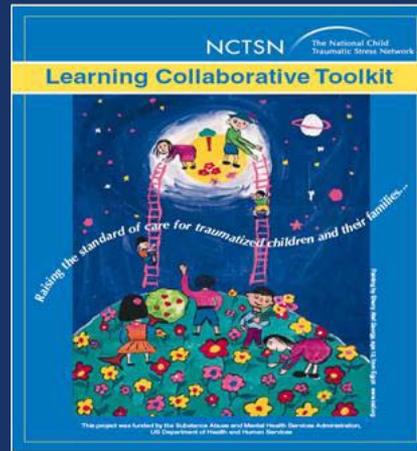


THE LEARNING COLLABORATIVE FRAMEWORK: A MODEL FOR IMPLEMENTATION AND DISSEMINATION OF BEST PRACTICES



North Carolina Institute of Medicine Task Force on the Mental Health,
Social, and Emotional Needs of Young Children and their Families

Robert Murphy, PhD
August 25, 2011

Duke Evidence-based Implementation Center

- Center for Child & Family Health
- National Center for Child Traumatic Stress
- North Carolina Child Treatment Program

- ...closing the gap between the establishment of evidence-based treatments and practices and their incorporation into frontline care.

Implementation is Integral Component

Implementation: methods to assure the use of evidence-based programs and other innovations with fidelity and benefit to consumers.

17 years

from research to everyday
practice



Learning Collaboratives & Breakthrough Series Collaboratives: 2004-2011

- 43 Learning Collaboratives or Breakthrough Series Collaboratives: 19 EPIC & 24 NCCTS
 - 12 in NC = 28% of total & 63% of EPIC (CCFH, CTP)
- 2,344 Participants: 1099 EPIC & 1245 NCCTS
 - 29% (682) in NC
- *It was completely different and completely successful compared to other attempts to learn new treatments. The structure of the Collaborative helped our momentum continue throughout the life of the Collaborative and beyond.”*
 - Jennifer Wilgocki, LCSW, Mental Health Center of Dane County

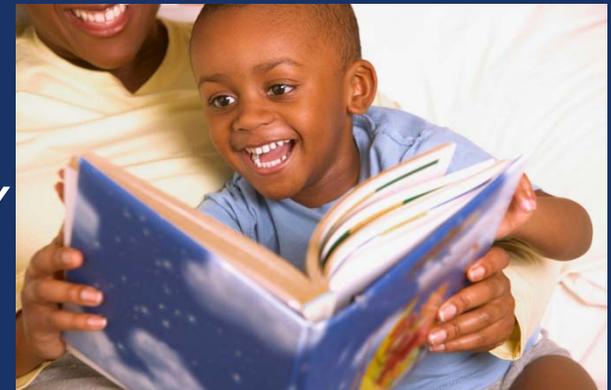
NC Learning Collaboratives

- Trauma Focused Cognitive Behavioral Therapy
- Parent Child Interaction Therapy
- Structured Psychotherapy for Adolescents Responding to Chronic Stress
- Attachment & Bio-Behavioral Catch-up
- Veteran Culture & Clinical Competence
- Wrap Around Services
- VA Primary Care Redesign
- VA Smoking Cessation

My entire practice has changed; my clinical expertise has been sharpened; my sessions are more focused and directed ... I am accepting more challenging cases ... I have witnessed the phenomenal results of the treatment in shorter treatment periods. (Wilson County)

The Challenge: Making Best Practice Usual Practice

- Over the past 10 years, tremendous progress has been made in the development of evidence-based practices (EBPs) for child trauma.
- However, the challenge of adapting and broadly adopting these practices by community agencies who serve traumatized children remains.
- *Attention to **Clinical Competence & Implementation Barriers** within All Settings, particularly Community Settings*



Essential Components of Clinical Training

NOT EFFECTIVE

- Workshops
- Seminars
- Self administered curricula
- Self directed study
- Didactic only instruction

EFFECTIVE

- Multi-Component
- Intervention manual
- Intensive instruction
- Extended consultation & booster sessions
- Video or live session review
- Supervisor training
- Guided practice

Learning from Improvement Science and Implementation Models in Healthcare

- Quality Collaboratives¹:
 - Reduce disparity between actual & best practice
 - Convene groups of practitioners from different organizations
 - Meeting series to learn about best practice, quality methods and to share experiences making improvements
 - Improve practice by testing & implementing changes quickly across organizations
- Learning Collaborative methodology informed by:
 - Institute for Healthcare Improvement (www.IHI.org)
 - National Initiative for Children's Healthcare Quality (www.NICHQ.org)
 - Casey Family Programs (www.casey.org)
 - Center for Healthcare Quality (www.centerforhealthcarequality.org)

¹Ovretveit, J., Bate P., Cleary, S., Cretin D., Gustafson, K., McInnes H. et al. (2002) Quality collaboratives: lessons from research. *Quality and Safety in Health Care*, 11, 345-351.

Model Development

- NCTSN Breakthrough Series Collaborative
 - Application IHI Breakthrough Series Collaborative model¹ to support full adoption & spread of a child trauma EBP (TF-CBT).
 - Focus on broad implementation of practice with fidelity, not basic training.
 - Emphasis on:
 - Organizational change & engagement; training in and application of improvement methods; Cross-site collaboration
 - 12 NCTSN sites
 - 485 children received TF-CBT
 - 70+ clinicians providing TF-CBT (85% increase in capacity)
 - 30 trained supervisors

¹Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Author.

2009, NCCTS and Duke EPIC

Learning Collaborative Model

- Adaptation of the IHI's Breakthrough Series Collaborative.
- Designed to support successful adoption of child trauma EBPs through:
 - Clinical competence via high quality training in the practice +
 - Implementation competence via a methodology developed to disseminate and adapt best practices.



2009, NCCTS and Duke EPIC

Essential Learning Collaborative Components

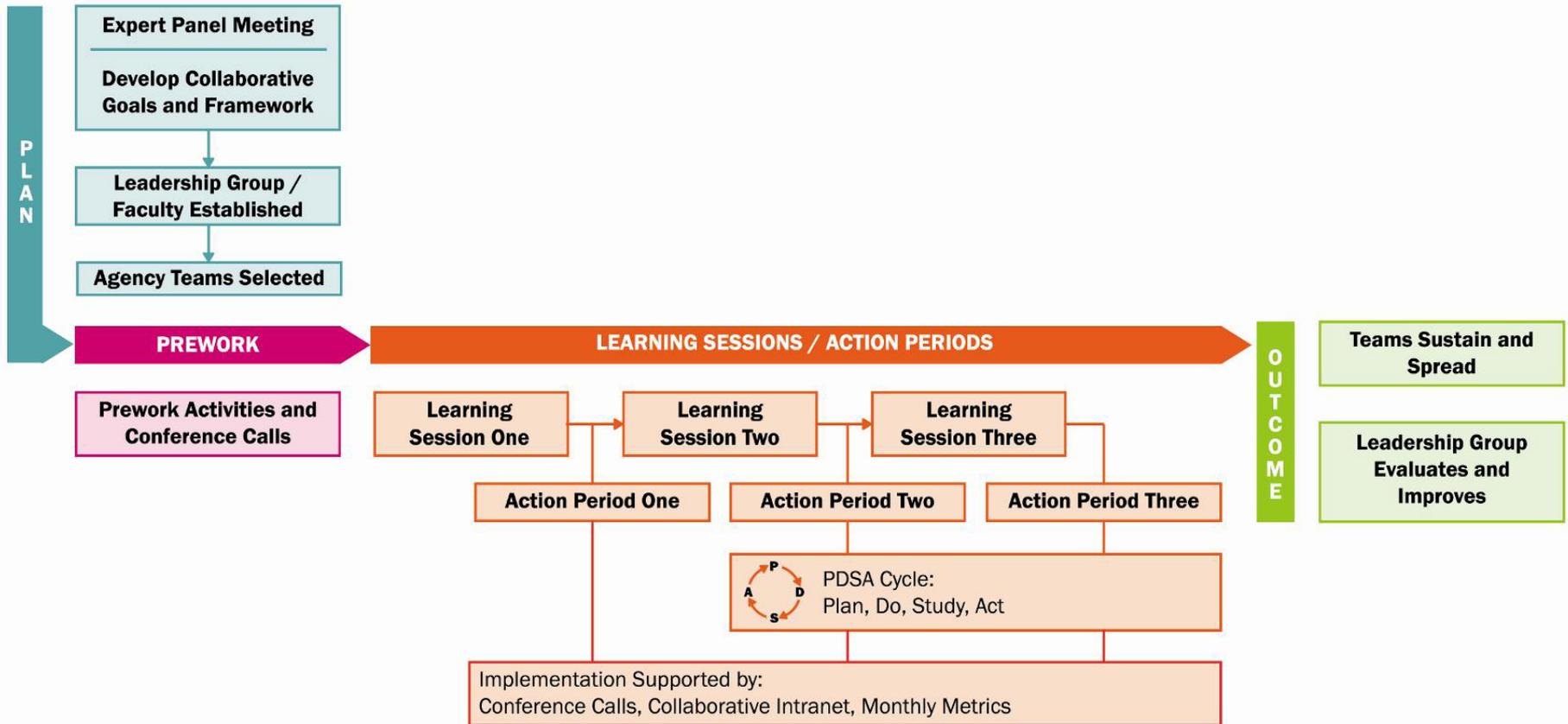


Figure adapted from Institute for Healthcare Improvement (IHI), 2003

Learning Collaboratives & Breakthrough Series Collaboratives: 2004-2011

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- LCs: CBITS, Complex Trauma Tx, CPP, PCIT, PFA, Smoking Cessation, SPARCS, TF-CBT, Traumatic Grief, Trauma Systems Therapy
- BSCs: Trauma informed & culturally informed systems
Pending: AF-CBT, SPARCS, PCIT, Core Tx Components, Welcome Back Veterans

Every system is perfectly designed to achieve the results it gets

Allow the people within the system to change the system

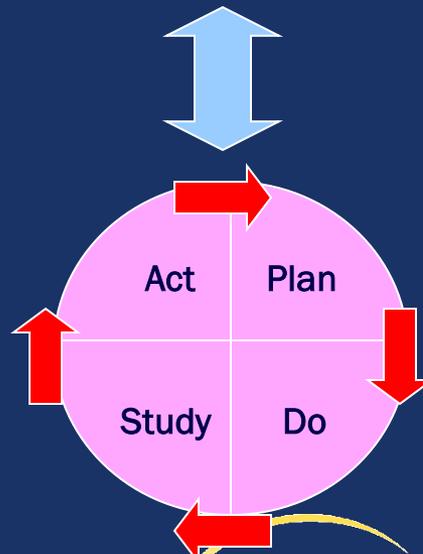
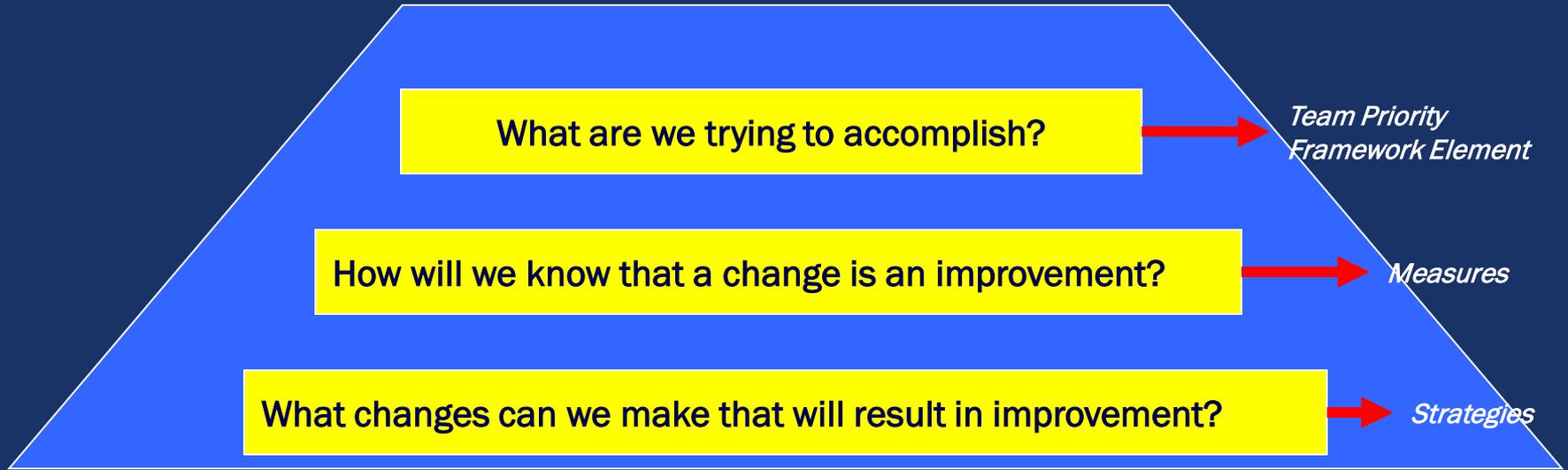
We can learn more from collaborating than from working alone

Learning sessions, collaborative calls, workspace, faculty

All improvement requires change, but not all changes lead to improvement

Monthly metrics, P-D-Study-A cycles

Model for Improvement



BSC Theories of Change (cont.)

*“Bridge the gap between knowledge
and practice”*

Model for Improvement

KNOWLEDGE =
CHANGE FRAMEWORK
KEY ELEMENTS

PRACTICE =
PDSAS / TESTS OF
CHANGE

Model for Improvement¹

- Collaborative Goals Framework – Guidelines for successful adoption and implementation of the practice developed by experts in the field.
 - Specifies collaborative mission and goals
 - Provides guidelines for achieving mission and goals
- Monthly improvement metrics – Simple measures used to guide participating organizations efforts to the adopt the intervention.
 - Primary purpose: Participating agencies (teams) use metrics measure progress toward collaborative goals and mission.
 - Metrics help agencies gauge whether organizational and practice changes are helping them meet their goals.
 - Faculty use metrics to inform collaborative activities.



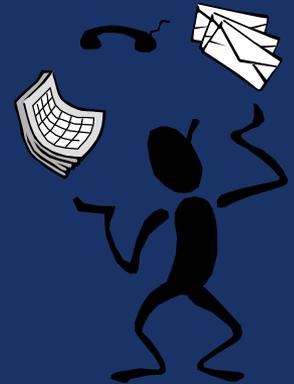
¹Langley, G. J., Nolan, K. M., Nolan, T. W., Norman, C. L., Provost, L. P. (1996). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass Publishers.

Collaborative Leadership Team

- Leadership Team – Designs and implements the collaborative. Includes faculty and staff responsible for coordinating collaborative activities.

Requires:

- Expertise in the intervention (treatment developers or trainers)
- Experience delivering the intervention in comparable settings
- Experience in roles essential to implementing and sustaining the practice, including agency leadership
- Expertise in implementation science or prior experience with the learning collaborative model
- Expertise in training, including principles of adult learning
- Project manager to plan and coordinate collaborative activities



2009, NCCTS and Duke EPIC

Collaborative Teams

- Collaborative Teams – Groups of individuals from multiple organizations selected to participate in the collaborative.
 - Teams complete a written application that describes the collaborative and specifies expectations for participation.
 - Teams represent organizational roles and functions necessary to implement the intervention with fidelity and sustainability, including senior leadership, clinical supervisors and clinicians.
 - 5-12 teams, with a minimum of 25 participants, are selected to participate.



2009, NCCTS and Duke EPIC

Collaborative Structure



Pre-work Phase – Activities conducted prior to the first face-to-face meeting to ensure that all teams are adequately prepared for full participation in the collaborative.



Learning Sessions – Teams and faculty meet for three two-day “learning sessions” (face-to-face meetings) over a period of 9 to 12 months.



Action Periods – Activities and resources offered between learning sessions are designed to support the growth of both clinical competence in the intervention and the capacity to use and sustain it.

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Guidelines for Learning Sessions

- Agendas address development of clinical competence necessary to skillfully deliver the intervention with fidelity implementation competence necessary to broadly provide, adapt and sustain.
- Sessions emphasize interactive, participatory learning techniques modeled on adult learning principles.
- Teams meet together for purposes of team building , time and structure to address barriers, and sustainability planning.
- Design promotes engagement and collaboration across teams (e.g. participants in comparable roles at different organizations meet to share information and address common challenges, teams intermingle for activities.)
- Design engages senior leaders and community stakeholders in task of implementing and sustaining intervention



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Guidelines for Action Periods

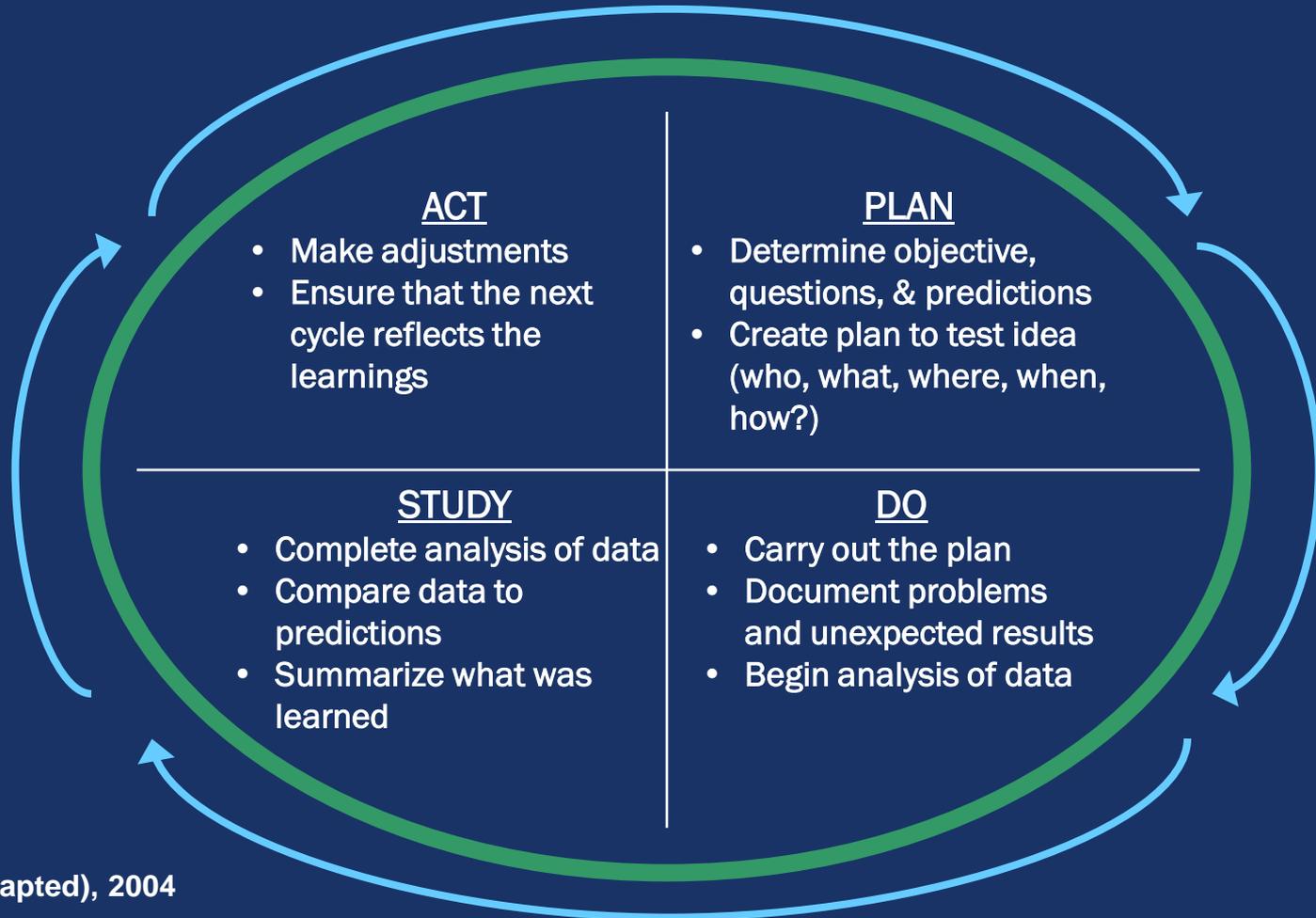


- Regular faculty-facilitated conference calls with structured agenda and opportunities for teams to share challenges and solutions.
 - Monthly (or biweekly) calls for all collaborative participants – Focus on developing competence in the intervention (e.g. engaging families, adapting the intervention for a particular cultural group) and addressing barriers to successful implementation.
 - Monthly calls for clinical supervisors – To enhance supervisors' competence in the intervention and develop supervisory skills.
 - Bimonthly calls for senior leaders – To foster implementation competence and capacity to sustain the intervention.
- Monthly improvement metrics used to guide teams' efforts in their local settings and collaborative activities.
- Collaborative intranet used to support teaching, promote collaboration and share resources.



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Plan-Do-Study-Act Cycles • Small Tests of Change – Improvement method used by participating organizations to address barriers and quickly make changes necessary to realize the collaborative goals.



Agosti, IHI (Adapted), 2004

Strengths

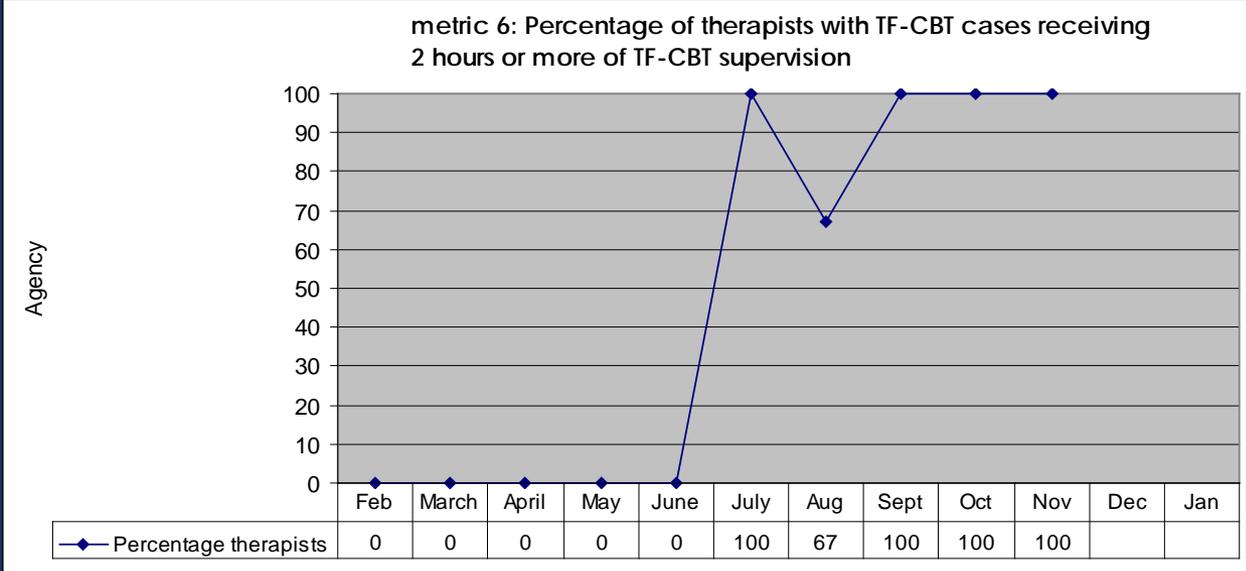
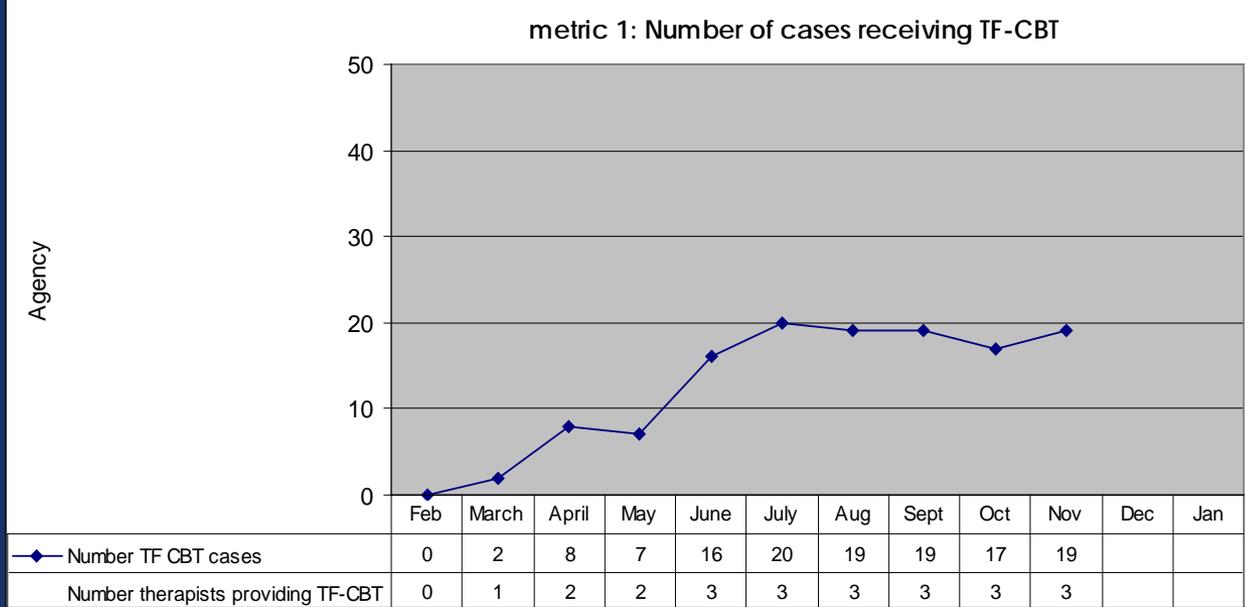
- Inclusive change process
- Changes developed by those who are closest to the work
- Changes connected to priorities
- Early successes as motivators
- Reduced tendency toward over-planning
- No delays for consensus or permission
- Measurement for learning
- Proactive approach to barriers
- Sharing of successes & learnings
- *“I felt like this was something the whole agency took on, versus me just learning something new. We were making changes and evaluating them at all levels.”*

NCTSN 2008 TF-CBT Learning Collaborative Goals & Metrics

- Increased use of TF-CBT
 - Number of cases receiving TF-CBT
- Use of standardized assessments to evaluate client progress
 - Percentage cases receiving requisite clinical assessments
- Implementation of TF-CBT with fidelity and skill
 - Percentage cases continuing in TF-CBT or successfully completed
 - Mean score for skill in implementing selected TF-CBT techniques (e.g. Psychoeducation, cognitive processing, trauma narrative)
 - Percentage TF-CBT sessions with significant caregiver involvement
- Capacity to deliver ongoing training/supervision in TF-CBT
 - Percentage of therapists receiving ≥ 2 hours of TF-CBT supervision

2009, NCCTS and Duke EPIC

NCTSN 2008 TF-CBT Learning Collaborative: Sample Metrics



VISN 6 SharePoint Portals > VISN 6 Main Office > Primary Care > VISN 6 ACS-OPT > Small Test of Change Questionnaire > New Item

Small Test of Change Questionnaire: New Item

Attach File | Spelling...

STOC Title *

Process used to develop change/improvement *

Primary collaborative goal addressed *

Purpose / Objective *
A A1 | B I U |

What was the specific purpose or objective of this change / improvement?

What did we do? *
A A1 | B I U |

Brief description of change / improvement.

Progress *

Did this change result in progress toward our targeted goal; i.e. did we achieve our objective?

Indirect Improvement *

Did this change lead to improvements that were not directly related to our original goal; i.e. was it useful in some other way?

Evidence of Improvement *
A A1 | B I U |

What evidence do we have that this change is an improvement? Enter "None" if no evidence, or "N/A" if no improvements.

NC Child Treatment Program

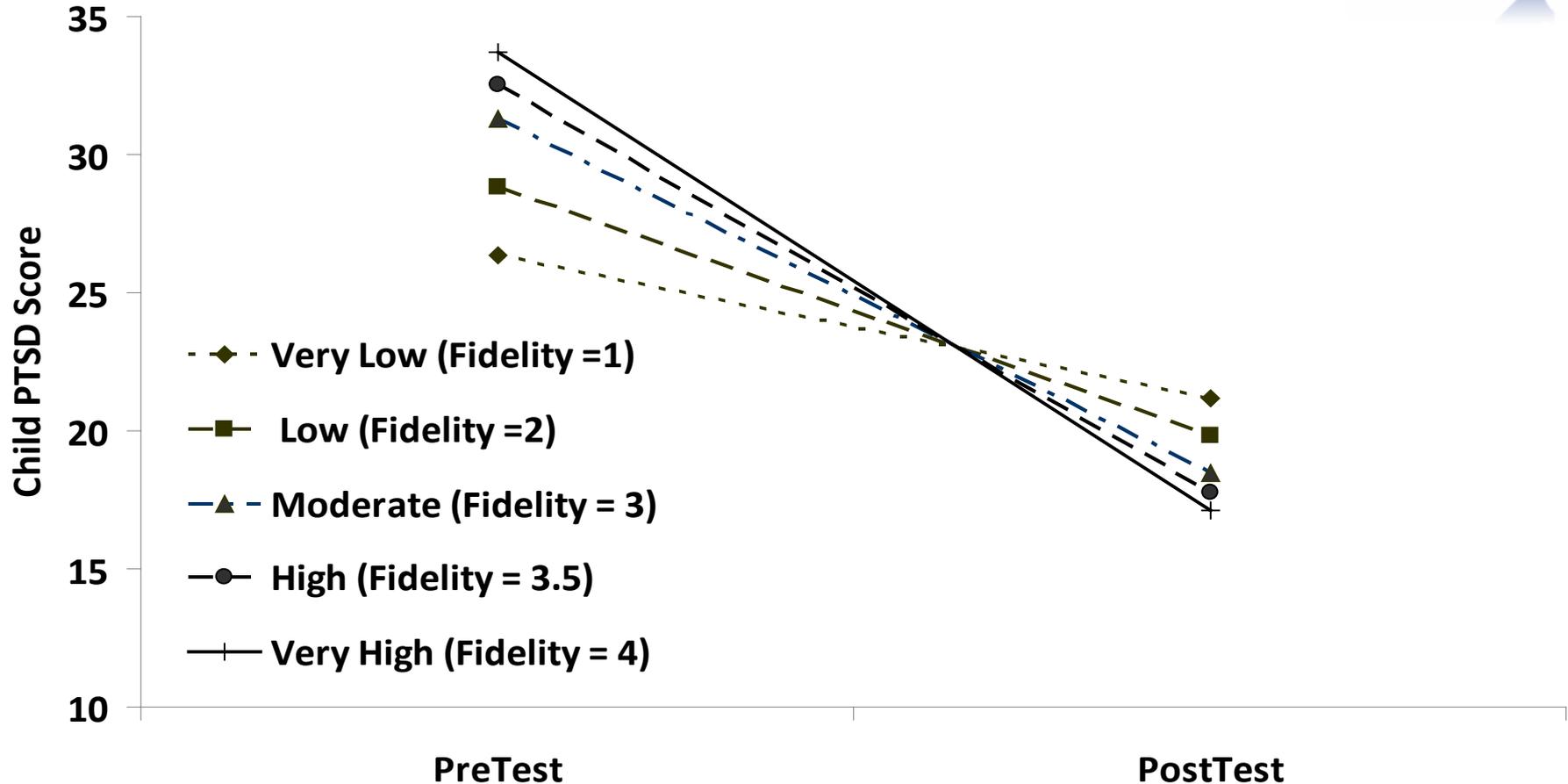


- 12 Month Intensive Learning Collaborative
- 3, 2-Day Learning Sessions (Provided in Region of Service)
- **3 Intermediary Action Periods****
 - 10 hours of individualized clinical consultation (coaching + fidelity checks)
 - 1-hour /month clinical & implementation conference calls: peer + faculty
 - Participation in Peer Support Groups & Internet Discussion Boards
 - Monthly Metrics on Progress (# clients, # sessions, Billing encounters, Model specific Supervision hours)

–Markiewicz & Amaya-Jackson '08; Amaya-Jackson, Hagele, et al. '09; Amaya-Jackson, Murphy, et al, '10



Change in Child Reported PTSD by Fidelity



--Amaya-Jackson, Hagele, et al, 2009

Service Members & their Families



- Welcome Back Veterans: Clinical and Cultural Competence Breakthrough Series Collaborative
 - NC Veterans & their families, esp. Guard & Reserve
 - Post-combat adjustment for veteran, spouse, children
 - Reduce stigma
 - Improve access
 - Improve quality of care via knowledge of military culture & evidence-based clinical techniques



Applying the Model for Improvement

What are we trying to accomplish?

Assess trauma-related strengths and needs

How will we know a change is an improvement?

- Reduction in the number of requests for moves from one placement to another (except when related to kinship or sibling reunification or concerns about the child's safety in the current placement)
- Increase in percentage of caregivers that report increased understanding of child's trauma-related symptoms and reactivity

What changes can we make that will result in improvement?

Communication with the child, birth family, and foster caregivers related to trauma assessment is open, direct, and easily understood.

Applying the Model for Improvement

What changes can we make that will result in improvement?

- Communication with the child, birth family, and foster caregivers related to trauma assessment is open, direct, and easily understood (*Collaborative Change Framework Objective*)

Model for Improvement

THE FIRST PDSA MIGHT BE SOMETHING LIKE....

PLAN: Child welfare worker uses easy to understand language to explain trauma assessment to foster caregiver

DO: Worker tests it with ONE foster caregiver who has just had placement made with her

STUDY: Worker asks foster caregiver how helpful this information is; worker asks caregiver to compare to information provided at time of previous placements; worker uses clinical wisdom about usefulness/effectiveness

ACT/AJUST: Worker thinks more structure/guidance is needed to formulate 'talking points'; some language needs more simplification; caregiver needs to understand impact on her

Model for Improvement

One small test of change....So what?

- First PDSA is just the first step
- Small so that it can be tested quickly, but...
- Small test does not equal small change
- Goal is to apply learnings and continue to make tests bigger and broader
- Sweep in more people as you go – moving toward implementation as you continue to learn and refine tools/develop processes

A single PDSA to changes in systems

PDSA: Using open communication with caregivers about trauma assessment

The Test: One worker talked with one foster caregiver following initial placement about trauma assessment.

Lessons: Language needs simplification; caregiver needs to understand impact on caregiving.

The Test: Two workers use talking points (as revised by caregiver on team and recommendations from first test) to talk with four caregivers at point of placement.

Lessons: Needs to be prior to (not after) placement; Written material to accompany conversation would be helpful to understand timelines, implications, next steps..

The Test: All workers in unit provide caregivers receiving new placements with written and verbal information about trauma assessment prior to placement.

Lessons: Workers and caregivers found process and information resulted in clearer understanding of what children were experiencing upon placement. Fewer placement challenges/problems seemed to be happening within first two weeks of placement.

PDSA
#1-3

A single PDSA to changes in systems

Implementation

The Test: Entire Unit uses written information and talking points 'protocol' to communicate with caregivers about trauma assessments for all children/youth in placement.

Lesson: Caregivers report increased patience with children's behaviors. Workers see a decrease in requests for unplanned placement moves. Process is developed and documented. Ready for Spread!



Spread

- Workers in unit present practice and tools at full staff meeting.
- Caregivers talk about impact of practice on their work with children in their home.
- Data are shared.
- Senior Leader makes commitment to support spread.
 - Group led by workers and caregivers is convened to formalize policy and training.
- Youth Advisory Group wants to adapt process and tools to be used in conversations with youth prior to placement.

Creating a “New” System

The “Usual” Way

Improvement (“pilot testing”)

Implementation

Spread

Sustain

The BSC Way

Improvement

Implementation

Spread

Sustain