Implementation Strategies in Social Service Settings:

A Research Agenda

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Why focus on implementation strategies?

- Represent the “how” of implementation
- Essential to closing the research to practice gap
- Have been prioritized by the Institute of Medicine (2009) and the National Institutes of Health (2013)

Purpose and Overview

Purpose:

- To identify research priorities pertaining to implementation strategies in social service settings

Overview of Priorities:

1) conceptualization and design of strategies
2) delivery of strategies
3) evaluation of strategies

Can implementation strategies be adequately specified?

- *To date strategies are:*
  - Inconsistently labeled (Brouwers et al., 2011; McKibbon et al., 2010)
  - Poorly described (Michie et al., 2009)
  - Rarely justified theoretically, empirically, or pragmatically (Bosch et al., 2007; ICEBeRG, 2006)
- *We need:*
  - Greater terminological clarity
  - Better integration of theories and conceptual frameworks
  - Reporting guidelines for strategies
- *Emerging examples:*
  - VA Expert Recommendations for Implementing Change
  - Michie et al.'s (2011) effort to specify components of behavior change interventions
  - Proctor et al. forthcoming strategies measurement paper

What can we learn from implementation as usual?

- *To date:*
  - We lack basic information about the types of implementation strategies used in usual care, and how they map onto “best practices” in implementation
  - Strategies, like clinical interventions, are too often developed without consideration of context
- *We need:*
  - A better understanding of the range of strategies deployed in usual care
  - An understanding of the types of strategies that will be acceptable and feasible in real world contexts
  - To build upon practice-based evidence and “positive deviants”
- *Examples:*
  - Cabassa and colleagues (in progress)
  - Schoenwald et al. (2008)
  - Powell dissertation study (in progress)

Can we improve the selection and tailoring of strategies?

- *To date*:
  - Increasing recognition that strategies should be tailored (Mittman, 2012)
  - Methods of tailoring are not well described
  - "…insufficient evidence on the most effective approaches to tailoring" (Baker et al. 2010)
  - Often a mismatch between identified barriers and chosen strategies (Bosch et al., 2007)

- *We need*:
  - Improved methods for identifying and prioritizing barriers
  - Studies that test methods of matching strategies to identified barriers

- *Examples*:
  - Wensing et al. (2011) and Flottorp (2013)
  - Beidas et al. (In Progress) will explore the potential use of Intervention mapping, group model building, etc.

Can strategies more readily address policy-, organizational-, & client-levels?

- *To date*:
  - Most implementation strategies have been primarily targeted at clinicians, neglecting other important levels of the implementation context
- *We need*:
  - Studies that examine policy-, organizational-, client-, and intervention-level influences
  - Development and refinement of strategies at these levels
- *Examples*:
  - Isett et al. (2007)
  - Beidas et al. (2013)
  - ARC (Glisson et al., 2010)

How can (inexpensive) technologies be harnessed?

- *To date:*
  - Training, supervision, consultation, fidelity monitoring etc. is often very expensive
  - It is likely that many clinicians will not be willing (or able) to pay these costs (Powell et al., 2013; Stewart & Chambless, 2010)
- *We need*:
  - Less expensive training initiatives with little sacrifice in intensity
  - Web-based implementation support tools
- *Examples*:
  - McMillen et al. (In Progress)
  - AutoMITI (Atkins), PracticeGround (Koerner)

What is the economic impact of implementation strategies?

- *To date:*
  - Very few studies consider the costs of implementation strategies (Grimshaw et al., 2004; Raghavan, 2012)
  - Those that do largely consider the time spent on implementation activities
- *We need:*
  - More complete information by which to base the selection of implementation strategies (and interventions)
  - Economic evaluations that include direct labor costs, indirect labor costs, and nonlabor costs (Raghavan, 2012)
- *Resources:*
  - Raghavan (2012)

How can we disentangle the mutative factors of multifaceted strategies?

- *To date*:
  - Components of multifaceted strategies not well understood
  - “Difficult to parse out the effects of individual intervention components and determine whether some components are more important than others” (Alexander & Hearld, 2012)

- *We need*:
  - Qualitative and mixed method studies that shed light on the contributions of strategies (Aarons et al., 2012, Palinkas et al., 2011)
  - Studies that employ adaptive designs to develop and test implementation strategies (e.g., multiphase optimization strategy and SMART Trials; Brown et al., 2009; Collins et al., 2007)

- *Examples*:
  - Rapp et al. (2008)

Are implementation strategies generalizable?

- *To date*:
  - Moved away from “magic bullet” philosophy of implementation strategies
  - However, the goal of implementation research is still to move towards a generalizable science of implementation
- *We need*:
  - Studies that test strategies from other fields and across interventions
  - To carefully consider the tension between tailored strategies and strategies that may be able to be used across settings
- *Emerging examples*:
  - Saldana and Chamberlain (2013) SIRC Presentation on “common elements for implementing EBP in CW”

Can we develop learning organizations and evidence-based systems of care?

- *To date:*
  - Focus has largely been on implementing single treatments
- We need:
  - Studies that examine strategies to facilitate innovation and exnovation (Glied, 2012)
  - Data to support institutionalizing some implementation strategies (e.g., what types of training and supervision structures, quality monitoring systems, and support systems are needed)?
- Examples:
  - Perhaps you'll have this figured out for SIRC 2015?

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