Responding to Needs of Clinical Operations Partners: Transferring Implementation Facilitation Knowledge and Skills

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This column describes a facilitation strategy that incorporates evidence-based implementation knowledge and practice-based wisdom. The authors also describe a partnership between research and clinical operations leaders in the U.S. Department of Veterans Affairs to bridge the gap between implementation knowledge and its use. The initial product of the partnership, the *Implementation Facilitation Training Manual: Using External and Internal Facilitation to Improve Care in the Veterans Health Administration*, is a resource that can be used by others to guide implementation efforts. (*Psychiatric Services* 65:141–143, 2014; doi: 10.1176/appi.ps.201300468)

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Implementation science is the study of methods or strategies to promote systematic uptake of research findings and other evidence-based practices into routine care (1). To change care on a broad scale, policy makers and clinical managers need to be able to integrate implementation research and strategies into clinical initiatives that foster adoption and spread of evidence-based practices. It should not be surprising that just as there is a gap between evidence-based practices and their application in clinical care settings, there may be a similar gap between evidence-based implementation strategies and their use in clinical and organizational change processes. This column describes a facilitation strategy that incorporates evidence-based implementation knowledge and practice- and operations-based wisdom. It also describes a partnership between research and clinical operations leaders in the U.S. Department of Veterans Affairs (VA). The partnership was created to bridge the gap between implementation evidence and its use. The initial product of the partnership, the *Implementation Facilitation Training Manual: Using External and Internal Facilitation to Improve Care in the Veterans Health Administration*, is a resource that can be used by others to guide implementation efforts (2).

Implementation facilitation strategy

Implementing evidence-based practices is a complex and challenging process, especially for multifaceted clinical programs that require engagement and support from multiple stakeholders (3). The Promoting Action on Research Implementation in Health Services (PARIHS) framework conceptualizes successful implementation as a function of the dynamic interaction between evidence, context, and facilitation (4). Evidence, broadly defined, focuses on quality of the scientific research, its match with clinical experience, and its perceived value to patients. Context includes dimensions, such as work culture, clarity of policies and procedures, leadership practices, resources, and performance evaluation practices. Facilitation, an enabling strategy, is a promising method for delivering sustainable practice change through a process of interactive problem solving and supports (5). Facilitation can address implementation challenges by using evidence-based implementation interventions.

VA researchers and regional and facility-level operational managers collaborated to design and pilot an implementation facilitation strategy within the context of VA's Primary Care–Mental Health Integration (PC-MHI) initiative (6). This strategy pairs an external facilitator, who is an expert in evidence-based implementation interventions and relevant clinical models and their evidence base, with an internal facilitator, a VA employee at the regional level who is familiar with facility-level organizational structures, procedures, culture, and clinical

processes and who also has protected time to support implementation activities. Essentially, the facilitation strategy bundles an integrated set of activities informed by implementation science (for example, stakeholder engagement, academic detailing, formative evaluation, and problem identification and solving) (5). During implementation processes, facilitators choose particular activities to help implement PC-MHI programs on the basis of stakeholder needs (7). Over time, and with close mentoring, the external facilitator transfers implementation facilitation skills to the internal facilitator, thus building capacity for implementing evidence-based practices within the local organization. The clinical pilot of this strategy showed promising outcomes (6). Building on previous research about facilitation, on experiences acquired in evaluating other implementation efforts, and on the pilot project, we tested the facilitation strategy in two other VA regional networks through the Blended Facilitation to Enhance Primary Care Mental Health Program Implementation study (referred to below as the Facilitation Study).

Research–clinical operations partnership

In May 2011, on the basis of the early success in the Facilitation Study but before data collection was completed, VA Office of Mental Health Operations (OMHO) leaders expressed interest in using this facilitation strategy. OMHO is charged with implementing VA's *Uniform Mental Health Services Handbook*, which establishes clinical standards for VA mental health settings (8). OMHO was a new organizational entity, and OMHO leaders wanted to build capacity at the national level for facilitating implementation of the handbook by training and supporting the work of their technical assistance staff. Leaders understood the complexity of the facilitation strategy and the value of the evidence-based implementation interventions that it incorporated, particularly for implementing complex programs.

In initial discussions, research and operational leaders explored how the facilitation strategy could help to address OMHO needs. To provide OMHO with information for the decision-making process, we formed a writing team and quickly drafted the outline of a manual that could be used for training and mentoring OMHO staff. The team delayed further development of the manual for three months while OMHO leaders identified and refined their specific needs and formally invited us to partner with them. We then began ongoing collaborative discussions about ways to meet our partner's needs, resources partners could contribute to the effort, future partnership activities, and a training manual that would provide the foundation for a workshop on facilitating implementation and reference material for ongoing mentoring in facilitation.

Literature and our own experiences suggested that our partners needed information that was relevant, timely, and written in nonacademic language (9). Although ongoing discussions ensured that manual content was relevant, we had only two-and-a-half months to develop the manual. Because this did not allow time to incorporate findings from the Facilitation Study, we developed the manual on the basis of the pilot study (6), facilitators' experiences in the Facilitation Study, and an updated review of the literature. We utilized a team approach to draft and edit manual sections and held weekly meetings to refine material. Because the facilitation strategy was developed, applied, and tested within the context of a clinical initiative, facilitators, who were also experienced clinicians, had been careful to use language that was straightforward and nontechnical when they were helping sites implement PC-MHI. During manual development, the writing team, which included the facilitators, also paid special attention to using language that was appropriate for clinical settings rather than technical research language.

To ensure its usefulness, we asked other implementation facilitation experts to review the manual and provide feedback. Finally, we incorporated feedback from a review by our clinical operations partner, who would be an end-user of the manual.

The manual

The *Implementation Facilitation Training Manual* describes an external and internal facilitation strategy for implementing new programs or practices and includes specific roles and activities of facilitators during the preimplementation, implementation, and sustainability phases. We grounded the manual in the literature about facilitation and the PARIHS framework (4), showing how facilitation addresses gaps and barriers related to evidence and organizational context. For example, the manual describes how facilitators can assess sites' clinical characteristics, organizational structures, and environment and recommends how facilitators can help sites to design, implement, and adapt programs to meet local needs.

We also incorporated a broad array of implementation evidence. For example, the manual discusses key stakeholders that need to be involved in implementation processes and how facilitators can identify and engage them in implementing and sustaining programs. The manual recommends ways that facilitators can systematically monitor program data, provide data to key stakeholders, and use data to further adapt and improve programs. It describes how facilitators can conduct academic detailing, train and mentor program staff, and build learning collaboratives. We also included recommendations for the practical application of this evidence, informed by the practice- and operations-based wisdom of our current and previous clinical and operational partners. Finally, the manual contains facilitation tools that our partners found useful. Thus we developed a manual informed by research, theory, and stakeholders at all levels of our health care system.

The *Implementation Facilitation Training Manual* is only one component of a training program designed in collaboration with operational partners to meet their needs. During an initial training workshop, experienced facilitators use the manual to introduce facilitation concepts and include opportunities for attendees to apply these concepts to scenarios experienced by facilitators. In addition, facilitators provide ongoing consultation and mentoring as trainees assume the external facilitator role in their

respective programs. The manual then becomes valuable reference material.

To date, the manual has been disseminated to three principal stakeholder groups. The first is the original target audience identified by our clinical operations partners, the technical assistance team providing field consultation for OMHO. On the basis of an assessment of facilities' needs for assistance, our OMHO partners identified requirements in the *Uniform Mental Health Services Handbook* that would benefit from implementation facilitation and other stakeholder groups that, with training, could provide this service. We thus trained personnel with specific programmatic implementation needs, including those working in VA's PC-MHI initiative and Serious Mental Illness Re-engagement Program. We expanded the training of PC-MHI implementation facilitators to include field-based subject matter experts, and we trained a team of facilitators to support implementation of evidenced-based psychotherapies.

Finally, we view the manual as a dynamic—not a static—document. It will be modified on the basis of new research knowledge and our partners' experiences in applying these activities outside of formal research. We plan to incorporate into future versions our findings from the Facilitation Study and the experiences of manual users.

Lessons learned

Brownson and colleagues (9) suggested that in addition to discovering new knowledge, scientists are obligated to ensure that new knowledge is used to improve health. This can be challenging. We took advantage of an opportunity to respond to VA operational leaders' needs before completion of the Facilitation Study, because the opportunity would have been lost had we waited for final results. We learned that we do not have to wait until findings are published to ensure that what we are learning improves care delivery. By initially providing our partners with what we knew about implementation facilitation and by updating them with new knowledge from our research, we could continue to help them integrate evidence-based implementation strategies into their efforts to improve VA mental health care.

Our partnership with VA operational leaders has been a rich and rewarding process, despite challenges inherent in such relationships. Scholars suggest that researchers and decision makers need to partner on research studies. Our experience supports the need for partnerships between these groups to close the gap between implementation knowledge and its use in clinical initiatives that foster adoption and spread of evidence-based practices. Our experiences are one example of how this can be done and confirm that partnering relationships are most effective when they include two-way communication, negotiation and a common understanding of partnership issues, and attention to meeting partners' needs, timelines, and limits (10).

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References

1. Eccles MP, Hrisos S, Francis J, et al: Do self- reported intentions predict clinicians' behavior? A systematic review. Implementation Science 1:28, 2006
2. Kirchner JE, Ritchie MJ, Dollar KM, et al: Implementation Facilitation Training Manual: Using External and Internal Facilitation to Improve Care in the Veterans Health Administration. North Little Rock, Ark, US Department of Veterans Affairs, Health Services Research and Development, Mental Health Quality Enhancement Research Initiative, 2013. Available at www.queri.research.va.gov/tools/implementation/Facilitation-Manual.pdf
3. Kilbourne AM, Schulberg HC, Post EP, et al: Translating evidence-based depression management services to community-based primary care practices. Milbank Quarterly 82:631–659, 2004
4. Rycroft-Malone J, Harvey G, Seers K, et al: An exploration of the factors that influence the implementation of evidence into practice. Journal of Clinical Nursing 13:913–924, 2004
5. Stetler CB, Legro MW, Rycroft-Malone J, et al: Role of "external facilitation" in implementation of research findings: a qualitative evaluation of facilitation experiences in the Veterans Health Administration. Implementation Science 1:23, 2006
6. Kirchner J, Edlund CN, Henderson K, et al: Using a multi-level approach to implement a primary care mental health (PCMH) program. Families, Systems and Health 28:161–174, 2010
7. Harvey G, Loftus-Hills A, Rycroft-Malone J, et al: Getting evidence into practice: the role and function of facilitation. Journal of Advanced Nursing 37:577–588, 2002
8. Uniform Mental Health Services in VA Medical Centers and Clinics. VHA Handbook 1600.01. Washington, DC, US Department of Veterans Affairs, Veterans Health Administration, 2008
9. Brownson RC, Royer C, Ewing R, et al: Researchers and policymakers: travelers in parallel universes. American Journal of Preventive Medicine 30:164–172, 2006
10. Kothari A, MacLean L, Edwards N, et al: Indicators at the interface: managing policymaker-researcher collaboration. Knowledge Management Research and Practice 9:203–214, 2011