


WHAT ARE WE GOING TO NEED TO IMPLEMENT THIS?"
DISSEMINATING THE LEARNING COLLABORATIVE METHODOLOGY
IN FOUR STATES

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Presentation Overview

- The Learning Collaborative (LC) method is an approach that focuses on spreading, adopting, and adapting best practices in mental health across multiple settings, and on creating changes in organizations that promote the uptake and delivery of effective interventions and services.
- The Adoption/Implementation Factors study, part of the Cross-Site Evaluation of the National Child Traumatic Stress Initiative (NCTSI), is a qualitative study that examines the adaptations, challenges, and factors leading to the successful implementation of the LC method in four child serving systems in which it has been adopted.
- The National Child Traumatic Stress Network (NCTSN) is funded through the NCTSI by the Substance Abuse and Mental Health Services Administration (SAMHSA) and has been designed to improve services, access to care, and outcomes for children and adolescents who have experienced trauma.

The Adoption/Implementation Factors Study

- **Objective:** to learn how new practices are adopted and implemented among NCTSN centers.
- **Data collection methods:** guided, retrospective interviews
- **Interview respondents:** clinicians and administrators involved with
 - NCTSN centers
 - providing services to children and adolescents who have experienced psychological trauma
 - the adoption and implementation of trauma-informed practices
- **Data analysis methods:** multiple passes through interview transcripts & other data resulted in thematic codes which were further analyzed, using Atlas.ti qualitative data analysis software, to yield qualitative findings

What Does a Learning Collaborative Do?

- **Helps organizations and individuals to implement and adopt various clinically effective practices across diverse settings.**
- **Supports implementation of changes in clinical practice by simultaneously introducing one new clinical practice, and relatively quickly planning and implementing the myriad organizational changes to support the sustainability of that practice.**

Findings: Overall

- **LCs helped make routine processes that were supportive of effective clinical practice, such as**
 - Sharing ideas with other clinicians: *"Formalizing the whole process of giving advice..."*
 - Monitoring the application of clinical techniques: *"Clinicians were held accountable."*
 - Community outreach: *"We have more cases now than we did a year ago. And I think that we have more opportunities coming up to have even more cases."*

Findings: Overall (cont.)

- **All respondents, including those who were very skeptical at first, recommended the LC approach overall.**

"I wanted to focus on the clinical stuff, but I remember from the first Learning Session, really made a lot of sense to me to learn about, it's not just about the clinical stuff, it's about is the organization ready and how are you going to get referrals and how are you going to kind of spread this. So I think the more that I got exposed to it, the more it made sense."

Findings: Recommendations from LC Organizers

- Obtain high levels of commitment from clinicians and agencies, especially from supervisors and senior agency leaders

A Mississippi LC organizer observed how it was a *"lesson learned that if you get the Senior Leader on board and motivated and excited about it then that will flow downward. We did honestly have some Clinicians at other sites who weren't enamored with the whole idea but they had the Senior Leaders who were committed to it and some of those Clinicians turned out to be some best TF-CBT-trained Clinicians we were a part of producing."*

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Findings: Recommendations (cont.)

- Provide adequate explanations of what LCs are and how they are different from other forms of training
- Attend to the distinct needs of different kinds of participants
 - Clinicians with different levels of experience
 - Supervisors
 - Senior agency leaders/administrators
 - Community members

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Findings: Local Innovations

- NCTSN centers participated in national LCs and then organized LCs in states including:

- Mississippi
- North Carolina
- California
- South Carolina

- Local innovations included:

- Rosters of clinicians trained in TF-CBT
- Peer Supervision
- Different number or length of learning sessions

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Local Innovations: Mississippi

- Mentoring system for supervisors: LC faculty assigned to *"check in with them every once in a while,"* or a *"point person to call or to say, 'Look we're really having this problem.'"*
- Supervisory learning sessions prior to LC
- LC organizers were seeking to *"blanket the state"* with TF-CBT
- Participants logged onto NCTSN intranet to share ideas and ask one another questions

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Local Innovations: North Carolina

- Peer supervision groups
- Roster of clinicians providing TF-CBT: *"So if a kid comes up and they say they've experienced some type of trauma or a really bad sexual abuse and they need a Clinician in that area, we can just on the new website what you can do is just kind of click and see who is available in that area."*
- "Fidelity coaches"
- Participants used NCTSN intranet

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Local Innovations: California

- Recruit participants from those already trained in a similar clinical intervention
- Participants included clinicians, home visitors, and child advocates
- One large agency, rather than multiple agencies
- Began with a primer in early childhood development
- One day Learning Sessions rather than two.
- Blog supported communication among participants.

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Local Innovations: South Carolina

- Community- rather than agency-based LCs
- Multidisciplinary “community change teams”
- Rostering system
- Four learning sessions instead of three

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Facilitating Factors for LCs

- Most LC organizers had previously participated in NCTSN-organized LCs
- Ongoing support from LC and intervention developers. South Carolina LC organizers described the benefits of “poring through the Learning Collaborative Toolkit, the manual,” and consulting LC developers and other LC organizers while planning.
- Supporting senior agency leaders and clinical supervisors

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Facilitating Factors (cont.)

- Organizing multiple LCs, and learning from prior experience. A veteran Mississippi LC organizer observed how participants in the first learning session are excited and say, “We’re going to learn TF-CBT or SPARCS or whatever, and we’re going to implement it and we’re going to... accomplish great things.” Then the next Learning Session is “where you’re actually having to do the work and so that’s where the struggles come in and you start looking at how much is this costing us and how different is this from the way we used to doing things... And then by the third one they have some success under their belt and they start to see that it’s going to work and you end up with more of an anxiety about the Learning Collaborative going away and how would they sustain it because now they like what they’ve done.”

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Challenges to LC implementation

- Explaining complex LC approach to potential participants
- Securing approval from senior leaders and supervisors to invest in year-long training. A North Carolina trainer observed, “there are still people that would rather have a one- or two-day training that’s all clinical focus versus embarking on nine to ten month kind of process that can be costly.”
- Beginning to practice new clinical skills. A Mississippi organizer observed that even though 3-4 months between Learning Sessions “sounds like a long time, you don’t get that many new clients and it gave you time to get some new clients.”

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Conclusions

- LCs supported the introduction of evidence-base treatments, but perhaps more importantly, they support the fidelity and sustainability of these practices.
- LC participants “have to have some examination of what’s been the past history... of taking a new practice and putting it into place in the agency. And I think that’s the unique thing about LCs that helps people along.”

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For more information:

- On research on LC adoption/implementation, please contact Charley Seagle (charles.h.seagle@macrointernational.com)
- On the Adoption/Implementation Factors study, please contact Elizabeth Douglas (elizabeth.b.douglas@macrointernational.com)
- On the Learning Collaborative model contact Jan Markiewicz (jan.markeiwicz@duke.edu) or visit nctsn.org

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Spreading and Sustaining Best Practices Through the Learning Collaborative Model

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RTC, March 2, 2009

The Ongoing Conversation....

- IOM Reported Time Lag of 17 years between practice development and movement into the field
- Translation Gap: Strategies for moving best practice into actual practice
- Implementation Science – add to the research base for effective implementation
- Identify the program, organizational and workforce capacity issues

Connecting with New Drivers “broadening the context....new conversations”

- Economic stimulus package/health care reform
- IOM Report on Prevention (Feb 2009)
- Social determinants of health

Economic Stimulus Package → Health Care Reform

HHS Working Committees:

- Prevention and Wellness
- Health Information Technology
- Comparative Effectiveness Studies
- Accountability and Measurement

Anticipated Priorities?

- Focus on Effective Practices
- Health Care Board (guidance re identification, standards for effective practices/technologies)

IOM Report on Preventing Mental Emotional and Behavioral Disorders Among Young People (Feb 2009)

- Key Areas of Progress since 1994 Report on Prevention:
 - Advances in implementation science
- 2009 Recommendations:
 - Putting Knowledge into Practice
 - Funding to “...implement and improve evidence-based practices”
 - Workforce development ...“training grants....should span creation, **implementation**, and evaluation of effective preventive interventions....”

Social Determinants of Health

- SDOH may account for more of the variance in health outcomes than individual factors, lifestyle behaviors and the health care delivery system.
- Implementation strategies:
 - Understanding the context in Learning Collaboratives
 - Race, ethnic, class, sexual preference, poverty, etc that impact outcomes beyond practice, program and organizational factors

A Few Questions re the Learning Collaborative Model?



- Investments in Learning Collaborative Model:
 - What does it cost?
 - Costs and benefits of this implementation strategy versus other approaches?
 - Staff/leadership time?
- Does this support scalability?
 - Is there spread within the organizations?
- What are the demographics of the LC participants?
 - Early adopter types? Incentives for clinician participatio?
- Quality improvement/process improvement framework: is there a data feedback component for client outcomes, practitioner implementation competency?

A few more questions...



- Is this an implementation infrastructure that could be used with other practices?
 - Are there practices that would not fit with this LC approach?
- Ultimate outcome: Are children doing better?