# *Building Blocks for Effective Implementation: Developing, Refining, and Applying a Compilation of Implementation Strategies*

## Overview of Today's Presentation

- **Introduction and Definitions**
- Developing and Refining a Compilation of Strategies
- Applying Implementation Strategies
- Improving Reporting of Implementation Strategies
- Priorities Moving Forward
- Acknowledgements and Discussion

# What we'd like

# What we would like to avoid

# Definition of Implementation Science

**Implementation Science**

BioMed Central

Editorial

Open Access

## Welcome to *Implementation Science*

Martin P Eccles*[1] and Brian S Mittman[2,3]

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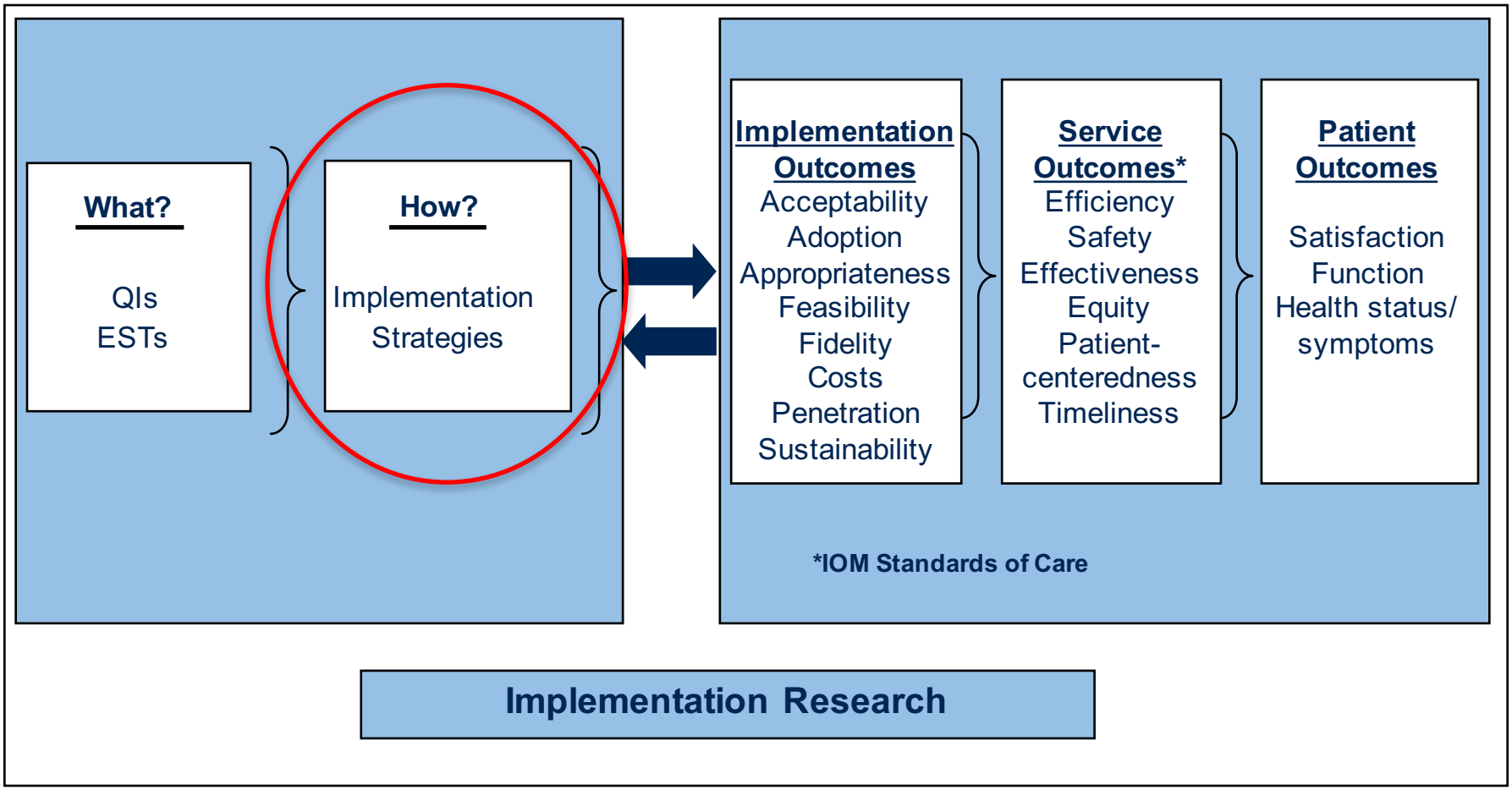
This article is available from: http://www.implementationscience.com/content/1/1/1

# Conceptual Model of Implementation Research




Proctor et al. (2009)

# Implementation Strategies

"…Methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice"

**Proctor, Powell, & McMillen. (2013)**

# Types: Discrete, Multifaceted, and Blended

- **Discrete** - Single action or process (e.g., institute system of reminders)
- **Multifaceted** - Combination of multiple discrete strategies (e.g., training + reminders)
- **Blended** - Multifaceted strategies that have been protocolized and (often) branded (e.g., ARC, LOCI)

Powell et al. (2012)

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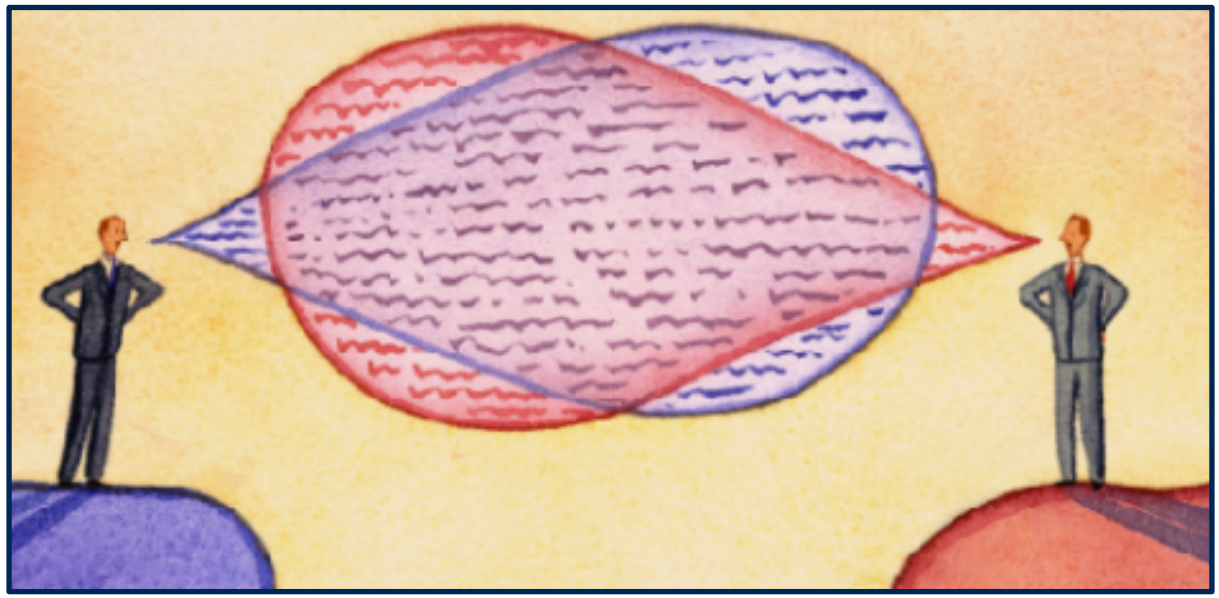
# Initial Question

What strategies can be used to implement effective clinical interventions?

# Problem – Lack of Conceptual Clarity

- Literature a “Tower of Babel”
- Strategy terms and definitions used inconsistently
- Strategies poorly described



McKibbon et al. (2010); Michie et al. (2009)

# Problem – Limited “Menu” of Strategies


# Strategies Compilation

***Structured Review:***

1. Compilations and lists
2. Blended models
3. Database search
4. Expert query

*Review*

**A Compilation of Strategies for Implementing Clinical Innovations in Health and Mental Health**

Medical Care Research and Review
69(2) 123–157

DOI: 10.1177/1077558711430690
http://mcr.sagepub.com
SAGE

**Byron J. Powell[1], J. Curtis McMillen[2], Enola K. Proctor[1], Christopher R. Carpenter[3], Richard T. Griffey[3], Alicia C. Bunger[4], Joseph E. Glass[1], and Jennifer L. York[3]**

**68 Discrete Strategies:**

***Planning (n = 17)***
- Gather information
- Selecting strategies
- Building buy-in
- Initiating leadership
- Develop relationships

***Educating (n = 16)***
- Develop materials
- Educate
- Educate through peers
- Inform and influence stakeholders

***Financing (n = 9)***
- Modify incentives
- Facilitate financial support

***Restructuring (n = 7)***

***Managing Quality (n = 16)***

***Policy Context (n = 3)***

# Establish Consensus on Terms and Definitions

Waltz *et al. Implementation Science* 2014, **9**:39
http://www.implementationscience.com/content/9/1/39


IMPLEMENTATION SCIENCE

STUDY PROTOCOL Open Access

## Expert recommendations for implementing change (ERIC): protocol for a mixed methods study

Thomas J Waltz[1,2*], Byron J Powell[3,4], Matthew J Chinman[5,6], Jeffrey L Smith[1], Monica M Matthieu[7], Enola K Proctor[3], Laura J Damschroder[8] and JoAnn E Kirchner[1,9]

**Stage 1**: Establish expert consensus on a common nomenclature for implementation strategy terms and definitions

# Expert Panel Participants

## Purposive Sampling:

- Editorial board of *Implementation Science*
- IRC's for VA QUERIs
- IRI faculty and fellows

## 71 Participants

- 97% from U.S.; 3% from Canada
- 90% had implementation expertise
- 45% also had clinical expertise
- ~66% affiliated with VA

# Stage One: 3 Round Delphi

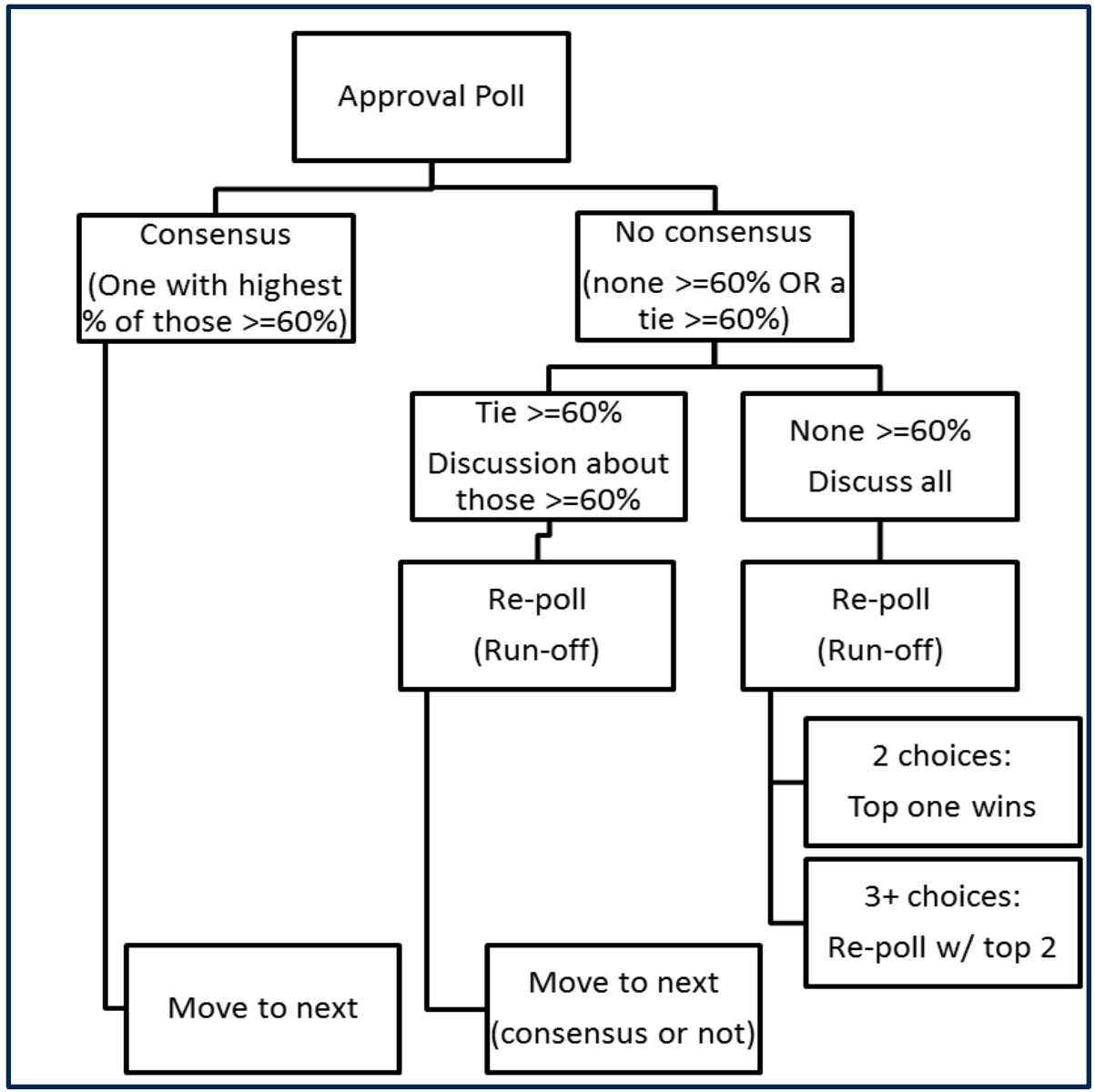
- Seeded with Powell et al. (2012) compilation
- Rounds 1 & 2 – Asynchronous web-based surveys to refine and extend original compilation
- Round 3 – Web-based polling and consensus process

***Powell et al. (2012)*** ***Rounds 1 & 2 (n = 57 & 43)*** ***Round 3 (n = 40)***


SurveyMonkey

GoToMeeting
by CITRIX

# Round 3 Voting Procedures



# Stage 1: Results of Rounds 1-3

- Majority of terms and definitions from original compilation (69%) considered “no contest” and weren’t subjected to voting
- 21 strategies and five new strategies voted on in R3
- Alternative def. selected 81% of the time
  - 75% of definitions from Powell et al. retained
- Each new strategy retained
- Final compilation = 73 strategies

# Updated Strategies Compilation*

Powell *et al. Implementation Science* (2015) 10:21
DOI 10.1186/s13012-015-0209-1

IMPLEMENTATION SCIENCE

RESEARCH Open Access

## A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project

Byron J Powell[1*], Thomas J Waltz[2], Matthew J Chinman[3,4], Laura J Damschroder[5], Jeffrey L Smith[6], Monica M Matthieu[6,7], Enola K Proctor[8] and JoAnn E Kirchner[6,9]

***See Additional File 6 for most complete version of the compilation**

# Develop Categories and Ratings

Waltz *et al. Implementation Science* 2014, **9**:39
http://www.implementationscience.com/content/9/1/39


IMPLEMENTATION SCIENCE

STUDY PROTOCOL Open Access

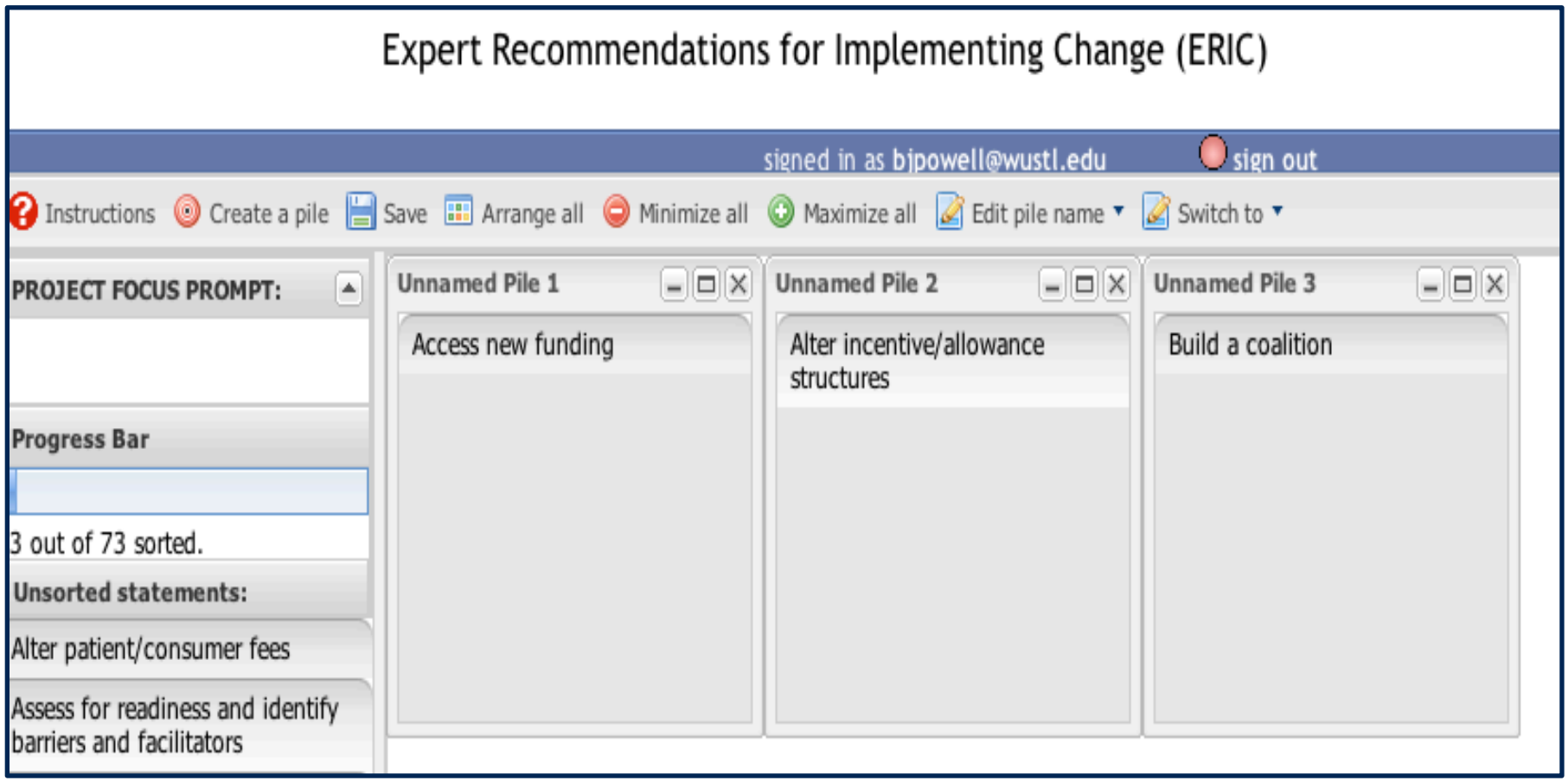
## Expert recommendations for implementing change (ERIC): protocol for a mixed methods study

Thomas J Waltz[1,2*], Byron J Powell[3,4], Matthew J Chinman[5,6], Jeffrey L Smith[1], Monica M Matthieu[7], Enola K Proctor[3], Laura J Damschroder[8] and JoAnn E Kirchner[1,9]

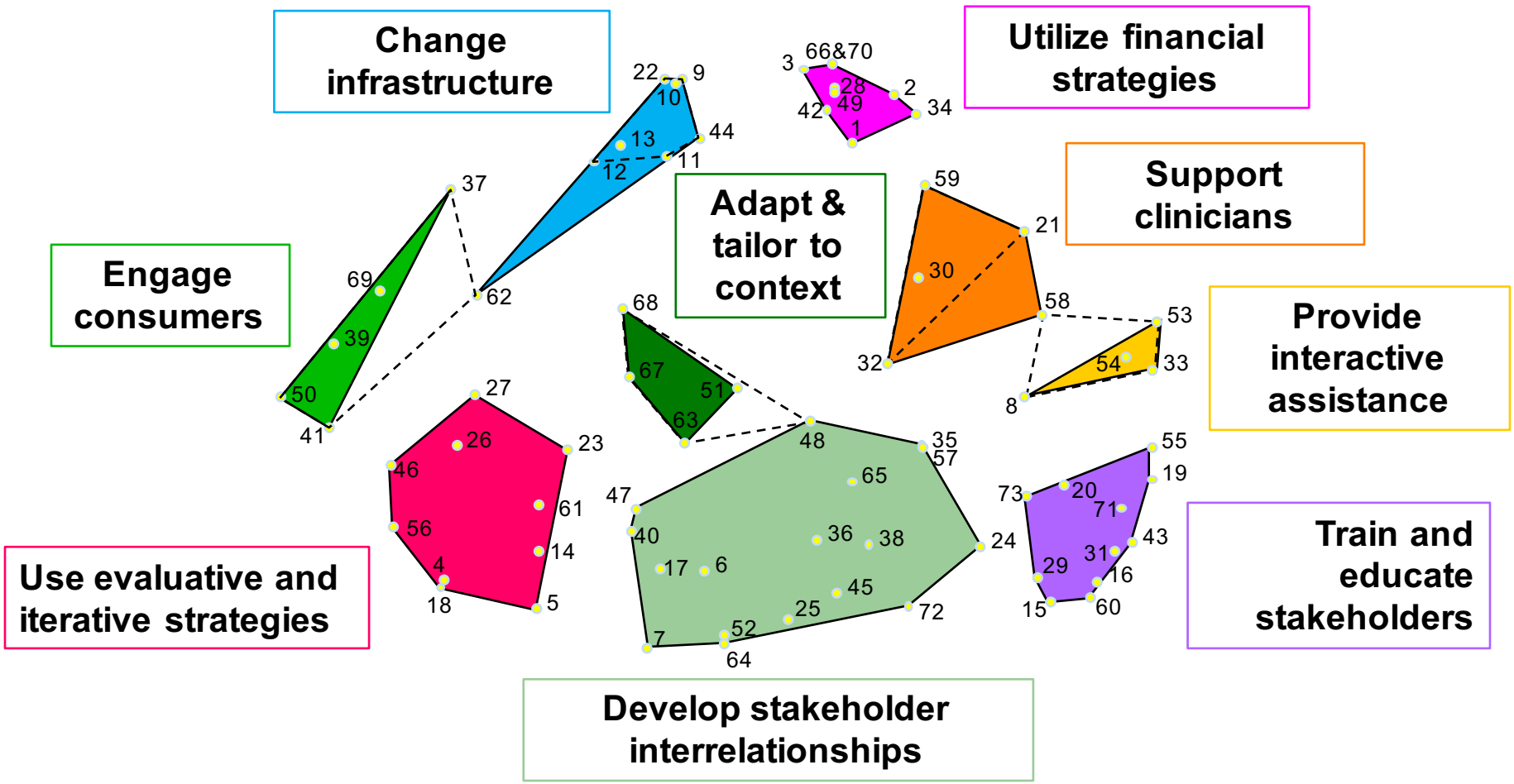
**Stage 2**: Develop conceptually distinct categories of implementation strategies and ratings of their feasibility and effectiveness

# Stage 2: Concept Mapping

- 35 members of the expert panel engaged in structured sorting and rating tasks

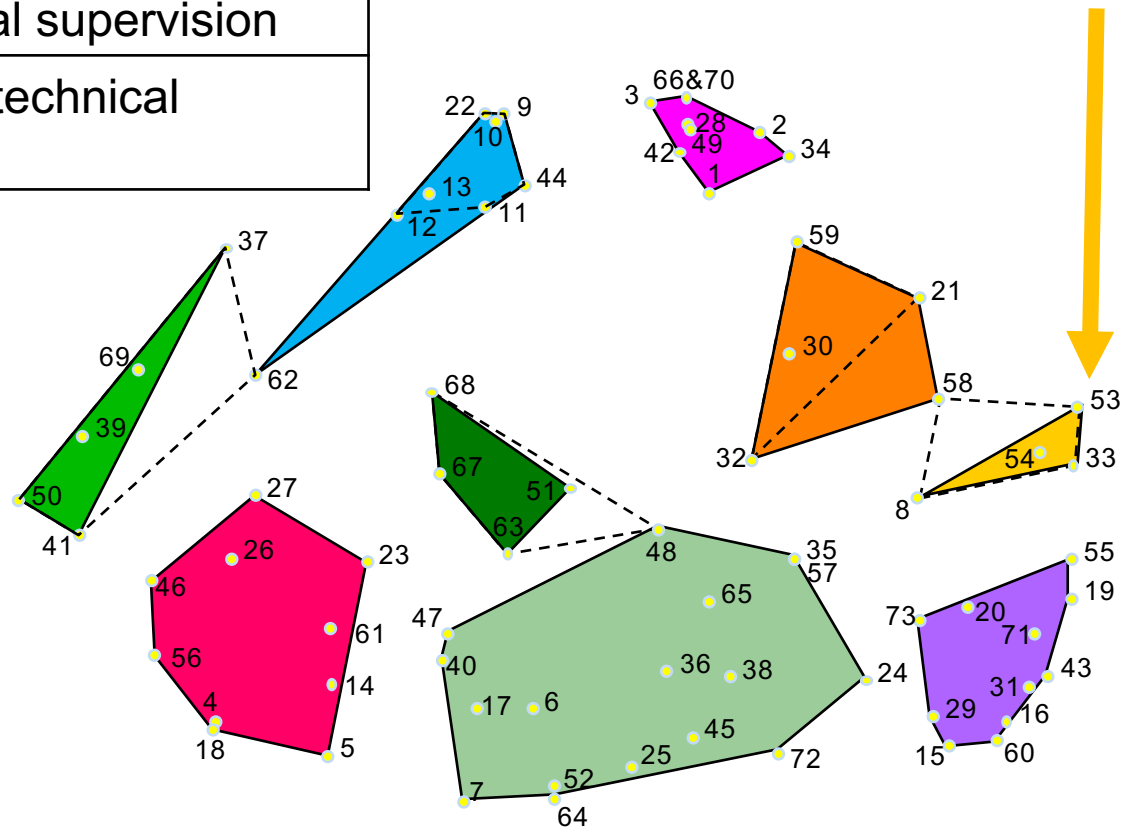


# Cluster Solution

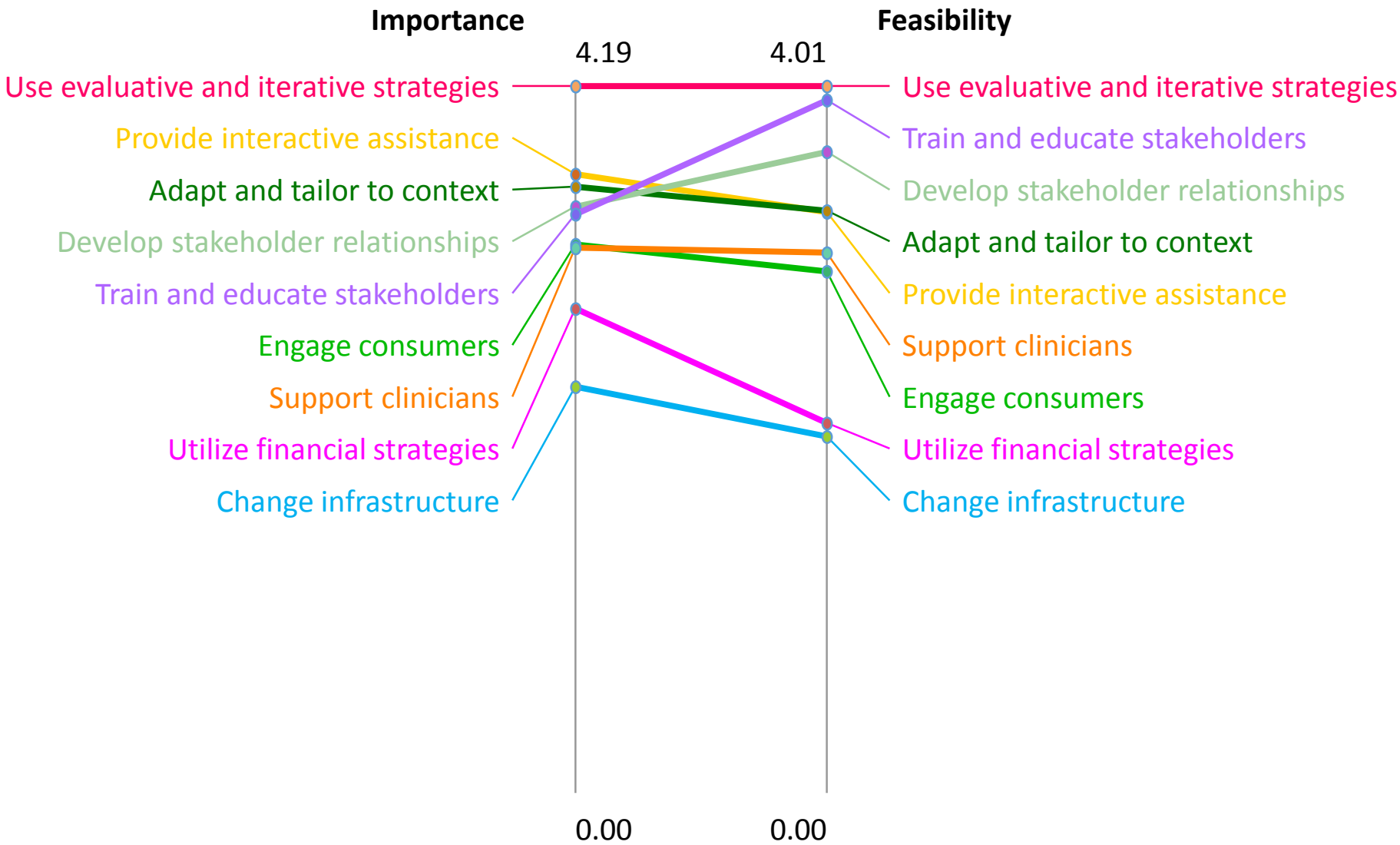


# Provide Interactive Assistance

| | |
|---|---|
| 8 | Centralize technical assistance |
| 33 | Facilitation |
| 53 | Provide clinical supervision |
| 54 | Provide local technical assistance |



# Relative Ratings By Cluster

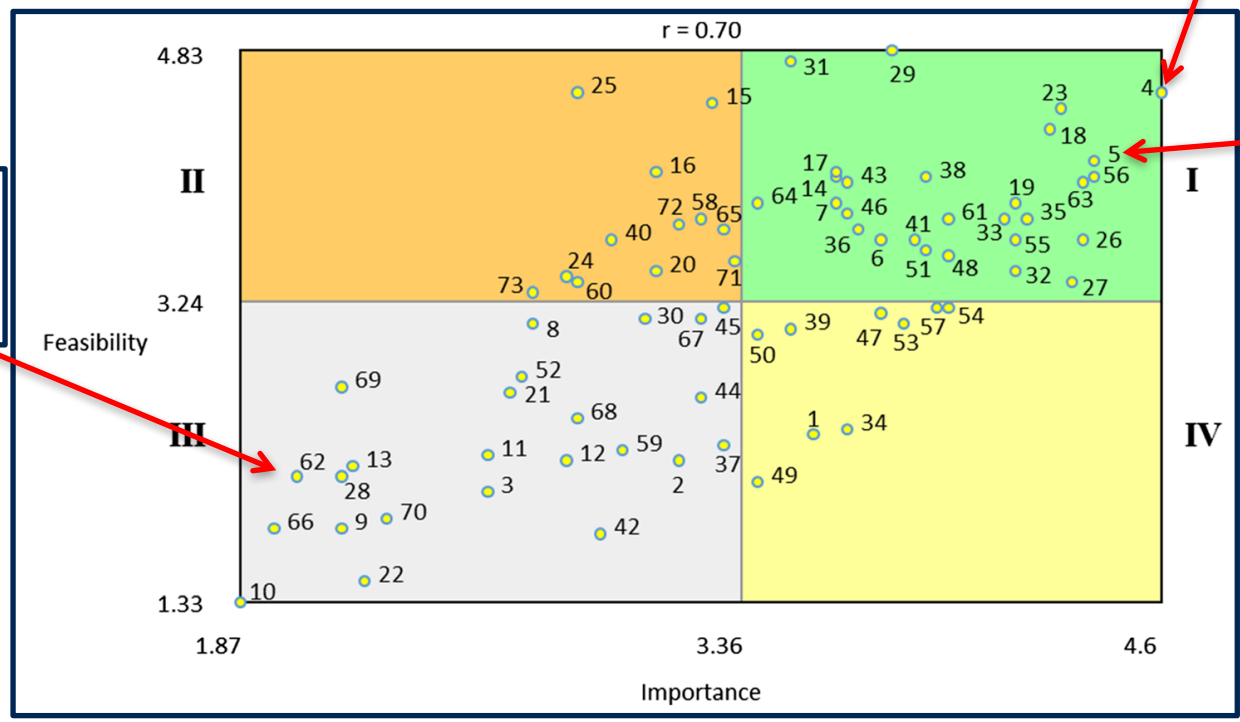


# “Go Zone”

**Assess for readiness & identify barriers and facilitators**

**Audit & Feedback**

**Start a dissemination organization**



# Categories + Feasibility and Importance Ratings

Waltz *et al. Implementation Science* (2015) 10:109
DOI 10.1186/s13012-015-0295-0

IMPLEMENTATION SCIENCE

SHORT REPORT Open Access

## Use of concept mapping to characterize relationships among implementation strategies and assess their feasibility and importance: results from the Expert Recommendations for Implementing Change (ERIC) study

Thomas J. Waltz[1,2*], Byron J. Powell[3], Monica M. Matthieu[4,5,10], Laura J. Damschroder[2], Matthew J. Chinman[6,7], Jeffrey L. Smith[5,10], Enola K. Proctor[8] and JoAnn E. Kirchner[5,9,10]

# Utility of Compilation(s) for Practice and Research

- Identifying and tracking strategies
- Building multi-level, multi-faceted strategies
- Developing intervention conditions
- Highlighting under-researched strategies
- Assessing fidelity of strategies

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# How Implementation Strategies Are Often Selected

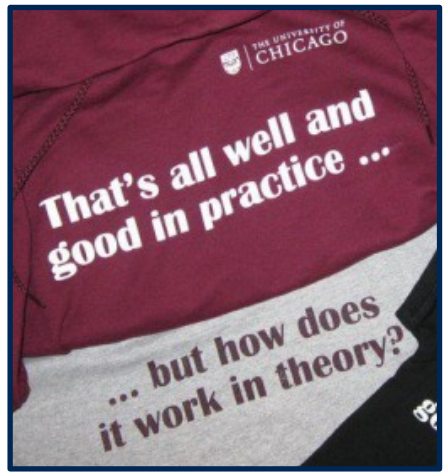

Grimshaw (2012) quoting Martin Eccles in KT Summer Institute Slide

# How Implementation Strategies Should Be Selected

## Evidence

got evidence?

## Theory




## Context

CONTEXT MATTERS

# Examples of Tailoring Strategies to Determinants

| Identified Determinants: | Implementation Strategies: |
|---|---|
| Lack of knowledge | Interactive education sessions |
| Perception/reality mismatch | Audit and feedback |
| Lack of motivation | Incentives/sanctions |
| Beliefs/attitudes | Peer influence/opinion leaders |
| Systems of care | Process redesign |

Onil Bhattacharyya (2012); Palda (2007)

# Efforts to Tailor Strategies Have Missed the Mark

"…results suggest a mismatch between identified barriers and the quality improvement interventions selected for use" (Bosch et al., 2007)


*There is a need for "systematic and rigorous methods…to enhance the linkage between identified barriers and change strategies" (Grol et al., 2013)*

# ERIC: Context-Specific Strategy Recommendations

Waltz *et al. Implementation Science* 2014, **9**:39
http://www.implementationscience.com/content/9/1/39


IMPLEMENTATION SCIENCE

STUDY PROTOCOL Open Access

## Expert recommendations for implementing change (ERIC): protocol for a mixed methods study

Thomas J Waltz[1,2*], Byron J Powell[3,4], Matthew J Chinman[5,6], Jeffrey L Smith[1], Monica M Matthieu[7], Enola K Proctor[3], Laura J Damschroder[8] and JoAnn E Kirchner[1,9]

**Stage 3**: Use menu-based choice methods to develop expert consensus on the types of strategies needed to implement different clinical innovations in different settings.

# Selecting Implementation Strategies For:

## 3 Different Interventions:

1) Metabolic Monitoring (20 participants)
2) Measurement Based Care (20 participants)
3) Prolonged Exposure (22 participants)

## 3 Different Scenarios:

1) Scenario A (weak evidence, weak context)
2) Scenario B (strong evidence, weak context)
3) Scenario C (weak evidence, strong context)

## 3 Different Stages of Implementation:

1) Pre-Implementation
2) Implementation
3) Sustainment

# Menu-Based Choice Task

**Implementation of Prolonged Exposure for Treating PTSD among Veterans in the VHA**

Please view the file ***PE for PTSD Description*** for the prose descriptions of the elements of this practice change (p. 2) and descriptions of Scenarios A, B, and C. Additional support materials are described in the *Read First* worksheet in this Excel workbook (bottom left tab).

**This worksheet is for Scenario A, found on p. 4 of the PE for PTSD Description file.**

To make a recommendation, click on a cell & small arrow will appear to the right. If you click on that arrow, you will view your recommendation options.

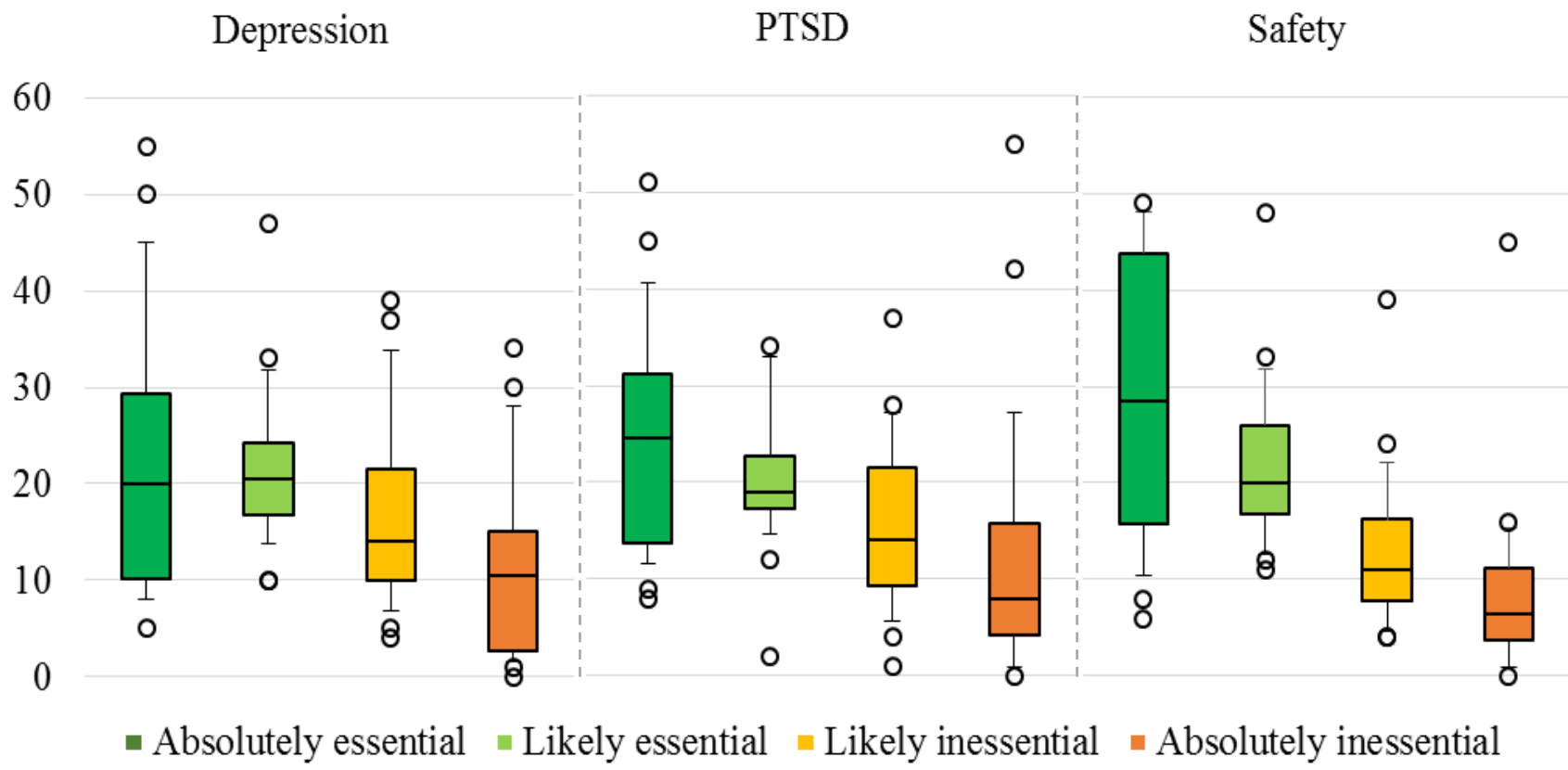
**Please make a recommendation for each strategy at each of the three phases of implementation.**

Feel free to take notes in the cells below. Suggestio material regarding how to fit particular strategies to t welcome, but not required.

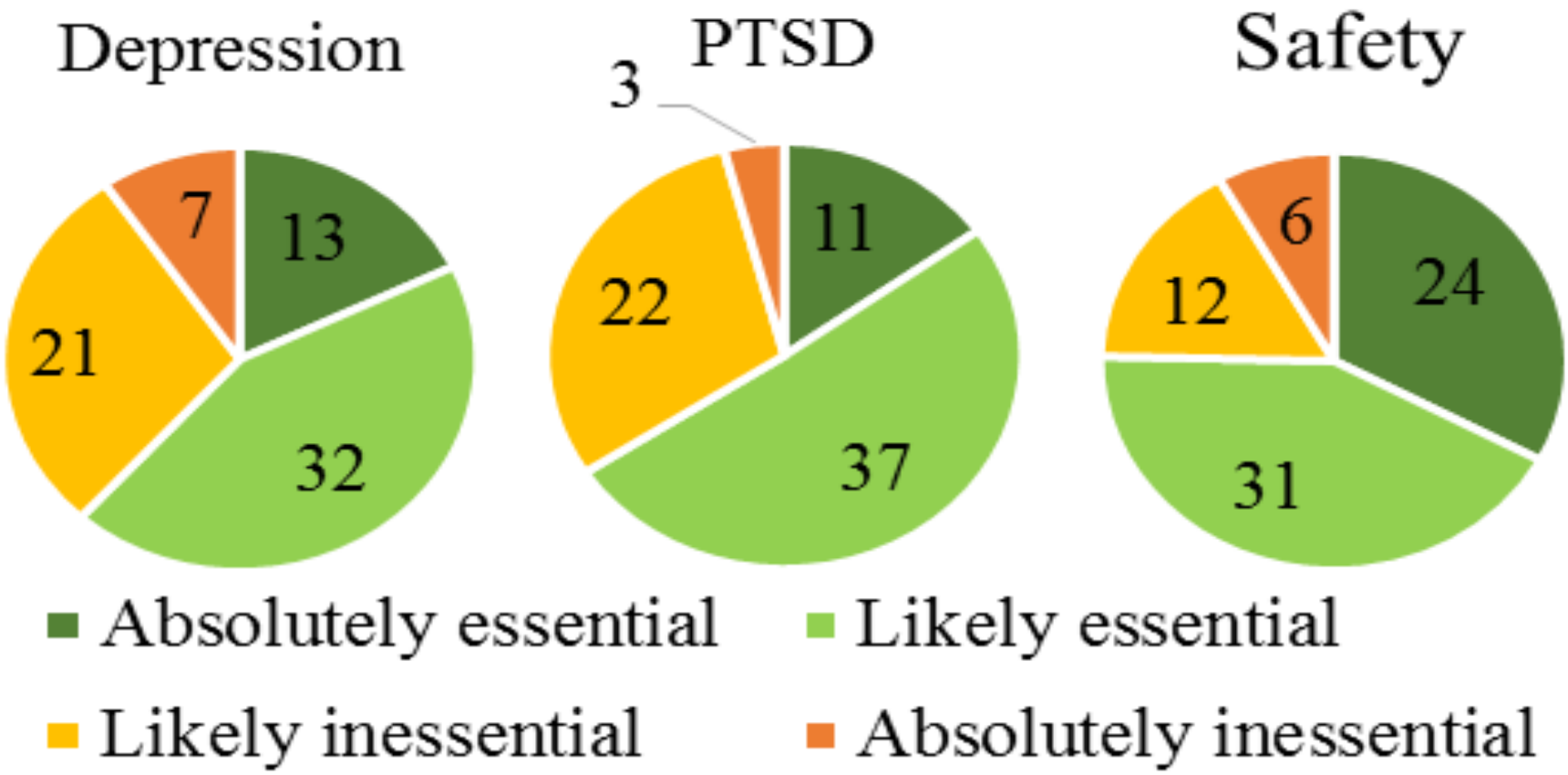
| | Recommendations for Scenario A | | |
|---|---|---|---|
| Discrete Strategy List by Cluster | Pre-implementation | Active Implementation | Sustainment |
| **Use Evaluative and Iterative Strategies** | | | |
| Assess for readiness and identify barriers and facilitators | A. absolutely essential | likely essential | B. likely essential |
| Audit and provide feedback | A. absolutely essential | A. absolutely essential | A. absolutely essential |
| Conduct cyclical small tests of change | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Conduct local needs assessment | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Develop a formal implementation blueprint | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Develop and implement tools for quality monitoring | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Develop and organize quality monitoring systems | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Obtain and use patients/consumers and family feedback | C. likely inessential | C. likely inessential | C. likely inessential |
| Purposefully re-examine the implementation | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Stage implementation scale up | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| **Provide Interactive Assistance** | | | |
| Centralize technical assistance | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Facilitation | B. likely essential | C. likely inessential | C. likely inessential |
| Provide clinical supervision | A. absolutely essential | A. absolutely essential | A. absolutely essential |
| Provide local technical assistance | B. likely essential | B. likely essential | C. likely inessential |
| **Adapt and Tailor to the Context** | | | |
| Promote adaptability | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |
| Tailor strategies | D. absolutely inessential | D. absolutely inessential | D. absolutely inessential |

Read First | Scenario A | Scenario B | Scenario C | Admin

# Number of Strategies Receiving Each Rating



# Proportion Receiving Majority (≥50%) Ratings



# Preliminary Results: "Absolutely Essential"

| "Absolutely Essential" Strategies (Part 1) | DEP | PTSD | Safety |
|---|---|---|---|
| Assess for readiness and identify barriers and facilitators | X | X | X |
| Audit and provide feedback | X | X | X |
| Conduct cyclical small tests of change | | | X |
| Conduct local needs assessment | X | X | X |
| Develop a formal implementation blueprint | | X | X |
| Develop and implement tools for quality monitoring | | | X |
| Develop and organize quality monitoring systems | | | X |
| Purposefully re-examine the implementation | | | X |
| Facilitation | X | X | X |
| Provide clinical supervision | | X | |
| Promote adaptability | X | | X |
| Tailor strategies | X | X | X |
| Build a coalition | X | | X |
| Capture and share local knowledge | | | X |

# Preliminary Results: "Absolutely Essential" (cont.)

| "Absolutely Essential" Strategies (Part 2) | DEP | PTSD | Safety |
|---|---|---|---|
| Conduct local consensus discussions | | | X |
| Identify and prepare champions | X | X | X |
| Identify early adopters | | X | X |
| Inform local opinion leaders | | X | X |
| Organize clinician implementation team meetings | | | X |
| Recruit, designate, and train for leadership | X | | X |
| Conduct educational meetings | | | X |
| Conduct ongoing training | X | X | X |
| Develop educational materials | X | | X |
| Distribute educational materials | X | | X |
| Make training dynamic | | | X |
| Provide ongoing consultation | | X | X |
| Facilitate relay of clinical data to providers | X | | X |
| Remind clinicians | X | | X |

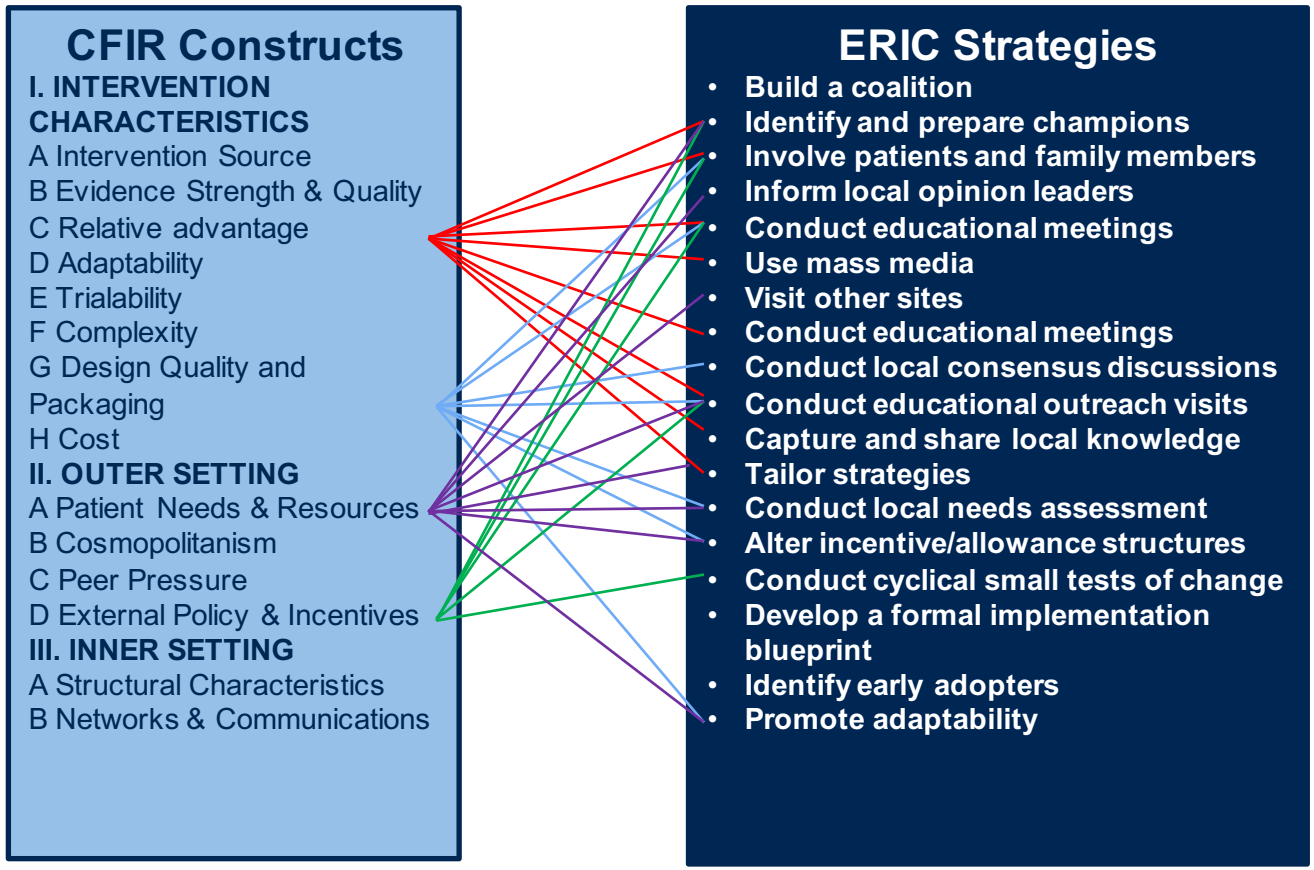
# Preliminary Results: "Absolutely Inessential"

| "Absolutely INESSENTIAL" Strategies | DEP | PTSD | Safety |
|---|---|---|---|
| Develop an implementation glossary | | X | |
| Work with educational institutions | X | | |
| Develop resource sharing agreements | X | | |
| Use mass media | X | | X |
| Alter patient/consumer fees | X | X | X |
| Develop disincentives | | | X |
| Make billing easier | | | X |
| Use capitated payments | X | | X |
| Use other payment schemes | X | | |
| Change accreditation or membership requirements | X | | X |
| Change liability laws | X | X | X |
| Change service sites | X | X | |
| Create or change credentialing/licensure standards | X | | X |
| Start a dissemination organization | X | X | |

# Summary: Preliminary Findings from ERIC Stage 3

- MBC produced distinct recommendations
- Experts endorsed a high number of strategies
  - Much higher than the number typically tested in trials of multifaceted strategies
  - Consistent with the high number of strategies reported in "real-world" implementation efforts
  - May reflect under-reporting of strategies in trials
- Participants wanted more context
- Next steps:
  - Complete analyses (phase and scenario-specific results forthcoming)
  - Compare recommendations to actual practice

# Developing a Tailoring Tool: Mapping ERIC to CFIR



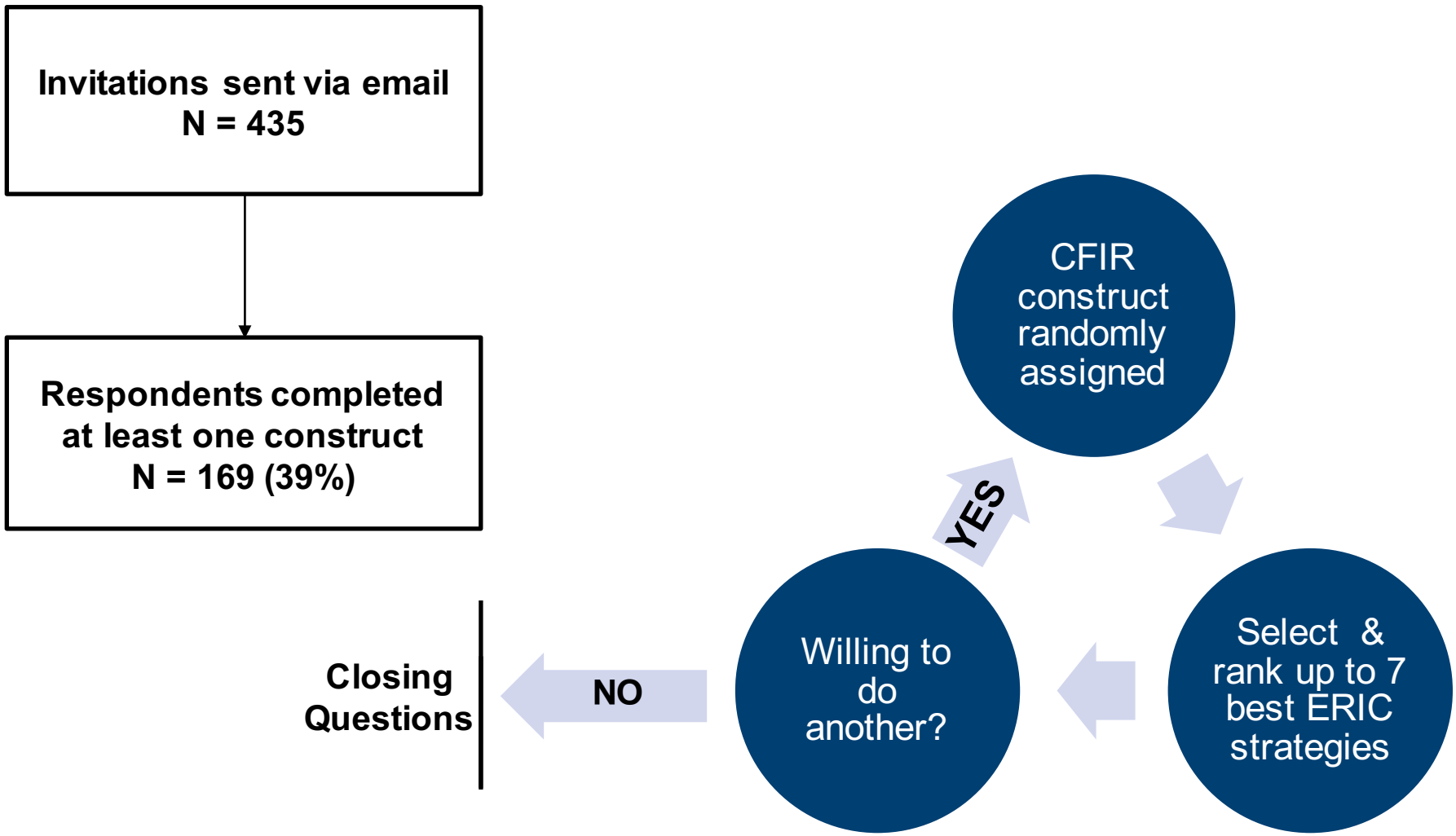
# Example of Barrier Related to "Relative Priority"

Select and rank up to 7 strategies that best address barriers related to:

**RELATIVE PRIORITY**

"Stakeholders perceive that implementation of the innovation takes a backseat to other initiatives or activities."

# Recruitment and Assignment of Constructs



# Wide Distribution of Endorsements

**Number of ERIC strategies ranked per CFIR Construct**

- Average = 47 strategies (Range: 35 – 55)

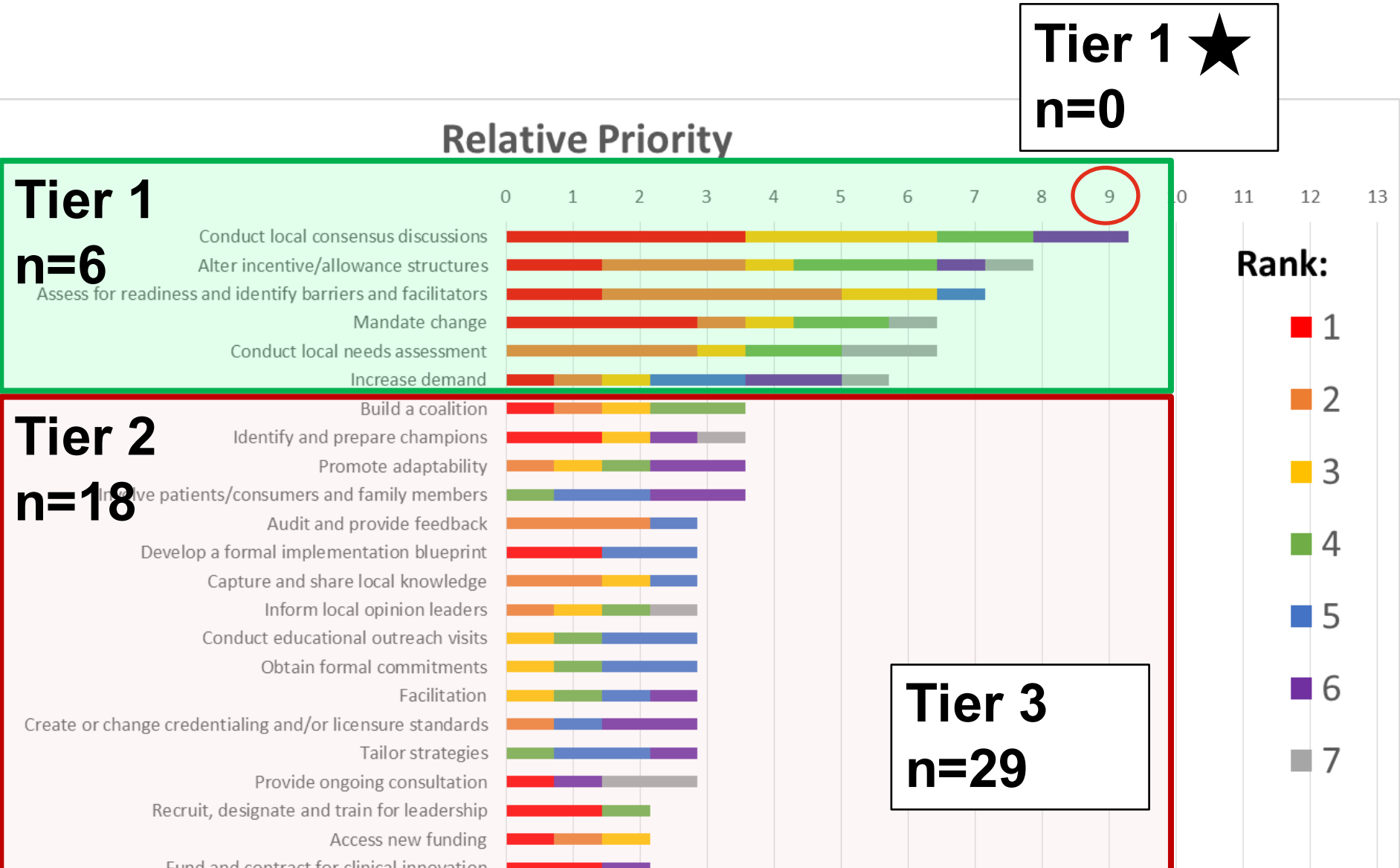
**Number of respondents varied by CFIR construct**

- Average = 26 (Range: 21 to 33)
- Normalized the number of “endorsements” as if n=20 for all CFIR constructs

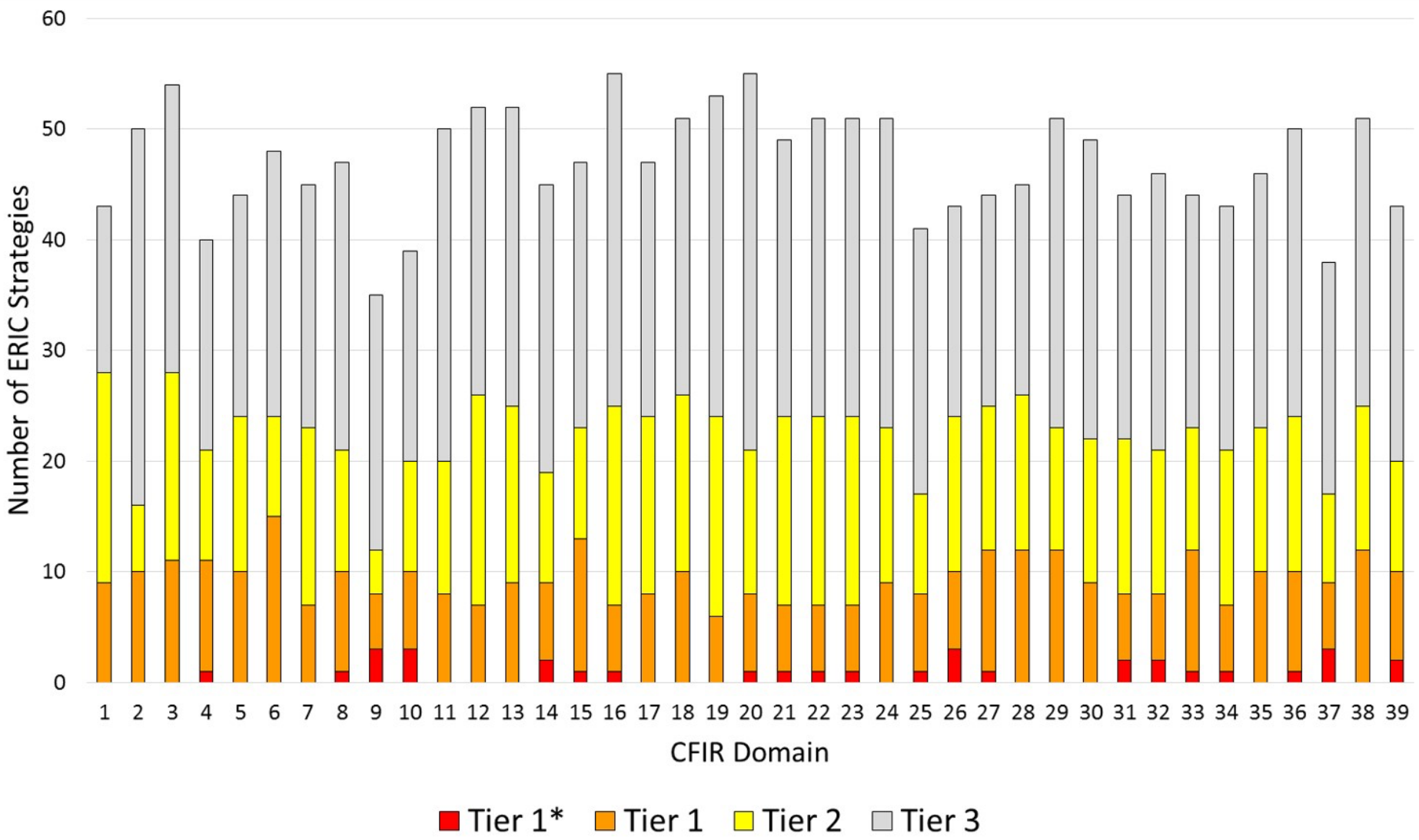
# Tiers of Endorsement

- At least 10 endorsed the strategy → Tier 1 ★
- 4 to 9.5 endorsed the strategy → Tier 1
- 2 to 3.5 endorsed the strategy → Tier 2
- 1 to 1.5 endorsement the strategy → Tier 3

# Endorsement Tiers for Relative Priority



# Endorsement Tiers Across All CFIR Constructs



# Summary of CFIR-ERIC Preliminary Findings

- Loose consensus on “best strategies” to address CFIR barriers
- Again, probably a need for more context
- Provides a starting point from which to build an evidence base for barrier-specific strategies
- Stay tuned for publication(s) and cfirguide.org tool

# Potential Methods for Selecting and Tailoring

## Methods to Improve the Selection and Tailoring of Implementation Strategies

Byron J. Powell, PhD
Rinad S. Beidas, PhD
Cara C. Lewis, PhD
Gregory A. Aarons, PhD
J. Curtis McMillen, PhD
Enola K. Proctor, PhD
David S. Mandell, ScD

*Journal of Behavioral Health Services & Research*, 2015. 1–17. © 2015 National Council for Behavioral Health. DOI 10.1007/s11414-015-9475-6

- Concept Mapping
- Conjoint Analysis
- Group Model Building
- Intervention Mapping

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# Poor Reporting Limits Accumulation of Evidence

Brouwers *et al. Implementation Science* 2011, **6**:111
http://www.implementationscience.com/content/6/1/111

IMPLEMENTATION SCIENCE

SYSTEMATIC REVIEW Open Access

What implementation interventions increase cancer screening rates? a systematic review

Melissa C Brouwers[1,2*], Carol De Vito[1,2], Lavannya Bahirathan[1,2], Angela Carol[3], June C Carroll[4], Michelle Cotterchio[5], Maureen Dobbins[6], Barbara Lent[7], Cheryl Levitt[8,9], Nancy Lewis[10], S Elizabeth McGregor[11], Lawrence Paszat[12,13], Carol Rand[14,15] and Nadine Wathen[16]

Understanding the Components of Quality Improvement Collaboratives: A Systematic Literature Review

ERUM NADEEM,[1] S. SERENE OLIN,[1]
LAURA CAMPBELL HILL,[2]
KIMBERLY EATON HOAGWOOD,[1]
and SARAH McCUE HORWITZ[1]

[1]*New York University;* [2]*Columbia University*

"Poor reporting, lack of precision and consistency in defining operational elements, and insufficient consideration of context and differences among populations are areas for additional research."

"Reporting on specific components of the collaborative was imprecise across articles, rendering it impossible to identify active QIC ingredients linked to improved care."

# Efforts to Develop Reporting Guidelines

Proctor *et al. Implementation Science* 2013, **8**:139
http://www.implementationscience.com/content/8/1/139

IMPLEMENTATION SCIENCE

DEBATE Open Access

## Implementation strategies: recommendations for specifying and reporting

Enola K Proctor[1*], Byron J Powell[1] and J Curtis McMillen[2]

## A Framework for Enhancing the Value of Research for Dissemination and Implementation

Gila Neta, PhD, Russell E. Glasgow, PhD, Christopher R. Carpenter, MD, MSc, Jeremy M. Grimshaw, MBChB, PhD, Borsika A. Rabin, PhD, MPH, Maria E. Fernandez, PhD, and Ross C. Brownson, PhD

Slaughter *et al. Implementation Science* (2015) 10:129
DOI 10.1186/s13012-015-0320-3

IMPLEMENTATION SCIENCE

METHODOLOGY Open Access

CrossMark

## What is the extent and quality of documentation and reporting of fidelity to implementation strategies: a scoping review

Susan E. Slaughter[1*†], Jennifer N. Hill[2†] and Erna Snelgrove-Clarke[3†]

# Recommendations for Specifying and Reporting

## *Name it, define it, and specify it!*

**Table 2 Specification of two implementation strategies**

| Domain | Strategy: clinical supervision | Strategy: clinician implementation team |
|---|---|---|
| Actor(s) | Clinician who is expert in the clinical innovation and recommended by the treatment developer. | A team of clinicians who are implementing the clinical innovation. |
| Action(s) | Provides clinical supervision via phone to answer questions, review case implementation, make suggestions, and provide encouragement. | Reflect on the implementation effort, share lessons learned, support learning, and propose changes to be implemented in small cycles of change. |
| Target(s) of the action | Clinicians newly trained in the innovation. | Clinicians newly trained in the innovation. |
| | Knowledge about the innovation, skills to use the innovation, optimism that the innovation will be effective, and improved ability to access details about how to use the innovation without prompts. | Knowledge about how to use the innovation in this context, intentions to use the innovation, social influences. |
| Temporality | Clinical supervision should begin within one week following the end of didactic training. | First meeting should be within two weeks of initial training. |
| Dose | Once per week for 15 minutes for 12 weeks, plus follow-up booster sessions at 20 and 36 weeks. | Once monthly for one hour for the first six months. |
| Implementation outcome(s) affected | Uptake of the innovation, penetration among eligible clients/patients, fidelity to the protocol of the clinical innovation. | Uptake of the innovation, penetration among eligible clients/patients, fidelity to the protocol of the clinical innovation, sustainability of the innovation. |
| Justification | Research that suggests that post-training coaching is more important than quality or type of training received [70]. | Cooperative learning theory [71]. |

**Proctor, Powell, & McMillen (2013)**

# Applied Example 1 (Trauma-Focused CBT)

Adm Policy Ment Health
DOI 10.1007/s10488-014-0621-x

ORIGINAL ARTICLE

## Can Learning Collaboratives Support Implementation by Rewiring Professional Networks?

**Alicia C. Bunger · Rochelle F. Hanson · Nathan J. Doogan · Byron J. Powell · Yiwen Cao · Jerry Dunn**

## Multifaceted Strategy (11 Component/Discrete Strategies*)

- Prepare change package
- Commitment
- Learning sessions
- PDSA cycles
- Conference calls
- Web support
- Quality improvement technique training
- Metrics reporting
- Coaching calls
- On-site visits
- Rostering

***Each specified according to Proctor et al. (2013) standards**

# Applied Example 2 (Diabetes Care)

MAYO CLINIC

BRIEF REPORT

## Reporting on the Strategies Needed to Implement Proven Interventions: An Example From a "Real-World" Cross-Setting Implementation Study

Rachel Gold, PhD, MPH; Arwen E. Bunce, MA; Deborah J. Cohen, PhD; Celine Hollombe, MPH; Christine A. Nelson, PhD, RN; Enola K. Proctor, PhD; Jill A. Pope, BA; and Jennifer E. DeVoe, MD, DPhil

**In Press @ Mayo Clinic Proceedings:**
**http://dx.doi.org/10.1016/j.mayocp.2016.03.014**

# Simplified Framework & AIMD Framework

Colquhoun *et al. Implementation Science* 2014, **9**:51
http://www.implementationscience.com/content/9/1/51

IMPLEMENTATION SCIENCE

SHORT REPORT Open Access

## Towards a common terminology: a simplified framework of interventions to promote and integrate evidence into health practices, systems, and policies

Heather Colquhoun[1*], Jennifer Leeman[2], Susan Michie[3], Cynthia Lokker[4], Peter Bragge[5], Susanne Hempel[6], K Ann McKibbon[4], Gjalt-Jorn Y Peters[7], Kathleen R Stevens[8], Michael G Wilson[9] and Jeremy Grimshaw[1,10]

**A**ims – What do you want your strategy to achieve and for whom?
**I**ngredients – What comprises the strategy?
**M**echanism – How do you propose the strategy will work?
**D**elivery – How will you deliver the strategy?

# *Building Blocks for Effective Implementation: Developing, Refining, and Applying a Compilation of Implementation Strategies*

## Overview of Today's Presentation

- Introduction and Definitions
- Developing and Refining a Compilation of Strategies
- Applying Implementation Strategies
- Improving Reporting of Implementation Strategies
- **Priorities Moving Forward**
- Acknowledgements and Discussion

# Priorities Moving Forward

- Building evidence for:
  - Discrete, multi-faceted, and blended strategies
  - Methods for developing, selecting, and tailoring
  - Strategies at patient, organizational, and policy level
- Organizational capacity and “learning organizations”
- Mechanisms of change
- Reporting of implementation processes and strategies

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# Thank You!

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