Cyberseminar Transcript

Date: September 6, 2018

Series: QUERI Implementation Network Series

Session: QUERI Implementation Roadmap: Supporting More Rapid Innovation and Sustainability in a Learning Health Care System

Presenter: Nick Bowersox, PhD, ABPP; David Goodrich, EdD; Amy Kilbourne, PhD, MPH

*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at* [http://www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm](file:///C:\Users\Kathy\Desktop\VA%20trans%20-%20in%20process%20&%20DONE\l)

Molly: Good afternoon, ladies and gentlemen. This is Molly Kessner from CIDER and I’d like to welcome you to today’s HSR&D Cyberseminar presentation. Today’s session is part of our QUERI Implementation Roadmap, I’m sorry, QUERI Implementation Network Series, and today’s topic is QUERI Implementation Roadmap: Supporting More Rapid Innovation and Sustainability in a Learning Health Care System. We are going to get started in just about three minutes at the top of the hour. For our attendees, if you are looking for a copy of today’s slides, you can refer back to the reminder email you received about three hours ago and there’s a live hyperlink in that email from HSR&D Cyberseminar, or as you can see on your screen, there is a web address that you can type into your web browser and that will take you to a PDF version of today’s slides.

If you are looking to view live captions, we have those available. Again, you can refer back to your reminder email or you can use the live caption link that’s on your computer screen. Just type that in to your web browser and you will be taken to a page where you can view those. You can resize the caption page as well as your GoToWebinar page so they both fit on your monitor at once. I am streaming the audio through your computer so you can turn up your speakers or plug in a headset, or for the best audio connection, please call in to the GoToWebinar toll number listed at the bottom center of your screen.

If you lose audio through your computer speakers at any point in time, you can exit and rejoin the session, or as a I mentioned, for the best audio quality, call in to the toll number listed at the bottom center of your screen, and again, that information is also included in the reminder email you received about three hours ago.

If you would like to submit a question, you will need to do so in writing as all attendees' lines are muted. Please use the GoToWebinar control panel located on the right-hand side of your screen and down towards the bottom you’ll see a question section. Just click the arrow next to the word questions. That will expand the dialogue box. Simply type your question or comment in there and we will get to those at the end of the presentation in the order that they are received.

Just a quick reminder to our organizers and presenters to make sure your telephones are muted at this time. And if you need to collapse the control panel so that you can see the entire slide being presented, you can just use the orange arrow in the upper left-hand corner of the control panel. Just click that and it will minimize that to the side of your screen. If you need to re-expand it, just simply click the arrow again.

And with that, we are just about at the top of the hour, so before we get into the meat and bones of the presentation I am going to run a quick poll for our attendees. We would like to get an idea of who is joining us today. So for our attendees, as you can see on your screen, there is a poll question open. Please select the circle next to your answer. We would like to get an idea of what your primary role in VA is. We understand that you may wear many hats within with organization, but we would like to know your primary role. The answer options are: student/trainee or fellow, clinician, researcher, administrator, manager or policymaker. And if you are selecting other, please note that there will be a feedback survey at the end of the presentation and in that you will be able to select your specific job title if it appears there.

Looks like about 80% of our audience has responded, so at this point I’m going to close out the poll and share those results. So as you can see on your screen, 6% of our respondents selected student, trainee, or fellow; 8% selected clinician; 46% researcher; 26% administrator, manager, or policymaker; and 14% selected other. So thank you to those respondents. And at this time I am going to to turn it over to Dr. Amy Kilbourne, our Director for QUERI, and she will kick us off. Amy, are you ready to share your screen?

Dr. Amy Kilbourne: Yes, I am. Thank you. And welcome everyone and thank you, Molly, and thanks for everyone for attending, which I hope will be an informative session for us as much as for you. So that this point I will begin, mainly to present at this point the QUERI Implementation Roadmap: Supporting More Rapid Innovation, Implementation, and Sustainability in a Learning Health Care System. And I really want to give special thanks to Nick Bowersox, who is Director of the Center for Evaluation Implementation Resources under QUERI, and David Goodrich, who is an Implementation Scientist with the CEIR Center as well.

So what we want to talk about today was really to present this roadmap for the first time, but this was a team effort, and I really want to acknowledge the following folks on the slide here: Mark Bauer, Melissa Braganza, Austin Frakt, Isomi Miake-Lye, Steve Pizer, Ryan Vega from the Diffusion of Excellence Initiative, Todd Wagner, Becky Yano, and the Office of Research & Development Research-to-Real-World Workgroup which was commissioned by our Chief Research and Development Officer. And that’s something that I think is very significant because we’ve had Dr. Rachel Ramone as our creator for the past year and a half now and she has been absolutely excited and very much wanting to embrace the field of implementation science and see it grow throughout research. And this also prompted us to, in kind of a stressful way, as an opportunity to say, hey, we need to really update the roadmap for QUERI and to see how it could also inform what else is going on in research as well.

So we’re going to present a background of QUERI then and now, then go into the roadmap and then talk about some next steps. But I also want to leave some time at the end to get questions and comments. This is a work in progress, the roadmap. It is a work in progress, so I do want to acknowledge that we are still doing a lot of great work and I have to hand it to Nick and David particularly for their efforts in putting this together.

So QUERI then and now and why we needed to update the model of implementation science that QUERI is using, that’s what we’re calling the roadmap. So I think, we all know this, but it’s always important to just reiterate why we exist in QUERI and the Quality Enhancement Research Initiative and why it’s in the VA and why it’s often informative of what else is going on outside the VA. And I have to thank Mark Bower for this particular slide. I think it really captures what are the barriers to making a public health impact of the research we create. And the barriers are, in many respects, we design things that are not quite suited for the population. We have the barriers in terms of not everything that gets created through research actually is able to be implemented for various reasons. So it ends up really having a, sort of a, not only a slow rate of research adapting or adopting into practice, but also just most of research that does get generated will not end up being implemented in the first place. And closing that gap is going to be very important in terms of thinking about how we maximize the public health impact of our research investment.

So the QUERI Centers around 2014, really just did that mainly to be focused into these focused areas. And at the time that was a very important thing to do because during the time that QUERI assisted about, several years ago, there was a focus on improving Veteran health for top conditions that were essentially causing morbidity and mortality. And when QUERI was created back in 1998, the idea was to really think of it as helping the VA transform from hospital-based system to primary care-focused system. And at the time there was a lot of focus on practice guidelines for specific disease areas that would be implementable in primary care. So it’s this idea of having disease-focused centers that focused on implementation of these practice guidelines so that primary care providers would feel comfortable and be able to work and to implement best practices for these particular areas of disease.

We also, at that time, established the Evidence-Based Synthesis Program Centers as a means to actually identify some of these best practices for primarily disease-focused areas that could be, again, implemented in the primary care and other settings in VA. But as you know, things change. And we did have, at the time, a pipeline model where we always felt that things, life at that time was always linear. Right? You always think that, we always try to have a model that would make sense to us, but sometimes it can get a little simplistic after a while. But I do want to commend the fact that we had a framework at the time in QUERI, back in 2008, that really helped to move the field of implementation science forward. We had to start somewhere. We had to have a plan of going forward. And really, this idea of socializing the notion of what implementation research does and how it helps was important. And to do that in a form of a pipeline at the time was the most, really I think, the most practical way of doing it.

So really this idea was having identification of a research area, identify best practice, and then do, and a series of implementation studies that would be pilots of small-scale demonstrations to regional demonstration, I think still in many respects holds true today. This is a very logical way of approaching how you present your research and how many of our careers have developed. And the idea was that if we follow this path simply, we would get to our endpoint and have something implementable. But as you know, things can always happen and things get complicated and people get impatient. So I think in general, it was [unintelligible 10:16] at the time, but at the same time we also needed to challenge ourselves in accommodating some of these complexity factors that often occur in implementation science.

Molly: Amy, I’m sorry...

Dr. Amy Kilbourne: So...

Molly: ...to interrupt. I’m sorry to interrupt, Amy. I just wanted to remind you that we can see your cursor if you want to use that for a pointer. I know you have some very intricate charts coming up.

Dr. Amy Kilbourne: Oh, thank you so much. I’m glad someone is like teaching me how to use this whole program, so I really appreciate it. And so my apologies if the cursor was distracting if I was moving it around too much. So in any case, thank you. So I will try to use the cursor in my more complicated slides going forward.

So I think just to get back to the persistent research-to-practice gap, why we needed a better model, or a better working model, was we really found that research was not aligned with national and local policies or priorities at that time. And oftentimes we needed to identify things were just off the shelf and good enough for government work or good enough to be implemented and just essentially move on with the implementation process.

But we also were challenged by the fact that many effective treatments or practices were not designed with the frontline providers in mind. There was variation in organizational capacity or commitment to implement these best practices. Top-down implementation strategies often had short-term focus. And in addition to that, we also realized that we needed to have effective implementation strategies that empowered providers to innovate or own the process. This is actually really going to be a recurring theme here. And that’s because at the time I had a really interesting conversation with Carolyn Clancy a couple days ago, and she had reminded me that back in 1998 she was, at least part of the selection process of some of the first leadership of the QUERI program, and I think at one point she said that, what was really intriguing was that, I think, until recently QUERI had not really found a regular, sustainable opportunity to involve frontline providers on a day-to-day basis. I think there were pockets of our QUERI investigators doing that and doing that in spades. And they were doing that very well from the bottom up. But a systematic way of actually encouraging frontline provider input into the QUERI program was still elusive to us, even until now. And that's something that we’re hoping to change with this new framework.

And so in thinking about that, we actually have to think about implementation as an iterative process. It’s not always linear. And in doing so we also want to catch up with the growing and exploding field of implementation science and think about ways of moving from theory to practice in the world of implementation by thinking about, okay, what are specific implementation strategies which are defined as highly specified, theory-based methods that need to be both, not like specified more but tested and replicated as well. So these were reasons why we needed a new framework going forward.

So also the important aspect of this was we wanted to ensure that QUERI was responsive and relevant to national and local priorities, whether they be in VA or beyond. These are our current goals and impacts of the QUERI program. And they’re broken down into three main priority goals, in part because we found that we had this wonderful opportunity to be a national resource and to be essentially a rapid implementer of best practices and at the same time be a promoter and ambassador between the world of real-world practice and our researchers and be the knowledge translators, especially when it came to implementation science. And so our three main priority goals focused on: One, the more rapid deployment of effective practices in routine care using implementation strategies. Supporting the rigorous evaluation of national programs and increasingly national policies as well, which is a really intriguing area that QUERI has gotten into really since its reorganization and its focus in areas of national policy, such as the Veterans Choice Act. And then also the expert knowledge, having that expert knowledge available of implementation practices, and for operations leaders to learn how to scale up and spread effective practices.

And really we implement these priority goals thanks to our over 40 centers and programs out there. We’ve have 15 QUERI programs, which are our major program sites that do a lot of the implementation strategies and implement a lot of the effective practices. In one year alone, over 50 effective practices were implemented. More recently they’ve been spearheading in several VISNs, the VISN-partnered initiatives, which are really more focused on helping VISNs to implement effective practices and I’ll talk about that in a second.

Our evaluation team has really been the partnership we created where we’ve really had our key operational partners pay QUERI program leads to do evaluations of national priorities. Those are our partnered evaluation initiatives. And also increasingly thinking about ways in which we can enhance the overall methods of evaluation work, mainly through our third priority goal of promoting implementation dissemination science. And that’s really been spearheaded by our national network of QUERI Resource Centers or Evidence-Based Synthesis Program Centers, our Partnered Evidence-Based Policy Resource Center, and of course, our Center for Evaluation and Implementation Resources as well, who have been absolutely instrumental in sharing a lot of that knowledge to other VA entities that are playing in this similar space such as the Diffusion of Excellence Initiative, which has really generated a lot of buzz with frontline providers in its Shark Tank format. They’ve really come to us more and more for guidance on how to actually do the evaluations and the implementation as well.

So today we are very, very proud. We have over 40 QUERI Centers around the country. The map is a little small and complicated, in part because we just had too many to showcase in one. And I think that we just wanted to at least provide just a general lay of the land of where we are with the QUERI programs. This also doesn’t do justice to all the sites involved in a QUERI program or project. We have several sites that have been involved in QUERI programs across the country, and I think that that’s also a testament to the growing recognition by our local leadership and our VISN leadership about the importance of QUERI.

But I think in terms of thinking about our role in really bridging that gap between research and practice, I think it’s important to remember how we came to be but also what we can do to really push our thinking further. VA Central Office, or VACO, priorities often, they seem like they change a lot, but they often remain the same but with different words. They often focus on national management issues: access, budget, workforce. There are concerns of the overall management and policymakers.

QUERI programs, increasingly, in our partnered evaluations and our centers focus on specific care processes. Really our bread and butter is the clinical care process. We really have left a lot of these systems engineering thinking to our Veterans Engineering Resource Center and that’s great. They’re great partners. We tend to think about clinical interventions, adopting them in practice, and also thinking about what clinicians have to do in order to really make those changes in the context of organizational constraints.

I think where QUERI comes to particular relevance and where our central nature is, is really that bridge between the frontline provider, the needs of the frontline provider and the desires of managers and policymakers in terms of initiatives that the manager or policymaker level cannot be successful unless they work at the clinic level. So actually getting these things to work, implementation science, is really the focus area of our programs in QUERI and making those implementation lessons learned generalizable beyond just evidence-based practice A or B, in other words.

So QUERI does align, we try to align our national leadership priorities with local and provider engagement, and in doing so, providing that clinical level expertise and doing it in a way where we can really understand the perspectives of providers and empower them to do the right thing.

So just a recap, these are top priorities for VA currently. And it’s always important to sort of know what is the lay of the land and these haven’t really changed with the leadership transitions happening in the last couple years. Essentially we’ve had the issue around access to care, the consistence issue, for a long time. Modernizing our systems is fairly new and also a very significant trend happening, especially with the adoption of the new EHR. Promoting efficiency and timeliness are always going to be important areas. And suicide prevention being the clinical priority, or a major clinical priority, for VA is also a priority increasingly in the DoD as well, and so it also affords some opportunities for collaboration there.

So what I think in terms of what QUERI can do is, okay, figure out how do these priorities make sense at the clinic level. So we took this opportunity and actually asked our leadership, our local leadership, particularly our Chief Medical Officers and our Chiefs of Staff for nominations, and in addition our VISN Directors, to vote on selecting what they considered to be their top clinical priorities that were keeping them awake at night. And this was the result from a live voting we did almost a year ago and resulted in one of our latest requests for applications for VISN-level partnered implementation initiatives where QUERI investigators team up with a VISN lead and help them implement, scale up, and spread a best practice addressing a priority area, and then essentially benchmarking it to measures such as scale or other quality metrics.

So you can see that there are several ones that were at the top in terms of nominations. The ones that really stood out were implementing effective care coordination models, poor community care, and in part because community care is relatively, it's expanding rapidly in VA and relatively a challenging area in terms of care coordination between VA and non-VA services. Improving access to medication-assisted opioid use and pain treatment, another major area, and a key priority in the national circuits as well. And enhancing implementation of suicide prevention services, trying to sift through the different suicide prevention programs, which ones work for what types of populations and where, that was also another key area that was selected as well.

What was very curious about the Veterans integration, or VA Integrated Service Network Directors, VISN directors, was they were very much willing to narrow down to these top three priorities and they voted on these as the top three priorities. What was also curious is that they reserved the right to select which of these priorities they wanted to focus on when they got QUERI funding through a VISN Partnered Implementation Initiative so it gave them some flexibility as well. So that was a nice, interesting approach to giving them a slight menu option but having them reserve the right to select the ultimate priority they wanted to work on right away.

So one of the exciting things that came out of this increased engagement at the VISN level has been the inclusion of QUERI into the fiscal year 2019 VHA Performance Plan Goals. Every network director and every facility director has a performance plan that they have to achieve and they are given clear instructions on what makes them an excellent person versus outstanding and so forth. And so the medical center and network director performance plan goals now include requirements if you want to be an outstanding, ranked outstanding in your performance plan and your assessment. If they scale up and spread promising practices at several sites, and especially if those are best practices, identified as best practices, defined as treatments based on QUERI projects or interventions, best practices that QUERI projects have implemented, as well as those derived from research or Diffusion of Excellence Gold Status practices. So this very much was groundbreaking. Also I have to acknowledge Ryan Vega’s leadership and Diffusion of Excellence and the RAPID team and Joe Francis and others for making this happen.

And so we really wanted to make sure we had out funding aligned with the performance plan goals, which is why we really encourage the QUERI-VISN Partnered Implementation Initiative to enable our leaders in the field to achieve their performance plan goals. So very exciting and also it will be very interesting to see how this pans out across different VISNs and especially VISNs that haven’t had as much QUERI activity in the past.

I also want to think about different ways of how we thought about QUERI over the last couple years and especially as we’ve worked with different partners. This is a map really showing the different QUERI resources, mapped onto the Diffusion of Innovations. And we sort of put this together deliberately with our friends in Diffusion of Excellence because they had used this as their model, or their framework, for thinking about the scale up and spread of best practices that were identified by frontline providers, submitted in a diffusion portal, are selected as semi-finalists with help from QUERI subject matter experts, finalists going to the Shark Tank, and then, which happened just last week for I think the fourth round, very exciting, and then finally being able to say these are our Gold Status best practices. They oftentimes are clinical, sometimes they’re administrative focused, but really I think meant to address the five VA priority goals, and being able to say, okay these are ready. They have the street cred of the frontline provider, the gravitas of evidence, and then the ability of the leadership national support to be scaled up and spread nationally and how QUERI can really help with that process once they get to a point where they’re about to be nationally implemented.

But if you think about it, there’s really these four phases where QUERI can really be a key part in helping not only identify the innovators but really moving from the early adopters to early majority, using our implementation strategies or highly specified methods to move from early to late majority and then really making a case at the national policy level that this is our culture and our best practice going forward. And essentially, it’s been a very interesting dialogue and conversation with Diffusion of Excellence and thinking about ways in which we really are, in many respects, complementary to each other’s goals.

I’m going to give some examples of our QUERI, national network of QUERI programs implementation strategies that they have created and used in their particular programs. And I call out these in particular, in part because there’s published literature on these areas. That doesn’t mean that this is the universe of possible implementation strategies. But we’re getting into a point of implementation science in general where there’s a growing need and interest in comparing the effectiveness of implementation strategies across different settings and provider groups to see what would be more effective and for what situations. But if you think about some of the ones that are really focused a lot on front-end fidelity, thinking of the replicating effective programs or the audit and feedback in terms of extraction of local quality performance and providing that feedback to clinicians. Think about the ones that are trying to deal with more complex cultural issues, there’s the evidence-based quality improvement approach and facilitation approaches, which take more of an interpersonal and systematic process for really understanding and mitigating those barriers at the organizational and provider level.

And I think some emerging literature on the de-implementation or unlearning areas of implementation, so it’s not just about giving more and more things on a frontline provider’s plate but thinking about ways in which we can work with frontline providers to take something off their plate, that’s also a growing area of research. And that’s been spearheaded by at least one of our programs, and of course, some others doing research in this area as well.

So that’s where we are circa now, that we’ve had 15 QUERI programs. They’ve developed and one of their goals was that they were supposed to be having an implementation core that would operationalize the implementation strategies. And we ended up supplementing many of those programs to create training programs in those implementation strategies out of a need from VA leadership and Diffusion of Excellence initiative to train clinicians in implementation strategies. But we still felt that there needed to be an overall roadmap to showcase how to actually think about implementation in the context of scaling up and spreading a best practice or thinking about taking something off a provider’s plate. So it comes of our implementation roadmap and basically our labor of love for the past year, and also again I have a number of folks to thank in terms of putting this together.

So again, recapping some of the trends underscoring the need for an updated implementation roadmap for QUERI. So why now and why bother? I think, again, I want to really emphasize we’re at a point and juncture where QUERI has an opportunity to further empower and engage frontline providers and many of whom, not being implementation scientists themselves, really needed a process of thinking how do we think about implementing something from a research perspective that can be translated to the local, frontline provider level?

And it also was really something that has been called out more and more recently, in part because there’s this notion of healthcare becoming what they call a high-performing high-reliability healthcare system. And that’s essentially coming from the quality management literature where you think about having fewer, really getting down to zero mistakes and having an appreciation for complexity and a psychologically safe environment to improve quality. But it also had to be thinking about ways in which, well, how do you take innovations and get them into the hands of providers and getting them used? And that’s where the other thinking around learning healthcare system is so crucial to that because the learning healthcare system is always looking for ways to improve. And you need innovations that are tested, that are evaluated, that could help improve the system, and the way to think about that is through implementation science.

We also have been having increased demand of diversity of partnered implementation opportunities. So we’ve had more demand on QUERI expertise on how to implement. So we had to have a way of at least reducing the jargon and then improving our clear communication of what implementation is. And I think we’re not there yet. It’s always hard. We have a common language as researchers. And trying to sort of sometimes tell our family members around the dinner table what exactly we do every day at work is sometimes a challenge, but it’s a necessary challenge, and it’s often a balance between not wanting to oversimplify but at the same time wanting to really think clearly about what exactly we’re doing.

We also wanted to have a pragmatic and learning-focused emphasis area and also establish some common set of terms and principles like any other work that many of you have already done in terms of creating your own models and frameworks.

The guiding principles of the roadmap were that implementation is a multi-phase process and we borrowed a lot, we didn’t want to throw the idea of a pipeline out the window. So we took models that had really appreciated that implementation is dynamic and multi-phased and really adapted them. So we kept some notion of there is a progression happening that may not necessarily be a straight and narrow pipeline but certainly is something where you want to progress toward achieving that goal of sustainability. We also wanted to acknowledge that there is specificity and technical skills that are absolutely important for implementation. Thirdly, the learning healthcare system principles, psychological safety, and team-based learning are essential, and they're absolutely essential for the specific implementation strategies. And we borrowed a lot of this from work of Bruce Avolio and others who have really thought about transactional leadership and transformational leadership skills as the essential skills that provider leaders are using to help implement an evidence-based practice.

And obviously we wanted to address some multi-level barriers and solutions that many of our models that we often reference for many things have really done a great job of really pinpointing. Our job was really not to replicate those models. Our job was really to see how they can be applied in practice and in terms of communicating these to frontline providers. And finally, we wanted to make sure we had the rigorous evaluation methods as well.

So the roadmap components. We’ll be going through the roadmap in three phases and really talking about the pre-implementation phase, implementation, and sustainability. And in each phase there's actually three levels that need to be described and those include the support. Who is to support the uptake/sustainment of an evidence-based practice? So the who, the what, the active stakeholders. And then the how, which is really the optimize, or use of data in measurement to assess progress. The phases are iterative cycles, and really the idea is ongoing adjustments for optimal fit with the flexible application of the model.

So diving right in, this is really the notion of what we’re hoping to get at with the roadmap, just essentially not too complicated but comprehensive way of thinking about what do you do, how do you actually think about how to implement something into routine practice? So taking the pre-implementation phase first, there’s really three areas in which you want to first identify a problem and solution, and that’s just with anything, that really is our first phase of any pipeline to begin with, identifying not only the evidence-based practice but the core elements of the evidence-based practice. What are the active ingredients and what are some areas that might want to be opportunities for frontline providers to adapt and giving some space for frontline providers to adapt.

Engaging stakeholders in terms of thinking about involving frontline providers so that they have some stake and ownership in the process and maybe even a process of adapting an evidence-based practice as well, and then really developing your measures and data. So what do you want to essentially show? How do you want to measure success? What does success mean in terms of implementing an evidence-based practice?

So in addition to presenting the roadmap, we wanted to maybe present some thoughts behind each of the sections of the roadmap. And we’ll call these sort of our pearls of knowledge or pearls of thinking. The pre-implementation pearls here really include a couple insights that we’ve gotten as we’ve vetted this roadmap. One is the Evidence Based Synthesis Program systematic reviews has really been a wonderful resource for identifying the evidence-based practices and also identifying ways that they can be adapted. It’s also important to engage operations early and often and identify stable point people within the operations. And so sometimes you may have a wonderful dynamic leader, but he or she may end up being promoted further and further up the chain. And that’s always wonderful to keep those relationships, but having folks who are in the organization that are relatively, been there for a while and can be your institutional memory is absolutely crucial.

Assessing local capacity for change and variation over time is really the local part of thinking through. And then also identifying, I mentioned identifying the core elements of the evidence-based practice is crucial, but also identifying data sources including provider networks who could be wonderful resources for identifying issues at the beginning in terms of implementation and then what you would need to do to collect data at the beginning. So it’s that one opportunity where if you need to collect primary data on either the organizational factors, provider factors, or baseline metrics that one cannot get in any database whatsoever, that’s your time to think about these things.

So the second phase: implementation. That includes the idea of selecting the implementation strategies and thinking about ones that focus on transactional or quality achieving essentially performance of implementing an evidence-based practice as well as transformational, which is the idea of how you would motivate and inspire providers to do that. Wanting to disseminate the implementation plan, so not just keep it to yourself but be very clear about how this will be implemented. And then in addition to that, provide those support tools to the providers and managers of the implementation strategy so they, in turn, can also learn how to implement in many respects the expansion of the train-the-trainer model. Activate the implementation teams is very key here because you really want to be able to create a channel that you can get information not only from managers but from frontline providers.

And then, in terms of monitoring implementation progress, thinking again about conveying what the performance goals are, reporting progress continuously to stakeholders, and that includes facility directors and VISN directors, and really showcasing how you’re making that progress. And adjusting plans based on any feedback as well.

So some key pearls we’re discovering, and I think what I want to do for the sake of time was not really walk through some examples of how these components have been used in the implementation roadmap but just figured we'd kind of cut to the chase and get to the pearls of this. And this is based on the literature reviews we’ve done in which different implementation studies have used different facets of this roadmap. And so I think, really, operationalizing discrete implementation strategies is going to be key. And also being able to systematically track the tailoring of those implementation strategies, including leadership and organizational practices that foster learning climates and cultures is going to be very important as well.

One thing to mention, I mean oftentimes I hear, well, would it be better if we all were just transformational leaders? Transactional leadership is just about meeting the test, the performance. And I think in general you want a balance of both. You have to have both. Employees have to have a sense of what their expectations are, what their job is, and what their goals ought to be in terms of the expectations of their performance. At the same time, they need to also see the work that they do as above and beyond just the tasks at hand but how it really is something that they can own, that they can provide input to, they can be the experts on, and then they can be also the go-to person for some very significant things in their work unit. So it’s a balance between knowing what you're expected to do but also being motivated and inspired to do those things.

In addition, the idea of having good data and effective use of data would help foster learning and monitoring the clinical impact. So not only is it important to, we think as researchers we have to keep our data integrity and that’s important, but for QUERI being non-research and being able to fund quality improvement activities, the idea of having accessible data on performance improvement so you can also have these facilities and VISNs be able to monitor on their own their progress, that’s actually key. And that’s actually something that has come up in many of these SAIL sites is that the places that can do well with the VA quality metrics know internally where they need, their pain points are and where they need to improve because they do their own personal audits. They don’t wait until VA Central Office comes down on them with a ton of bricks and saying, hey, you need to improve your performance. People are constantly monitoring what’s going on and they’re getting the right data, that validated data to figure out what’s going on with, whether it be primary care workflows or mental health capacity or things like that.

So some resources in thinking about both implementation strategies and measuring include our Center for Evaluation Implementation Resources, and then most recently CEIR is also helping to coordinate the Diffusion of Excellent Initiative Implementation Strategies Learning Network, which are hub sites that are training individuals in implementation strategies.

So just one thing I also just want to point out too, this is a very interesting slide. I have to thank David for putting this one together, David Goodrich. And it’s really this idea of accountability being compatible with psychological safety. And again, the bottom line here is that you want to be in this learning zone. You want to have the ability to be honest in your work flow and that's key to implementation strategies that foster that psychological safety but also that foster that accountability. So you want to be able to really match and maximize both, and that’s where you end up getting the most learning and most inspiration opportunity.

So finally, with sustainability, I think in terms of handing it off is going to be the most important piece. The idea that, as implementation scientists, you can help guide people on how to implement, but you definitely want to teach others how to do it down the road and make sure that there is an owner of the implementation process so that it can be sustainable. And that’s part of the plan for spread and maintenance. You want to be able to monitor for changes in the implementation process and then also be able to understand fully the cost of maintaining the implementation of an evidence-based practice. Knowing full well that some implementation strategies, the more intensive ones, will probably need to scaled back and probably could be scaled back because they are not needed up front. But having said that, some implementation strategy or some components of implementation strategies would need to be remained in order to maintain a program in which the evidence-based practice is being implemented.

There’s also the important transition to ownership to other stakeholders. So at some point in time, once the implementation process is done, there’s going to need to be an owner and then planning and budgeting and resourcing that. And I think one signature example of that has been the facilitation implementation strategy and the ability of the Behavioral Health QUERI to use the implementation strategy for the Primary Care Mental Health Integration Program and then being able to pass that on to ownership and having the Office of Mental Health own some of the key processes of facilitation for other areas of promoting evidence-based practices in mental health. So again, really where you get that is ultimately with that strong relationship you'll have with those program offices and also with the VISNs who would be important maintainers of the implementation process as well.

And finally, thinking about ongoing evaluation and reflection and thinking about ways where you can have relatively easy-to-get data to monitor the sustainability of the evidence-based practice over time.

And to conclude on this sustainability front on this sustainability pearls, things we’ve learning from all of your experiences. Again, identifying the owners of the sustainability process, making a business case in terms of being able to say this is how much it will cost to maintain this evidence-based practice or program or policy. And involve policymakers so that you can be aware of a potential policy shift that would impact or be impacted by the continued implementation and sustainability of the evidence-based practice. And obviously linking, continuing to link it to local and national initiatives. So as priorities change, or at least the words of the priorities, or the words describing the priorities change, being able to update the description of what the evidence-based practice can do for you is going to be key.

I also thought that the high-reliability organization reference from AHRQ and Weick & Sutcliffe was, I think, a very key resource here as well. Because looking at that book which talked about how airlines and other industries are high-reliability organizations and how key aspects of those organizations can also be applied to healthcare is actually something that’s being talked a lot about in VA. Increasingly, this was played up in the Mission Act. That’s the new Choice Act law that got passed, among other things. But it’s also an important area for VA to become a high-reliability organization because the VA was put on the government accounting office high-risk list, which means that as an organization it was not so reliable. So this idea of promoting a culture in implementation science, and hopefully QUERI can help with this, where you have has a preoccupation with failure, not paranoia but essentially being, always trying to think a few steps ahead, reluctance to simplify, which is why we have, probably that's why we have a nine-part model here. Sensitivity to operations, deference to expertise, and commitment to resilience. These are all really important concepts, often hard to operationalize. What we hope to do is at least get some of those operationalized in this roadmap as well. And again, it’s a work in progress.

And in addition to that, I want to just reiterate the QUERI impact measures, and again, why sustainability is key. But this is how we measure our impact over time across all of our projects, particularly the sustainability piece around inspiring action and affecting change. Policies, practices shaped in response to your implementation work, being able to showcase that you’ve had more providers trained in an evidence-based practice, more Veterans receiving. Again, we do this for Veterans. We do this for the providers of Veterans. Our idea here and our goal here is, are we impacting Veteran care in long run?

So putting it all together. I’m going to spend the final part of the call just really talking a little bit about some key areas of thinking of how we’re really trying to organize ourselves to be most helpful to the field, the most helpful to you as we journey through this roadmap and improve upon it. So where is QUERI in a learning healthcare system? Well, I think one of the things that we’ve continuously evolving to do is to meet the needs of a changing VA. So we were at the front and center when we were asked to do some evaluations of the Choice Act in terms of looking at the initial impact of the Choice Act, which made people understood, well, that was when they first rolled out this idea of Veterans seeking care outside the VA. But the law, like the new Mission Act, which is the updated Choice Act law, it was also chock full of other things that needed to happen. And one of the things that they did was an independent assessment that recommended that VA identify and disseminate best practices for high-quality care. So it didn’t get that this larger issue of what are we doing to create a high-reliability organization, high-performing healthcare system by implementing best practices that improve Veteran health. And that then included as a theme of the Mission Act, which was just passed in 2018, which expands the Choice Act but also really focuses on quality standards as well. And that’s, again, some of the work that we’re trying to do in striving to create this is through our new partnerships or extended partnerships to help QUERI extend its reach and to engage locally, the Diffusion of Excellence being a great partnership, and also with, increasingly, our VISNs with the Partners Implantation Initiative.

This could not come at a better time, in part because QUERI sits in the Office and Research and Development in VA, which is being reorganized under a new Deputy Undersecretary for Discovery Education and Affiliate Networks, otherwise known as DEAN, which will put research, academic affiliations, the innovation ecosystem, and then also in addition to that, I think, the Center for Compassionate Innovation. But it’s going to be a very strong connection here with the innovation ecosystem and academic affiliations for QUERI to be in the same box on the course that’s going to really enhance our ongoing collaborations with the Diffusion of Excellence program as well.

So to steal a slide from Diffusion of Excellence, you’ll see that we really borrowed a lot of their ideas about empowering the frontline, minimizing negative variation, and fostering commitment to excellence, and having this idea of a cycle. And again, moving from a pipeline to a cycle, I have to thank Ryan for this slide, was really key for us in rethinking the QUERI roadmap.

So moving forward again, what do we mean by that? So we created this model that was based on the high-performing model where we wanted to think about what were QUERI’s strengths, the idea of pre-implementation, minimizing negative variation which is a core component of a high-reliability healthcare system. We can identify best practices, implement them, and evaluate them. And then we can also align and activate the system where we get the leadership support, provider and Veteran engagement, institutional commitment that’s done by all of our QUERI investigators in the field, and really being able to accelerated that adoption of evidence-based practices by prioritizing, discovering what works, validating it, scaling up and spreading and sustaining it. So in many respects, there’s really these three phases that we’ve described in our roadmap, the pre-implementation, implementation, and then sustainability are absolutely aligned with this idea of a learning healthcare system and high-reliability organization.

And then, finally, this is a busy, complicated slide and still subject to a lot of work. And I have to thank Steve at PEPReC for putting this together. But what this does is really tries to formulate a more formal way in which we can more rapidly respond to both Central Office and our local leadership in terms of getting our evidence-based practices off the academic shelf and into the hands of frontline providers to achieve national priorities.

So we think about that first phase, discovering that’s really our friends in research, creating the best practices, our Evidence-Based Synthesis Program. Validating and further implementing those evidence-based practices are done very robustly in our QUERI programs and supported by our methodologists from our HSR&D friends in the Health Economics Resource Center and VIREC. And our Partnered Evaluations Centers often are increasingly focused on the implementation of these best practices and to evaluate them in terms of how they are impacting national policies.

And then we have our Center for Evaluation and Implementation Resources doing time-sensitive consultation. Okay, we're scaling up and spreading, now what? Or how do we actually get to this point? So they actually are, in many respects, our immediate consultants available to a number of our high-level leadership folks who are interested in how can QUERI help?

And then finally, our PEPReC, Partnered Evidence-based Policy Resource Center is really the key here to really aligning the work that we’re doing with what is going on in terms of VA national policy, supporting development and evaluation of national policies from VA leaders using rigorous designs, but also being at the head of things in looking at ways in which new policies coming down the pipe can be maximized with QUERI implementation as well.

So I think I’ll stop there and I really, again, want to thank Nick and David for putting the roadmap together and for their help in really formulating a lot of the key ideas. I just want, I will leave up this slide so you have my contact information. On the slides that you will be provided, I just want to give you a sneak peek. This was done with a lot of literature work, especially thanks to David Goodrich. He provided some key references that will be available in the slide deck. I’m going through them very fast, but you can see that we stand on the shoulders of giants. I mean this is a lot of our key folks in the area of implementation science. We could not have developed this roadmap without their thinking. So thanks again, and I will welcome your questions or comments. Thank you.

Molly: Thank you very much, Amy. So while we wait for any, oh, can you actually put that back up and do slideshow mode? We’ll just keep that up during the Q&A.

Dr. Amy Kilbourne: Okay.

Molly: Perfect! Thank you. So for our attendees, I know many of you joined us after the top of the hour. To submit your questions or comments, please use the GoToWebinar control panel located on the right-hand side of your screen. Down towards the bottom, you’ll see a question section. Click the arrow next to the word questions. That will expand the dialogue box and you can then submit your question or comment there. And Amy, I’m sorry, did you, I was doing something on the back end. Did you get a chance to introduce David and Nick?

Dr. Amy Kilbourne: No, I have not actually. So I think I did very briefly at the beginning. I’d like to reintroduce them. Nick Bowersox and David Goodrich are part of CEIR, the Center for Evaluation and Implementation Resources. If they're online, if possible, if they want to say a few words that would be great. Nick? Or maybe unmute them actually?

Molly: Oh, I’m sorry. That is all me. Let me unmute him. There you go, Nick and David, you’re both unmuted.

Dr. Amy Kilbourne: Okay. Nick, if you want to introduce yourself or just say a few words, that would be great. Thanks.

Molly: Yeah, I think you might have, there we go.

Dr. Nick Bowersox: Great, now folks can hear me. Practice makes perfect, so I’m sure that the fourth time I’m doing this it will be good, with all the muting and so forth. Thank you, so yeah, as Amy said, I’m the Director of the QUERI CEIR Center, the Center for Evaluation and Implementation Resources. But basically what we do at our center is we serve as sort of the frontline resource for folks who want to get consultation on best practices when it comes to program evaluation, implementation, and spread of best practices. We work a lot with the Central Office organization, operational offices. And my personal background, I’m a clinical psychologist, and I’ve been in VA Central Office and QUERI for the last six years or so. So happy to work with any of you and very open to questions after this if you want to discuss particular projects or how CEIR might be able to support the work you do.

Dr. Amy Kilbourne: Great. Thanks Nick. David, you want to introduce yourself very quickly?

Dr. David Goodrich: Sure. I don’t want to ruin Q&A time. I’m David Goodrich. I’m an educational health psychologist. And my role with CEIR is really to be kind of a knowledge resource or boundary spanner to link you with either other researchers, operational partners, best practices and knowledge. And I’m happy to discuss any of the technical aspects of the roadmap because there’s quite a literature base or scientific evidence base underline it. So I’ll leave it there.

Dr. Amy Kilbourne: Thanks, David.

Molly: Excellent, thank you. So I think this presentations was just so comprehensive that no questions have come in yet. Maybe people need a little time to digest this. If you do have any comments, though, feel free to write those in as well. And we’ll give people another couple minutes to get those in.

Dr. Amy Kilbourne: I sure hope we didn’t shock all of you. That’s the only concern I have.

Molly: Well, I have had people write in asking about the slides. The slides that were available to the attendees this morning, they have been updated, so after the presentation I will be uploading the more current version that you saw during this live session. So those will be accessible. Two from now you will receive the follow-up email from HSR&D Cyberseminar, and in that email there will be a live hyperlink to the archive materials, which will include the most up-to-day slides. And we do have a few questions that are now coming in. Okay, the first one: How can we think of applying these concepts to specific QUERI programs work that is being done?

Dr. Amy Kilbourne: Yeah, I think that’s a great question. So for QUERI programs already launched where your, now the programs are all supposed to be implementing an evidence-based practice and at least one local one and then scaling up and spread a national one is really to maybe take stock of the implementation processes and strategies you’re using and see if the roadmap, actually it's also helpful for us, see if the roadmap makes sense to you. If there are things that might be missing or could be described more, or maybe we’ve oversimplified. That’s what we need to know. So I think, taking inventory of what you’ve done so far using the roadmap as a guide could be really helpful. In addition to that, it's thinking about ways in which, if you were to sort of take what you've done in terms of implementation in the project you’ve done with your QUERI programs already, and then you wanted to teach someone else how to implement the same evidence-based practices, what would be, the roadmap is really intended to help with that process as a way of having a frontline provider or a frontline clinical leader of other providers think about how to implement. So it also could be a guide in terms of how to actually teach others how to go through the implementation process.

Molly: Thank you for that reply. And David or Nick, if you have anything to add at any point in time, you can jump in as well. The next question a couple people asked: What did Amy think was going to be most shocking for us?

Dr. Amy Kilbourne: I love it! I don’t know. I think in general we, in QUERI we’ve moved quite fast in some respects. We’ve had to pivot very quickly in the changing VA. And I think in many respects I was mostly concerned that it was not going to be looking like the original pipeline. And that was one of the issues was it’s more of a box, although we tried to put in some cyclical type models to help embellish on the box. But in general I think, what we hoped to do, and I have to really thank our CEIR folks really leading this process, we wanted this to be comprehensive but also understandable. So I was probably just, much of my willingness and openness to take critique as much as questions on the model. So it is a work in progress still and in many respects we’re looking for the experts, all of you in the field, to help us figure out how to explain things better or maybe frame things a little differently and so forth. So that’s probably what I meant.

Molly: Thank you. All right, the questions are just streaming in now, so we will get right to them. Thanks for presenting the roadmap, which was very clear. Are there recommendations on whether to start implementation and evaluation of a new intervention to address top priorities at the VISN level or national level to start?

Dr. Amy Kilbourne: I think that’s really good question. I think that what we’re seeing in the field is a shift to more focus on VISN-level priorities. And I think that it’s important to distinguish that there are going to be some global priorities that the VA is articulating and that’s what it did with its five priorities. Having said that, that they actually, it gets back to where QUERI can be helpful, which is we try to make the national priorities and policies work at the clinic level. So I think the most crucial aspects of how we can contribute as implementation people is to help, is really to support our local and regional leadership to be able to select best practices, get them used, get frontline provider input, have them essentially used with fidelity, and to have them sustained. And that’s what the roadmap is really intended for that local/regional aspect.

In terms of funding, if you’re a QUERI investigator or if you’re interested in getting QUERI funding, we still will have a mixture of both national and local/regional funding opportunities, which is why we put out the VISN Partnered Implementation Initiative. We felt that there was a missing piece there and we wanted to really have the regional groups have an opportunity to work with QUERI.

The other thing, too, and this is a kind of an important distinction is that there is going to be a push to more regional decision-making about healthcare in the community care under the Mission Act. So the Veteran’s Choice Act was the beginning. The Mission Act is really the law of the land now for VA in terms of, what the VA is saying is that it’s wanting to think about some key foundational services, but a lot of decision making is being pushed down to local levels, especially about buying [unintelligible 1:01:19] purchasing community care, aspects of specialty care, and so forth. And I think we’re absolutely going to need QUERI expertise in thinking about some of those decisions.

Molly: Thank you. Do you know of cost studies that have outlined the ongoing costs of implementation support in the sustainability stage?

Dr. Amy Kilbourne: That’s a really good question. Not offhand. I know that Todd Wagner and others at HERC have also worked in this space and there may be others as well. It’s also a relatively unexplored area outside of VA in terms of what we’ve seen with funded research. But there may be some other emerging research coming out. And I’d welcome if folks want to email me if they know otherwise, I’d love to just get a bibliography of some studies.

Dr. David Goodrich: Amy, could I add to that?

Dr. Amy Kilbourne: Yeah, please. Yeah, I was going to call you.

Dr. David Goodrich: Just to draw people’s attention to that fact about cost effectiveness, when we’re doing partnered research, operations is very much oriented towards the cost and the impact. And you’ll note in the roadmap there’s a really strong emphasis on specifying discrete implementation strategies so that we can cost them with the help of HERC and PEPReC. And I’m speaking as a CEIR resource employee, but also that we can compare the effectiveness of these strategies over time and across context. That’s very important from a scientific perspective. And so you’re going to hear that coming over and over again as we develop new products and resources to support people, researchers in this field, to be able to cost and track implementation strategies.

Dr. Amy Kilbourne: Thanks David.

Dr. Nick Bowersox: And to add to that just a bit. I know we’re pretty much out of time. From what I’m seeing, this is the expectation for new applications and new projects that are looking at implementation science. So even if that data is not available based on past work, I imagine it's being collected pretty quickly. So hopefully we will have that kind of information pretty soon.

Dr. Amy Kilbourne: Thanks Nick.

Molly: Thank you all. We do just have one last question. Can we get to that or do we need to get off?

Dr. Amy Kilbourne: Sure.

Molly: All right, okay. If any of our attendees are dropping off at the top of the hour, once you exit the session, please wait while the feedback survey populates on your screen. It’s just a few questions. It won’t take much time, but we look very closely at your responses and it helps us to improve the program. And the last question: Is development of implementation/adaptation guides one good way to achieve the goals of the roadmap?

Dr. Amy Kilbourne: I love the idea! I think that’s a great thing we should do is being able to develop a guide. I think that might be something we can work on once we hammer out the details and get the manuscript out for the implementation roadmap paper. So it will be on our list of actually having a guide. Our first test of also operationalizing the roadmap as a guide will be in next month’s Diffusion of Excellence QUERI Basecamp, which will be for first time, essentially starting to teach or provide guidance on implementation strategies for the Gold Status Fellows who were selected via the Shark Tank and Diffusion of Excellence. So that will be a great opportunity for us to start operationalizing some of this thinking and being able to share with others how to do it. So great idea, thank you!

Molly: Thank you. Well, that does wrap up with questions, but I’d like to give you the opportunity to make any concluding comments you’d like to. So in no particular order, Amy we’ll just start with you.

Dr. Amy Kilbourne: Sure. I just want to thank Nick and David for their efforts in putting together this roadmap and the others who have contributed to this effort. And I want to thank all of you for your questions and your participation.

Molly: Nick or David, did you want to add anything?

Dr. Nick Bowersox: Just a quick question. I think Amy made this really clear, but we’re very open to feedback about this. So if, as you take a look at this, you have ideas or questions, please don’t hesitate to reach out because we want this to be as useful and accurate and applied as possible, so feedback from the field is very welcome.

Molly: David, do you want to add anything?

Dr. David Goodrich: I’ll just end on a plug for the middle column of the roadmap. We’re focusing a lot more on the behavioral change strategies for changing provider and organizational behavior. And I just want to put a plug in for the November 7th Cyberseminar. It’s jointly supported by RAPID, NCOD, and QUERI, and the featured speaker will be Amy Edmondson, who will be talking about how to work with middle managers and leaders to create a psychologically safe environment for innovation and learning.

Dr. Amy Kilbourne: Awesome. Thank you.

Molly: Well, thank you very much. And for our attendees, you will see that announcement as well as all the other sessions for next month right around the 15th. So thank you so much to Dr. Kilbourne and to Dr. Bowersox and to David Goodrich that might be a doctor as well. And thank you to our attendees for joining us.

Dr. Amy Kilbourne: Dr. Goodrich, yes.

Molly: Okay, thank you. I was getting a little confused. So thank you all very much for joining us. For our attendees, I am going to close out the session. Please fill out the feedback survey as it comes up on your screen. Have a great day, everyone!

[ END OF AUDIO ]