# Participatory system dynamics: Empowering teams to increase access to timely, high-quality mental health care

@LZPhD

**September 21, 2017**


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Team Participatory System Dynamics


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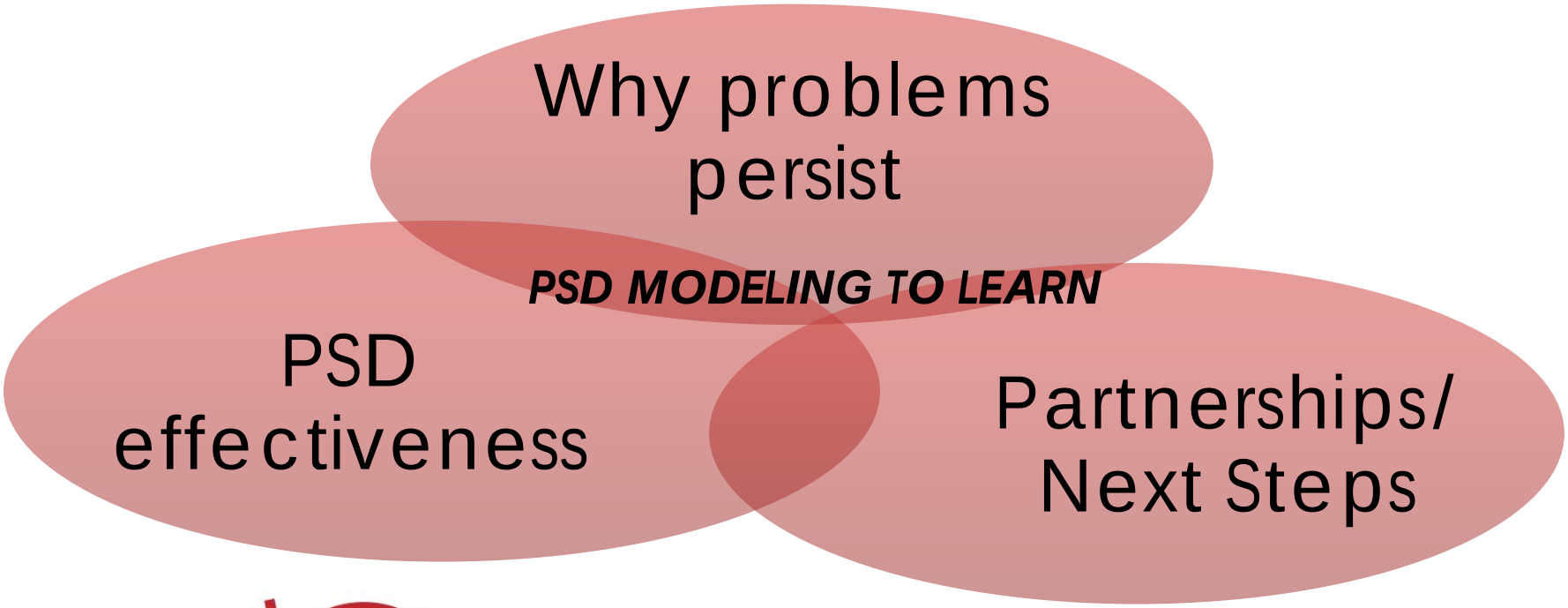
Rachel Kimerling, PhD, Jodie Trafton, PhD,
Steve Lindley MD, PhD and Tom Rust, PhD

# Three Goals for Today our PSD introduction today:




Team
Participatory System Dynamics

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER


# Context 1: PSD for quality improvement

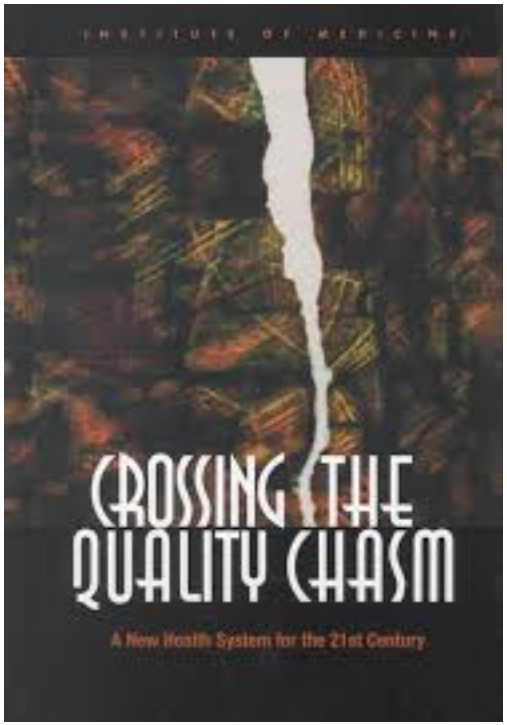
Care System

- Regulatory environment
- Organizations facilitate teams
- Patient-centered teams
- Population Outcomes

Institute of Medicine, 2001

# PSD for balancing priorities.

| | |
|---|---|
| *Safe* | **Effective** |
| Efficient | Personalized |
| *Timely* | Equitable |




Institute of Medicine, 2001

# Context 2:
# PSD as implementation science.

*Evidence-based* – healthcare practices with proven efficacy & effectiveness.

Rabin & Brownson, 2012

# There is strong evidence for the best practices to meet patient needs in VA.

- Evidence-based Psychotherapy (EBPsy)
- Evidence-based Pharmacotherapy (EBPharm)
  - reduce PTSD and depression symptoms, reduce alcohol or opiate use
  - reduce risk of chronic impairment, relapse, suicide and overdose.
- **Model(s) Problem: "Limited EBP reach"**
  - ~5-30% of eligible patient populations

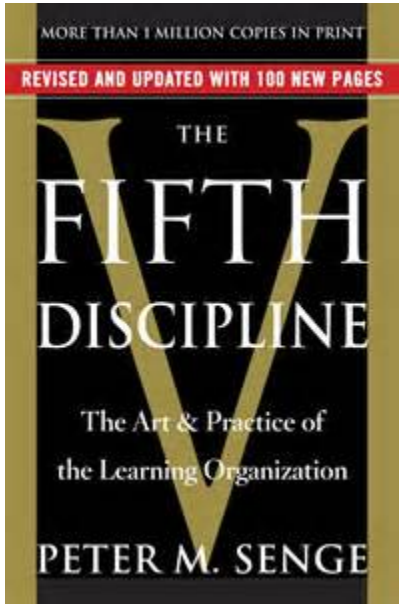
# Veterans Health Administration

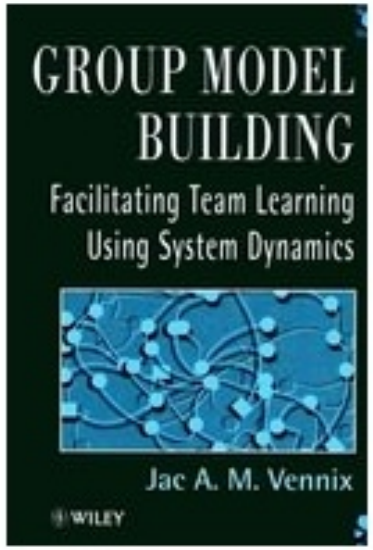
Model of a US National Health Care System

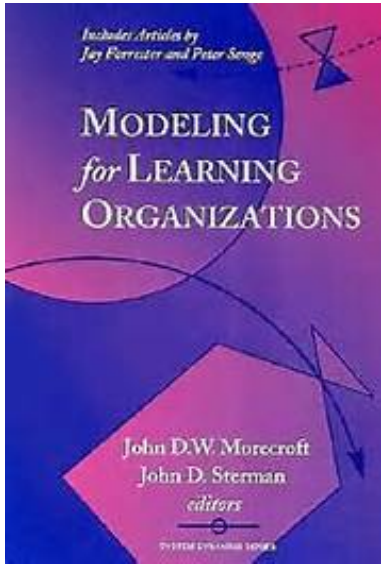
*American J. Public Health 97, 2007*

1. VA innovates with national dissemination efforts to train providers in evidence-based mental health practices
2. Enterprise-wide quality measures
3. Clinical practice guidelines and mandates for evidence-based care
4. National electronic health information system
5. Mental health care coordinated in multidisciplinary teams

# PSD in the era of the learning health system



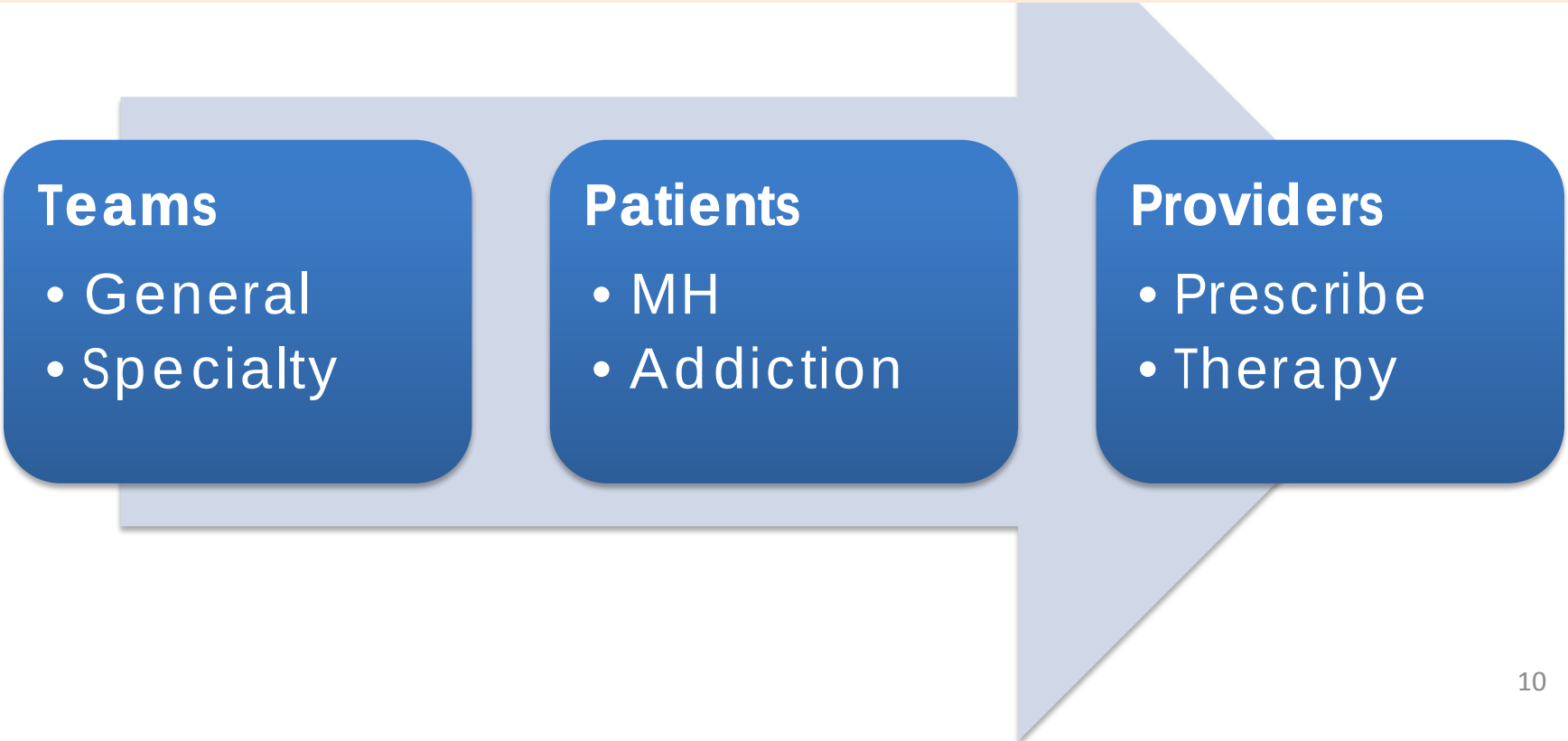

(Atkins, Kilbourne, Shulkin, 2017)

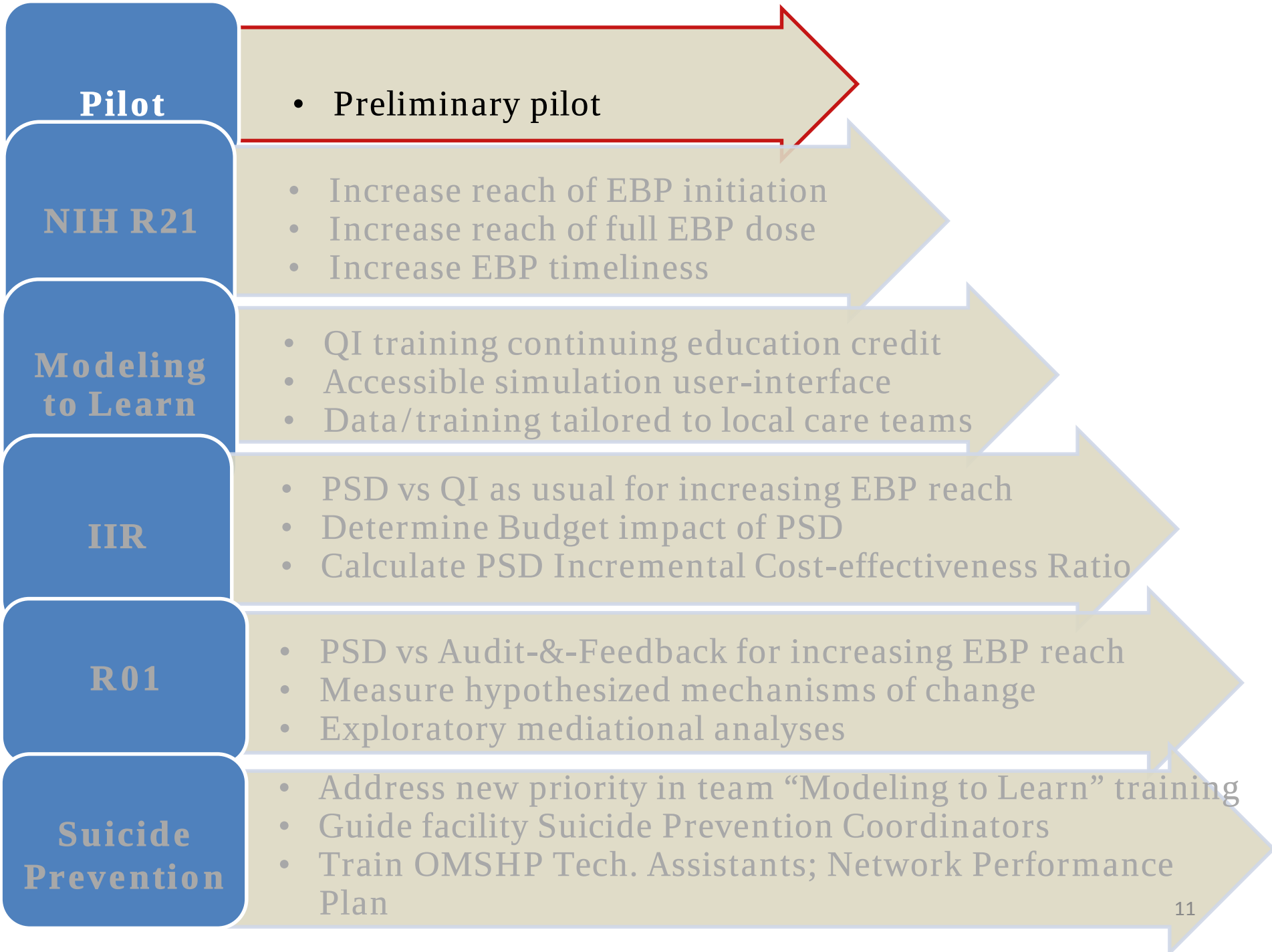
# Healthcare Learning Organization (Akhnif, et al., 2017)

- Senge, 1990
  - Personal mastery
  - Mental models
  - Shared vision
  - Team learning
  - Systems thinking
- Garvin, 2008
  - Leadership that reinforces learning
  - Learning processes and practices
  - Supportive learning environment

# PSD theory: Understanding how common dynamics emerge from team capacities/constraints

**KEY IDEA: Systems Theory + Simulation Learning increases team psychological safety and thereby MH quality (EBP reach)**

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• Preliminary pilot
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• Increase reach of EBP initiation
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• QI training continuing education credit
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Suicide Prevention
• Address new priority in team "Modeling to Learn" training
• Guide facility Suicide Prevention Coordinators
• Train OMSHP Tech. Assistants; Network Performance Plan

# The aim of our research:

- ...is to develop a systems understanding of mental health service delays and how they contribute to limited reach of evidence-based mental health care.
- ...and empower mental health stakeholders to make optimized quality improvement decisions with ex ante assessments of their proposed redesign solutions.

We define EBP *reach* as the proportion of patients with a PTSD, depression or SUD diagnosis who

a) *initiate*

b) *timely* EBP session

c) complete an adequate, therapeutic EBP *dose*

# EBP Reach: Starts and Completes

| Population Coverage - Denominator (*diagnostic* cohorts) | Continuity of Care - Denominator (diagnosis + active *treatment*) |
|---|---|
| SAIL MH Domains | |
| PTSD | EBPsy |
| Depression | EBPsy and EBPharm |
| OUD | EBPharm |
| AUD | EBPharm |

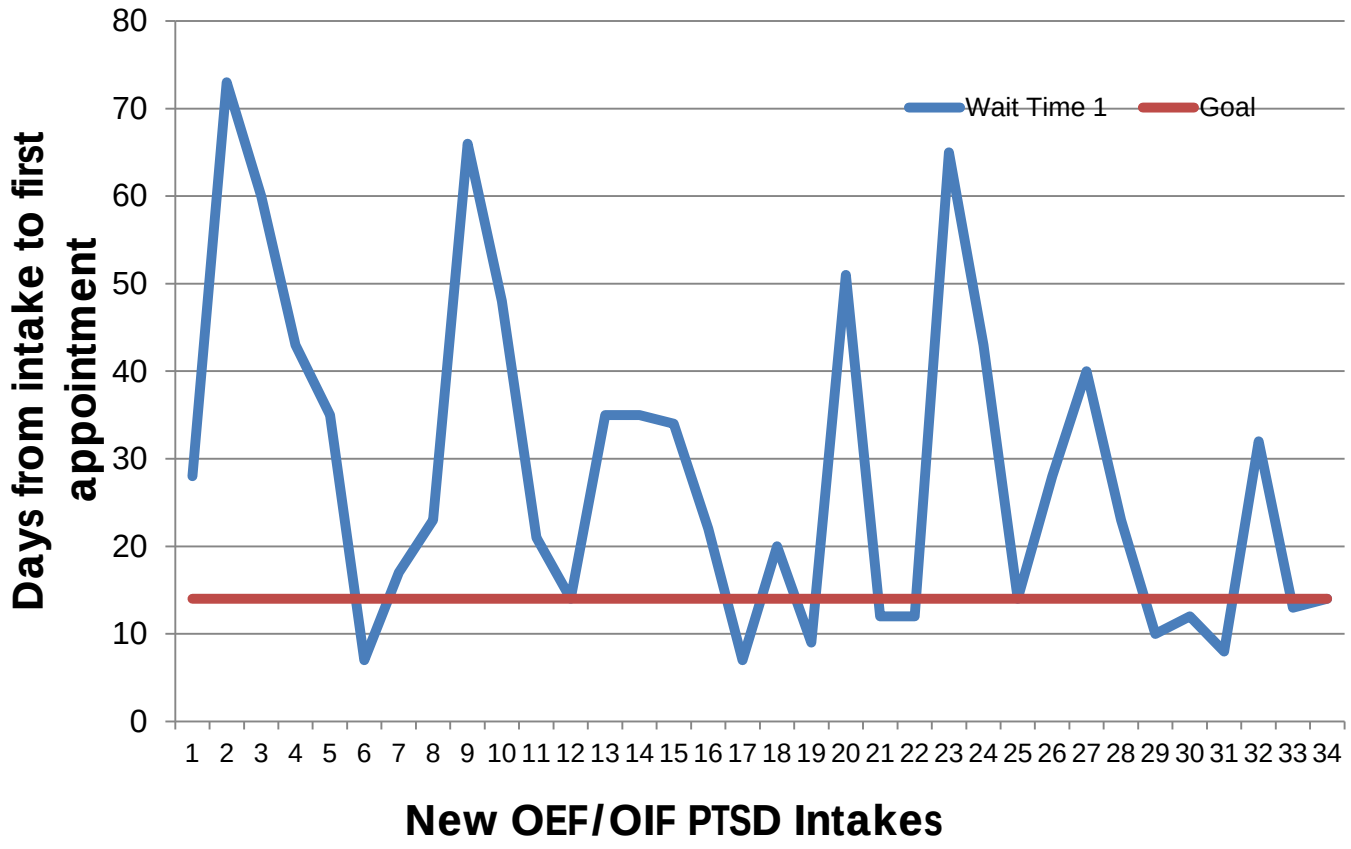
Complex interventions delivered by multidisciplinary teams

*Reach as a system behavior*: the whole set of *mechanisms* by which the needs of the patient population are or are not addressed by their health care system.

# Palo Alto VA Health Care System


- Main facility and nine outpatient clinics
- +85K patients served
- >17,000 patients receive MH care each year

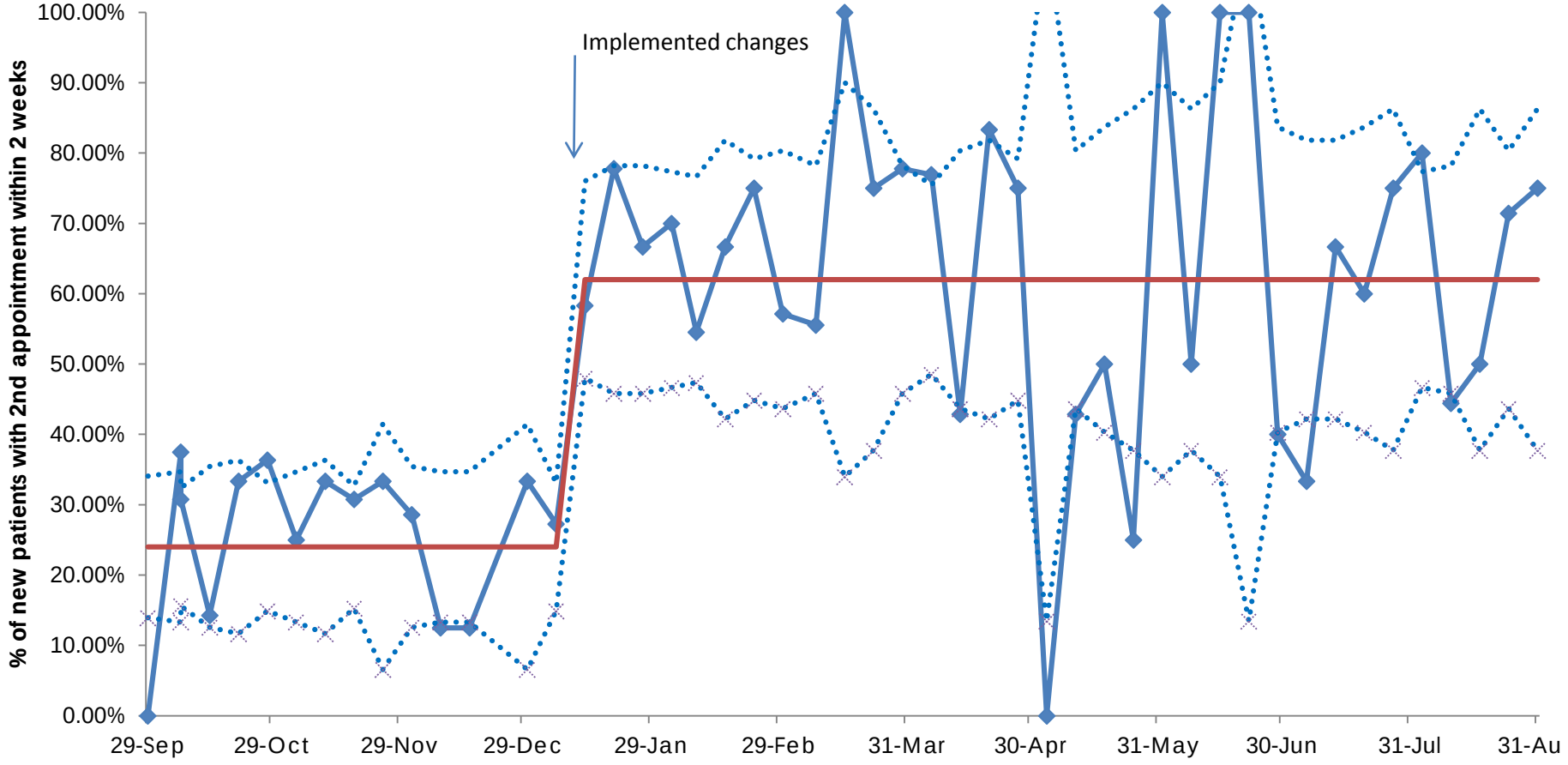
# Existing State: Inadequate proportion of patients getting timely, high-quality care



# Target State: Lean SMART Goal

By April 2015, 40% of patients newly seen in outpatient mental health at Menlo Park for depression, PTSD, or anxiety disorders will have two psychotherapy visits completed within 28 days from time of intake assessment.

# Local improvement, but wide variability & goal not achieved.



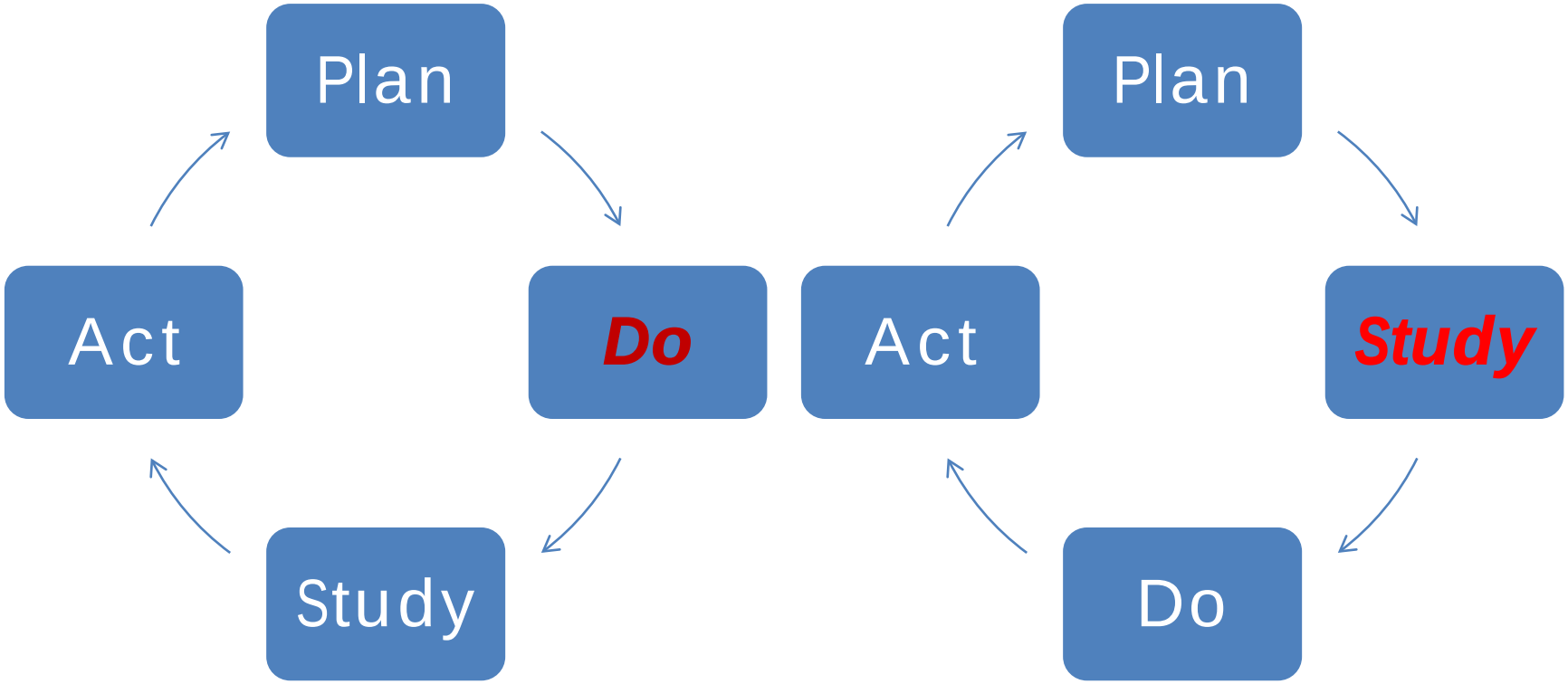
# Gap between scheduling and completing psychotherapy remained.

# Target State: Lean SMART Goal

By April 2015, 40% of patients newly seen in outpatient mental health at Menlo Park for depression, PTSD, or anxiety disorders will have two psychotherapy visits completed within 28 days from time of intake assessment.

**Specific.**
**Measurable.**
***Attainable*:** if never achieved morale may suffer.
***Realistic*:** with the available resources.
***Time frame*:** A due date.

# Systems have properties of self-organization, emergence & adaptation.



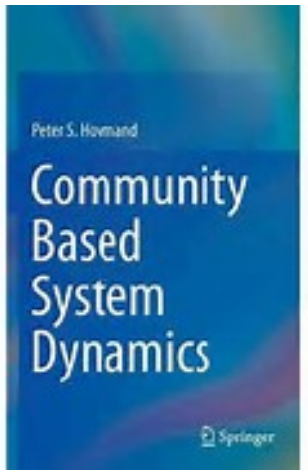

Damschroder et al., 2009 – *Process* domain: ***Engage,*** Plan, Execute, Evaluate
*Consolidated Framework for Implementation Research*

# Why do problems persist?

| Scientific Model | Problem | Description of why quality problems persist. |
|---|---|---|
| General QI Teams | Learning | Stakeholders cannot or do not learn and adapt to their situation. |
| | Coordination | Conflict or lack of stakeholder consensus. |
| EBP Specific Systems Theory | Analysis | Policies are inconsistent with the real system constraints. |
| | Restructuring | The underlying structure of the system prevents workable solutions. |

Hovmand, 2013; Scaccia et al., 2015

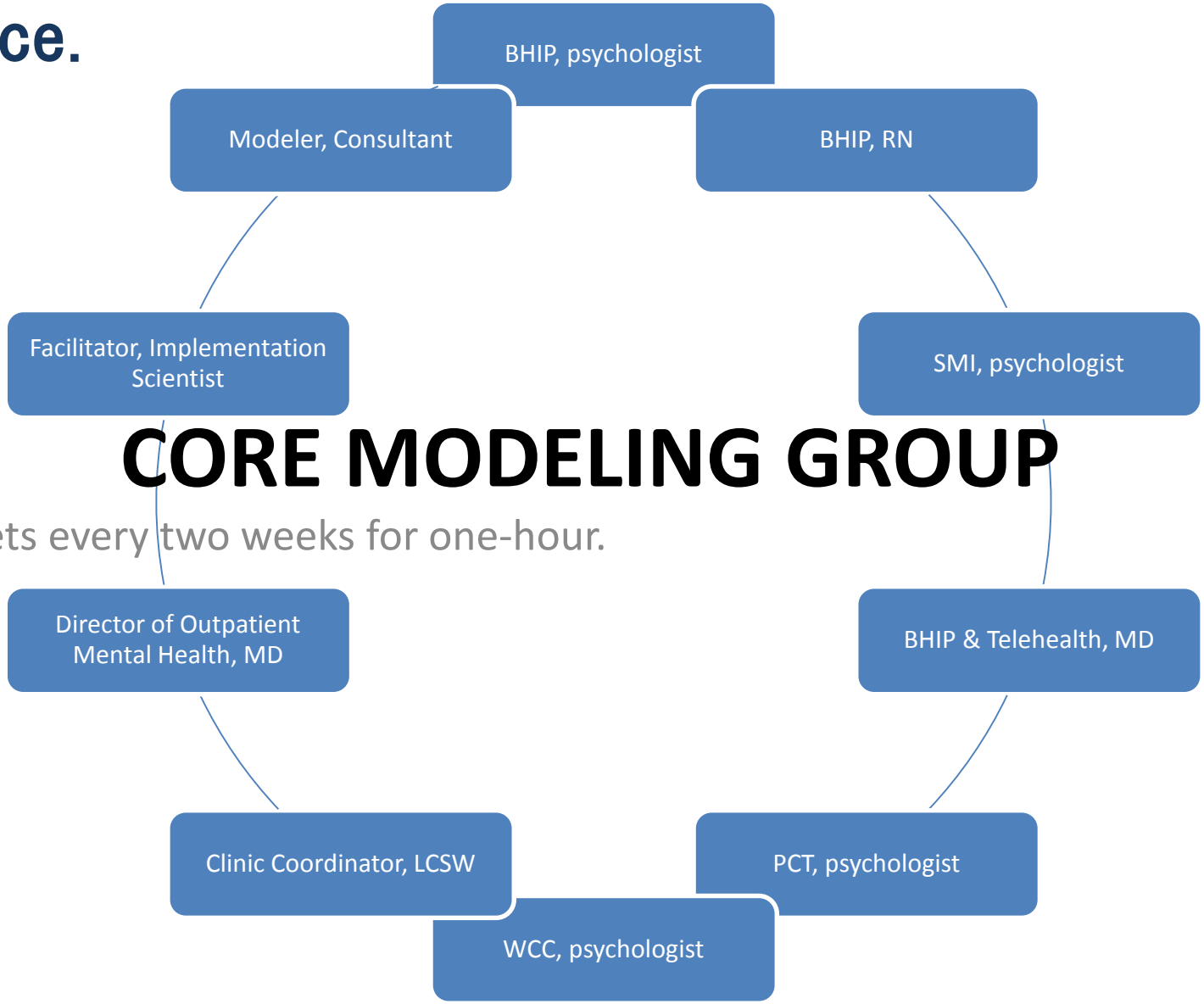
*Community-based Participatory Research:* A partnership approach to research that equitably involves stakeholders in all aspects of the research process and in which all partners contribute expertise and share decision-making and ownership.




Hovmand, 2014; Israel, Eng, Schulz & Parker, 2013

# We partner with national stakeholder.

# We put a local stakeholder engagement process in place.



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*System* - A set of elements interconnected in such a way that they produce their own internal dynamics. The system, to a large extent, *causes* its own behavior.

Meadows, 2008

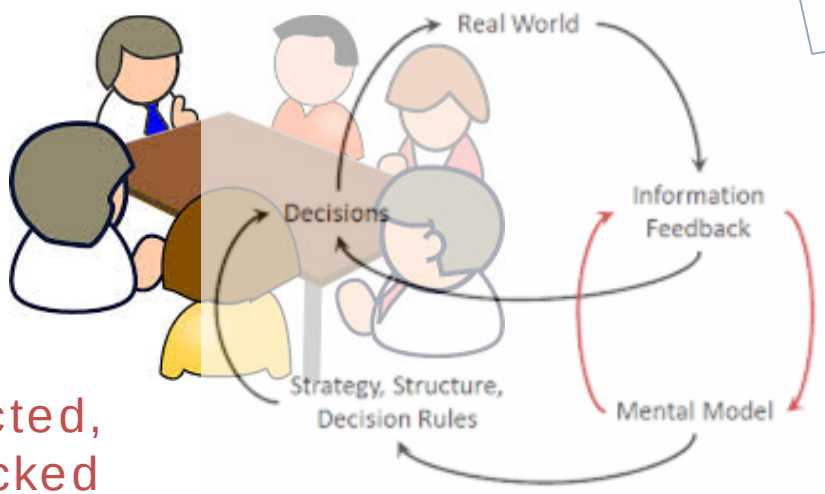
*Reach as a system behavior:*

the purposes of subunits in a system may add up to an overall behavior no one wants; changing elements usually has the *least* effect on the system.

Meadows, 2008

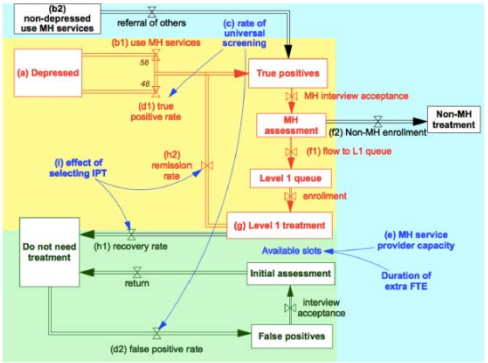
# Participatory System Dynamics

1. Stakeholder engagement & input



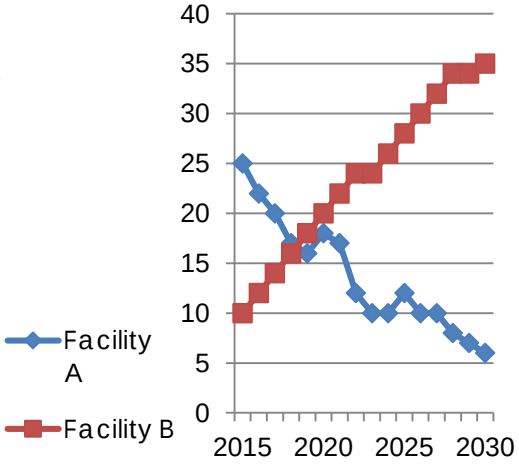

Mental models made explicit

2. System 'behavior' observed holistically




*Administrative data, stakeholder estimates & research evidence*

3. Implementation impacts tested via simulation




4 & 5. Re-design selected, implemented & tracked

1. Participate
2. Calibrate
3. Simulate
4. Translate
5. Evaluate
6. *Iterate*

# Participatory system dynamics for implementation planning.

Adm Policy Ment Health
DOI 10.1007/s10488-016-0754-1

CrossMark

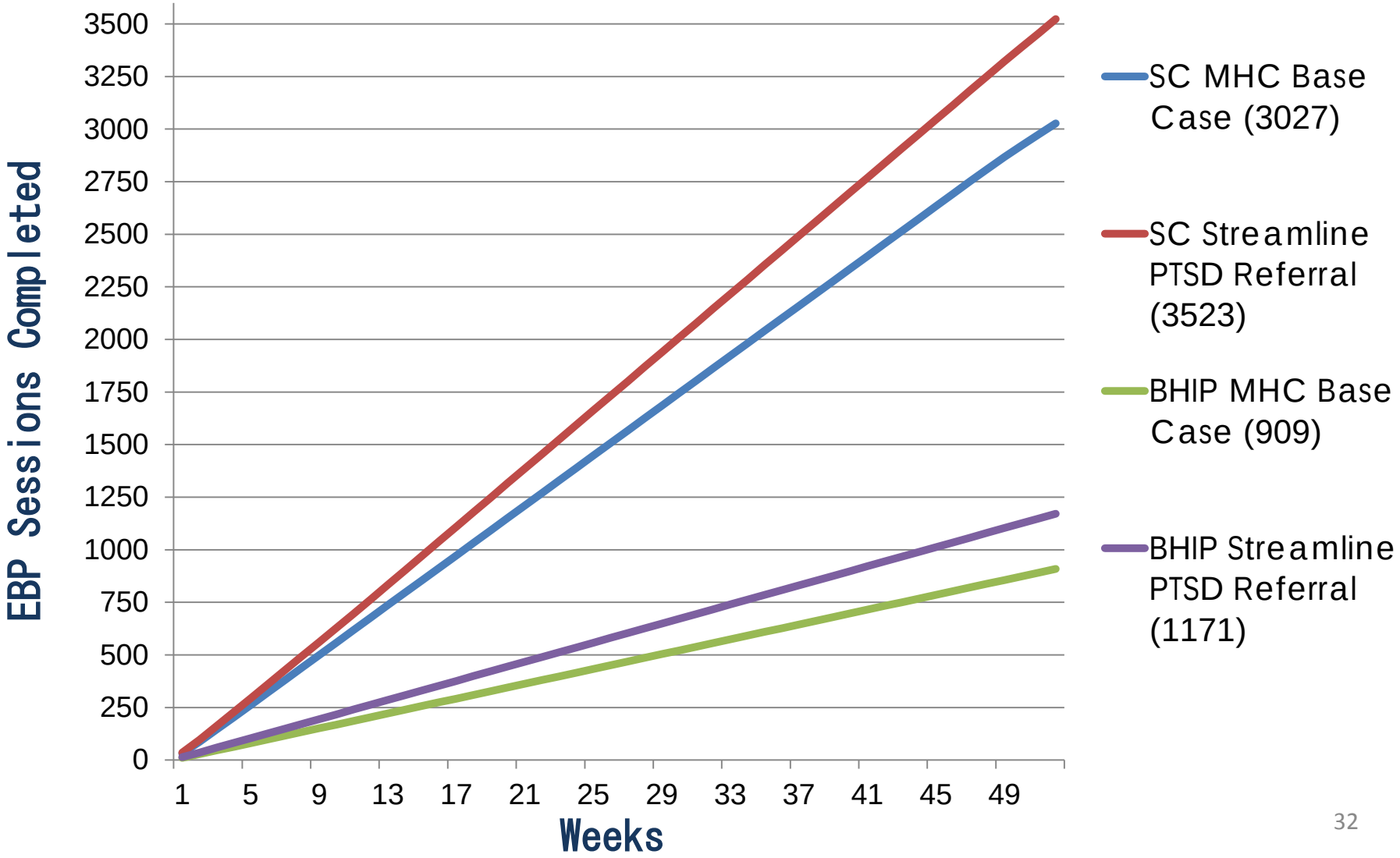
ORIGINAL PAPER

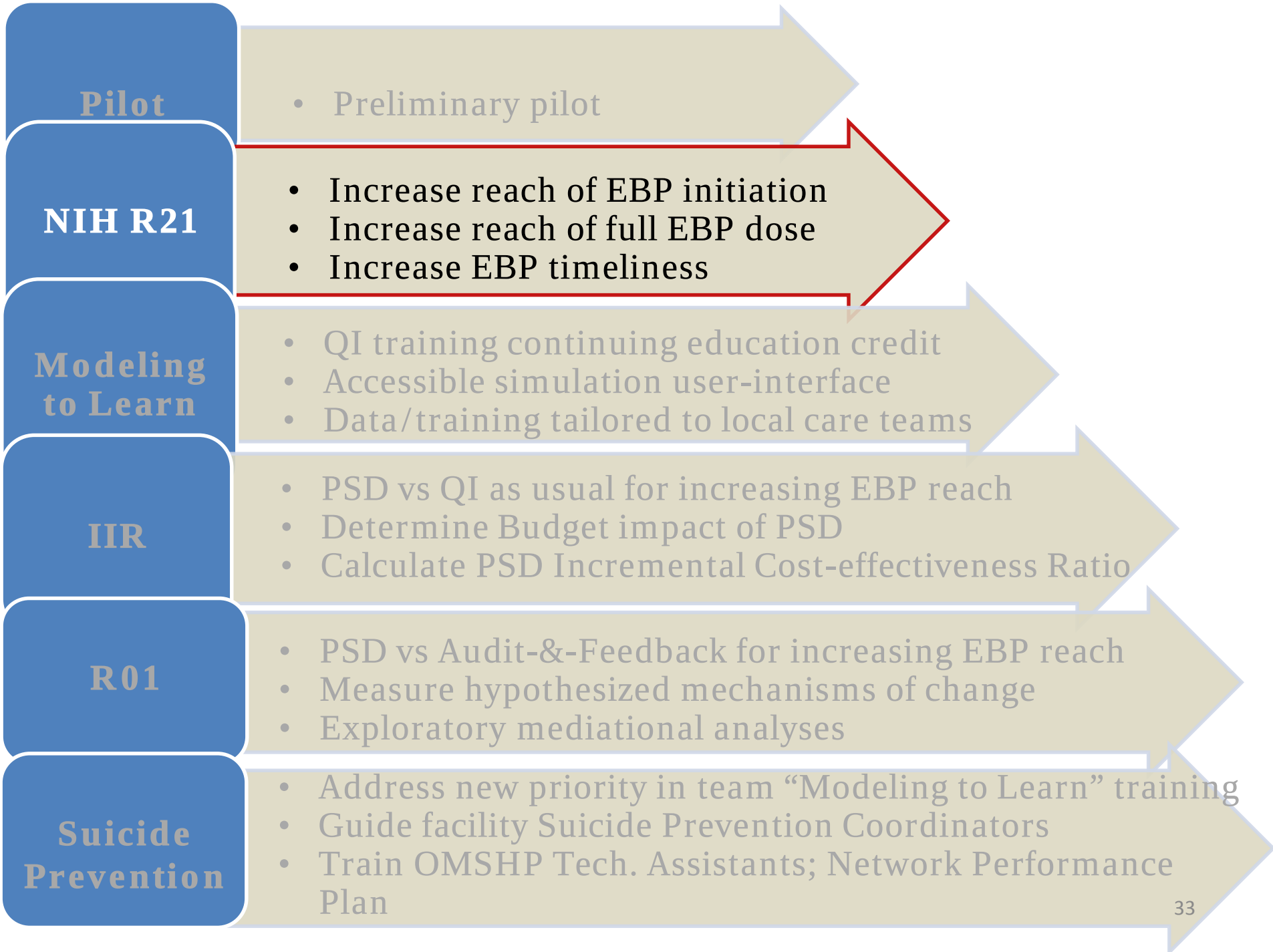
**Participatory System Dynamics Modeling: Increasing Stakeholder Engagement and Precision to Improve Implementation Planning in Systems**

Lindsey Zimmerman[1,2] · David W. Lounsbury[3] · Craig S. Rosen[1,4] · Rachel Kimerling[1] · Jodie A. Trafton[4,5] · Steven E. Lindley[4,6]


*Please email me for even more "tech specs"*

# PCT Streamline Scenario

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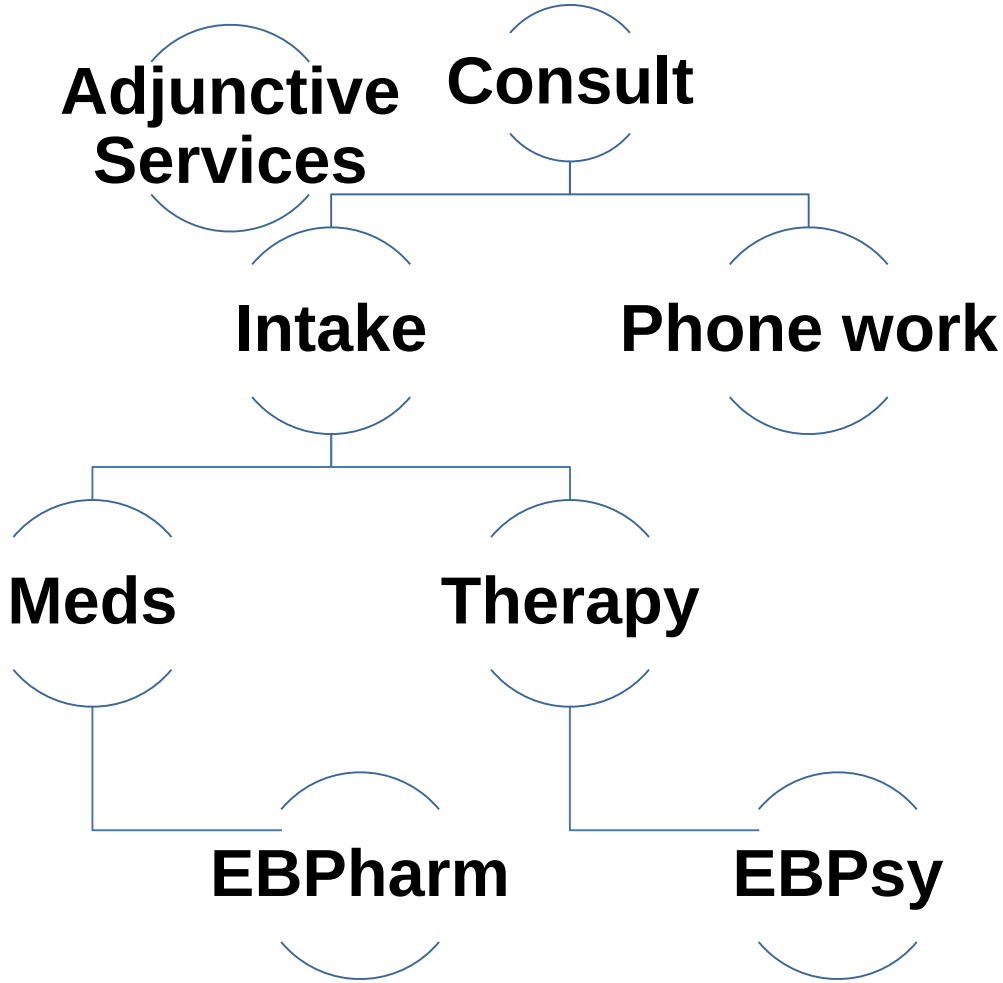
# The research question in our current effort:

Using *simulation tests of stakeholder hypotheses* about what procedural and policies changes would increase timely access to EBPs:

- Which proposals are most likely to align *existing* mental health resources to maximally increase reach of EBPs?

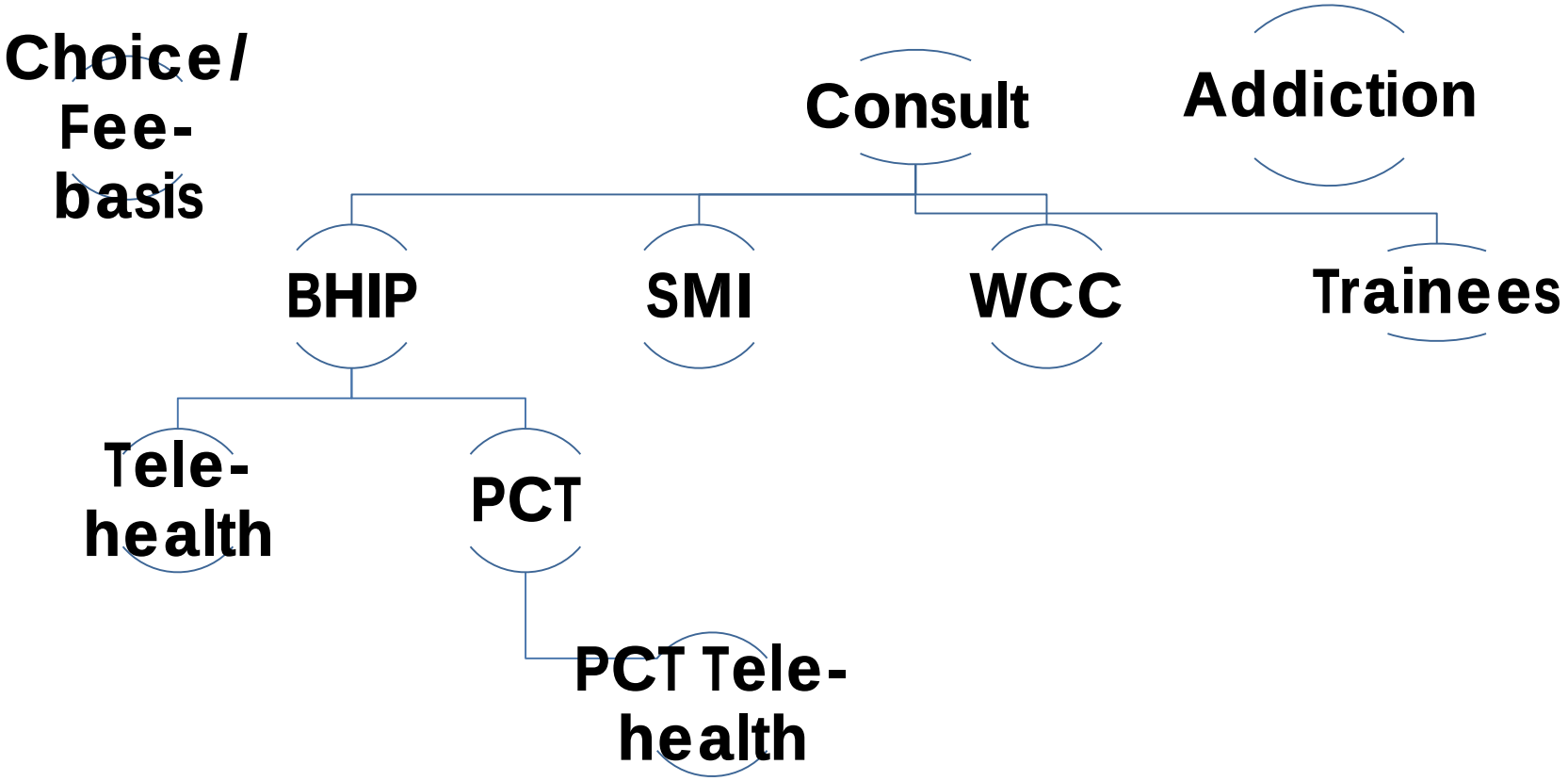
# Each team has capacities for particular services.



# Teams Coordinate Care

| Menlo Park Teams | Stockton Team |
|---|---|
| **3548 unique patients/year** | **2043 unique patients/year** |
| Lower caseload per provider | Higher caseload per provider |
| Rare wait for initial appointment | Occasional waitlist to get into clinic |
| **5.2 psychiatrists per 9 EBPsy providers** | **3.0 psychiatrists per 4 EBPsy providers** |
| Higher EBPsy providers/MD ratio | Lower EBPsy provider/MD ratio |
| Higher EBPsy base rate | Higher EBPharm base rate |
| **Providers often self refer for EBPs** | **Referrals to other providers by necessity** |
| **Multiple on-site specialty programs** | **Only telehealth specialty care** |
| **Training program site multiple disciplines** | **No trainees providing care** |
| **Most groups "open" (ongoing enrollment)** | **Most groups "closed" (infrequent opening)** |
| Shorter time to next available appointment | Longer time to next available appointment |

# The team as the fundamental molecule of the model.



# Teams in the VA learning health system

- PACTs (2009) created in primary care due to
  - lagging patient access
  - increasing rates of clinician burnout and turnover
  - inefficient use of staff
- PACTs effectiveness variable, depends on implementation
  - use of clinical information
  - care coordination
  - provider turnover and burnout, still an issue

(Atkins, Kilbourne, Shulkin, 2017; Nelson et al., 2014)

# PSD Uses Existing VA Data

**VA Corporate Data Warehouse (CDW) Data Source**

**Patient cohorts**

ICD diagnostic information from visits and clinic usage (below)

**Clinic capacity**

Clinic/Scheduling hours VISTA/BISL clinic availability

**Provider capabilities**

Provider disciplines with user input to map to encounter types

**Clinic utilization**

Visit (workload) schema. CPT encounters.

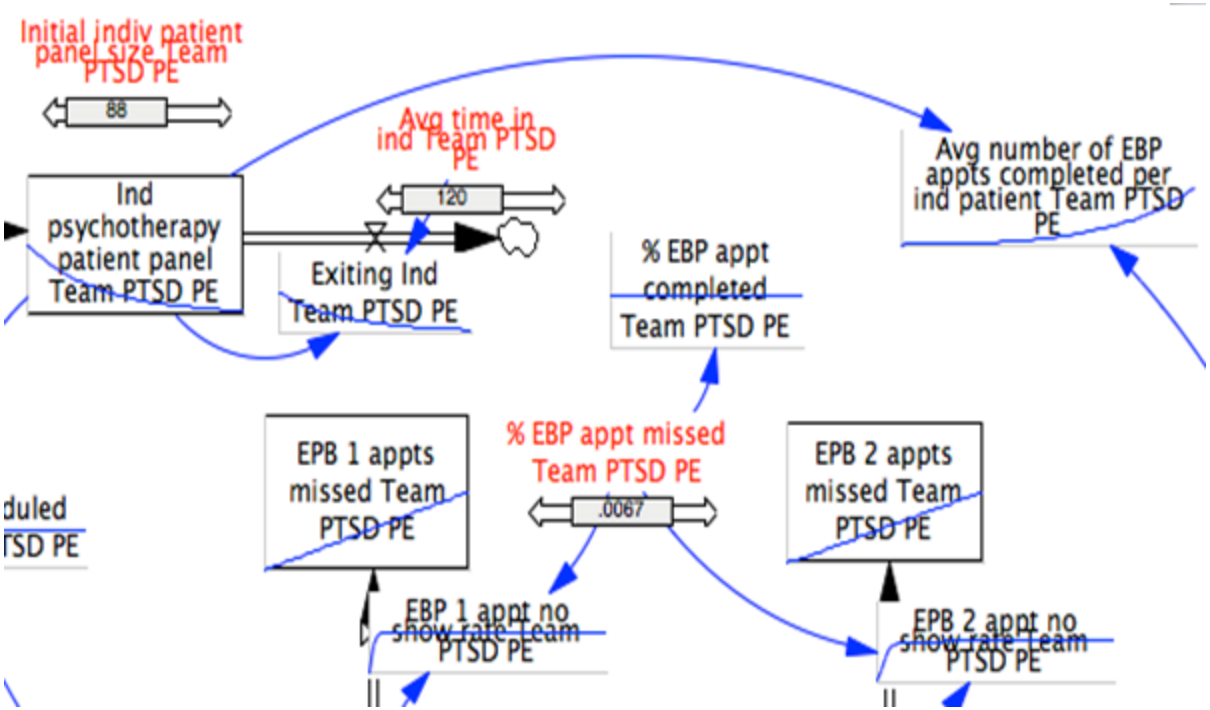
Appointment data = ‘no shows’

**EBP reach**

Template usage from health factor schema

# Stakeholder Hypotheses: Testing policy/procedure changes.

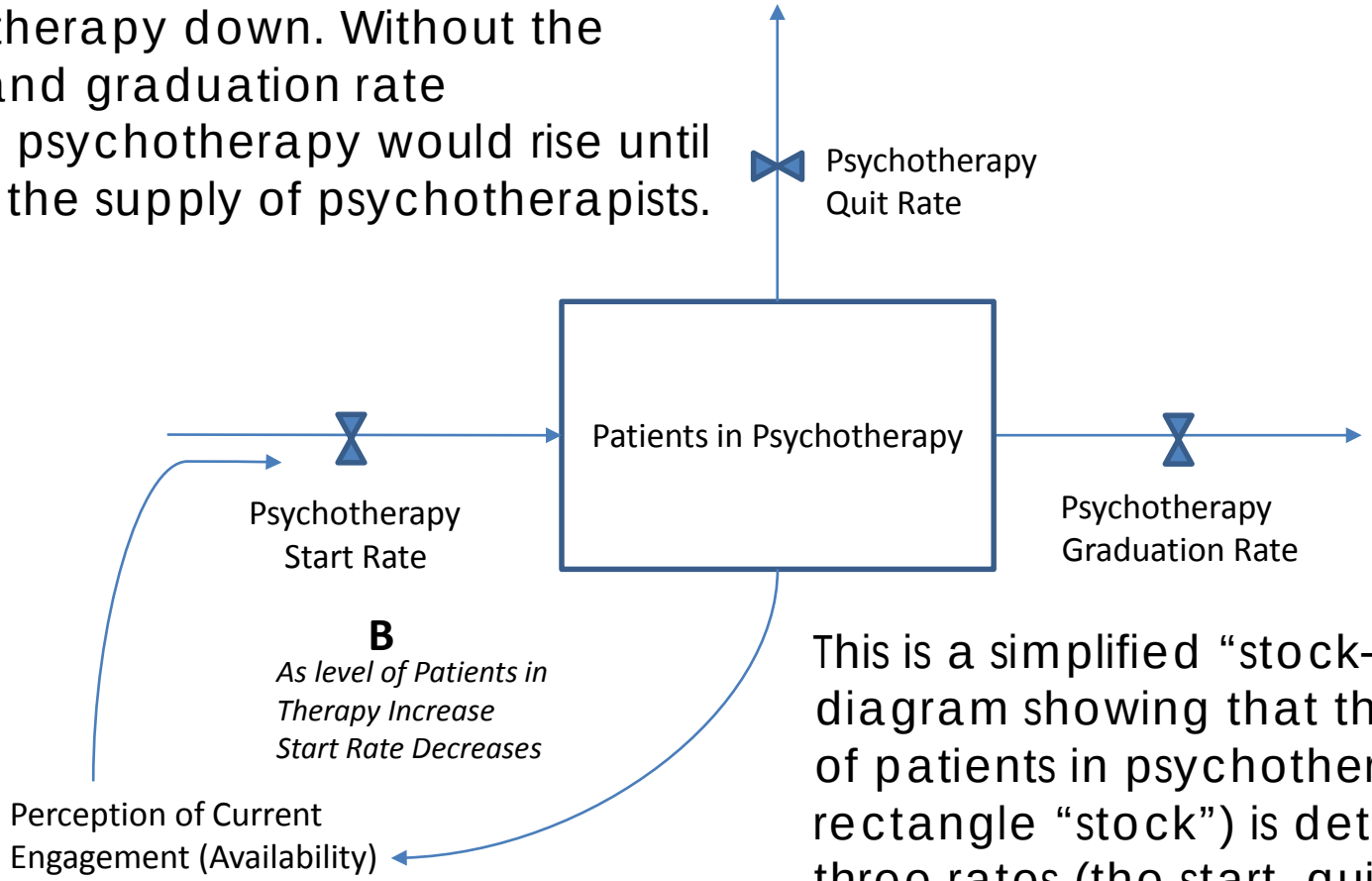
**BHIP to PCT: What if intake was in BHIP and PCT started treatment without another intake?**



# Modeling to Learn: Example

- Flow of Psychotherapy Patients in Multi-Disciplinary Teams Over Time
- Data Review Tools for Simulation Modeling in Teams

We know identification of psychotherapy need far exceeds graduate rate.
The quit rate brings the level of patients engaged in psychotherapy down. Without the quit rate and graduation rate
Patients in psychotherapy would rise until limited by the supply of psychotherapists.



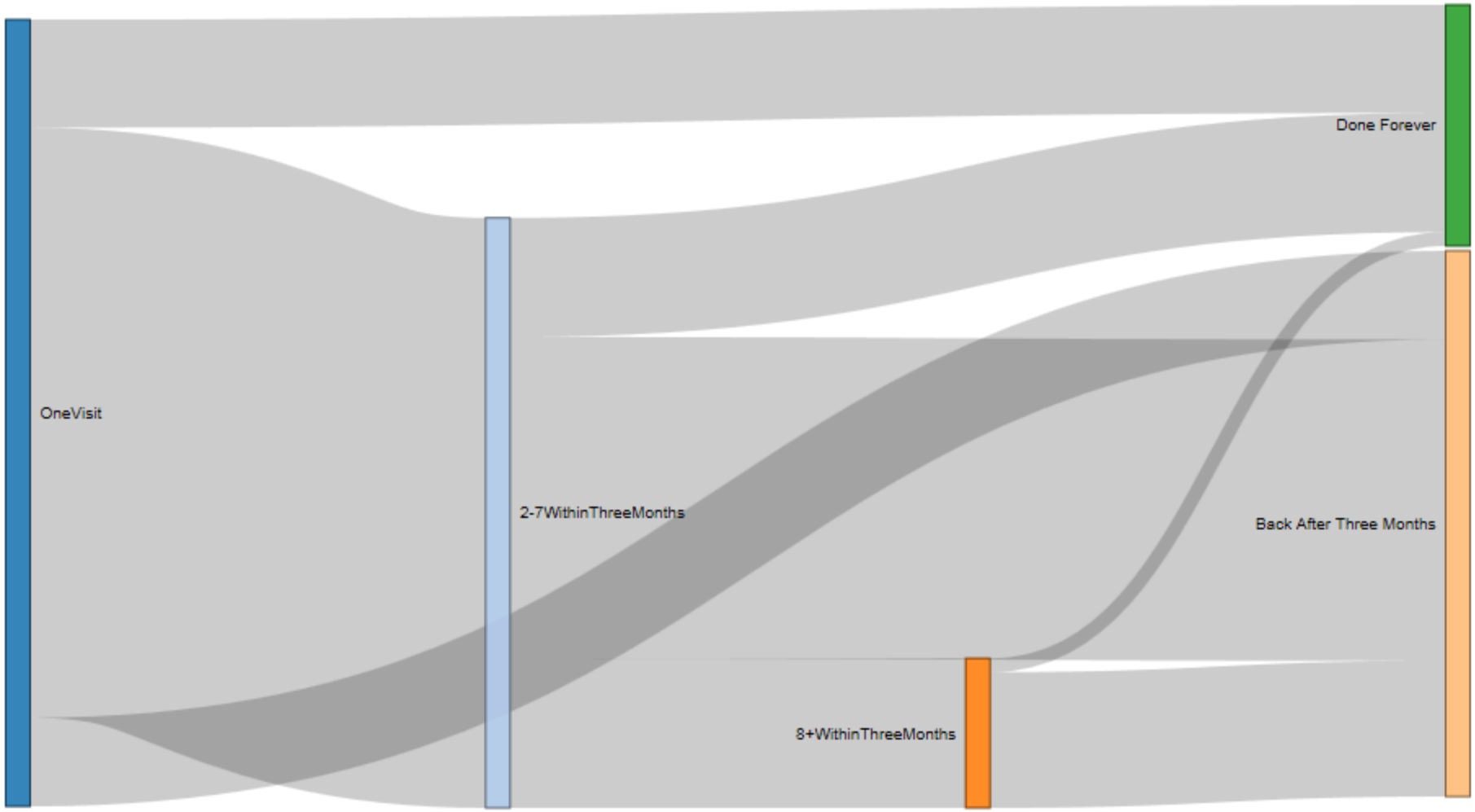

This is a simplified "stock-and-flow" diagram showing that the number of patients in psychotherapy (the rectangle "stock") is determined by three rates (the start, quite and graduate "flows") and it also determines the start rate through a feedback loop: perception of psychotherapy availability.

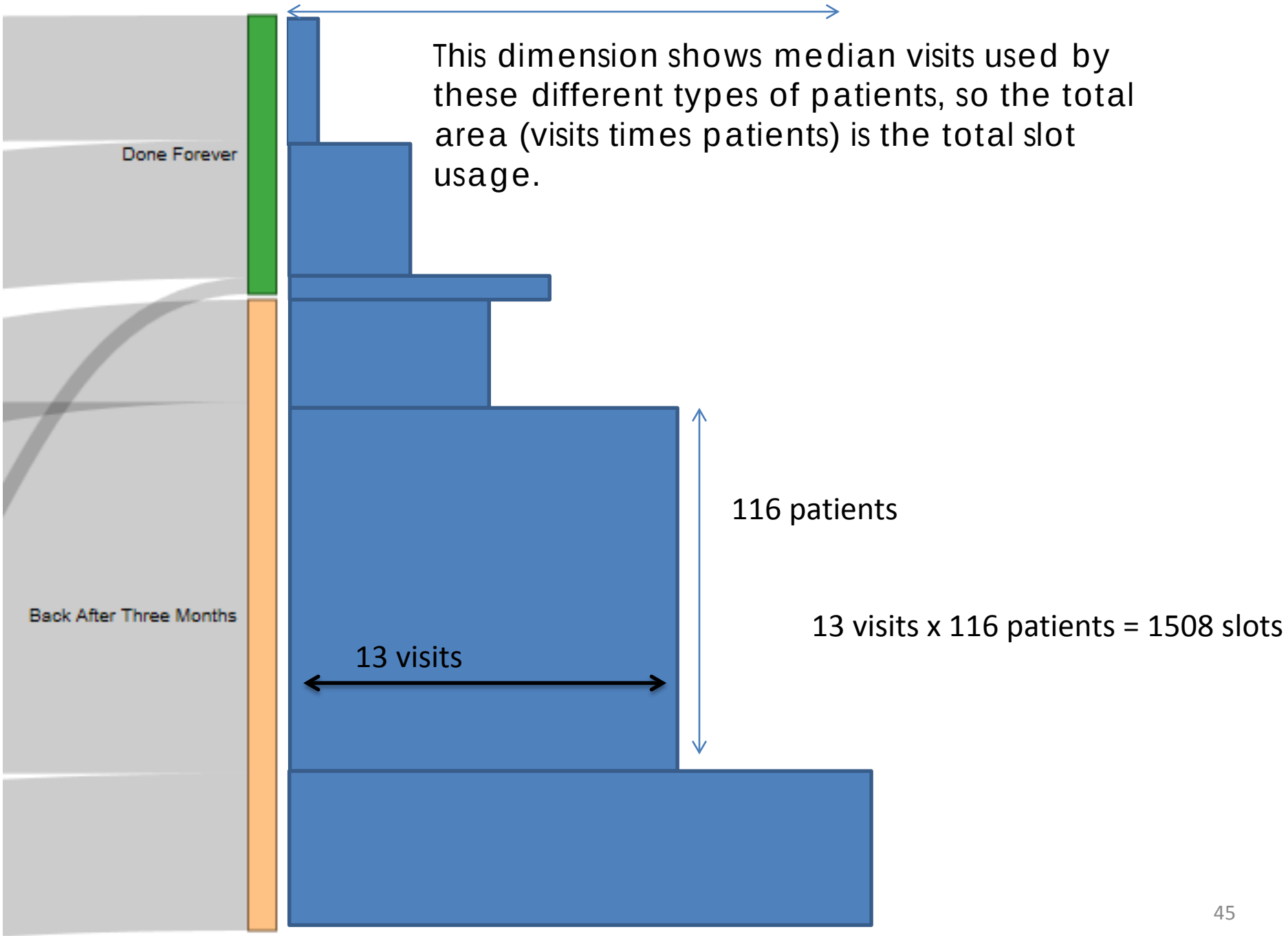
# We identified 6 patterns of psychotherapy engagement in teams.

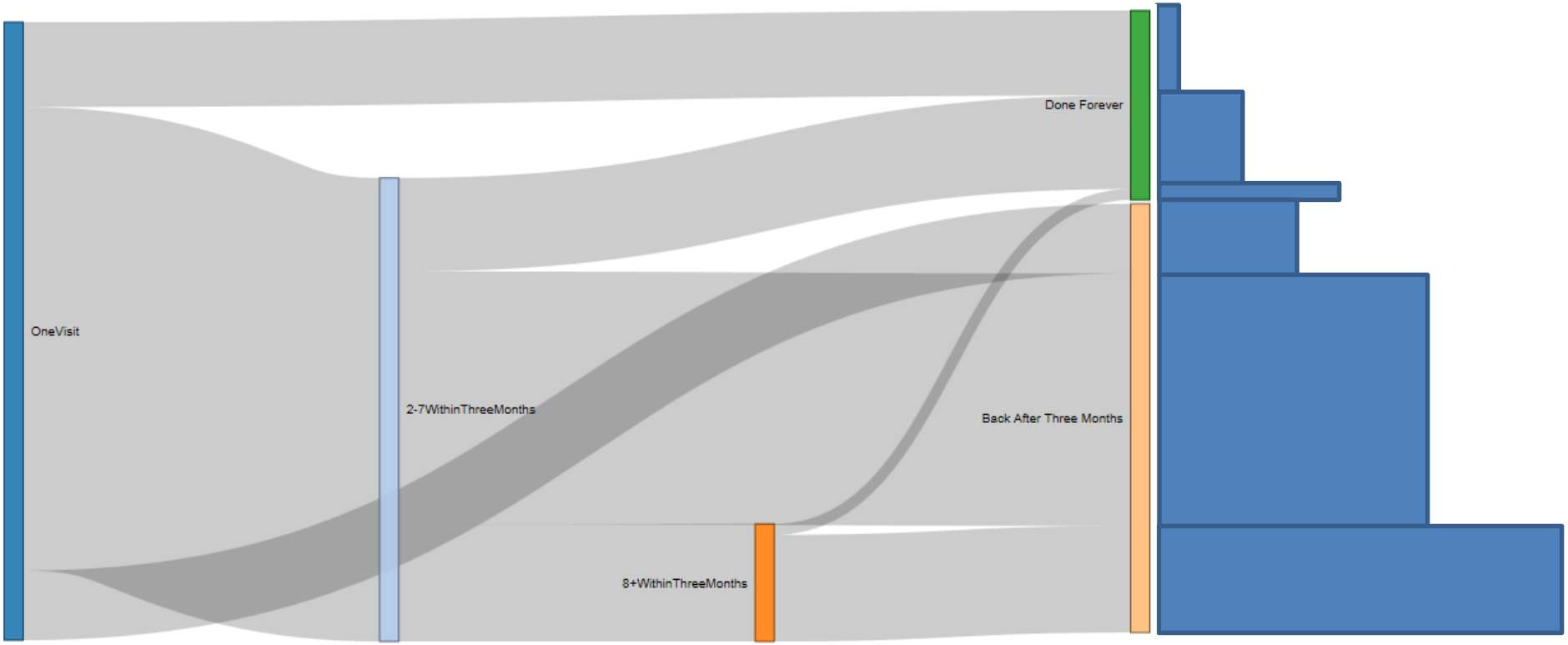
1. One and done
2. Initiators
3. Completers
4. One visit and return later
5. Initiators who return later
6. Completers who don't graduate

- To get a sense of patients' typical psychotherapy flow in the teams, we examined the total psychotherapy engagement for any patient seen in CY2016.
- If a patient had any psychotherapy visit in CY2017 we looked backward in time to find their first visit, and then looked forward to August of 2017.

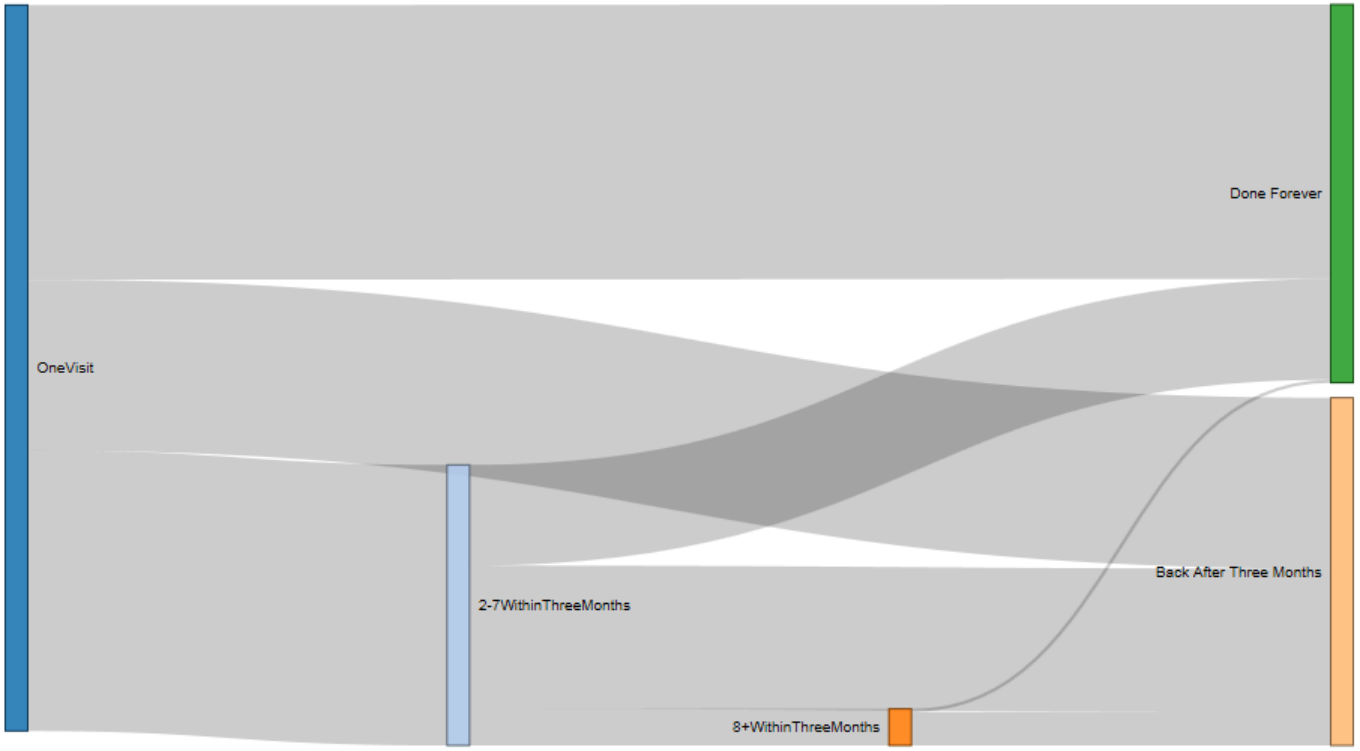
# 284 psychotherapy patients in CY 2016 in PCT

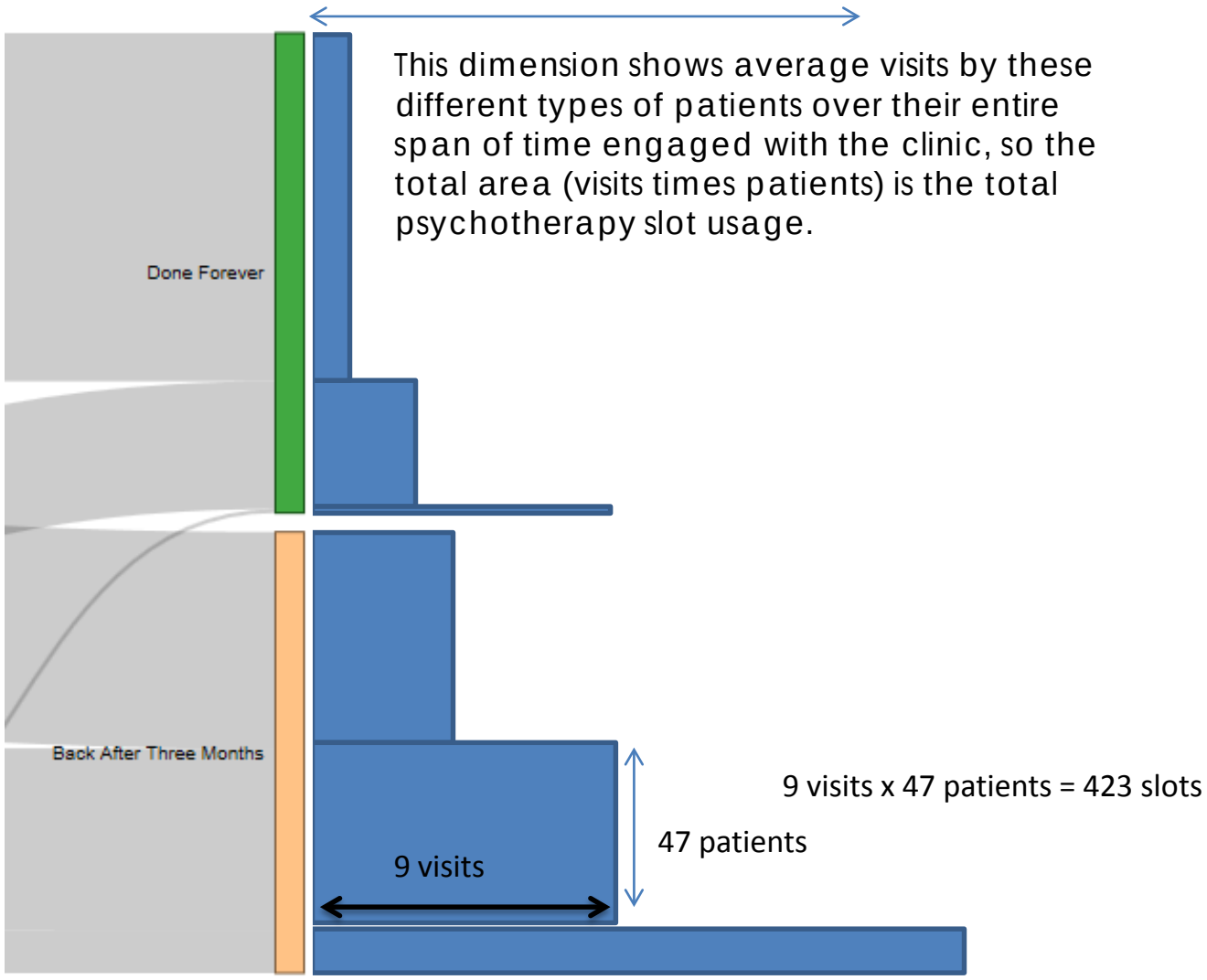


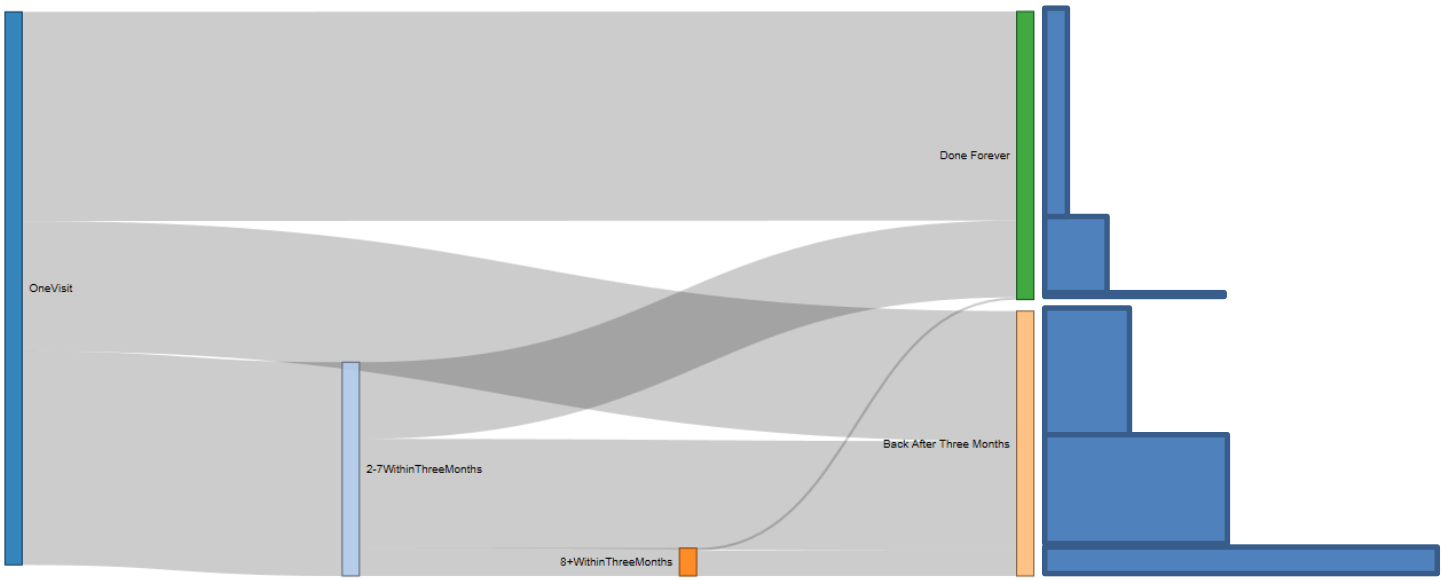

This dimension shows median visits used by these different types of patients, so the total area (visits times patients) is the total slot usage.
Done Forever
Back After Three Months
116 patients
13 visits
13 visits x 116 patients = 1508 slots


OneVisit
2-7WithinThreeMonths
8+WithinThreeMonths
Done Forever
Back After Three Months

# 238 psychotherapy patients in BHIP Team Blue in CY 2016




This dimension shows average visits by these different types of patients over their entire span of time engaged with the clinic, so the total area (visits times patients) is the total psychotherapy slot usage.
Done Forever
Back After Three Months
9 visits
47 patients
9 visits x 47 patients = 423 slots


OneVisit
2-7WithinThreeMonths
8+WithinThreeMonths
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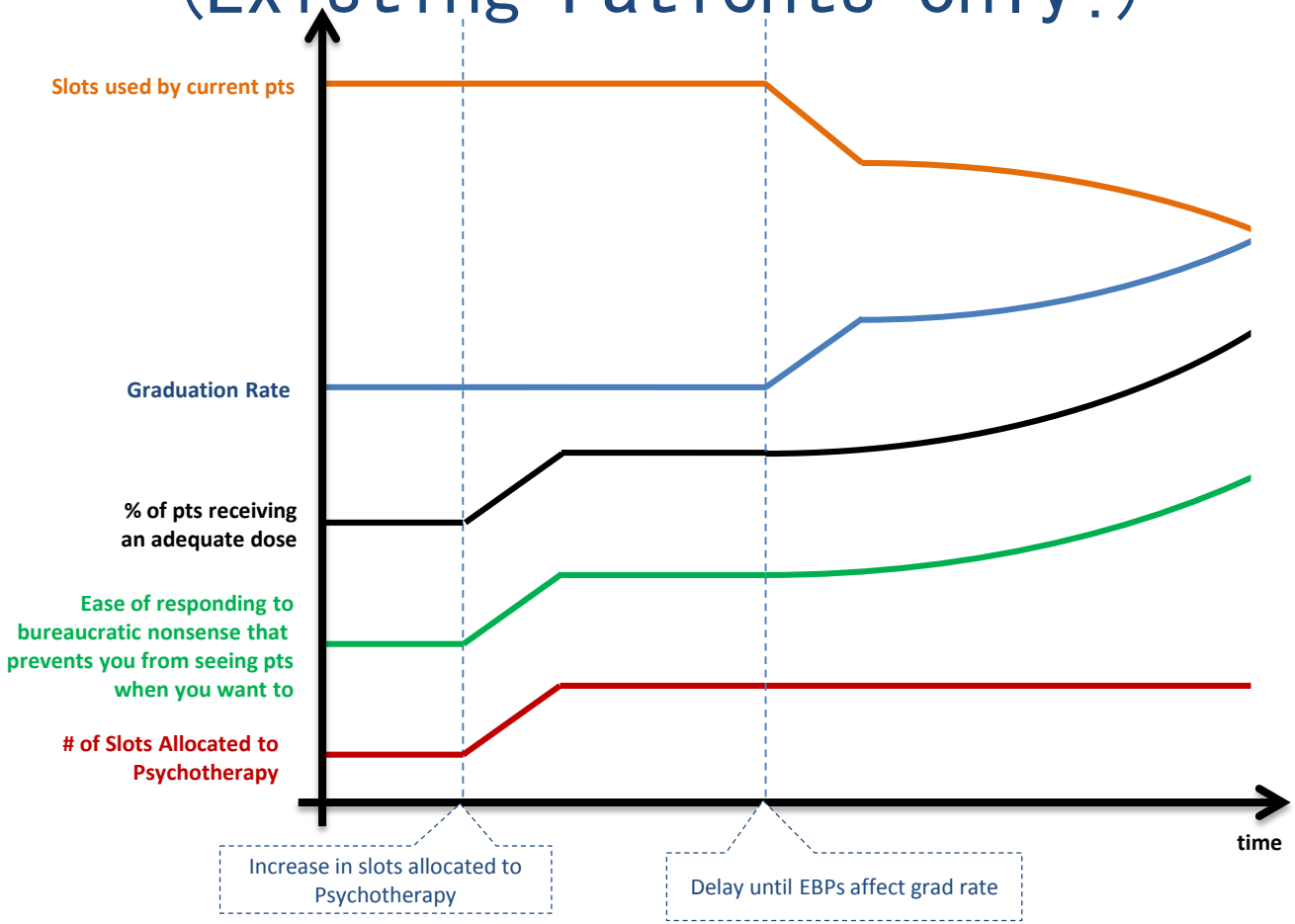
Back After Three Months

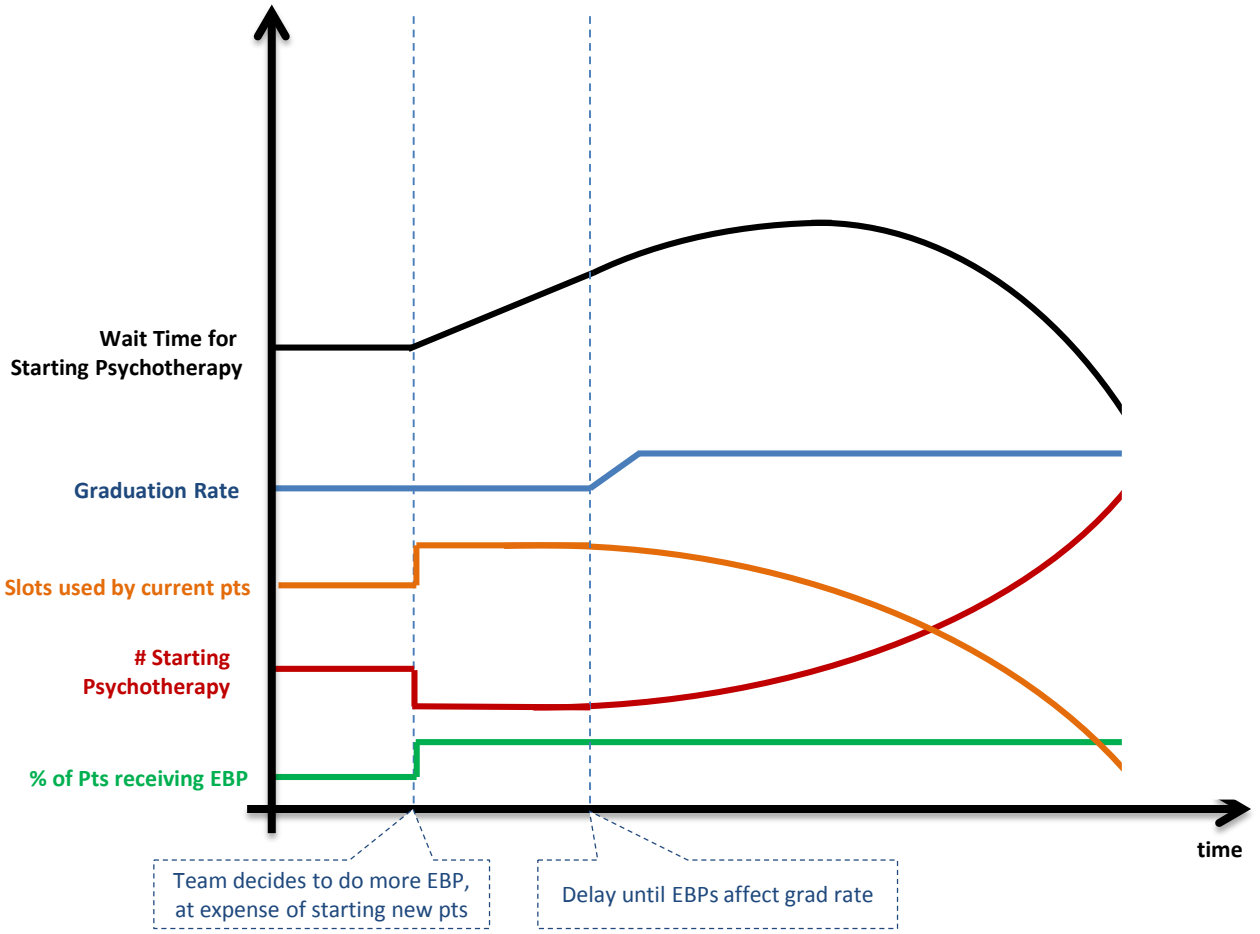
# Dynamic Hypotheses about Psychotherapy

## Continuity of Care

## (Existing Patients only!)

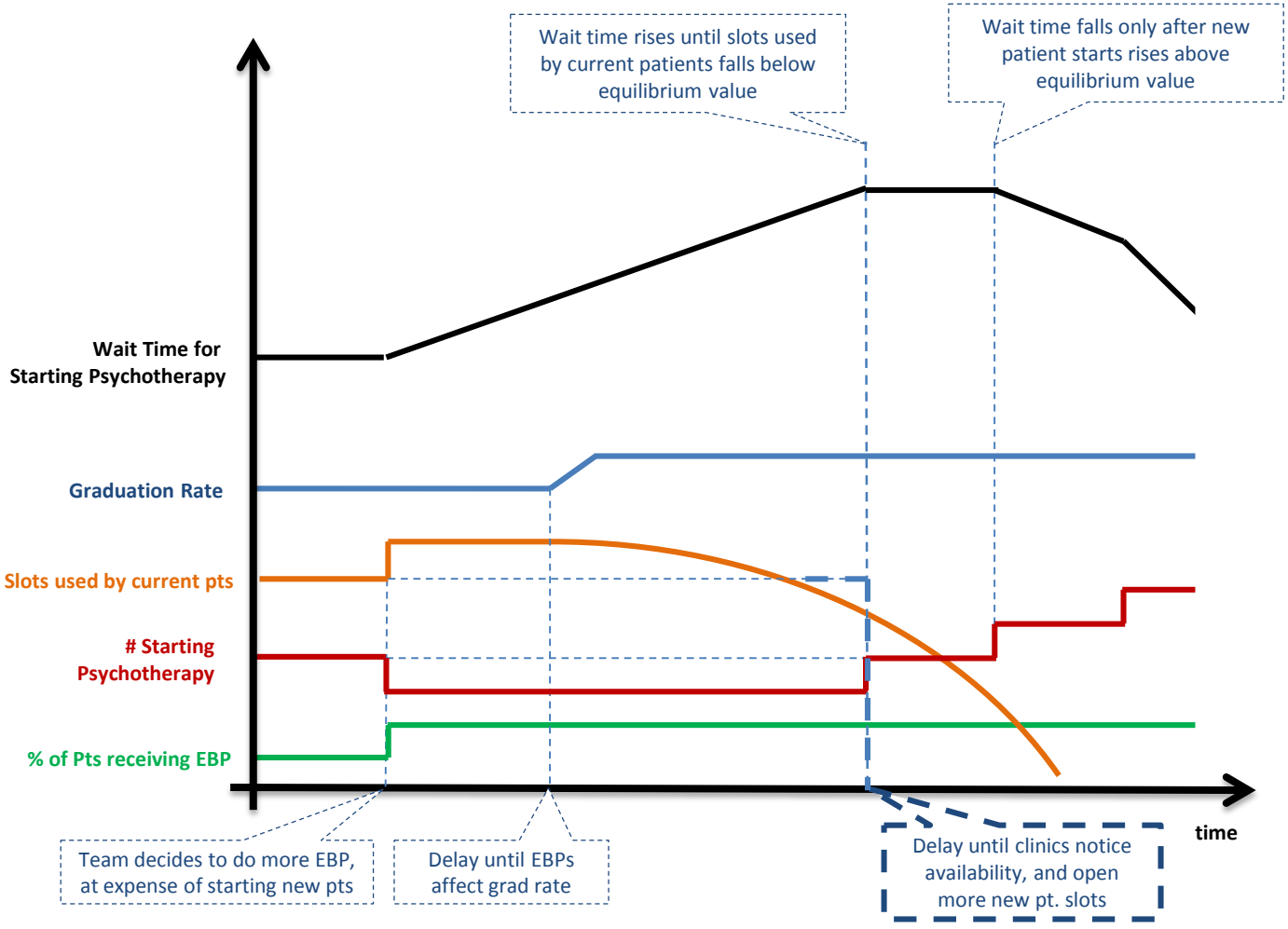


# Balancing Access to Care Priority for New Patients, with Completion of EBPs by Existing Patients

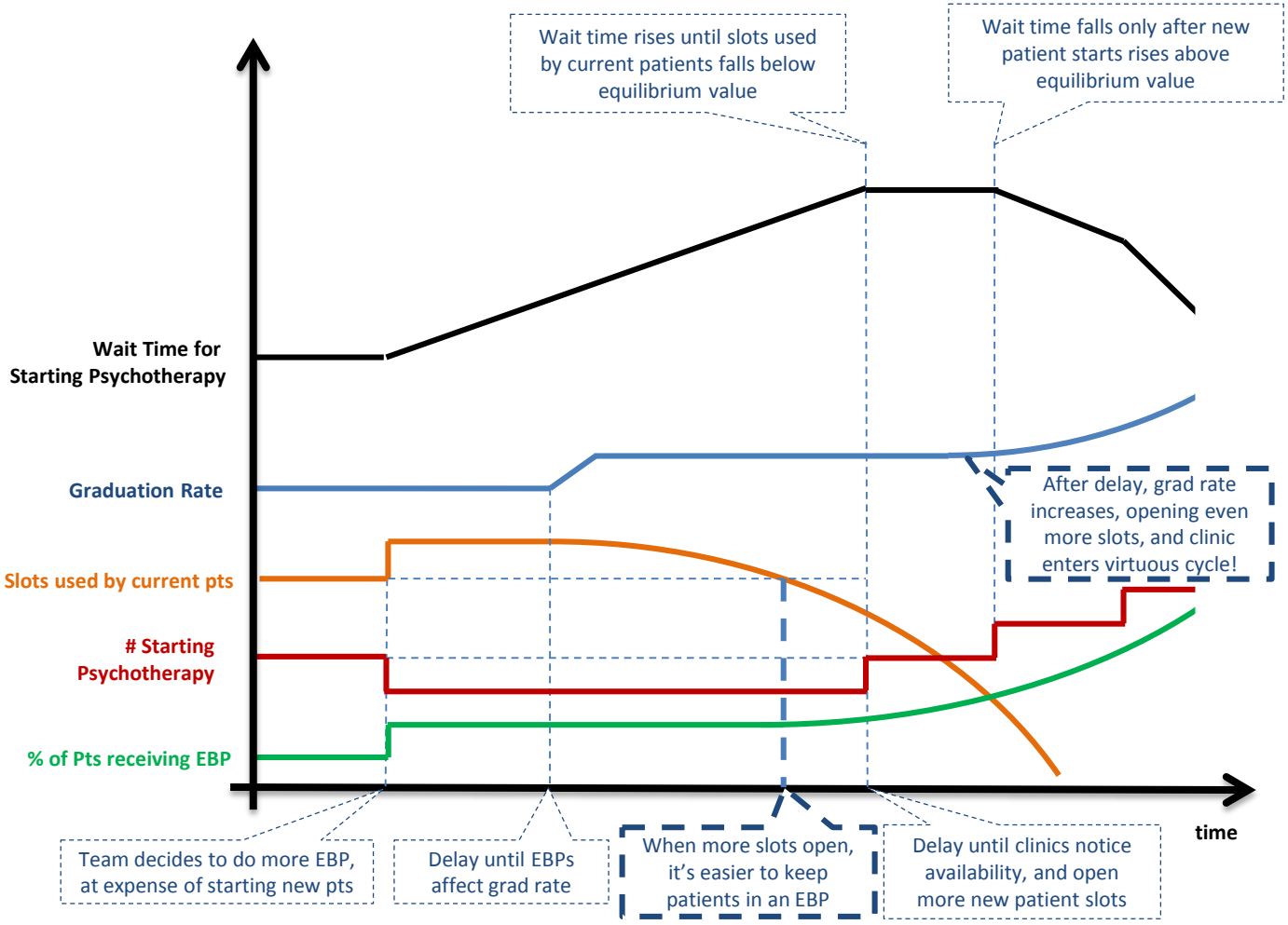



Dynamic Hypothesis: Worse before better!

# With information delays among providers, it's actually way worse before better!!!!!



# Yes, way worse before better, but with increasing long term improvement!!!!!!!



**Pilot**

- Preliminary pilot

**NIH R21**

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- Increase EBP timeliness

**Modeling to Learn**

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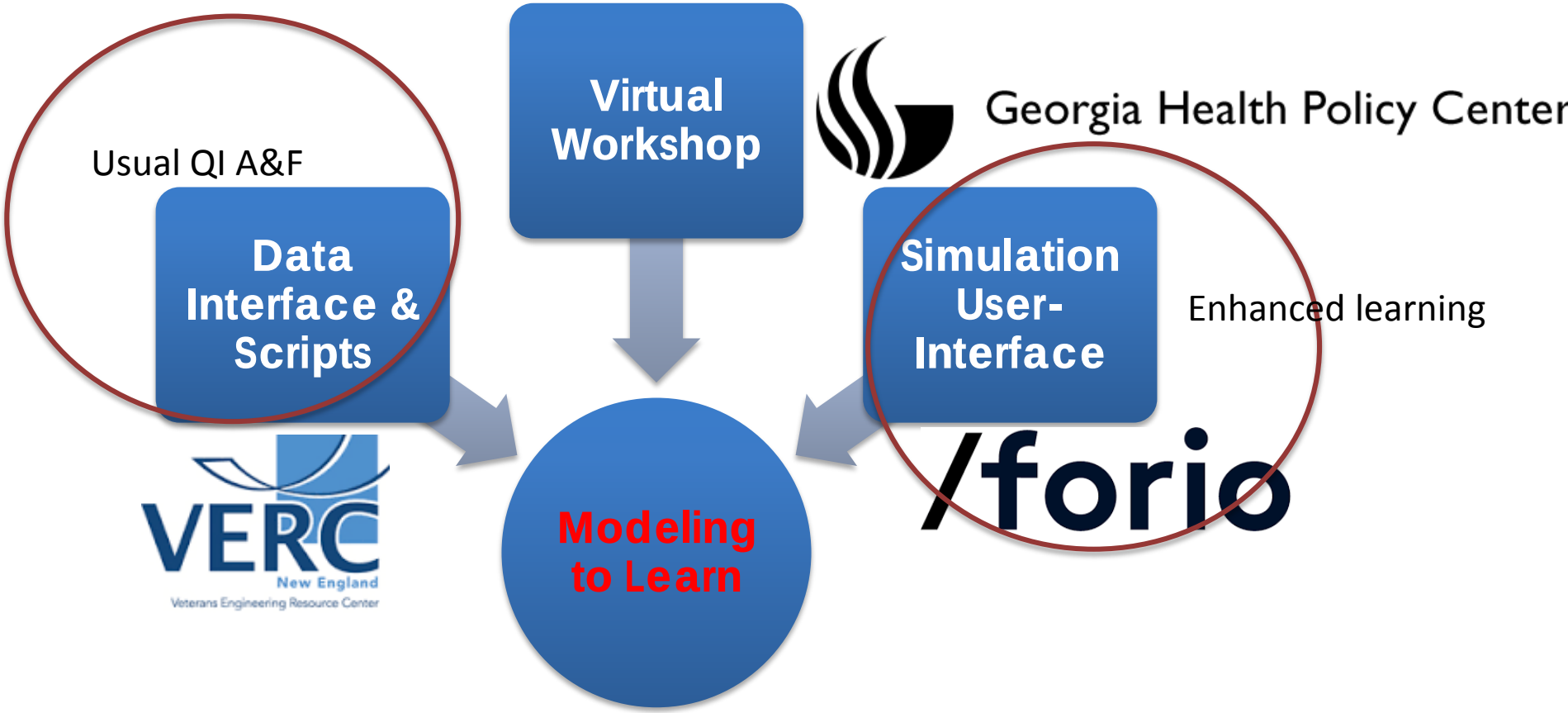
# VA learning health system

- VA learning to achieve
  - timely access
  - coordination of care
  - consistent high quality
- Using systems theory PSD examines trade-offs among competing priorities to optimize existing resources

(Atkins, Kilbourne, Shulkin, 2017)

# Modeling to Learn Workshop Series




**Team-based quality improvement training.**
**VA Employee Education Services (EES) working with us for accreditation.**

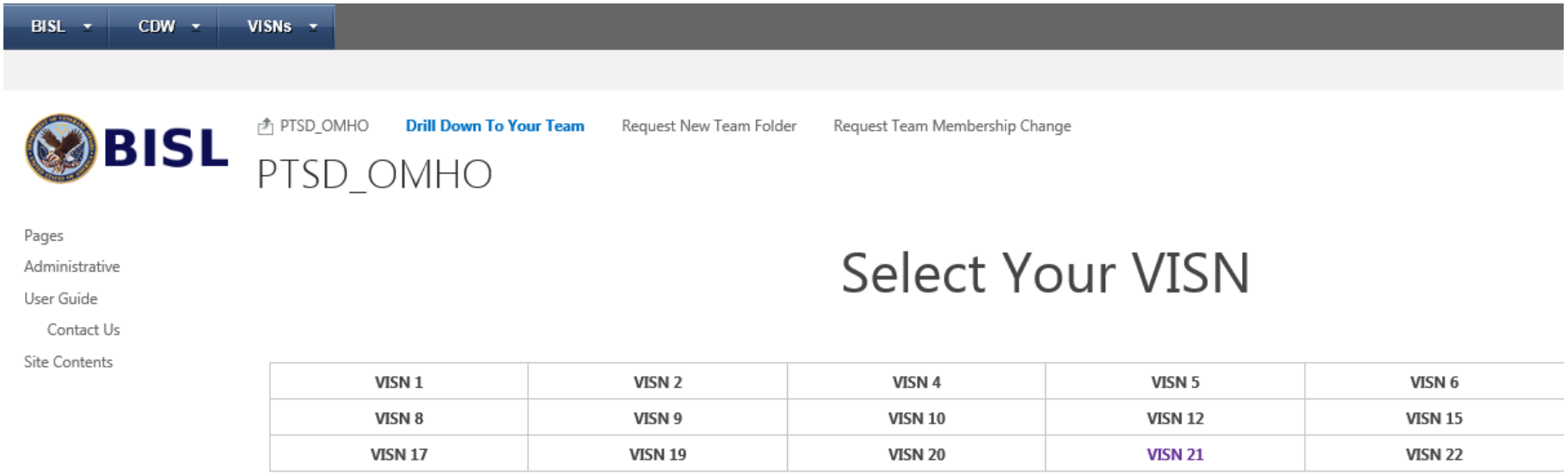
# Session prototypes in Rmarkdown
# https://github/lzim/teampsd

**Four simulation models have been developed**

Lessons that can be learned in 1 team meeting:

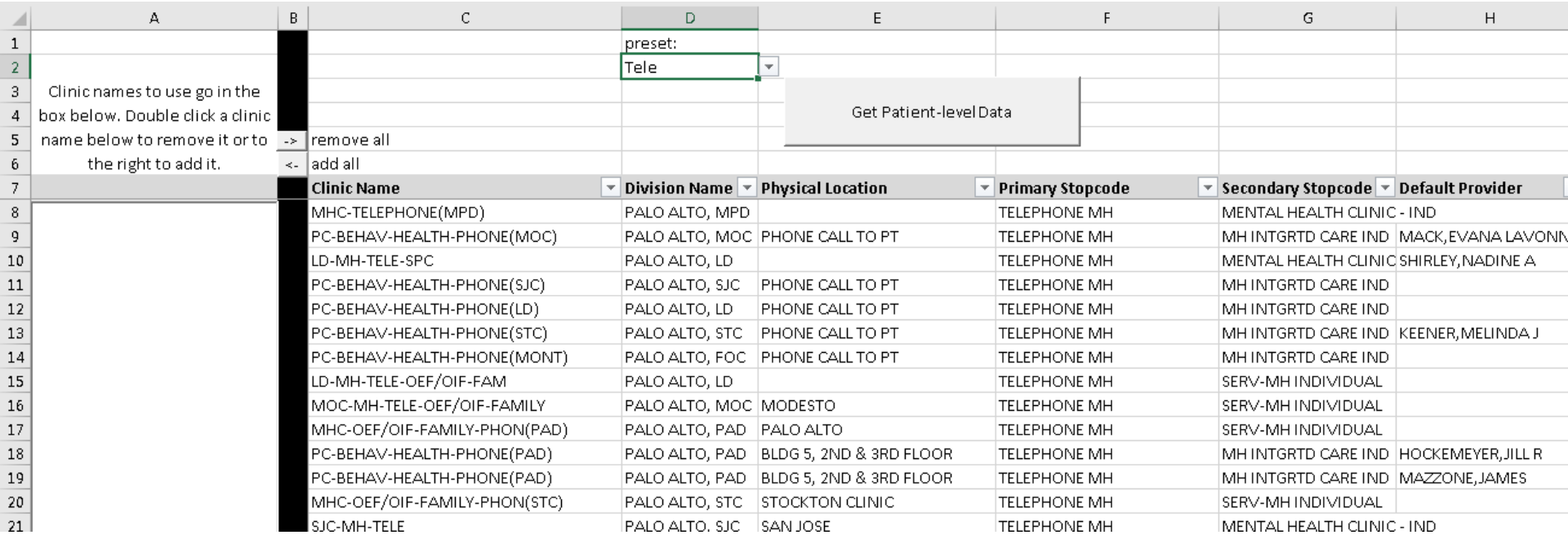
1. Care Coordination
2. Medication Management & EBPharm
3. Psychotherapy & EBPharm
4. Aggregate Model "Putting it all Together"

# OSI/VERC and NCPTSD/ OMHSP developed a site for reviewing data used in team simulations.




- VA Office of Strategic Integration (OSI) and Veterans Engineering Resource Center (VERC)
- National Center for PTSD (NCPTSD) and Office of Mental Health and Suicide Prevention (OMHSP)
- The data and code have been developed for consistency with other OMHSP dashboards and quality metrics, such as SAIL.

# Dynamic Data Tool for Reviewing Data Used in Simulation Model



preset: Tele

Get Patient-level Data

Clinic names to use go in the box below. Double click a clinic name below to remove it or to the right to add it.

-> remove all

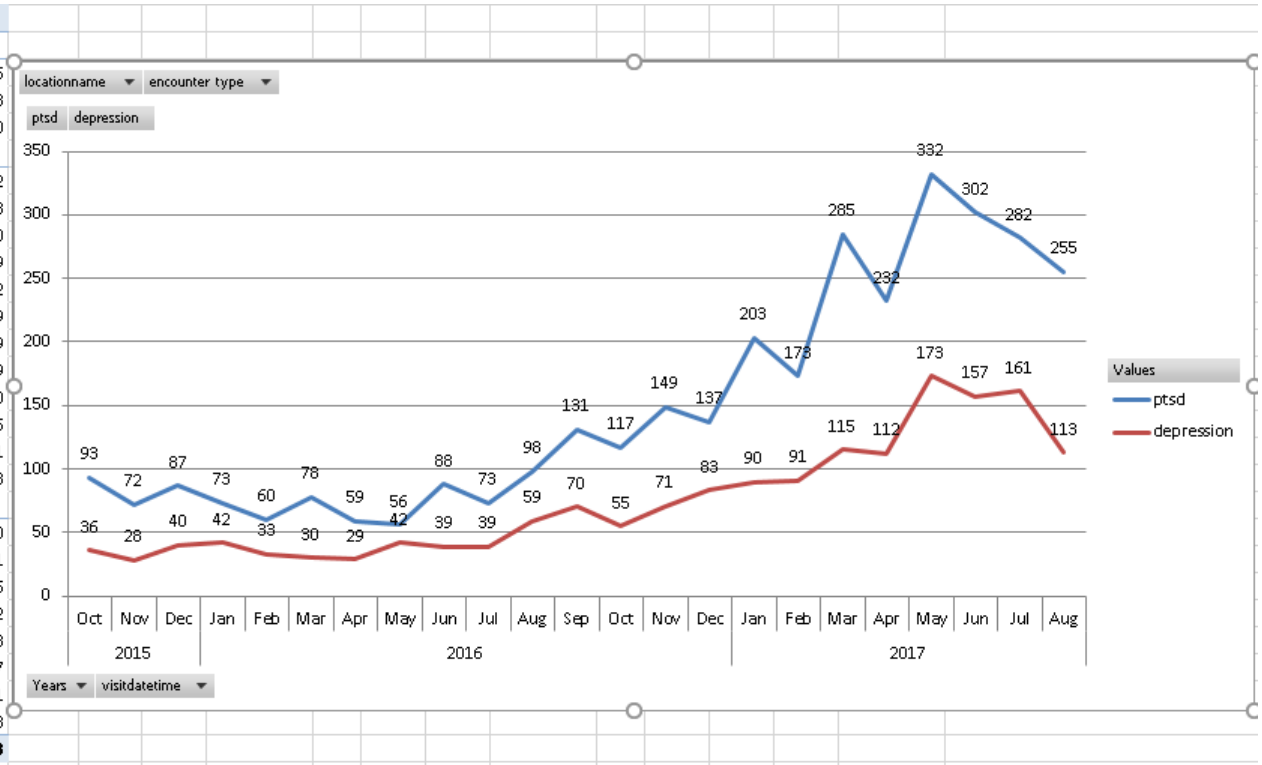
<- add all

| Clinic Name | Division Name | Physical Location | Primary Stopcode | Secondary Stopcode | Default Provider |
|---|---|---|---|---|---|
| MHC-TELEPHONE(MPD) | PALO ALTO, MPD | | TELEPHONE MH | MENTAL HEALTH CLINIC - IND | |
| PC-BEHAV-HEALTH-PHONE(MOC) | PALO ALTO, MOC | PHONE CALL TO PT | TELEPHONE MH | MH INTGRTD CARE IND | MACK,EVANA LAVONN |
| LD-MH-TELE-SPC | PALO ALTO, LD | | TELEPHONE MH | MENTAL HEALTH CLINIC | SHIRLEY,NADINE A |
| PC-BEHAV-HEALTH-PHONE(SJC) | PALO ALTO, SJC | PHONE CALL TO PT | TELEPHONE MH | MH INTGRTD CARE IND | |
| PC-BEHAV-HEALTH-PHONE(LD) | PALO ALTO, LD | PHONE CALL TO PT | TELEPHONE MH | MH INTGRTD CARE IND | |
| PC-BEHAV-HEALTH-PHONE(STC) | PALO ALTO, STC | PHONE CALL TO PT | TELEPHONE MH | MH INTGRTD CARE IND | KEENER,MELINDA J |
| PC-BEHAV-HEALTH-PHONE(MONT) | PALO ALTO, FOC | PHONE CALL TO PT | TELEPHONE MH | MH INTGRTD CARE IND | |
| LD-MH-TELE-OEF/OIF-FAM | PALO ALTO, LD | | TELEPHONE MH | SERV-MH INDIVIDUAL | |
| MOC-MH-TELE-OEF/OIF-FAMILY | PALO ALTO, MOC | MODESTO | TELEPHONE MH | SERV-MH INDIVIDUAL | |
| MHC-OEF/OIF-FAMILY-PHON(PAD) | PALO ALTO, PAD | PALO ALTO | TELEPHONE MH | SERV-MH INDIVIDUAL | |
| PC-BEHAV-HEALTH-PHONE(PAD) | PALO ALTO, PAD | BLDG 5, 2ND & 3RD FLOOR | TELEPHONE MH | MH INTGRTD CARE IND | HOCKEMEYER,JILL R |
| PC-BEHAV-HEALTH-PHONE(PAD) | PALO ALTO, PAD | BLDG 5, 2ND & 3RD FLOOR | TELEPHONE MH | MH INTGRTD CARE IND | MAZZONE,JAMES |
| MHC-OEF/OIF-FAMILY-PHON(STC) | PALO ALTO, STC | STOCKTON CLINIC | TELEPHONE MH | SERV-MH INDIVIDUAL | |
| SJC-MH-TELE | PALO ALTO, SJC | SAN JOSE | TELEPHONE MH | MENTAL HEALTH CLINIC - IND | |

Providers can select the clinic “grids” that make up the dataset they want to explore.
There may be a preset set up already, such as the telephone encounters presented here.

# Data Used in Simulation Model is Graphically Displayed as Trends over Time for the Team.

| Row Labels | ptsd | depression |
|---|---|---|
| 2015 | | |
| Oct | 93 | 36 |
| Nov | 72 | 28 |
| Dec | 87 | 40 |
| 2016 | | |
| Jan | 73 | 42 |
| Feb | 60 | 33 |
| Mar | 78 | 30 |
| Apr | 59 | 29 |
| May | 56 | 42 |
| Jun | 88 | 39 |
| Jul | 73 | 39 |
| Aug | 98 | 59 |
| Sep | 131 | 70 |
| Oct | 117 | 55 |
| Nov | 149 | 71 |
| Dec | 137 | 83 |
| 2017 | | |
| Jan | 203 | 90 |
| Feb | 173 | 91 |
| Mar | 285 | 115 |
| Apr | 232 | 112 |
| May | 332 | 173 |
| Jun | 302 | 157 |
| Jul | 282 | 161 |
| Aug | 255 | 113 |
| Grand Total | 3435 | 1708 |




This shows that the Telehealth team has been serving an increasing number of patients in which the visits (all encounter types shown) listed PTSD or depression as a primary or secondary diagnosis. Providers can filter to different views.

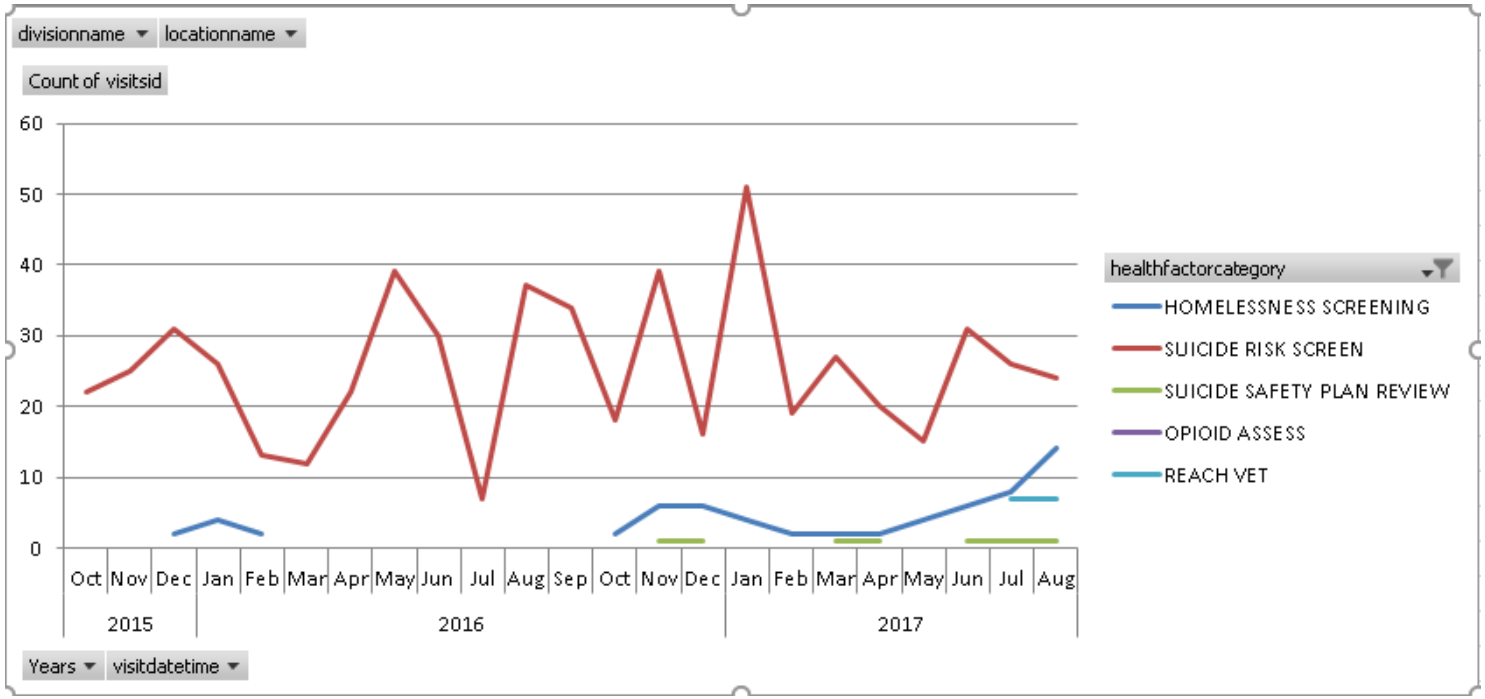
# Trends Graphs also produce searchable reports.

| A | B | C | D | E | F | G | H | I | |
|---|---|---|---|---|---|---|---|---|---|
| patients | visitsid | visitdatetime | patientName | patientSSI | divisionname | locationname | encounter typ | icd10cd | icd10description |

Teams can discuss graphs and reports during team huddles for care coordination decisions and for quality improvement.

- Providers review data, and have the ability to drill-down to individual patient data
- This afford strengths for
  - Improving the quality of coding encounter, diagnosis and other EHR data through nearly real-time review
  - Improving provider confidence in the data that feeds the simulation models
  - Model simulations can more precisely guide decisions when parameters are a from a particular team

# Teams report that they value graphically displayed trends (peaks) of time spent with high-risk patients.

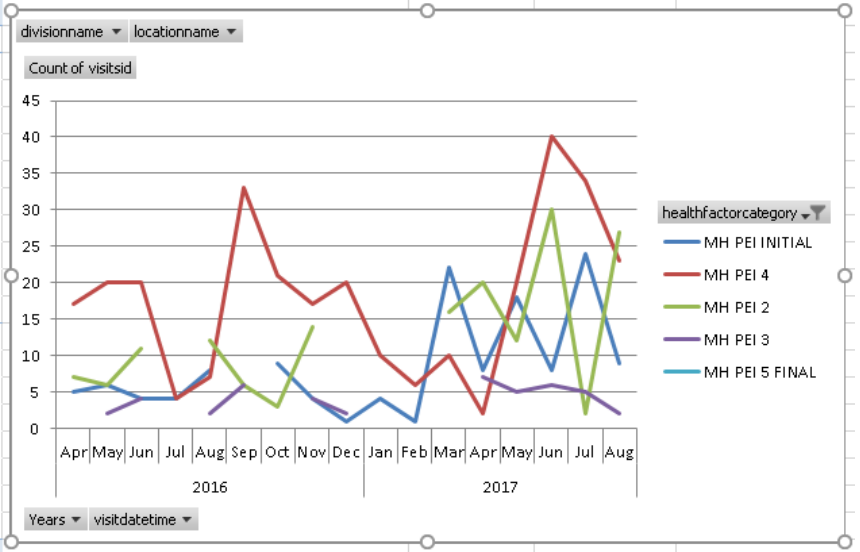



The team can review their typical screening practices to note where gaps in quality exist. They can also review the underlying report to follow-up with specific patients who require care coordination and follow-up.

# Teams value graphical review of EBP template data, such as this Team Prolonged Exposure graph.

| | |
|---|---|
| divisionname | (All) |
| locationname | (All) |

| Count of visitsid | Column Labels | | | | | |
|---|---|---|---|---|---|---|
| Row Labels | MH PEI INITIAL | MH PEI 4 | MH PEI 2 | MH PEI 3 | MH PEI 5 FINAL | Grand Total |
| 2016 | | | | | | |
| Apr | 5 | 17 | 7 | | | 29 |
| May | 6 | 20 | 6 | 2 | | 34 |
| Jun | 4 | 20 | 11 | 4 | 4 | 43 |
| Jul | 4 | 4 | | | | 8 |
| Aug | 8 | 7 | 12 | 2 | | 29 |
| Sep | | 33 | 6 | 6 | | 45 |
| Oct | 9 | 21 | 3 | | | 33 |
| Nov | 4 | 17 | 14 | 4 | | 39 |
| Dec | 1 | 20 | | 2 | | 23 |
| 2017 | | | | | | |
| Jan | 4 | 10 | 10 | | | 24 |
| Feb | 1 | 6 | | 3 | | 10 |
| Mar | 22 | 10 | 16 | | | 48 |
| Apr | 8 | 2 | 20 | 7 | | 37 |
| May | 18 | 20 | 12 | 5 | | 55 |
| Jun | 8 | 40 | 30 | 6 | | 84 |
| Jul | 24 | 34 | 2 | 5 | | 65 |
| Aug | 9 | 23 | 27 | 2 | | 61 |
| Grand Total | 135 | 304 | 176 | 48 | 4 | 667 |




The team can review EBP delivery to determine where gaps in continuity exist. They can also filter and review the underlying report to review specific patients and where they are in their treatment.

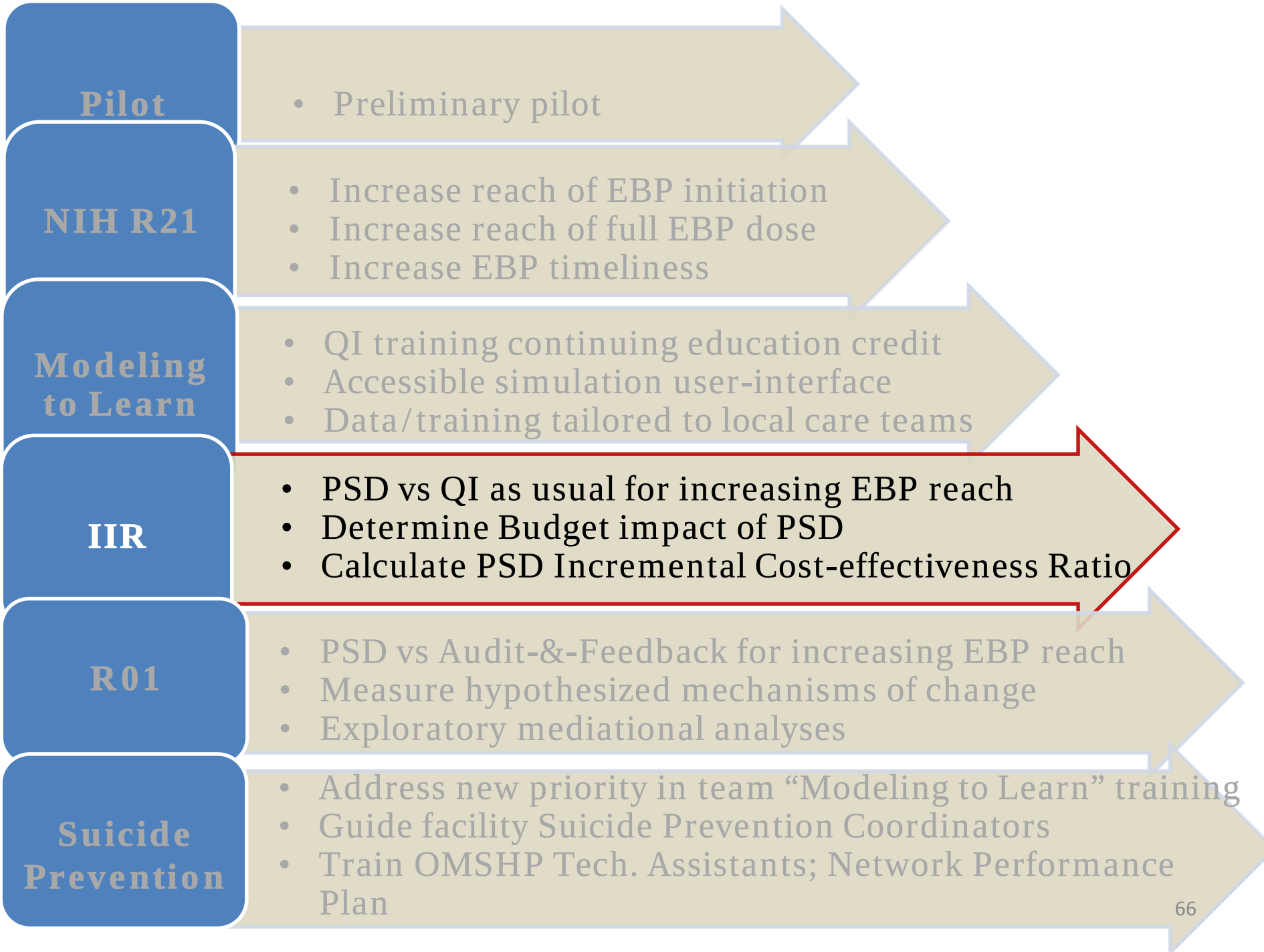
# PSD Modeling Approaches for Building Consensus and Commitment for System Changes

| | |
|---|---|
| **Provide information about the local need for change** | Show the system behavior reference mode (quality gap) |
| **Identify demands/resources/constraints driving quality gaps** | Explore tradeoffs and mechanisms of system behaviors |
| **Explore how changes will impact frontline staff and patients** | Simulate QI changes proposed by staff using local data |
| **Use accessible tools for selecting and sharing the best changes** | Interactive, Online Data Visualization, Simulation Tools |

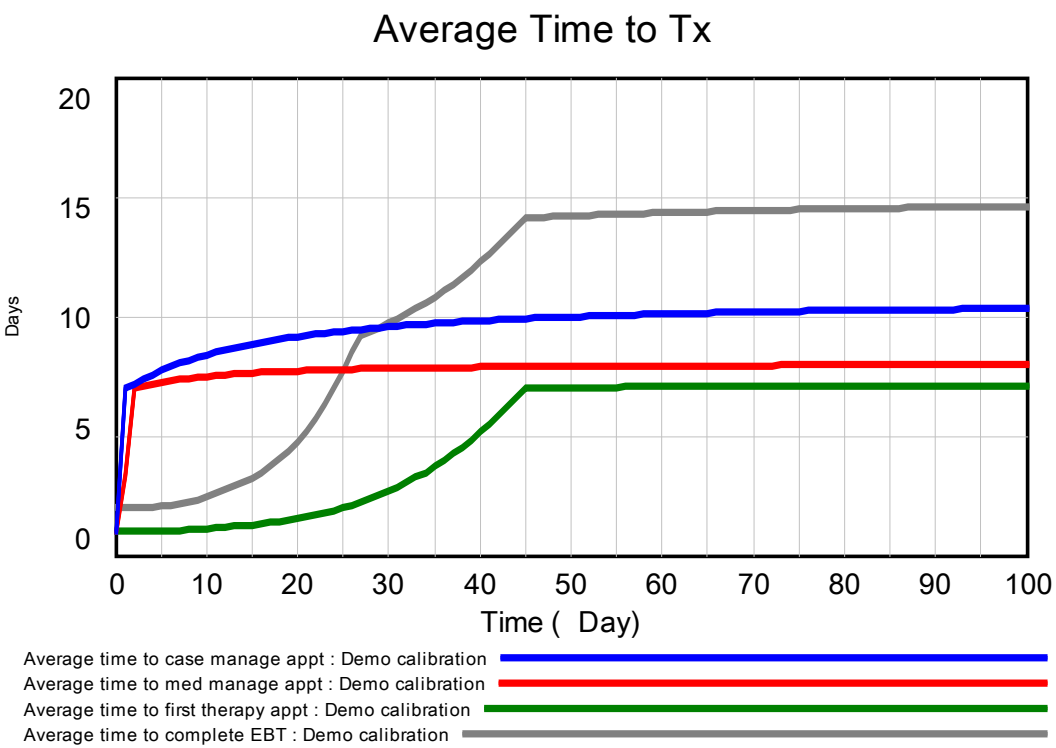
**Adapted from Morecroft & Sterman, Modeling for Learning Organizations, 1994; Vennix, Group Model Building, 1996; Langley G.J. et al., The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. San Francisco: Jossey-Bass**

# What staff think is useful

- If staff feel heard, that will improve morale. Some basic changes will be very helpful.
- Better scheduling and sensible workflow.
- Getting everyone on the same page.
- Show accurate numbers/stats to help give the overall staff understanding of process, uniformity and reflect workload adequately.
- Being able to implement change in a far more targeted way.
- Having a physical representation for fine tuning a process.
- That is looking at systems and allowing needed dialogue.
- Taking into consideration more real world complexity.
- Integration.
- Having an outside consultant with the potential to engage without vested interest to manipulate.


Pilot
• Preliminary pilot
NIH R21
• Increase reach of EBP initiation
• Increase reach of full EBP dose
• Increase EBP timeliness
Modeling to Learn
• QI training continuing education credit
• Accessible simulation user-interface
• Data/training tailored to local care teams
IIR
• PSD vs QI as usual for increasing EBP reach
• Determine Budget impact of PSD
• Calculate PSD Incremental Cost-effectiveness Ratio
R01
• PSD vs Audit-&-Feedback for increasing EBP reach
• Measure hypothesized mechanisms of change
• Exploratory mediational analyses
Suicide Prevention
• Address new priority in team "Modeling to Learn" training
• Guide facility Suicide Prevention Coordinators
• Train OMSHP Tech. Assistants; Network Performance Plan

# Modeling saves time and effort.




**We use simulation to see impacts of proposed changes on the whole system in real time *before* we actually try to implement anything.**

**We also determine when we should achieve our goal.**

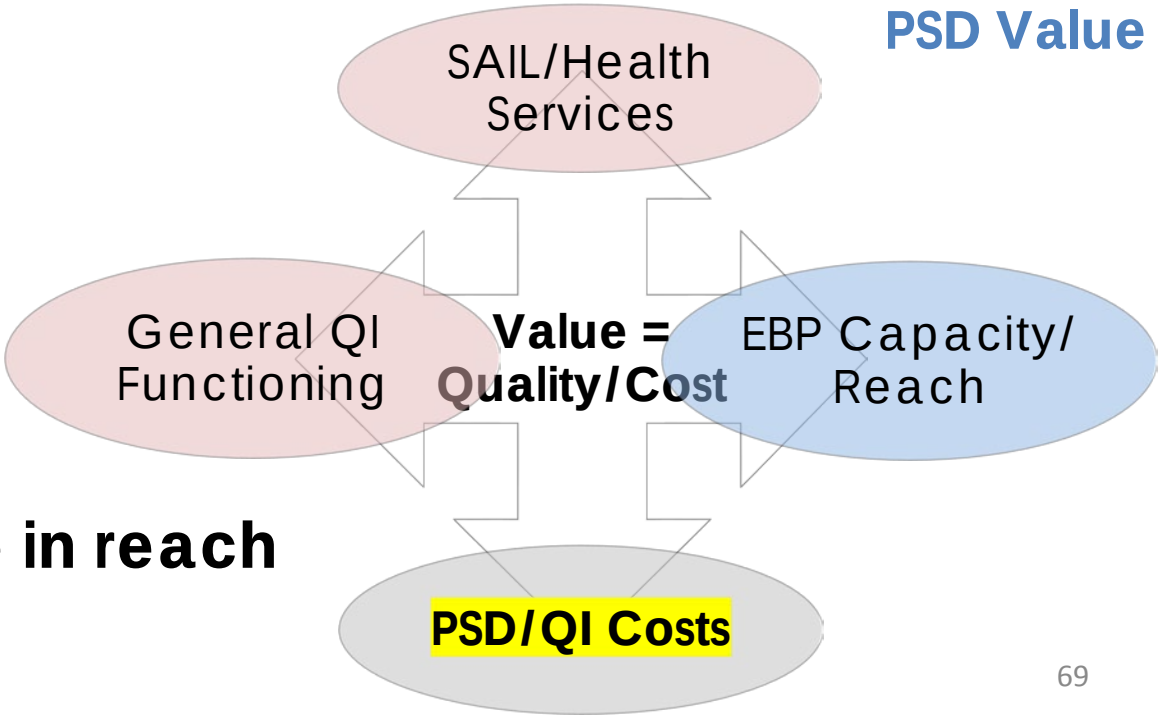
# Value of PSD Review

- **Front-end Value Proposition**
  - Improved consensus 49% (53 of 107 projects)
  - More efficient than other modalities for problem-solving 33% (34 of 107)
- **Back-end Value Proposition**
  - Systems change 42% (46 of 107)
    - Most (89%; 41 of 46) use the model to guide and evaluate
  - Commitment to change increased 33% (35 of 107)

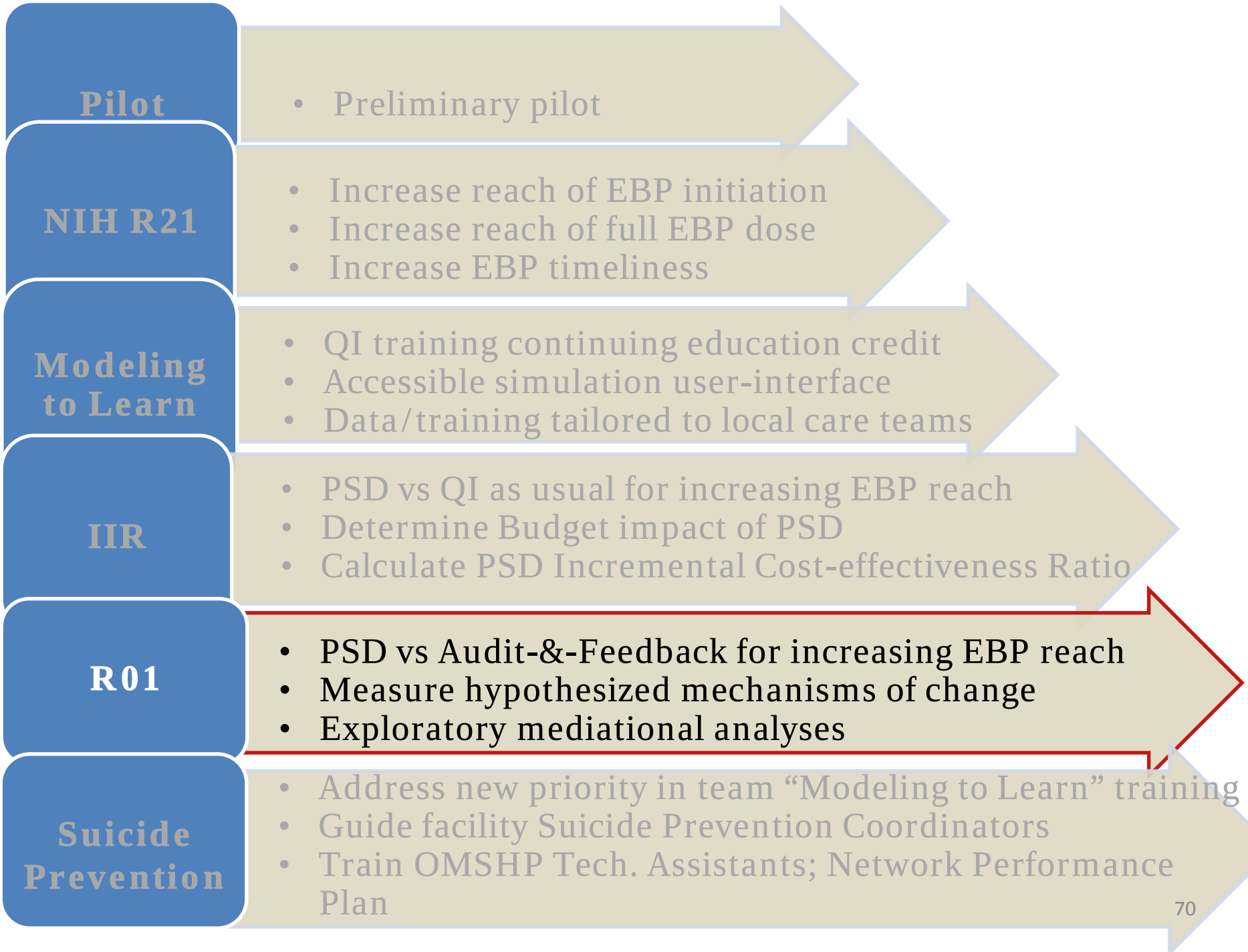
(Rouwette et al. 2002)

# Frameworks for the IIR

| | |
|---|---|
| **Theory** | Systems Theory |
| **Policy** | OMHO SAIL (pink QI)<br>VA EBP Dissemination (blue) |
| **Strategy** | Participatory System Dynamics (PSD) |
| **Target** | Quality Improvement Defined by EBP Reach |




**$/% increase in reach**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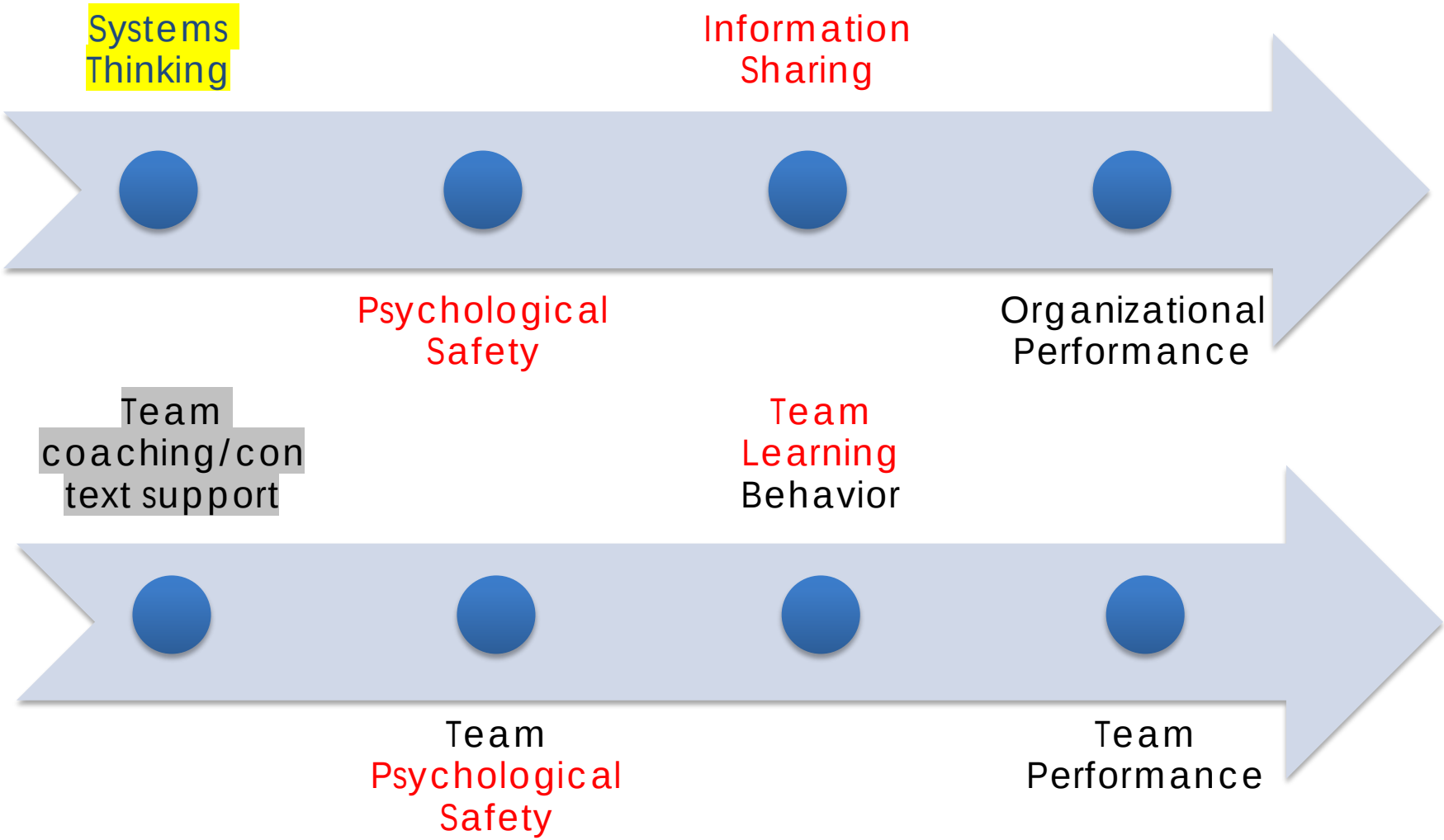
# Mechanism of Change in Learning Organizations

## Systems, Simulations and Psychological Safety

- Learning key to effectiveness (Senge, 1990; Argyris,1993)
- Interpersonal interactions inhibit/facilitate learning
- Shared belief that a team is safe for interpersonal risk taking

# Bendoly, 2014




# Edmonson, 1999

# Measures – Learning Organization Survey (LOS-27)

**Singer et al., 2012**

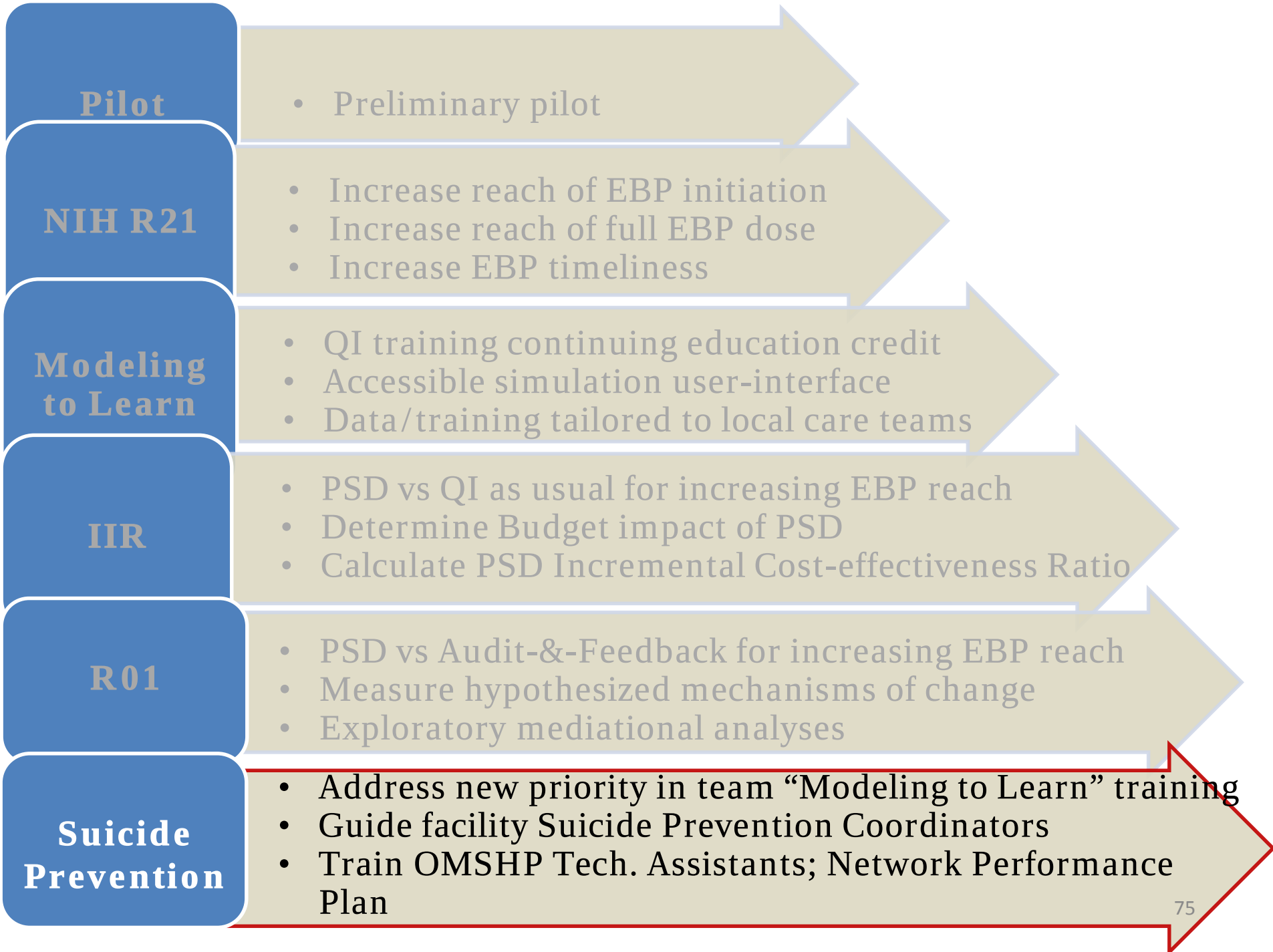
1. Supportive learning environment
2. Leadership reinforces learning
3. Experimentation
4. Time for reflection
5. Training
6. Knowledge acquisition
7. Performance monitoring

# Measures – Systems Thinking Scale (STS)

**Moore et al., 2010/VA Quality Scholars**

– The 20-item Systems Thinking Scale has good reliability and construct and discriminate validity.

- **Systems thinking:** The ability to recognize, understand, and synthesize interactions and interdependencies.
- an understanding of how actions and components can reinforce or counteract each other.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# High value deliverables for the suicide prevention priority.

1. An EES supported, accredited (CMEs/CEUs for mental health) "Modeling to Learn" national training program to improve care delivered by multidisciplinary mental health teams (BHIPs and special program teams)
2. A facility simulation model of the suicide prevention coordinator workflow and staffing to prevent suicide

# Aim is for these resources to become standard practice for guiding mental health improvements.

1. Training of OMSHP Technical Assistants in this approach
2. Participating in the Suicide Prevention Council
3. Provide resources to support the suicide prevention priority in the network directors performance plan

Team
Participatory System Dynamics

# Questions?

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