WHAT IF?* Implementation Facilitation Manual

*Working with HIV Clinics to adopt Addiction Treatment using Implementation Facilitation

Adapted by

E. Jennifer Edelman, M.D., M.H.S.

David A. Fiellin, M.D.

Text throughout this manual has been incorporated and adapted from:

The Implementation Facilitation Training Manual
Using External and Internal Facilitation to
Improve Care in the Veterans Health Administration
Version 1

Developed by: JoAnn E. Kirchner, MD, Mona Ritchie, MSW, PhD, Katherine Dollar, PhD, Patricia Gundlach, MSSW, and Jeffrey Smith, PhD

And:

Ritchie MJ, Dollar KM, Miller CJ, Oliver KA, Smith JL, Lindsay JA, Kirchner JE. Using Implementation Facilitation to Improve Care in the Veterans Health Administration (Version 2). Veterans Health Administration, Quality Enhancement Research Initiative (QUERI) for Team-Based Behavioral Health, 2017. Available at: https://www.queri.research.va.gov/tools/implementation/Facilitation-Manual.pdf

Users of this manual are expected to review the two manuals described above prior to using this manual to guide Implementation Facilitation

Understanding Implementation Facilitation

Implementation facilitation involves a purposeful set of individuals and processes designed to increase the adoption of specific evidence-based clinical activities. It is a multi-faceted process of enabling and supporting individuals, groups and organizations in their efforts to adopt and incorporate clinical innovations into routine practices.

Background on Implementation Facilitation:

Across healthcare, sustainable evidence-based practice implementation has emerged as a complex and challenging process. Effective implementation typically involves a focus on adopting multicomponent clinical innovations or programs tailored to individual settings, application of diverse implementation strategies to support adoption, and involvement of multiple stakeholders. Defined as a "process of 'helping individuals and teams to understand what they need to change and how they need to change it in order to apply evidence to practice,'" Implementation Facilitation is an effective intervention[1] that includes a "deliberate process of interactive problem solving and support that occurs in the context of a recognized need for improvement and supportive interpersonal relationship."[2] Implementation Facilitation has been used by large healthcare organizations including the Veterans Health Administration and Practice Facilitation is endorsed by the Agency for Health Care Research and Quality as a way to assist practices in becoming Primary Care Medical Homes.[3] A systematic review and meta-analysis found that Implementation (Practice) Facilitation has a positive impact on guideline adoption in primary care.[1] A central aspect of Implementation Facilitation includes the active role of the facilitator(s) working in partnership with relevant stakeholders, and other implementation components.[2,4] Implementation strategies that are tailored to a specific site have been found to be more effective than generic non-tailored interventions in changing practice[5] and have been applied to changing primary care and mental health treatment delivery.[6,7] Importantly, Implementation Facilitation begins with and uses ongoing "Formative Evaluation" to identify the specific and dynamic needs of stakeholders and the context (i.e. clinic) for the implementation of evidence-based practices.[4] A "diagnostic" formative evaluation informs the initial tailoring and refinement of the Implementation Facilitation, which includes the "bundle" of services[4] (Table 1) tailored to meet site-specific needs. The formative evaluation process is iterative and continues during the early implementation, implementation, evaluation and maintenance phases.[8]

This Implementation Facilitation is based on a manual developed by Kirchner and colleagues[7] that has had significant impact on implementing healthcare practices in clinical settings. Building on the mixed-methods analysis it uses the Promoting Action on Research Implementation in Health Services (PARiHS) framework to tailor the Implementation Facilitation for site-specific needs. The PARiHS framework proposes that successful implementation of research into practice is a function of the relation between the Evidence, Context and the Facilitation activities.[9] As described below, PARiHS is used to further explicate and design the Implementation Facilitation, guide the ongoing quantitative and qualitative aspects of the Formative Evaluation, and revise the strategy in an iterative manner to improve Facilitation success.

1. **Brief overview of facilitation in general and specific to WHAT IF?**
    a. Purpose of facilitation – The purpose of this facilitation is to help HIV clinics adopt effective screening and treatments for tobacco, alcohol, and opioid use disorders (addictive disorders).
    b. Origin - The tenets of facilitation arose from the education and health science disciplines and acknowledge the fact that, while research evidence supporting a practice is important, clinical experience and professional knowledge provide additional evidence that directly affects the adoption of a practice such as treatment for addictive disorders.
    c. Process - Facilitation is a multi-faceted process and involves helping rather than telling. It involves interactive problem solving and support. Establishing a partnership based on mutual respect with stakeholders at the HIV clinic is considered critical to successful facilitation activities. The idea is to create a supportive environment within which knowledge can be exchanged barriers to implementation of screening and treatment for tobacco, alcohol, and opioid use disorders are identified and processes to overcome those barriers developed.

d. “Facilitation Interventions” – Facilitation uses a “bundle” of integrated “components” outlined in Table 1.

Table 1. Components of a Facilitation

Component	Description
External Facilitator	Outside content and implementation expert who assists site
Internal Facilitator	Local site stakeholder(s) who promotes change
Provider Education and Academic Detailing	Provision of unbiased peer education
Stakeholder Engagement	Aligning goals of implementation and those impacted
Tailor Program to Site	Addressing site specific needs based on formative evaluation, problem identification and resolution, assistance with technical issues
Audit and Feedback	Assess implementation of screening and treatment efforts and inform site of results
Formative Evaluation	Quantitative and qualitative determination of impact
Learning Collaborative	Shared learning opportunities tailored to stakeholders
Program Marketing	Efforts designed to increase attention to availability of on-site addiction treatment services

e. Characteristics of a good External Facilitator
   i. Strong communication and interpersonal skills
   ii. Group/team management skills
   iii. Ability to rapidly assess the needs and resources of individuals, teams and organizations
   iv. Ability to identify and solve problems and help others do the same
   v. Ability to empathize and understand the needs of others
   vi. Ability to respond to stakeholder feedback and suggestions in a timely manner
   vii. Credibility with their audience
   viii. Provides positive feedback when organizations make even small movements
   ix. Provides negative feedback in an encouraging manner
   x. Strong teaching skills
   xi. Marketing skills
   xii. Political skills
   xiii. Ability to analyze and interpret data and teach that skill to stakeholders

2. **Facilitation roles**

a. External facilitators The External Facilitator(s) are individuals who do not work in the in the HIV clinic who are experts in implementation activities and Addiction Medicine. They provide a consistent presence during the implementation phase through site visits, conference calls and/or emails. They work with the Internal Facilitators (see below), also known as local champions, to promote implementation of the evidence-based clinical practice tailored to the clinic specific needs and applied as needed over the course of the implementation. External Facilitators are expected to be a content expert who possesses superior communication and interpersonal skills and flexibility who will provide training, coach and mentor local champions, and encourage the exchange of ideas within and among sites. Following an in-person meeting, the External Facilitator provides facilitation (email, phone calls, face-to-face meetings) which includes a monthly phone meeting. During these meetings and calls, information is captured on the challenges, barriers, facilitators and proposed strategies to address each is discussed. This information is integrated into the ongoing formative evaluation. Key responsibilities of the External Facilitator include:
   i. Understanding the setting – early in the facilitation process the External Facilitator will conduct a Formative Evaluation to understand the HIV clinic and work with key stakeholders to identify barriers to change and ways to overcome these barriers. It is important to understand the “context” and perspectives and experiences of stakeholders with regards to the “evidence” for the evidence-based practice as well as “facilitation”

opportunities and needs. The External Facilitator should look for facilitators of change and leverage these. This is an iterative process during which the External Facilitator must actively engage with stakeholders and observe the political climate (see glossary) of the organization, the unique characteristics of the setting and the culture (see glossary) of the organization. This includes understanding the organizational structure of the HIV clinic as well as organized team meetings (e.g. quality improvement meetings) and educational opportunities (e.g. Grand Rounds, journal club, noon conferences).

ii. Engaging stakeholders – creating an environment that supports practice change requires identification and engagement of key stakeholders among leadership, providers and support staff.

iii. Building relationships- building and maintaining relationships is a critical function, especially early, in the process of implementation facilitation.

iv. Setting program goals – It is important to work with each clinic to develop clinically-meaningful performance improvement goals to determine program success.

v. Providing evidence – Termed "Academic Detailing" (see below, glossary and https://www.narcad.org), External Facilitators are expected to provide a concise review of the research and clinical evidence that supports addiction screening and treatments and in particular, examples of how other HIV clinics have implemented such screening and treatments, patient or provider satisfaction with such implementations, efficiencies or organizational benefits. This most frequently occurs early in the implementation process and in the context of brief (~15 minutes in duration) 1:1 meetings between the external facilitator and providers. Using motivational interviewing skills, the external champion helps "move" providers in their readiness towards implementing the target evidence-based practice by providing insight into the importance of the clinical problem and key knowledge for addressing the problem. These visits, ideally, culminate in a commitment by providers to make a practice change and plan for follow-up.

vi. Developing processes to inform implementation – The External Facilitator helps sites identify their own data elements that allow them to monitor the implementation process and progress towards performance improvement goals. These will be used in the Audit and Feedback (see below) process and help the clinic assess the success of program implementation.

vii. Identifying barriers and strengths – using data gathered in the formative evaluation, the External Facilitator works directly with an Internal Facilitator to identify barriers to implementation and develop feasible solutions for the local context. Working with clinic personnel to identify problems and solutions, rather than directly telling them what to do.

viii. Envisioning Change - The facilitator should help the organization develop its own vision for change, program development, and implementation.

ix. Teaching, Training, Mentoring - Facilitators can provide implementation assistance to all relevant stakeholders through multiple mechanisms. The facilitator can provide education in formal meetings with larger groups or through one-on-one training. The facilitator should work to identify forums and opportunities for continued education, collaboration, and discussions among stakeholders. Forums might include monthly conference calls, weekly team meetings or quarterly educational seminars or trainings to foster growth. Early on, the facilitator identifies gaps in knowledge or skills and helps provide the needed training or resources through direct education or linkage with additional resources. For example, the facilitator may identify and arrange for a guest expert to present information. Through these forums, the Internal Facilitator not only continues to provide education and consultation but also establishes a forum for programmatic review.

x. Supporting change and reinforcing positive change - Creating momentum for change within the organization is one of the goals of implementation facilitation. The facilitator identifies and uses systems, leaders, disciplines, programs or groups that have an interest in the desired outcome to help propel the organization toward the desired

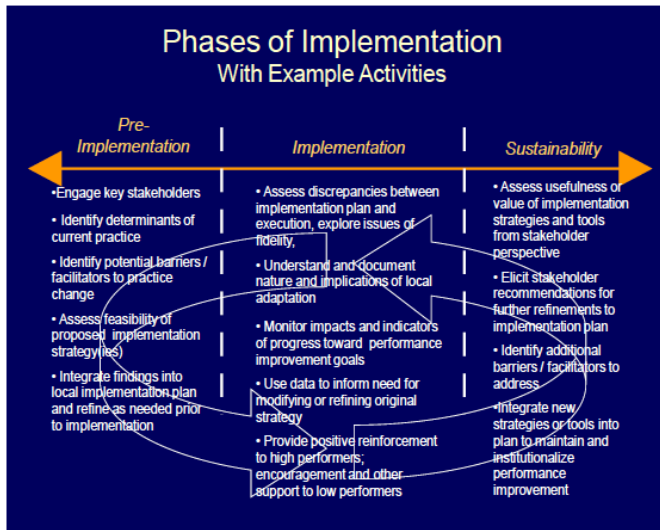
change. The facilitator fosters growth toward the desired change by communicating positive results across the organization.

xi. Linking to local and outside resources – The External Facilitator can serve as a link to local and national experts or resources when needed. Examples of local resources could include individuals with expertise in Addiction Medicine, Addiction Psychiatry, Psychiatry and Mental Health, Motivational Interviewing, Pharmacy or Smoking Cessation at the same institution who may or may not already be providing services in the HIV clinic. National resources include the Prescribers Clinical Support System for Medication Assisted Treatment https://pcssmat.org, https://careacttarget.org/ihip/buprenorphine, http://www.attcnetwork.org/home/, https://www.aidsetc.org/topic/substance-use-abuse, https://www.iasusa.org/content/opioid-agonist-treatment-considerations-hiv-infected-and-hivhcv-coinfected-patients, and others.

b. Internal Facilitators- The External Facilitator works with the local leaders to identify and engage Internal Facilitators, including physicians, clinic directors, pharmacy or nursing leads or local organizational re-design/quality improvement experts. These individuals, and their current level of involvement in the HIV clinic, will likely vary by site and substance. For instance, there may be a provider who is an Internal Facilitator for buprenorphine in the clinic but no one with training or knowledge around the use of medications and medication management for alcohol use disorders. If expertise is not present within the clinic, the team should work to identify potential local experts and facilitate their involvement (educationally and/or clinically) in the HIV clinic. This model has worked well in projects where Addiction Psychiatrists were brought on site in HIV clinics to provide care for unhealthy alcohol use.[10]

   i. The Internal Facilitator is someone who works in the HIV clinic and is committed to making a change in the way the clinic screens for and treats either tobacco, alcohol, or opioid use disorders. Notably, for WHAT IF? the Internal Facilitator should not be the site Principal Investigator. In addition, there can be separate Internal Facilitators used to help address each substance. The Internal Facilitator should be a local champion who understands the culture and unique characteristics of the clinic and the larger organization. They will assist the External Facilitator in overcoming obstacles for successful implementation and sustainability of addiction treatments in the HIV clinic.
   ii. The Internal Facilitator has insider information about the HIV clinic and how the system and current practices evolved.
   iii. Internal Facilitators can provide direct training and technical assistance to all relevant stakeholders. They work to identify forums that the clinical already conducts (weekly team meetings, monthly calls or educational meetings) and opportunities for education and collaboration.
   iv. Internal Facilitators should be a “visionary” change creator who reinforces positive change in the clinic. This person may also be someone who is already leading Quality Improvement initiatives in the clinic. Further, this person need not have specific training – for example, this person may be a physician, nurse practitioner, pharmacist, or counselor.

3. **Phases of Implementation Facilitation**
   a. **Pre-Implementation** - is a time period for designing a customized, local plan for implementing a clinical innovation and conducting other activities that need to occur PRIOR to implementation.
   b. **Implementation** - is the time period during which the local implementation plan is actually executed, monitored and refined to meet the performance or clinical goals defined during the pre-implementation phase.
   c. **Sustainability** - focuses on activities and strategies to ensure that performance or clinical goals are achieved, and changes in clinical structure or processes that produced that improvement persist over time.



Adapted from: Stetler, et al. (2006)[35]

4. **Stakeholder Engagement**

Stakeholder Engagement takes place at the administrative, provider, and patient level. Efforts at increasing engagement will be informed by the focus groups conducted during the initial Formative Evaluation and supported by the efforts of the Internal Facilitators. This work should be informed by the Normalization Process Model[11] whereby the External Facilitator works to make attention to tobacco, alcohol and opioid use disorders a routine focus of stakeholders (e.g. embedded) and processes are developed whereby practices such as routine screening and medication use are sustained and routinely monitored. The goal of stakeholder engagement is to align the efforts of the facilitation with the overarching goals (e.g. improved health, efficiency, cost) of those impacted by the facilitation efforts and the HIV clinic. The key processes that of stakeholder engagement include, (1) identify stakeholders, (2) Engage stakeholders as described below:

a. Identify
    i. Identify leadership at every level. This can include the medical director, the directors of nursing, pharmacy, social work, mental health, and education. In this process it can be useful to <u>ask for an organizational chart</u> for the clinic ahead of time or at the first Formative Evaluation meeting.
    ii. Identify front-line personnel (doers) who will help identify process steps and potential problems. These can include clinicians, nursing, clerical staff, and administrators.
    iii. Identify “centers of influence” who do not have an official title but serve as glue and hold everything together. Consider using a “snowball sampling” by asking stakeholders to name others who could be useful to the implementation.
    iv. Those with Information Technology specialty. This can be useful for access to data, changes to the EMR and educational (eg. Videoconferencing) activities.
b. Engage
    i. Engagement means creating relationships that stimulate action or system change through the work of the members of the HIV clinic.
        1. Engagement strategies
            a. Create an open, non-critical, non-judgmental and goal-oriented atmosphere
            b. Develop collaborative problem solving including a menu of options
            c. Provide positive reinforcement
    ii. Engage leadership at all phases of implementation
        1. Keep them updated on progress, data and impact of the facilitation. Ask them if there are any regular cycles (monthly, quarterly) of updates to which you can attach reports of the implementation.
        2. Invite leaders to any special events or meetings to lend their support – especially kickoff meetings or initial site visits. Be aware of the need to schedule such events well in advance.
    iii. Tailor each presentation to stakeholder type (e.g. administrators vs. clinicians)
    iv. “Roll with Resistance.” The use of a Motivational Interviewing (MI) approach may be useful for more actively engaging ambivalent stakeholders although use caution if this approach is resisted by a stakeholder who is trained in MI.
    v. Characterize major stakeholders as to their levels of engagement

1. Active, Semi-active, Passive, Non-engagement, Negative engagement

vi. Introducing Stakeholders to Facilitation – This can occur during site visit or via teleconference. Describe the roles of External and Internal Facilitators. Communicate the goals and timing and duration of the Facilitation.

vii. Special issues to be aware of:
1. Identify and address stakeholders with negative engagement
2. Anticipate and address stakeholder turnover

Conducting the Formative Evaluation

The facilitation will begin with an overall review of the site through a site formative evaluation, program implementation meetings and collection of qualitative data via focus groups and quantitative survey data including the Organizational Readiness to Change Assessment (ORCA)[12] and the Readiness Rulers.

Overview of Formative Evaluation

A three-stage formative evaluation will be conducted at each site using mixed-methods[13] (qualitative and quantitative) to identify evidence, context, and facilitation-related factors impacting the provision of addiction treatments and use these data to tailor, refine, monitor and evaluate the effectiveness of the Implementation Facilitation. Formative Evaluation is a widely accepted implementation assessment approach designed to identify influences on the development, progress and effectiveness of implementation efforts.[8] To increase use of addiction treatments, the Formative Evaluation will be used to understand: 1) current site-specific practices, 2) determinants of these practices, 3) barriers and facilitators to practice change, and 4) perspectives regarding Implementation Facilitation. The Formative Evaluation will be conducted in accordance with the PARiHS framework, and use a mixed-methods approach with 1) quantitative methods, using the Organizational Readiness to Change Assessment (ORCA)[12] and Readiness Rulers followed by 2) qualitative methods (focus groups, one on one interviews) to develop an understanding of evidence, context and facilitation-related factors impacting the provision of addiction treatments from the perspectives of diverse stakeholders including patients, nurses, social workers, physicians, pharmacists, addiction specialists, clinic administrators, and clinic directors.

Formative Evaluation will take place during three distinct phases of the Facilitation and serve different purposes as outlined below:

Diagnostic Formative Evaluation occurs at the beginning of the implementation in each site and is designed to enhance the likelihood of success in the HIV clinic and involves collecting data on potential influences such as (1) current practice with respect to screening and treatment of tobacco, alcohol and opioid use disorders, (2) determinants of current practices, (3) potential barriers and facilitators to practice change and implementation of Facilitation and (4) feasibility of Facilitation, including perceived utility of the project.[8]

Progress-focused Formative Evaluation monitors achievement of implementation goals and performance targets to identify blocked progress, allowing steps to be taken to optimize the intervention. It focuses on the discrepancies between the implementation plan and its operationalization. Examples of processes that will be examined include: 1) number and types of educational trainings attended by staff, 2) number of staff who view the audit and feedback reports, and 3) number of Internal Facilitators that attend facilitation meetings. Progress-focused Formative Evaluation meetings should focus on barriers and strategies to address identified barriers. Non-attendance of site participants will be documented and outreach through individual facilitation meetings, calls or emails will be initiated to assess for stalled progress and offer assistance.[8]

Interpretive Formative Evaluation uses the data collected from the prior Formative Evaluations and information collected at the end of the project regarding the participant experiences to clarify the meaning of successful or failed implementation and to enhance understanding of Implementation Facilitation's impact. At the conclusion of the maintenance phase (12 months), there will be an interpretive evaluation that will assess stakeholder views regarding (a) value of each addiction treatment, (b) satisfaction or

dissatisfaction with various aspects of Implementation Facilitation, (c) reasons for clinic level action or inaction, (d) additional barriers and facilitators, and (e) recommendations for further refinements. Information will also assess stakeholders' beliefs regarding Implementation Facilitation's success and overall "worth".[8]

Conducting the site Formative Evaluation

NB: It is useful to plan for initial full day site visit that includes tour of clinical space, focus group with clinic providers/staff and separately with patients, interview with medical director and review of EMR. Follow-up visits as needed to meet with additional leadership, staff.

5. **Assessing the site ahead of time -** Get to know some basic information about a site even before visiting. This includes descriptive information about: type, size, setting, population served, academic affiliation, organizational structure. In addition, structured assessments such as the ORCA and Readiness Rulers can be reviewed ahead of time. This process can also include obtaining data on the clinic population as it relates to HIV characteristics, prevalence of alcohol, opioid and tobacco use disorders and proportion of patients receiving counseling or medication-based treatment. Be cautious to understand the basic data elements that are provided to you and consider their validity.

    a. Review the organizational chart, staffing and names of key staff members to be sure that all important stakeholders are considered.
    b. Review all relevant measures of organizational performance such as clinic or provider report cards or quality assurance activities. This will help determine if some metrics such as proportion of patients who smoke or drink alcohol are already collected on a routine basis. Review of quality assurance activities for other diseases (e.g. HIV viral load, lipids and monitoring of LDL cholesterol) can help form the basis of adapting current models to tobacco, alcohol or opioid use disorder.
    c. How is data currently collected, presented and used for performance monitoring in the HIV clinic?
    d. Identify Information Technology's (IT) role in data collection and dissemination and how those resources may be used to assist in the facilitation.

Conducting the Facilitation

NB: These activities are designed to occur over the course of a 6-month period and include three full-day in person site visits with phone calls and email exchanges in between as needed. Interviews and focus groups conducted during the site visits are digitally recorded and transcribed. Combined with field notes, these transcripts are analyzed by a multidisciplinary team and are used to develop the tailored Implementation Facilitation by external champions in combination with internal champion and other key stakeholders (e.g. HIV clinic director). External Facilitators can provide some of these services in a "virtual" manner and so should consider the pros and cons of conducting some aspects of Facilitation onsite and some virtually.

The Facilitation should follow an **Implementation Planning Guide**. This guide should include all the required program elements including the target population, inclusion/exclusion criteria for the implementation, team composition, activities, services, barriers to look for and how to resolve them, monitoring activities, protocols and tools. The guide allows stakeholders to think through each step of implementing the program, identify who should take responsibility for each step and detect any unresolved action items.

6. **Mentor the Internal Facilitator**
   Attempt to identify and begin training and mentoring the Internal Facilitator early in the Facilitation process. This relationship should allow for the transfer of skills and knowledge to the Internal Facilitator so he/she can ultimately lead change efforts at the site. Meet with the Internal Facilitator regularly (weekly to every other week) to review implementation progress, discuss next steps, review major actions and identify additional strategies that may be helpful.

7. **Tailoring the program to each site**
   Tailoring the program to local site occurs as a result of the Formative Evaluations and is informed by local stakeholders and Internal Facilitators. For instance, certain sites may have already incorporated routine screening processes that need to be modified or supported. Similarly, there may be local resources in place for onsite provision of tobacco treatment or buprenorphine. The External Facilitator should work with the local stakeholder and champion to identify specific facilitators and barriers to the adoption of each of the target efforts and tailor a brief (less than one page) response plan to address each.

8. **Conducting program implementation meetings**
   a. Involve leadership AND front-line staff
   b. Give adequate lead time to allow for scheduling and to assure good attendance.
   c. Identify times of regularly-scheduled provider meetings and attempt to add WHAT IF? activities or trainings to these meetings.
   d. Create and use a pre-meeting checklist to ensure that everything you hope to accomplish during the meeting is addressed.
   e. Plan to write up notes based on the implementation meetings and organize according to the PARiHS framework for the target evidence-based practice.
   f. Sequence of meetings – note, these meetings can occur in one day or over a series of days:
      i. Entrance briefing – overview meeting with leadership and key stakeholders
         1. Goal is to engage leaders, provide an overview of the facilitation, establish rapport, support and convey to all stakeholders that leaders are invested in implementation.
         2. Consider a formal presentation describing the evidence base that supports addiction treatment in HIV clinics and outcome data describing how successful implementation may positively influence key outcomes in the HIV care continuum such as retention in treatment and undetectable viral load, as well as overall morbidity and mortality.
      ii. Program implementation meeting – focuses on designing an implementation that considers local needs, preferences and resources. If possible, provide a program implementation checklist.
      iii. Clinic tour – the EF and IF should tour clinic with staff to understand flow and space allocation.
      iv. Individual meetings – it is may be necessary to set up series of meetings with individual stakeholders as needed.
      v. Exit briefing – the primary audience is top-level leadership. The goal is an immediate is a summative overview of what was learned throughout the meetings and decide on potential action steps.
      vi. After meeting – the team should document specific decision and required actions on implementation checklist organized according to the PARiHS framework. It is useful to include specific time frames and assignments. The lead External Facilitator should get input, additions and modifications from all present prior to finalizing site report. The final report should be sent to all stakeholders.
      vii. Create a Site Visit Report according to the PARiHS framework for the target evidence-based practice
      viii. Follow up – This initial action plan should be monitored and revised throughout implementation.

Sample agenda for a first site implementation meeting

TIME	EVENT	ROOM
9:00-9:30	Entrance Briefing (Leadership)	M204
9:30-11:00	Program Implementation Meeting with Managers, Staff, and stakeholders	M204
11:00-11:30	Tour Facilities and Clinics	M204
11:30-1:00	Lunch and afternoon prep	M204
1:00-3:00	Individual meetings (Other Stakeholders; e.g.,)	M204
3:30	Exit Briefing	

9. **Tips for facilitating implementation meetings**
   a. Know the audience
   b. Focus purpose and goals
   c. Provide information
   d. Get stakeholder input
   e. Provide meeting structure
   f. Refocus group as needed
   g. Follow verbal and nonverbal cues
   h. Listen and reflect
   i. Ensure all stakeholders are heard
   j. Correct any misinformation
   k. Provide written documentation

10. **Stakeholder innovation education overview presentation** – this is typically the largest meeting of the day. It provides the opportunity to educate the broadest group of stakeholders about the clinical innovation and the facilitation process. It typically lasts 30-40 minutes and includes a formal didactic presentation (e.g. powerpoint). The goals are for stakeholders to understand:
    a. The basic components of screening and treatment for alcohol, tobacco, and opioid use disorders
    b. Why these are important
    c. What are the policy requirements
    d. How the interventions can improve care
    e. How/where this fits within the continuum of services already provided
    f. What is the supporting evidence
    g. Common implementation challenges or concerns
    h. Common facilitators or characteristics that support implementation
    i. How the Facilitation is and how it can help

11. **Provider Education -** Provider education will be provided by the External Facilitators and local content experts who will be primarily responsible for delivering interactive training sessions. Training strategies should be based on adult learning theory and include didactic presentations on the effectiveness and safety of addiction treatment and skill's based practice sessions. These sessions should focus on 1:1 and small group activities to promote the education of providers regarding the use of motivational interviewing, brief interventions, addiction counseling and medications. These should be frequent brief presentations at provider meetings, lectures with meals/refreshments and provide instructional handouts. All providers involved in the implementation will have dedicated educational sessions on addiction treatments specifically tailored to each provider's tasks based on the Diagnostic Formative Evaluation and potentially modify, remove or add strategies to enhance implementation. Provider Education should address practical issues such as efficient use of the electronic medical record, public, private and AIDS Drug Assistance Program payment for treatments, and patient monitoring strategies. Whenever possible, it is useful to share protocols for integration that have been developed for integration of buprenorphine and naltrexone at the other HIV clinics and elsewhere (e.g. PCSS-MAT).
12. **Academic Detailing** – Academic Detailing, https://www.narcad.org, includes a providing a concise review of research and clinical evidence that supports screening for a providing addiction treatment with key stakeholders. It is an educational service designed to better align practices with the scientific evidence and guidelines. One use of Academic Detailing is to highlight gaps between the evidence-based and actual practice and encourages uptake of the clinical practice. Typically, Academic Detailing involves brief one-on-one interactions between providers and either the External or Internal Facilitator. Academic Detailing includes briefly investigating the baseline knowledge and motivation for current practices and then provides clear behavioral objectives through the repetition of essential educational

messages and the provision of positive feedback for improved clinical practices. Academic Detailing, as part of either External Facilitation or Internal Facilitation, frequently occurs during the initial interactions with the site. Academic Detailing may also be used when presenting the program or practice to providers who may interact with the implementation effort. Trainings are available through NARCAD.

13. **Program Marketing** – The goal of marketing is to describe the benefits of the program to patients, providers, and the clinic. It is designed increase awareness and referrals to the new addiction treatment services, and increase the likelihood of appropriate referrals. Program Marketing should promote awareness among patients and providers in the clinics of the availability of on-site addiction treatment services. This will include dissemination of promotional materials such as "What if? Ask me!" buttons, flyers, pens, pads and sticky notes for all clinic staff. The goal of the marketing will be to promote appropriate evaluation and treatment of patients and address patient motivation. While the efficacy of addiction treatment is clear, most research is conducted on motivated patients seeking treatment for their addictive disorders. Research in HIV clinics and general medical settings demonstrates that patient motivation to address their addictive disorder is often very low, especially when their disorder is detected during a routine visit for a general medical condition.[10,14-17] This means that it is imperative for efforts to increase treatment of addictive disorders in HIV settings to address patient motivation. The "What if? Ask me!" slogan is designed to initiate a motivational discussion between patients and providers. The final marketing approach should be tailored to the needs of the stakeholders and include direct (e.g. "in-services" to discuss the treatment services and referral processes, flyers) and indirect (e.g. informal conversation) approaches. Program Marketing can also include a newsletter every six months to provide updates about the "What if?" program across the sites. Other aspects of Program Marketing that can be included are outlined below:
    a. Basic elements of marketing strategies
        i. Know the audience and what information is likely to capture attention
        ii. Decide if marketing will be direct, indirect or a combination of both
        iii. Marketing should be ongoing and monitored
    b. Marketing strategies
        i. Presentations to staff and providers
        ii. Stakeholder meetings and team huddles (brief, <5 minute, staff meetings)
        iii. Phone/conference calls
        iv. Web-based meetings
        v. Emails
        vi. Flyers
        vii. Newsletters
        viii. Data
        ix. Individual discussions

14. **Learning Collaborative** – The Learning Collaborative will give stakeholders the opportunity to share what they have learned with others in a manner that promotes understanding that "we learn from each other and help each other progress." The Learning Collaborative should be formed by inviting each of the sites' Internal Facilitators, and other key stakeholders, to participate in a monthly call to promote shared learning regarding issues promoting and hindering implementation of addiction treatment. The sites will be added to the Learning Collaborative in a sequential manor as they enter the Facilitation phase. The Internal Facilitator and key stakeholders will set the agenda and the calls will be facilitated by the lead External Facilitators and provide a dedicated time to discuss site-specific updates, challenges and possible solutions for implementation of addiction screening and treatment services. The External Facilitators will make resources, protocol templates, materials and presentations available through the New England HIV Implementation Science Network and other websites so they will be widely accessible.
    a. Other strategies that can be used include regular (e.g. monthly) conference calls with follow-up newsletters to discuss cases and share resources, e-mail listservs to share information or request input, or tele-video conferences.

b. It is useful from time to time to identify and highlight successful programs and persuade stakeholders to share implementation lessons with each other.

15. **Audit and Feedback**– monitoring in the form of periodic audits help identify areas for improvement and create action plans to address. To the extent possible, this should involve regular assessment of individual clinician performance and providing information about that performance.[7] The External Facilitator(s) will work with clinic directors and other members of the clinic team to identify the optimal outcomes to be tracked as well as how often and in what format feedback will be provided based on clinic and provider-level data. Some researchers and facilitators have used theoretical frameworks to guide the selection of metrics. The RE-AIM framework is one model that has been widely used for such purposes because it addresses issues related to real-world settings.[18] You can use data collected for each of the five RE-AIM dimensions (reach, effectiveness, adoption, implementation, and maintenance) to monitor implementation and assess the innovation's overall effect. Outcomes, broken down by condition (alcohol, tobacco, opioids) can include the number of screenings performed and/or prescriptions of addiction treatment medications provided or number of sessions of the counseling provided among those identified to be eligible for such treatment. If education is a barrier, the External and Internal Facilitator will work to provide additional training or educational booster sessions for sites with low implementation and those requesting such services.
    a. Audit and Feedback tools
        i. Direct observation
        ii. Program fidelity measures
        iii. Dashboards
        iv. Chart reviews
        v. Informal input from supervisors clinicians and clinical staff
    b. Supervising and mentoring program auditing efforts
        i. Ensure that new providers receive adequate training and support for competencies
        ii. Monitor program data and provider panel management metrics. Provide benchmarks and help individual provider set goals for program implementation.
        iii. Review individual provider metrics monthly if possible. Individual data can be presented in a de-identified fashion.
        iv. The External Facilitator, Internal Facilitator or local champion should conduct individual discussions with providers whose data consistently fails to demonstrate adequate implementation.
    c. Interface with primary clinician supervisors
        i. Throughout the process, the facilitation team, and especially the Internal Facilitator, must maintain consistent communication with the primary supervisor for many reasons. First, the supervisor must be aware of the specific goals for the program and be "on-board" for the specific training objectives. The supervisor is ultimately responsible for the program while the facilitation team members are expert consultants tasked with program implementation. Ultimately, it is the supervisor's program and staff. Thus, inform and obtain approval from the primary supervisor regarding any data monitoring and the nature and function of any contacts with staff.

16. **Other Quality Improvement Processes**
There are a number of important and effective Quality Improvement (QI) processes that can be incorporated into Facilitation. It is useful to be familiar with these and potentially use them if appropriate for the specific context in which you are working. Competency may require specific additional training or certification. Many of these processes may be being used at clinics for other initiatives, or have local champions in the processes (e.g. systems redesign champions); and it may be helpful to identify and partner with these initiatives and leaders.
    a. Lean Management[19]
    b. Six Sigma - https://www.hopkinsmedicine.org/armstrong_institute/training_services/workshops/lean_sigma_training/index.html

c. Spaghetti Diagrams
d. Plan-Do-Study-Act (PDSA) Cycle - http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx
e. NIATx - https://niatx.net/Home/Home.aspx

17. **Sustainability** – In addition to implementing, adapting and monitoring the intervention, it is important to engage in certain activities that can help the site assume responsibility for ensuring that the innovation is sustained over time.
    a. Assess site factors that may impact sustainability – these include relevant to the needs and mission of the organization, leadership factors, resource factors, training and education needs.
    b. Create a Sustainability Action Plan (SAP). The SAP can include the leader of an activity, the frequency with which monitoring will occur, the criteria for monitoring and the resources needed to complete each activity. The SAP can be written using SMART goals (Specific, Measurable, Attainable, Relevant, Time bound).
18. **Tracking –** Tracking Facilitation can help assess fidelity, dose, and cost, among other aspects of Facilitation. Specific domains to track include
    a. Date and time spent
    b. Event type
    c. Communication type (email, phone, video, face-to-face)
    d. Person or personnel type with whom the facilitator is interacting
    e. Facilitation activity

Glossary

Academic Detailing - Non-commercial prescriber education (academic detailing) removes the profit motive and replaces carefully crafted sales messages with objective, educational messages based on the most up-to-date and complete scientific evidence available. This approach represents an important service to prescribers because it helps them get the unbiased information they need to make the best possible prescribing decisions for their patients.

Climate - Concerns the effect of systems on individuals and groups and focuses on organizational members' perceptions of observable phenomena such as organizational practices and procedures.

(Learning) Climate
A climate in which: a) leaders express their own fallibility and need for team members' assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.

(Implementation) Climate
The absorptive capacity for change, shared receptivity of involved individuals to an intervention and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.

Culture - Norms, values, and basic assumptions of a given organization. Organizational culture concerns system evolution and involves an in depth exploration of underlying assumptions not readily apparent to outside observers.

Early Adopters
"Early adopters are a more integrated part of the local social system than are innovators. Whereas innovators are cosmopolites, early adopters are localites. This adopter category, more than any other, has the greatest degree of opinion leadership in most systems. Potential adopters look to early adopters for advice and information about an innovation. The early adopter is considered by many as 'the individual to check with' before adopting a new idea. This adopter category is generally sought by change agents as a local missionary for speeding the diffusion process. Because early adopters are not too far ahead of the average individual in innovativeness, they serve as a role model for many other members of a social system. Early adopters help trigger the critical mass when they adopt an innovation. The early adopter is respected by his or her peers, and is the embodiment of successful, discrete use of new ideas. The early adopter knows that to continue to earn this esteem of colleagues and to maintain a central position in the communication networks of the system, he or she must make judicious innovation-decisions. The early adopter decreases uncertainty about a new idea by adopting it, and then conveying a subjective evaluation of the innovation to near-peers through interpersonal networks. In one sense, early adopters put their stamp of approval on a new idea by adopting it."
-Diffusion of Innovations, Everett M. Rogers, fifth edition, page 283.

Organizational readiness to change assessment (ORCA)
Quantitative measure designed based on the PARiHS framework to assess context, evidence and facilitation related factors relevant for implementation of an evidence based practice.[12] It can be used for diagnosis (determining barriers/facilitators to implementation of evidence-based practice), prognosis (predict how a site will do in implementing an evidence-based practice), and evaluation (determining the impact of an implementation strategy).

Promoting Action on Research Implementation in Health Services (PARiHS)
An implementation science framework that highlights the roles of the "context", stakeholder perspectives on the "evidence" and the "facilitation" or process of helping as determining the success of implementation. This framework can be used to guide the formative evaluation.

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