## MBC Implementation Planning Worksheet

**Site:**  
Identified Lead:

<table>
<thead>
<tr>
<th>Roles/Tasks</th>
<th>Actionable Items/Examples*</th>
<th>Plan (including timeframe)</th>
<th>Who’s in Charge?</th>
<th>Potential Barriers/Notes</th>
</tr>
</thead>
</table>
| **A. Identify Setting and Participating Staff**  
  - Clinic(s)/Team(s)  
  - Local Lead  
  - Participating Providers  
| - Identify setting(s): Primary Care MH; Outpatient MH; Residential; etc.  
  - Identify Local Lead  
  - Determine staff to participate: e.g., LCSWs, Psychiatrists, Psychologists, Addiction Therapists, trainees, admin support staff, etc. | **Outpatient BHIP**  
LCSW, Psychiatrists, Psychologists, Advanced Practice Nurses | De-identified (enter staff name here) | - Duplication  
- Clinicians remembering to do the measures  
- Do we need a templated note? |
| **B. Engage & Train Staff** | - Engage all staff through meetings and communications.  
  - Ensure all staff complete all MBC training as needed.  
  - Determine which staff will be involved in Implementation Planning process (a meeting to complete the rest of this sheet)  
  - *Recommend as many participating staff participate in implementation planning as possible* | Meet with staff several times through various venues including larger all staff meetings as well as with PTSD staff treatment team. Set up program line MBC email groups. Identified POC is chief psychologist, as well as advanced practice nurse is administrator of department, and attends treatment team meetings weekly | MBC staff training will be added to TMS to do list and also added as an external event for tracking purposes | Reaching consensus on implementation plan; crafting clinical reminder and note templates as needed; tracking and designing a process to give feedback if measures missed and obtaining missing data |
<table>
<thead>
<tr>
<th>Roles/Tasks</th>
<th>Actionable Items/Examples*</th>
<th>Plan (including timeframe)</th>
<th>Who’s in Charge?</th>
<th>Potential Barriers/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Veterans Advisory Council representative, Outpatient PTSD program line staff, ACOS of Behavioral Health, Chief Psychologist, Behavioral Health administrator, Social work supervisor: CAC’s</td>
<td></td>
<td>Lack of budget support</td>
</tr>
</tbody>
</table>

C. Determine Additional Ways Leadership can Support Participants

- Leadership will have already signed off on participation
- Examples of additional support:
  - Provide recognition for participating providers.
  - Consider site-specific resources that may be available to support implementation (e.g., admin support, dedicated time for local champion during initial implementation phase, budget support for MBC support materials, e.g. color printers, tablets, etc.).
  - Provide opportunities for participants to present to local leadership on progress.
- Monthly reports to Behavioral Health Council and minutes to facility administration
- I CARE certificates to engaged staff
- MBC updates on weekly treatment team agendas
- Monthly MBC staff luncheon to share success stories and foster continued engagement
- Reports on MBC at medical executive meetings

Lack of budget support, Change Fatigue, Conflicting Priorities
### D. Determine Who to be Assessed

- **Identify Veteran population to receive MBC**
  - All patients served by participating providers/programs or clinics
  - Subset of Veterans (e.g., those engaged in new episodes of care, group tx, individual tx, those who screen positive for specific diagnoses, etc.)
    - *Recommend initiating MBC with Veterans engaged in a new episodes of care since changes in outcomes are more likely to occur and be reflected in outcome measures*
    - Other__________________

- **All new Veterans in Behavioral Health with a Substance Use diagnosis as of kickoff date (January 9th, 2017)**

### E. Determine Measures & Frequency

- **Select Measures**
  - PHQ-9
  - GAD-7
  - PCL-5
  - BAM-R
  - Other__________________

*We require a minimum of one of the identified measures administered at two time points within 3 months.*

Consider whether all Veterans will get same measures & how will be

- **GAD-7; PHQ-9**
  - All Veterans will receive GAD-7 and PHQ-9

### Managing administration of measures in group setting if Veteran not in individual therapy;
Managing administration of measures if MHTC does not typically see Veterans

Chosen measures driven by program line rather than diagnosis or current concerns
determined (e.g., one PCMHI clinic determined that Veterans screening positive on 4 item PTSD screen would receive PCL-5).*

- Determine timing of measurement:
  - Intake into clinic?
  - Post treatment? Mid-treatment?
  - Every relevant MH encounter?
  - Clinical judgment?
  - As recommended by a particular roll out that clinic has been involved in?
  - Other predetermined intervals?
    If so, document ________________

F. Determine Method of Administration & Who Administers

<table>
<thead>
<tr>
<th>Method to administer</th>
<th>Tablets are preference if request for 27 approved; 2\textsuperscript{nd} choice is secure desktop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper survey</td>
<td>Veteran (self-administered);</td>
</tr>
<tr>
<td>Kiosk</td>
<td></td>
</tr>
<tr>
<td>Tablet</td>
<td></td>
</tr>
<tr>
<td>Veteran at computer</td>
<td></td>
</tr>
<tr>
<td>(Secure Desktop)</td>
<td></td>
</tr>
<tr>
<td>Provider reading</td>
<td></td>
</tr>
<tr>
<td>aloud (e.g. from MHA)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

We do not have approval for system-wide use of tablets or other mobile devices for instrument administration.
at this time. If a site has mobile devices that can be used on the network, we will support their use to administer instruments through one of our identified software applications such as BHL.

- Determine who administers (this may be redundant depending on response to previous question)
  - Veteran (self-administered)
  - Provider
  - Other staff (e.g. admin support, trainees)
  - Other _________________

- Determine timing of when administration happens during visit:
  - Lobby, before session
  - In session with provider
  - Different at intake/first visit than subsequent visits?
  - Other _________________

G. Determine Method of Documentation within MHA and Who Documents

- Establish method to ensure that data are entered in MHA
  - MHA entry is required

- If administration method is paper/pencil or otherwise not directly linked to MHA, identify who will enter data into MHA:
  - Provider
  - Other clinical staff

<p>| 2nd choice is other staff | Lobby before session or in session with provider | 1st preference is tablets; 2nd preference is secure desktop | N/A |</p>
<table>
<thead>
<tr>
<th>H. Determine Clinical use of MBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Based on data collection method, determine if scores can be available at time of visit</td>
</tr>
<tr>
<td>- How will providers make use of data to promote shared decision-making and individualize treatment in this particular setting? (e.g. reviewing graphs, motivational enhancement discussions, adaptive treatment planning, linking to other sources of clinical data, discussing sx change in context of Veteran’s identified goals, facilitating discussions about level of care decisions, etc.)</td>
</tr>
<tr>
<td>- How will you know that this is happening, e.g. keep as an agenda item in team meetings, share</td>
</tr>
</tbody>
</table>

<p>| | In cases where the data is collected via paper/pencil, the timing of the data entry is crucial. Optimally within 24 hours of the data collection when assessments are weekly and with 7 days if assessments are monthly. |
| | At time of administration |
| | At time of administration |
| | Yes, available at time of visit |
| | Yes, available at time of visit |
| | Reviewing scores and changes from last administration as well as discussion of factors impacting scores; facilitating motivational enhancement discussion of barriers and level of care decisions |
| | Agenda item on BH monthly staff meetings; tracking via a clinical reminder; agenda item on weekly program line treatment team meetings |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>success stories, brainstorm barriers, etc.</td>
<td></td>
</tr>
<tr>
<td>I. Decide how to Engage Veterans</td>
<td>• Identify how clinic/team will collect and incorporate Veteran input/feedback on implementation of MBC. (e.g., Random selection of Veterans to complete a satisfaction survey on the MBC process).</td>
<td>Veterans Council member *part of core workgroup team, and workgroup members also invited to monthly Veterans Council meetings to get feedback. May explore Veterans Council doing satisfaction survey at midpoint and at completion of implementation</td>
</tr>
<tr>
<td>J. Defining MBC Success</td>
<td>• Identify why this is important; what are your clinic/team’s goals and how would you define success?</td>
<td>MBC important to further improve quality and effectiveness of clinical care. Utilizing MBC allows providers to document symptom improvement and/or facilitate changes in level or intensity of care to best match Veteran’s needs throughout treatment. In additional goal is to improve documentation and provide solid clinical rationale for provider interventions.</td>
</tr>
</tbody>
</table>
| K. Develop implementation support plan | • Identify frequency/format of meetings for clinic implementation team to self-assess progress, navigate any barriers, celebrate successes (e.g., MBC implementation becomes a boilerplate agenda item on team meetings).
  • Identify how participating staff can make use of Pulse Site to support shared goals.
  • Determine which staff will join support conference calls/coaching calls (Local Lead, others?). | Meetings with core workgroup twice monthly
Core team members from each program line and administrators invited to restricted access Pulse Site (done)
Local Lead, core workgroup team members, program line POC’s as schedule permits |
| L. Determine MBC Start Date | • Identify start date for MBC
  o Recommend starting ASAP (e.g., within 30 days of first meeting with coach)
  o It is ok to have kinks in the plan- this is about learning together not about doing it perfectly.
  o Some sites with several barriers or more complex implementation plans have opted for a phased approach- starting with a more bare bones implementation plan for the first few months and then adding more measures, etc. later on. | January 9th, 2017 |
| M. Determine how to Sustain MBC | • Develop Standard Operating Procedures (SOP) for MBC (this document as it evolves)  
• Recognize high MBC providers  
• Celebrate implementation of MBC. | I CARE certificates to engaged staff  
MBC updates on weekly treatment team agendas  
Monthly MBC staff luncheon to share success stories and foster continued engagement |  |

* See supplementary document for Specialty Care considerations.