

Think Tank Summary: Evidence-Based Implementation Models: What Does it Take?

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Key issue/challenge

The Institute of Medicine has concluded that there is a persistent gap between research and practice. Mental disorders, including depression, bipolar disorder, and schizophrenia, affect up to 10% of the population and are represented in the top ten causes of disability according to the World Health Organization. Despite the development of guidelines and empirically-supported treatment models, persons with mental disorders experience a substantial mortality gap (up to 25 years) compared to the general population. Hence, the National Institute of Mental Health's Roadmap strongly encourages a more rapid implementation and dissemination of empirically-supported interventions to close this persistent research-to-practice gap. However, there has been little guidance on how to translate best practices into routine care, and which implementation strategies are effective in adapting, implementing, and disseminating best practices into routine care. While many implementation models exist, few have been empirically tested in practice.

Barriers

There is no consensus regarding which specific elements of implementation models are universal, or which are directly related to improved uptake of evidence-based care and ultimately, outcomes. Implementation models are often difficult to operationalize and replicate because they involve a combination of stakeholder engagement (relationship building with community practices), training strategies, and ongoing technical assistance, and in many cases, the process of implementation is not entirely linear.

Strategies to overcome barriers

Our Think Tank described two implementation models that are currently being tested to implement two chronic care model (CCM)-based programs: Life Goals Collaborative care (LGCC) for bipolar disorder and the TIDEs program for unipolar depression. We outlined the Replicating Effective Programs implementation model (REP; RO1 MH79994) which combines customized intervention packaging with training and technical assistance to implement psychosocial interventions for bipolar disorder. REP was developed by the Centers for Disease Control and Prevention in 1996 to translate HIV prevention programs to community-based settings. A key component of REP is the "packaging" process which translates the intervention into user-friendly language based on local agency input, as well as easy to read guidelines for implementing the program in routine practice. The package not only includes a structured manual but also "talking points" of the program as well as samples of actual materials needed to implement it. Another advantage of the packaging process is that programs are distilled into their "core elements" or components that represent the underlying theory or internal logic that lead to the program's desired effect. Articulating the programs' core elements allow end users to identify areas in which the program can be adapted to local settings without sacrificing fidelity. The implementation of the package is supported by structured training in the program and proactive technical assistance. This combined approach (packaging, training, technical assistance) resulted in the majority (75%) of AIDS services organizations implementing HIV preventions compared to 54% of sites offered training with the package and 4% of sites offered the package only (Kelly 2000). REP has been used to package over 15 HIV prevention interventions and most recently, a bipolar disorder chronic care model. The REP toolkit includes a facilitator manual for administrators that describes the program, including resources, benefits, etc; an implementation manual for users of the program, a structured training manual, and a technical assistance guide for regular phone or in-person contacts. The strengths of REP include specific guides for front-end efforts to maximize program fidelity through the packaging of programs into user-friendly language, involvement of community and stakeholder input in the design of the package, as well as opportunities for adaptation without compromising core elements through the packaging process, training and technical assistance.

The VA's Quality Enhancement Research Initiative (QUERI) Facilitation model was also described, which is being applied to implement depression CCMs within VA networks as part of the VA's Primary Care-Mental Health Integration Program. Facilitation is defined as the process of enabling site level personnel to implement and sustain the program. This model utilizes implementation strategies that are applied through both an external facilitator (expert in depression chronic care models) as well as an internal facilitator who resides within the clinical organization and is familiar with the organization's structure and culture. The Facilitation model addresses important challenges in maintaining and sustaining successful implementation efforts, notably, the importance of local provider involvement (i.e., top-down initiatives are insufficient), a realization that readiness to participate may vary across sites, and limited time providers have to devote to implementation efforts. The Facilitation toolkit includes a description of the depression CCM program, local champion role description, implementation meeting guide and planner, clinic self-assessment (readiness) and fidelity tool, provider education presentations and information sheets, patient education and information sheets, and a customization tool. The external facilitator is responsible for training and clinical support, link to model developers, and providing technical assistance of barriers and facilitators. The internal facilitator is familiar with the local structure of the organization, works directly with site personnel, and helps integrate new program by aligning it with local priorities and new initiatives.

Questions for future research

Both REP and Facilitation implementation models emphasize the importance of local input and a guided roadmap for training and technical assistance. While REP emphasizes much of the important front-end work in packaging interventions for local use, the facilitation model provides a roadmap for ongoing provider engagement and articulates the two key roles of implementationists, when and how to engage providers, methods for adapting programs without compromising core elements. Additional questions for further research discussed by the audience included the following:

1. Is there an evidence-based process for distilling a program's core elements to facilitate its adoption/adaptation in routine care?
2. How can we make the business case for REP and Facilitation components, so that stakeholders understand the value added in program packaging, facilitator roles, etc?
3. How can REP and Facilitation models help providers see the value of implementation efforts (e.g., identifying how the implementation process can benefit providers beyond the program itself)?
4. How can the success of REP and Facilitation be measured?
5. Is implementation a linear process? Can implementation efforts be used to promote "practice-base" research that informs T1 and T2?