

## The NCCTS Learning Collaborative Model for the Adoption & Implementation of Evidence-Based Mental Health Treatment

### NCCTS GUIDELINES FOR CONDUCTING A LEARNING COLLABORATIVE<sup>®</sup>

A large gap exists between best practices for mental health treatment and what is practiced in many community agencies. There has been much progress in the development of efficacious treatments for child trauma. However, the dissemination of these evidence-based practices (EBPs) to community settings has proved challenging. Traditional didactic clinical trainings focused on developing therapists' skill and knowledge about a practice do not effectively translate EBPs into standard agency practice. Barriers to the adoption of EBPs in community settings include inadequate training and supervision, limited resources, wariness of change, and the challenges inherent in transforming organizational policies, procedures and complex systems. The *NCCTS Learning Collaborative Model for the Adoption & Implementation of Evidence-Based Mental Health Treatment* is designed to address these barriers using an adaptation of a well-regarded methodology for disseminating practice improvements in healthcare.

#### Topic Selection

*The learning collaborative model was adapted from Breakthrough Series Collaborative<sup>1</sup> (BSC), a quality improvement methodology designed to disseminate best practices across multiple settings. The topic selected for a learning collaborative should target closing the gap between best practice and usual practice.*

**A. Topic:** Practice that is the focus of the learning collaborative is an empirically based intervention (i.e. evidence-based or evidence-informed practice) that has not been broadly implemented in the target population and addresses an unmet need.

#### Model for Improvement

*The Model for Improvement<sup>2</sup>, a framework designed to accelerate improvements needed to adopt best practices, is integral to both the BSC and learning collaboratives. Key components include a) setting aims, b) establishing measures and c) selecting and systematically testing changes. Applications of each component in the learning collaborative model are outlined below.*

**B. Collaborative Goals Framework:** A Collaborative Goals Framework (CGF), also referred to as a Change Package, specifies the collaborative mission and goals and provides guidelines for achieving the mission and goals. The CGF provides a “roadmap” for how to implement the practice with fidelity and sustain it.<sup>3</sup>

1. CGF is developed by a panel of experts (“expert panel”) who convene in person or via distance-learning technology.

<sup>1</sup> Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Author.

<sup>2</sup> Langlely, G. J., Nolan, K. M., Nolan, T. W., Norman, C. L., Provost, L. P. (1996). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass Publishers.

<sup>3</sup>An existing CGF may be adopted where developed in a manner consistent with the guidelines specified above.

2. Expert panel is representative of the types of individuals who will be involved in or impacted by implementation of the practice including agency staff in various roles (e.g. administrators, clinicians), community partners and consumers.
3. Expert panel also includes professionals with a) expertise in the intervention (e.g. treatment developers), b) experience implementing the intervention in settings comparable to those targeted for the collaborative and c) expertise in implementation science and/or prior experience with the learning collaborative model.
4. CGF a) states the collaborative mission, b) specifies measurable goals and c) provides guidelines for how to achieve the collaborative mission and each goal.

**C. Monthly Improvement Metrics:** Simple measures or “metrics” are used to track progress toward the collaborative mission and goals. Although these data can sometimes be used for other purposes (e.g. evaluation), monthly metrics should first and foremost serve as a tool to guide participating organizations’ efforts to adopt the intervention. This section focuses on metrics development, collection, and distribution; use of metrics is discussed elsewhere.

1. Leadership team (see below) includes an improvement advisor or other individual(s) with experience developing and applying metrics.
2. Expectations for use of metrics are clearly communicated to faculty.
3. Expectations for full and consistent participation in metrics a) are clearly communicated to interested organizations and b) agreed to by those accepted into the collaborative.
4. Metrics follow directly from the collaborative mission and goals including one or more indicators of a) use of the intervention, b) supervisory capacity and c) skill or fidelity.
5. Metrics are likely to be responsive to change in the short-term (i.e. able to track progress from month-to-month).
6. Forms and procedures for collecting metrics are designed with an eye toward minimizing burden on collaborative participants, with leadership team (see below) initially assuming responsibility for collecting and computing metrics.
7. Metrics are distributed to participating organizations each month in a format this is easily understood. Metrics are typically displayed as time series graphs referred to as “run charts.”
8. For the collaborative’s second face-to-face meeting and bi-monthly thereafter, information gathered for the metrics is compiled into a brief report that summarizes progress toward the collaborative mission and goals across participating organizations.

**D. Small Tests of Change:** Organizations participating in a learning collaborative use a scientific method—Plan-Do-Study-Act cycles, also referred to as small tests of change (STOCs), to address barriers and quickly make improvements necessary to realize the collaborative goals. This section focuses on basic requirements for successfully incorporating the STOC method; application of STOCs is discussed in subsequent sections.

1. Leadership team (see below) includes an improvement advisor or other individual(s) with experience coaching organizations in use of STOCs or comparable method(s).
2. Expectations for use of the STOC method are clearly communicated to faculty.
3. Expectations for use of the STOC method are clearly communicated to interested organizations (e.g. in the collaborative application).
4. Prior to the time STOCs are introduced to the collaborative, faculty are offered training in and demonstrate basic competency in the STOC method (e.g. understand key elements of a STOC, know the difference between a STOC and a task).

## Leadership Team & Collaborative Teams

**E. Leadership Team:** A collaborative leadership team is selected to design and implement the learning collaborative. The leadership team includes teaching faculty and staff responsible for coordinating and executing collaborative activities. Where appropriate, team members can serve in multiple roles.

1. Leadership team operates using a team-based rather than a traditional/hierarchical organizational structure (e.g. key activities are not consistently planned by one or two individuals and presented to the group, but rather planned as a group).
2. The faculty includes professionals with a) expertise in the intervention (e.g. treatment developers, trainers), b) experience delivering the intervention in comparable settings to those targeted for the collaborative, c) experience in key roles necessary to implement and sustain the practice, including agency leadership and d) expertise in implementation science and/or prior experience with the learning collaborative model.
3. Faculty commit to attending collaborative meetings (see Section H “Learning Sessions”) and facilitating regular conference calls (see Section I “Action Periods”).
4. Leadership team includes an improvement advisor, project manager, and trainer to plan, coordinate and execute collaborative activities (e.g. metrics and evaluation activities, instructional materials and agendas for collaborative meetings and conference calls, meeting logistics).

**F. Collaborative Teams:** Teams of individuals from multiple organizations apply and are selected to participate in the collaborative.

1. Teams voluntarily choose to participate in the collaborative. Mandated participation for organizations or individual team members is discouraged given the demands and collaborative nature of the experience.
2. Teams complete a written application that describes the collaborative and specifies expectations for participation (e.g. team composition, data collection for metrics and other required activities.) Teams agree in writing to fully meet these expectations, documenting any exceptions.
3. Teams are broadly representative of organizational roles and functions necessary to implement the intervention with fidelity and sustain it including a) senior leadership in the organization (“senior leaders”), b) clinical supervisors and c) clinicians. Inclusion of community partners and consumers (e.g. as consulting team members) is also encouraged.
4. Leadership team reviews completed applications and selects 5-12 teams, with a minimum of 25 participants, to join the collaborative.<sup>4</sup>

## Collaborative Pre-Work, Learning Sessions & Action Periods

**G. Pre-work Phase:** Pre-work activities are conducted prior to Learning Session 1 (first face-to-face meeting) in an effort to ensure that all teams are adequately prepared for full participation in the collaborative.

1. Team members complete assignments designed by faculty to ensure that all have adequate exposure to the intervention prior to Learning Session 1 (e.g. read book chapters or articles, review instructional videotapes or online course material.)
2. Teams meet to complete an assessment of organizational readiness and capacity.

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<sup>4</sup> Conducting a collaborative with fewer than five teams typically does not allow adequate opportunities for cross-team sharing; larger initiatives may be feasible with experienced faculty and appropriate resources.

3. Teams participate in pre-work conference calls. Calls have a structured agenda and include activities and information designed to facilitate teams' readiness to begin implementing the intervention shortly after Learning Session 1.
4. Team members are introduced to the collaborative intranet.

**H. Learning Sessions:** Teams and faculty meet for three two-day “learning sessions” (face-to-face meetings) over a period of 9 to 12 months. (Adaptations can be considered with a suitable rationale.)

#### **General Guidelines**

1. *Developing clinical and implementation competence.* Learning sessions address both a) the development of clinical competence necessary to skillfully deliver the intervention with fidelity and b) the development of implementation competence necessary to broadly provide, adapt and sustain it. At Learning Session 1, more time is allocated to clinical skill-building, with the emphasis on implementation competence increasing over the course of the collaborative.
2. *Applying adult learning principles.* Learning sessions emphasize interactive, participatory learning techniques modeled on adult learning principles. For example, skill building activities are utilized to teach intervention components rather than relying mainly on didactic presentations by trainers.
3. *Fostering sustainability by empowering learners.* Execution of the learning sessions is a participatory process intended to empower teams to sustain and spread the intervention. Team members' knowledge and observations are highlighted from the start, with members given increasing responsibility for providing the content for learning sessions (e.g. facilitating activities, presenting practice innovations) over the course of the collaborative.
4. *Modeling continuous improvement.* The design of learning sessions is fluid and responsive to team members' feedback and evolving needs. For example, agendas are shaped by evaluations completed by participants at the end of each learning session, feedback from conference calls, reviews of the collaborative metrics and teams' requests.
5. *Building effective teams.* Teams are given opportunities to meet together at each of the learning sessions for purposes of team building and to provide time and structure for addressing barriers to skillful implementation of the intervention and for sustainability planning.
6. *Promoting collaboration across teams.* The design of learning sessions promotes engagement and collaboration across teams to accelerate progress. For example, rather than remaining seated with their teams, participants are expected to move to different tables for activities. Additionally, participants in comparable roles at different organizations are given opportunities to meet with their “affinity group” to share information and address common challenges.
7. *Engaging senior leaders.* Support from an organization's leadership is critical to the successful adoption of a new practice; therefore, learning sessions are designed to actively engage senior leaders in the task of implementing and sustaining the intervention. Where practicable and appropriate a senior leader track is offered at each of the learning sessions, with senior leader participation in Learning Session 2 considered a priority.
8. *Encouraging self-care to sustain providers and best practice.* Learning sessions address self-care, burn-out, and/or secondary trauma, with materials, presentations, and/or activities. Potential benefit to the organization of supporting self-care (e.g. in reducing staff-turnover and associated costs) is discussed with senior leaders.

## Individual Learning Sessions

*Below are key guidelines and objectives for each of the learning sessions; emphasis is on session-specific information, assuming attention to general guidelines (above.)*

### 9. Learning Session 1

- a) Activity that encourages participants to communicate information about them and their organization and allows for cross-team sharing is offered early in the learning session (e.g. storyboard presentations by each team).
- b) In-depth exposure to the intervention is provided including multiple opportunities for skill practice.
- c) Administration and use of clinical assessments and the relationship between assessment and evidence-based practice is addressed.
- d) Overview of the learning collaborative methodology is provided.
- e) The collaborative metrics are explained including rationale, metrics forms, data collection procedures and feedback mechanisms. Emphasis is on use of measurement for improving practice (e.g. rather than for research).
- f) Expectations for the “action period” between Learning Sessions 1 and 2 are clearly communicated (e.g. schedule of conference calls is reviewed).

### 10. Learning Session 2

- a) Provides training in both clinical competence and implementation competence, with minimum of 40% of the session addressing implementation competence.
- b) Structure is provided for different groupings of participants to work together throughout the two days to maximize solution and innovation sharing. Faculty showcase participants’ successes and emphasize “stealing shamelessly” and “sharing relentlessly” to accelerate implementation.
- c) Clinically competent delivery of the intervention is emphasized through skill practice. Agenda has a) participants demonstrating skills and/or giving feedback to others and b) faculty coaching in small groups to address treatment fidelity.
- d) Small tests of change (STOCs) are introduced as a tool to accelerate progress toward the collaborative goals. Participants are given opportunities to develop a STOC with their affinity group and with their team.
- e) Metrics are actively used to assess progress toward the collaborative goals, inform STOCs, and support cross-team sharing of solutions (e.g. by pointing to early successes in the metrics progress report.) Faculty coach teams in the use of metrics to identify implementation challenges and craft STOCs to address these.
- f) Senior leader track is offered to promote collaboration and implementation competence among agency leadership (e.g. role of senior leader, use of metrics and STOCs in team meetings).
- g) Expectations for the “action period” between Learning Sessions 2 and 3 are clearly communicated (e.g. regarding number of clients seen by final learning session, posting of STOCs).

### 11. Learning Session 3

- a) Both clinical and implementation competence addressed, with minimum of 60% of the session addressing implementation competence including adapting, sustaining and spreading the intervention.
- b) Metrics are used to inform the agenda (e.g. ascertain clinical competencies that merit additional attention, identify potential presenters) as well as in the learning session

(e.g. to highlight progress toward the collaborative goals and help teams target areas that still need improvement).

- c) Structure is provided for teams to present practice innovations and improvements (e.g. an adaptation of an intervention component for a specific population, tools for engaging families).
- d) Participants are provided opportunities to demonstrate competencies, by leading or co-leading presentations or activities in which they have expertise.
- e) The issue of sustaining and spreading the practice within participants' organizations and/or communities is explicitly addressed in collaborative activities and team meetings. Issues discussed include a) hiring and training new staff, b) sustaining use of the intervention with fidelity, and c) and integrating the intervention into the structure of an organization (e.g. into policies and procedures).
- f) Opportunity is provided for teams to celebrate their successes and reflect on the collaborative experience (e.g. share treats from their home-town along with a storyboard that documents their process).
- g) Mechanisms for participants to maintain connections after the learning session are discussed (e.g. transition from faculty to participant led consultation calls, continued sharing of resources via the intranet, listservs).
- h) Process evaluation of the learning collaborative (e.g. via questionnaires or focus groups) is conducted to facilitate continuous improvement of the model.

**I. Action Periods:** Action periods between learning sessions are designed to support the growth of both clinical competence (e.g. fidelity to the intervention) and implementation competence (e.g. the capacity to use and sustain the intervention.)

1. *Intensive training from faculty.* Collaborative leadership team coordinates faculty-facilitated conference calls. All calls have a structured agenda and provide opportunities for teams to share challenges and solutions.
  - a) Monthly (or biweekly) calls for all collaborative participants<sup>5</sup> are offered. Calls focus on developing participants' competence in the intervention—from skillful application of treatment components, to engaging families, to adapting the intervention with fidelity (e.g. for a particular cultural group). Barriers to successful implementation (e.g. inadequate screening procedures, “crises of the week”) are also addressed.
  - b) Monthly calls for clinical supervisors are offered in order to increase supervisors' competence in the intervention and develop supervisory skills (e.g. capacity to evaluate and enhance fidelity).
  - c) Bimonthly calls for senior leaders are offered to support the development of implementation competence and capacity to sustain the intervention (e.g. role of measurement in the competent delivery and spread of evidence-based practice).
  - d) In conference calls during the second action period, faculty promote use of STOCs enhance progress toward the collaborative goals and address barriers to skillful and sustainable adoption of the practice.
2. *Use of improvement metrics.* Collaborative participants and leadership team, including faculty, evidence commitment to monthly metrics.
  - a) Participants regularly submit forms for metrics.
  - b) Leadership team regularly provides metrics to teams in a timely manner.

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<sup>5</sup> For larger collaboratives, it is recommended that faculty divide teams into subgroups to ensure adequate participation.

- c) Faculty assist collaborative leadership with collection of metrics as necessary (e.g. follow up with team that is not submitting forms or metrics).
  - d) Faculty use metrics on conference calls (e.g. as a tool to facilitate skillful use of the intervention with fidelity, to identify and address potential barriers to implementing and sustaining the practice, to assess impact of STOCs).
3. Collaborative intranet. Technology is used to support teaching, promote collaboration and share resources during the action periods.
- a) Faculty encourage and model use of the intranet by (1) “seeding” the site with posts (e.g. putting materials requested at the first learning session on the intranet rather than emailing, initiating dialogue on the discussion board), (2) promptly responding to questions posted on the discussion board, and (3) rewarding frequent contributors (e.g. giving a prize to the team that posts the most STOCs).
  - b) Participants use the intranet to (1) ask questions and share potential solutions to clinical and implementation challenges via the discussion board, (2) share improvement efforts by posting STOCs, (3) share clinical tools and other resources, and (4) obtain metrics and progress reports.
4. Team meetings. Teams meet monthly (or biweekly) to assess their progress and address barriers to skillful implementation of the intervention.
- a) Senior leaders participate in team meetings.
  - b) Metrics are reviewed at team meetings.
  - c) Use of STOCs to tackle implementation challenges and enhance organizational capacity is encouraged.
5. Third action period. A third action period is offered following Learning Session 3 to assist teams in their efforts to sustain and spread the intervention with fidelity (e.g. to additional clinicians at the agency) and to address outstanding clinical competencies (e.g. implementing the intervention with special populations).

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### **National Child Traumatic Stress Network**

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

#### **Suggested Citation:**

Ebert, L., Amaya-Jackson, L., Markiewicz, J., Burroughs, J. (2008). *The NCCTS Learning Collaborative Model for the Adoption & Implementation of Evidence-Based Mental Health Treatment: NCCTS Guidelines for Conducting a Learning Collaborative*. Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress and Duke University Evidence-Based Practice Implementation Center.

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