Lecture Transcript

Module Name	Mental Health in the Community
Week 5	Implementation in Health Care
Topic	Implementation Strategies (Part 2 of 4)

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In the first part of this lecture, we defined implementation strategies and saw that over 70 discrete strategies have been identified. In this second part, we're going to look at how relationships between strategies have been found, leading them to be mapped into separate groups.

The learning outcome for Part 2 involves an awareness of the importance of implementation strategies in getting evidence-based interventions into practice.

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The second study of the ERIC project used concept mapping to characterise the relationship among the 73 discrete implementation strategies, making it easier to search for and consider the full range of implementation strategies available. A panel consisting of 35 experts in implementation science and clinical practice, were asked to sort the discrete strategies into similar groups.

This process resulted in 73 discrete implementation strategies being organised into nine categories. If you'd like to read about the 73 strategies, please see Waltz's paper for the complete detail. We will now discuss the nine categories.

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Waltz's paper summarises the 73 implementation strategies and has organised them by cluster with mean importance and feasibility ratings. We will now discuss examples for each of the nine categories.

Ten of the 73 discrete implementation strategies were characterised as 'Evaluative and integrative strategies', including assessing for readiness and identifying barriers and facilitators, defined as 'assessing various aspects of an organisation to

determine its degree of readiness to implement, barriers that may impede implementation and strengths that can be used in the implementation effort'.

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Four of the 73 discrete implementation strategies were characterised as 'Provide interactive assistance', including provide clinical supervision, defined as 'providing clinicians with ongoing supervision, focusing on the innovation; provide training for clinical supervisors who will supervise clinicians who provide the innovation'.

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A further four discrete implementation strategies were characterised as 'Adapt and tailor to context', including promote adaptability, defined as 'identifying the ways that clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity'. Again, if you'd like to read the full list of strategies, please have a look at Waltz's paper.

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Seventeen of the 73 discrete implementation strategies were grouped as 'Develop stakeholder interrelationships', including identify and prepare champions, defined as 'identifying and preparing individuals who dedicate themselves to supporting, marketing, and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organisation'.

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Eleven of the 73 discrete implementation strategies were characterised as 'Train and educate stakeholders', including distributing educational materials, defined as 'distribute educational materials, including guidelines, manuals, and toolkits in-person, by mail, or electronically'.

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Five implementation strategies were characterised as 'Supporting clinicians', including revising professional roles, defined as 'shifting and revising roles among professionals who provide care and redesigning job characteristics'.

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Five of the 73 discrete implementation strategies were characterised as 'Engage consumers', including intervening with patients to enhance uptake and adherence, defined as 'developing strategies with patients to encourage and problem-solve around adherence'.

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Nine of the 73 discrete implementation strategies were characterised as 'Utilise financial strategies', including accessing new funding, defined as 'access new or existing money to facilitate implementation'.

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Eight of the 73 discrete implementation strategies were characterised as 'Change infrastructure', including mandating change, defined as 'having leadership declared the priority of the innovation and the determination to have it implemented'.

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In summary, in Part 2, we have learned that there are over 70 discrete implementation strategies that can be used to improve the adoption, implementation, and sustainability of evidence-based interventions in healthcare. We have seen how these discrete implementation strategies have been organised into nine categories.

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