Module 2:

Creating a Learning Collaborative

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Learning Outcomes for Faculty

Presented here are important steps and timeline considerations for the faculty and planning team in their preparation and creation of a Learning Collaborative. This module focuses on the following objectives:

- Faculty will be able to identify the steps for leading a Learning Collaborative.
- Faculty will be able to develop a Change Package utilizing resources provided.

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"Assembling the faculty is a key challenge. Ensuring that there is expertise represented on the Faculty that can address issues across the Change Package is difficult but adds a broader and crucial perspective to the experience."

Jan Markiewicz

National Center for Child Traumatic Stress

Training Director

Priority Tasks for Faculty

1. **Topic Selection: Choose a practice or intervention for a Learning Collaborative.** While most planning teams reaching this point have a specific collaborative topic already in mind, it is important to consider carefully why you chose this topic. It is critical to be able to spell out to collaborative participants, funding agencies, and key stakeholders within and outside the organization why embarking on this venture is worthy of time and money.

2. **Identify design, time frame, and duration of the Learning Collaborative.** Planning team members must identify the design, location, and schedule for the Learning Collaborative over the recommended 12 to 18 month time frame. This schedule should incorporate adequate time for the following key steps:

- Faculty selection
- Information calls
- Application phase
- Team selection process
- Prework phase (to be done immediately before the first Learning Session, typically 4 to 6 weeks in advance)
- Learning Session 1 (LS1)
- Action Period 1 (period between LS1 and LS2)
- Learning Session 2 (LS2), typically 3 to 4 months after LS1
- Action Period 2 (between LS2 and LS3)
- Learning Session 3 (LS3), typically 6 to 7 months after LS2

3. **Choose a Faculty.** Be thoughtful about the selection of faculty—they round out the "dream team" with the planning team. The planning team is typically composed of individuals who will coordinate the activities of the LC. Sometimes the faculty and planning team are the same individuals. Faculty members should have expertise in the clinical content area (e.g., the specific intervention) but also in areas such as organizational structure (administration and supervision), learning and teaching-improvement strategies, and methods of establishing and working with teams. The faculty and planning team should also include a noted

authority (other than a treatment developer) on the collaborative topic.

4. **Prepare faculty around LC Goals, Change Package objectives, and the "right kind" of data collection.** The role of the faculty is specific to achieving the adoption and implementation of the designated intervention. Training on clinical competence is a necessary but insufficient component to facilitate successful implementation; the Goal Statement and Change Package will need to steer faculty to address some additional key components.

5. **Create a clearly designated Goal Statement.** A specific, measurable, time-sensitive statement of expected results of this collaborative process is the starting point in the planning process. The Learning Collaborative is clearly more than just training on a specific treatment model—but how much more? Each agency team can individualize its goal statement. (See Support Materials for Sample Goal Statement).

6. **Develop the Change Package for your collaborative.** The Change Package delineates the conceptual model (mission, philosophy, principles, and values), summary framework, goals, and strategies to successfully train clinicians, facilitate the delivery of the specified intervention to clients, and promote the adoption of the intervention within an organization.

The template Summary Framework (in the Support Materials) is organized by the following components: (1) organizational readiness, (2) clinically competent practice, and (3) effective youth and family engagement. This template is designed to be used and modified based on the content of your collaborative and is intended to provide a roadmap for approaching each piece in the infrastructure necessary for successful implementation. The NCCTS Intervention Change Package included for your use has been "genericized" to allow your faculty and planning team to apply to your specific intervention. Suggestions for adaptation are included.

"I don't think we could have adopted any of these interventions as fully or as deeply if the collaborative structure wasn't provided for us. We've started to use a version of the Learning Collaborative locally as we serve as "experts" to other agencies here. In terms of training we are becoming more insistent that one-day or one-shot trainings don't create practice change, and so we're offering a 6-month to 1-year collaboration with local agencies who want to change their practice. We're using a lot of the methodology and format of the collaboratives to guide our involvement with local agencies. This is a brand new approach to training and having gone through several collaboratives with the network, I feel so much more confident in 'selling' this approach."

Jennifer Wilgocki

Mental Health Center of Dane County, Inc.

Participant, Breakthrough Series and SPARCS Learning Collaborative

Priority 1:

Topic Selection: Choose a practice or intervention for a Learning Collaborative.

Tips:

The Institute for Healthcare Improvement recommends being able to articulate the basis and criteria for your topic selection in any of the following categories:

- Closes the gap between science and practice.
- Is an example of best performance that has been accomplished in other settings.
- Makes sense from a business perspective; it can improve agency outcomes, positively impact patients, positively impact the agency, and makes financial sense.

Delineating clearly and upfront to organizations that are participating in the Learning Collaborative, what the level of evidence is for the intervention topic is important. Some interventions are chosen based on level of evidence. Other interventions are chosen because they fill a gap in services, even though the empirical support may be less strong than for other interventions. When level of evidence is lower, some Learning Collaborative evaluation strategies may lean toward additional data collection. This should be taken into consideration in your topic selection.

Priority 2:

Identify design, time frame, and duration of Learning Collaborative.

Tips:

- Carefully consider the needs of the collaborative membership and the challenges involved in implementation and adoption when choosing a design. Some practices require extensive prework and preparation for introducing a new practice, so a longer Prework Phase might be recommended. Practices that include partnering with other systems (e.g., a school-based intervention or one involving juvenile justice) might require a different level of groundwork before the introduction of the intervention to clinicians. Enhanced involvement of senior leadership might be recommended for a collaborative that requires extensive partnering with other agencies. Alternate designs are included in the Support Materials.

- There is considerable detailed planning prior to LS1 that requires timeline consideration. Below is a list of events and a sample timeline that illustrate necessary considerations beyond the planning time for the individual Learning Sessions.
- After LS1 the primary focus switches to scheduling Action Period activities such as organizing and eliciting participant involvement in conference calls, facilitating the use of the Intranet, and supporting not only clinical competence and fidelity to the model but also implementation and its metrics.
- LS2 should be 3 to 4 months after LS1.
- LS3 begins 6 to 7 months after LS1.

Events to consider	Sample timeline
Faculty selection	5/15
In–person or phone conference orienting faculty to Learning Collaborative model and planning protocol for calls and meetings	5/26
Date applications are sent out and announcement for informational call for potential applicants	6/15
Scheduling of second informational call for applicants (optional)	6/24
First faculty call	6/28
Application deadline	7/13 5pm EDT
Applications reviewed and scored—review call with faculty	7/14–7/18, 7/19
Team selection announced	7/20 5pm EDT
Prework Package set out	7/25
Prework activity and call(s)	7/26–9/8
LS1	9/8–9/9
LS2	1/19–1/20
LS3	July or August

Priority 3:

Choose a faculty.

Tips:

- Faculty should be knowledgeable on the clinical / technical content and how to communicate ideas to teams.
- Consider expert clinicians in the field—for example, credible real practitioners who have experience with implementation in different settings and can help move the ideas forward.
- Consider experts in other areas of leadership such as supervision, administrative direction (senior leadership in an agency), and community partnering.
- Consider involving a consumer parent or consumer "graduate" of the intervention—who can voice comfortably the components of the intervention that they considered helpful or not-so-helpful in the delivery of the intervention to them.
- Consider a practitioner with special interest or expertise in culturally specific areas that will be relevant to the practice of interest.
- Alert faculty ahead of time regarding faculty expectations in terms of time (about 5-7 hrs per month, including three months prior to LS1) and the shared learning atmosphere that will be required for success.

Priority 4:

Prepare Faculty around LC goals, Change Package objectives, and the "right kind" of data collection.

Tips:

- A clear Goal Statement (per Priority 5, below) will assist faculty in delineating appropriate data to collect. Faculty will need to put careful thought into the kind and amount of data they recommend site participants collect. Learning Collaboratives on evidence-based practices should limit measurement to bare-bones metrics that simply monitor for participants their progress in implementation and improvement and are far removed from an academic research approach. Collaboratives on promising practices may choose to incorporate data measurement to enhance the evidence base.
- Faculty should have sufficient time prior to the Prework phase to be oriented to the goals and objectives of the change package, the timeline of calls and activities, and their roles. Structured discussion of these topics as well as introduction and subsequent finalization of what metrics will be used should be done via calls, e-mail, and in some cases in-person meetings. Decisions about metrics and the use of monitoring progress should

be finalized before any prework calls with participants. The best scenario is for baseline (basic!) data collection to be done before and then presented (grouped data) at LS1 if there is already some exposure to the intervention among participating teams.

- Faculty will need to decide on the kind of measures they consider critical for participants to collect. Practitioner, administrator ("senior leader"), and consumer representation on the faculty should weigh in heavily, despite their inclination to defer to the research-oriented faculty. Universal feedback from prior collaborative participants is to keep data measurement to a minimum and to recognize that participants will struggle with both the logistics and buy-in on all data collection until (and even after) they begin to see the benefit and payoff on what monitoring does.

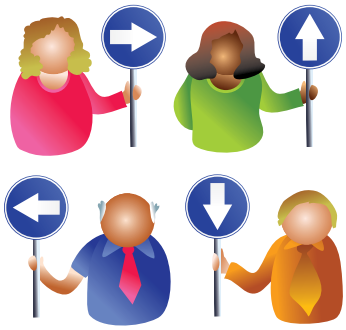
Priority 5:

Establish a clear Goal Statement.

Tips:

- A strong clear aim gives necessary direction to improvement efforts and is characterized as:
  - Deliberate, planned, unambiguous, specific, concrete
  - Measurable with a numeric goal, preferably one that provides a "stretch" to motivate significant improvement
  - Aligned with other organizational goals or strategic initiatives
  - Agreed upon and supported by those involved in the improvement and leaders
- Make your aim actionable and useful. Include:
  - General description of what you hope to accomplish
  - Specific population who will be the focus
  - Some guidance for carrying out the activities to achieve your aim

Priority 6:



Develop a Learning Collaborative Change Package.

Tips:

- The faculty/planning team should review the template Change Package and have a clear understanding of and familiarity with each element and component. Particular attention should be paid to the Goals and the Summary Framework. The template Intervention Change Package is in a generic format that allows transportability (with modification) to your specific intervention in most cases.
- In modifying this template Change Package, there are designated places (indicated by blank spaces) to note aspects specific to your intervention. Acknowledging or modifying each component to the particulars of your intervention is recommended unless a specific component is clearly not applicable.
- Either minor or major adaptations may be necessary to adjust the descriptive requirements for your implementation—the level and kinds of changes will depend on the target population. Examples of target populations for whom major adaptation may be necessary are parents in the home, school personnel, and clients in residential settings. Learning Collaboratives built around topics involving large-scale system change should refer to the experiences of IHI /Casey programs for examples involving multi-agency/ cross-community involvement and the many modalities involved.

Frequently Asked Questions

Q: The faculty from our Learning Collaborative would like to use the collaborative experience to gather additional evidence regarding the intervention. Is that an acceptable use of the collaborative experience?

A: Learning Collaboratives are aimed to facilitate training and implementation. Each experience warrants evaluation given the time, energy, and funding usually involved. Burdening participants with additional measures should be done cautiously, and participant applicants must be fully informed up front as to the level of data collection they will be required to complete. For interventions that are considered promising practicies, we have found that it is reasonable and achievable for Collaborative Teams to replicate positive outcomes and garner feedback on protocol and implementation strategies.

Q: We are organizing a collaborative and would like to include non-Network members. Is that acceptable?

A: This is a great way to accomplish spread! It is important to consider how expenses for their participation will be met, and their team should be assisted by faculty to be fully involved in the shared-learning- experience of the collaborative.

Q: We are not funded for dissemination activities but want to lead a collaborative. Can we charge participants for their involvement in the Learning Collaborative?

A: Most Network-led collaboratives have attempted to use cost-saving strategies to facilitate participant and faculty involvement when resources are limited. This includes requesting teams to take turns in being the host city (arranging logistics such as meeting space, etc.) (See Priority tasks for Faculty in Module 8.). Charging participants for their involvement is something that IHI has done successfully, but which the NCTSN has tried to keep to a minimum.

Glossary of Terms for Module 2

Action Period: The period between Learning Sessions when teams work on improvement in their home organizations. They are supported by the Collaborative Faculty and they are connected to other Collaborative Team members.

Change Package: The change package in a Learning Collaborative is the key document that guides all work of participating teams. It contains the following elements: Collaborative Mission; Collaborative Philosophy, Principles, and Values; Goals for the Collaborative; The Challenge; and a Summary Framework.

Collaborative Faculty: A small group of experts in the topic area who assit the Planning Group and chair in teaching and coaching participating teams. Usually the group contains representatives from the disciplines that are involved in the change process.

Learning Session: A two-day meeting during which participating teams meet with faculty and collaborate to learn key changes in the topic area, including how tio implement changes, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meeting with new knowledge, skills, and materials that prepare them to make immediate changes. Learning Sessions are abbreviated as LS.

Planning Team: A steering committee for the collaborative consisting of the faculty, improvement advisor, and often representatives from spronsoring or stakeholder organizations.

Prework Phase: The time prior to the first Learning Session when teams prepare for their work in the collaborative, including selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their aim, and initiating data collection.

Summary Framework: A document developed to guide the work of the Collaborative. It consists of five components, all of which are believed to be critical aspects for adopting and implementing evidenced-based interventions. Teams will use the summary framework to help narrow their tests of change and ensure that they are impacting the entire system. During the course of the Collaborative, each team will be required to make improvements in all five of the Summary Framework components.

"I believe the Learning Collaborative approach to training within the Network has been an incredibly significant innovation. I particularly like the group learning model which, over time, builds a learning community."

Judy Holland, MPH

National Center for Child Traumatic Stress

Liaison

Support Materials Module 2

List of Support Materials

- Faculty Checklist
- Sample Goal Statement by NCCTS for TF-CBT Breakthrough Series Collaborative
- Sample NCCTS Intervention Change Package to Adapt for Your Use
- IHI Collaborative Evaluations: Mistakes in Planning and Operations
- Designs for a Learning Collaborative

Faculty Checklist Module 2

Creating a Learning Collaborative

- ❑ Choose a practice for the Learning Collaborative.
- ❑ Identify the design, time frame and duration of the Collaborative.
- ❑. Choose and invite the faculty and clearly describe the activities and time commitment involved in their role.
- ❑ Development of goal statement by the faculty describing the desired outcome for the collaborative experience.
- ❑ Develop/adapt the Change Package for this Collaborative experience.

Sample Goal Statement for Implementing TF-CBT

(from the NCTSN Breakthrough Collaborative Series)

By October 31, 2006, the TF-CBT Breakthrough Series Collaborative (BSC) will increase the availability at participating agencies of TF-CBT provided with sufficient fidelity to improve outcomes for traumatized children and their families. Twelve NCTSN centers and their affiliated agencies are participating in this initiative.

This initiative will use the BSC model to effect improvement in three domains: (1) clinical competence in the implementation of TF-CBT, (2) child and caregiver engagement in TF-CBT, and (3) organizational practices that support implementation of evidence-based practices.

Example goals each team should set are:

1. 90% of children referred for psychotherapy are screened for referral to TF-CBT using a protocol that incorporates standardized assessments
2. 95% of clinicians who provide psychotherapy to traumatized children receive basic training in TFCBT
3. 100% of clinicians who provide TF-CBT receive ongoing supervision in the model
4. 100% of clinicians who provide TF-CBT implement the model using a fidelity checklist
5. 95% of children designated to receive TF-CBT have documentation of the core components in their case records

National Center for Child Traumatic Stress Intervention Change Package

For a Learning Collaborative on Adoption and Implementation of _____

The goal of the National Child Traumatic Stress Network (NCTSN) is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. The Network works to develop and disseminate effective, evidence-based treatments for child trauma; collect data for systematic study; and help to educate professionals and the public about the effects of trauma on children. The NCTSN is a groundbreaking effort that blends the academic best practices of the clinical research community with the wisdom of front-line community service providers.

In order to achieve its overall goal, the Network is sponsoring a Learning Collaborative ("Collaborative" or "LC") focused on the Adoption and Implementation of _____. This LC will include approximately _____ sites that are committed to providing _____ with sufficient fidelity in order to appropriately serve and improve outcomes for children and families. Participating sites are committed to testing small, rapid changes that are quickly implemented to accomplish this goal. These sites will share their adoption and adaptation successes and learnings in real time to further accelerate their achievement of improved outcomes. The Change Package that follows will serve as the foundation for this LC.

ABOUT THIS CHANGE PACKAGE

This Change Package is comprised of the following elements: Collaborative Mission; Collaborative Philosophy, Principles, and Values; Goals for the Collaborative; The Challenge; and the Summary Framework. The Summary Framework will help focus the work of participating sites in the LC through a diagram that depicts the relationship between the key components that must be addressed in this work and a summary that provides descriptions and strategies for achieving the success described in the Goals for the Collaborative. The strategies will serve as a launch pad for the small tests of change that sites will be conducting throughout this LC.

COLLABORATIVE MISSION

The mission for participating Network sites in this Collaborative is twofold:

1) Improve capacity to deliver high-quality services and supports through the adoption and adaptation of evidence-based practice models; and

2) Adopt and implement _____ in diverse settings, including Network and non-grant sites and their local communities.

COLLABORATIVE PHILOSOPHY, PRINCIPLES, AND VALUES

This Change Package is built upon nine foundational principles. These principles express the overarching values that must guide all work in adopting and implementing evidence-based practices in child trauma. They are interrelated and work together in a dynamic, synergistic way. The order does not reflect a judgment of each principle's respective worth or relevance. We believe that:

1. Children and families deserve the highest quality of services, including assessment and treatments delivered by professionals knowledgeable and skilled in the use of evidence-based practices.
2. Children and families have strengths and resiliency, can recover from trauma, and can regain a sense of hope and opportunity.
3. Children and families are courageous to seek and engage in trauma treatment and this courage is recognized and acknowledged by treatment providers.
4. Clinicians believe that children and families have the ability to heal from trauma.
5. Children are parts of family units and larger support systems and as such engaging the family and these support systems as partners in defining the treatment process is critical to effective intervention.
6. Children and families exhibit a range of responses to traumatic events. This range of responses requires the individualized application of practices tailored to meet the needs of the child and family.
7. Understanding the developmental, cultural, and environmental dimensions of the child and family are basic to effective treatment.
8. Collaboration between multiple agencies and service systems (e.g., child welfare, juvenile justice, schools, healthcare), the community, clinicians, and children and families is often necessary for effective treatment and for enhanced support within the recovery environment.
9. Agency leadership takes responsibility and provides support for adopting and implementing evidenced-based practices at all levels of the organization (e.g., time off for training, consideration of staff productivity requirements).

GOALS OF THIS COLLABORATIVE

The Collaborative Goals fall into six key categories. The ultimate goal of this Collaborative is for each participating site to achieve measurable improvements in each of these categories. The six categories for improvement include:

- Awareness and knowledge of _____
- Skill in use of _____
- Fidelity to _____ model
- Provision of training, supervision, and support for using _____
- Youth engagement and satisfaction in _____
- Improved functioning and outcomes for youth receiving _____

Note: *Each Specific Learning Collaborative Faculty/Planning group should suggest specific targets to the participating teams in the LC for each of the above goals. They will do this in the form of a Goal Statement. The suggested targets listed in the goal statement will likely need to be individualized by each agency team in order to be useful, achievable targets for the above goals by each of the individual teams.*

THE CHALLENGE

The President's New Freedom Commission on Mental Health was established in April 2002 to transform the mental health system in part by accelerating the process of identifying and adopting evidence-based practices. Over the last 10 years, the field of child trauma has made tremendous progress in identifying evidence-based practices, however, the challenge of broadly adapting and adopting these practices in the field remains.

The NCTSN and other practitioners across the country are committed to providing the highest quality of treatment for children and families that have been traumatized. The prevalence and seriousness of child traumatic stress requires that increasing numbers of these mental health professionals be provided tools, best practice guides, support, and encouragement so that they can deliver the highest quality services and treatments possible to traumatized children and their families. While training on these evidence-based practices plays an important part in the adoption of new practices, it is not enough to ensure true understanding, increased skills and full implementation of these practices.

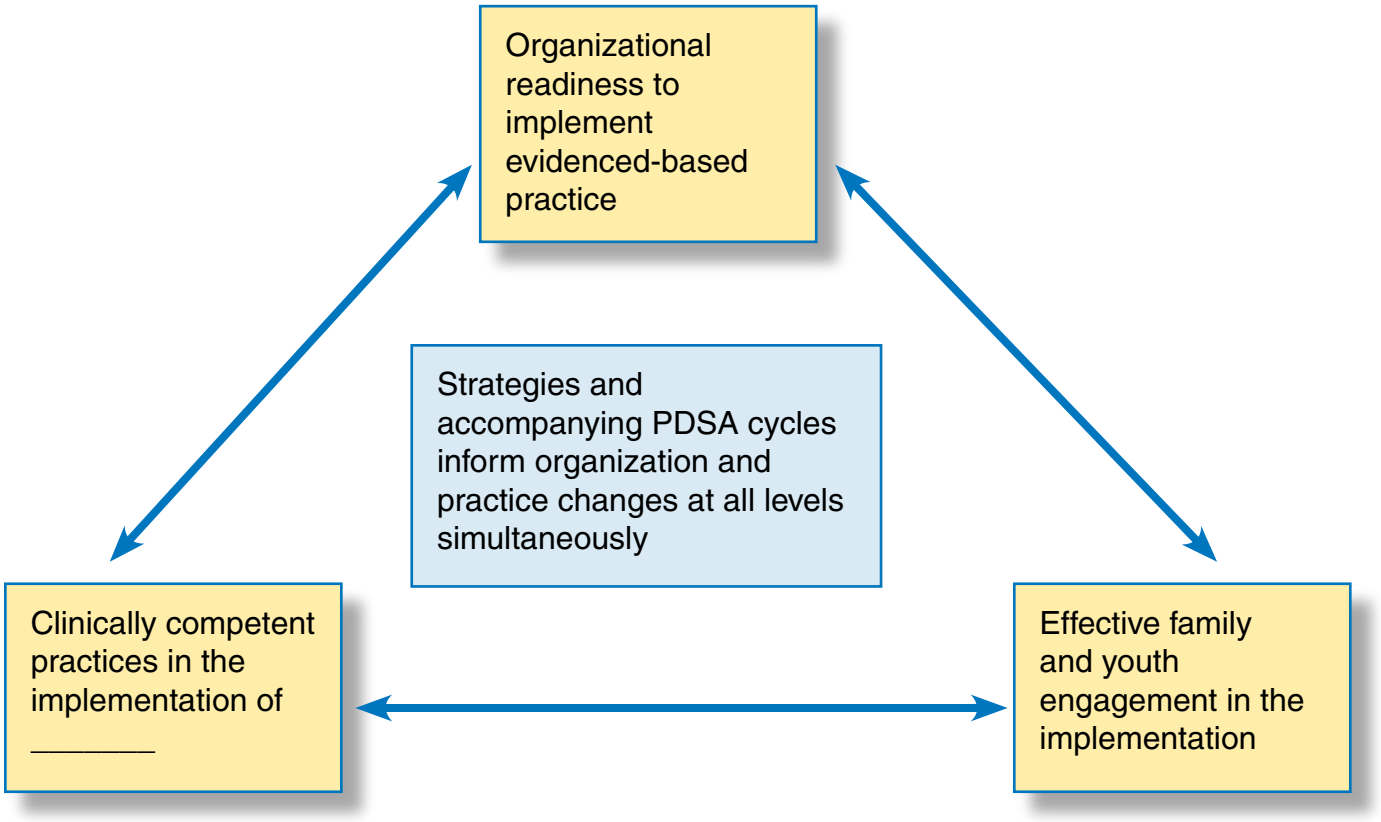
The Network has found that while many Network members are getting exposure to or receiving training on a range of evidence-based practices for childhood trauma through different venues, several Network sites continue to face challenges around the adoption of a particular treatment practice in their settings. As many Network sites are struggling with these adoption and adaptation challenges, they are trying to overcome these challenges largely on their own. This Collaborative provides a systematic way for sites to simultaneously test ideas, exchange experiences, and share ongoing feedback that will enable the learners to become each other's teachers.

_____ is an intervention that has proven to be effective treatment for traumatized youth who have been physically or sexually abused, exposed to domestic or community violence or traumatic loss. Through participation in this Learning Collaborative, approximately ____ sites will strive to fully implement _____ in their diverse settings.

SUMMARY FRAMEWORK

While the Philosophy, Principles, and Values provide an overarching foundation for this work, the components describe what sites and staff at various levels must do to apply these principles. In this framework, there are three levels of components identified:

1) Organizational readiness practices, 2) Clinically competent practices in the implementation of _____, and 3) Effective family and youth engagement specific to _____. It is organized in this way because in order to successfully implement _____, changes must occur at the agency, management, and practitioner levels. An organization must have the capacity to implement a new evidence-based practice model, must have worked through organizational culture barriers to implementing evidence-based practice, and must have an infrastructure in place that allows for data collection and analysis. Additionally, _____ will be most successful when the clinical practice of the agency has a strong understanding of trauma's impact on child development and family systems.



In this Learning Collaborative, agencies are expected to test ideas within each of these component areas. The diagram above illustrates the inter-connectedness of these three component areas. The work in these component areas will not be sequential; it will be simultaneous. Furthermore, work in one component area will often be related to, if not overlapping with, work being done in another component area. This synergy is what causes small tests of change in a LC to result in dramatic system-wide improvements.

I. ORGANIZATIONAL READINESS

1. Demonstrate a minimum threshold of organizational readiness and build the capacity to implement a new practice model.

A. Leadership and staff at all levels are committed to implementing evidence-based practices with appropriate clients

B. Agency leadership explicitly addresses the organizational policy and cultural barriers, both internally and externally, that impede successful implementation of evidence-based practices

C. Agency utilizes systematic and standardized approaches to compiling implementation outcome information (including the Core Data Set) so that success in implementation of evidence-based practices can be effectively monitored on an ongoing and continuous basis

D. Organizational incentives are in place to support the staff at all levels in making the shift to evidence-based practice models

E. Agency leadership balances caseloads with productivity requirements so that practitioners are able to learn and implement new evidence-based practices.

2. Provide support and infrastructure to monitor and evaluate clinical processes and outcomes on an ongoing and continuous basis.

A. Agency provides administrative and financial support for practitioners to utilize standardized approaches and to see and measure progress with individual children and families

B. Agency provides the resources (technology, staffing, and training) required to collect, aggregate, and report clinical data to see and measure agency progress

C. Agency demonstrates a commitment to utilizing standard assessment approaches, including the Core Data Set

D. Agency identifies and address internal and external barriers to data collection

E. Agency uses clinical data, including compiled case narratives, to facilitate effective care and to “make the case” both internally and externally for the model on an ongoing and continuous basis

II. CLINICALLY COMPETENT PRACTICES IN THE IMPLEMENTATION OF _____

3. Demonstrate clinically competent therapeutic practices in the implementation of _____.

A. Clinicians are committed to ongoing development of their skills and knowledge base in child trauma treatment

B. Clinicians receive initial and ongoing training on the use of _____ and evidence supporting it and demonstrate understanding, enthusiasm, and belief in the benefits of utilizing _____ as a treatment model

C. Clinicians receive initial and ongoing training on the use of evidence-based assessment and monitoring of recovery in making thoughtful treatment decisions

D. Clinicians and supervisors demonstrate an ability to integrate assessment information collected through interviews, observations and standardized measures in terms of its implications for determining presenting concerns and diagnoses, i.e. appropriateness of _____

E. Clinicians utilize the following clinical techniques as indicated in the treatment of trauma:

1. Please insert relevant items regarding the intervention
2.
3.
4.
5.
6.

F. Clinicians are sensitive to trauma-specific influences on developing and maintaining a therapeutic relationship

G. Clinicians effectively integrate community professionals who are critical to the child's recovery environment (e.g., teachers, caseworkers, medical staff, foster parents, clergy, coaches) into ongoing treatment planning

H. Clinicians understand and incorporate the history and culture of the child and family in engagement, treatment and enhancing the recovery environment of the child

I. Clinicians are committed to appropriate self-monitoring, health self-care and additional forms of support

4. Demonstrate quality clinical supervisory and training skills.

A. Supervisors receive training and consultation that promotes supervisory skills in:

- Core clinical competencies
- Meeting individual training needs
- Assessing and supporting various learning styles of their supervisees
- Balancing fidelity, flexibility, and creativity

B. Supervisors are trained to understand the use of _____

C. Supervisors are given the time required to effectively oversee quality clinical work

D. Supervisors support clinicians in decision-making at all points of treatment, including initial assessment, development of a treatment plan, evaluation of progress, ongoing treatment, and conclusion of treatment

E. Supervisors continuously maintain cultural competency relevant to the population of children and families being served by staff

F. Supervisors continually assess effective documentation of the use of _____

III. EFFECTIVE YOUTH AND FAMILY ENGAGEMENT IN THE IMPLEMENTATION OF TRAUMA SYSTEMS THERAPY

5. Clinicians are effective in engaging youth and families in _____.

A. Clinicians educate the youth/family/caregiver about the _____ model prior to treatment to ensure that youth will be effectively engaged and family/caregivers will be appropriately supportive throughout the youth's treatment process in a culturally competent manner

B. Clinicians review assessment findings with youth and families/caregivers in developing and agreeing upon the treatment plan

C. Clinicians actively engage and support youth in their treatment plans, including identification of specific needs and practical strengths and resources and utilize the clinical techniques outlined

D. Clinicians flexibly adapt the components of the _____ treatment based on the individual cultures, settings, and developmental capacities of the family/caregiver being served

E. Clinicians monitor content and process of treatment to ensure relevancy and likelihood of skill implementation within the context of youth's social environment/culture

1 This project was funded in part by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS), The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of HHS, SAMHSA, or CMHS.

2 Citation: Kisiel, C., Agosti, J., Amaya-Jackson, L., Markiewicz, J., Wood Maze, J., Saunders, B., Wilson, C., (2006) NCCTS Intervention Change Package. Durham NC: UCCLA-Duke National Center for Child Traumatic Stress.

Collaborative Evaluations:

Mistakes in Purpose and Preparation

Error #1: Choosing a subject which is too difficult or for which a collaborative is not appropriate

Error #2: Participants not defining their objectives and assessing their capacity to benefit from the collaborative

Error #3: Not defining roles or making clear what is expected of individuals taking part in the collaborative as faculty or participants

Error #4: Neglecting team building and preparation by teams for the collaborative

Mistakes in Fostering a Learning Community Focused on Improvement

Error #5: Teaching rather than enabling mutual learning

Error #6: Failing to motivate and empower teams

Error #7: Teams not having measurable and achievable targets

Mistakes in Post-Collaborative Transition

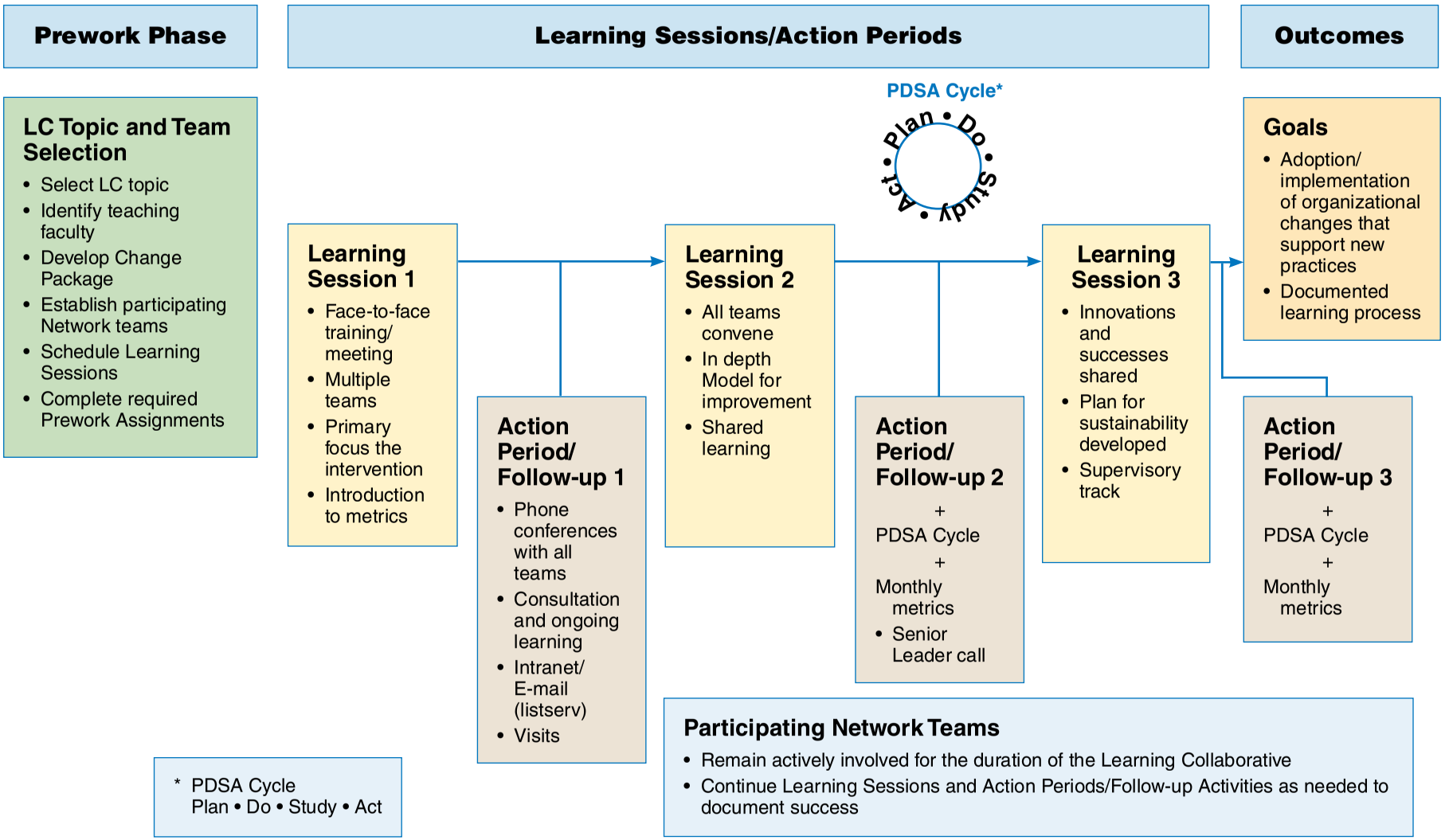
Error #8: Failing to learn and plan for sustaining change

Error #9: Failing to learn and plan for spread

From: J Ovretveit, Quality and Safety in Health Care, 2002 As cited in: 2004 Institute for Healthcare Improvement Breakthrough Series College

Learning Collaborative Approach

Basic Design (6–12 months time frame)



Learning Collaborative Approach

Alternative Design (6–18 months time frame)