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GREATER GREEN TRIANGLE UNIVERSITY DEPARTMENT OF RURAL HEALTH, FLINDERS AND DEAKIN UNIVERSITIES

ORGANISATIONAL DEVELOPMENTAL APPROACHES IN PRIMARY CARE

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1. INTRODUCTION

In our Stream Six report for the Australian Primary Health Care Research Institute, we investigated the contribution of approaches to organisational change in optimising the primary healthcare workforce. We defined Organisational Development (OD) as the application of behavioural science action research and systems theory to human systems to increase the internal and external effectiveness of the organisation, especially managing change, using participative processes that involve all those affected. We concentrated on the challenges of having a workforce fit for the purpose of chronic disease prevention and management.

We found convincing evidence of OD's use in the general economy and for its contribution to chronic disease management, and improvement in quality and safety. Performance in healthcare organisations is inextricably linked to leadership, culture, climate and collaboration which can be improved by OD.

During our travelling fellowship to the US, we visited medical faculties, public health institutes and private health research and consulting organisations at the University of Washington, Dartmouth College, Harvard Business School, Indiana University School of Medicine, the Institute for Family Health New York, University of North Carolina, Kaiser Permanente Colorado, and RAND Corp. (appendix 1 full itinerary). We had opportunities to study the antecedents of chronic disease management, collaborative care and safety and quality, in particular the work of W Edwards Deming and the epistemologist C I Lewis. At times we digress to describe how the results of randomised controlled trials are implemented in practice because organisational development is inextricably linked with other methods for bringing about change. OD could be thought of as facilitating change for human beings, but sometimes change also involves engineering in technical and social systems, for example, the use of information technology and creating and maintaining healthy environments. This report is a story about change and therefore improvement in healthcare. The lessons for Australia are many and outlined in the final section of this report.

2. LEADERSHIP, TEAMWORK, CULTURE AND THE QUALITY OF HEALTHCARE

Dartmouth College, set in the rolling hills of rural New Hampshire was founded in 1769. The red brick Georgian buildings of the University are the epitome of Ivy League colleges and contrast with the ultra modern Dartmouth Medical Center. Professor Paul Batalden MD, Professor of Pediatrics and Community and Family Medicine, works at the Institute for Health Policy and Clinical Practice. He is the doyen of the quality improvement movement, chairs the Board of the Institute for Healthcare Improvement (CEO Dr Donald Berwick), and is credited with drawing the prototype framework for Collaboratives on a serviette while dining with Berwick and the two other founders of Collaboratives.



Figure 1. Sketch of the Breakthrough Series Model by Paul Batalden, MD (1994)

One of the early and fundamental challenges for this group was the nature of scientific knowledge for improvement. The work of W Edwards Deming, a statistician who pioneered quality improvement in industry, profoundly influenced Batalden's thinking. Batalden was probably the first person to ask Deming how his work might be applied to medicine. Deming took some months to respond but he had been reflecting on how his knowledge of industrial processes could be applied to improve the healthcare that his wife had received.

During our Fellowship, whenever we talked to medical practitioners in the US, we saw how comprehensively the work of Deming applied to medicine by Batalden and his colleagues has embedded the methodology for quality improvement into healthcare. We consider later in this report how the widespread application of quality improvement in healthcare contrasts with Australia.

W Edwards Deming played an important role in improving the quality of American manufacturing during World War II. He is probably best known for teaching statistical process control to Japanese industry leaders which played a crucial role in Japan's postwar economic success based on the quality of its products. The Deming cycle of quality improvement is the basis for the Plan-Do-Study-Act cycle of the Collaboratives.

Deming realised that quality was more than using statistical process control to identify causes of variation. He went beyond statistical analysis of variation in manufacturing processes, developing a theory of management by looking at the processes of leadership. In his books, *Out of the Crisis*¹ and *The New Economics of Industry, Government, Education*² he describes his system of profound knowledge and 14 points for management.

Deming's philosophy has been summarised as:

'Adopting appropriate principles of management, organisations can increase quality and simultaneously reduce costs (by reducing waste, rework, staff attrition and litigation while increasing customer loyalty). The key is to practise continued improvement and think of manufacturing as a system, not as bits and pieces.' ¹

This philosophy can be applied to the delivery of healthcare especially for chronic disease management. Deming pointed out that focusing on quality results in both increased quality and a fall in costs. He could have been thinking of the Australian healthcare system when he said that if people and organisations focused primarily on costs, they tend to rise and quality declines over time. This is because waste is not minimised, reworking occurs, staff morale declines, disputes arise, the product does not improve, and there is a loss of customer loyalty.

In Deming's System of Profound Knowledge he believed managers needed:

- 1. Appreciation of a system: understanding the overall processes involving suppliers, producers and customers.
- 2. Knowledge of variation: the range and causes of variation in quality, and the use of statistical sampling and measurements.
- 3. Theory of knowledge: the concepts explaining knowledge and the limits of what can be known
- 4. Knowledge of psychology: concepts of human nature.

He defined a system as a network of interdependent components that work together to try to accomplish the aim of the system. He said that: 'A system must have an aim. Without an aim, there is no system. The aim of the system must be clear to everyone in the system. The aim must include plans for the future. The aim is a value judgment.' ¹

Deming's 14 points are his principles for transforming organisations in pursuit of improved quality. They are as applicable to the Australian healthcare system today as they were when he first stated them nearly 30 years ago.¹

- 1. Create constancy of purpose towards improvement of product and service, with the aim to become competitive and stay in business, and to provide jobs.
- 2. Adopt the new philosophy. We are in a new economic age. Western management must awaken to the challenge, must learn their responsibilities, and take on leadership for change.
- 3. Cease dependence on inspection to achieve quality. Eliminate the need for inspection on a mass basis by building quality into the product in the first place.
- 4. End the practice of awarding business on the basis of price tag. Instead, minimise total cost. Move towards a single supplier for any one item, on a long-term relationship of loyalty and trust.
- 5. Improve constantly and forever the system of production and service, to improve quality and productivity, and thus constantly decrease costs.
- 6. Institute training on the job.
- 7. Institute leadership. The aim of supervision should be to help people and machines and gadgets to do a better job. Supervision management is in need of overhaul, as well as supervision of production workers.
- 8. Drive out fear, so that everyone may work effectively for the company.
- 9. Breakdown barriers between departments. People in research, design, sales, and production must work as a team, to see problems of production and in use that may be encountered with the product or service.
- 10. Eliminate slogans, exhortations, and targets for the workforce. Such exhortations only create adversarial relationships, as the bulk of the causes of low quality and low productivity belong to the system and thus lie beyond the power of the workforce. Ask for zero defects and new levels of productivity.
- 11. Eliminate work standards (quotas) on the factory floor. Substitute leadership. Eliminate management by objective. Eliminate management by numbers, numerical goals. Substitute workmanship.
- 12. Remove barriers that rob the hourly worker of his right to pride of workmanship. Responsibility of supervisors must be changed from sheer numbers to quality. Remove barriers that rob people in management and engineering of their right to pride of workmanship. This means *inter-alia* abolishment of the annual merit rating and of management by objectives.
- 13. Institute a vigorous program of education and self-improvement.

14. Put everyone in the company to work to accomplish the transformation. The transformation is everyone's work.

Deming's System of Profound Knowledge and his 14 Points could be taken as the general agenda for organisational development and organisational change in healthcare. These points have been modified for healthcare by the Institute for Healthcare Improvement (IHI).³ Many of Deming's ideas are captured in one-liners: ^{1,2}

'Knowledge is theory. We should be thankful if action of management is based on theory. Knowledge has temporal spread. Information is not knowledge. The world is drowning in information but is slow in the acquisition of knowledge. There is no substitute for knowledge.'

'The most important things cannot be measured.'

'Experience by itself teaches nothing.'

'By what method?... only the method counts.'

'You can expect what you inspect.'

'A system must be managed. It will not manage itself. Left to themselves in the Western world, components become selfish, competitive. We can't afford the destructive effect of competition.'

It is not only the experts who are saying these things about the need to improve healthcare. We know that millions of patients are hurt everyday by inappropriate treatments. At Dartmouth Medical College, we heard Michael L Millenson, author of *Demanding Medical Excellence*, ⁴ talk about quality improvement from the patient's aspect. Patients are asking questions such as, "Why do places offer very different treatments?" He said that "trust, but verify" was the Zeitgeist. Information technology now permits measurement of clinical performance, and consumers wanted to see the results - just like looking at the dashboard of a car. Asking which rate is right, tells us about the practice style of the physician, and challenges many core beliefs. His main point was that there had to be transparency so that patients can see providers' clinical outcomes. The patient needed to be able to know "what rate is right?" For example, what rate of complications represents poor quality?

Millenson also expected that improvements should be rolled out rapidly across the system. He pointed out that Everett Rogers had enunciated what leads to spread of innovation.

- Relative advantage over the status quo
- Compatibility with values and behaviours
- Lack of complexity
- Trialability
- Results observable

The theory of knowledge (epistemology), Deming's third component of the System, was probably influenced by the contemporaneous Harvard philosopher, C I Lewis, founder of conceptual pragmatism. Whereas logical empiricism emphasised scientific models of knowledge, Lewis emphasised the importance of experience and his pragmatic conception of empirical meaning.

The second great challenge for Batalden and the pioneers of quality improvement was to gain wide recognition that there was more to knowledge than the traditional hierarchy of evidence suggests.



Figure 2. The role of experiential learning in quality improvement: Paul Batalden

General scientific knowledge, usually gained through randomised trials to demonstrate efficacy has all context removed to create it, and is therefore inert. Batalden believes that generalisable scientific evidence is built by design of the research, but this knowledge just sits there. In order to move from there, you have to build knowledge of the particular context because we know the context is all important when implementing scientific knowledge in health services. Context knowledge is a very different knowledge. It requires active work to build this knowledge; sometimes from less formal sources like anecdotes and stories. Batalden argues that we need a very different way to find that knowledge. In Batalden's equation the + sign indicates the plans and options, and the _____ indicates "making it happen".

There is a third system – time. Time is included as a variable like measurement of a river over time. You want to change the system over time.

Batalden emphasises experiential learning. He points out that champagne was discovered by a monk who noticed that adding sugar resulted in a second fermentation. There never was a randomised controlled trial to demonstrate or test the phenomenon.

How is good evidence about the improvement of health care obtained?

- Evidence re: intended effect
 - 1. Randomized controlled trials
 - 2. Prospective f/u studies
 - 3. Retrospective f/u studies
 - 4. Case-control studies
 - 5. Anecdotal: case report and series
- Evidence re: discovery, explanation
- Anecdotal: case reports & series, findings in data, literature
- 2. Case-control studies
- 3. Retrospective f/u studies
- 4. Prospective f/u studies
- 5. Randomised controlled trials

J.P.Vandenbroucke, PLoS 5:339-343,2008 (March)

Figure 3. Evidence: Intended effect compared with discovery and explanation

Vandenbroucke contrasts two views of medical science: one emphasises discovery and explanation, the other emphasises evaluation of interventions. ⁵ He concludes that these two views lead to opposite research hierarchies. Drawing on the writings of Vandenbroucke,

Batalden points out that creating evidence about how to improve healthcare inverts the traditional hierarchy of evidence. The new SQUIRE guidelines will make it easier for this kind of research to be accepted by high-impact journals. ⁶ These guidelines resolve the difficulties of the IMRaD format when reporting quality improvement projects.

Reflective teaching & learning Impact testing Inference, publication

Fostering Scholarship of Improvement

Figure 4. Guidelines for fostering a scholarship of improvement: Paul Batalden

Batalden brings together scientific knowledge and experiential learning combined for improvement. He understands that new ideas have to be attractive, and that they should contribute to joy and pride in clinical work which he calls appealing to the "head, heart, and hands." He imbues passion for clinical improvement.

'Continue all the behaviors and processes until change has the opportunity become anchored in the culture.' W Edwards Deming.

Earlier we remarked on the widespread understanding of methodology of quality improvement in healthcare among American medical practitioners. A breakthrough occurred when Dr David Leach, MD became the Executive Director of the Accreditation Council for Graduate Medical Education. He turned to Batalden for advice which led to the Outcome Project funded by the Robert Wood Johnson Foundation. The Outcome Project devised a residency program with required competencies in six areas which were applied to all medical specialties. (See appendix 2.) The competencies which have been adopted by all the specialist Colleges are:

- **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- **Medical Knowledge** about established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioural) sciences and the application of this knowledge to patient care.
- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and the assimilation of scientific evidence, and improvements in patient care.
- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
- **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

• **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to access effectively: system resources to provide care that is of optimal value.

At a stroke, Batalden had permanently embedded quality improvement into the training program for all doctors. Also he had linked both the educators and those who certify competency at the end of specialist training.



Figure 5. Aims for sustainable improvement: Paul Batalden

Batalden says, 'When I stepped down as a founder of IHI, I wanted to focus on professional development-mentoring of young doctors - they will be the leaders of the next generation.' As part of the Masters in Public Health program at Dartmouth, residents undertake a quality improvement project - Clinical Learning Leadership Applications - from start to finish. It is based on experiential learning. Other clinicians, sometimes less experienced in quality improvement serve as mentors, spreading knowledge of quality improvement among senior doctors. The residents get feedback on their performance as team members as well as their clinical performance. Case studies are used with students taking different roles; physician, patient or family member, for instance. In other sessions the class is divided into persona groups, e.g. James Reason or Florence Nightingale. Students are required to present to the group in the person's identity, thinking and history.

The students are encouraged to assess themselves as leaders, to reflect on their role as leaders; develop curiosity, creativity and trust; and recognise how these are related. Batalden believes that curiosity is essential for best clinical leadership.

Speaking about organisational culture, Batalden believes that Paul Bates got it right: culture is embedded in the structure and strategies of the organisation. He thinks Edward Schein was partly correct: culture is about social learning - and that when you want to change the culture, you should not try to change the culture! Much better to start people on a project or to have a plan of action. But Batalden believes that culture is more than social learning; it is social learning and lived culture. It is the lived culture that makes things happen. The gaps in the lived culture are what can be used to provoke change, particularly with smart people in loosely coupled systems. He says, 'If you play with the logic, you can change loosely coupled systems. You're inviting people to query the assumptions that people hold about things. You can invite nurses and doctors to work together by using systems language, which is owned by neither profession.'

Batalden believes in the "illusion of control". He says, 'If you're dealing with smart people like health professionals, you won't get very far by using control. It's only when they realize that they don't have control that they get things to happen.' He has a deep interest in the wider

professional development of his residents. Social ethics forms part of his contribution to their training. He says that they need to know what performance is required of them, know their role, and do their role. He teaches them about the language of diminishment and invites them to discuss examples where messages inadvertently diminished a resident's interest or enthusiasm for exemplary patient care or created distortions in professional development. (Medical students will remember disparaging remarks being made about general practice.)

Batalden is an extraordinary scholar who brings to bear on quality improvement in healthcare a wide range of disciplines: philosophy, history, management studies and clinical practice. The impact of his work on healthcare in the US and worldwide is enormous.

Veterans Administration – a tale of a turnaround in quality

We were lucky to be able to interview Dr Karl Lorenz MD, a palliative care physician at the Veterans Administration (VA) Hospital, academic at the University of California Los Angeles, and research fellow at RAND Corp. Last year he was a Packer Fellow at the Cancer Council of Australia and has good insight into the differences between the health systems.

VA is known internationally in the quality improvement world for its turnaround in performance to become one of the best providers in the United States. VA systematically uses quality improvement methodology and has probably the premier approach to implementation of evidence. The structure in VA that allows this to happen includes:

- Performance measurement
- Equifinality for implementation of new interventions (you measure the final performance and everybody gets there in their own way)
- Electronic medical records
- National, regional and local oversight of performance
- Incentives for managers based on performance
- Linking the efforts of operations, research and management
- Linking quality and performance
- Trialling good ideas and then operationalising them

VA regards performance measurement as the most important contributors to quality and recognises that it requires good IT systems especially electronic medical records. It has an Office of Quality and Improvement that brings together research findings, identifies promising ideas, and works with operations to go from pilot studies to implementation.

Dr Lorenz thought that the feasibility of this approach was a problem for Australia. The medical records system is not electronically linked; clinicians do not have even rudimentary systems for collecting data and are not trained to use it. Managers have even less understanding of using clinical performance measures. Lorenz remarked that although Australia had a marvellous system for vetting the entry of new drugs onto PBS, there was no equivalent for health services. He felt that there was no cultural acceptance of using the evidence base for health services.

There is a National Quality Forum in the United States which judges when performance measures are suitable. ⁷ In the 4-page guide on attributes of measures, it requires information about the evidence, reliability and validity, responsiveness, stability and feasibility. There must be evidence of variation in clinical performance that is responsive to improvement. Measures are required to take gender and ethnicity into account.

The Center for Medicare and Medicaid Services which pays doctors, works with the National Quality Forum in adopting performance measures. The Physician Quality Reporting Initiative of the Center has created some pay for performance based on measures, as have some private payers.

3. MAKING IT HAPPEN FOR PEOPLE WITH DIABETES

Edwin B Fisher is Professor of Health Behavior and Health Education at the Gillings School of Global Public Health, University of North Carolina, Chapel Hill. Among health psychologists and others, Professor Fisher has the highest international reputation for his research into diabetes management.

Most of Fisher's work occurs within health services, where he faces all the real world problems of implementation. Like Batalden he has views on the limitations of randomised controlled trials. He quotes Arnold Lazarus, a leader in the field of Cognitive Behavioural Therapy who initially presented his results as case studies, not a randomised trial. When faced by critical questioning, Lazarus replied that science is defined by how we talk about our data. 'There are scientific and nonscientific ways of talking about your data.' ⁸ Randomised trials study things independently of context and therefore are not a good way of studying context.

Fisher believes in multiple methods for understanding context. ⁹ He gives the analogy of an architect designing a bridge. The architect does not look for evidence from randomised trials. He studies the local climate, the river, the riverbed, the land on both banks, the purpose for which the bridge is built and considers its aesthetic characteristics. Then he designs a bridge precisely for that river crossing. Translating the results of randomised trials into real-world settings fits with this analogy. To improve services for diabetes, Fisher believes that we need to learn from observations and knowledge. No matter how good any methodology is, he believes it requires judgment to decide if the evidence fits that category of patient or service. When measuring outcomes he looks at individual, system and implementation factors.

He says that while someone with diabetes will have limited time contact with health professionals, 'diabetes is for the rest of your life.' This simple but profound observation is leading him to focus his research on three areas a) managing the daily task of living with diabetes, b) social and emotional support, c) linkage to clinical care. He points out that for chronic conditions non-directive counselling works best. He is working on how peer support can help people master and maintain their skills in managing their diabetes.

The Diabetes Initiative described below gives some idea of the organisational developmental support provided to its 14 sites by the project team. We were particularly impressed by the standard of project teams that we saw in this and similar projects throughout the USA. The quality of experience and qualifications, the numbers of staff, and the standard of data management are probably unmatched in Australia except for drug trials. Certainly the Australian field of health services implementation research has nothing like the skilled people deployed on similar programs.

The diabetes initiative collaborative learning network: an approach to maximising program effectiveness

The story of the Diabetes Initiative shows how the research funder and researchers can work together to use OD to get good outcomes. The Robert Wood Johnson Foundation seeks to maximise design outcomes in target populations, by providing relevant and useful technical assistance to help funded programs incorporate state-of-the-art processes and tools, increase project effectiveness, and enhance sustainability and dissemination of lessons learned. ^{10, 11}

The Diabetes Initiative was a national program intended to demonstrate feasible and successful models of self-management in primary care and community sites around the USA. The 14 sites of the Initiative included urban, rural, frontier, and Indian Country settings; Latino, African-American, American Indian and White populations - all representing groups experiencing substantial health disparities. The Diabetes Initiative National Program Office (NPO) oversaw and provided technical assistance to the grantee organisations. The NPO provided an approach to technical assistance that built upon the activities grantees already had in place and provided them the flexibility to adapt general models to their own settings and populations. This is the concept of equifinality, i.e. using different approaches, but reaching the same endpoint. To

provide a general structure for equifinality, a toolkit called Resources and Supports for Management (RSSM) outlined broad categories of key components of self-management.

A Collaborative Learning Network (CLN) was implemented by the NPO to guide and cultivate the 14 unique, real-world programs by using the RSSM framework and building on the experience and energy of the grantees. The CLN provided opportunities for the grantees to learn about improved practices, share experiences, set goals, quality improvement, share accomplishments and barriers to improvement efforts, and working groups on issues critical to diabetes self-management. With its strong emphasis on peer-to-peer learning, many CLN components were guided by the evolving needs of the grantees.

There were multiple formats for use for CLN activities including face-to-face meetings, workgroup meetings related to specific topics and challenges, teleconferences, learning intensives, site visits, website, e-mail and phone contacts.. Ten face-to-face meetings each lasting a day and a half over the 45 months of the funding were crucial. Meetings included sessions on special themes like working with the media, facilitated discussion sessions about what works well and what doesn't, work group sessions addressing key issues like depression or organisational capacity, and quality improvement sessions. These face-to-face meetings were attended by the project coordinator, and key clinical and non clinical staff.

Participants were also encouraged to submit papers and posters for national meetings following a dress rehearsal at the face-to-face meeting.

The staff from the National Program Office who had PhD level research and project management experience, conducted site visits, for instance to help setup databases, advice on recruiting and involving local doctors.

An evaluation of the CLN show that it had created synergy that accelerated quality improvement such that projects develop beyond their original goals or expectations, and grantees are able to contribute products that transcended individual project interests. There were four full-time staff in the NPO as well as experts and researchers. The four full-time staff built strong collaborative relationships with the 14 grantees. This OD approach supported by resources for the NPO and face-to-face meetings appears to have contributed substantially to the success of the Diabetes Initiative.

4. DIABETES PREVENTION: FROM RANDOMISED TRIAL TO THE 'REAL WORLD' IN FIVE YEARS

Our own academic experience includes close observation of the translation from randomised controlled trial to real-world intervention for diabetes prevention. In 2002-03, two major randomised trials demonstrated that lifestyle improvement can prevent type 2 diabetes: the Finnish Diabetes Prevention Study and the US Diabetes Prevention Program (DPP). In 2004 in the Greater Green Triangle we replicated the Finnish implementation trial GOAL which followed the randomised trial. In Finland and Victoria we have now rolled out diabetes prevention for the wider population. This personal experience gives us a unique interest in how evidence translates into clinical practice through policymaking processes.

In the United States we visited two site leaders of the US Diabetes Prevention Program -Professor Ed Fisher and Professor David Marrero. Professor Marrero PhD is the JO Ritchey Professor of Medicine at the Indiana University School of Medicine. Like Professor Fisher, he has great insights into translating programs from randomised trials into the real world. We asked Marrero how the US DPP had achieved such good results with people of low literacy, Hispanic and African-American backgrounds. He replied, 'The US DPP cost US\$190 million for 3000 people. With that amount of money you can achieve anything!' This anecdote probably says more about 'real' and 'unreal' worlds than anything else we've heard. Each participant's data was monitored and necessary resources were deployed to move all the outcome measures in the correct direction. Money was no object in these trials.

To the best of our knowledge, the only project following the US DPP is Marrero's project (the DEPLOY Pilot Study) in Indianapolis. ¹² A/Professor Ron Ackermann MD MPH works on the program with him. The challenge for Marrero has been to balance fidelity for DPP lifestyle

intervention with new design elements that optimise the effectiveness, minimize costs, and improve sustainability. This has led him to work at community level with the YMCA, which has 2700 facilities in 18 million members in the USA. They already have similar education programs for asthma and exercise. Of the three real-world interventions; Finland and Victoria being the two others, he is the only one to train nonprofessional people as group facilitators, i.e. the YMCA wellness instructors.

His three translation tasks were:

- 1. to identify those at risk
- 2. to come up with a way to train and replicate delivery (standardised training)
- 3. to come up with a method of evaluation.

As in Finland and Victoria screening is by using a 7-item questionnaire which was posted to 40,000 people. They got close to 1000 people to come to the YMCA site, where they assessed BMI, glucose, HbA1c, cholesterol and HDL using point of care testing. They randomised into one of two YMCA sites. The control group was given the same lifestyle information pack (in itself a fairly good intervention) as the US DPP participants.

The training program for the group facilitators (YMCA wellness instructors) is identical to the one given to the DPP lasting two and half days with an annual review day. One difference from the DPP is that they only have a group intervention, which is a feature of rollout in Finland and Victoria too. Group size is 7 to 12, and meets for 60-90 minutes a week for 16 weeks. After 16 weeks there are monthly maintenance meetings. Like Victoria, training includes group dynamics, how to encourage participation and how to get people to talk together.

The follow-up measurements are taken at six and 12 months. They show a 6% weight loss in the intervention group at 12 months, compared with 2% in the control condition. Although the control group improved by losing weight their cholesterol did not improve. They think there is a dose response (like Greater Green Triangle DPP): the more the visits, the more contact, the better the response.

By contrast with Professor Fisher's equifinality in the Diabetes Initiative, Marrero is adamant that training must be standardised with checks carried out on performance. Marrero uses an interesting method for checking the effectiveness of the group intervention training. Participant observers were included in the groups to report back on how facilitators performed. Also the YMCA supervisor drops in on three to four sessions to check for consistency. They use session checklists to make sure that what's supposed to happen in a session has happened which also gives opportunities for qualitative feedback.

They have learned that the risk assessment in itself is potent and that 60 to 70% have a firstdegree relative with diabetes. Other lessons include that you can use lay facilitators, the importance of training in how to organise groups, group process and group dynamics, and how to control problem participants. They found that monthly facilitators' meetings are worthwhile to share ideas and stories, and to add new content to group work. They modified the training in response to participant and facilitator feedback.

Kaiser Permanente - the use of new technology

Like the Veterans Administration, Kaiser Permanente has an international reputation as a leading healthcare provider. Integration of primary, secondary and tertiary health of Kaiser's services creates the business conditions that support the best chronic disease management and prevention. Kaiser has its own research institutes and has internal resources, motivation and capability to implement the best evidence rapidly.

Dr Russ Glasgow PhD is Co-Director, Center for Health Dissemination and Implementation Research, Institute for Health Research, Kaiser Permanente, Colorado. His office in Denver, the mile high city, looks out to the snowcapped Rockies. He is renowned for his work on design and evaluation of practical and generalisable behaviour change interventions, particularly for diabetes, utilisation of interactive technologies in healthcare settings, application of the RE-AIM framework for planning and evaluation of translation for public health programs.

The RE-AIM framework is useful for researchers who want to translate theory into practice, and assess the impact of interventions. ¹³ RE-AIM stands for:

Reach

Efficacy/effectiveness

Adoption

Implementation

Maintenance

The RE-AIM website provides a number of useful resources including checklists, figures and tables, calculations, measures, and publications. We have found the RE-AIM framework useful for our Victorian diabetes prevention program.

We heard about and saw demonstrated their latest project in self-management, which uses Internet support and interactive voice response technology. ¹⁴ The emphasis is on medication adherence and lifestyle change maintenance. Patients log on to the website and can work through setting their own individual goals and monitor their own progress. Goals are labeled A B C D E F

- A = HbA1c
- B = blood pressure
- C = cholesterol
- D = doctor's advice
- E = exercise and physical activity
- F = good choices

Patients can print out copies of their goals and stick them on the refrigerator door. For physical activity for example, the patient can decide whether to track steps or track minutes, or for food they could make choices of improving on sugary drinks, fried food, or fast food. Over time the goals become most stringent. There are aides to decision making, for instance nutritional content of foods. Participants can see their lab results.

The participant's clinical care manager can also access the information as can the participant's doctor. A 'just-in-time' prompt links the participant's consultation with the doctor's electronic medical record. More information about the program is contained in Appendix 3.

We had a roundtable discussion on getting evidence into practice with Dr Russ Glasgow PhD, Dr Paul Estabrooks PhD, Dr. Elizabeth Bayliss MD MSPH, and Professor Perry Dickinson MD. Dr Estabrooks is an investigator at the Institute for Health Research with an interest in behavioural science, health promotion and disease prevention, physical activity, healthy eating behaviours, obesity treatment and management, patient self-management, dissemination and implementation science. Dr Bayliss is also an investigator at the Institute for Health Research with interests in processes of care for persons with multiple medical conditions including identifying and addressing barriers to medical self-care, improving functional health outcomes, and methods for measuring mobility. Professor Dickenson is Professor of Family Medicine at the University of Colorado and runs practice-based research networks devoted principally to the care of patients but for the purpose of examining healthcare processes that occur in practices. Much of his research aims to improve the care of patients with cardiovascular disease, diabetes or their risk factors. He is particularly interested in how evidence translates into practice.

The use of new technologies including the Internet-based interactive programs, voice activated programs, and automated telephone counselling are increasingly used by large organisations like Kaiser. The main reason is workforce shortage but it also allows more accurate measurement of a participant's progress. In trying to improve lifestyle risk factors, they apply

social ecology theory to the environment and protection motivation theory to the individual. A combination of both appears to give the best result.

The extent to which quality improvement methodology has been widely adopted in the US became evident from listening to the doctors talking. Everyone agreed that moving from randomised trials to the real world was difficult. Not only is far less resource available, but interventions are not necessarily well enough understood and there is the risk of watering things down. At Kaiser, like the VA and elsewhere, they scale up from a small pilot project in two or three stages. They use mixed methods to study individual and system factors related to context. The RE-AIM framework is helpful.

Within the medical arena, rapid cycle change is used to implement projects in small steps. Medical practices are given a menu of options for change and improvement and they choose which bits to start on first. For instance for diabetes, they might need to fix their recall IT system because they cannot do anything until it is working. Dickinson uses 'field agents,' facilitators who go into the practices to help them with implementation. Research funders recognise the need for these people. One of Dickinson's projects is funded by the Robert Wood Johnson Foundation. Dickenson recognises that getting these projects published is difficult because of the absence of control groups but they have learned to use qualitative measures alongside quantitative ones giving pre-and post-data.

5. IMPACT COORDINATED CARE FOR DEPRESSION: FROM RANDOMISED TRIAL TO IMPLEMENTATION

A substantial body of evidence has emerged for the effectiveness of collaborative care models for depression in primary care. Essential elements of collaborative care programs delivered in primary care include: evidence based protocols for treatment, structured collaboration between primary care providers and mental health specialists, and active monitoring of adherence to treatment and of outcomes. In 2006, a paper in the *Archives of Internal Medicine*¹⁵ reported a meta-analysis of the evidence for collaborative care based on 37 randomised controlled trials with a total of 12,355 patients. The researchers concluded:

'Sufficient randomised evidence had emerged by 2000 to demonstrate the effectiveness of collaborative care beyond conventional levels of statistical significance. Further and subsequent randomised trials have only sought to increase the precision of existing estimates of effectiveness, and it is unlikely that further randomised evidence will overturn this result.'¹⁵

The Department of Psychiatry at the University of Washington in Seattle has conducted a number of landmark clinical trials pioneering coordinated care of depression under the banner of the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) model. Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:

- The patient's primary care physician works with a care manager to develop and implement a treatment plan.
- The care manager and the primary care provider consult with a psychiatrist to change treatment plans if the patient does not improve.

The depression care manager may be a nurse, social worker or psychologist. The care manager's role is to: educate patients about depression; support prescribed antidepressant therapy; coach patients in behavioural activation and pleasant events scheduling; offer brief problem-solving counseling; monitor depression symptoms for treatment response; and complete a relapse prevention plan for patients who have not improved. A designated psychiatrist consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected.

The other two essential elements of the IMPACT model are:

Outcome measurement. The care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. The PHQ-9 [Patient Health Questionnaire – 9 items] is the recommended depression measure.

Stepped care: Treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm. The collaborative care team aims for a 50% reduction in symptoms within 10-12 weeks, and if the patient is not significantly improved the treatment plan is changed. Changes may include an increase in medication dosage, change to a different medication, addition of psychotherapy, or other treatments.

The original study conducted by lead researchers Professor Jurgen Unutzer and Professor Wayne Katon, was a randomised clinical trial of 1,800 adults aged 60 years or older with clinical depression. They tested IMPACT in 18 primary care clinics associated with diverse healthcare organisations in the United States. IMPACT proved to be significantly more effective than usual depression in all the organisations. Compared with the usual care group, the IMPACT group also had higher rates of depression treatment, greater satisfaction with depression care, lower severity of depression, less functional impairment, and better quality of life. ¹⁶

Research studies and evaluations of the IMPACT model in different populations and settings in recent years have shown its effectiveness with a range of adult patients with depression, including depression co-occurring with chronic diseases such as diabetes and cancer. An editorial published in the *British Medical Journal* in 2006 made favourable observations about the short-term and long-term acceptability and effectiveness of the IMPACT collaborative care for depression and urged movement to implementation:

'The evidence base is now sufficient for the emphasis to shift from research to dissemination and implementation' $^{\rm 17}$

We attended the 2-day IMPACT training program conducted by Professor Unutzer and colleagues at the University of Washington to see how they have managed to rollout the results of a randomised trial across the United States. The IMPACT group has set up an Implementation Center to assist organisations adopting the model, and some of the training focused on organisational change issues. Recognising that clinical environments that adapt quality improvement programs to fit their own needs are most likely to sustain them, the group encourages practices to adapt the IMPACT model to fit their own organisation, but encourages the use of patient outcomes as a benchmark for measuring program effectiveness.

The first day of the course workshop provides an introduction to the IMPACT model, emphasising a team-based approach to depression care. Breakout sessions are divided into content relevant to health care managers and similar professionals who will be adapting IMPACT to their practice settings, and content relevant to care managers and clinicians. The second day provides more in-depth work in these areas, including detailed sessions on problem solving treatment for depression, and developing a plan for implementing IMPACT in individual settings.

The course concentrates on how to do it, demonstrating tools and techniques, with clear identification of the key features of the program. A number of the trainers are working clinicians from different healthcare providers who participated in the randomised trial, and others like Dr Virna Little had been recruited subsequently, because of their ability to make things happen. The main effect is that course participants leave confident that they can make it happen in their organisations too. A copy of the program is contained in appendix 4; in appendix 5 is a copy of the IMPACT team tool as example of organisational development.

IMPACT Collaborative Care: From randomised trial to a family practice in the Bronx

This section will describe how the results of the IMPACT trial came to be disseminated to the extent that we could visit a family practice on the other side of the country to see collaborative care in action. Professor Wayne Katon and Professor Jurgen Unutzer finished their randomised

trial of coordinated care for depression in 2002. Earlier Unutzer had undertaken a similar study when working at UCLA only to see that nothing changed in day-to-day clinical practice. This time he was determined to see the implementation of the results. A key moment came when talking to a friend who worked in the Hollywood film industry. The friend asked, 'How much do you have for distribution?' Unutzer had to reply, 'Nothing.' The friend pointed out that for each dollar spent on film production, two dollars would be spent on distribution. So Unutzer went back to the funders of the randomised controlled trial and asked for distribution money to develop the training, tools and support for rolling out collaborative care to 150 clinics. Now 3,000 people have been trained to provide collaborative care. As time went on, people who showed special aptitude in applying collaborative care were drawn in as trainers by Unutzer. Dr Virna Little, manager and former clinical psychologist from the Institute of Family Health in New York is one such trainer.

The Institute of Family Health is based in the Lower East side of Manhattan with family practices elsewhere in Manhattan, the Bronx, and upstate New York. All 26 practices now provide collaborative care for depression. The Institute of Family Health provides a good case of what is required for local implementation. Dr Neil Calman who is a family physician and CEO provided top-level commitment. Dr Little was given the time and resource for implementation. She started with one early adopter practice gaining commitment from family physicians, nurses, case manager and psychiatrist. A key feature is that the organisation has electronic medical records so that it is easy to track performance. The clinical staff of the first practice became the champions who presented their results to other practices. Using the electronic record, the performance of each practice was tracked and clinicians called to account for poor performance. She describes the success as "being all over them like a cheap suit" reinforcing the key features of IMPACT with its pre-defined professional roles, supporting guidelines and protocols recall supported by IT and especially the monitoring of PHQ-9 scores. They enter PHQ-9 scores into the computer like lab values. A PHQ-9 score greater than 5 indicates depression. There is a question on suicidality with a score ranging from 0 to 3. A patient scoring 6 and indicating suicidal thoughts every day would be entered on the computer as 6.3.

We visited Parkchester Family Practice in south Bronx to see collaborative care in action. The staff spoke with pride and enthusiasm about their work in collaborative care. They had built it into their daily workflow and were committed to it. Building changes into workflow is a key step for local implementation. A nurse screens every patient presenting at the clinic and enters the score on the computer. The care manager who is a social worker is at the centre of the patient's care arranging treatment according to the guidelines which involves the family physician prescribing. The psychiatrist practices differently from usual in that he consults to the team of care manager, family physician and nurses on how to manage the patients and only sees those with the most serious problems. It is interesting that the nurse, care manager, family physician and psychiatrist have all subsequently become professional leaders outside of the Institute of Family Health and in roles beyond simply championing collaborative care.

Implementation of collaborative care at the Institute of Family Health is organisational development in action.

6. HARVARD BUSINESS SCHOOL: TALKING WITH WORLD EXPERTS ON LEADERSHIP AND TEAMS

Across the Charles River from Harvard's main campus in Cambridge lies Harvard Business School, itself the size of a small university. There we met Professor Amy Edmondson and Professor Ruth Wageman.

Our visit to Professor Edmondson was to find out about the Harvard leadership programs for doctors. There is a range of them but the one which seemed most relevant is a 3 x 1 week program. There is some preparatory work including accountancy and a small number of books and articles to be read in advance. Most of the learning comes from examination of case histories - experiential learning. The case history is used to get course participants to bring their experience to bear and learn from each other, working out how they would address the

problems posed by the stories. Some of the patients' stories were written by Paul Batalden. Sometimes course participants are expected to play roles within the case history or scenario. Theory comes later and includes strategy, marketing, accounts, understanding human behaviour, understanding group dynamics, group decision-making, safety and quality in healthcare.

Professor Ruth Wageman is Visiting Scholar in Psychology at Harvard University and Director of Research for the Hay Group's McClelland Center for Research and Innovation. Before moving to Harvard, Professor Wageman was at Tuck School of Business, Dartmouth College where she worked with Paul Batalden. Her research interests include power dynamics in teams, leader development and behaviour, and performance of senior management teams. She is best known for co-developing the Team Diagnostic Survey with Professor Richard Hackman. The Team Diagnostic Survey can be used both for the diagnosis of the strengths and weaknesses of work teams and for research on team behaviour and performance. ¹⁸ It is based on existing research and theory about conditions that foster team effectiveness. It provides an assessment of how well a team is structured, supported, and lead, as well as several indicators of members' work processes and affective reactions to the team and its work. Recently Wageman, Hackman and others have published a book called *Senior Leadership Teams*. ¹⁹ Drawing on a study of over a hundred top teams from around the world, the authors explain how to create a clear and compelling purpose for the team, recruit the right people, provide structural support and sharpen team members' competencies.

Professor Wageman writes beautifully and her theoretical work is referenced. ¹⁸⁻²¹ But it is her practical approach to facilitating organisational development that we want to capture here. This is her recipe for success which is based on her research. Interdisciplinary work requires interdependency between different departments within a system. Professor Wageman facilitates teams getting off to a good start. Her Team Diagnostic Instrument often helps to diagnose what the team needs to work on for better performance. Time and space, often an off-site retreat, is chosen to help make for a good launch. Teams go through a development exercise including discussing team norms, resources and roles, and what they expect from each other. There are also natural times in the life of the team to revisit the team as a facilitator. Usually these are the calendar reviews when she invites them to describe what's working for them and what they would like to do differently. She helps them diagnose what obstacles are in the way of the team's work getting done and produces a summary of the lessons learned. Sometimes she uses stimulus material; cases that are different from the work of the team. It can lead to inductive strategies and insight into what is good teamwork. These calendar reviews can last from a few hours to a whole day. Each ends with an action plan.

She likes to visit the site, to see how people are working collaboratively, to test the individuals' understanding of their roles, to see how well tasks are defined, and to look at the quality of leadership. She points out that a strict definition of individual tasks with performance reviews linked to them can work against the team achieving its goals because it is the 'whitespace' between the individuals' tasks that allows for improved performance. One of her techniques is to use 'public narrative' - teaching people to tell their own story by way of a call to action, shared 'choice points' of what it is that they have in common. Everyone hearing others' narratives can strengthen the interdependency and identify what people can do together. She asks what things in each narrative was most memorable to them as shared calls to action and what did they understand from each others? She calls it emergent purpose built on shared values.

THE HAY GROUP AND THE MCCLELLAND CENTRE FOR RESEARCH AND INNOVATION

During our Stream Six work, two senior consultants from Hay Group Melbourne participated in our advisory panel bringing their professional expertise in organisational development. Melbourne-based Hay Group director, Nicholas Jackson put us in touch with Professor Wageman and arranged for our visit to the McClelland Center for Research and Innovation. We learnt about how David C McClelland, a Harvard psychologist, had made a huge contribution to understanding achievement motivation. This is now evident in the work of Hay Group which specialises in aligning individuals, skills and jobs. Hay Group has the most widely used job evaluation methodology in the world and advises companies on assessment, selection and development of managers and executives. Their experience includes a very large project for Queensland Health. Hay Group brings behavioural research into industrial practice rapidly. Professor Wageman's research team at the Institute shared with us a number of their projects on organisational development in health services across the USA.

7. LINKAGE AND EXCHANGE

"Linkage and exchange" is a term coined by Jonathan Lomas, inaugural Executive Director of the Canadian Health Services Research Foundation. The concept is that evidence is as applicable to policy and management as it is for clinical practice, but that there is still a large gap between research evidence, and policy development and implementation at a local level. Lomas posited the idea that researchers and policy makers should work side by side throughout the research process from developing the research question to interpreting and reporting the data.

The 1:3:25 report format has proved useful when presenting to public servants. In truth, linkage and exchange did not work for us in the way it was intended mainly because the policymakers were either too junior or did not attend. Once the report was complete, we (JD & PR) made a visit to the First Assistant Secretary Primary Care, Richard Eccles, to present our results. Five weeks later he moved to another government post. Although linkage and exchange did work well between the nine research teams of Stream Six, in our view, it is naïve in influencing long-term change, and we review here how three groups view the links between research and policy. First we review the work of Professor John Kingdon, second the writings of Professor Huw Davis, and third we look at RAND Corp.'s approach.

Agendas, Alternatives, and Public Policies is the title of a book by John W Kingdon used as the primer for policy students at the University of Melbourne and elsewhere. ²² At the time of writing the book, Kingdon was Professor of Political Science at the University of Michigan (now Emeritus). He became interested in how some items rise and fall on a government's agenda, how problems are recognised and defined, policy proposals developed, how political events intervene and how these things are joined at critical junctures. Using case histories from health and transportation he studied how subjects came to officials' attention, how alternatives were generated, the government agenda set, and especially why an idea's time comes when it does.

In the preface to his second edition, he describes the process of agenda setting, alternative specification and policy formation as highly fluid and loosely coupled, various streams - problems, policies and politics - seemed to flow through and around the federal government largely independent of one another, and the policy changes occurred when the streams joined.

Here is brief summary of his analysis:

"An idea whose time has come" is almost a political catchphrase. What makes an idea's time come? Subjects drift onto and off the agenda, some become hot for a time and often no one knows why. Though Kingdon says it is a drastic oversimplification, public policymaking can be considered to be a set of processes, including at least (1) setting the agenda, (2) the specification of alternatives from which a choice is made, (3) an authoritative choice among those specified alternatives, as in a legislative vote for a presidential decision, and (4) the implementation of the decision. An idea whose time has come has to succeed in all four processes.

The political agenda is the list of subjects or problems for which the government has an intention to develop policy. Alternatives are usually prepared by public servants to give government a range of choices in how to proceed with items on the agenda. Agenda setting and alternative specification are governed by different processes with different actors. Generally agendas are set by politicians and alternatives by experts including academics undertaking research, though they may also have influenced the agenda. A little cameo about the origins of Health Maintenance Organizations (HMOs) illustrates this analysis and action. The Nixon administration was concerned about the dramatically rising cost of medical care. Senator Edward Kennedy had health initiatives on his agenda. The Nixon administration was

casting about for ideas unsuccessfully. They wanted something that fitted with less regulation and smaller government.

Paul Elwood, the head of a Minneapolis-based policy group was a firm believer in the values of prepaid group practice. In other words a subscriber paid a fee for services annually in return for an organisation providing medical care rather than fee-for-service. Elwood was well known in the community of health policy specialists. He was known to Thomas Joe, then a top assistant to health Undersecretary John Veneman. According to one of Kingdon's interviewees:

'Elwood was in town, and when he left, he happened to sit on the plane next to Tom Joe. They got into conversation, and Joe started bitching about how they have this problem, and nobody has any ideas. So Elwood says, "I've got an idea," and laid it out for him.'

Elwood packaged HMOs as a way of introducing marketplace competition into the medical care system rather than as a liberal do-gooder idea. This twist made it congruent with Nixon's policies. The idea of prepaid medical care had been around for a long time but it took this set of coincidences for the idea's time to come.

The inexorable march of problems pressing in on the system, the gradual accumulation of knowledge and perspectives among specialists and political processes themselves may all be considered agenda setting. In the US system, the president sets the agenda but the alternatives are usually set elsewhere. Politicians come and go but the bureaucracy endures, accumulating expertise. One feature of this part of the process is muddling through. There are two reasons. First, we have a limited ability to process information about more than one comprehensive approach far less many options. Second, clarifying goals too specifically may operate against obtaining broad support for a proposal. There is a bureaucratic tradition of incrementalism. This means that a proposal rarely goes ahead completely *de novo* but is adapted to fit with and be built onto an existing program. In other words, proposals undergo transformation.

In addition to not defining goals clearly, members of the bureaucracy often don't understand their own organisational arrangements very well, and people drift in and out of the decision-making processes. Turnover of personnel adds to the fluidity. Kingdon coined the term "policy primeval soup" for what happens to ideas like research findings as they make their way into policy.

In an article entitled *Why 'knowledge transfer' is misconceived for applied social research* written earlier this year, Professor Huw Davies et al question the accuracy of terms like knowledge transfer and exchange. ²³ Professor Davies holds the Chair of Health Care Policy and Management at the University of St. Andrews, is formerly Deputy Director of the Service Development and Organisation NHS national R&D program and a former APHCRI visiting International Fellow with substantial experience on the relationship between research and policy in healthcare.

The authors contend that using evidence to support policy and practice has become a shibboleth. In their view evidence-based policy, evidence-based practice, and knowledge transfer overstate what is happening and understate the complexities of translating research into policy. Echoing Batalden, Fisher, Glasgow, Vandenbroucke and others the authors point out that using the hierarchy of evidence with the primacy of randomised trials is conceptually too narrow. We also require knowledge about scale, source and structuring; practical knowledge to support effective program implementation in different contexts; and insights into the relationships between values and policy directions. Discovering this knowledge requires methodological diversity including non-research techniques such as clinical audit and consequently the results cannot always be neatly integrated or synthesised.

Moreover research is needed not only to support and elaborate policy, but also sometimes to challenge widely held assumptions. This may find the researcher in a position critical of government policy. Contestedness has an important role in the advancement of knowledge but may be seen as obstructing (short-termist) policy.

Knowledge transfer and translation implies that convergent knowledge can be neatly packaged for transfer elsewhere. The authors point out that only the simplest and most incontrovertible findings are amenable to this mechanism. In healthcare the subtlety and complexity of research use in context is unlikely to fit such a simple model of 'translate and transfer.'

In keeping with the ideas of John Kingdon, the authors describe how research outputs contribute in a continual and iterative process, drawing on diverse kinds of knowledge through many different channels and involves more or less translation or indeed transformation along the way. Interpersonal and social interactions are often seen as key to accessing and interpreting such knowledge, whether among policy or practice communities, research intermediaries or more directly with researchers themselves. It is an elaborate and dynamic process involving complex social processing and unpredictable integration with pre-existing knowledge and expertise.

Above all, for research to be useful it is the knowledge about context for an intervention that is critical. The context of local priorities, cultures and systems influences the usefulness of research. Linkage and exchange, and knowledge transfer are rooted in traditional rational-linear models of research use and assume that there are two communities -research producers and potential research users working in the policy arena. It is assumed that interactivity between the two groups will improve the transfer and application of research. In the social world, no single source of knowledge can be counted on to provide definitive answers, results can be contested and contradictory, and evidence is partial, contingent and provisional. The authors suggest that knowledge interaction better reflects the messy engagement of multiple players with diverse sources of knowledge, and knowledge inter-mediation begins to articulate some of the managed processes by which knowledge interaction might be promoted. They argue for a nuanced understanding of knowledge transfer.

RAND CORP motto: *'Improved policy and decision making through research and analysis'*

For 60 years, decision makers in the public and private sectors have turned to the RAND Corporation for objective analysis and effective solutions that address the challenges facing the nation and the world. RAND specialises in three fields of research: military (its origin was in the Douglas Aircraft Corporation until 1948), health and education. A long list of Nobel laureates have worked with RAND. About half of the 500 researchers in RAND work in health. Its research program is done in partnership with universities and health providers

Dr Allen Fremont is the director of RAND's action program. Typical projects are focused on something practical, e.g. diabetes care. Part of the iteration between research and policy is how a government decides what it wants to research based on having general policy areas, then calling for one to two page expressions of interest to see what matches the general policy areas, and then calling for full proposals. A group of researchers is involved in advising government about which projects to select. One of the important aspects of this program is its rapid turnaround. At Dr Fremont's level and above, findings from research are fed into policy in other ways including congressional hearings. RAND has an office in Washington DC with staff who look for opportunities to provide input to the various policy making government bodies who in turn will often ask RAND for information. It is interesting to note that people at RAND do not see linkage and exchange as the mechanism but rather work with the political and government processes as opportunity arises.

RAND has a communications group which tries to get research findings into the media. They also take information to congressional aides as well as to the congress representatives and to the Congress.

8. OPTIONS FOR IMPROVING LINKAGE AND EXCHANGE

- Recognise that policymakers are too busy to participate in the research process. The best way to present the results to them is by visiting them at the end of the study. Emphasise the importance of drawing research findings to the attention of policymakers through social interaction.
- Make personal presentation to the appropriate level of policymaker part of the funded work and develop a short training program on research and policy based on a more sophisticated approach than simply Linkage and Exchange.
- APHCRI now has a huge body of knowledge which could be shared between those who have produced it. It is unlikely that anyone will read more than a fraction of it. Consider bringing leading researchers together for a forum that synthesises what is known. This process should be complete before the next stage of bringing the results to the attention of policymakers.
- Health Forum: arrange for researchers and policy makers to meet at the relevant time, for instance, shortly after the publication of the primary care strategy.

8.1 POLICY OPTIONS

In the Stream Six report we listed three options. They were:

- Continuation of the Collaboratives
- Practice accreditation extended to clinical standards and systems
- Initiatives in clinical leadership and team development

The information we gathered in Stream Ten supports these options and adds further refinement to how they would work.

8.2 COLLABORATIVES

The quality improvement methodologies used in the United States are now more sophisticated than simply Collaboratives. Indeed they regard Collaboratives as a bit boring and definitely yesterday's idea. We were struck by how every medical doctor we met knew about quality improvement and used it routinely at work. It is embedded in the core competencies required by Colleges for accreditation – see page xx and appendix 2. One of the most sophisticated implementation of Collaborative methodologies is the IMPACT team approach to managing depression that we described earlier. Numerous adaptations of IMPACT have been made for different populations and organisational settings across the US, and are being taken up in other health systems such as Canada.

Aim: To enlarge substantially the understanding and practice of quality improvement methodology in Australian research and healthcare. Some of the ways this aim can be realised are:

- The Australian Commission for Safety and Quality in Healthcare benchmarks itself against the US National Quality Forum.
- The National Institute for Clinical Studies, the Improvement Foundation or both be funded to run training programs in quality improvement methodology for health professionals.
- Research into quality improvement of Australian healthcare be strongly supported by ensuring that the NHMRC has Grant Review Panel chairs for primary care, public health and health services research trained in quality improvement methodology.
- The NHMRC Partnership round could set a priority for collaborations that seek to implement the results of randomised trials in the real world.
- The techniques used in Collaborative Learning Networks (see page xxx) could be embedded in Divisions of General Practice.

- The government requires accreditation to be based on an Australian version of the six competencies. This will involve working with the medical colleges and accreditation agencies like AGPAL.
- The Australian Healthcare Agreement could be used to embed quality improvement methodology for translation of evidence into practice in the same way that it has been used to promote patient safety.

8.3 INITIATIVES IN CLINICAL LEADERSHIP AND TEAM DEVELOPMENT

In the Stream Six report we drew attention to clinical leadership training run by the Improvement Foundation and others. We also drew attention to the UK Royal College of General Practitioners Quality Team Development program. We continue to recommend these approaches for widespread use throughout general practice. In addition we recommend that selected medical leaders in Divisions be funded to complete programs such as the Harvard Business School course with an integrated course at the Institute for Healthcare Improvement.

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APPENDIX 1 – ITINERARY APHCRI TRAVELLING FELLOWSHIP, 1ST-18TH OCTOBER 2008

1. University of Washington

IMPACT Training University of Washington

Centre for Urban Horticulture Seattle, Washington

Professor Jurgen Unutzer, M.D., M.A., M.P.H. Vice-Chair of Psychiatry

Professor Wayne Katon, MD, BS

Professor, Psychiatry & Behavioral Sciences Adjunct Professor, Health Services

Dr Virna Little, PsyD Vice President for Psychosocial Services and Community Affairs

Professor Tom E Norris, MD Vice Dean for Academic Affairs

2. Dartmouth Medical School, New Hampshire

Professor Paul Batalden, MD Professor of Paediatrics and Community and Family Medicine

3. Harvard Business School

Professor Ruth Wageman

Edgar Pierce **Professor** of Social and Organizational Psychology

Professor Amy Edmondson, PhD Novartis Professor of Leadership and Management Co-Unit Head, Technology and Operations Management

Hay Group and McClelland Institute

Professor Ruth Wageman

Director of Research

Research Staff in Healthcare and leadership

4. Indiana University, Indiana

Professor David Marrero, PhD J. O. Ritchey Professor of Medicine Division of Endocrinology & Metabolism

Associate Professor Ron Ackermann, M.D., M.P.H Assistant Professor, Internal Medicine

5. The Institute for Family Health, New York

Ms Charmaine Ruddock Project Director, REACH 2010

Dr Virna Little, PsyD Vice President for Psychosocial Services and Community Affairs

On-site visit and meeting with staff, Parkchester Primary Care practice, Bronx

Dr Jane Bedell, MD Assistant Commissioner of Public Health

Dr Neil Calman, MD President and CEO

Dr Joseph Lurio Chief Medical Officer, Medical Director Amsterdam Center

6. University of North Carolina, Chapel Hill

Professor Edwin Fisher, PhD Professor of Health Behavior and Health Education

Discussion with faculty and students

Professor Morris Weinberger, PhD Professor of Health Policy and Management

Dr. Renee Boothroyd, PhD Director, *Peers for Progress* Program Development Center

Zulfia Chariyeva, M.P.H Peers for Progress Program Development Center

Dr Claudia de Oliveira, M.D Peers for Progress Program Development Center

Teleconference with Dr Carol Brownson, MSPH **and Mary O'Toole**, PhD Deputy Directors of Robert Wood Johnson Foundation Diabetes Initiative

7. Kaiser Permanente, Denver, Colorado

Dr Russell Glasgow, PhD Senior Scientist

8. RAND Corporation

RAND Health, California Staff seminar

Dr Karl Lorenz, MD, MSHS Greater Los Angeles Healthcare System Veterans Integrated Palliative (VIP) Program

Dr Allen Fremont, MD, PhD Natural Scientist and Sociologist

Dr Chloe Bird, PhD Social Scientist

Dr Cathy Sherborne, PhD Senior Behavioral Scientist

Dr Yee-Wei Lim, MD, PhD Natural Scientist

APPENDIX 2 – EXAMPLE OF REVIEW OF INTERNAL MEDICINE PROGRAM FROM PROFESSOR PAUL BATALDEMN

EXAMPLE

AN INTERNAL REVIEW CHECKLIST FOR THE GENERAL COMPETENCIES

Can be completed as part of a Program Director's questionnaire if used in the internal review or can be completed by the internal reviewers.

Example of review for an *Internal Medicine* Program

General Competencies	List Evaluation Tools Used or In Development by the program (completed by the program director in internal med. At Sample Hospital)					
					Other tools designed by program?	
Patient Care	Developing OSCE	Mini CEX	Patient Surveys	Procedure Logs		
Medical Knowledge	Chart Stimulated Recall	Oral Exam	Written Exam- Multiple Choice			
Interpersonal and Communication Skills	Developing 360 Degree	Patient Surveys	Standardized Patients			
Professionalism	360 Degree	Checklist				
Practice Based Learning	Resident Portfolios	Developing Oral Exam	Record Review			
Systems Based Practice	Developing Resident Portfolios	Developing 360 Degree				

List the evaluation tools used by the program for the following General Competencies:

The Program Director to provide the internal review committee with

- **1.** documented evidence of a curriculum with goals and objectives for the general competencies currently implemented;
- 2. documented evidence of the evaluation tools used that he/she has listed; List Evaluation Tools Used or In Development by the Program (completed by program director in internal med. at Sample
- **3.** *the status of developing and using dependable measures to assess a resident's competence in these areas; and,*
- 4. the status of developing a process that links educational outcomes with program improvement.

APPENDIX 3 – FROM DR RUSSELL GLASGOW, KAISER PERMANENTE

Linking Self-Management and Primary Care for Diabetes (Linkbase 2)

Specific Aims:

1. Revise the current interactive, CD-ROM-based diabetes self-management

program for an effectiveness trial based on findings from the current grant,

formative research, and related interactive programs in partnership with our implementation settings, to include components on medication adherence and patient activation, as well as more frequent follow-up contact and ongoing support via the Internet and interactive voice response (IVR) telephone support.

2. Conduct a randomized, practical effectiveness clinical trial to evaluate the impact of I) the revised interactive program in Aim 1 compared to 2) the interactive program plus a diabetes care manager maintenance component focused on social-environmental factors and; 3) an enhanced usual care condition. Participants will be English- and Spanish-speaking adult type 2 diabetes primary care patients. The key outcomes will be: a) improvement in health behaviors (e.g., dietary patterns, physical activity, medication taking) and b) biologic outcomes as assessed by the UKPDS heart disease risk formula (made up of components including hemoglobin A1 c, lipid ratio, blood pressure, and smoking status). Key secondary outcomes and process measures will include diabetes-specific quality of life (Diabetes Distress Scale), patient activation (PAM scale), and perceived social environmental support (the Chronic Illness Resources Survey) at 4- and 12-month follow-ups.

3. Use the RE-AIM model to evaluate the reach, adoption, effectiveness, and maintenance of the above programs for adult diabetes patients from staff model managed care, primary care settings.

4. Important secondary aims will be to understand the implementation and

utilization of this integrated program, its linkages to primary care, and facilitators and barriers to program success, with particular emphasis on:

- a. cost and cost-effectiveness, and
- b. mediators and moderators of outcomes.

5. Based upon the findings above, to revise the condition found to be most cost effective, develop user-friendly implementation guides, and implement a multipronged dissemination plan.

APPENDIX 4 – IMPACT TRAINING AT UNIVERSITY OF WASHINGTON, SEATTLE

IMPACT Workshop Agenda

University of Washington Center for Urban Horticulture Seattle, WA October 2-3, 2008

October 2nd

- 8:00 Registration & Continental Breakfast
- 8:30 Welcome, Introductions
- 8:45 IMPACT: A Practical Approach to Team-Based Depression Care (Jürgen Unützer)

Objectives:

- 1. What is depression and why treat it in primary care?
- 2. Describe the IMPACT model of depression care.
- 3. Summarize the evidence supporting IMPACT.
- 4. Describe the stepped-care treatment algorithm for depression.

9:45 Team Care: the Intersection of Behavioral Health and Primary Care (Jürgen Unützer, Rita Haverkamp, Lori Higa)

Objectives:

- 1. Recognize the importance of a team approach to depression.
- 2. Discuss benefits of collaborative care for both patients and providers.
- 3. Describe effective ways to interact with a patient's primary care provider.
- 4. Demonstrate ways to introduce the program to PCPs and patients.
- 5. Discuss strategies for bridging the divide between behavioral healthcare and medical care.

10:30 Break

10:45 Concurrent Sessions

<u>A: Implementation</u>

Adapting IMPACT to Diverse Practice Settings: Translating Research to the 'Real World'

(Jürgen Unützer, Virna Little, Diane Powers)

Objectives:

- Discuss building the IMPACT team, hiring and training staff, and options for clinical tracking systems.
- 2. Describe options regarding financing IMPACT care.
- Describe adaptations of the IMPACT model for diverse practice settings (eg. disease management, behavioral health, rural settings) and populations (eg. Latino diabetics, coronary artery disease, HIV/AIDS).

12:15 Lunch

B: Clinical

Depression and Chronic Medical Illness

(Wayne Katon, Stephen Thielke, Rita Haverkamp, Lori Higa) Objectives:

- Describe the intersection of depression and medical illness: diabetes, congestive heart failure, coronary artery disease, chronic pain.
- 2. Discuss integration of depression and chronic disease care management.

1:00 Key Components of Depression Care Management

(Rita Haverkamp, Lori Higa)

- Care management and Caseload tracking
- Initial session / education / treatment options
- Follow-up contacts / PHQ-9 / symptom tracking
- Relapse prevention

Objectives:

- 1. Describe and demonstrate the key components of the IMPACT intervention as they are implemented by the care manager.
- 2. Describe and demonstrate patient education about depression and treatment planning.
- 3. Discuss the importance of tracking clinical outcomes and changing treatment plan if patient not adequately improved.
- 4. Describe and demonstrate the elements of a relapse prevention plan.

2:30 Break

2:45 Antidepressant Medications - Overview and Care Manager Role

(Jürgen Unützer, Lori Higa, Rita Haverkamp)

Objectives:

- 1. Describe key principles of antidepressant therapy and types of medications commonly used in primary care.
- 2. Discuss patient education about antidepressants.
- 3. Describe care manager role in supporting medication therapy.

3:45 Behavioral Activation

(Rita Haverkamp, Lori Higa, Jürgen Unützer)

Objectives:

- 1. Appreciate the role of behavioral activation in managing depression.
- 2. Describe ways to encourage behavioral activation.
- 3. Describe how to integrate behavioral activation into depression care management.

4:25 Homework Assignment

4:30 Adjourn Day 1

October 3rd

- 8:00 Continental Breakfast
- 8:30 Review of Day One, Q&A

9:15 Challenging Cases and Psychiatric Consultation

(Jürgen Unützer, Rita Haverkamp & Lori Higa)

- Persistent depression, comorbid medical conditions, comorbid psychiatric conditions <u>Objectives</u>:

- 1. Recognize difficult cases that may benefit from psychiatric consultation.
- 2. Discuss the most effective ways to obtain psychiatric consultation in a variety of clinical settings.
- 3. Managing patients at risk for suicide.

10:15 Break

10:30 Concurrent Sessions

C: Clinical

Problem-Solving Treatment (PST): Introduction and Initial Session

(Steven Vannoy, Rita Haverkamp, Lori Higa)

Objectives:

- 1. Understand the theoretical model and evidence base for PST.
- 2. Outline key steps of problem-solving therapy.
- 3. Discuss key elements of initial PST session.
- 4. Observe initial PST session.
- 5. Role play

12:30 Lunch

1:15 Concurrent Sessions

E: Clinical

Problem-Solving Treatment (PST): Follow-up Sessions, Group PST, Certification Process

(Steven Vannoy, Rita Haverkamp, Lori Higa) Objectives:

Objectives:

- 1. Discuss key elements of successful follow-up session.
- 2. Observe follow-up PST session.
- 3. Describe Group PST.
- 4. Develop skills in PST through role play.
- 5. Discuss two step certification process.

3:15 Break

3:30 Panel Discussion with Presenters Objectives:

Questions and answers on all topics addressed in the training.

4:30 Adjourn Day Two

<u>D: Clinical</u> Medications In-depth: What To Do When Antidepressants Fail

(Marty Hoiness) Objectives:

- Describe when to initiate, titrate, and switch antidepressants.
- 2. Discuss combination therapy and drug interactions.
- 3. Address special considerations for antidepressant use.

<u>F: Implementation</u> Individual Consultancy

(Jürgen Unützer, Virna Little, Diane Powers) Objectives:

 Individual consultations regarding implementation challenges and opportunities in your practice or organization.

Training Faculty

Rita Haverkamp MSN, PMHCNS-BC, CNS

Rita is a psychiatric nurse clinical specialist. She has her masters' degree in psychiatric nursing from the University of Cincinnati. She has been ANA certified as an advanced practice psychiatric nurse/ clinical specialist since 1985. She is the past president of the California Chapter of the American Psychiatric Nurses Association.. She has previous experience as an inpatient head nurse and a manager for multiple psychiatric units. She has worked for Kaiser Permanente for the last 20 years as an outpatient therapist. She was a depression specialist in the original IMPACT depression care research. The last 9 years she has been providing IMPACT depression care within her role at Kaiser. She currently does consulting with the IMPACT dissemination grant. She is a frequent speaker presenting on the IMPACT model, problem solving therapy and cognitive therapy. She provides PST-PC supervision to depression care managers.

Lori Higa, RN

Lori is a home health and hospice nurse for Group Health Cooperative in Seattle. She received her Bachelor's in nursing from Seattle University. She started community mental health nursing, 14 years ago, working with deaf mentally ill adolescents and adults, adjudicated youth, and school-based mental health programs at Seattle Mental Health. In a slight detour, she coordinated a wound healing study looking at effectiveness of radiant heat to treat deep pressure ulcers at the University of Washington Biobehavioral Nursing and Health Systems. She has worked as a care manager providing behavioral activation and problem-solving therapy for three different research studies following the original IMPACT study. Those studies were Pathways, a research study treating diabetic patients with depression, and CARE study, providing education and treatment options for adolescents with depress, and IMPACT-DP pilot study, treating older patients with arthritis pain and depression. She uses behavioral activation techniques through an obsessive-compulsive relationship to playing beach volleyball.

Marty Hoiness, MD

Marty Hoiness, MD is section head of Psychiatry at Virginia Mason Medical Center. He also is on the clinical faculty at the University of Washington. Dr. Hoiness spent his early career at the University of Washington. He was medical director of the Harborview Medical Center DBT program and worked exclusively with patients with Borderline Personality Disorder. At Virginia Mason, his work involves medication treatment of patients with depression, anxiety, and bipolar disorder. Dr. Hoiness also is in the process of implementing an IMPACT program at Virginia Mason.

Wayne Katon, MD

Wayne Katon, MD, is Professor of Psychiatry, Director of the Division of Health Services and Epidemiology, and Vice Chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington Medical School. He is Director of a NIMH-funded National Research Service Award Primary Care Fellowship that has successfully trained psychiatrists and primary care physicians for academic leadership positions. Dr. Katon is internationally renowned for his research on the prevalence of anxiety and depressive disorders in primary care, the relationship of psychiatric disorders to medically unexplained symptoms such as headache and fatigue, and the impact of depression and anxiety on patients with chronic medical illness. In recent years, his research has focused on developing innovative models of integrating mental health professionals and other allied health personnel into primary care to improve the care of patients with major depression and panic disorder.

Dr. Katon has been awarded the American Academy of Family Practice Award for Excellence in Teaching in Primary Care numerous times. He also has been awarded the Academy of Psychosomatic Medicine Research Award (1993) and the American Psychiatric Association Senior Scholar Health Services Research Award (1999). He is Editor-in-Chief of *General Hospital Psychiatry*.

Dr. Katon has written over 300 peer-reviewed journal articles and chapters, as well as *Panic Disorder in the Medical Setting*, a book for primary care physicians. In addition, Dr. Katon and his research team have written a self-help book for depressed patients titled *Depression: Self-Care Companion for Better Living*.

Virna Little, LCSW-R, SAP, PsyD

Virna Little is responsible for the administration and delivery of social work and mental health services at all Institute For Urban Family Health and Continuum Family Practice Management health centers in the Bronx and Manhattan. This includes social services program development and outreach, and administration of and participation in client support services; oversight of the Institute's Ryan White Programs in the Bronx and Manhattan, New York; a 340B Pharmacy Program; and services for the uninsured.

Ms. Little has extensive experience working with clients in need of counseling and support relating to HIV and AIDS, substance abuse, domestic violence prevention, child abuse prevention, and psychiatric assessment. Before joining the Institute, she provided social services at the Department of Corrections and New York City Health and Hospitals Corp. She received a Master of Social Work degree from Fordham University and a BA in social work and psychology from the State University of New York at Albany. Ms. Little has served as an Adjunct Professor at Westchester Community College and the College of New Rochelle. She is currently working on a doctorate in psychology from California Coast University.

Diane Powers, MA

Diane Powers manages the IMPACT Implementation Center at the University of Washington as part of an overall program in geriatric mental health services research headed by Jürgen Unützer. She has over seventeen years experience as manager of a wide range of public health and health services research projects and programs. She also has more than eight years experience providing mental health services in both inpatient and outpatient settings. Ms. Powers received a BA in Psychology and English Literature from Gonzaga University and a master's degree in Psychology from Seattle University.

Stephen Thielke, MD, MA, MSPH

Stephen Thielke is an Acting Assistant Professor of Psychiatry at the University of Washington, and an investigator at the Geriatric Research, Education, and Clinical Center of the Puget Sound VA Health Care System. He grew up in Seattle, and attended the University of Washington for medical school, residency in psychiatry, fellowship in geriatric psychiatry, and a fellowship in Geriatric Mental Health Services Research. He conducts research about various topics, including the treatment of mental health conditions in primary care, the effects of pain on the lives and health of older adults, population modeling of depression and illness, and interventions to sustain independence. He enjoys spending time with his family, and tearing down things in his house well in advance of fixing them up.

Jürgen Unützer, MD, MA, MPH

Dr. Unützer is Director of the IMPACT Implementation Center and an internationally recognized mental health services researcher who works with national and international organizations to improve care for common mental disorders, such as depression. Dr. Unützer's research focuses on integrating innovative models of mental health care into general medical settings and on 'translating' research on evidence-based mental health treatments into effective clinical and public health practice.

Dr. Unützer is Professor and Vice-Chair of Psychiatry and Behavioral Sciences at the University of Washington and Chief of Psychiatric Services at the UW Medical Center. He is also an Adjunct Professor of Health Services at the UW School of Public Health and an Affiliate Investigator at the Center for Health Studies at Group Health Cooperative. Dr. Unützer has served as Senior Scientific Advisor to the World Health Organization and as an advisor to the President's New Freedom Commission on Mental Health. His awards include the Paul Beeson Physician Faculty Scholars Award in Aging Research from the American Foundation for Aging Research, the Gerald L. Klerman Investigator Award from the Depression and Bipolar Support Alliance, and the Distinguished Scientist Award from the American Association of Geriatric Psychiatry.

Dr. Unützer received his MD from Vanderbilt University, his MA in Public Policy from the University of Chicago, and his MPH in Health Services from the University of Washington. He completed fellowships in Geriatric Psychiatry at UCLA and in Primary Care Psychiatry / Health Services Research at the University of Washington.

Steven Vannoy, PhD, MPH

Steven Vannoy is an Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington. Dr. Vannoy has received clinical training and conducted outcome research in a wide range of psychotherapy modalities. These modalities include cognitive behavioral therapy, interpersonal psychotherapy, group-based psychotherapy, family therapy for post partum depression, and problem solving therapy in primary care. Dr. Vannoy's current research interests focus on delivery of effective prevention and treatment of depression and suicide in late-life in community settings.

Dr. Vannoy received his PhD in counseling psychology from the University of Wisconsin - Madison and performed his internship in the Public Behavioral Health and Justice Policy program at the University of Washington.

APPENDIX 5 – MATERIAL FROM IMPACT WORKSHOP

IMPACT Implementation Center Team Building Worksheet

The purpose of this worksheet is to help your organization identify components of collaborative care that are:

- important to your mission
- already part of your program or services
- something that you want to add to your existing program or services and to link these tasks to specific individuals within your collaborative care team.

This worksheet is designed to be completed by treatment-team members, including:

- primary care providers (e.g. physicians, physician assistants, nurse practitioners)
- nurses
- mental health providers (e.g. psychiatrists, psychologists, social workers, counselors)
- medical assistants
- clinic administrators and managers

The worksheet is intended to support a collaborative effort, with all team members completing the worksheet and then having a series of discussions aimed at resolving any gaps or discrepancies in the "ownership" of the various collaborative care tasks. It is quite possible that you will have important tasks that are a part of your care process that are not represented on the worksheet - please feel free to comment and/or add items as appropriate to your organization (there is room at the end of the document for doing this).

Each task in the worksheet contains a brief description of the task. As a part of the on-going training and support services being provided, we will all come to understand the details of these tasks and the individual nature of implementing them by each team. By engaging in this process, we hope to identify the training and support that would be most helpful to your organization regarding building and utilizing collaborative care teams.

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

IMPACT Implementation Center Team Building Worksheet

What is your main job category? (check all that apply) Care coordinator or care manager Primary care provider (e.g., MD, DO, PA, ARNP) Clinic administrator Quality improvement Clinic support staff (e.g., RN, MA) D Psychiatrist (MD) D Psychologist Social worker Other mental health provider Other: What do you consider your main discipline? Social work Psychology □ Nursing Medicine (primary care) □ Medicine (psychiatry) Other: Have you completed your training in this discipline? No (e.g., completing internship or residency) Yes (finished degree and clinical training) What is your highest degree (e.g. MD, MSW, PhD, RN, MA, BS)? ____ How many years have you had worked in MENTAL HEALTH? ___ How many years have you had worked in PRIMARY CARE? ____ How would you describe your primary role in IMPACT depression care? ___

How long have you worked with the other team members on your depression care team? ____ yrs

Depression Care Tasks	A. How IMPORTANT is this task in depression care?	B. How COMFORTABLE are you with your level of skill performing this task?	C1. To what extent is this task part of YOUR ROLE?	C2. If you responded "maybe my role" cr "not my role" to C1, please indicate WHOSE ROLE it is:	D. Are you CURRENTLY PERFORMING this task?
Identify patients for depression care management (e.g., by screening)	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Make or confirm depression diagnosis	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Rule out or treat medical causes or comorbid medical conditions	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Provide patient education about depression and self management	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Provide behavioral activation or pleasant events scheduling	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Provide evidence- based brief psychotherapy (e.g. PST, CBT, IPT)	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Prescribe antidepressant medications	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Follow-up to evaluate medication adherence and side effects	 Very Somewhat Not at all 	 □ Very □ Somewhat □ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Assist patient with addressing medication side effects	 Very Somewhat Not at all 	 ❑ Very ❑ Somewhat ❑ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Follow-up with patients who don't return after starting treatment to make sure they don't 'fall through the cracks'	 Very Somewhat Not at all 	 ❑ Very ❑ Somewhat ❑ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Track patients' treatment response using a structured tool (e.g. PHQ-9)	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No

Depression Care Tasks	A. How IMPORTANT is this task in depression care?	B. How COMFORTABLE are you with your level of skill performing this task?	C1. To what extent is this task part of YOUR ROLE?	C2. If you responded "maybe my role" or "not my role" to C1, please indicate WHOSE ROLE it is:	D. Are you CURRENTLY PERFORMING this task?
Record patients' treatment response in a database or registry to aid identification of patients needing treatment change	Very Somewhat Not at all	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Facilitate change in treatment plan if patient not at least 50% improved after 10-12 weeks	 Very Somewhat Not at all 	□ Very □ Somewhat □ Not at all	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Support medication therapy (e.g. monitoring adherence, side effects)	 Very Somewhat Not at all 	 □ Very □ Somewhat □ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Make and follow-up on referrals for specialty mental health care for complex patients or those not responding to treatment in primary care	Very Somewhat Not at all	 Very Somewhat Not at all 	□ Definitely my role □ Maybe my role □ Not my role		□ Yes □ No
Make and follow-up on referrals for other specialty care, as needed (e.g. substance abuse)	 ❑ Very ❑ Somewhat ❑ Not at all 	 ❑ Very ❑ Somewhat ❑ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Complete relapse prevention plan with patients who are sufficiently improved to leave acute treatment	Very Somewhat Not at all	 □ Very □ Somewhat □ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Provide consultation to primary care providers about managing difficult patients	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No

	A. How	B. How	C1. To what extent is this task part of YOUR	C2. If you responded "maybe my role"	D. Are you CURRENTLY
Depression Care Tasks	is this task in depression care?	are you with your level of skill performing this task?	ROLE?	or "not my role" to C1, please indicate WHOSE ROLE it is:	PERFORMING this task?
Communicate with other providers (PCP / CC / Psychiatrist) about patients who are not improving	□ Very □ Somewhat □ Not at all	 ❑ Very ❑ Somewhat ❑ Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Observe other team members' caseloads and performance	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Provide in-person consultation to evaluate patients who present diagnostic or therapeutic challenges	□ Very □ Somewhat □ Not at all	 ❑ Very ❑ Somewhat ❑ Not at all 	Definitely my role Maybe my role Not my role		□ Yes □ No
Other task not listed (write in):	□ Very □ Somewhat □ Not at all	□ Very □ Somewhat □ Not at all	Definitely my role Maybe my role Not my role		□ Yes □ No
Other task not listed (write in):	 Very Somewhat Not at all 	 Very Somewhat Not at all 	 Definitely my role Maybe my role Not my role 		□ Yes □ No
Other task not listed (write in):	□ Very □ Somewhat □ Not at all	□ Very □ Somewhat □ Not at all	 Definitely my role Maybe my role Not my role 		□ Yes □ No