Title Slide: Implementation and Spread of Multilevel Interventions in Practice: *Implications for the Cancer Care Continuum*

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Slide 3: Introduction

- Scientific evidence about what works in health care takes decades to move to routine care
  - Evidence is flawed → tested under highly controlled and homogenized circumstances
  - Applied to real world settings □ "voltage drop"
- Greater recognition of contextual influences underlying intervention success (or failure)
  - Motivated interventions that target context levels (patients, providers, practices, communities, policy)
- Few multilevel interventions (MLIs) conducted along cancer continuum: fewer implemented

Slide 4: Implementation and Spread

- How is implementation different?

    - *Not* testing the original efficacious intervention
    - Testing a set of strategies for deploying the MLI
    - Adapted to different contexts (settings, levels)
    - Focused on activities that facilitate uptake of MLI
- Requires engagement/involvement of wide range of stakeholders
    - Partners in implementation at each level
    - Researchers' capacity to influence determined by handoffs and support constructed through partners
    - Creating new ways of "doing business"

Slide 5: Approach

- Identified cancer and non-cancer MLI exemplars
- Span different levels and different stages of care continuum

Slide 6: Implementation and Spread of Multi-Level Interventions

[image]

Figure 1: Implementation and Spread of Multi-Level Interventions: Levels Covered by Cancer and Non-Cancer Exemplars

There are six levels in the image and 6 Exemplars. The list of levels are:

- National
- State
- Communities
- Practices
- Providers
- Patients

This section lists the exemplars and which level they are connected to:

- Choice
    - Practices
    - Providers
    - Patients
- H V M A Systems
    - Practices
    - Providers
    - Patients

- Pool Cool
  - State
  - Communities
  - Practices
- Tobacco Control Program
  - National
  - State
  - Communities
  - Practices
- TIDES Collaborative Care
  - National
  - State
  - Communities
  - Practices
  - Providers
- CRC Care Collaborative
  - National
  - State
  - Communities
  - Practices
  - Providers

This is additional information on exemplars:

- Choice: Communication Health Options through information and Cancer Education (Lewis, et al., 2010; Pignone, et al.), in press;
- Pool Cool Diffusion Trial, skin cancer prevention program (Glanz, et al., 2005);
- H V M A: Harvard Vanguard Medical Associates (Sequist, et al., 2009; Sequist, et al., 2010);
- Tobacco Control (CDC, 1999 and 2007);
- TIDES: Translating Interventions for Depression into Effective Care Solutions (depression collaborative care) (Rubenstein, et al., 2010; Smith, et al., 2008; Chaney, et al., in press);
- CRC: Colorectal Cancer Care Collaborative (C4) (Jackson, et al., 2010; Chao, et al., 2009)

[End image]

Slide 7: Implementation and Spread of MLIs

- Combinations, phases of MLI implementation
  - Attend to stakeholders at each level
  - Understand how levels may interact
  - Create inter-dependencies (e.g., local funding based on mapping to state-level program activities)

    - Determine quality of evidence for interventions at each level (in lieu of evidence, blend experience)
    - Use social marketing for interventional messaging
    - Use PDSA pilots to test within/across levels
    - Consider staged approaches, give adequate time
    - Top-down and bottom-up implementation

Slide 8: Implementation and Spread of MLIs

- Partnerships within and across levels
    - Research-clinical partnerships essential
    - Reduced researcher control over implementation
    - Shared knowledge, trust, role specification
    - Team building before, during, after MLI implementation
    - Continual identification of stakeholders in network
    - Strong leadership support at each level, over time
        - Help elucidate other key players
        - Accountable
        - Role in coalition building
    - Partnerships with health IT staff (e.g., in EMR sites)

Slide 9: Implementation and Spread of MLIs

- Implementation facilitators
    - Organizational supports (e.g., direct grants, special funding allocations, protected time for QI)
    - May be centralized (e.g., state media campaign for tobacco control) or shared (e.g., EMR support)
- Implementation barriers
    - Implementation requiring interdisciplinary cooperation may be met with resistance
        - “Turf” (especially if competition for resources exists)
        - “Silos” (must create communication/coordination mechanisms)
    - Perceived value of MLI balanced with competing demands among busy members at each level

Slide 10: Implementation and Spread of MLIs

- Policy context, fiscal climate, performance incentives
    - Critical to understand contextual influences surrounding players at each implementation level

        - Ex: Harvard Vanguard “perfect storm”
        - Ex: Master Settlement Agreement with tobacco industry
- Determinants of spread
    - Timing/applicability of available evidence
    - Champions can support spread; tools important
    - Explication of handoffs
    - Quality monitoring programs

Slide 11: Conclusions

- Implementation and spread of MLIs into routine practice and policy feasible and effective
- Attention needed within *and* across levels
    - Partnerships, relationships, teams, coalitions
    - Facilitators and barriers (resources, perspectives)
    - Contextual factors
- Current mismatch between review and reality
- Sustainability a myth → evidence, stakeholders, context all continually changing
    - But investment will pay important dividends

Slide 12: Questions

- What does implementation mean…
    - in the context of your intervention(s)?
    - in the context of the best available evidence?

- What kinds of implementation strategies should be deployed and tested for each level?