

The Use of Learning Collaboratives to Promote Implementation of Evidence-Based Practices in New York State

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Overview

- Challenges in Implementation of Evidence-Based Practices in Mental Health
- Learning Collaboratives: A Structure for EBP Implementation
- Learning Collaboratives in NYS Adult Behavioral Health
 - Wellness Self-Management
 - Family-Oriented Services
- Implications for Future Initiatives

Challenges in Implementation of EBPs

- “Gold standard” model of expert consultation and toolkits
 - Resource intensive
 - Dependent on internal champions/early adopters: uneven access
- Fidelity vs. adaptation: how much is enough?
- Staffing issues
 - Turnover
 - Core competencies

Learning Collaboratives: A Structure for EBP Implementation

Learning Collaboratives in Healthcare

- 1995: “Breakthrough Series” collaborative model developed at the Institute for Healthcare Improvement
- Moves beyond traditional training to support healthcare leaders in system-level change
- Has been used to address a wide range of issues in healthcare
- Key principles: Transparency and Learning Orientation

The Learning Collaborative Process

- Identify a felt need to change a high priority process, function, practice or outcome
- Recruit a panel of experts to provide clinical, technical, and social support
- Enroll participating providers
- Alternate face-to-face Learning Sessions with agency-based Action Periods

Learning Collaborative Participants

- Agency QI teams, including clinical supervisor, administrator, and QI/data staff
 - Agencies encouraged to bring in ad hoc QI team members as needed
- Resource panel of experts

Advantages of the Learning Collaborative Approach

- Aligned with IOM's vision of health systems as "learning organizations"
- Emphasis on rapid, practical and sustainable improvements
- Innovation and problem solving shared with and by members: build on collective strengths of members
- Use of data and information to inform decision making and assess improvements
 - Action Periods = Plan, Do, Check, Act cycles

Examples of Learning Collaboratives in Healthcare

- Reduction of cesarean section rates
- Reduction of delays and wait times
- Improvements in asthma care
 - Decreased hospital admissions
 - Decreased ER use
 - Increased prescription for inhalers
- Reduction in adverse drug events

Learning Collaboratives in Behavioral Health

- NYC Dept. of Health and Mental Hygiene Quality IMPACT Initiative
- National Child Traumatic Stress Network
 - Used to disseminate trauma-focused CBT
- Cavaleri et al. (2006): intervention to improve use of mental health services by low-income urban children and families
 - First NYSOMH initiative to use a learning collaborative
 - Training in CQI methods and workforce development as critical needs
 - Positive response of agencies to LC approach

Learning Collaboratives in NYS Adult Behavioral Health

Wellness-Self Management

Wellness Self- Management Pilot

- Wellness Self-Management (WSM): a curriculum-based treatment program based on Illness Management and Recovery, a nationally recognized evidence-based practice
- May 2006 – December 2007: Pilot implementation in 9 NYC agencies
 - Partnership between NYSOMH and Urban Institute for Behavioral Health
 - Housing programs (6), day treatment (2), CMHC (1)

WSM Learning Collaborative Activities

- Leadership Forum: partnership and consensus-building to generate buy-in and support
- Training of supervisors and clinicians
- Five collaborative learning sessions
 - 80-100% agency attendance
- Monthly phone calls

Sample Agenda for Learning Session

- Presentation of Aggregate Data
 - Psychiatric Hospitalizations
 - Number of consumers in WSM groups
 - Retention rate
- Agency presentation of data
- Discussion
- Spread Exercise: how to sustain and spread WSM
 - Strategies
 - Pros and Cons
- Agency exercise

Evaluation Data

- Agency Survey
 - # staff trained, # groups, # consumers
- Performance Indicators
 - Recovery Assessment Scale
 - Administered to group participants at beginning and end of pilot
 - Psychiatric Hospitalizations
- Qualitative Data
 - Learning Session notes
 - Focus groups

Results: Program Data

- 8 of 9 agencies provided data
- Total of 64 clinical staff trained
 - Ranged from 2 -22 per agency
- 17 groups to start, 2 added
 - Group size range 3 - 23
 - Median size of group = 10
- Total of 230 consumers started WSM
 - 76% retention rate (55 discontinued)
 - Both positive and negative reasons for discontinuation

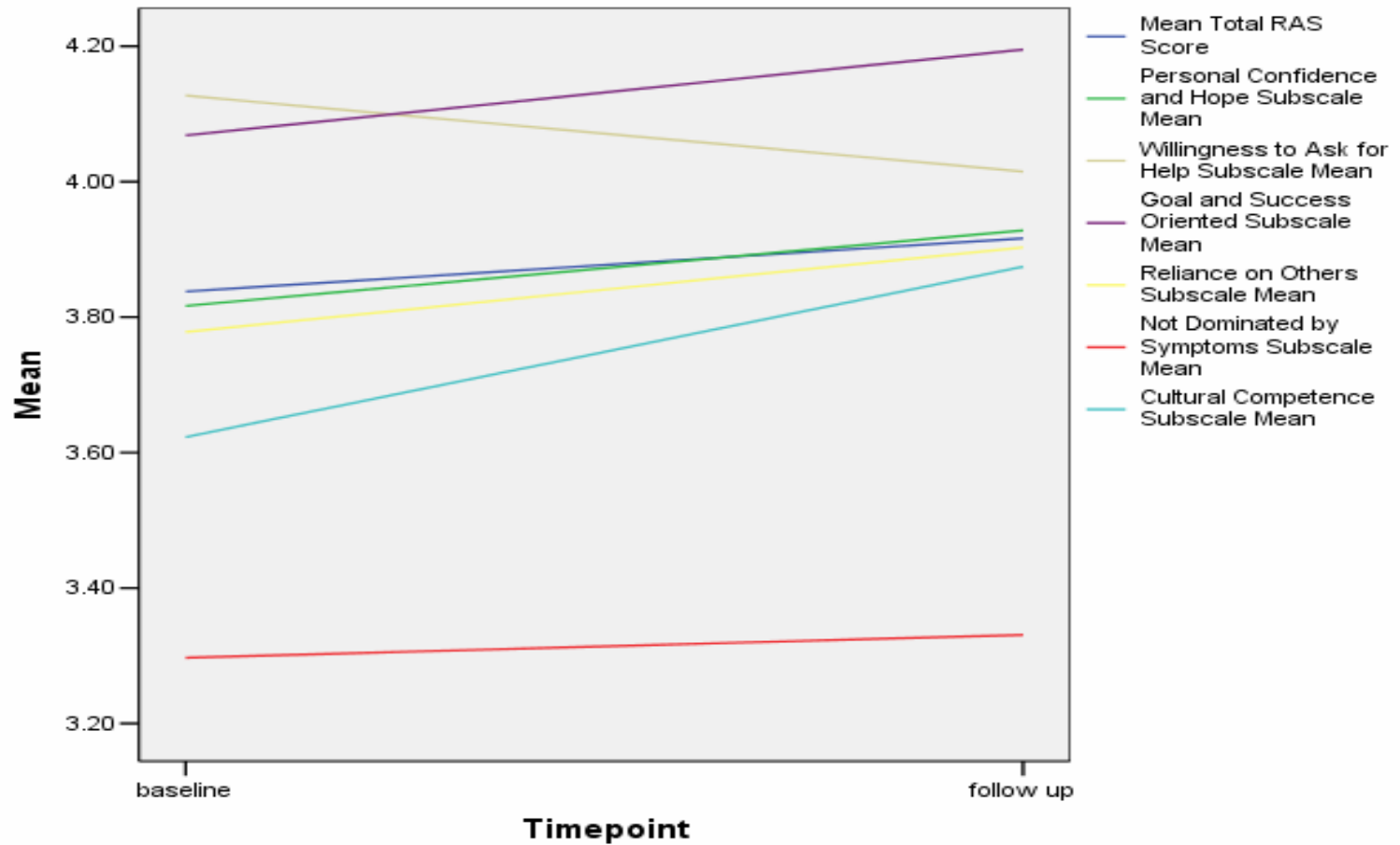
Results: Program Data

- All groups met at least weekly
- 7 groups completed workbook
 - 8 completed 33-66% of topics
 - 6 completed < 33% of topics
- 4 agencies planning additional WSM groups

Results: Recovery Assessment Scale

- Developed by Patrick Corrigan et al. at University of Chicago
- Includes 24 items rated by consumer on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree)
- Scale items fall into five subscales: Personal Confidence and Hope, Goal and Success Orientation, Willingness to Ask for Help, Not Dominated by Symptoms
- For this evaluation, added 4 questions on cultural competence

RAS Over Time



Results: Psychiatric Hospitalization

- Downward trend observed at 6 month point
- Data collection efforts faltered
- Questionable value
 - Direct, strong relationship between intervention and outcome?
 - Sensitivity?

Benefits of WSM

- WSM promotes a recovery orientation in both consumers and clinicians.
- WSM works best when it is embedded in agency philosophy and practice.
- The WSM structure and content keeps the group focused.
- Group leaders' stance as participants rather than experts promotes a shared experience.

Benefits of a LC Approach for WSM Implementation

- Ongoing meetings promote enthusiasm, focus, and penetration.
 - Opportunity to get away from daily distractions
- Network of providers gives social support, help with problem-solving.
 - Parallel process with WSM groups

Family-Oriented Services

Promoting Family Oriented Services: Challenges and Opportunities

- **Challenges:** Most MH systems not well designed to involve family members in a manner that:
 - Acknowledges the diversity of needs, wants and life circumstance of consumers and members of their family or social support system.
 - Reinforces the values of recovery including consumer choice, involvement and self determination
 - Integrates the involvement of others into the core treatment process to support the accomplishment of the expressed goals of the consumer.

Promoting Family Oriented Services: Challenges and Opportunities

- **Opportunities:** Explore approaches that are practical and feasible as well as recovery supporting, integrated and flexible.
 - Approaches that reflect principles that are consistent with research informed practices.
 - Approaches that don't exceed the basic competencies of the workforce
 - Approaches that don't carry much risk with respect to resource demands and fiscal viability
 - Approaches that expand the range of options available to consumers and families.

Developing a Spectrum of Family-Oriented Services

- Goal: to promote a range of consumer-centered, family-oriented services that will meet unique needs
- MFG model evidence-based but challenging to implement
- Family consultation as “gateway” service

Implementation of Family-Oriented Services

- Fall 2006 – present: statewide implementation of consumer-centered family consultation in 50 agencies
 - Collaboration between OMH and University of Rochester Family Institute
 - One Learning Collaborative in each of 5 regions
 - Wide range of participating programs: Clinics, CDTs, IPRTs, ACT teams, residences, vocational programs, case management

Family-Oriented Services LC Activities

- Leadership Forums: partnership and consensus-building
- Learning sessions
 - #1 and #2 preceded clinical training to support implementation planning
 - #4 postponed in favor of booster training
- Training of supervisors and clinicians
- Monthly phone calls
 - Attendance ranged from 36%-90%

Sample Agenda for Learning Sessions

- QI Team Updates
- Open discussion: Implementation challenges, role of QI team, feedback from staff
- Connecting data to clinical work
- Team exercise: Planning for 2008
 - What additional services to offer
 - Implementation strategies

Use of Data in the Family-Oriented Services LC

- Agency QI teams collected data on 3 performance indicators
- Agency QI teams entered data monthly on Family Institute Website
- Family Institute staff aggregate data
- Family Institute staff share data at monthly phone calls and learning sessions

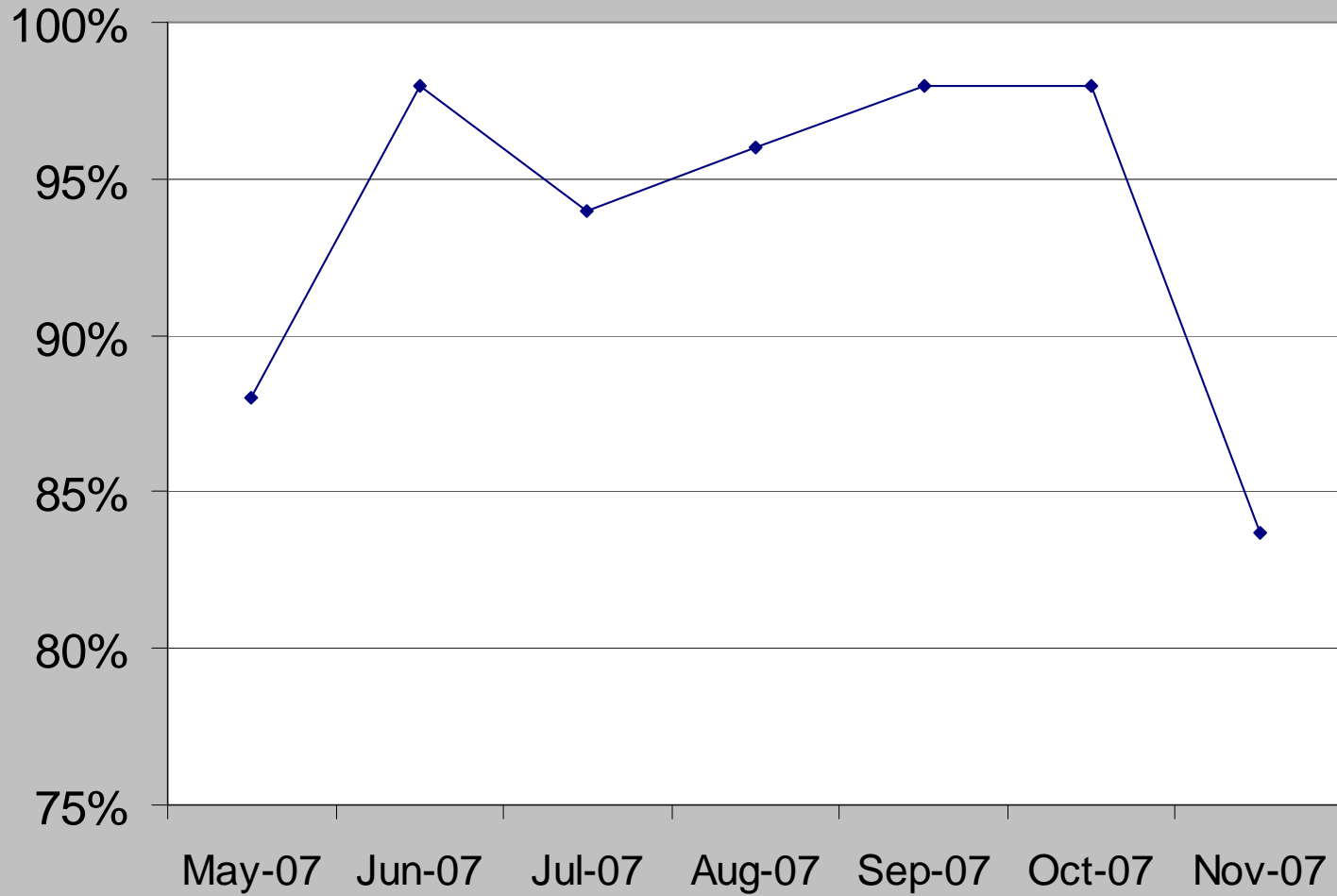
Web-based Data Entry

Data Collection and Performance Indicators for the Spectrum of Family Services Initiative: Family Consultation Data	
Reporting Period	<i>(Drop down list of Months/Years)</i>
Agency Person Reporting	<input type="text"/>
1a. Total number of active consumers enrolled in program	<input type="text"/>
1b. Total number of consumers in program who have been engaged in a discussion regarding the involvement of family members or social network in their treatment and recovery	<input type="text"/>
2a. Total number of family consultation in which the process has begun submitted for this month	<input type="text"/>
2b. Total number of family consultation with all four components (engagement, presenting family needs, services provided & disposition completed	<input type="text"/>
<p><i>NOTE: Please double check all data prior to hitting the "submit" button below. Once the data has been submitted, you will be provided with a summary of your submission but will not be able to change it.</i></p>	

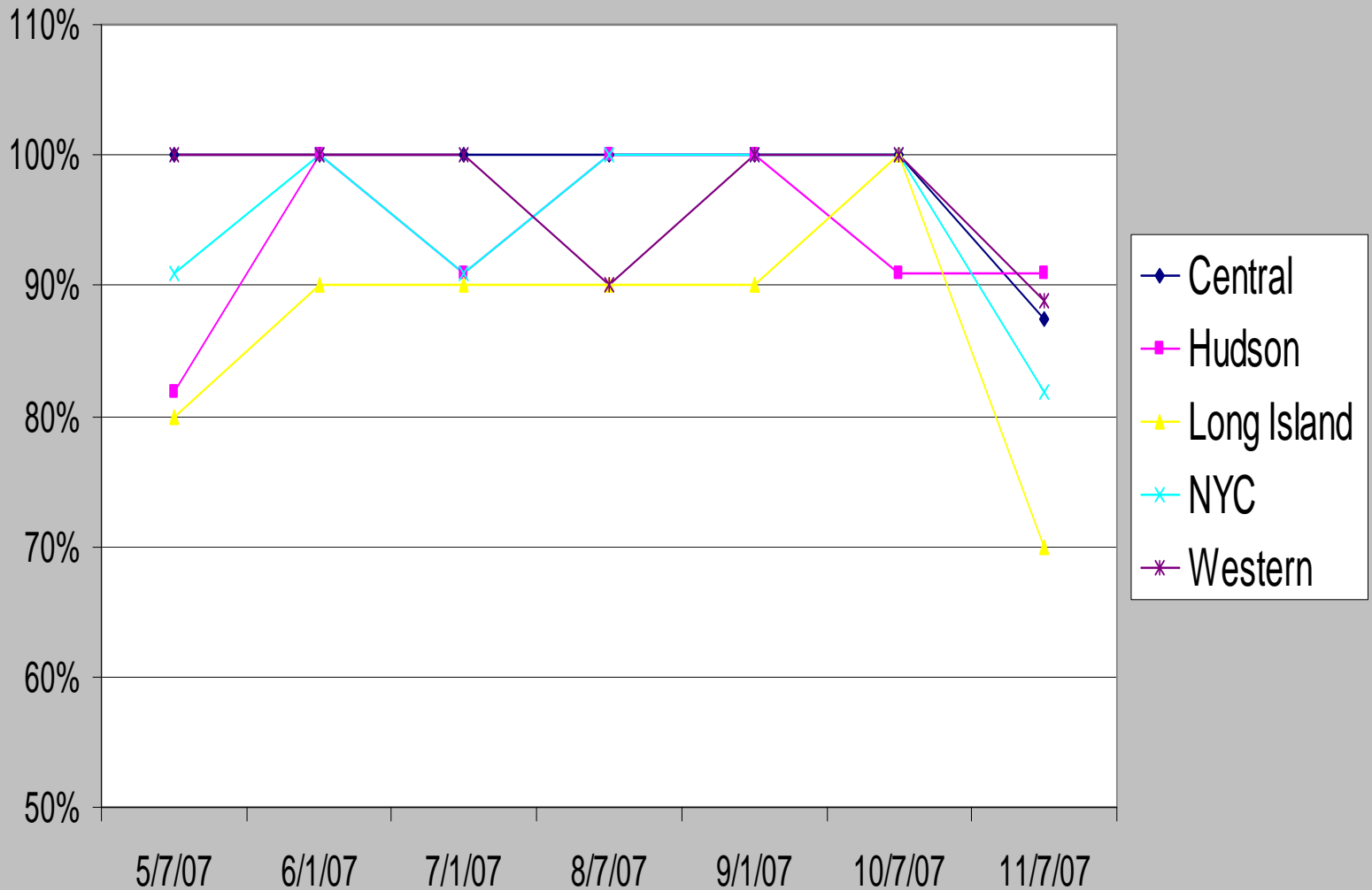
Status after 6 months of LC Activities (12/2007)

- 48 out of 50 agencies remain active participants
- Approximately 250 clinical staff trained
- 875 family consultations conducted
- 98% of families providing feedback were satisfied with the consultation

% of Agencies Reporting Data Overall



% of Agencies Reporting Data by Region



Issues with Data Reporting

- Agencies generally able to track and report data
 - Drop-off around holiday periods
- Staffing turnover can be disruptive
 - Smaller agencies lack QI staff
 - Clinicians need support around data
- Need to reinforce data as tool for agencies, not reporting requirement

Performance Indicator: Consumer Engagement

- Goal: to monitor clinician-consumer engagement around family consultation
- Definition: $\frac{\# \text{ of consumers approached about family consultation}}{\# \text{ of consumers in program}}$

Consumer Engagement: Measurement Issues

- Snapshot indicator may not capture engagement process
- Census turnover will affect rate
- Confusion re: what data to report
 - Inconsistencies in data necessitate review with agencies

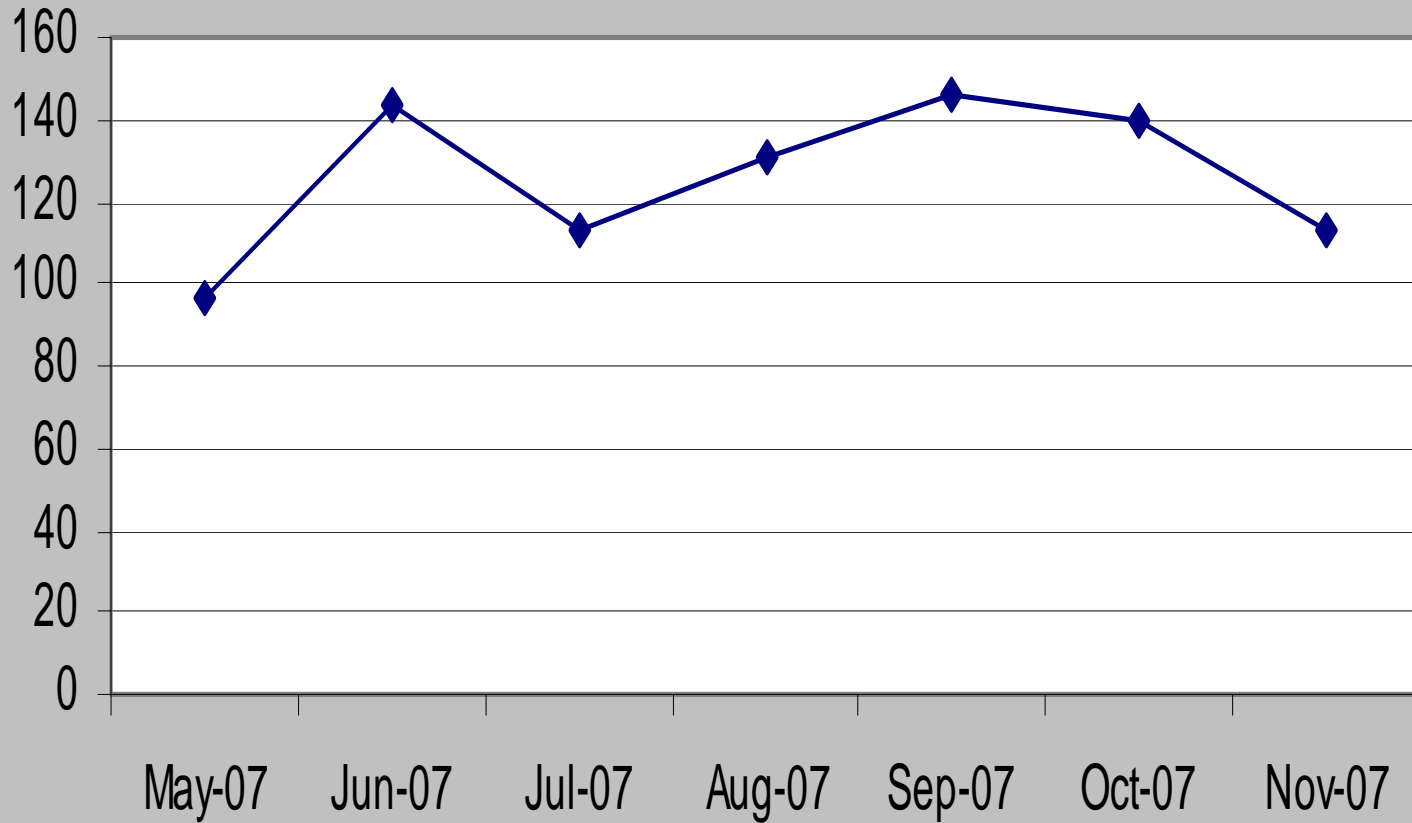
Consumer Engagement: Clinical Issues

- Consumers DO have families
- Consumer engagement is a process
 - Agencies using a number of outreach strategies: brochures, letters, family nights, open houses, whitepages.com
- Interaction between staff and consumer resistance
- Clinical staff need training and support around consumer engagement

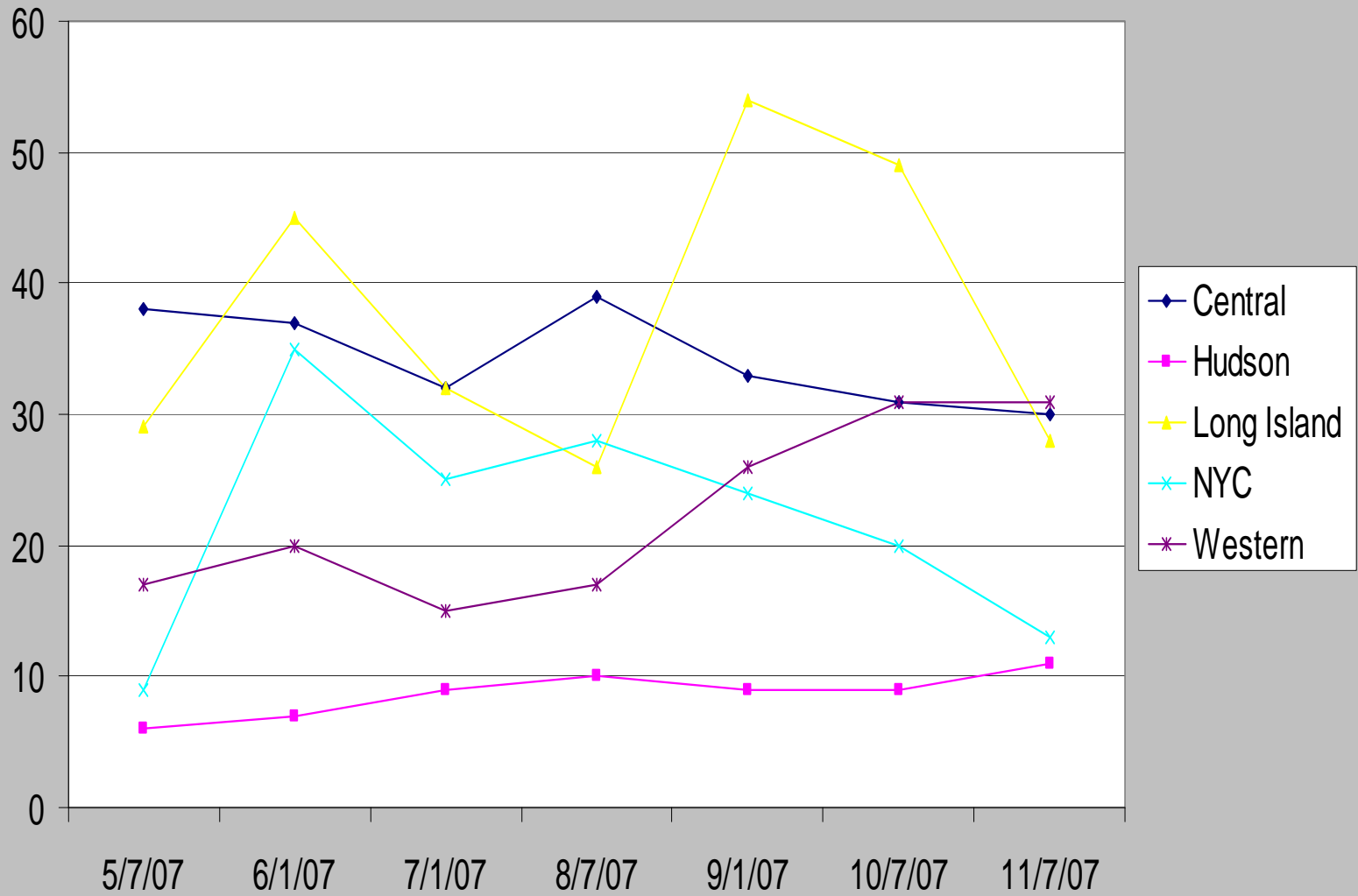
Performance Indicator: Frequency of Family Consultations

- Goal: to monitor progress over time in conducting family consultations
- Definition: # of family consultations conducted

of Family Consultations Overall



of Family Consultations by Region



of Family Consultations: Measurement Issues

- Relatively straightforward: fewer problems with data reporting
- Does not reflect unique number of families served

of Family Consultations: Clinical Issues

■ Barriers:

- Organizational: Staff turnover, scheduling, increased work demands
- Psychological: Staff anxieties, stigma regarding mental illness

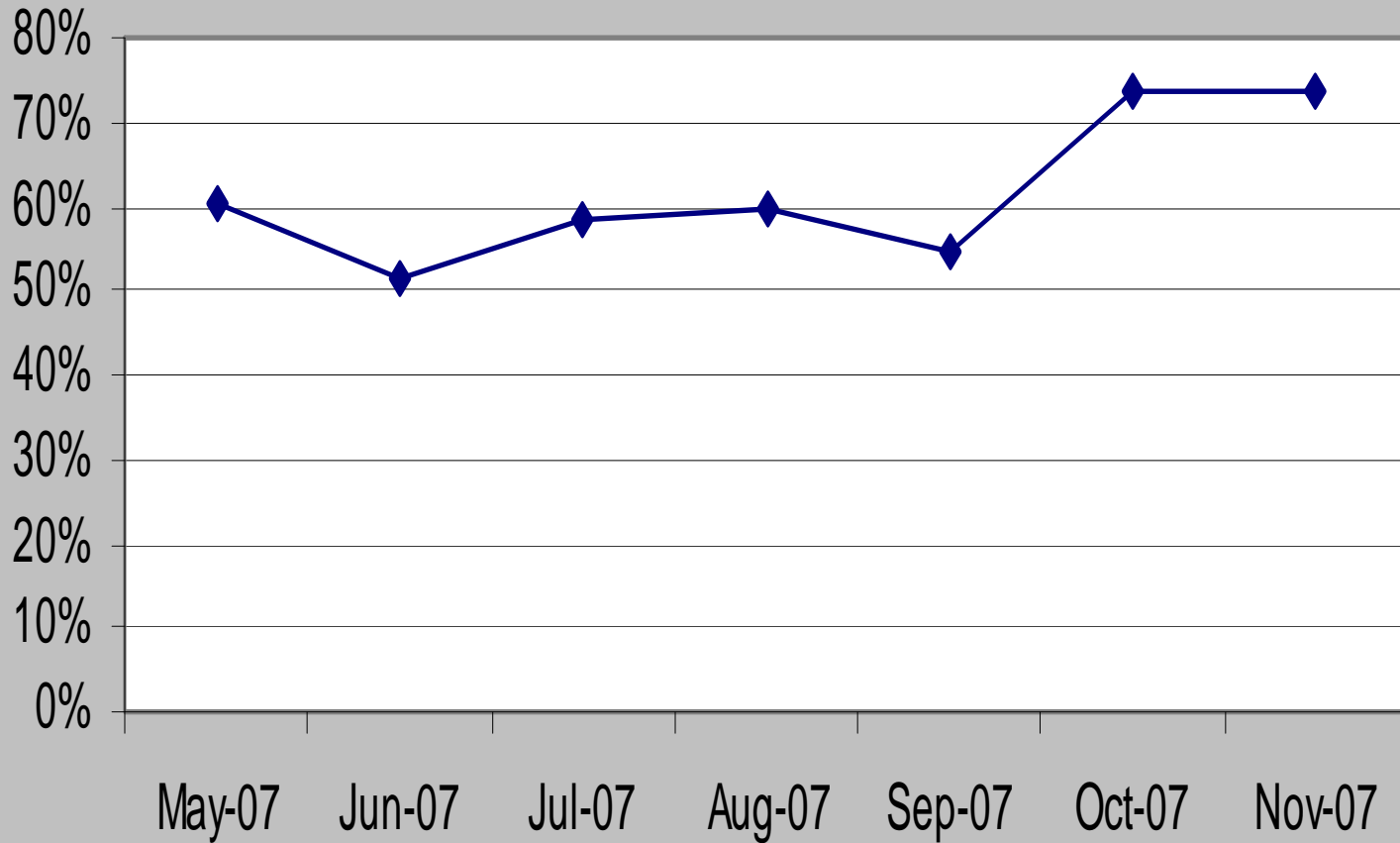
■ Strategies:

- Begin engagement process during intake process
- Booster sessions to re-energize staff
- Consider intervention-program fit

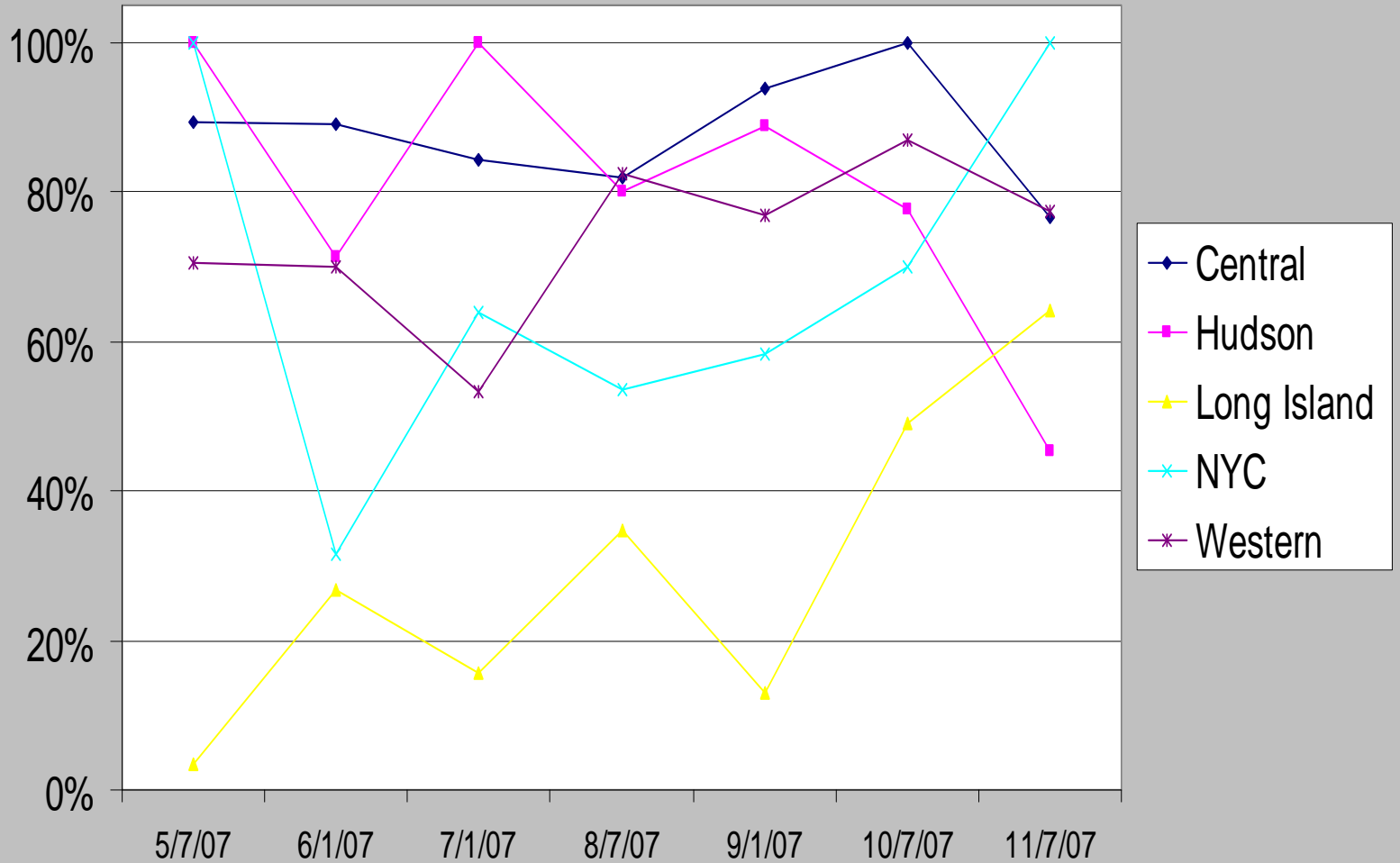
Performance Indicator: Quality of Family Consultations

- Goal: to monitor treatment fidelity
- Definition: # of FC structured progress notes completely filled out

% of Complete Progress Notes Overall



% Complete Progress Notes by Region



Quality of Family Consultation: Measurement Issues

- Sensitive to organizational influences
 - Delay in approval of form meant some agencies could not report
- Aggregate data does not reflect which sections are problematic

Quality of Family Consultations: Clinical Issues

- High variability among and within regions
- Assesses recordkeeping rather than clinical skills

Performance Indicator: Satisfaction with Services

- Goal: to monitor family satisfaction with family consultation services
- Definition: six questions rated Strongly Agree to Strongly Disagree on
 - Satisfaction
 - Helpfulness
 - Respect
 - Recommend to others

Satisfaction with Services: Results

Item	N = "Strongly Agree"	%
Felt satisfied	47	75%
Answered questions	43	68%
Treated w/ respect	59	91%
Provided guidance	49	77%
Materials were helpful	42	67%
Recommend to others	52	80%

Satisfaction with Services: Measurement issues

- Low response rate
 - 65 postcards received (7%)
- Low variability in responses
 - For all items, over 96% responded strongly agree/agree

Satisfaction with Services: Clinical Issues

- Somewhat lower (though still high) ratings for “helpfulness of materials” and “consultant answered questions” may suggest that clinicians need additional training and resources to meet unmet family needs
- How else could agencies collect data on satisfaction?

Benefits of a LC Approach for Family Consultation

- Use of data supports timely assessment of barriers
 - Low numbers spurred conversations around consumer engagement
 - Some agencies developing own performance indicators (# of consultations expected / month)
- Ongoing process provides support and keeps agencies connected even when struggling
 - Brainstorming during monthly calls and Learning Sessions
 - Sense of connection and support even outside of formal LC activities (site visits)

Benefits of a LC Approach for Family Consultation

- Learning Sessions support focused work away from day-to-day distractions
- LC/QI approach models organizational and clinical processes for agencies
- Provides access to external resources
 - Staff training, website, resource panels (NAMI and OMH Recipient Affairs)

Implications for Future Initiatives

What Can a LC Do?

- Promote sustained engagement of agencies in implementation process
- Provide feedback about barriers and challenges
- Support change in agency culture as well as clinical processes
- Help agency develop internal capacity to start, sustain, and spread quality practices
 - Staff development and supervision

What Does a LC Need?

- Resource Panel
 - Human capital
- Resources: materials, technology, space
- Support around data and QI

Choosing Performance Indicators

- Agencies most familiar with data relevant to organizational survival (billing, risk management): clinical outcomes more difficult and require more support
- Tension between ease of collection and meaningfulness
 - Infrastructure vs. relevance

Consideration for Selecting Performance Indicators

- Need to be relevant across various program types
- Need to be data available to and collectable by agency staff
 - Build on existing systems
- Need to be relevant to day-to-day work

The Bottom Line

- Any sustainable change requires organizational, technical, and staff development components.
- Learning Collaboratives offer a promising methodology for widespread dissemination of quality practices.
 - Focus on developing internal capacity

For more information ...

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