collect patient-level clinical outcomes due to limits of clinical data systems
  - Thus, we report process of care measures assumed to be correlated with patient outcomes
- Clinical data systems also do not provide us with information about the implementation process – we used a proxy measure

# Qualitative Methods, Results and Discussion

# Baseline Status of PC-MHI Implementation

Sites		Clinic Size	Staff Identified for PC-MHI	Policy Compliant PC-MHI Program?
Intervention Sites	Site A1 – VAMC	5,632	MSW*	No
	Site A2 – CBOC	9,224	MSW*	No
	Site A3 – CBOC	4,025	MSW*	No
	Site A4 – CBOC	5,654	MSW*	No
	Site C1 – VAMC	34,805	MSW**	No
	Site C2 – CBOC	14,763	MSW,* RN*	No
	Site C3 – CBOC	8,125	Newly hired MSW**	No
	Site C4 – CBOC	4,715	MSW*	No
Comparison Sites	Site B1 – VAMC	7,454	No	No
	Site B2 – CBOC	11,308	No	No
	Site B3 – CBOC	5,944	No	No
	Site B4 – CBOC	7,527	No	No
	Site D1 – VAMC	35,000	RN,* 2 newly hired psychiatrists**	No
	Site D2 – CBOC	13,600	No	No
	Site D3 – CBOC	8,463	No	No
	Site D4 – CBOC	4,527	No	No

\*Located in PC but providing specialty mental health care, assessment only, or triage and referral

\*\*Identified but not yet working in PC-MHI



# Methods

- Developed an instrument to identify and document PC-MHI program components sites did implement
- Goal: to gain a comprehensive understanding of each facility's program for integrating mental health into primary care
- Assessment process
  - Informants
  - Structured telephone interviews conducted at two time points for each intervention and comparison site pair



# Methods

## Creation of Program Summaries

- To facilitate review by PC-MHI experts:
  - Created a structured program summary template
  - Information displayed in bulleted lists, tables and checkboxes
- Created structured summaries from notes for each PC-MHI program component assessment
- 23 program summaries; site identifiers and time periods removed

# Methods

## Expert Rating Process

- Six national experts in PC-MHI
  - Blind to informant, site and time period
  - Reviewed and rated 11-12 program summaries
  - Used a 7-point Likert scale to rate programs on:
    - Overall program quality
    - Use of evidence-based program components
    - Potential for long-term sustainability
    - Expected level of improvement in quality of care
- Three experts rated each summary



# Results

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# Time One Expert Ratings of PC-MHI Programs

Sites		Overall	
Intervention Sites	Site A1 – VAMC	3.33	3.33
	Site A2 – CBOC	4.33	4.67
	Site A3 – CBOC	4.67	5.00
	Site A4 – CBOC	4.00	4.00
	Site C1 – VAMC	4.00	3.33
	Site C2 – CBOC	1.33	1.33
	Site C3 – CBOC	6.33	6.33
	Site C4 – CBOC	No Program	No Program
Comparison Sites	Site B1 – VAMC	No Program	No Program
	Site B2 – CBOC	2.67	2.67
	Site B3 – CBOC	2.33	2.33
	Site B4 – CBOC	1.33	1.33
	Site D1 – VAMC	No data	No data
	Site D2 – CBOC	No Program	No Program
	Site D3 – CBOC	No Program	No Program
	Site D4 – CBOC	No Program	No Program

- 7 of 8 intervention sites but only 3 of 8 comparison sites had PC-MHI programs

- 
- Experts rated intervention programs most highly (with one exception)



# Time Two Expert Ratings of PC-MHI Programs

Sites		Overall Quality	Adherence to Evidence
Intervention Sites	Site A1 – VAMC	5.00	4.33
	Site A2 – CBOC	5.33	5.33
	Site A3 – CBOC	5.33	5.67
	Site A4 – CBOC	5.00	5.00
	Site C1 – VAMC	1.67	1.67
	Site C2 – CBOC	3.00	3.00
	Site C3 – CBOC	6.00	5.67
	Site C4 – CBOC	3.67	3.33
Comparison Sites	Site B1 – VAMC	2.00	2.33
	Site B2 – CBOC	3.33	3.33
	Site B3 – CBOC	3.67	3.33
	Site B4 – CBOC	4.33	4.00
	Site D1 – VAMC	4.33	4.33
	Site D2 – CBOC	No Program	No Program
	Site D3 – CBOC	No Program	No Program
	Site D4 – CBOC	No Program	No Program

- All 8 intervention sites but only 5 of 8 comparison sites had implemented PC-MHI programs
- 
- All but 1 of the intervention sites had a higher rated program than its comparison site

# Results

Not all intervention sites did as well

Site	Time 1: Overall Quality	Time 1: Evidence	Time 2: Overall Quality	Time 2: Evidence
Site C1 – VAMC	4.00	3.33	1.67	1.67

- C1 VAMC ratings
  - Similar to other intervention sites at time 1
  - Lower than all other sites at time 2
- What happened?
  - High level leadership not engaged – no support for making structural changes (PCPs sent everyone to urgent MH care clinic) or providing resources
  - PC-MHI staff instability (turnover and diversion of time to other duties)

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# Results

Not all intervention sites did as well

Site	Time 1: Overall Quality	Time 1: Evidence	Time 2: Overall Quality	Time 2: Evidence
Site C2 – CBOC	1.33	1.33	3.00	3.00

- C2 CBOC ratings
  - Very low rating at time 1
  - A little higher at time 2 but still lower than other intervention sites at time 1
- C2 (Very low at time 1; OK at time 2):
  - PCL not engaged/MHL actually resistant to change
  - MH clinic backlogged – saw PC-MHI providers as MH resource thus staff diverted to conduct lengthy MH assessments and referrals
  - Child CBOC to C1 VAMC – lack of resources



# Discussion

Facilitation and strength of leadership structure may have a synergistic effect on ability to implement high quality/evidence-based programs

- With both → success most likely
- Without either → success is unlikely
- With one or the other, success is possible, but difficult

		Implementation Facilitation Intervention:	
		Yes	No
Strength of Leadership Structure:	Strong	Network A Sites: Most Successful	Network B Sites: Variable Success
	Moderate	Network C Sites: Variable Success	Network D Sites: Least Successful



# Discussion

- Facilitation can foster adoption and implementation of high quality and evidenced based new practices at challenging sites
- Even with intensive facilitation, there may be some sites that continue to have difficulty implementing new programs
- Even when sites have a program, staff turnover can set the process back – challenged sites may need refresher facilitation

# Summary

- This implementation facilitation strategy targeted sites believed by leadership to be unable to implement a PC-MHI program without assistance
- The success of this strategy provides health care systems with an evidence-based option for settings that lack implementation capacity
- This strategy has been adopted by the Office of Mental Health Operations to support implementation of PC-MHI and EB Psychotherapy programs across VA

# Questions?

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