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Welcome from the Conference Directors

Looking Back

SIRC was born out of the recognition that there were multiple researchers and community leaders working on parallel innovative implementation projects and research, but no one seemed to know what each other was doing. To address the need for communication and collaboration among behavioral health implementation researchers and stakeholders, Kate Comtois (founder of SIRC) and several implementation scientists at the University of Washington submitted an NIMH proposal for a conference grant to fund three biennial conferences. SIRC received NIMH R13 funding (i.e., a total of $150,000 for 5 years) for this conference series in 2010.

After the first conference, SIRC became a productive community of diverse researchers and stakeholders with the potential to help shape the field of implementation science. SIRC changed its name in 2014 to reflect its larger mission - a Society dedicated to promoting Implementation Research Collaboration to achieve effective and sustained use of Evidence Based Practices (EBP) across community settings. As a society, SIRC provides a forum within which implementation researchers and stakeholders can learn from each other, refine approaches to science and practice, and develop an implementation research agenda using common measures, methods, and research principles to improve both the frequency with which the implementation of EBPs is evaluated and the quality of those evaluations. As a testament to the interest in SIRC within the field of implementation science, SIRC has grown to over 800 members between 2011 and 2015.

Although not explicitly used to guide SIRC’s development, SIRC’s objectives and activities are well aligned with Glasgow and colleagues’ (2012) five core tenets deemed necessary to advance dissemination and implementation:

- **Collaboration and Efficiency and Speed.** SIRC promotes collaboration through thoughtful orchestration of conference foci, presenters, and activities. The first two conference themes were 1) Key Issues in EBP Implementation Methods and Research and 2) Solving Implementation Research Dilemmas. This third conference (2015) focuses on work that Advances Efficient Methodologies through Community Partnerships and Team Science. To speed up the engagement of non-researchers and ensure our methodologies are efficient, SIRC formed an EBP Champion Task Force who helped design both this year’s workshops and the call for proposals for the 2015 conference.

- **Rigor and Relevance.** The Implementation Development Workshop (IDW) has rigor and relevance as its primary goal. The IDW is offered to all new and established investigators, EBP champions, and Intermediary members of the SIRC Network of Expertise (NoE). The IDW leverages the group’s collective wisdom in the planning stages of a project to identify creative solutions to enhancing the rigor and relevance of methods and measurement and increase competitiveness for funding. It is an optional day at the beginning or end of the conferences, and more recently, an online meeting held three times annually. If you are interested in becoming an NoE member or wish to nominate someone, please email sirc@uw.edu.

- **Improved Capacity.** The SIRC Dissemination and Implementation Training webpage serves as a single comprehensive source to find current implementation-focused training opportunities. We invite you to review the page and contribute to the list of programs and mentors identified: https://www.societyforimplementationresearchcollaboration.org. In addition, the New Investigator Mentorship Program is SIRC’s main effort to build the implementation science workforce capacity through strategic matching of new to established investigators. Given the success of the New Investigator Mentorship Program (28 matches to date; 100% success rate), SIRC is currently developing a Student NoE (for undergraduates and graduate students) in which they will have the opportunity to receive mentorship from new investigators. We invite you to nominate student or new investigators to the NoE by emailing us at sirc@uw.edu.
• **Cumulative Knowledge.** The Instrument Review Project (IRP; Lewis, Stanick, et al., 2014) is one of SIRC’s main initiatives seeking to advance the tenet of cumulative knowledge. The SIRC IRP is an enhanced systematic review of dissemination and implementation instruments that assess implementation outcomes (Proctor et al., 2009) and constructs outlined by the Consolidated Framework for Implementation Research (Damschroder et al., 2009). The SIRC IRP will culminate in an online repository for use by SIRC members.

**Looking Ahead**

This third biennial conference marks the end of our NIMH funding. In anticipation of this transition period, SIRC has become a Society to provide the necessary infrastructure for sustaining its place in the implementation resource landscape, but we need your help. To support SIRC’s livelihood, we will begin charging for membership in January 2016. Membership will cost $175 annually for full members, $50 for students, with financial hardship scholarships available. An annual budget will be made available to all contributing members for transparency, and resource priorities will be informed by biannual member surveys. SIRC will be led by a core team of internally elected officers over the next two years to ensure a smooth transition off of NIMH funding. In 2017, SIRC members will be asked to nominate incoming officers and a formal vote of all SIRC members will take place. Please see our “Meet the Officers” page in the conference program to learn more about our team.

Following the conference, SIRC will prioritize several ongoing initiatives and solicit interest and feedback on a few new initiatives for the coming year. If you would like to be involved in any initiative, please email your interest to sirc@uw.edu.

**EBP Champion Task Force,** chaired by Doyanne Darnell, is a group of core SIRC members and EBP Champions who advise SIRC on how to maximize its relevance to EBP Champions and to increase their involvement. The focus for the upcoming year is connecting with EBP Champion organizations and meetings to expand SIRC membership and reach.

**Implementation Development Workshop (IDW).** As described above, the IDW is one of SIRC’s longest standing offerings that has grown from a conference-related event to a thrice annual, web-based meeting for Network of Expertise members. The meetings will continue to occur one month prior to the NIH deadline cycle. SIRC is currently wrapping up an evaluation to determine what features of the IDW are most effective in supporting proposal development and to compare the face-to-face versus online formats. Preliminary results indicate that the facilitation maximizes the number of unique pieces of feedback, which is critical to the IDW’s impact and that while both in person and online formats are effective’ the online version is more accessible. Based on a subset who responded to a survey, 40% of IDW projects presented were funded, with an additional 26.7% receiving scores that would invite resubmission. We have expanded our focus in 2015 to include implementation projects that are not research to increase the IDW’s relevance to our EBP Champions and Intermediaries.

**Instrument Review Project.** Also described above, SIRC will continue to lead the field with its Instrument Review Project in the coming years. With new NIMH R01 funding, Drs. Cara Lewis, Cameo Stanick, and Bryan Weiner will pursue SIRC’s long-term goal to develop a comprehensive battery of reliable, valid, and pragmatic measures that researchers and stakeholders can use to advance the science and practice of implementation. The overarching objective of this project is to put forth a measurement-focused research agenda for implementation science (i.e., which constructs possess psychometrically strong and pragmatic measures, which require further development) as well as measures and methods to accomplish this work. The methods, measures, and results from this grant will be made available to SIRC members in our online repository. Results from our unfunded preliminary work are currently available on the members section of the SIRC website:
https://www.societyforimplementationresearchcollaboration.org/sirc-projects/sirc-instrument-project/
There are several new SIRC initiatives planned for this year:

**Journal.** As the field of implementation science grows, the number of publication outlets and their focus is unable to meet the demands of the innovative work being produced, particularly for those of us working in behavioral health. Tentatively titled Behavioral Health Implementation Research, SIRC proposes to establish an open access, double-blind peer-reviewed, online journal that publishes rigorous and pragmatic original empirical research related to methods of facilitating the implementation and sustainment of EBPs in behavioral health policy and practice.

On Saturday, September 26th, we will launch our feedback phase of the SIRC journal development process. You are invited to join us during lunch to discuss your priorities, ideas, and interest in supporting a behavior health implementation journal. Subsequently, an international survey feedback initiative will commence to further focus the journal’s scope, assess general interest, as well as identify manuscript priorities and members interested in supporting the journal on the planning committee, advisory board, editorial board, as a reviewer, etc.

**SIRC Training Institute for Collaborative Science (STICS).** Aaron Lyon, PhD is leading a SIRC team to develop and conduct a collaborative research training institute that expands the scope of the implementation research workforce and promote rigorous and locally-relevant and pragmatic science. Using Interprofessional Education and Team Science models, STICS will train teams of an EBP Champion, Intermediary, and Researcher with mentors from each role. STICS is designed as a compliment to other implementation research training opportunities as it explicitly includes non-researchers in the process.

**SIRC Resource Library.** SIRC will develop a series of pages on the website which summarize and provide useful resources focused on specific topics. Initial areas of foci will include the best introductory materials for implementation science, approaches to efficiently measuring fidelity across multiple EBPs, strategies for performance monitoring, etc. We will link relevant videos of SIRC conference presentations to each resource page as well as key articles and chapters, policy briefs, funding announcements and website links. To maintain quality, all materials in the Resource Library will be created or recommended by members of the SIRC Network of Expertise.

**Intermediary Webcasts** will be developed on topics related to training, consultation, internal and external facilitation, and other issues of relevance to SIRC Intermediaries that will be open to all SIRC members. We envision offering webcasts every 3 or 6 months at times to maximize international participation depending on interest and availability of presenters.

In conclusion, although SIRC’s NIMH funding is coming to an end, SIRC’s membership and contributions to the field continue to grow. We hope that you will remain an engaged member of SIRC, contributing to resource prioritization and development, to help push the field in new directions.

Kate Comtois, PhD, MPH  
Associate Professor, Department of Psychiatry and Behavioral Sciences  
Adjunct Associate Professor, Department of Psychology  
University of Washington  
Co-Director, SIRC

Cara C. Lewis, PhD  
Assistant Professor, Department of Psychological & Brain Sciences, Indiana University  
Adjunct Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Washington  
Co-Director, SIRC
2015 Conference Core Planning Committee

Kate Comtois, PhD, MPH (PI)¹
Cara C. Lewis, PhD (Co-I)¹,²
Cameo Stanick, PhD³
Jonathan Chi, BS¹
Doyanne Darnell, PhD¹
Shannon Dorsey, PhD (Co-I)¹
Karin Hendricks, MA¹
Suzanne Kerns, PhD (Co-I)¹
Sara J. Landes, PhD (Co-I)¹,⁴
Aaron R. Lyon, PhD (Co-I)¹
Brigid Marriott, BSc²
Maria Monroe-DeVita, PhD (Co-I)¹
Abby Melvin, BA²
Andria Pierson, MEd¹

Sponsored by:

1 University of Washington; ² Indiana University; ³ University of Montana; ⁴ National Center for PTSD, VA Palo Alto Health Care System, & Center for Implementation Research, University of Arkansas for Medical Sciences; ⁵ University of California, San Diego; ⁶ FPG Child Development Institute, University of North Carolina at Chapel Hill; ⁷ Western Psychiatric Institute & Clinic, University of Pittsburgh; ⁸ Kaiser Permanente Southern California Department of Research and Evaluation & VA Center for Implementation Practice and Research Support Department of Veterans Affairs Greater Los Angeles Healthcare System; ⁹ HealthPartners Institute for Education & Research; ¹⁰ Group Health Cooperative; ¹¹ VA Boston Healthcare System, National Center for PTSD, & Boston University; ¹² Lutheran Community Services Northwest

Funded by:

Grant No. 5 R13 MH086159

The Washington Institute
For Mental Health Research & Training

Posttraumatic Stress Disorder

University of Washington
Indiana University
Meet the 2015-2017 SIRC Officers

President: Cara C. Lewis, PhD
The SIRC president plans the next conference, represents SIRC, calls meetings, oversees initiatives and coordinates the other officers. Cara Lewis is an assistant professor at Indiana University. She is an established implementation researcher with two NIMH-funded R01s focused on leveraging measurement to improve mental health services in community-based settings.

Past-President: Kate Comtois, PhD, MPH
The past president advises the president. Kate Comtois is associate professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington. She is an EBP Champion as she directs a clinic in which she has been implementing EBPs as well as an Intermediary - providing training and consultation on Dialectical Behavior Therapy implementation.

Secretary: Jill Locke, PhD
The secretary schedules meetings, takes minutes, tracks tasks, monitors the website and sirc@uw.edu email. Jill Locke is a research assistant professor in the UW Department of Speech and Hearing Sciences. Her research interests are in implementing and sustaining evidence-based interventions for children with autism spectrum disorder in school settings.

Membership Chair: Sara J. Landes, PhD
The membership chair oversees membership, collects dues, and conducts initiatives to increase membership of under-represented groups. Sara Landes is currently a psychologist at the VA’s National Center for PTSD and an assistant professor at the University of Arkansas for Medical Sciences in the Center for Implementation Research. Her research interests are in implementing evidence-based psychotherapies in large health care systems such as the VA, with a focus on treatments for suicide.

Treasurer: Andria Pierson, MEd
The treasurer manages the budget and accounts and forecasts funds for future conferences and initiatives. Andria Pierson is currently the SIRC Conference Coordinator at the University of Washington Department of Psychiatry and Behavioral Sciences. Her background is in educational program management, curriculum development, and international student advising.

Communications Chair: Aaron Lyon, PhD
The communications chair organizes and coordinates SIRC marketing, social networking, liaising with related initiatives and outreach to stakeholders as well as the content of SIRC webpages. Aaron Lyon is an assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington and Co-Director of the School Mental Health Assessment, Research, and Training (SMART) Center. His research interests include (1) the identification and implementation of low-cost, high-yield practices – such as the use of routine outcome monitoring / measurement-based care – to reduce the gap between typical and optimal practice in low-resource service contexts, and (2) development and adaptation of health-information technologies for use by community-based practitioners.
Program Chair: Cameo Stanick, PhD

The program chair co-leads development of the conference vision with the President and organizes the biennial conference. Cameo Stanick is an associate professor at the University of Montana. With Drs. Cara Lewis and Bryan Weiner, Dr. Stanick leads the NIMH-funded R01 for the Instrument Review Project. Her research and clinical work focus on dissemination and implementation of EBPs in community- and school-based mental health settings, with specific emphasis on childhood trauma.

EBP Champion Task Force Chair: Doyanne Darnell, PhD

The EBP Champion Task Force chair leads an effort to increase EBP Champion involvement and ensure that SIRC’s efforts advance the tenets of relevance, efficiency, and collaboration. Doyanne Darnell is an acting assistant professor at the University of Washington, Department of Psychiatry & Behavioral Sciences. Her research focuses on the development and implementation of evidence-based screening and intervention with trauma populations to address alcohol use problems, post-traumatic stress disorder, and related behavioral health comorbidities.

Technology Chair: Phil Fizur, MA

The technology chair oversees and programs the website and related online initiatives. Phil Fizur is a doctoral candidate in clinical psychology at La Salle University. He is currently on internship at Penn State Milton S. Hershey Medical Center in the Department of Psychiatry.

Volunteer Coordinator/Co-Conference Coordinator: Karin Hendricks, MA

Karin Hendricks has served as the volunteer coordinator for the conference series since the inception of SIRC and served as the conference coordinator for the 2011 conference. She has assisted Drs. Comtois and Lewis over the course of the development of SIRC from a series of conferences to a society for implementation research collaboration. She currently works for the University of Washington, Department of Psychiatry and Behavioral Sciences, as Dr. Comtois’ research coordinator.

Student Representatives: Brigid Marriott, BSc & Colleen Harker, MS

The student representatives lead the Student Mentoring Program and provide support to the SIRC officers as needed to maximize SIRC conferences and initiatives. This is the only officer position to change annually.

Brigid Marriott is a first year clinical doctoral student in the Department of Psychological Sciences at the University of Missouri. She has experience with implementing EBPs, specifically CBT and measurement based care in community-based settings, with a focus on tailored methods and social psychology informed implementation interventions.

Colleen Harker is a doctoral student in the child clinical psychology program at the University of Washington. Her research interests involve working with community providers to improve service delivery systems for individuals with autism spectrum disorder and their families.
Registration & Badges

All SIRC conference attendees must be registered. The conference registration table will be located outside the Grand Ballroom.

Badges are required for admission to all sessions, meals, and receptions. Please wear your badge during the conference... and remember to remove it outside the hotel.
# Schedule at a Glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Thursday 9/24</th>
<th>Friday 9/25</th>
<th>Saturday 9/26</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 AM</td>
<td></td>
<td></td>
<td>SIRC Fun Run! – Meet in Lobby 6:30AM</td>
</tr>
<tr>
<td>7:00 AM</td>
<td></td>
<td>Registration &amp; Continental Breakfast 7:00AM-8:00AM</td>
<td>Registration &amp; Continental Breakfast 7:00AM-8:00AM</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>Registration &amp; Continental Breakfast 7:30AM – 8:30PM</td>
<td>Welcome &amp; Plenary Presentations 8:00AM-9:00AM</td>
<td>Updates on SIRC Initiatives 8:00AM-8:45AM</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>IDW Part 1 8:30AM – 10:15 AM</td>
<td>Symposium I 9:00AM-10:15AM</td>
<td>Symposium III 8:45AM – 10:00AM</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
</tr>
<tr>
<td>11:00 AM</td>
<td>IDW Part 2 10:30AM – 12:00 PM</td>
<td>Breakouts A 1-5 10:30AM-11:45AM</td>
<td>Breakouts D 1-5 10:30AM-11:45AM</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Lunch/Registration 12:00PM – 1:30PM</td>
<td>Lunch 11:45AM-1:00PM</td>
<td>Lunch 11:45AM-1:00PM</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>Break</td>
<td>Breakouts B 1-5 1:00PM-2:15PM</td>
<td>Breakouts E 1-5 1:00PM-2:15 PM</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
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<tr>
<td>3:00 PM</td>
<td>Break</td>
<td>Breakouts C 1-5 2:30PM-3:45PM</td>
<td>Breakouts F 1-5 2:30PM-3:45PM</td>
</tr>
<tr>
<td>4:00 PM</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
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<tr>
<td>5:00 PM</td>
<td>Break</td>
<td>Symposium II 4:00PM-5:15PM</td>
<td>Symposium IV 4:00PM-5:15PM</td>
</tr>
<tr>
<td>6:00 PM</td>
<td>Reception &amp; Poster Session with Live Music, Hors d’Oeuvres, &amp; Cash Bar 5:30PM-7:30PM</td>
<td>Discussion of Conference &amp; Ideas for the Future 5:45PM-6:30PM</td>
<td>Break</td>
</tr>
<tr>
<td>7:30 PM</td>
<td>Group Dinner</td>
<td>Group Dinner</td>
<td>Group Dinner</td>
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</tbody>
</table>
## Schedule

### Thursday, September 24

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30-8:30</td>
<td>Registration &amp; Continental Breakfast</td>
<td></td>
</tr>
<tr>
<td>8:30-10:15</td>
<td>Implementation Development Workshop (IDW) Part 1</td>
<td>Please be sure to check in at the registration desk and pick up a colored folder with the materials that correspond to your IDW group. Detailed information will be available on-site.</td>
</tr>
<tr>
<td>10:15-10:30</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:30-12:00</td>
<td>Implementation Development Workshop (IDW) Part 2</td>
<td>Please be sure to check in at the registration desk and pick up a colored folder with the materials that correspond to your IDW group. Detailed information will be available on-site.</td>
</tr>
<tr>
<td>12:00-1:30</td>
<td>Registration &amp; Lunch</td>
<td>(Please see a list of nearby restaurants on page 168)</td>
</tr>
<tr>
<td>1:30-5:00</td>
<td>Concurrent Workshop Sessions</td>
<td></td>
</tr>
<tr>
<td>President</td>
<td>Getting SMART About Adaptive Implementation Interventions</td>
<td>Daniel Almirall and Amy Kilbourne</td>
</tr>
<tr>
<td>Regent</td>
<td>Transformative Healthcare Technologies: What Implementation Researchers and Practitioners Need to Know About mHealth, Electronic Health Records (EHR), and Big Data Analytics</td>
<td>Patricia Areán, David C. Atkins, Amy Bauer, Kari Stephens, Roger Vilardaga, &amp; Jennifer Villatte</td>
</tr>
<tr>
<td>Chancellor</td>
<td>Sustainability – Making EBPs Work in the Long-Run</td>
<td>Gregory A. Aarons, Lucy Berliner, Helen Best, Dan Fox, Nancy McDonald</td>
</tr>
<tr>
<td>College</td>
<td>Practical, Empirically Based Resources for Integrating Routine Outcome Monitoring into Clinical Practice</td>
<td>Matthew S. Ditty, Kelly Koerner, Cara C. Lewis, &amp; Bradley Steinfeld</td>
</tr>
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</table>
Friday, September 25

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00-8:00</td>
<td>Registration &amp; Continental Breakfast</td>
</tr>
<tr>
<td>8:00-9:00</td>
<td>Welcome &amp; Plenary Presentations</td>
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<tr>
<td></td>
<td><strong>Ballroom</strong></td>
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<tr>
<td>8:00</td>
<td>Opening Remarks</td>
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<tr>
<td>8:10</td>
<td>Plenary Presentation: A Behavioral Economic Perspective on Adoption, Implementation, and Sustainment of Evidence-Based Interventions</td>
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<tr>
<td>8:40</td>
<td>Plenary Presentation: Towards Making Scale-up of EBPs in Child Welfare Systems More Efficient and Affordable</td>
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</table>

**Symposium I: Beyond Practitioners: Leadership and Vision for Effective Mixed Method Examination of Strategic Leadership for Evidence-Based Practice Implementation**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:00-10:15</td>
<td>Symposium I: Beyond Practitioners: Leadership and Vision for Effective Mixed Method Examination of Strategic Leadership for Evidence-Based Practice Implementation</td>
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<tr>
<td></td>
<td><strong>Ballroom</strong></td>
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<tr>
<td></td>
<td>Mixed Method Examination of Strategic Leadership for Evidence-Based Practice Implementation</td>
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<td></td>
<td>Implementing Practice Change in Federally Qualified Health Centers: Learning from Leaders’ Experiences</td>
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<td></td>
<td>Efficient Synthesis: Using Qualitative Comparative Analysis (QCA) and the Consolidated Framework for Implementation Research (CFIR) Across Diverse Studies</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>10:15-10:30</td>
<td>Break</td>
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<tr>
<td>10:30-11:45</td>
<td>BREAKOUTS A1-A5</td>
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<tr>
<td></td>
<td><strong>College</strong></td>
</tr>
<tr>
<td></td>
<td>Breakout A1: Stakeholder Partnerships in Practice Change and Research Part 1</td>
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<tr>
<td></td>
<td>MC: Doyanne Darnell</td>
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<tr>
<td></td>
<td>Establishing a Veterans Advisory Council to Empower Patients and Inform VA Health Services Research</td>
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<td></td>
<td>Convening and Consulting a Patient-Stakeholder Panel to Optimize Implementation Planning in a Complex Healthcare Setting</td>
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<td>Building Patient-Practitioner Partnerships in Community Medical Settings to Sustainably Implement EBPs for Anxious and Depressed Cancer Survivors</td>
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<td></td>
<td><strong>Ballroom</strong></td>
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<tr>
<td></td>
<td>Breakout A2: Innovative Evaluation Strategies to Advance Implementation Science</td>
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<tr>
<td></td>
<td>MC: Cara C. Lewis</td>
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<tr>
<td></td>
<td>Tailoring a Cognitive Behavioral Therapy Implementation Protocol Using Mixed Methods, Conjoint Analysis, and Implementation Teams</td>
</tr>
<tr>
<td></td>
<td>Conceptualizing and Measuring External Context in Implementation Science: Studying the Impacts of Regulatory, Fiscal, Technological, and Social Change</td>
</tr>
<tr>
<td></td>
<td>WrapSTAR: An Efficient, Yet Comprehensive Approach to Wraparound Implementation Evaluation</td>
</tr>
</tbody>
</table>
Breakout A3: Good, Cheap, and Fast Exemplars of Fidelity Monitoring
MC: Maria Monroe-DeVita
- Improving the Efficiency of Standardized Patient Assessment of Clinician Fidelity: A Comparison of Automated Actor-Based and Manual Clinician-Based Ratings
  Benjamin C. Graham
- Measuring Treatment Fidelity on the Cheap
  Rochelle F. Hanson
- Leveraging Routine Clinical Materials To Assess Fidelity
  Shannon Wiltsey Stirman

Breakout A4: Efficiently Leveraging Technology to Increase Reach
MC: Aaron Lyon
- Mobile Mental Health Apps are Flooding the Marketplace: Who is Using Them and to What Effect?
  Diego Castaneda
- Implementing Online Interventions for Mental Health in the Veterans Health Administration
  Carolyn J. Greene
- An Efficient Process of Gathering Diverse Community Opinions to Inform an Intervention
  Nancy Pandhi & Natalie DeCheck

Breakout A5: Understanding How Service Brokers can Facilitate Implementation
MC: Suzanne E. Kerns
- Efficient Strategies to Support Trauma-Informed Care for Children and Youth in Foster Care
  Suzanne E. Kerns & Barbara J. Putnam
- Using Integrated Administrative Data to Evaluate Implementation of a Behavioral Health and Trauma Screening for Children and Youth in Foster Care
  Michael D. Pullmann & Barbara Lucenko
- Intermediary Organizations as a Vehicle to Promote Efficiency and Speed of Implementation
  Robert Franks

11:45-1:00 Lunch (Please see a list of nearby restaurants on page 168)

1:00-2:15 BREAKOUTS B1-B5

Breakout B1: The Consolidated Framework for Implementation Research: Qualitative Applications
MC: Karin Hendricks
- Operationalizing the Consolidated Framework for Implementation Research (CFIR) to Guide Evaluation of a Complex Intervention and Produce Actionable Findings
  Rosalind Keith
- Applying the CFIR Constructs Directly to Qualitative Data: The Power of Implementation Science In Action
  Edward J. Miech
- Efficient and Effective SBIRT Training: A Snowball Implementation Model
  Jason M. Satterfield

Breakout B2: Individual Factors in the Midst of Implementation: Long-Term Applicability
MC: Doyanne Darnell
- Towards Efficient and Sustainable Motivational Interviewing Training: A Multisite Implementation Trial in the Wake of the American College of Surgeons’ Alcohol SBI Policy Mandate
  Doyanne Darnell
- Monitoring the Fidelity of Motivational Interviewing Counselors: Counting Frogs in the Jungle
  Chris Dunn
- Matching Models of Implementation to System Needs and Capacities: Addressing The Human Factor
  Helen Best
**Ballroom**

**Breakout B3: Assessing Large-Scale Implementation: How Do We Assess Success?**
MC: Shannon Dorsey
- Agency Characteristics that Facilitate Efficient and Successful Implementation Efforts
  Miya Barnett
- Rapid Assessment Process: Application to the Prevention and Early Intervention (PEI) Transformation in Los Angeles County
  Jennifer Regan
- The Development of the Practice-Concordant Care Scale: An Assessment Tool to Examine Treatment Strategies Across Evidence-Based Practices
  Nicole Stadnick

**College**

**Breakout B4: The ERIC Project: Implementation Methods and Recommendations**
MC: Aaron Lyon
- Refining a Compilation of Discrete Implementation Strategies and Determining their Importance and Feasibility
  Byron J. Powell
- Structuring Complex Recommendations: Methods and General Findings
  Thomas J. Waltz
- Implementing Prolonged Exposure for PTSD in the VA: Expert Recommendations from the ERIC Project
  Monica M. Matthieu

**President**

**Breakout B5: When We Can’t Wait for Readiness: Stakeholder-Informed Assessments for Risk and Recidivism**
MC: Sara J. Landes
- When Readiness is a Luxury: Co-Designing a Risk Assessment and Quality Assurance Process with Violence Prevention Frontline Workers in Seattle
  Mariko Lockhart
- Implementation Potential of Structured Recidivism Risk Assessments with Justice-Involved Veterans: Qualitative Perspectives from Providers
  Allison L. Rodriguez
- Developing Empirically-Informed Readiness Measures for Providers and Agencies for the Family Check-Up Model Using a Mixed Methods Approach
  Anne M. Mauricio

**2:15-2:30 Break**

**2:30-3:45 BREAKOUTS C1-C5**

**President**

**Breakout C1: Stakeholder Partnerships in Practice Change and Research Part 2**
MC: Aaron Lyon
- Pebbles, Rocks, and Boulders: The Implementation of a School-Based Social Engagement Intervention for Children with Autism
  Jill Locke
- PST.Net: A Stakeholder Analysis Examining the Feasibility and Acceptability of Teletherapy in Community Based Aging Services
  Marissa C. Hansen
- Collaborative Intervention Design: A Process That May Help Keep the Bonfire Stoked
  Bryan Hartzler

**Regent**

**Breakouts C2: Integrated Behavioral Health – Impacts on Suicide Risk Prevention**
MC: Sara J. Landes
- Implementation of Suicide Risk Prevention in an Integrated Delivery System
  Bradley Steinfeld
- Implementation of Suicide Risk Prevention in Mental Health Specialty: Where it All Starts
  Bradley Steinfeld
- Role of the Integrated Behavioral Health Consultant in Suicide Risk Prevention: Where it All Ends
  Zandrea Harlin
- Implementation of Suicide Risk Prevention in Primary Care: A New Frontier
  Frederic Shephard and Zandrea Harlin
<table>
<thead>
<tr>
<th>College</th>
<th>Breakout C3: Translating a QI Intervention into Safety Net Clinics: Effectiveness, Role of Implementation Strategies, Next Steps</th>
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<tbody>
<tr>
<td>MC: Maria Monroe-DeVita</td>
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<tr>
<td>• Successful Translation of a Diabetes Care Quality Initiative From Integrated Care Into Safety Net Clinic Settings</td>
<td>Rachel Gold</td>
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<tr>
<td>• Making Visible the Invisible: Reporting Implementation Strategies to Improve Intervention Uptake Across Care Settings</td>
<td>Arwen Bunce</td>
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<tr>
<td>• The Complex Role of Data Feedback in Intervention Uptake</td>
<td>Arwen Bunce</td>
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<tr>
<td>• Protocol for the “Practices Enabling Implementation and Adaptation in the Safety Net (SPREAD-NET)” Pragmatic Cluster-Randomized Trial</td>
<td>Celine Hollombe</td>
</tr>
</tbody>
</table>

| Chancellor | Breakout C4: Advice From the Real World: Installation, Implementation, Fidelity, and Outcome Monitoring |
| MC: Kate Comtois | |
| • ICED: A Step-by-Step Approach to Dialectical Behavior Therapy Program Implementation | Matthew S. Ditty |
| • The Challenges in Implementing Multiple EBPs in a Community Mental Health Setting | Dan Fox & Sonia Combs |
| • Using EHR to Promote and Support EBT Assessment and Treatment Intervention | David Lischner |

| Ballroom | Breakout C5: Methodological Advances in Implementation Research |
| MC: Ruben Martinez | |
| • Are Existing Frameworks Adequate for Measuring Implementation Outcomes? Results from a New Simulation Methodology | Richard A. Van Dorn |
| • Development and Validation of Implementation Measures for Low-Resource Global Contexts | Emily E. Haroz |
| • A Treatment Integrity Measure for Early Childhood Education Settings | Ruben G. Martinez |

| 3:45-4:00 | Break |

| 4:00-5:15 | Symposium II: Common Elements Intervention to Support Scale-Up and Sustainment |
| MC: Doyanne Darnell | |
| • Effectiveness of Lay Counselor Delivery of a Common Elements CBT Approach | Shannon Dorsey |
| • Beyond Training and Moving to Sustainability Globally: A Train-the-Trainer Approach for Low-Resource Contexts | Laura K. Murray |
| • Taking Global Local: Evaluating Training of Washington State Clinicians in a Modularized CBT Approach Designed for Low-Resource Settings | Maria Monroe-DeVita |

| 5:15-5:30 | Break |

| 5:30-7:30 | Reception & Poster Session with Live Music, Hors d’oeuvres, & Cash Bar |

| 7:30 | Group Dinner |
### Saturday, September 26

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<tr>
<th>Time</th>
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<tr>
<td>6:30</td>
<td>SIRC FUN RUN! – Meet in Lobby</td>
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<tr>
<td>7:00</td>
<td>Registration &amp; Continental Breakfast</td>
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<tr>
<td>8:00</td>
<td>Updates on SIRC initiatives: Instrument Review Project &amp; Implementation Research Development Workshop (IDW) Evaluation</td>
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<td>8:45</td>
<td>Symposium III: Data-Driven, Theoretically-Informed Processes for Efficient and Effective International Implementation</td>
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<td><strong>Ballroom</strong></td>
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<td><strong>MC:</strong> Sara J. Landes</td>
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</table>
|       | - The Use of Continuous Quality Improvement Evaluations to Drive Service Improvement: The Tale of Two Projects  
  |       |  Robyn Mildon & Aron Shlonsky                                          |
|       | - Implementation Efficiency in Context: National Implementation of Dialectical Behavior Therapy in Ireland  
  |       |  Daniel Flynn                                                           |
|       | - Factors Implicated in Successful Implementation: Evidence to Inform Improved Implementation from High and Low/Middle Income Countries  
  |       |  Melanie Barwick                                                      |
| 10:00 | Break                                                               |
| 10:30 | BREAKOUTS D1-D5                                                      |
|       | **College**                                                          |
|       | **MC:** Suzanne E. Kerns                                              |
|       | - Implementation Frameworks Applied: The Status Quo in Child, Youth, and Family Services  
  |       |  Bianca Albers                                                        |
|       | - Tracking Implementation Strategies Prospectively: A Practical Approach  
  |       |  Alicia C. Bunger                                                    |
|       | - Trained but Not Implementing: The Need for Effective Implementation Planning Tools  
  |       |  Christopher Botsko                                                  |
|       | **Ballroom**                                                          |
|       | **MC:** Karin Hendricks                                               |
|       | - Evidence, Context and Facilitation Variables Related to Implementation of Dialectical Behavior Therapy: Qualitative Results from a Mixed Methods Inquiry in the Department of Veterans Affairs  
  |       |  Sara J. Landes                                                      |
|       | - 'Successful' Usual Care: Therapeutic Interventions and Contextual Factors  
  |       |  Julia Revillion Cox                                                 |
|       | - Learning from Implementation as Usual in Children's Mental Health  
  |       |  Byron J. Powell                                                    |
|       | **Chancellor**                                                        |
|       | **MC:** Doyanne Darnell                                               |
|       | - Cognitive Processing Therapy in the Democratic Republic of Congo: Moving From RCT to Implementation  
  |       |  Debra Kaysen                                                          |
|       | - Impact of Training and Clinician Allegiance on Adherence to Dialectical Behavior Therapy Model in a Public Sector Mental Health Team in Australia  
  |       |  Carla Walton                                                        |
|       | - Rates and Predictors of Implementation after Dialectical Behavior Therapy Intensive Training  
  |       |  Melanie S. Harned                                                  |
Breakout D4: Mapping the Context: Use of Evidence in Community Settings
MC: Shannon Dorsey
• Contextual Determinants of Research Evidence Use in Public-Youth Systems of Care
  Antonio Garcia
• Mobile Community Mapping to Integrate Evidence-Based Depression Treatment in Primary Care in Brazil: A Pilot Project
  Annika Sweetland
• The Use of Concept Mapping to Efficiently Identify Determinants of Implementation in the NIH-PEPFAR PMTCT Implementation Science Alliance
  Gregory A. Aarons

Breakout D5: Studying Implementation Efficiently: An Overview of the Ontario's Healthy Babies Healthy Children Program Evaluation
MC: Meredith Boyd
• Application of a Multi-Level Implementation Framework to Evaluate Ontario’s Province-Wide Healthy Babies Healthy Children Program
  Heather Manson
• Assessing Implementation Fidelity in Ontario’s Healthy Babies Healthy Children Program
  Eunice Chong
• Contribution of Province-Wide Process Implementation Evaluation to Continuous Quality Improvement through Tailored Knowledge Dissemination to 36 Local Public Health Units
  Eunice Chong
• The Impacts on Program Reach of Cumulative Declines and Losses to Contact as Clients Traverse the Multi-Step Healthy Babies Healthy Children Program
  Heather Manson

11:45-1:00 Lunch
(Please see a list of nearby restaurants on page 168) SIRC Journal Discussion. Location TBA

1:00-2:15 BREAKOUTS E1-E5
Ballroom Breakout E1: Strategies for Efficient Supervision and Consultation to Facilitate Implementation
MC: Maria Monroe-DeVita
• Longitudinal Remote Consultation for Implementing Collaborative Care for Depression
  Ian M. Bennett
• Integrating a Peer Coach Model to Support Program Implementation and Ensure Long-term Sustainability of the Incredible Years in Community-based Settings
  Jennifer Schroeder
• Efficient Sustainability: Existing Community Based Supervisors as EBT Supports
  Shannon Dorsey

Regent Breakout E2: Use of Facilitation and Practice-Based Implementation Networks in VHA
MC: Sara J. Landes
• From Theory to Practice: Conducting Implementation Facilitation Interventions in Clinical Settings
  Sara J. Landes
• Establishment of a National Practice-Based Implementation Network to Accelerate Adoption of Evidence-Based and Best Practices
  Sara J. Landes
• Facilitation as a Mechanism of Implementation in a Practice-Based Implementation Network: Improving Care in a Veteran’s Affairs PTSD Outpatient Clinic
  Ruth L. Varkovitzky
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<th>Session</th>
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<tr>
<td><strong>President</strong></td>
<td><strong>Breakout E3: Partnering with EBP Champions Across Health Care Settings</strong></td>
<td>MC: Doyanne Darnell</td>
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<tr>
<td></td>
<td>• The ACT SMART Toolkit: An Implementation Strategy for Community-Based Agencies Providing Services to Children with Autism Spectrum Disorder</td>
<td>Amy Drahota</td>
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<td>• The Collaborative Intervention Planning Framework: An Approach to Engage Stakeholders in Preparing and Customizing Interventions for Implementation</td>
<td>Leopoldo J. Cabassa</td>
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<td>• Community Capacity Building: Training Providers to Address the Psychological Health of Military Families through HomeFront Strong</td>
<td>Laura Supkoff Nerenberg</td>
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<td><strong>College</strong></td>
<td><strong>Breakout E4: Leveraging Policy Initiatives to Advance Implementation</strong></td>
<td>MC: Kate Comtois</td>
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<tr>
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<td>• Supporting Policy In Health with Research: An Intervention Trial (SPIRIT) - Protocol and Early Findings</td>
<td>Anna Williamson</td>
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<td>• From EBP Initiatives to Infrastructure: Lessons Learned from a Public Behavioral Health System’s Efforts to Promote Evidence Based Practices</td>
<td>Ronnie M. Rubin</td>
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<td></td>
<td>• Applying the Policy Ecology Model to Philadelphia’s Behavioral Health Transformation Efforts</td>
<td>Byron J. Powell</td>
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<tr>
<td><strong>Chancellor</strong></td>
<td><strong>Breakout E5: Moving Theory and Framework to Real World Testing and Outcomes</strong></td>
<td>MC: Shannon Dorsey</td>
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<tr>
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<td>• A Model for Providing Methodological Expertise to Advance Dissemination and Implementation of Health Discoveries in Clinical and Translational Science Award (CTSA) Institutions</td>
<td>Donald Gerke</td>
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<td>• Establishing a Research Agenda for the Triple P Implementation Framework</td>
<td>Jenna McWilliam</td>
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<td>• Cheap and Fast, but What is “Best?” Examining Implementation Outcomes across Sites in a State-Wide Scaled-Up Evidence-Based Walking Program</td>
<td>Kathleen Conte</td>
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**2:15-2:30 Break**

**2:30-3:45 BREAKOUTS F1-F5**

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<th>Session</th>
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<tr>
<td><strong>Chancellor</strong></td>
<td><strong>Breakout F1: Evaluating Usual Care Practice Patterns to Inform Implementation Efforts</strong></td>
<td>MC: Ruben Martinez</td>
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<tr>
<td></td>
<td>• Which Treatments Does Our Agency Need and Which Do We Know Already?</td>
<td>Michael A. Southam-Gerow</td>
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<td></td>
<td>• Do Community Mental Health Therapists Match Treatment Techniques to Child and Adolescent Disorders?</td>
<td>B.K. Elizabeth Kim</td>
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<td>• Characterizing the Delivery of Cognitive Behavioral Therapy for Youth Anxiety in Community Settings</td>
<td>Bryce D. McLeod</td>
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<tr>
<td><strong>College</strong></td>
<td><strong>Breakout F2: Identification and Implementation of Technologies to Support Measurement-Based Care</strong></td>
<td>MC: Cara C. Lewis</td>
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<tr>
<td></td>
<td>• Measurement Feedback Systems in Mental Health: Initial Review of Capabilities and Characteristics</td>
<td>Aaron Lyon &amp; Meredith Boyd</td>
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<td>• A Qualitative Investigation of Case Managers’ Attitudes Toward Implementation of a Measurement Feedback System in a Public Mental Health System for Youth</td>
<td>Amelia Kotte</td>
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<td>• Evidence-Based Quality Improvement to Reduce Information Delays</td>
<td>Steven E. Lindley</td>
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</tbody>
</table>
Breakout F3: Innovative Approaches for Identifying and Impacting Quality Improvement Targets
MC: Suzanne E. Kerns

- Multiple Pathways to Sustainability: Using Qualitative Comparative Analysis to Uncover the Necessary and Sufficient Conditions for Successful Community-Based Implementation
  Brittany Rhoades Cooper
- Evaluating a Medication Alert to Reduce Concurrent Opioid and Benzodiazepine Use at a Single VA Health Care System
  Eric Hawkins
- Usage of Promotional Media in Prolonged Exposure Therapy for PTSD: Current Practices and Practical Implications in VA Mental Healthcare
  Lindsay Trent

Breakout F4: Doing More and Reaching Further: Technology-Assisted Training, Treatment, and Evaluation
MC: Sara J. Landes

- A New Model for Training an Evidence-Based Practice for Suicidal Risk
  David A. Jobes
- Adaptation of Coordinated Anxiety Learning and Management (CALM) for Comorbid Anxiety and Substance Use Disorders: Delivery of Evidence-Based Treatment for Anxiety in Addictions Treatment Centers
  Kate Wolitzky-Taylor
- Opportunities and Challenges of Measuring Program Implementation with Online Surveys
  Dena Simmons

Ballroom Breakout F5: Fidelity Assessment: Common Challenges and Unique Successes Across Intervention Programs
MC: Maria Monroe-DeVita

- Observational Assessment of Fidelity to a Family-Centered Prevention Program: Differentiation and Predictive Validity
  Justin D. Smith
- Strategies and Challenges in Housing First Fidelity: A Multistate Qualitative Analysis
  Mimi Choy-Brown & Emmy Tiderington
- Developing Treatment Fidelity Rating Systems for Psychotherapy Research: Recommendations and Lessons Learned
  Kevin A. Hallgren

3:45-4:00 Break

4:00-5:15 Symposium IV: Innovative Implementation: Money, Automation, and Technology
MC: Doyanne Darnell

- Procurement and Contracting as an Implementation Strategy: Getting To Outcomes® Contracting
  Ronnie M. Rubin
- Automated Feedback on Therapist Fidelity: Current Status and Future Directions
  David C. Atkins
- Web-Based Feedback to Aid Successful Implementation: The Interactive Stages of Implementation Completion Tool
  Lisa Saldana

5:15-5:30 Awards and Closing

5:30-5:45 Break

5:30-6:30 Discussion of Conference & Ideas for the Future
Thursday, September 24

**EVENTS**

7:30AM – 8:30PM
REGISTRATION & CONTINENTAL BREAKFAST

8:30AM – 10:15 AM
IDW PART 1

10:30AM – 12:00 PM
IDW PART 2

12:00PM – 1:30PM
LUNCH/REGISTRATION

1:30PM – 5:00 PM
WORKSHOPS

7:30PM
GROUP DINNER
Getting SMART About Adaptive Implementation Interventions
1:30-5:00 p.m.
Presenter: Daniel Almirall, University of Michigan and Amy Kilbourne, University of Michigan
Contact: dalmiral@umich.edu

The effective treatment and management of a wide variety of health disorders often requires individualized, sequential decision-making. To do this, each patient’s treatment is dynamically tailored over time based on the patient’s history and changing disease state. Adaptive interventions (also known as dynamic treatment regimens) operationalize such individualized decision making using a sequence of decision rules that specify which intervention option to offer, for whom, and when. Intervention options in this case correspond to varying doses, types or delivery modes of pharmacological, behavioral and/or psychosocial treatments. Recently, there has been a surge of clinical and methodological interest in developing and evaluating adaptive interventions via clinical trials. Specifically, there is great interest in the use of sequential multiple assignment randomized trials (SMART), a type of multi-stage randomized trial design, to build high-quality adaptive interventions. The primary aim of this workshop is to provide a brief, conceptual introduction to adaptive interventions and SMART designs. We will use examples of SMART studies in child and adolescent mental health to explain and illustrate ideas. A secondary aim of this workshop is to introduce the idea of adaptive implementation interventions and the use of cluster-randomized SMART designs for their development. In an adaptive implementation intervention, the intervention options correspond to different types and intensities of implementation strategies; these are tailored to site-specific contextual factors. Implementation strategies are highly-specified, theory-based approaches that are used to improve the uptake of effective clinical practices in routine care. For example, not all sites require more intensive (and costly) implementation strategies (e.g., provider coaching, or Facilitation approaches), and may adopt a clinical practice via less costly approaches such as provider training and clinical reminders. As an example, we will present the design and rationale of the ADEPT Study, a NIMH-funded cluster-randomized SMART which aims to develop a high-quality adaptive implementation intervention to improve the uptake/adoption of an evidence-based intervention, known as Life Goals, in community mental health settings.

Notes:
Transformative Healthcare Technologies: What Implementation Researchers and Practitioners Need to Know About mHealth, Electronic Health Records (EHR), and Big Data Analytics

1:30-5:00 p.m.

Presenters: Patricia Areán, University of Washington; David C. Atkins, University of Washington; Amy Bauer, University of Washington; Kari Stephens, University of Washington; Roger Vilardaga, University of Washington; Jennifer Villatte, University of Washington

Information technology is steadily becoming embedded in routine healthcare. Smartphones and wearable technologies facilitate health assessment and intervention, regardless of time or location. Electronic health records (EHR) and clinical registries store a wealth of valuable data containing potential insights into population health and treatment in the real world. The ubiquity of these technologies in our daily lives allows for data collection on an unprecedented scale, ushering in the era of a new data science based on predictive analytics that extract actionable knowledge from this “big data.” These innovations are creating new possibilities to advance the aims of implementation science: To translate knowledge about evidence-based assessment, prevention, and intervention into routine healthcare in clinical, organizational, and policy contexts. This workshop will provide an overview of novel health information technologies in evidence-based psychosocial intervention (EBPI) implementation research and practice, with an emphasis on mobile health (mHealth), EHRs, and big data analysis. The goals of this workshop are to 1) introduce promising technologies for implementation science and practice, 2) discuss advantages and limitations of these technologies, and 3) provide tips for working effectively with technical partners in academia or industry, such as app designers and engineers, biomedical informaticists, and data scientists. Workshop presenters comprise the core faculty in the Behavioral Science and Technology (BeST) Program at the University of Washington, all of whom are actively engaged in implementation research in the areas of mHealth assessment and intervention, bioinformatics, and technology-enhanced EBPI training and implementation. Taking a team science view, we will not teach programming or technical skills, but rather focus on the necessary knowledge base to promote effective collaborations of EBPI stakeholders with experts in these technical fields. Case vignettes from our own research will be used throughout to provide concrete examples and contextualize recommendations.

Notes:
Workshop

Sustainability – Making EBPs Work in the Long-Run
1:30 – 3:30 pm
Presenters: Gregory A. Aarons, Lucy Berliner, University of Washington; Helen Best, Treatment Implementation Collaborative, LLC; Dan Fox, Lutheran Community Services Northwest; Nancy McDonald, County of Chester

This 90 minute workshop will be a panel discussion on practical as well as evidence-based strategies for sustaining evidence-based practices (EBPs) in community behavioral health settings. The presenters will represent clinicians, agency directors, policy makers/funders, and implementation practitioners as well as implementation researchers. Topics discussed will include: Organizing supervision and fidelity monitoring when implementing multiple EBPs, innovative strategies to retain staff, and rebuilding after staff turnover.

Notes:
Workshop

Practical, Empirically Based Resources for Integrating Routine Outcome Monitoring into Clinical Practice
3:30 – 5:30 pm
Presenter: Matthew S. Ditty, The Ebright Collaborative, LLC; Kelly Koerner, Evidence-Based Practice Institute, LLC; Cara C. Lewis, Indiana University; Bradley Steinfeld, Group Health Cooperative

This 90 minute workshop will be a panel discussion focused on providing practical, empirically based resources for stakeholders and researchers interested in integrating routine outcome monitoring into clinical practice (i.e., measurement based care). The panelists will reflect the perspectives of researchers, clinical directors, and intermediaries. Topics to be covered include: resources for determining what to measure and how, options and strategies for selecting and integrating technological solutions, solutions to structural and administrative barriers, and strategies for engaging and informing clinician use of data in treatment sessions.

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<td>REGISTRATION &amp; CONTINENTAL BREAKFAST</td>
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<td>8:00AM-9:00AM</td>
<td>WELCOME &amp; PLENARY PRESENTATIONS</td>
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<tr>
<td>9:00AM-10:15AM</td>
<td>SYMPOSIUM I</td>
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<td>10:30AM-11:45AM</td>
<td>BREAKOUTS A 1-5</td>
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<td>11:45AM-1:00PM</td>
<td>LUNCH</td>
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<td>1:00PM-2:15PM</td>
<td>BREAKOUTS B 1-5</td>
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<td>2:30PM-3:45PM</td>
<td>BREAKOUTS C 1-5</td>
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<td>4:00PM-5:15PM</td>
<td>SYMPOSIUM II</td>
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<td>5:30PM-7:30PM</td>
<td>RECEPTION &amp; POSTER SESSION WITH LIVE MUSIC, HORS D’ŒUVRES, &amp; CASH BAR</td>
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<tr>
<td>7:30PM</td>
<td>GROUP DINNER</td>
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Plenary Presentation: A Behavioral Economic Perspective on Adoption, Implementation, and Sustainment of Evidence-Based Interventions

Presenter: Lawrence A. Palinkas, University of Southern California
Contact: palinkas@usc.edu

For the most part, current models of evidence-based intervention (EBI) dissemination and implementation offer a systems approach to understanding and identifying potential facilitators and barriers to adoption, implementation and sustainment. However, these models do not necessarily reflect the priorities or decision-making processes of clinic, agency and systems leaders when considering whether to adopt, implement and/or sustain. Drawing upon two ongoing mixed methods investigations of EBI implementation, one for child mental health in New York State and one for HIV prevention in Mexico, this presentation will illustrate the application of principles of behavioral economics in understanding how and why EBIs are adopted, implemented and sustained. These principles are rooted in the observations that the assessment of the costs and acceptability of EBIs and the capacity of organizations and individuals to adopt, implement and sustain them is not always a rational process in the traditional economic sense but often reflects notions of bounded rationality, use of heuristics in decision-making, and loss aversion.

Notes:
Plenary
MC: Cara C. Lewis

Plenary Presentation: Towards Making Scale up of EBPs in Child Welfare Systems More Efficient and Affordable

Presenter: Patricia Chamberlain, Oregon Social Learning Center
Contact: pattic@oslc.org

This presentation will describe experiences in two states to simultaneously scale up multiple EBPs in child welfare systems and how lessons learned in state #1 informed the subsequent efforts in state #2. An integrated method will be described for monitoring fidelity, and for promoting ongoing quality improvement in multiple EBPs. A full transfer model (from developer to system practitioners) that includes training of new generations of in-house interventionists will be discussed. Examples will be given of a low burden continuous outcome monitoring measures, and of a system for monitoring implementation progress. Finally, data on child and system-level outcomes from state #1 will be presented.

Notes:
Mixed Method Examination of Strategic Leadership for Evidence-Based Practice Implementation

Gregory A. Aarons, UC San Diego; Amy Green, UC San Diego; Mark Ehrhart, San Diego State University; Elise Trott, Pacific Institute for Research and Evaluation; Cathleen Willging, Pacific Institute for Research and Evaluation

Presenter: Gregory A. Aarons
Contact: gaarons@ucsd.edu

Leadership that supports effective evidenced-based practice (EBP) implementation is a critical concern. The recently developed Implementation Leadership Scale (ILS) is a valid and reliable 12-item scale with four subscales: proactive leadership, knowledgeable leadership, supportive leadership, and perseverant leadership. The ILS factor structure was developed using exploratory factor analysis (EFA) and supported using confirmatory factor analysis (CFA) with a sample of 459 mental health clinicians. In the current study, we analyzed quantitative and qualitative data from a large mixed-method study of EBP sustainment to examine the utility and structure of the ILS. Participants included home visitors from 25 community-based organizations across ten child welfare service systems implementing the EBP SafeCare® to prevent child neglect. Home visitors (n=190) completed the ILS as part of an annual web-survey during the same year qualitative focus groups (n=18) were conducted, focusing on implementation and sustainment of SafeCare. During focus groups, home visitors were asked to respond to the prompt, “How have leaders influenced the ongoing use of SafeCare?” A CFA of the ILS confirmed the original factor structure. Qualitative data supported the four ILS subscales. The theme of “accessible leadership” emerged from the qualitative data and is an area for future research.

Notes:
Implementing Practice Change in Federally Qualified Health Centers: Learning from Leaders’ Experiences

Maria E. Fernandez, School of Public Health, University of Texas Health Science Center - Houston; Nicholas H. Woolf, Henley Business School at The University of Reading; Shuting (Lily) Liang, Rollins School of Public Health, Emory University; Natalia I. Heredia, School of Public Health, University of Texas Health Science Center - Houston; Michelle Kegler, Rollins School of Public Health, Emory University; Michelle Carvalho, Rollins School of Public Health, Emory University; Betsy Risendal, University of Colorado Cancer Center, Denver; Andrea Dwyer, University of Colorado Cancer Center, Denver; Vicki Young, South Carolina Primary Health Care Association; Dayna Campbell, South Carolina Primary Health Care Association

Presenter: Maria E. Fernandez
Contact: Maria.E.Fernandez@uth.tmc.edu

We report on a qualitative study of 59 FQHC leaders who described their experiences of implementing both mandated and non-mandated evidence-based programs and practices. Interviews were informed by the Consolidated Framework for Implementation Research (CFIR) and discussions guided by a modified Appreciative Inquiry approach to identify organizational strengths, values, motivations, and leaders’ vision of a transformed future. We first describe factors reported as most significant in supporting successful implementation of change, including: necessary and sufficient staff and leadership characteristics; the roles of mandates, financial consequences, and leaders’ personal passions in prioritizing change; and the significance of external relationships and collaborations. We then describe challenges not yet overcome that are yet amenable to intervention, including: staff knowledge and competence; the impact of practice change on existing provider and staff time constraints; and the continuing need for more automated and systematic procedures. We discuss lessons learned from both successes and on-going challenges, the interaction of individual and organizational factors in each area, and the incomplete integration and realization of potential of EMR in supporting practice change. We conclude with proposals for acting on the resulting levers of change to support further implementation of practice changes in the current FQHC climate.

Notes:
Efficient Synthesis: Using Qualitative Comparative Analysis (QCA) and the CFIR Across Diverse Studies

Laura J. Damschroder, VA Ann Arbor Center for Clinical Management Research & Diabetes QUERI; Julie C. Lowery, VA Ann Arbor Center for Clinical Management Research & Diabetes QUERI

Presenter: Laura J. Damschroder
Contact: laura.damschroder@va.gov

Syntheses are needed to understand what works where and why across diverse implementation studies. However, even with increasing numbers of published syntheses of organizational interventions, most highlight gaps in knowledge of contextual factors that influence implementation success. We synthesized findings from six implementation studies of different programs that all systematically assessed context using the Consolidated Framework for Implementation Research (CFIR). QCA methods were used to analyze ratings and outcomes data from 44 Veterans Affairs medical centers. Findings reveal that organizations engaged in implementing change should establish formal systems for obtaining and discussing quantitative and qualitative feedback throughout implementation, regardless of the intervention being implemented. When combined with good leadership, or good intervention design, or good networks and communications, its association with implementation success is even stronger. Use of a framework like the CFIR enabled a synthesis of multiple studies using QCA to identify key contextual factors related to success. This approach is particularly important for the field of implementation research, where studies often suffer from small sample sizes. The CFIR offers a means of standardizing definitions of key constructs across studies, while QCA acknowledges the causal complexity of context in implementation in a way that is impossible using traditional correlation-based statistical approaches.

Notes:
Establishing a Veterans Advisory Council to Empower Patients and Inform VA Health Services Research

Travis Lovejoy, Center to Improve Veteran Involvement in Care, VA Portland Health Care System; Sarah Ono, Center to Improve Veteran Involvement in Care, VA Portland Health Care System; Kathleen Carlson, Center to Improve Veteran Involvement in Care, VA Portland Health Care System; Erika Cottrell, Center to Improve Veteran Involvement in Care, VA Portland Health Care System; Maya O’Neil, Center to Improve Veteran Involvement in Care, VA Portland Health Care System

Presenter: Travis I. Lovejoy
Contact: travis.lovejoy@va.gov

In 2013, VA Health Services Research & Development funded 19 Centers of Innovation (COINs), each with unique research foci and each forming partnerships between researchers and clinical and operations leaders. The goal of these partnerships is to conduct timely, relevant, and rigorous research that can be implemented quickly and efficiently to improve health outcomes. The VA Portland Health Care System’s COIN, The Center to Improve Veteran Involvement in Care (CIVIC), emphasizes community based participatory research principles and patient engagement in research at all stages. Recently, CIVIC instituted a program to involve not only clinical and operations leaders, but also veteran patients in all phases of the research process. As part of this program, CIVIC established a Veterans Advisory Council composed of veteran patients. We sought to assemble a diverse group of patients across sex, race/ethnicity, mental health history, and military service era. The Council offers feedback to CIVIC investigators on design and conduct of studies and the interpretation and dissemination of results. This presentation describes processes of creating the Council and addresses issues germane to participatory research in VA and non-VA settings, such as ensuring a representative Council composition, navigating IRB, compensation for Council members, and maintaining sound research ethics.

Notes:
Convening and Consulting a Patient-Stakeholder Panel to Optimize Implementation Planning in a Complex Healthcare Setting

Eve B. Carlson, National Center for PTSD, VA Palo Alto Health Care System; David A. Spain, Stanford University School of Medicine

Presenter: Eve B. Carlson
Contact: eve.carlson@va.gov

Implementation of evidence-based practices is fostered when the perspectives of patients, providers, and other stakeholders are taken into account. These perspectives are especially critical to success in settings where stakeholders with a variety of different types of training, responsibilities, and interests cooperate to provide healthcare. In the context of planning a hybrid effectiveness-implementation study of a risk screening and referral system for traumatically-injured hospital patients, we convened a patient-stakeholder panel to obtain input on implementation factors and research and services planning. Most of hospitalized trauma patients recover without intervention, but 10-20% develop PTSD or depression and very few seek treatment on their own. After developing a screen for risk of psychological disorder, we brought together patients, family members, trauma surgeons, trauma nurses, social workers, and psychologists and sought their input on a patient preferences survey and a system for risk screening, providing risk information, and referral. We will share our experiences and address issues such as who needs to be included, how to recruit panel members who will be most engaged, how to explain the purpose and tasks of the panel, and how to insure that patients and family members are not intimidated by a roomful of health care professionals.

Notes:
Building Patient-Practitioner Partnerships in Community Medical Settings to Sustainably Implement EBPs for Anxious and Depressed Cancer Survivors

Joanna J. Arch, University of Colorado Boulder; Jill Mitchell, Rocky Mountain Cancer Centers-Boulder

Presenter: Joanna J. Arch  
Contact: joanna.arch@colorado.edu

Many cancer survivors with anxiety and depression symptoms are treated in medical settings that are ill equipped to recognize or treat such symptoms or to offer EBPs. To address these unmet needs, over the past several years we have built a collaboration with the administrators, practitioners, and patients at a local community oncology care network. Together, we have implemented an empirically-based screening system for assessing anxiety and depression symptoms among cancer survivors at seminal office visits (n = 200+ screened to date). We next partnered to refine and assess an EBP intervention offered onsite for the cancer survivors who screen positively on the screener (n = 51 participants to date), which led to moderate to large effect size improvements on relevant mental health outcomes. Currently, we are in the process of implementing this EBP intervention at community oncology sites throughout the state and adapting it to meet additional patient needs. In summary, our work demonstrates how a partnership with a local community cancer care network led to the successful uptake of EBP in a novel and high-needs context.

Notes:
Tailoring A CBT Implementation Protocol Using Mixed Methods, Conjoint Analysis, and Implementation Teams

Cara C. Lewis, Indiana University; Brigid Marriott, Indiana University; Kelli Scott, Indiana University

Presenters: Cara C. Lewis & Brigid Marriott
Contact: lewiscc@indiana.edu

A recent Cochrane review revealed that tailored implementation outperforms standardized approaches. However, few tailoring methodologies exist. This study will provide an overview of a model-based, mixed methods prospective tailored implementation of cognitive behavioral therapy (CBT) in youth residential settings. Clinicians and staff at two sites completed surveys (clinician N = 21; staff N = 49) and participated in focus groups (clinician N = 15; staff N = 38) guided by the domains of the Framework for Diffusion (Mendel et al., 2008). Results revealed moderately positive attitudes toward adopting evidence-based practices among therapists and staff (M = 2.67, SD = 0.64; Aarons, 2004) and negative perceptions of organizational culture (M = 2.71, SD = 1.02; Glaser, 1987). The most frequently endorsed barriers from the qualitative analysis included morale, team structure, and communication. Mixed methods analysis (QUAN + QUAL) revealed 76 barriers, which administrators prioritized according to feasibility and importance. Twenty-three barriers were subjected to a conjoint analysis wherein administrators and implementation team members selected implementation strategies. Researchers rated identified strategies based on feasibility and potential impact on CBT adherence. Top-rated strategies (N = 36 strategies) were then matched with the barriers and compiled into an implementation blueprint. Implementation teams consisting of opinion leaders from each staff level oversaw the activities of the pre-implementation period. The data and process of prospectively and collaboratively generating a tailored implementation blueprint will be discussed along with qualitative analysis of themes of the implementation team meetings.

Notes:
Conceptualizing and Measuring External Context in Implementation Science: Studying the Impacts of Regulatory, Fiscal, Technological, and Social Change

Alison Hamilton, UCLA & VA Greater Los Angeles (GLA) Healthcare System; Brian Mittman, VA GLA & Kaiser; Alicia Eccles, UCLA; Craig Hutchinson, UCLA; Gail Wyatt, UCLA

Presenter: Alison Hamilton
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Implementation science has focused extensively on internal context, conceptualizing and measuring factors such as features of organizational settings. The theoretical literature highlights the importance of external context, but little has been done to measure external context and examine its impact on implementation. We identified several features of external context influencing the progress of an NIMH-funded hybrid effectiveness-implementation multisite study of an HIV/AIDS prevention program. This abstract presents a preliminary taxonomy of key dimensions of external context and describes the role of this taxonomy in augmenting and elaborating existing frameworks for context in implementation science. To develop this taxonomy, we reviewed notes from weekly interdisciplinary calls and data from interviews with agency leaders to identify the key features of external context reported to be important substantial influences on project progress. Key dimensions of external context include regulatory factors (e.g., changing regulations), fiscal factors (e.g., changes in public health financing), technological change, and social and economic change and pressures. Growth in the pace and magnitude of changes in the external environment and context of healthcare delivery and public health agencies highlight the need for richer, more complete conceptualization and measurement of these factors in implementation science.

Notes:
WrapSTAR: An Efficient, Yet Comprehensive Approach to Wraparound Implementation Evaluation

Jennifer Schurer Coldiron, University of Washington, Wraparound Evaluation and Research Team; Eric J. Bruns, University of Washington, Wraparound Evaluation and Research Team; Alyssa N. Hook, University of Washington, Wraparound Evaluation and Research Team

Presenter: Jennifer Schurer Coldiron
Contact: jscold@uw.edu

Wraparound is a well-established model for care coordination for youth with complex emotional and behavioral needs and their families. While several measures of fidelity and outcomes exist, they have been used sporadically by the field and have, until now, been used in isolation, providing little in the way of comprehensive information for improvement. This talk will describe the development of the Wraparound Structured Assessment and Review (WrapSTAR), an intensive review process that builds off of major research-based implementation frameworks, and synthesizes information about a Wraparound provider organization in four domains: outcomes, fidelity, implementation, and system support. An initial pilot indicates that the process is feasible, with minimal burden to provider personnel, and yields actionable information for stakeholders that can be used to develop targeted quality improvement efforts. Recent experiences taking the protocol to scale in one state and teaching another state to conduct the review independently provide further evidence of the approach's utility and efficiency. Next steps and wider applications will be discussed.

Notes:
Improving the Efficiency of Standardized Patient Assessment of Clinician Fidelity: A Comparison of Automated Actor-Based and Manual Clinician-Based Ratings

Benjamin C. Graham, National Center for PTSD, Dissemination and Training Division; Katelin Jordan, National Center for PTSD, Dissemination and Training Division

Presenter: Benjamin C. Graham
Contact: benjamincgraham@gmail.com

Standardized patient (SP) assessment is a well-established method of measuring skill acquisition in dissemination of training in evidence-based practices. Trainee interactions with actors offer a more ecologically valid approach than proxy measures, but are time consuming and unscalable (Dickinson, et al., 2010). Clinician-based statements are dynamic and challenging to code, whereas actor-based responses are less so. Scoring based on actor statements may offer a more parsimonious yet effective method for certain areas of SP assessment. This presentation compares automated actor-based scoring to manual clinician-based ratings in the appraisal of SP interviews. Data for this study are based on SP sessions conducted for a large training dissemination study involving 414 clinicians treating veterans with PTSD. Pilot reliability scores between methods were promising yet varied, and ranged from very good (Cohen’s kappa = 1.0) to fair (Cohen’s kappa = .21) dependent on the item. We will share more comprehensive analyses based on forthcoming assessment of 414 current transcripts. The methodology is described, including a cost analysis, strategies for ensuring actor fidelity, and times in which actor-based scoring is inappropriate. We discuss design implications for future projects evaluating clinician performance, and how this method might interface with technology-based and traditional approaches.

Notes:
Measuring Treatment Fidelity on the Cheap

Rochelle F. Hanson, Medical University of South Carolina; Angela Moreland, Medical University of South Carolina; Benjamin E. Saunders, Medical University of South Carolina

Presenter: Rochelle F. Hanson
Contact: hansonrf@musc.edu

One significant challenge to implementation researchers is determining a cost-effective, yet reliable and valid measure of treatment fidelity. While observational measurement represents the ‘gold standard,’ such methods are expensive, time consuming, and generally not feasible or sustainable in community-based settings. This presentation examines data on clinician self-reported fidelity in delivering TF-CBT components throughout participation in a community-based learning collaborative (CBLC). All clinical participants completed weekly online reports of their use of and perceived competence in delivering TF-CBT components to their training cases, as required for the CBLC. 268 clinicians, participating in 8 TF-CBT focused CBLCs, completed weekly metrics related to 593 training cases (mean # of weekly metrics completed per case = 7.72). Of these 593 training cases, 433 completed treatment. For these cases, clinicians reported completing an average of 8.87 (out of 11) TF-CBT components, and at least 10/11 components with 51.8% of clients. Clinicians reported an average competence of 2.06 (out of 4) across all TF-CBT components. Participation in the CBLC training requirements (i.e., attendance at learning sessions, consultation calls, rostering) were significantly related to self-reported use and perceived competence in TF-CBT. Self-reported use of TF-CBT components was related to significant pre to post treatment declines in rates of PTSD and depression for completed training cases. Specifically, post treatment declines in both PTSD and depression were significantly related to self-reported use of the trauma narrative and in vivo exposure components; declines in depression were additionally related to completion of the PRAC components. These findings yield promising directions for measuring treatment fidelity in a cost-effective, feasible, and sustainable manner.

Notes:
Leveraging Routine Clinical Materials To Assess Fidelity

Shannon Wiltsey Stirman, National Center for PTSD, VA Boston Healthcare System and Boston University; Cassidy Gutner, National Center for PTSD, VA Boston Healthcare System and Boston University; Jennifer Gamarra, National Center for PTSD, VA Boston Healthcare System and Boston University; Dawne Vogt, National Center for PTSD, VA Boston Healthcare System and Boston University; Patricia Resick, Duke University; Jennifer Schuster Wachen, National Center for PTSD and Boston University; Katherine Dondanville, The University of Texas Health Science Center at San Antonio; Jim Mintz, The University of Texas Health Science Center at San Antonio; COL Presenter: Shannon Wiltsey Stirman
Contact: shannon.wiltsey-stirman@va.gov

A critical barrier to efforts to monitor and support fidelity in routine care settings and large systems is the lack of availability of feasible, scalable, and valid fidelity measurement strategies. Indirect methods of fidelity monitoring have limitations. However, observation and expert fidelity ratings, considered the “gold standard”, are not feasible in large systems in which thousands of providers have been trained, nor is it likely to be feasible in smaller, less well-resourced community settings. We will present a strategy for assessing fidelity to Cognitive Processing Therapy (CPT) for PTSD that uses existing clinical materials (worksheets and clinical notes), and was developed to be feasible and scalable, with potential broader applicability to other CBTs. We will present results from phase I of development, based on materials from 158 patients. Rater agreement and internal consistency for adherence and competence across different sessions ranged from acceptable to excellent, and there was a high correlation between the aggregated competence items and observer-rated fidelity. Data will also be presented for a second set of ratings with over 100 patients enrolled in a practical clinical trial using the refined measure. Implications for implementation research and assessment of fidelity in routine care will be discussed.

Notes:
Mobile Mental Health Apps are Flooding the Marketplace: Who is Using Them and to What Effect?

Diego Castaneda, University of California San Francisco School of Medicine; Patricia Areán, University of Washington; Joaquin Anguera, University of California San Francisco School of Medicine

Presenter: Diego Castaneda
Contact: diego.castaneda@ucsf.edu

Objective: Technology offers a clear path for scaling up the dissemination of mental health treatments. As the number of smart phone and/or tablet apps related to mental health wellness steadily increases, our work provides practical insights for clinicians and service providers who continually come into contact with patients who use these technologies.

Methods: A cross sectional Internet based survey (US) targeted mobile device users who reported having and using at least one health app on their smartphone or tablet device.

Findings: Survey results of a representative US sample (N=1536) show that 31% of all health app users reported using at least one mental or emotional health wellness app over the past 30 days. Usability, functionality, and overall satisfaction of these apps were all consistently high across a diverse range of mental health apps with respect to function and desired use (targeted therapy, treatments for anxiety/depression, stress relief, and/or meditation).

Impact: The rapid growth and the surprising diversity of mental/emotional wellness apps makes it clear that self-directed, consumer centered therapies via mobile technology play an increased role in how individuals conceptualize and manage their own mental health. While clinicians and service providers should strive to familiarize themselves with these as adjuncts to traditional services, the flood of these apps presents clear challenges in how clinicians manage patient interaction, expectation, and data management.

Notes:
Implementing Online Interventions for Mental Health in the Veterans Health Administration

Kenneth R. Weingardt, Veterans Health Administration; Carolyn J. Greene, Veterans Health Administration

Presenter: Carolyn J. Greene
Contact: carolyn.greene.phd@gmail.com

The U.S. Department of Veterans Affairs has created a self-help portal where Veterans and their families can find award winning online courses on topics such as Parenting, Problem Solving, and Anger Management (www.veterantraining.va.gov). This talk will review lessons learned by the project team in creating and deploying these tools, and in developing and executing a strategic communications plan to promote them nationally. Evaluation activities, including the use of Google Analytics to obtain real time user data, the use of online focus groups to formatively evaluate the programs as they are being developed, and the use of an online market research panel to conduct summative evaluation will be discussed. Finally, the Consolidated Framework for Implementation Research (CFIR) will be used to organize two case studies that demonstrate some of the innovative ways in which VA staff are integrating these new technologies into their clinical practices.

Notes:
An Efficient Process of Gathering Diverse Community Opinions to Inform an Intervention

Nancy Pandhi, University of Wisconsin-Madison Department of Family Medicine; Nora Jacobson, University of Wisconsin School of Nursing; Neftali Serrano, Access Community Health Centers; Armando Hernandez, Group Health Cooperative of South Central Wisconsin; Elizabeth Zeidler-Schreiter, Access Community Health Centers; Natalie DeCheck, University of Wisconsin-Madison Department of Family Medicine; Zaher Karp, University of Wisconsin Department of Family Medicine

Presenter: Nancy Pandhi & Natalie DeCheck
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Background: Gathering community opinions from a diverse population to inform interventions are highly desirable. Methods that produce quality results while being timely and cost-effective are needed.

Objective: To describe the design, dissemination and results of video vignette survey designed to elicit community perceptions of two models that integrate mental health care into primary care.

Methods: Working with three health systems, scripts depicting models were developed. Practice videos were vetted with various stakeholders including an advisory group drawn from a nontraditional research population. Final videos used local actors and were embedded in a survey disseminated online and in person via tablet computers. Besides socio-demographics, the survey asked three open ended questions about likes, dislikes and desired outcomes.

Results: 381 individuals completed the survey. Thirty percent of surveys were answered online, 43% in clinic waiting rooms, and 27% at community locations. Thirty-five percent of respondents identified as low income, 28% as non-white and 44% as having a mental health diagnosis. Preferences were elicited in four domains: access to care, care experience, future services, and dignity. The process took seven months and non-staff cost was ~$7,000.

Conclusions: Video-vignette surveys are a promising, efficient method for gathering community perspective to inform intervention design.

Notes:
Efficient Strategies to Support Trauma-Informed Care for Children and Youth in Foster Care

Suzanne Kerns, University of Washington; Barb Putnam, Washington State Children’s Administration; LaRessa Fourre, Washington State Division of Behavioral Health and Recovery; Michael D. Pullmann, University of Washington; Jacqueline A. Uomoto, University of Washington; Andrea Negrete, University of Washington; Dae Shogren, Children’s Administration

Presenters: Suzanne Kerns & Barb Putnam
Contact: sekerns@uw.edu

There are national calls to create trauma-informed systems of care for children and youth in foster care. However, the extent to which these efforts actually change practice behavior and child wellbeing is not well established. In this presentation, we describe workforce training efforts that support ‘crux points’ that influence the pathway from identification to referral to receipt of services. Guided by several factors previously identified (Kerns et al., 2014), the efforts include: 1) statewide implementation of a trauma screening tool, 2) development of training for child welfare screeners on conducting, interpreting, and sharing results, and 3) development and implementation of two curricula for child welfare workers: a pre-service training for all incoming workers and an in-service training for existing workers. The trainings were efficiently designed with differential degrees of depth and intensity to meet worker needs during their first year of employment. Early results indicate a bi-modal distribution in the extent to which social workers feel comfortable administering trauma screenings. The social worker curriculum is highly acceptable and participants report increased confidence in applying knowledge for case planning by one standard deviation from pre-training to the post-training. Lessons learned from the implementation of this statewide workforce initiative will be discussed.

Notes:
Using Integrated Administrative Data to Evaluate Implementation of a Behavioral Health and Trauma Screening for Children and Youth in Foster Care

Michael D. Pullmann, University of Washington, Division of Public Behavioral Health and Justice Policy; Barbara Lucenko, Washington State Department of Social and Health Services, Research and Data Analysis Division; Suzanne Kerns, University of Washington, Division of Public Behavioral Health and Justice Policy

Presenters: Michael D. Pullmann & Barbara Lucenko
Contact: pullmann@uw.edu

Effective statewide implementation of new approaches to identifying and treating youth in foster care with behavioral health problems requires monitoring of process and outcomes, but data collection efforts for such analyses can be expensive and burdensome. Administrative information systems can provide high-quality, efficient, and readily available data (i.e. good, cheap, and fast), but these data are often underutilized due to administrative, technical, and legal concerns. This presentation will describe the integration of Medicaid and social service information in Washington State, challenges and complexities in using such integrated information, and how this infrastructure has been leveraged in an evaluation of an academic-government partnership, Creating Connections. Creating Connections has implemented a screening protocol to identify mental health and trauma-related symptoms in youth who are entering foster care, track their progress over time, and refer them to appropriate services. Preliminary analyses will be presented, summarizing potential system-level impacts of the screening on proportions of youth who are identified, referred to, and engaged in services, the types of services received, and the impact on outcomes in the juvenile justice and other systems.

Notes:
Intermediary Organizations as a Vehicle to Promote Efficiency and Speed of Implementation

Robert P. Franks, Judge Baker Children's Center, Boston, MA; Christopher Bory, Judge Baker Children's Center

Presenter: Robert P. Franks
Contact: rfranks@jbcc.harvard.edu

The goal of this presentation is to describe how intermediary organizations can promote efficiency and speed of implementation through the Active Implementation Framework as defined by the National Implementation Research Network (NIRN). This presentation will draw from case examples and descriptive research to describe how intermediaries are integrally involved in active implementation. The discussion will focus on the intermediary’s role in selecting effective interventions and co-creating capacity; creating well-defined implementation teams, structuring implementation methods; and helping to create and facilitate enabling contexts that result in socially significant outcomes. Specifically, examples will be provided of the intermediary’s role in facilitating efficient progress through the implementation process by playing a critical role in structuring and driving the change process and developing and using tools to support implementation. The intermediary’s role in facilitating competency, organizational, and leadership drivers through structured implementation and engagement of key stakeholders will also be discussed. And finally, the intermediary’s role in promoting fidelity and sustainability through quality improvement and plan-do-study-act cycles will also be described. This presentation will demonstrate that intermediaries can help drive efficiency and speed of implementation by acting as a facilitator of the active implementation process leading to positive social outcomes and sustained practice change.

Notes:
Operationalizing the Consolidated Framework for Implementation Research to Guide Evaluation of a Complex Intervention and Produce Actionable Findings

Rosalind Keith, Mathematica Policy Research; Jesse Crosson, Mathematica Policy Research; DeAnn Cromp, Group Health Research Institute; Ann O’Malley, Mathematica Policy Research; Michael Parchman, Group Health Research Institute

Presenter: Rosalind Keith
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There is growing recognition of the need for researchers, decision makers, and program implementers to understand how context influences the implementation of complex interventions. The purpose of this presentation is to describe how to use the Consolidated Framework for Implementation Research (CFIR) to systematically analyze qualitative data from an implementation evaluation to produce timely, relevant, and actionable findings. We purposefully selected twenty one primary care practices for one to two day site visits to collect in-depth qualitative data about clinician and staff experiences implementing the Comprehensive Primary Care (CPC) initiative, a primary care redesign intervention. During the first year of CPC implementation, we conducted 103 interviews (approximately two to seven interviews per practice) and documented detailed field-notes after each site visit. To systematically analyze the data, we developed operational codes to delineate the intervention into five components based on CPC guidelines. We used the CFIR to develop contextual codes to guide our examination of factors that emerged to influence the implementation of the CPC components. The findings we produced were used by decision makers to identify where implementation differed from planned objectives and provide focus to technical assistance providers on the areas where additional implementation support was needed.

Notes:
Applying the CFIR Constructs Directly to Qualitative Data: The Power of Implementation Science In Action

Edward J. Miech, VA Stroke QUERI; Teresa M. Damush, VA Stroke QUERI

Presenter: Edward J. Miech  
Contact: edward.miech@va.gov

An innovative new analytic strategy for implementation-related projects is the direct application of constructs from the Consolidated Framework for Implementation Research (CFIR) to qualitative data. In May 2013 Damschroder and Lowery published the first study to assign valence (i.e., positive or negative) and magnitude (i.e., weak or strong) to individual CFIR constructs and to use these ratings to analyze association of CFIR constructs with implementation outcomes. Building on this novel strategy, an eight-person study team based in Indianapolis led by PI Miech undertook the task of systematically rating more than 300 interview transcripts generated over 33 site visits with 20 CFIR constructs for valence and magnitude as part of the VA-funded RE-INSPIRE project in 2014-15. In completing this work, the RE-INSPIRE team developed new rubrics, devised technical methods for on-demand access to CFIR-related information and pioneered the use of an Audience Response System to harness the expertise and autonomy of individual team members yet adhere to a standard of team consensus when applying CFIR constructs to RE-INSPIRE data. The direct application of CFIR constructs to qualitative data yielded original, key findings in the RE-INSPIRE project into how interventions, implementation strategies, and local contexts influenced implementation success.

Notes:
Efficient and Effective SBIRT Training: A Snowball Implementation Model

Jason M. Satterfield, University of California, San Francisco (UCSF); Derek Satre, UCSF; Maria Wamsley, UCSF; Patrick Yuan, UCSF; Patricia O’Sullivan, UCSF

Presenter: Jason M. Satterfield
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Background/Purpose: Medical clinics often “re-invent the wheel” when promoting new evidence-based behavioral practices rather than building on the gains of prior implementation efforts. Our purpose was to determine if a “snowball implementation” model with near-peer consultations and community partnerships could be effective.

Methods: We conducted a 5 year case study of “snowball implementation” involving 5 medical residency training programs interested in implementing screening, brief interventions, and referrals to treatment (SBIRT) for substance use disorders into their clinical practices. Each year, one program implemented SBIRT training using materials and processes developed by the prior year’s program. Qualitative interviews of key informants and review of program materials assessed important implementation processes and outcomes drawn from the CFIR framework.

Results: All programs successfully implemented SBIRT training and systems adaptations. Early programs invested more time and resources in developing materials and processes but each program “handed off” products and lessons learned to subsequent programs. Internal champions effectively used near-peer consultations, enabling them to design more effective and efficient program-specific implementations to successfully train residents in SBIRT.

Discussion/Conclusion: By creating a near-peer community, programs evolved successful program-specific implementations, gleaning lessons from each other. This model could inform others regarding how to build implementations collaboratively rather than relying solely on individual strategies.

Notes:
Towards Efficient and Sustainable Motivational Interviewing Training: A Multisite Implementation Trial in the Wake of the American College of Surgeons’ Alcohol SBI Policy Mandate

Doyanne Darnell, University of Washington; Chris Dunn, University of Washington; David C. Atkins, University of Washington; Leah Ingraham, University of Washington; Doug Zatzick; University of Washington

Presenter: Doyanne Darnell
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The American College of Surgeons mandates that Level I trauma centers have a mechanism to identify and intervene with problem drinkers. Brief interventions using Motivational Interviewing (MI) are efficacious in reducing alcohol use and re-injury among trauma inpatients. A crucial implementation issue in this setting is that trauma centers choose their brief interventionists without assessing provider ability to learn MI in advance. We present training data from a randomized implementation trial with usual care nurses and social workers at 20 U.S. trauma centers. The study deployed a novel 27-month training/evaluation package using standardized patients to assess MI skills following a 6-month training period consisting of a workshop, emailed feedback, and telephone coaching. Training resulted in improved MI scores across multiple MI skill domains; however, provider ability to meet established proficiency cut-offs varied considerably. Baseline predictors of post-training MITI scores included years since receiving professional degree (negative relationship) and the MITI Percent MI-Adherent aptitude (positive relationship). Findings suggest that training usual care trauma providers to do brief interventions using MI is feasible, yet not all providers undergoing training can reach MI proficiency. Obtaining reliable estimates of pre-training skill may help direct training efforts. Funding: NIH R01/AA016102, K24/MH086814, and T32/MH082709.

Notes:
Monitoring the Fidelity of Motivational Interviewing counselors: Counting Frogs in the Jungle

*Chris Dunn, University of Washington; Doyanne Darnell, University of Washington; David C. Atkins, University of Washington; Peter Roy-Byrne, University of Washington*

Presenter: Chris Dunn  
Contact: cdunn@uw.edu

Many studies have established the clinical impact of Motivational Interviewing (MI), but little is known about the long-term MI fidelity of trained counselors during the years after their MI training is over. In the study presented, we explored two aspects of counseling expertise: improvement in skill over time and consistency of MI performance within counselors. Using an established MI scoring system to rate as many as 56 MI sessions per counselor allowed us to quantify MI consistency within counselors. Our sample of counselors performed MI for drug abuse with challenging safety net primary care patients for up to three years after MI training. For most MI fidelity summary scores, there was little evidence of within-counselor improvement with practice. Furthermore, within-counselor variability significantly exceeded between-counselor variability, raising doubt about how much we should depend on these scores as a means of comparing counselors with each other. These data suggest that large scale MI fidelity monitoring would be impossible using human coders. Automated fidelity monitoring systems currently under development are more promising for providing efficient and sustainable quality control of counseling.

Notes:
Matching Models of Implementation to System Needs and Capacities: Addressing the Human Factor

Helen Best, Treatment Implementation Collaborative, LLC; Susan Velasquez, Department of State Hospitals - California

Presenter: Helen Best
Contact: hbest@ticllc.org

While Dialectical Behavior Therapy has been widely disseminated, most of the large scale system initiatives have faced formidable obstacles which make the implementation extremely challenging. In a large scale installation of DBT in the California State Hospital System, the authors of this presentation have defined five pillars of support that are interdependent and often incongruent across time. The need for an overarching plan addressing the fit of the treatment, funding, administrative and clinical support, all supported by high quality training, consultation and supervision is well documented and in play within this implementation of DBT. Yet the five levels of support required to move from planning to outcomes requires constant and ongoing tending. These areas are: Central Office (DSH), Hospital Level Executive Administration, Discipline Silo’s, Units implementing DBT, Clinicians learning to provide DBT, and system flow (patient fit, beds, mandates, incidents, etc.). This presentation will overlay the impact of Good, Cheap and Fast against the backdrop of time, funding and scalability to discuss how these hierarchical layers play critical roles across day to day implementation of an EBP. Installation can be achieved. Sustainability is most impacted by the human factor as decisions roll across all levels and impact day to day treatment outcomes and endurance. It is our goal to illustrate the need to address ongoing development of implementation champions and/or teams across all systemic levels and highlight learning from Napa State Hospital in particular.

Notes:
Agency Characteristics that Facilitate Efficient and Successful Implementation Efforts

Miya Barnett, University of California, Los Angeles; Jennifer Regan, University of California, Los Angeles; Nicole Stadnick, University of California, San Diego; Alison Hamilton, University of California, Los Angeles; Anna Lau, University of California, Los Angeles; Lauren Brookman-Frazee, University of California, San Diego

Presenter: Miya Barnett
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To tailor implementation approaches to community needs, it is important to address the following questions: (1) How do agency characteristics impact efficient, successful evidence-based practice (EBP) uptake? (2) What supports are needed when agencies have barriers to implementation? In 2009, Los Angeles County Department of Mental Health (LACDMH) launched the Prevention and Early Intervention (PEI) Transformation. The PEI Transformation required agencies to quickly change staffing and infrastructure to meet a fiscal mandate, which amended contracts to reimburse only for provision of approved practices. From 2012 to 2013, LACDMH conducted site visits at PEI-contracted agencies to support early implementation efforts. In this project, mixed-methods are being used to integrate qualitative site visit narratives and quantitative claims data from 103 agencies to identify agency characteristics associated with effective implementation efforts. Preliminary qualitative analyses have elucidated several themes related to infrastructure, client characteristics, and administrative challenges. It is hypothesized that agency size will impact implementation outcomes, with larger agencies having or creating infrastructure that promotes successful uptake. Similarly, it is hypothesized that agencies that predominately serve ethnic minorities will need additional implementation support. Results may pinpoint elements of implementation support needed to promote agency success in delivering specific types of EBPs.

Notes:
Rapid Assessment Process: Application to the Prevention and Early Intervention (PEI) Transformation in Los Angeles County

Jennifer Regan, University of California, Los Angeles; Nicole Stadnick, University of California, San Diego; Miya Barnett, University of California, Los Angeles; Alison Hamilton, University of California, Los Angeles; Anna Lau, University of California, Los Angeles; Lauren Brookman-Frazee, University of California, San Diego

Presenter: Jennifer Regan
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Qualitative data analysis, although greatly informative, is often viewed as time-consuming and labor-intensive. The rapid assessment process (RAP) represents a quick and efficient qualitative analytical method, allowing research teams to swiftly develop a preliminary understanding of complicated situations from an insider’s perspective. This submission will illustrate multiple applications of RAP within an NIMH-funded, mixed-methods study examining the sustainment of specific practices in Los Angeles County following an extensive mental health transformation. RAP procedures will be outlined, including identifying consistent domain names for items, developing a template to summarize domains and assessing its utility, applying summary templates to data, creating a matrix of domains by variables of interest, and comparing data in the matrix according to variables of interest. In application to document review describing early implementation conditions, RAP identified important common themes, such as the development of administrative and procedural infrastructure to facilitate implementation, high level of staff training needs, and use of the train-the-trainer model for sustainment. These findings were used to inform code development for further document review and future applications of RAP to qualitative interviews will inform quantitative data. Take-home points will be conditions that lead to successful RAP application as well as possible challenges in application.

Notes:
The Development of the Practice-Concordant Care Scale: An Assessment Tool to Examine Treatment Strategies Across Evidence-Based Practices

Nicole Stadnick, University of California, San Diego; Miya Barnett, University of California, Los Angeles; Jennifer Regan, University of California, Los Angeles; Scott Roesch, San Diego State University; Anna Lau, University of California, San Diego; Lauren Brookman-Frazee, University of California, San Diego

Presenter: Nicole Stadnick
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To understand the impact of large-scale implementation efforts of evidence-based practices (EBPs) in mental health (MH) systems, it is important to understand if providers are delivering the essential components of the practices. To assess delivery across a range of EBPs, it is necessary to develop a common metric. This project developed the Practice-Concordant Care Scale (PCCS) to assess the extent to which community providers report delivering strategies considered essential to six specific practices that treat a range of ages and presenting problems. Existing practice inventories were reviewed to inform item selection and structure. Twenty-two practice experts (i.e., intervention developers or master trainers) of the six practices completed an electronic survey in which they rated 63 strategies as “essential” versus “interfering” on a Likert-scale. Practice-specific and a “common elements” algorithms were developed using the 56 strategies for which there was inter-rater agreement based on the Delphi rating system. An additional 10 strategies were added based on practice expert input. The current 66-item self-report PCCS will be validated using a corresponding observational coding measure and preliminary data will be presented. The PCCS offers promise to efficiently assess therapist report of practice delivery to facilitate EBP implementation efforts in community MH settings.

Notes:
Refining a Compilation of Discrete Implementation Strategies and Determining Their Importance and Feasibility

Byron J. Powell, Center for Mental Health Policy and Services Research, Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania; Thomas J. Waltz, Eastern Michigan University; VA Center for Clinical Management Research; Matthew J. Chinman, VISN 4 MIRECC; RAND Corporation; Laura J. Damschroder, VA Center for Clinical Management Research and Diabetes Quality Enhancement Research Initiative (QUERI); Jeffrey L. Smith, Central Arkansas Veterans Healthcare System, VA Mental Health Quality Enhancement Research Initiative (QUERI), HSR&D Center for Mental Healthcare and Outcomes Research; Monica M. Matthieu, Central Arkansas VA Healthcare System and Saint Louis University; Enola K. Proctor, Brown School, Washington University in St. Louis; JoAnn E. Kirchner, Central Arkansas Veterans Healthcare System, HSR&D and Mental Health Quality Enhancement Research Initiative (QUERI), Department of Veterans Affairs Medical Center

Presenter: Byron J. Powell
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Identifying feasible and effective implementation strategies remains a significant challenge. This is partly due to a lack of conceptual clarity in the field, and insufficient guidance about how to select appropriate strategies. The Expert Recommendations for Implementing Change (ERIC) project aimed to 1) establish expert consensus on implementation strategy terms, definitions, and categories, and 2) develop recommendations for strategies likely to be effective in integrating EBPs into VA mental health service settings. Findings from Aim 1 will be presented. Purposive sampling was used to recruit a panel of implementation science and clinical experts (n=71). The expert panel was engaged in a three-round modified Delphi process to generate consensus on strategies and definitions. Rounds 1 and 2 involved web-based surveys that prompted edits and additions to the strategy terms and definitions from Powell et al (2012). The third round involved a live, web-based polling and consensus process that yielded a final compilation of 73 strategies and definitions (Powell et al., 2015). Experts were subsequently engaged in a concept mapping process that organized implementation strategies into nine clusters and provided ratings of the importance of each strategy and cluster. Implications for research and practice will be discussed.

Notes:
Structuring Complex Recommendations: Methods and General Findings

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Presenter: Thomas J. Waltz
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The ERIC project’s penultimate activity involved a menu-based choice (MBC) task. MBC was used to facilitate building multi-strategy implementation approaches for a clinical practice change by providing ratings for each of 73 implementation strategies in terms of how essential they would be for implementing that practice change while taking care not to overburden staff with unnecessary activities. Recommendations were obtained for three high priority practice changes in the VA: improving safety for patients taking antipsychotic medications, depression outcome monitoring in primary care-mental health, and Prolonged Exposure therapy for treating post-traumatic stress disorder. Twenty or more experts provided recommendations for each of the practice changes, each of which presented three different scenarios that reflected varying contextual strengths and weaknesses. In addition to describing how the ERIC project used MBC to structure complex practice-change-specific recommendations, recommendations that were consistent across all three practice changes will be presented. The discussion will also highlight how the MBC ratings of the strategies relate to the more generic ratings obtained in the Concept Mapping task.

Notes:
Implementing Prolonged Exposure for PTSD in the VA: Expert Recommendations from the ERIC Project

Monica M. Matthieu, Central Arkansas VA Healthcare System, Saint Louis University; Craig Rosen, National Center for PTSD, VA Palo Alto Health Care System, Department of Psychiatry & Behavioral Sciences, Stanford University; Thomas J. Waltz, Department of Psychology, Eastern Michigan University, HSR&D Center for Clinical Management Research, VA Ann Arbor Healthcare System; Byron J. Powell, Center for Mental Health Policy and Services Research, Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania; Matthew J. Chinman, VISN 4 MIRECC, RAND Corporation; Laura J. Damschroder, VA Center for Clinical Management Research and Diabetes Quality Enhancement Research Initiative (QUERI); Jeffrey L. Smith, Central Arkansas Veterans Healthcare System, VA Mental Health Quality Enhancement Research Initiative (QUERI), HSR&D Center for Mental Healthcare and Outcomes Research; Enola K. Proctor, Brown School, Washington University in St. Louis

Presenter: Monica M. Matthieu
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The Expert Recommendations for Implementing Change (ERIC) project utilized rigorous methods to support a highly structured and transparent recommendation process that actively engaged key stakeholders throughout the project’s execution. This presentation will first provide a brief overview of how stakeholders at the National Center for PTSD were engaged in an iterative process of evaluating the Prolonged Exposure for PTSD implementation scenarios for reliability, credibility, and transferability. Second, this presentation will describe the ERIC recommendations for this practice change focusing on high consensus strategies. Finally, a discussant from the National Center for PTSD will compare and contrast the implementation strategies used in the actual VA rollout for Prolonged Exposure (past, present, and future) with the strategies recommended by the ERIC project.

Notes:
When Readiness is a Luxury: Co-Designing a Risk Assessment and Quality Assurance Process with Violence Prevention Frontline Workers in Seattle

*Asia Sarah Bishop, University of Washington; Mariko Lockhart, City of Seattle, Seattle Youth Violence Prevention Initiative*

Presenter: Mariko Lockhart  
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The Seattle Youth Violence Prevention Initiative (SYVPI) is a complex community initiative involving multiple independent service providers. The initiative values community empowerment while seeking to address risk reduction and asset building with evidence-based approaches. This is a delicate balance most clearly evidenced in the approach SYVPI adopted to develop a risk assessment tool. Initiative staff ultimately decided that a locally-developed tool was needed to respond to 1) the specific informational needs of SYVPI staff; and 2) to promote buy-in for implementation. Facilitated by University of Washington staff, an SYVPI workgroup oversaw the development of this tool using research-informed items and anchors to derive violence risk classifications while adjusting item wording and format to appeal to staff and youth. This process occurred while simultaneously co-designing a quality assurance infrastructure. By engaging in a co-design process, the workgroup team developed a research-informed product while also enhancing engagement. The tool is now being evaluated as a valid predictor of violence with the intended youth population. This project illustrates the feasibility and benefits of a co-design process as an alternative to implementing previously developed products in new settings, particularly when readiness for empirically supported products is complicated by contextual factors.

Notes:
Implementation Potential of Structured Recidivism Risk Assessments with Justice-Involved Veterans: Qualitative Perspectives from Providers

Allison L. Rodriguez, National Center for PTSD, VA Palo Alto Health Care System; Luisa Manfredi, HSR&D Center for Innovation to Implementation, Department of Veterans Affairs, VA Palo Alto Health Care System; Andrea Nevedal, HSR&D Center for Innovation to Implementation, Department of Veterans Affairs, VA Palo Alto Health Care System; Joel Rosenthal, VHA Veterans Justice Programs; Daniel M. Blonigen, HSR&D Center for Innovation to Implementation, Department of Veterans Affairs, VA Palo Alto Health Care System

Presenter: Allison L. Rodriguez
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Utilization of structured tools to evaluate risk for recidivism in justice-involved individuals is central to the Risk-Need-Responsivity model (Andrews et al. 1990) of offender rehabilitation. The Veterans Health Administration’s (VHA) Veterans Justice Programs (VJP) Specialists serve as first-line responders to Justice-Involved Veterans (JIVs) in the reentry process, and aim to link JIVs with appropriate VA and community services in order to reduce recidivism risk in this population. Qualitative semi-structured interviews were conducted with 63 randomly selected VJP Specialists representing each of the 21 Veterans Integrated Service Networks in the VHA, and standard qualitative content coding and pile sorting were used to identify major themes in the data. Analyses revealed that few sites use structured risk assessments to measure level of risk for recidivism. However, many Specialists indicated that such a tool would be highly valuable for case management purposes. Informal methods used by Specialists to measure level of risk for recidivism in this population are reviewed, and facilitators and barriers to possible implementation of structured risk assessments within VHA are discussed. Findings support the need for systematic efforts in VHA to implement use of structured risk assessments with JIVs.

Notes:
Developing Empirically-Informed Readiness Measures for Providers and Agencies for the Family Check-Up Model Using a Mixed Methods Approach

Anne M. Mauricio, Arizona State University REACH Institute; Thomas D. Dishion, Arizona State University REACH Institute; Jenna Rudo-Stern, Arizona State University REACH Institute; Justin D. Smith, Baylor University Department of Psychology & Neuroscience

Presenter: Anne M. Mauricio
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The Family Check-Up (FCU) is a brief, family-centered intervention model that tailors sessions to each family’s needs and stage of change. The FCU reduces child problem behavior and substance use and improves child and parent mental health (e.g., Dishion, Brennan et al, 2014; Shaw, Dishion et al, 2006; Smith, Stormshak et al, 2014). Optimizing scale-up required assessment-based planning to resolve implementation barriers, which included selection of early adopting providers (Fixen et al, 200). Phase one of this study examined the validity of the FCU Provider Readiness Assessment (PRA), developed based on literature linking provider attributes with implementation success (Chaudoir et al., 2013). We administered the PRA during the implementation exploration phase (Novins et al., 2013) to approximately 40 providers across three agencies using the FCU; we examined associations between readiness scores and direct observations of provider fidelity (Smith, Dishion et al, 2013). The second phase included focus groups with FCU providers to refine the PRA and understand provider perspectives concerning the professional and agency capacities needed to implement the FCU in real world settings. Focus group data will also inform training and consultation adaptations to increase provider acceptability of the FCU and to develop an FCU agency readiness measure.

Notes:
Pebbles, Rocks, and Boulders: The Implementation of a School-Based Social Engagement Intervention for Children with Autism

Jill Locke, University of Pennsylvania; Courtney Benjamin Wolk, University of Pennsylvania; Colleen Harker, University of Washington; Anne Olsen, New York University; Travis Shingledecker, University of Pennsylvania; Frances Barg, University of Pennsylvania; David Mandell, University of Pennsylvania; Rinad S. Beidas, University of Pennsylvania

Presenter: Jill Locke
Contact: jill.locke@gmail.com

Few evidence-based practices for children with autism have been successfully adopted, implemented, and sustained in public school settings. This study used qualitative methods to examine staff perspectives on the implementation of a social engagement intervention for children with autism in public schools. Semi-structured interviews were conducted with administrators (n = 15), teachers (n = 10), and school personnel (n = 14) who participated in a randomized controlled trial of a school-based social engagement intervention for children with autism. Participants answered questions about: 1) school factors related to general intervention implementation; 2) experiences implementing or overseeing the social engagement intervention; and 3) barriers to and facilitators of intervention implementation and sustainment. Themes were identified and coded using a grounded theory approach. Six nodes (implementation process, staff, leadership, support, barriers, facilitators) were identified. Schools used a top-down approach where multiple staff (pebbles, rocks, and boulders as a principal described them) played a role in implementation. A number of barriers (i.e., lack of time, resources, staff, and training) and facilitators (i.e., support, space, communication, and feedback) emerged. These data suggest that there are important factors that should be considered prior to adopting and implementing interventions for children with autism in public school settings.

Notes:
PST.Net: A Stakeholder Analysis Examining the Feasibility and Acceptability of Teletherapy in Community Based Aging Services

Marissa Hansen, California State University, Long Beach, School of Social Work; Maria P. Aranda, University of Southern California, School of Social Work; Isabel Torres-Vigil, University of Houston, Graduate College of Social Work

Presenter: Marissa C. Hansen
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Introduction: Effective psychosocial depression treatments exist for older adults, yet individual, provider, and organizational barriers impact service use. Video-based teletherapy services is a cost-savings approach to ease access to services. In this study, contextual factors framed by theories of diffusion of innovation were examined to understand the feasibility and acceptability of using Problem Solving Teletherapy (PST) in urban community based older adult services. Methods: Conducted semi-structured interviews and focus groups with a purposive sample of stakeholders from a social service agency serving older adults that included management staff(n=4), clinicians(n=5), and older adult clients(n=14). Results: Using methods informed from grounded theory, analysis revealed PST was not viable but better suited as an adapted supportive counseling and case management model. This approach would increase ability for case-management follow-up, address client need for socialization, and maximize provider-client interactions. Organizational process related to technology training would enhance staff-client interactions and outcomes in this model. Resources are needed to ensure access to suitable infrastructure and technology for agency and clients. Implications: Findings present practice implications for teletherapy as it relates to providing services to homebound urban dwelling older adults, as well as increasing capacity for social service providers in managing ongoing client mental health needs.

Notes:
Collaborative Intervention Design: A Process That May Help Keep the Bonfire Stoked

Bryan Hartzler, Alcohol & Drug Abuse Institute, University of Washington

Presenter: Bryan Hartzler
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To promote sustainable use of contingency management (CM) in community settings, one may pool a purveyor’s conceptual expertise and contextual insights from treatment personnel to collaboratively design interventions. In the context of a hybrid effectiveness-implementation trial at an opiate treatment program (for which a range of successful implementation and clinical effectiveness outcomes were reported at a prior SIRC), an elicitation interview was conducted at trial conclusion to cull qualitative impressions of a collaboratively-designed CM intervention among its managerial staff. Based on attributes in Rogers’ (2003) Diffusion of Innovations framework, a phenomenological narrative analysis examined managerial staff opinions of the intervention’s relative advantages, compatibility, complexity, trialability, and observability. Based on 90 days of implementation experience at their opiate treatment program, managerial staff regarded the CM intervention to be: 1) cost-effective and clinically-useful, 2) compatible with existing service structure and resources, 3) procedurally uncomplicated to implement, 4) trialable among the program’s direct-care staff, and 5) offering palpable benefits for staff-patient interactions. Taken together with the opiate treatment program’s sustained and independent implementation of this CM intervention thereafter, this work offers a qualitative account of collaborative intervention design as a useful process to foster effective dissemination of empirically-supported therapeutic practices.

Notes:
Implementation of Suicide Risk Prevention in an Integrated Delivery System

*Bradley Steinfeld, Group Health Cooperative*

Presenter: Bradley Steinfeld  
Contact: steinfeld.b@ghc.org

Suicide is the major safety concern for patients who are seen in behavioral health specialty settings yet nearly half of the individuals who died by suicide visited their primary care physician in the preceding month. The National Action Alliance for Suicide Prevention has identified essential dimensions of suicide prevention for health care organizations. This symposium will describe the experience of Group Health Cooperative in applying these dimensions in developing a systematic approach to suicide prevention in both mental health specialty and primary care settings. Focus will be on how to implement suicide prevention processes of care that are both effective and efficient within high volume mental health specialty and primary care practices. Strategies for leveraging data, electronic medical records and engaging both front line staff and organizational leadership will also be shared.

Notes:
Implementation of Suicide Risk Prevention in Mental Health Specialty: Where it All Starts

Sarah Stuckey, Group Health Cooperative

Presenter: Bradley Steinfeld
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Given that suicide is the major safety risk for patients with psychiatric disorders, mental health clinicians will report that suicide risk prevention is a routine part of their practice. Yet, this has been found to not consistently occur in usual practice. This presentation will describe the experience of group health behavioral health services in transitioning to a mental health specialty practice where suicide risk prevention became a routine practice for every patient at every visit. Focus will be on how patient and stakeholder feedback was integrated within research findings to develop processes of care that were able to be easily integrated into clinician’s current practice. Strategies and data that address how suicide risk prevention was incorporated into the routine management of care within behavioral health specialty clinics will also be shared.

Notes:
Role of the Integrated Behavioral Health Consultant in Suicide Risk Prevention: Where it All Ends

*Tory Gildred, Group Health Cooperative*

Presenter: Zandrea Harlin  
Contact: harlin.z@ghc.org

The integrated behavioral health consultant given their mental health expertise and role within the primary care team are in a unique position to help address suicide risk prevention in primary care. This presentation will describe how suicide risk prevention is incorporated within this role both within urgent care as well as primary care settings at Group Health. Key issues to be addressed include the process of cultural transformation of medical social workers into integrated behavioral health consultants and how to leverage strategic initiatives within primary care (i.e. the patient centered medical home) to enhance suicide risk prevention. How to incorporate suicide risk prevention into universal mental health screening as well as the role of the integrated behavioral health consultant in increasing the competencies of health care providers in conducting suicide risk assessment will also be discussed.

**Notes:**
Implementation of Suicide Risk Prevention in Primary Care: A New Frontier

Frederic Shepard, Group Health Cooperative; Zandrea Harlin, Group Health Cooperative

Presenter: Frederic Shephard and Zandrea Harlin
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Implementation of suicide risk prevention in primary care presents unique challenges given the complexity of primary care practice in terms of addressing multiple patient care needs in a limited time frame. Given that context, what are appropriate expectations for the primary care team in conducting suicide risk prevention? What is the role of the primary care physician? What is the role of nursing and ancillary staff? The presentation will provide the audience with a foundational understanding of what occurs within a primary care practice and the steps Group Health has taken to incorporate suicide risk prevention into primary care including the leveraging of existing behavioral health screening tools within primary care along with enhancing collaborative relationships both with behavioral health specialty care and integrated behavioral health consultants.

Notes:
Successful Translation of a Diabetes Care Quality Initiative From Integrated Care Into Safety Net Clinic Settings

Rachel Gold, Kaiser Permanente - Center for Health Research; Christine Nelson, OCHIN, Inc.; Arwen Bunce, Kaiser Permanente - Center for Health Research; Celine Hollombe, Kaiser Permanente - Center for Health Research; James Davis, Kaiser Permanente - Center for Health Research; Jon Puro, OCHIN, Inc.; Nancy Perrin, Kaiser Permanente - Center for Health Research; Stuart Cowburn, OCHIN, Inc.; Jennifer DeVoe, Oregon Health & Science University (OHSU) and OCHIN, Inc.

Presenter: Rachel Gold
Contact: Rachel.Gold@kpchr.org

Purpose. A Kaiser Permanente (KP) diabetes quality improvement intervention uses EHR-based tools to improve guideline-based cardioprotective prescribing. We assessed the feasibility of implementing this intervention in community health centers (CHCs).

Methods. We adapted and implemented KP’s intervention in 11 CHCs. Our translational trial randomly assigned clinics with six ‘early’ clinics implemented one year before five ‘late’ clinics. Through segmented regression analyses, we tested differences in trends in prescribing rates over time.

Results. Rates of guideline-based prescribing improved significantly: over 12 months the rate of ‘early’ patients with appropriate prescriptions increased from 59% to 68% (statins) and 69% to 76% (ACE-inhibitors). In the same period, the ‘late’ CHCs had little change [57% to 59% (statins) and 64% to 64% (ACE-inhibitors)]; post-implementation, these increased to 68% and 74%, respectively, in these sites. Barriers to intervention integration included: providers’ mistrust of automated alerts; fitting intervention tools into workflows; developing population-level tools for individual patients.

Conclusions. It is feasible to adapt an intervention developed in the private sector for implementation in CHCs. Our results illustrate the impact of doing so, and challenges involved in using EHR-based tools to support practice change and quality improvement efforts in CHCs.

Notes:
Purpose: Implementation strategies - the approaches, methods, structures, and resources used to introduce and encourage uptake of a given intervention’s components - are rarely reported in the implementation literature. This lack of reporting hinders efforts at efficient future dissemination. We demonstrate how a framework for describing implementation strategies, recently proposed by Proctor and colleagues, can be used to standardize reporting and therefore advance appropriate and timely implementation and dissemination.

Methods. We use the Proctor framework to report on the implementation of one intervention in two care settings. We describe how we used the framework to refine our understanding of the strategies’ impact, and clarify our reporting on the strategies.

Results. Differences in organizational resources and culture necessitated adapting the implementation strategies across care settings. Proctor’s framework facilitated our analysis and reporting on these adaptations. Per the framework: the target (clinic staff) and outcome (prescribing rates) of the implementation strategies remained the same; the actor, action, temporality and dose were adapted to fit local context.

Conclusions. Proctor and colleagues’ framework supports standardized reporting on how interventions are implemented and adapted across care settings. Researchers should consistently report this information, which could be crucially important to enhancing intervention uptake and dissemination.

Notes:
The Complex Role of Data Feedback in Intervention Uptake

Arwen Bunce, Kaiser Permanente - Center for Health Research; Rachel Gold, Kaiser Permanente - Center for Health Research; James Davis, Kaiser Permanente - Center for Health Research; MaryBeth Mercer, Virginia Garcia Memorial Health Centers; Victoria Jaworski, Multnomah County Health Department; Christine Nelson, OCHIN, Inc.; Celine Hollombe, Kaiser Permanente - Center for Health Research

Presenter: Arwen Bunce
Contact: Arwen.E.Bunce@kpchr.org

Purpose: Implementation researchers commonly provide study data updates to participant clinics to stimulate performance around the metric in question. Such data could be a powerful tool to improve both uptake and care quality, but reactions to and/or use of these feedback data is rarely explored.

Methods: Ethnographic process evaluation of the translation of a diabetes-focused quality improvement intervention from an integrated care setting to community clinics. Analysis guided by the constant comparative method.

Results: Diverse factors contribute to use of study data, including: 1) perceived gap between desire and ability to use data to improve patient care; 2) tension between good patient care and meeting performance metrics; 3) concerns that data do not accurately reflect care provided; and 4) availability of guidance, resources to act on findings. Provider suggestions include: 1) ensure measured actions under provider’s control; 2) include individual patient-level clinical data in addition to metrics targeted by study; 3) provide data in a customizable format; and 4) include concrete guidelines for action.

Conclusion: Despite its apparent simplicity, making study data available to clinicians in a way that is both appreciated and helpful is a complex undertaking that deserves careful thought.

Notes:
Protocol for the “Practices Enabling Implementation and Adaptation in the Safety Net (SPREAD-NET)” Pragmatic Cluster-Randomized Trial

Rachel Gold, Kaiser Permanente - Center for Health Research; Christine Nelson, OCHIN, Inc.; Arwen Bunce, Kaiser Permanente - Center for Health Research; Celine Hollombe, Kaiser Permanente - Center for Health Research; James Davis, Kaiser Permanente - Center for Health Research; Jon Puro, OCHIN, Inc.; Nancy Perrin, Kaiser Permanente - Center for Health Research; Stuart Cowburn, OCHIN, Inc. and OCHIN, Inc.; Jennifer DeVoe, OHSU and OCHIN, Inc.; Michael Horberg, Kaiser Permanente - Mid-Atlantic Permanen

Presenter: Celine Hollombe
Contact: celine.b.hollombe@kpchr.org

Purpose. Care guidelines and effective interventions are rarely integrated into everyday practices in a timely manner, diminishing their population-level potential. Little is known about how best to implement evidence-based interventions across care settings, or about which ‘implementation strategies’ (the components used to introduce interventions into new care settings, and support interventions’ uptake and sustainment) best support implementation of interventions in Community Health Centers (CHCs). Research is needed to compare the effectiveness of strategies for supporting implementation of evidence-based care in CHCs.

Methods. Our pragmatic cluster-randomized trial will compare how three increasingly hands-on implementation strategies (Arm 1: toolkit; Arm 2: toolkit plus training; Arm 3: toolkit and training, plus facilitation) support adoption of a diabetes quality improvement initiative, among 30 CHCs that share an EHR.

Results. We plan to assess the comparative effectiveness of these implementation strategies in CHCs, and impact on diabetes care quality, how these strategies may be used to support widespread dissemination of effective interventions, and the cost effectiveness of the different support strategies. We will present our planned methods in detail.

Conclusions. This study is designed to address important knowledge gaps in implementation science, with the potential for widespread impact on dissemination of proven interventions into CHCs.

Notes:
ICED: A Step-by-Step Approach to Dialectical Behavior Therapy Program Implementation

Matthew S. Ditty, The Ebright Foundation, LLC; Andrea Doyle, The Ebright Foundation, LLC; School of Social Policy and Practice, University of Pennsylvania; John A. Bickel III, The Ebright Foundation, LLC; Katharine Cristaudo, The Ebright Foundation, LLC

Presenter: Matthew S. Ditty  
Contact: dittydsw@gmail.com

Organizational support has been identified as a key facilitator of Dialectical Behavior Therapy (DBT) implementation. DBT is a psychosocial treatment that effectively reduces symptoms of Borderline Personality Disorder, suicidality, non-suicidal self-injury, and severe emotional and behavioral dyscontrol. To increase access to care for those in need, organizations must know how to support DBT. ICED – an acronym for implementation team, checklist, evaluation and feedback, and DBT skills – is a behaviorally-specific, step-by-step approach for DBT program implementation informed by implementation science. Each step has been defined and piloted when implementing a DBT practice in Wilmington, Delaware. Case material is provided to illustrate each step of ICED in action, and future research is recommended for testing ICED across organizations and settings.

Notes:
The Challenges in Implementing Multiple EBPs in a Community Mental Health Setting

Dan Fox, Lutheran Community Services Northwest

Presenter: Dan Fox & Sonia Combs
Contact: dfox@lcsnw.org

Dan Fox, LICSW, is a clinical manager at Lutheran Community Services Northwest in Spokane (LCSNW). His program implements components-based CBT, parent-child interaction therapy, and cognitive processing therapy, among others, with children, families, and adults in a community mental health setting. Dan will discuss the unique challenges of maintaining model fidelity, ensuring revolving clinicians are adequately trained in each model, and weaving EBPs into the paperwork and culture of his agency. In addition, a clinician from his program will discuss the front line creative challenges of implementing each model with a diverse range of clients.

Notes:
Using EHR to Promote and Support EBT Assessment and Treatment Intervention

David Lischner, Valant Medical Solutions, Inc

Presenter: David Lischner
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First generation EHR technology was designed for process automation and capturing maximum billing fees. With the 2nd generation, there is an opportunity to utilize extensible big data technologies and a modern and intuitive mobile app-like user experience. This design has the potential to streamline workflows, remove the need for training and make data easy to capture, store, and analyze. The result will be an EHR platform that can be rapidly configured to support EBP service delivery and data analysis and then tuned to make the EBP stick.

Notes:
Are Existing Frameworks Adequate for Measuring Implementation Outcomes? Results From a New Simulation Methodology

Richard A. Van Dorn, RTI International; Stephen J. Tueller, RTI International; Jesse M. Hinde, RTI International; Georgia T. Karuntzos, RTI International

Presenter: Richard A. Van Dorn
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Existing implementation frameworks guide the measurement of implementation outcomes. However, empirically validating implementation outcomes, for example those identified by Proctor and colleagues, is often challenged by limited data sources, a constrained item pool, and inadequate sample size. In order to establish the minimum requirements for sufficient power to detect Proctor and colleagues’ eight implementation outcomes going forward, we used an exploratory factor analysis simulation. We assumed a fixed population and sampled from an infinite pool of items to simulate realistic item selection processes, where data can be collected from only one sample and there is limited control in selecting the loadings, crossloadings, and error variances from the pool of potential items. Our simulation modeled sample size (200, 500, 1000), item pool size (24, 40, 80), item response distribution (normal, binary, Likert), and a range of (cross)loadings and error variances. Results show the adjusted Bayesian Information Criterion was the most accurate factor extraction criterion, and that item pool size and sample size had larger impacts on correctly detecting eight factors than ideal item characteristics (e.g., high loadings, low crossloadings, low error variance) across response distributions. Results can be used to inform instrument development and power calculations for future implementation science research.

Notes:
Development and Validation of Implementation Measures for Low-Resource Global Contexts

Emily E. Haroz, Johns Hopkins Bloomberg School of Public Health; Laura K. Murray, Johns Hopkins Bloomberg School of Public Health; Amanda J. Nguyen, Johns Hopkins Bloomberg School of Public Health; Judith K. Bass, Johns Hopkins Bloomberg School of Public Health; Shannon Dorsey, University of Washington; Paul Bolton, Johns Hopkins Bloomberg School of Public Health

Presenter: Emily E. Haroz
Contact: eharoz1@jhu.edu

Global mental health (GMH) has few, if any, suitable implementation measurement instruments for low and middle income countries (LMIC) and diverse cultural contexts. Our group’s research has showed that existing measures developed in high-resource settings did not match with lower resource settings (e.g., asking about insurance or technology). Without appropriate instruments, examining the factors involved in implementation and scaling-up of interventions is challenging. The aim of this study was to develop and evaluate practical instruments specifically for LMIC to measure implementation outcomes across the domains of acceptability, adoption, appropriateness, feasibility, penetration and sustainability. Instruments were created for four stakeholder levels: government/policy, organizational directors/staff, service providers, and consumers. Questions were based on leading implementation frameworks: CFIR, RE-AIM, and a conceptual model of evidence-based implementation in public service sectors, as well as feedback from local partners and experts in the field of GMH and implementation science. Testing consisted of examining the acceptability, reliability and validity of the instruments for providers and consumers, using a mixed-methods approach. A total of n=183 individuals provided data. Preliminary results indicate the scales are acceptable, reliable and valid at the provider level. At the consumer level, reliability and validity results were mixed.

Notes:
A Treatment Integrity Measure for Early Childhood Education Settings

Ruben G. Martinez, Virginia Commonwealth University; Bryce D. McLeod, Virginia Commonwealth University; Kevin S. Sutherland, Virginia Commonwealth University; Maureen A. Conroy, University of Florida; Patricia Snyder, University of Florida; Michael A. Southam-Gerow, Virginia Commonwealth University

Presenter: Ruben G. Martinez
Contact: martinezrg@vcu.edu

Research on improving the quality of instruction in early childhood classrooms is a national priority. Many preschool children exhibit problem behaviors that place them at risk for emotional and behavioral disorders. Teacher-delivered, evidence-based programs (EBPs) have demonstrated positive effects for children with problem behavior; however, efforts to implement and evaluate EBPs across early childhood settings face barriers. Early childhood classrooms may differ across a variety of structural and process dimensions, which may influence implementation of EBPs with integrity. Additionally, few measures exist that are capable of characterizing the process used to implement instructional practices with integrity and characterize business as usual, which makes interpreting findings from effectiveness trials difficult. To address these barriers, the field needs a validated, pragmatic measure capable of assessing the delivery of instructional practices found in existing EBPs. This presentation will describe the development of The Treatment Integrity Observational Coding System for Early Childhood Settings and accompanying teacher self-report, designed to characterize the implementation of evidence-based instructional practices delivered by teachers in early childhood classrooms. The validation and dissemination of such a measure would provide stakeholders with the ability to assess integrity of multiple EBPs, facilitating the efficiency with which EBPs are assessed in school settings.

Notes:
Effectiveness of Lay Counselor Delivery of a Common Elements CBT Approach

Shannon Dorsey, University of Washington; Laura K. Murray, Johns Hopkins University; Michael D. Pullmann, University of Washington; Emily E. Haroz, Johns Hopkins University; Jeremy Kane, Johns Hopkins University; Paul Bolton, Johns Hopkins University

Presenter: Shannon Dorsey
Contact: dorsey2@uw.edu

Perhaps nowhere are efficiency and effectiveness more important than in low and middle income countries, where the burden of mental disorders is large, comorbidity is common, and there is a dearth of mental health professionals. To achieve scale up, innovative approaches that move beyond a reliance both on professionals and on singularly-focused disorders is critical. The Common Elements Treatment Approach (CETA), a modular treatment designed to address Posttraumatic Stress (PTS), depression, and anxiety was developed for delivery by lay counselors with little to no formal mental health training. Lay counselors and their local supervisors were trained in decision making for module selection and module dose. We will report on two completed RCTs which both showed high effect sizes: Thai Burma border with Burmese refugees (N = 347; ES: 1.19 PTS, 1.16 depression, 0.79 anxiety) and in Southern Iraq (N=149; ES: 2.40 PTS, 1.82 depression, 1.60 anxiety). Clinical outcomes will be reviewed as the “litmus test” for effectiveness of implementation strategies [use of lay counselors; modular approach]. We will present analytic breakdown on lay counselor decision making for CETA module selection and dose.

Notes:
Beyond Training and Moving to Sustainability Globally: A Train-the-Trainer Approach for Low-Resource Contexts

Laura K. Murray, Johns Hopkins University; Shannon Dorsey, University of Washington; Emily E. Haroz, Johns Hopkins University; Catherine Lee, Johns Hopkins University; Amanda Nguyen, Johns Hopkins University; Paul Bolton, Johns Hopkins University

Presenter: Laura K. Murray
Contact: lmurra15@jhu.edu

Global mental health has been receiving increasing attention, with accumulating evidence for the effectiveness of CBT and other EBT delivered in low-resource countries, by lay counselors. However, to date, implementation strategies for EBT training are slow and expensive, relying heavily on training and oversight by mental health professionals from high-income countries. Now that clear evidence exists for the effectiveness of CBT and other EBT, it is critical to begin to test strategies for broader training and support of counselors that maintains quality, but is cheaper and faster. Scale up requires a more viable, affordable, and sustainable approach.

Building on effectiveness of the Common Elements Treatment Approach, our research team developed a Train-the-Trainer (TTT) approach that has been tested in two disparate settings—Southern Iraq and Myanmar. We will describe the TTT approach and outcomes including knowledge of counselors and trainers across both settings. As the ultimate litmus test of the effectiveness of the TTT strategy, client outcomes for counselors trained by local trainers (Myanmar: n=328) showed similar results when benchmarked against client outcomes under the expert trainer model (Myanmar: n=187). We discuss implications for next steps to scale-up mental health care in low-resource settings.

Notes:
Taking Global Local: Evaluating Training of Washington State Clinicians in a Modularized CBT Approach Designed for Low-Resource Settings

Maria Monroe-DeVita, University of Washington, Department of Psychiatry; Roselyn Peterson, University of Washington, Department of Psychiatry; Doyanne Darnell, University of Washington Harborview Medical Center; Lucy Berliner, University of Washington Harborview Center for Sexual Assault and Traumatic Stress (HCSATS); Shannon Dorsey, University of Washington Department of Psychology; Laura K. Murray, Johns Hopkins Bloomberg School of Public Health

Presenter: Maria Monroe-DeVita
Contact: mmdv@uw.edu

Objective: The Common Elements Treatment Approach (CETA) is a modularized cognitive behavioral treatment to address posttraumatic stress, anxiety, and depression among people in low-to-middle-income countries. CETA is efficient, low-cost, accessible, and utilized by clinicians from diverse backgrounds. Implementation in U.S. community mental health seems prudent. We present data exploring the feasibility and benefits of training clinicians in CETA.

Method: In 2014, 45 clinicians and 13 supervisors from 9 community mental health agencies in Washington participated in CETA training. Clinicians evaluated themselves pre- and post-training on 17 core CETA skills. Participants present cases in bi-weekly consultation for 6 months and consultants assess the quality of each case presentation. Participants will evaluate their CETA skills after consultation is complete.

Results: Before training, common counseling skills such as “identifying clients at risk for suicide and to what extent” were most highly rated (M=3.86, SD=.88). Most poorly rated skills were specific to CETA. Self-perception of all skills improved after training. This presentation will include consultation data and a discussion of encountered implementation successes and challenges.

Conclusions: Low-cost and accessible interventions such as CETA hold promise for community mental health. Post-training data will provide insight into the impact of ongoing consultation on CETA skills.

Notes:
5:30 – 7:30PM.

Posters will be presented during the reception.

Location: UW Tower at 4333 Brooklyn Ave NE (across the street from Hotel Deca)

Please check in at the security desk in the lobby wearing your SIRC conference badge, then proceed to the 4th floor. Signs will guide you to the reception area. Cash bar and Hors d’oeuvres will be available.

Poster Presentations
Attitudes Toward Evidence-Based Practices Across Therapeutic Approaches

Yevgeny Botanov, University of Washington and Behavioral Tech, LLC; Tianying Chen, University of Washington; Marivi Navarro-Haro, University of Washington; Melanie S. Harned, University of Washington and Behavioral Tech, LLC; Anthony DuBose, Behavioral Tech, LLC; Marsha M. Linehan, University of Washington

Presenter: Yevgeny Botanov
Contact: ybotanov@uw.edu

The goal of evidence-based practice (EBP) is to integrate clinical expertise with scientific evidence while also providing services that reflect client-centered interests, values, and needs. Mental health providers’ attitudes and preferences about EBPs may represent the largest obstacle to EBP implementation. Thus, we explored the attitudes of mental health practitioners attending a Dialectical Behavior Therapy (DBT) intensive training. Participants were attendees at 9 trainings (N = 411) conducted from 2009 – 2013 in two parts, 6 months apart. The three most commonly reported primary therapeutic approaches were cognitive-behavioral therapy (CBT; n = 191), psychodynamic (n = 49), and DBT (n = 48). At the first part of training, CBT practitioners reported significantly higher openness – or the extent to which they are willing to attempt a new or manualized intervention – in comparison to psychodynamic practitioners. Six months later, psychodynamic practitioners reported significantly lower intent to adopt an EBP if it were required compared to DBT practitioners. These results indicate differences in attitudes between theoretical orientations of mental health practitioners already attending an EBP training. Furthermore, the findings highlight preexisting differences between therapeutic approaches that are a potential barrier in EBP implementation.

Notes:
Predicting the Use of an Evidence-Based Intervention for Autism in Birth-to-Three Programs

Colleen Harker, University of Washington; Elizabeth Karp, University of Washington; Sarah Edmunds, University of Washington; Lisa Ibanez, University of Washington; Wendy Stone, University of Washington

Presenter: Colleen Harker
Contact: charker@uw.edu

A research-to-practice gap exists in the use of evidence-based interventions for children with autism in community practice (e.g., Lord et al., 2005). This study examined factors associated with the use of an evidence-based intervention for children with autism by community providers (n = 76) from geographically and ethnically diverse communities (65% rural) across Washington State. Providers attended one-day workshops on Reciprocal Imitation Training (RIT), a play-based, autism-specialized intervention with a strong evidence base (Ingersoll, 2008), and rated the acceptability and feasibility of RIT (URP-I, selected items; Chafouleas, 2009) and the implementation climate of their work setting (PICS, selected items; Dingfelder 2012) immediately post-training and at a 3-month follow-up. At follow-up, providers also reported whether they used RIT with children in their caseload. RIT use at follow-up was associated with: (1) post-training ratings of intervention acceptability (OR = 3.30, p = .03); and (2) implementation climate at 3-month follow-up (OR = 9.23, p < .01). Provider ratings of intervention feasibility did not predict RIT use. These results highlight the importance of understanding the environment in which an intervention is delivered. By identifying factors associated with intervention uptake, we can disseminate interventions that are effective and appropriate for use in community practice.

Notes:
Supervision Practices and Improved Adherence Across Evidence-Based Practices: A Literature Review

*Mimi Choy-Brown, Silver School of Social Work, New York University; Victoria Stanhope, Silver School of Social Work, New York University*

Presenter: Mimi Choy-Brown  
Contact: mimi.choybrown@nyu.edu

Behavioral health service settings urgently need onsite strategies to integrate evidence-based practices (EBPs). With behavioral health service systems endorsing multiple EBPs, providers are concurrently implementing and sustaining these practices. This is particularly challenging for direct practice supervisors responsible for ensuring quality service provision and responsiveness to consumer needs, through the translation of and adherence to EBPs. EBP implementation often relies on direct practice supervision for fidelity and sustainability. Direct practice supervision has been related to improved practitioner adherence to new practices. However, research investigating clinical supervision is EBP specific and supervision models used in efficacy trials may vary thus presenting challenges for supervisors charged with overseeing multiple EBPs. There is still limited understanding of potential conflicts among supervision models and those core elements most important for supervisors integrating EBPs in their work. The aim of this presentation is to review literature of supervision across EBPs. Inclusion criteria are specified supervision models related to an EBP (e.g. MST, MI, CBT) with empirical support for supervision practices positively related to adherence. Common elements of supervision and areas for potential tension for concurrent implementation are highlighted. Recommendations for efficient supervision models will be offered by taking a common elements approach.

Notes:
Beyond Symptom Tracking: Clinician Perceptions of a Hybrid Measurement Feedback System for Monitoring Treatment Fidelity and Client Progress

Jack H. Andrews, University of Missouri - Columbia; Benjamin D. Johnides, University of Missouri - Columbia; Kristin M. Hawley, University of Missouri - Columbia

Presenter: Jack H. Andrews
Contact: andrewsjh@missouri.edu

A growing body of research suggests that measurement feedback systems (MFSs) have the potential to produce widespread improvements in mental healthcare quality (Landes et al., 2015). Previous studies have focused on MFSs that assess client factors such as symptoms, functioning, and therapeutic alliance, but expanding the scope of MFSs to also target clinicians’ fidelity to specific evidence-based practices (EBPs) may offer additional utility for enhancing EBP implementation efforts and client outcomes. The current study is a community-based pilot test of a MFS prototype that assesses clinician use of core components of evidence-based cognitive behavioral therapy (CBT) for youth anxiety, depression, trauma history, and/or disruptive behaviors, in addition to client symptoms and therapeutic alliance. Data collection began in March 2014 and is ongoing. To date, 35 therapists have consented to participate, 29 have used the MFS for at least one CBT session, and 16 have completed participation, including a qualitative interview about their experience using the MFS. Analysis of interview transcripts will examine clinicians’ perceptions of the MFS’s potential for routine use in practice, including acceptability, feasibility, adoption and perceived sustainability. The proportion of missing data from clinicians and their clients will also be examined as an indicator of implementation feasibility.

Notes:
A Guideline Decision Support Tool: From Creation to Implementation

Beth Prusaczyk, Washington University in St. Louis; Alex Ramsey, Washington University in St. Louis; Ana Baumann, Washington University in St. Louis; Graham Colditz, Washington University in St. Louis; Enola K. Proctor, Washington University in St. Louis

Presenter: Beth Prusaczyk
Contact: beth.prusaczyk@wustl.edu

Background: While clinical practice guidelines are important aides to delivery of evidence-based practices, their implementation is problematic. Investigators often conduct clinical practice guideline (CPGs) research in substantive-area silos, unaware of the potentially helpful perspectives of implementation research. The Dissemination and Implementation Research Core (DIRC) of Washington University’s CTSA developed a decision support tool to support CPG research and to foster collaboration on cross-cutting CPG implementation issues.

Methods: DIRC leadership facilitated a meeting of implementation researchers and investigators interested in CPG research. The meeting revealed confusion about different research purposes, including CPG creation, effectiveness testing, modification, and implementation.

Results: We developed a flowchart distinguishing between different CPG-related research aims. The tool helps investigators clarify whether they wish to create new CPGs, study CPG effectiveness, modify CPGs, or implement CPGs. Those studying guideline implementation are directed to resources, including exemplar reports of CPG implementation and conceptual frameworks and methods for CPG research. The decision support tool has been refined through user feedback.

Discussion: The CPG decision support tool is a helpful resource for the CTSA DIRC, whose staff periodically updates it with new resources. Fostering collaboration and providing tools to investigators is important in advancing and enhancing efficiency of implementation research.

Notes:
I Like This, I’ll Change That: Clinician Intent to Modify CBT and Treatment Fidelity

Rosemary Meza, University of Washington; Shannon Dorsey, University of Washington; Shannon Wiltsey Stirman, National Center for PTSD, VA Boston Healthcare System and Boston University; Georganna Sedlar, University of Washington; Leah Lucid, University of Washington

Presenter: Rosemary Meza
Contact: rosemarydmeza@gmail.com

Until recently, research has rarely included a focus on clinician interest, intent, and plans for modifying EBPs, despite the fact that fidelity in many implementation efforts is low. Recent studies suggest clinicians regularly modify for clients and settings and that modifications may enhance fit and sustainability. To our knowledge, no one has examined clinicians’ prospective intent to modify at the time of EBP training, and the relation to fidelity. We plan to examine clinicians’ (N=175) perceived need and intent to modify after receiving training in a common elements CBT approach, as well as factors that might influence perceived need to modify (e.g., organizational climate; from an agency with an established CBT program). Preliminary results (N = 91) indicate the majority (76%) intend to modify and most (85.6%) endorsed a need for modifications specifically to integrate CBT with current practices. We will examine the relation between perceived need to modify and delivery of appropriate, core treatment elements during the 6-month post-consultation period. Data come from clinician self-report in a web-based monitoring system and independent, expert consultant ratings (data available June, 2015). Findings will inform training and supervision efforts by providing a better understanding of how clinicians plan for modifications and fidelity.

Notes:
Understanding Intervention Adaptations: Comparing Observed Implementation Processes Across Experimental and Real-World Contexts in a Widely Used Parenting Program

W. Alex Mason, National Research Institute for Child and Family Studies, Boys Town; Robert Oats, National Research Institute for Child and Family Studies, Boys Town; Ronald Thompson, National Research Institute for Child and Family Studies, Boys Town; Kevin Haggerty, Social Development Research Group, University of Washington

Presenter: Alex Mason
Contact: walter.mason@boystown.org

We present implementation fidelity assessment data from an RCT of Common Sense Parenting compared to implementation data in real world contexts. Common Sense Parenting is a parent-training program that holds promise for preventing child and adolescent problem behaviors. In the trial, thirteen workshop leaders were trained to conduct CSP workshops by Boys Town staff. In total, workshop leaders conducted 141 parenting sessions. Parent workshops were videotaped, and a random sample of 27% of the videotapes were coded by independent experienced coders for adherence and quality. Coders had a high degree of correspondence in their ratings (96% agreement). While overall adherence was high (95%), with variation across each session's learning activities, experienced coders noted that workshop leaders were not as flexible or responsive to program participants compared to workshop leaders conducting the intervention in real-world contexts. RCT’s should consider implementation in real-world settings to help close the research-to-practice gap. We use the RE-AIM (Glasgow et al., 1999) framework to compare program participation, participant satisfaction, and program adherence and quality between the RCT and implementation sites conducting Common Sense Parenting. We discuss the tradeoffs between highly structured adherence in RCTs and group leader responsiveness in real world applications.

Notes:
Assessing Components of the Outer Setting of an Implementation Process: The Impact of Structure, Infrastructure, and Metastructure

Caitlin Dorsey, Indiana University

Presenter: Caitlin Dorsey
Contact: cadorsey@indiana.edu

Numerous studies have focused on identifying barriers and facilitators to implementation of evidence-based practices (EBPs). However, an organization’s outer setting (e.g. documentation, insurance, funding structures, etc.) has received limited attention, despite its influence on implementation effort success. The outer setting has three components (SIM): structure (i.e. the physical parts with direct system influence), infrastructure (i.e. the structure’s supportive factors), and metastructure (i.e. the organizational/individual cognitive-rule base) (Stelk & Slaton, 2010). To characterize these under-studied components, this study aimed to explore the outer setting component’s expression within an organization and examine the relation between components of the outer setting and previously identified determinants of practice. Included data comes from a pre-implementation needs assessment of a Cognitive Behavioral Therapy implementation project in a youth residential setting. Focus group (N=53, staff across stakeholder levels) transcripts will be qualitatively analyzed for SIM components via NVivo. Additionally, staff (N=99) completed self-report questionnaires assessing previously identified implementation determinants (e.g., attitudes towards evidence-based practices) and an Impact of Infrastructure scale. This measure’s subscales will be correlated with previously identified barriers and facilitators (e.g., stress and burnout). This study will uncover how SIM components influence the implementation process and will inform future efforts to increase EBP adoption.

Notes:
Influencing Sustainment of Trauma-Focused Evidence-Based Practices

Dana Saifan, University of California, Los Angeles; Anna Lau, University of California, Los Angeles; Lauren Brookman-Frazee, University of California, San Diego

Presenter: Dana Saifan
Contact: dsaifan92@gmail.com

Given the proliferation of evidence-based practices (EBPs) for youth, research can inform decisions about adoption of EBPs in the marketplace of dissemination and implementation. The present exploratory study will describe factors that may influence sustainment of trauma-focused EBPs following a large-scale reform to increase the use of EBPs in Los Angeles County. Practices of interest include Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Child-Parent Psychotherapy (CPP), Seeking Safety (SS), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). 3,810 therapists claimed for these practices in FY 2013-14 and/or the first quarter of 2015, and the average treatment cost per client was as follows: CBITS (M=$912.26, SD=$950.47), CPP (M=$3364.63, SD=$2176.92), SS (M=$3257.30, SD=$3301.50), TF-CBT (M=$3266.80, SD=$1709.04). Collection of survey data assessing therapist attitudes is currently underway. The EBPs will be compared on three dimensions of interest that may affect sustainment: therapist attitudes and perceptions of their own knowledge and confidence in using EBPs, treatment costs per client, and potential to reach more clients. The study will examine how these factors are related to each other. Components of therapist attitudes will also be explored to understand differences in utilization. Implications for treatment costs and influencing therapist attitudes will be discussed.

Notes:
The Community Engaged Scholars Program: Training Partnerships for Community-Engaged Research

Susan D. Newman, Medical University of South Carolina; Carolyn Jenkins, Medical University of South Carolina; Cathy Melvin, Medical University of South Carolina; Dana Burshell, Medical University of South Carolina; Holly Pierce, Medical University of South Carolina; Jeannette Andrews, University of South Carolina

Presenter: Susan D. Newman
Contact: newmansu@musc.edu

Introduction: Community engaged research (CEnR) is a collaborative approach to research that involves academic and community partners in the research process and recognizes the unique strengths that each brings.

Objective: South Carolina Clinical and Translational Research Institute and the College of Nursing Center for Community Health Partnerships (SCTR/CCHP) offer the Community Engaged Scholars (CES) Program to: foster community and academic partnerships, provide a 15-week didactic and interactive curriculum, and provide funds to help teams collect pilot data for future funding applications.

Methods: CEnR topics include but are not limited to: partnership readiness, community problem identification, ethics and the IRB, pilot testing, data collection and analysis, evaluation, translation and dissemination, and grant writing. After completing the CES Program, participants are encouraged to incorporate CEnR into their research activities in both community and academic settings.

Results: The CES Program trained 5 Cohorts, 21 teams and 65 team members. Outcomes generated include 8 peer-reviewed publications, 17 podium presentations and posters, and 9 follow-up grants.

Conclusions: CES Program research training and pilot funding support of community and academic partner teams can be an effective method for addressing community priorities, training research teams and contributing to health improvements among diverse populations.

Notes:
From Karelia to Kerala: Successful Adaptation and Implementation of a Diabetes Prevention Program in India

Fabrizio D’Esposito, The University of Melbourne

Presenter: Fabrizio D’Esposito
Contact: fabrizio.desposito@unimelb.edu.au

Effective implementation of evidence from clinical and public health interventions for diabetes prevention in low- and middle-income countries is a challenge, and attempts to adapt community-based and scalable approaches to countries like India have been very limited so far. The Kerala Diabetes Prevention Program is a culturally tailored, community-based, peer-led intervention for individuals at high risk of developing diabetes in the state of Kerala, Southern India. Delivery of this program to over 500 individuals has now been completed, and end-of-intervention implementation and outcome data suggest that the program i) was well implemented; ii) improved diabetes risk in participants; and iii) has become well-embedded in the local communities. Thus more two thirds of participants attended half or more of the 15 peer-led lifestyle intervention sessions over a year, there were significant improvements in participants’ clinical profile, and more than one third of the communities went on to autonomously set up health promotion activities. This poster explores the methodology used for the successful adaptation of diabetes prevention programs from Finland and Australia for implementation in India. The poster will also present preliminary findings on the moderators of program implementation, and the impact that these, in turn, had on participant outcomes.

Notes:
Effects of Consultation Method on Implementation of Cognitive Processing Therapy for PTSD

Cassidy A. Gutner, Boston University School of Medicine & National Center for PTSD at VA Boston Healthcare System; Candice M. Monson, Ryerson; Norman Shields, Veterans Affairs Canada; Josh Deloriea, Ryerson; Meredith SH Landy, Ryerson; Shannon Wiltsey Stirman, Boston University School of Medicine & National Center for PTSD at VA Boston Healthcare System

Presenter: Cassidy A. Gutner
Contact: cgutner@gmail.com

The current presentation will present an overview of results from a recently completed large study that investigated the impact of post-workshop follow-up strategies on CPT fidelity, clinician attitudes, and clinical outcomes in the context of an effort to implement CPT in VA Canada’s Operational Stress Injury National Network. Clinicians were randomized into one of three conditions. Two consultation strategies (with and without review of session recordings and work samples) were compared to a no post-workshop consultation. The proposed presentation will provide an overview of clinician (n=134) and patient-level (n=198) study outcomes, and focus on qualitative data on individual and contextual sources of variability in outcomes. A subset of participants was interviewed at baseline, post-consultation, and follow-up, with an interview guide based on CFIR, to provide perspectives on the intervention, training experience, and contextual factors that influence key implementation outcomes. Interim patient-level results across all conditions indicate a large pre-to-post effect, providing evidence of CPT effectiveness in routine care settings. Variation in fidelity was evident, with interim data on two-thirds of the participants indicating that 65% of participants across conditions met criteria for satisfactory or higher competence. The qualitative data will contextualize the findings regarding variability in outcomes across conditions.

Notes:

Natalie K. Finn, University of California, San Diego; Elisa Torres, University of California, San Diego; Mark Ehrhart, San Diego State University; Gregory A. Aarons, University of California, San Diego

Presenter: Natalie K. Finn
Contact: nfinn@ucsd.edu

Background: The Implementation Leadership Scale (ILS) is a brief and efficient measure to assess leader behaviors and actions that actively support effective implementation of evidence-based practices (EBPs). The ILS was validated with mental health clinicians. This study examines the ILS factor structure with child welfare service providers. Methods: Participants were 214 service providers working in 12 child welfare organizations in California, Illinois, Washington, and Oklahoma. All participants completed the ILS, reporting on their immediate supervisor. Multilevel confirmatory factor analyses were conducted to examine the factor structure of the ILS, accounting for the nested data structure (i.e., service providers nested within 43 teams), and indicating a hypothesized second order factor structure. Results: Multilevel confirmatory factor analyses showed good fit to the hypothesized first ($\chi^2(50)=115.02$, $p<0.001$; CFI=0.967, TLI=0.956; RMSEA=0.078; SRMR=0.047) and second order factor structure ($\chi^2(50)=115.18$, $p<0.001$; CFI=0.967, TLI=0.956; RMSEA=0.078; SRMR=0.047). First order factor loadings ranged from 0.85-0.95 for Proactive Leadership, from 0.94-0.99 for Knowledgeable Leadership, 0.86-0.95 for Supportive Leadership, and 0.85-0.96 for Perseverant Leadership, and second order factor loadings ranged from 0.83-0.90. Conclusions: The higher order factor structure of the ILS is robust indicating its utility in assessing leadership for implementation of EBPs in mental health and child welfare organizations.

Notes:
Sustainability of Integrated Smoking Cessation Care in Veterans Affairs Posttraumatic Stress Disorder Clinics: A Qualitative Analysis of Focus Group Data from Learning Collaborative Participants

Carol A. Malte, Center of Excellence in Substance Abuse Treatment and Education, Veterans Affairs Puget Sound Health Care System; Aline Lott, Center of Excellence in Substance Abuse Treatment and Education, Veterans Affairs Puget Sound Health Care System; Andrew J. Saxon, Center of Excellence in Substance Abuse Treatment and Education, Veterans Affairs Puget Sound Health Care System and Department of Psychiatry and Behavioral Sciences, University of Washington

Presenter: Carol A. Malte
Contact: Carol.Malte@va.gov

To address the disproportionately high smoking rates among individuals with mental illness, clinical guidelines strongly recommend delivery of smoking cessation treatment in mental health settings. Prior studies indicate incorporating integrated care (IC) for smoking cessation into routine posttraumatic stress disorder (PTSD) treatment significantly increases long-term quit rates relative to standard care in Department of Veterans Affairs (VA) settings. In order to facilitate implementation of IC, we conducted a Learning Collaborative involving multidisciplinary teams of 38 staff members from 6 VA PTSD clinics. LC evaluation included 4 focus groups – divided into clinicians, clinical champions, clinic directors and prescribers – involving 28 team members designed to better understand barriers and facilitators to sustaining IC. Using the PARiHS (Promoting Action on Research Implementation in Health Services) framework, we analyzed qualitative data for key themes related to intervention characteristics, provider acceptability, context and facilitation. Specifically, teams spoke to the need to adapt IC based on varying clinic structures (consultation-based, group-based, rural) and workload considerations, the importance of external facilitators, including consultation with LC faculty, monthly calls and in-person meetings with other participating sites, and internal facilitation at the clinic level through clinical champions and clinic directors. Findings can be utilized to inform future implementation efforts.

Notes:
Key Characteristics of Effective Mental Health Trainers: The Creation of a Measure

Meredith Boyd, Indiana University; Kelli Scott, Indiana University; Cara C. Lewis, Indiana University

Presenter: Meredith Boyd
Contact: mereboyd@indiana.edu

Despite the emergence of empirically supported treatments for a range of mental health problems, the majority of mental health care providers do not receive training in these approaches. Those who do, often receive training that is ineffective in producing behavioral changes. Although strategies have been delineated to improve the effectiveness of training, to our knowledge, no one has explored the personal characteristics of trainers that could contribute to training effectiveness. To address this gap, this study has two aims: 1) to create a valid, reliable, and pragmatic measure of trainer characteristics by following the gold standard test development procedures and 2) to conduct a preliminary evaluation of the impact of trainer characteristics on training effectiveness. These aims will be addressed in an online randomized trial in which undergraduates will view two training vignettes counterbalanced for content and trainer characteristics. Participants will complete measures to assess for convergent (e.g., trainer charisma), divergent (e.g., training strategies), and predictive validity (e.g., knowledge gain, intention to use skills). An exploratory factor analysis will be performed to delineate subscales for the created measure. Results will be discussed in regards to the degree to which trainer characteristics uniquely explain variance in trainee knowledge and skill gains.

Notes:
Coaching to Improve Teacher Implementation of Behavioral Interventions

Jennifer D. Pierce, University of Washington; Carol A. Davis, University of Washington

Presenter: Jennifer D. Pierce
Contact: jdp6@uw.edu

Although research suggests coaching can lead to improved teacher practice and student outcomes (Kretlow & Bartholomew, 2010), the relationship between teachers and coaches, also referred to as alliance, remains a barrier to changes in teacher practice (Hershfeld, Pell, Sechrest, Pas, & Bradshaw, 2012). Moreover, while positive alliance correlates with high levels of fidelity of teacher practice (Wehby, Maggin, Partin, & Robertson, 2012), it is currently unknown if systematic attempts to improve alliance lead to improved teacher practice. This presentation will summarize findings from a study on the effects of a unique intervention, feedback from teachers to coaches and coach action planning, to improve alliance and teacher use of behavioral interventions. Implications for implementation in schools will also be provided, including new insight into how an efficient model of coaching can more effectively lead to sustained implementation of intensive behavioral interventions by teachers.

Notes:
The Use of Telehealth to More Efficiently Disseminate an Evidence-Based Parent Training Intervention for ASD

Katherine Pickard, Michigan State University; Allison Wainer, Michigan State University; Brooke Ingersoll, Michigan State University

Presenter: Katherine Pickard
Contact: pickar11@msu.edu

Research within the autism spectrum disorder (ASD) field has called for the use of telehealth programs as a means to more efficiently disseminate evidence-based practices into community settings. However, little is known about the acceptability, feasibility and adoption of telehealth programs for this population. The current study utilized telehealth to deliver an internet-based, parent training intervention for ASD, ImPACT Online. The current study used mixed methods analysis to create a more nuanced understanding of parent experiences likely to influence the adoption of the program. Specific research questions included: 1) What are parents’ perceptions of the feasibility and usability of the online program?; 2) How does the ImPACT Online compare to other services parents are accessing for their children?; and 3) Do parents’ perceptions of the program differ based on whether they received remote coaching throughout the program?

Quantitative and qualitative findings from 27 parents of a child with ASD indicate that parents saw improvements in their child’s social communication skills during the course of the program, regardless of whether parents received supplemental remote coaching. However, qualitative interviews indicate that parents who received additional remote coaching were more likely to emphasize the feasibility and usability of the program. These findings indicate the potential for telehealth to increase the dissemination of evidence-based, parent training interventions for ASD.

Notes:
Implementation of Universal Screening for Lynch Syndrome in an Academic Colorectal Cancer Multidisciplinary Clinic

Deborah Bowen, University of Washington; Stacey Shiovitz, University of Washington; Mercy Laurino, University of Washington; Melissa Upton, University of Washington; Colin Pritchard, University of Washington; Gail Jarvik, University of Washington; Alessandro Fichera, University of Washington; Robin Bennett, University of Washington; Lorraine Naylor, University of Washington; Angela Jacobson, University of Washington; William Grady, University of Washington; Wylie Burke, University of Washington

Presenter: Deborah Bowen
Contact: dbowen@uw.edu

Universal screening of colorectal cancer (CRC) cases for Lynch syndrome is recommended by major national guidelines groups, including the National Comprehensive Cancer Network (NCCN) and Evaluation of Genomic Applications in Practice and Prevention (EGAPP) Working Group. Screening for Lynch syndrome has evolved from a clinical diagnosis to tumor-based testing. Lynch syndrome has been characterized as being associated with tumors that display key pathologic features, including DNA microsatellite instability (MSI) and loss of protein expression of one or more of the mismatch repair (MMR) genes by immunohistochemistry (IHC). Therefore, MSI and IHC testing form the basis of universal screening recommendations for all CRC patients. Implementation of guidelines can be complex on an institutional level, necessitating a thorough evaluation to apply the suggested changes. Damschroder and colleagues have articulated a model of clinical implementation that include characteristics of the innovation itself, the functions of existing networks and communications, the implantation climate of the organization, the characteristics of individuals involved in the change, and the process used to implement the innovation. All of these can have effects on the final outcome of implementation. We will describe the multidisciplinary process of evaluating, troubleshooting, and implementing guidelines for universal Lynch syndrome screening. We then present data from the first year of implementation and identify areas for improvement of the implementation process. We close with impressions of patients of their universal screening process. This has important implications for the emerging complexity of molecular oncology in an era of rapidly changing technology.

Notes:
Implementing Brief Intervention for Substance Use within HIV/AIDS settings: Preliminary Findings from Substance Abuse Treatment to HIV Care (SAT2HIV) Project

Bryan R. Garner, RTI International; Michael Chaple, NDRI; James Ford, University of Wisconsin - Madison; Heather Gotham, University of Missouri - Kansas City; David Kaiser, RTI International; Steve Martino, Yale University; Traci Rieckmann, Oregon Health & Sciences University; Debbie Rockford, University of Missouri - Kansas City; Kate Speck, University of Nebraska; Denna Vandersloot, Vandersloot Training & Consulting; Mark Zehner, University of Wisconsin - Madison

Presenter: Bryan R. Garner
Contact: bgarner@rti.org

With an estimated 42% of adults receiving HIV care reporting substance use in the past 12-months, comorbid substance use and HIV/AIDS is an issue of great public health relevance. Unfortunately, despite the high levels of comorbid substance use and HIV/AIDS, integration of substance use and HIV/AIDS services remains quite limited. This presentation describes and presents preliminary findings from the Substance Abuse Treatment to HIV care (SAT2HIV) project. Funded by the National Institute on Drug Abuse (R01-DA038146), the SAT2HIV project is a Type 2 Effectiveness-Implementation Hybrid Trial that is experimentally testing a) the effectiveness of a motivational interviewing-based brief intervention (BI) for substance use and b) the effectiveness of an organizational-level implementation enhancement strategy. In addition to providing an overview of the SAT2HIV project’s innovative design, which when complete will include 36 HIV/AIDS organizations and 2,592 individuals living with HIV/AIDS, the current presentation will present preliminary results regarding between condition differences in initial implementation (i.e., staff achievement of BI proficiency), as well as in changes over time in HIV/AIDS organizations implementation climate and implementation readiness. The presentation will conclude with a discussion of the implications of current findings as well as next steps.

Notes:
Factors Influencing the Implementation of Peer-led Health Promotion Programs Targeting Seniors: A Literature Review

Agathe Lorthios-Guilledroit, Université de Montréal Public Health Research; Lucie Richard, Faculty of Nursing Sciences, Université de Montréal; Université de Montréal Public Health Research Institute (IRSPUM); Johanne Filiatrault, School of Rehabilitation, Faculty of Medicine, Université de Montréal; Research Centre, Institut universitaire de gériatrie de Montréal

Presenter: Agathe Lorthios-Guilledroit  
Contact: agathe.lorthios-guilledroit@umontreal.ca

Recent conceptual frameworks suggest that health promotion program implementation is influenced by factors related to participants, providers, organizational and environmental contexts, as well as program’s characteristics. However, few research efforts have been devoted to empirical testing of these frameworks. Peer-led health promotion programs targeting seniors may particularly benefit from such endeavors given their emerging popularity. This presentation reports findings from a literature review on factors influencing the implementation of peer-led health promotion programs targeting seniors, as a first step for developing a theoretical framework for implementation of such programs. Five databases were searched with keywords related to implementation, peers, health promotion programs and seniors. Among the few studies that have examined the implementation of peer-led health promotion programs targeting seniors, participation rate was commonly reported as a key indicator of successful implementation. While factors identified were in line with current literature on program implementation, they were more often inferred from authors’ opinions rather than from study results. Findings from this literature review reveal the need for theoretical and empirical developments about factors influencing implementation of peer-led health promotion programs targeting seniors. The next step of our research is to develop and test a theoretical framework for implementation of such programs.

Notes:
Developing Treatment Fidelity Rating Systems for Psychotherapy Research: Recommendations and Lessons Learned

Kevin A. Hallgren, University of Washington; Shirley Crotwell, Boston Veteran Affairs Health Care System; Rosa Muñoz, University of New Mexico; Becky Gius, University of New Mexico; Benjamin Ladd, Reed College; Barbara McCrady, University of New Mexico; Elizabeth Epstein, University of Massachusetts Medical School in Worcester

Presenter: Kevin A. Hallgren
Contact: khallgre@u.washington.edu

Measuring fidelity to evidence-based treatments is a key component of dissemination and implementation research. However, developing reliable, valid, and clinically-relevant treatment fidelity measures remains a challenge. Although much of the literature has focused on theoretical and psychometric aspects of measure development, the literature often omits practical considerations for developing and using fidelity measures. The present study describes the development and testing of a treatment fidelity rating system used in couple-based alcoholism treatment. Over a three-year period, seven coders received extensive training and rated 74 components of treatment fidelity across 284 psychotherapy sessions. During this presentation, the theoretical model underlying the instrument and psychometric properties will be briefly described. However, a considerable portion of the presentation will focus on practical recommendations and lessons learned from our work, which we hope will inform future measure development. Major themes include challenges in (1) measure development (e.g., adapting existing fidelity measures for new treatments), (2) defining “treatment integrity” (e.g., conceptual and practical difficulties in rating various therapist behaviors), (3) process improvement (e.g., procedures for improving quality and efficiency of coder training and ongoing monitoring), and (4) inferring information from the ratings (e.g., improving clinical relevance and internal/external validity).

Notes:
Shifting from Compliance to Outcomes

Sabrina Salmon, Arizona Department of Education

Presenter: Sabrina Salmon
Contact: sabrina.salmon@azed.gov

This presentation will describe the process of assisting school districts with developing an action plan and strategies to improve both academic and functional outcomes for students with disabilities. Arizona State Department of Education revised the system of general supervision using guidance from the Federal Office of Special Education Programs to develop a process of examining practices with an emphasis on results-driven accountability. This system uses implementation science as a framework to examine data, apply evidence based practices with fidelity, and monitor progress based on the needs of each student, school, and district. Educational organizations improve the effectiveness of interventions through a process that strategically proceeds from using data to identify a problem to initiating systemic changes that are individualized and sustainable.

Notes:
Poster Presentations

Guidelines for the Use of a Recommended Practice in Survivorship Care: A Systematic Quality Appraisal Using the AGREE II Instrument

Sarah Birken, University of North Carolina at Chapel Hill; Shellie D. Ellis, University of Kansas School of Medicine; Jennifer S. Walker, University of North Carolina at Chapel Hill; Lisa D. DiMartino, University of North Carolina at Chapel Hill; Devon K. Check, University of North Carolina at Chapel Hill; Adrian A. Gerstel, University of North Carolina at Chapel Hill; Deborah K. Mayer, University of North Carolina at Chapel Hill

Presenter: Sarah Birken
Contact: birken@unc.edu

Background: Survivorship care plans (SCPs) are written summaries of cancer treatment and follow-up care plans intended to promote evidence-based care for cancer survivors. A growing number of guidelines for SCP use exist, yet SCP use remains limited. This may be due to poor guideline quality. The purpose of the study was to evaluate the quality of SCP use guidelines.

Methods: We conducted a comprehensive literature search. We assessed guideline quality using the AGREE II instrument (Appraisal of Guidelines for Research and Evaluation, 2nd edition), a tool developed to advance the quality of clinical practice guidelines, and summarized AGREE II scores by strongly recommending, recommending, or not recommending included guidelines.

Results: Of 128 documents screened, we included 16 for evaluation. We did not strongly recommend any guideline; we recommended 5 and did not recommend 11. Guidelines were generally unambiguous in their recommendations that SCPs should be used, but few guidelines discussed facilitators and barriers to guideline application; advice and tools for implementing guidelines were vague; and none explicitly discussed resource implications of implementing the guidelines.

Conclusions: Guidelines often advocated SCP use without justification or suggestions for implementation. Improved guideline quality may promote SCP use.

Notes:
Rapid Translation of Alcohol Prevention Science

John D. Clapp, The Ohio State University; Danielle Ruderman, The Ohio State University

Presenter: Danielle Ruderman
Contact: Ruderman.5@osu.edu

Despite a growing body of science documenting effective prevention approaches to alcohol-related problems among college students, recent research suggests most colleges and universities are not implementing such approaches. Commonly cited reasons for implementation failure in this field include inadequate resources, staff training, insufficient guidelines for interventions and the like. This presentation will present a rapid model of translation that includes the collaboration of research scientists and senior prevention professionals and results in a scalable, step-by-step checklist. A case study will be provided for a prevention approach to managing large drinking events.

Notes:
Community-Academic Partnerships: A Systematic Review of the State of the Literature and Recommendations for Future Research


Presenter: Amy Drahota
Contact: adrahota@mail.sdsu.edu

Involving community stakeholders as partners in research is increasingly emphasized by communities, funding agencies, and institutions. This systematic review aims to increase understanding of the characteristics of CAPs and current state of the science, identify facilitating and hindering influences on the collaborative process, and develop a common term and conceptual definition for use across disciplines. A systematic search generated 1,062 articles, forty of which met criteria for inclusion and provided data on 46 CAPs. Studies indicate CAP research spans disciplines, involve a variety of community groups, and focus on a large range of study topics. Articles rarely reported CAP characteristics. Most studies involved case studies using qualitative methods to collect data related to the collaborative process. Various terms were used to describe collaborative partnerships, yet few provided conceptual definitions. Twenty-three facilitating and hindering factors influencing the CAP collaboration process emerged. CAP outcomes most often included developing or refining tangible products. This systematic review identified a single term, community-academic partnership, most commonly used within the articles and provides a conceptual definition for the term. A universal term and conceptual definition will provide consistency as this burgeoning field emerges and assist in development of tools to measure CAPs in the future.

Notes:
Creation and Evaluation of a Fidelity Measure of Collaborative Care for Maternal Depression in Federally Qualified Health Centers

Johnny Mao, University of Washington; Ian M. Bennett, University of Pennsylvania; Jürgen Unützer, University of Washington

Presenter: Johnny Mao
Contact: jmao@uw.edu

Objective: To develop and evaluate a fidelity measure of the evidence based collaborative care (CC) model for maternal depression care in multidisciplinary primary care sites caring for low income and race/ethnic minority populations.

Method: Fourteen federally qualified community health centers (FQHCs) in Seattle and King County, Washington implemented (2008-present) CC for maternal depression care. The evaluation team developed and evaluated six indicator-based fidelity measures to measure how CC programs complete key elements of the CC model for their patients.

Findings: 1748 of 2500 (70%) unique women who received care for depression symptoms over the course of the study period were eligible for inclusion in this analysis. We created six fidelity measures covering elements such as the use of a patient registry, evidence based measures, and appropriate clinical follow up. A simple dichotomous score for each element was associated with increased clinical improvement in depression for four of five of the measures after adjusting for age, pregnancy status, race/ethnicity, baseline depression and anxiety symptoms, and suicidal ideation (aOR 1.44-3.04; P<0.001). A summary measure of these scores had a higher point estimate of clinical benefit than any individual item (aOR 7.41, 95% CI 4.72-11.62) supporting our hypothesis that these reflect distinct components of a summary scale.

Notes:
Drift in Fidelity in a Multiyear Trial of the Family Check-Up Predicts Child Problem Behavior Outcomes

Justin D. Smith, Baylor University; Amanda Chiapa, Arizona State University; Hanjoe Kim, Arizona State University; Thomas J. Dishion, Arizona State University; Daniel S. Shaw, University of Pittsburgh; Melvin N. Wilson, University of Virginia

Presenter: Justin D. Smith
Contact: jd_smith@baylor.edu

Therapist fidelity to evidence-based family interventions has consistently been linked to child and family outcomes. However, few studies evaluate the potential ebb and flow of fidelity of therapists over time. We examined therapist drift in fidelity over four years in the context of a Family Check-Up prevention services in early childhood (age 2–5). At age 2, families engaging in Women, Infants, and Children Nutritional Supplement Program (WIC) services were randomized and offered annual Family Check-Ups. Seventy-nine families with a child in the clinical range of problem behaviors at age 2 were included in this analysis. Latent growth modeling revealed a significant linear decline in fidelity over time (M = −0.35, SD = 0.35) and steeper declines were related to less improvement in caregiver-reported problem behaviors assessed at ages 7.5/8.5 (b = −.69, p = .003; β = −.95, CI: −2.11 | −0.22). These findings add to the literature concerning the need to continually monitor therapist fidelity to an evidence-based practice over time to optimize family benefits. Limitations and directions for future research are discussed.

Notes:
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Notes:
Saturday, September 26

6:30AM
SIRC FUN RUN! – MEET IN LOBBY

7:00AM-8:00AM
REGISTRATION & CONTINENTAL BREAKFAST

8:00AM-8:45AM
UPDATES ON SIRC INITIATIVES

8:45AM – 10:00AM
SYMPOSIUM III

10:30AM-11:45AM
BREAKOUTS D 1-5

11:45AM-1:00PM
LUNCH & SIRC JOURNAL DISCUSSION

1:00PM -2:15 PM
BREAKOUTS E 1-5

2:30PM-3:45PM
BREAKOUTS F 1-5

4:00PM-5:15PM
SYMPOSIUM IV

5:45PM-6:30PM
AWARDS AND CLOSING DISCUSSION OF CONFERENCE & IDEAS FOR THE FUTURE

7:30PM
GROUP DINNER
The Use of Continuous Quality Improvement Evaluations to Drive Service Improvement: The Tale of Two Projects

Robyn Mildon, Parenting Research Centre; Aron Shlonsky, University of Melbourne; Catherine Wade, Parenting Research Centre; Bianca Albers, Parenting Research Centre; Cheryl Majka, Parenting Research Centre

Presenters: Robyn Mildon and Aron Shlonsky
Contact: rmildon@parentingrc.org.au

Continuous quality improvement (CQI) evaluation methods may be one of the more promising ways to rapidly improve implementation and achieve the outcomes evidence-informed service models can help to achieve in real world service delivery settings. This presentation will report on the results of two evaluations conducted in different areas of Australia, both applying CQI evaluation methodology and both aiming to improve outcomes for children and families currently receiving services aimed at decreasing child maltreatment but in different ways. One will report the results of a three-year evaluation of an intensive family support service aimed at decreasing child neglect. Here the process allowed for continual use of implementation and outcome data to support joint work of stakeholders to tailor infrastructure required to support implementation. In teams, data were used to determine implementation fidelity (adherence, quality, coverage and uptake) and plan for improvements, tailor implementation support strategies to target improvements, and monitor clinic impact. How this process was done will be described and implementation and outcomes data reported. The other will report on an evaluation of child protection practice reform framework where only a brief (3 month) CQI evaluation process could be conducted. Here data and methods for collection were applied and implementation and outcome data collected and analyzed however no structure or ongoing process was established to use data in a CQI way. The method, processes and findings will be compared and contrasted for each project the effectiveness of the data and process to, over time, improve implementation towards achieving outcomes will be discussed.

Notes:
Implementation Efficiency in Context: National Implementation of DBT in Ireland

Daniel M. Flynn, Cork Mental Health Services, Cork, Ireland; Andre Ivanoff, Columbia University New York and the Linehan Institute

Presenter: Daniel M. Flynn
Contact: danielm.flynn@hse.ie

The potential for identifying efficiencies in the training and implementation of DBT has grown immensely, particularly in the US and the UK. System implementations in 17 US states and 6 international entities, along with rapid expansion in international dissemination and program development suggest that ongoing use of existing data will best inform promising implementation practices and build further efficiencies. The 2012 Linehan Institute (LI) post hoc evaluation of teams intensively trained between 2008-2011, and the Swales et al 2012 report have been supplanted by a larger LI project with two objectives: 1) evaluating the impact of DBT Intensive training on team functioning, attitudes toward evidence-based practices and implementation abilities/barriers (n=220) and 2) the extent of DBT implementation after training completion (n=110). Since 2011, Cork Mental Health Services has been engaged in a systematic implementation of DBT, evaluating client and economic effectiveness, and also including evaluation of the implementation process. The enhanced multi-site implementation process is described and data on the quality of implementation as measured by the PETQ (Schmidt et al, 2011) and the experience of implementation by team leads and therapists are compared to that of the U.S. LI data. Hypotheses informing future work and the contribution the Irish implementation makes to the DBT implementation knowledge based are discussed.

Notes:
Factors Implicated in Successful Implementation: Evidence to Inform Improved Implementation from High and Low/Middle Income Countries

Melanie Barwick, The Hospital for Sick Children, University of Toronto; Raluca Barac, The Hospital for Sick Children; Stanley Zlotkin, The Hospital for Sick Children, University of Toronto; Marnie Davidson, CARE Canada; Laila Salim, Save the Children Canada

Presenter: Melanie Barwick
Contact: melanie.barwick@sickkids.ca

Feasible methods to inform effective and sustainable implementation of evidence in practice require knowledge about which factors are implicated in successful implementation. Our program of research has conducted two studies to explore these factors in the context of Canadian child and youth mental health service providers (high income country) and maternal newborn child health in Ethiopia and Mali (low and middle income countries, LMIC). We used the Consolidated Framework for Implementation Research (CFIR) to examine which of CFIR’s 37 implementation factors were most present in relation to changes (1) in exclusive breast feeding (EBF) rates in Ethiopia and Mali, from baseline to endline, and (2) in the adoption of motivational interviewing in 4 CYMH provider organizations in Ontario. Our comprehensive analysis of CFIR factors is unique in identifying factors that are most implicated in successful implementation of evidence in two distinct contexts, which can support improved efforts moving forward.

Notes:
Implementation Frameworks Applied: The Status Quo in Child, Youth and Family Services

Bianca Albers, Parenting Research Centre; Robyn Mildon, Parenting Research Centre; Aron Shlonsky, University of Melbourne; Aaron Lyon, University of Washington

Presenter: Bianca Albers
Contact: balbers@parentingrc.org.au

In recent years, the growing interest in implementation in the different sectors of human services has led many researchers to develop conceptual frameworks that can be defined as coherent sets of interlinked concepts that – together – constitute a generic structure for describing, understanding or guiding complex implementation processes. A few examples of these frameworks are The Active Implementation Frameworks (Metz & Bartley, 2012), the EPIS Implementation Conceptual Model (Aarons, 2012), The Consolidated Framework for Implementation Research – CFIR (Damschroder, 2009) or The Quality Implementation Framework – QIF (Meyers, Durlak & Wandersman, 2012). However, the application of these frameworks in practice settings is still rare, and our knowledge about the evidence behind these frameworks is limited.

This presentation will give an overview of the results of a scoping review that aimed to
• Identify studies related to the field of child and youth services that apply an implementation framework
• Summarise the results generated through these studies in order to describe the current evidence behind implementation frameworks that have been applied in child and youth services
• Discuss the common and inherent weaknesses of existing implementation frameworks that likely prevent them from rigorous empirical testing through scientific studies

The Scoping review is based on a total 831 papers of which titles and abstracts were screened to determine if they related to evaluations or any other applications of implementation frameworks in the child, youth and family service sector.

Notes:
Tracking Implementation Strategies Prospectively: A Practical Approach

Alicia C. Bunger, Ohio State University; Byron J. Powell, University of Pennsylvania; Hillary Robertson, Ohio State University

Presenter: Alicia C. Bunger
Contact: bunger.5@osu.edu

Descriptions of implementation strategies in the literature often lack precision and consistency, which limits replicability and slows the accumulation of knowledge. Recent publication guidelines for implementation strategies call for improved description of the activities, dose, rationale, and expected outcome of strategies. However, capturing implementation strategies with this level of detail can be challenging, as responsibility for implementation is often diffuse and strategies may be flexibly applied as new barriers and challenges emerge. Few (if any) tools are available for capturing implementation in real-time. We present a practical approach to tracking implementation strategies, which we piloted in an evaluation of a multi-component intervention to improve children’s access to behavioral health services in a county-based child welfare agency. This tracking method gathers monthly accounts of the implementation team’s activity and categorizes it based upon Powell et al.’s (2012) taxonomy of implementation strategies. In addition to type of strategy, the tool captures intent, frequency of use, timing, and individuals involved. This approach allows us to monitor implementation over time, estimate “dose,” and describe temporal ordering of implementation strategies. We will highlight the utility of this approach for implementation research and practice, discuss its limitations, and present avenues for future development.

Notes:
Trained but Not Implementing: The Need for Effective Implementation Planning Tools

Christopher Botsko, Altarum Institute

Presenter: Christopher Botsko
Contact: christopher.botsko@altarum.org

One of the most inefficient and common occurrences when implementing evidence-based practices (EBPs) is that a large number of trained providers do not end up implementing the practice. This presentation explores the phenomena of failure to implement through an evaluation of the Triple P parenting support program. Two communities were provided with resources to implement Triple P through a partnership of Local Health Departments and Federally Qualified Health Centers. Data assessing progress on implementation was collected through surveys of advisory group members and providers, three years of annual interviews with key informants, focus groups with parents and providers, and program tracking. The presentation will use the data to show progress that was made on implementation and the challenges that were faced. Project leadership was provided an implementation framework that drew upon implementation research. Project leadership developed a better understanding of what implementation entailed beyond training but needed more practical tools and information to effectively use the framework. An implementation planning tool will be presented that was developed from feedback from the implementing organizations and other evaluation data. More efforts are needed to evaluate implementation tools that support agencies and communities implementing EBPs.

Notes:
Dialectical Behavior Therapy (DBT; Linehan, 1993) is an evidence-based psychotherapy designed to address suicidal behavior and emotion dysregulation. DBT is effective among female veterans with Borderline Personality Disorder (Koons, et al., 2001) and helpful in reducing VA healthcare costs of veterans (Meyers, Landes, & Thuras, 2014). DBT has been implemented locally across VA. However, DBT suffers from sporadic funding, limited training resources, and lack of evaluation of its spread. Given this, there is a pressing need to document implementation of DBT across VA to inform strategic planning and advocacy.

Using the PARIHS model (Kitson, et al., 1998) as a conceptual framework, the current study is using sequential quantitative and qualitative methods (Creswell & Plano Clark, 2007; Palinkas, et al., 2011) to characterize DBT implementation. Interviews are being conducted with clinicians and administrators at 16 sites. These sites include high and low adopters of DBT (determined by number of components implemented).

This presentation will focus on qualitative data examining the process of implementation and highlight how sites have utilized evidence to make decisions, what contextual factors were barriers or facilitators, and what factors facilitated the process of implementation. Information that is likely generalizable to other interventions will be highlighted.

Notes:
In some effectiveness trials, usual care (UC) therapists have demonstrated ‘successful’ treatment outcomes (e.g., diagnostic remission, reduced symptoms) on par with therapists delivering evidence-based treatments. The goal of the present study is to characterize one such sample of UC therapists by describing (1) the therapeutic interventions delivered and (2) the context in which such interventions were delivered, including therapist characteristics (e.g., training level), child characteristics (e.g., severity of psychopathology), and level of family engagement (e.g., attendance). Therapy process and contextual data were obtained from the UC condition of a randomized controlled trial of CBT for youth anxiety (Southam-Gerow et al., 2010); therapists treated a diverse sample of children, aged 8-15, in community clinics (N=24, 56% female, 38% Caucasian). The extensiveness of interventions delivered was double coded on a 7-point scale using the Therapy Process Observational Coding System of Child Psychotherapy – Revised Strategy Scale (TPOCS-RS; Mean ICC= 0.77; McLeod, Smith, Southam-Gerow, Weisz, & Kendall, 2014). We will describe the delivery of different therapeutic strategies interventions along with the contextual factors described above. Findings may help inform future dissemination and implementation efforts, including training, supervision, consultation, and effective measurement of treatment integrity within community-based mental health settings.

Notes:
Learning from Implementation as Usual in Children’s Mental Health

Byron J. Powell, University of Pennsylvania; Enola K. Proctor, Washington University in St. Louis

Presenter: Byron J. Powell
Contact: bjpowell@email.unc.edu

To ensure that implementation strategies are feasible, acceptable, sustainable, and scalable, efforts to identify and develop implementation strategies need to be grounded by a thorough understanding of real-world service systems and what constitutes “implementation as usual.” The aim of this multiple case study was to identify and characterize the strategies used in six children’s mental health organizations, and to evaluate the extent to which implementation as usual reflects best practices specified in the implementation literature. Semi-structured interviews and focus groups were conducted with organizational leaders (n=27) and clinicians (n=58) respectively. Interviews were recorded, transcribed verbatim, and analyzed using qualitative content analysis. Across organizations, provider-focused strategies (e.g., training, supervision) were dominant; however, these strategies were not offered at the frequency and intensity required to implement EBTs effectively. Multiple areas of implementation were not well addressed, including process, client, organizational, financial, and policy levels. Several problematic trends related were identified, such as the inconsistent provision of training and supervision, monitoring fidelity in unhelpful ways, and failing to measure or appropriately utilize clinical outcome data. We suggest how these results can inform the development of implementation strategies that will be practical and effective, and discuss implications for practice, policy, and research.

Notes:
Cognitive Processing Therapy in the Democratic Republic of Congo: Moving From RCT to Implementation

Debra Kaysen, University of Washington; Cindy Stappenbeck, University of Washington; Monika Bakayoko-Topolska, International Rescue Committee; Katie Robinette, International Rescue Committee; Viviane Maroy, International Rescue Committee; Paul Bolton, Johns Hopkins University, Bloomberg School of Public Health; Judith K. Bass, Johns Hopkins University, Bloomberg School of Public Health

Presenter: Debra Kaysen
Contact: dkaysen@u.washington.edu

There is high need for mental health care services for sexual violence victims in eastern Democratic Republic of Congo (DRC) but few services exist. In a recent randomized clinical trial (RCT), Congolese psychosocial assistants delivered group Cognitive Processing Therapy – Cognitive (CPT-C) in community mental health settings, with significant improvements in PTSD, depression, and overall functioning (Bass et al., 2013). A recent first stage implementation study trained 14 health workers employed in public health facilities in delivery of Group CPT-C. Fifty four women participated in CPT-C groups in the implementation study and we compared results to the 158 women and 7 counselors from the original RCT in terms of symptoms scores, change in symptoms over time, and whether study (i.e., RCT vs. implementation) impacted symptom change. We conducted a generalized estimating equation (GEE) and specified an autocorrelation of 1, a Gaussian distribution with an identity link, and robust standard errors. We found symptoms significantly decreased across the 12 sessions, b = -1.90, 95% confidence interval (CI): -1.99, -1.82, p < .001. Change in symptoms did not differ for those in the RCT versus implementation study, b = -0.07, 95% CI: -0.32, 0.19, p = .61. Results suggest complex cognitive behavioral therapies can be implemented and delivered in low resource community health settings by paraprofessionals.

Notes:
Impact of Training and Clinician Allegiance on Adherence to DBT Model in a Public Sector Mental Health Team in Australia

Carla Walton, Centre for Psychotherapy, Hunter New England Mental Health Service & University of Newcastle

Presenter: Carla Walton
Contact: Carla.Walton@hnehealth.nsw.gov.au

The Centre for Psychotherapy is a public sector specialist service for Borderline Personality Disorder in Newcastle, Australia. We conducted a Randomised Clinical Trial of Dialectical Behaviour Therapy (DBT) and the Conversational Model (CM; a psychodynamic therapy) for individuals with Borderline Personality Disorder between 2007 and 2014. Some therapists delivered the intervention in both therapy arms of the trial, some DBT only and some CM only. All therapists treating patients in the DBT arm of the study had some training in DBT before commencing in the trial. Ten days of DBT intensive training then occurred in 2010. Throughout the duration of the trial, sessions were audio recorded. Adherence coding was conducted on a subset of sessions for each therapist-patient dyad for both DBT and CM. Adherence coding was commenced in 2013 and feedback was not provided to the therapists during the trial. Therapists self-rated regarding their allegiance to each treatment model as well as being rated by other therapists in the service regarding their therapeutic allegiance. This presentation will focus particularly on DBT and will report on the impact of training as well as clinicians’ allegiance on adherence scores, with a focus on whether potential improvements from DBT intensive training were sustained in the long-term.

Notes:
Rates and Predictors of Implementation after Dialectical Behavior Therapy Intensive Training

Melanie S. Harned, University of Washington & Behavioral Tech, LLC; Marivi Navarro-Haro, University of Washington; Kathryn E. Korslund, University of Washington; Tianying Chen, University of Washington; Anthony DuBose, Behavioral Tech, LLC; Andre Ivanoff, Behavioral Tech, LLC; Marsha M. Linehan, University of Washington

Presenter: Melanie S. Harned
Contact: mharned@uw.edu

Background: Dialectical Behavior Therapy (DBT) Intensive Training is the gold standard for training clinicians to deliver DBT. This team-based training includes two 5-day workshops separated by a 6-month period for self-study and implementation. Although DBT Intensive Training has been widely used, little research has evaluated its effectiveness. The present study evaluates the rates and predictors of implementation of DBT after DBT Intensive Training.

Method: Participants were attendees at 9 DBT Intensive Trainings (n=411 clinicians from 81 teams) conducted from 2012-2013. All attendees completed self-report measures at Part 1 and Part 2. In addition, team leaders completed a follow-up survey 6-12 months after Part 2 to assess implementation.

Results: Overall, 75% of teams had implemented all four DBT modes after training. Only 2% of teams had not implemented any DBT mode. Teams with fewer training and program needs and more positive attitudes toward evidence-based practice implemented significantly more DBT modes after training. In contrast, teams with a higher proportion of bachelor’s-level clinicians as well as clinicians with less prior experience delivering DBT implemented significantly fewer DBT modes.

Conclusion: These findings provide evidence of the effectiveness of DBT Intensive Training in promoting implementation of DBT among clinicians from diverse practice settings.

Notes:
Contextual Determinants of Research Evidence Use in Public-Youth Systems of Care

Antonio Garcia, University of Pennsylvania; Lawrence A. Palinkas, University of Southern California; Minseop Kim, University of Pennsylvania; Lonnie Snowden, University of California - Berkeley; John Landsverk, Oregon Social Learning Center

Presenter: Antonio Garcia
Contact: antgar@sp2.upenn.edu

While evidence-based practices (EBPs) exist to promote positive developmental outcomes among at-risk youth, they are not implemented to fidelity (Axford & Morpeth, 2013). One way to address this gap is to understand and promote conditions through which evidence is used (Barwick et al., 2008). This study identified which contextual determinants (poverty, foster care placements, mental health expenditure) predict research evidence use (REU). Public records from 37 counties in California were collected in 2008; and child welfare, juvenile justice, and mental health system leaders’ (n=96) perceptions of their REU while implementing an EBP were measured via the Structured Interview of Evidence Use (SIEU) between 2010 and 2012 (Palinkas et al., 2012). The 45-item SIEU assesses the extent to which system leaders obtain research evidence (input), whether they assess the validity (process), and when they use evidence (output). Regression results showed an inverse relationship between mental health expenditures and REU. Higher educational attainment increased the likelihood of REU. Positive relationships between scores on the “input” subscale and racial minority concentration and poverty were detected. Findings underscore the need to identify organizational conditions by which mental health expenditures influence REU, and hire providers with graduate degrees to ensure EBPs are implemented.

Notes:
Mobile Community Mapping to Integrate Evidence-Based Depression Treatment in Primary Care in Brazil: A Pilot Project

Annika Sweetland, Columbia University/New York State Psychiatric Institute; Maria Jose Fernandes, Itaborai Municipality of Health, Brazil; Edilson Francisco dos Santos, Itaborai Municipality of Health, Brazil; Cristiane Duarte, Columbia University/New York State Psychiatric Institute; Afranio Kritski, Federal University of Rio de Janeiro; Noa Krawczyk, Columbia University/New York State Psychiatric Institute; Caitlin Nelligan, Columbia University/New York State Psychiatric Institute; Milton Wainberg, Columbia University/New York State Psychiatric Institute

Presenter: Annika Sweetland
Contact: acs2124@columbia.edu

Several evidence-based interventions (EBIs) for depression have been adapted and demonstrated efficacious in diverse low-resource settings, but few of these innovations have been brought to scale within ‘real world’ health systems. In preparation for a dissemination and implementation study to integrate evidence-based depression treatment in primary care using tuberculosis (TB) as a model in Itaboraí, Brazil, this study will use GPS-enabled smartphones to create a map of currently available mental health care services. With the administrative and logistical support from the Itaboraí Municipal TB Program, two research assistants will conduct brief face-to-face interviews in all 49 public health facilities in Itaboraí to record basic characteristics including the type, location (GPS coordinates), size, structure and staffing, with a particular focus on adult mental health services and resources, and the current management of depression in individuals with TB. The interactive web map will be used to plan for the integration of evidence-based MDD treatment within the Itaboraí health system, as well as serve as platform for planning health services for other medical conditions in Itaboraí. Data collection is scheduled to occur from January – April 2015.

Notes:
The Use of Concept Mapping to Efficiently Identify Determinants of Implementation in the NIH-PEPFAR PMTCT Implementation Science Alliance

Gregory A. Aarons, University of California, San Diego; David Sommerfeld, University of California, San Diego; Rachel Sturke, NIH Fogarty International Center; Lydia Kline, NIH Fogarty International Center; Laura Guay, Elizabeth Glazer Pediatric AIDS Foundation; George Siberry, NIH National Institute of Child Health and Human Development

Presenter: Gregory A. Aarons
Contact: gaarons@ucsd.edu

HIV acquisition for children in sub-Saharan Africa occurs primarily from mother-to-child transmission during pregnancy, childbirth, or breastfeeding. The NICHD in collaboration with the NIH Fogarty International Center and PEPFAR, established the PMTCT Implementation Science Alliance (ISA) that serves as a platform to bring together NIH R01 implementation science grantees along with program implementers and policy-makers. Studies took place in Kenya, Mozambique, Nigeria, Zambia, South Africa, and the Democratic Republic of Congo. ISA members have a multi-dimensional vantage point to identify key implementation factors for PMTCT interventions across countries, communities, and cultures. We utilized Concept Mapping (CM), a mixed qualitative/quantitative method, over a two-week period, to distill implementation issues across projects and stakeholders. ISA members responded to the focus question: “In your experience, what factors have facilitated or hindered implementation of PMTCT interventions?” Over 150 responses from ISA members (N=50) online or in-person were distilled to 88 distinct statements. ISA members (n=28) sorted statements into categories based on similarity and sort matrices were analyzed using multidimensional scaling and hierarchical cluster analysis. Fourteen key factors that influenced the implementation of PMTCT were identified. CM can be efficiently utilized for understanding issues for multiple implementation strategies across stakeholders, cultures, countries, and health systems.

Notes:
Application of a Multi-Level Implementation Framework to Evaluate Ontario’s Province-Wide Healthy Babies Healthy Children Program

Heather Manson, Public Health Ontario; Adrienne Alayli-Goebbels, Public Health Ontario; Anne Philipneri, Public Health Ontario; Helen Cerigo, Public Health Ontario; Lori Webel-Edgar, Public Health Ontario; Sarah Muir, Public Health Ontario

Presenter: Heather Manson
Contact: heather.manson@oahpp.ca

Introduction: Ontario’s Healthy Babies Healthy Children (HBHC) program aims to provide services to families to help children achieve their full potential. In 2013, program enhancements were introduced to strengthen services to vulnerable families. A process evaluation was conducted to understand how local public health units (PHU) implemented these enhancements during the first six months, and to explore factors contributing to implementation outcomes.

Methods: An adapted multi-level implementation framework by Chaudoir et al. guided our evaluation. Based on the framework, we used an embedded mixed methods design to explore factors at different levels (innovation, client, provider, organization, and system levels) that may have contributed to implementation outcomes (program reach, fidelity and other outcomes related to program enhancements).

Results: Factors that positively impacted implementation included the multi-faceted approach to facilitate program changes at the PHU level, highly committed HBHC staff, positive organizational cultures within PHUs, and staff’s openness to change. Challenges included increased staff workload and ongoing engagement with community partners for service delivery. Underlying population characteristics, health unit size, and local adaptations partially explained variability across PHUs.

Conclusion: The implementation framework was useful in planning our evaluation. Based on the evaluation results, recommendations were provided to improve the HBHC program implementation.

Notes:
Assessing Implementation Fidelity in Ontario’s Healthy Babies Healthy Children Program

Eunice Chong, Public Health Ontario; Adrienne Alayli-Goebbels, Public Health Ontario; Anne Philipneri, Public Health Ontario; Helen Cerigo, Public Health Ontario; Lori Webel-Edgar, Public Health Ontario; Sarah Muir, Public Health Ontario

Presenter: Eunice Chong
Contact: eunice.chong@oahpp.ca

Introduction: The Healthy Babies Healthy Children (HBHC) program is funded by the Ontario Government and is being implemented in all 36 local public health units (PHUs) across Ontario. The guidance document for the enhanced HBHC program specifies fidelity requirements including HBHC Screen completion and follow-up of postpartum clients screened within 48 hours. In our evaluation, we examine fidelity by assessing the extent to which these and other core components were carried out in all PHUs.

Methods: Client data on screen completion rates, 48-hour contact rates, and other program components were extracted from the HBHC administrative database. Survey and focus groups with PHU staff provided insights related to their experiences in implementing these components.

Results: Overall, 66% of the HBHC screens were complete, with high levels of variation across PHUs in 48-hour contact (9–89%) and other key components. Findings from surveys and focus groups revealed the challenges that PHUs faced in implementing these functions, and different strategies used to address these challenges, including local adaptations.

Conclusion: Results showed that fidelity to core components greatly varied during the first six months of the enhanced HBHC program. PHUs will require additional supports in order to improve the consistency of program delivery.

Notes:
Introduction: Results from Ontario’s Healthy Babies Health Children process implementation evaluation were presented at a provincial level. However, local public health unit (PHU) level findings were anonymized. In this presentation, we describe a tailored approach to broker and disseminate evaluation findings, as guided by Graham et al.’s Knowledge-to-Action framework.

Methods: We customized individual PHU reports that included data related to reach and fidelity specific to each of Ontario’s 36 PHUs and allowed for geographical comparisons. To facilitate knowledge uptake, tailored dissemination meetings were organized with individual PHUs to help program staff understand their evaluation results, and to discuss how results can support continuous quality improvement. An online survey was developed to measure the awareness and reception of the evaluation results, and to evaluate the usefulness of the individualized report and dissemination meeting to support evidence uptake. The survey was completed by PHU staff who attended the meetings.

Results: All 36 individual PHU dissemination meetings have been completed. Descriptive analysis of the survey results will be shared at the time of the presentation.

Conclusion: Tailoring results and dissemination methods for intended knowledge users can help facilitate knowledge application and can help identify local strategies for continuous program improvement.

Notes:
The Impacts on Program Reach of Cumulative Declines and Losses to Contact as Clients Traverse the Multi-Step Healthy Babies Healthy Children Program

*Heather Manson, Public Health Ontario; Helen Cerigo, Public Health Ontario; Eunice Chong, Public Health Ontario*

Introduction: Ontario’s Healthy Babies Healthy Children (HBHC) program includes screening, contact, in-depth assessment (IDA), and referrals to blended home visiting (BHV) and community services. For an evaluation of the enhanced HBHC program, we assessed program reach as an implementation outcome by examining cumulative declines and losses of clients at each step of the program.

Methods: Client data were extracted from the HBHC administrative database, with reach denominators at each step defined as those who successfully completed the step immediately before. Characteristics of those reached were collected from the initial screening.

Results: In the first six months of the enhanced program, 46% of postpartum clients screened with risk (25,930). Progressive client declines and losses to follow-up meant that only 37% of these went on to IDA and 9% were referred to BHV. Clients with pregnancy, labour and delivery related risk factors were less likely to receive IDA and BHV compared to those with socioeconomic and parenting risks.

Conclusion: Progressive client declines and losses to follow-up impact program reach in multi-step programs. Our evaluation demonstrated advantages to using existing administrative data for program evaluation, and present opportunities to explore reasons for declines/losses and optimize service outcomes.

Notes:
A major obstacle to achieving the benefits to patients observed in effectiveness trials of complex interventions in large scale implementation efforts is the limit of resources available to support the training to mastery of staff carrying out the intervention. Although ongoing support in the form of training, technical assistance, quality improvement, and tools improves both implementation and patient outcomes through longitudinal consultation by content experts, most large implementation efforts rely primarily on brief intensive training for staff because of cost limitations. We conceptualize consultants as intervention-specific practice facilitators. We have developed an innovative and pragmatic remote model of longitudinal consultation for implementation of the team based collaborative care intervention for treatment of adult depression in primary care. Targeting key elements of the intervention we make use of video conferencing technologies to allow consult liaison psychiatrists to deliver this consultation to many sites simultaneously in an efficient manner. Key elements of this implementation strategy, measurement tools, and our experience with the model used in an ongoing multi-state implementation effort will be presented.

Notes:
Integrating a Peer Coach Model to Support Program Implementation and Ensure Long-term Sustainability of the Incredible Years in Community-based Settings

Jennifer Schroeder, The Implementation Group; Lane Volpe, The Implementation Group; Julie Steffen, Invest in Kids

Presenter: Jennifer Schroeder
Contact: jen@theimplementationgroup.com

The Incredible Years (IY) is an evidence-based social-emotional skill-building program implemented in school- and community-based settings. As a community partner, Invest in Kids (IIK) serves as the Intermediary Purveyor in Colorado and provides support functions required for effective implementation, including readiness assessment, and ongoing training and coaching necessary to ensure sustainable replication of evidence-based programs. Since 2011, 30 teachers with at least two years of experience implementing the program have participated in ten days of peer coach training. Each participant completed satisfaction and readiness surveys after each day of training so that IIK could support skill development in preparation for implementation of the Peer Coach model. During the 2012-2013 school year, peer coaches began providing on-site coaching to their fellow teachers and themselves received ongoing supervision and coaching to ensure consistent delivery of the peer coach model. Peer coaching has been identified by IIK as an essential strategy for fostering community readiness, site-level sustainability, and ensuring long-term quality implementation.

Notes:
Efficient Sustainability: Existing Community Based Supervisors as EBT Supports

Shannon Dorsey, University of Washington; Michael D. Pullmann, University of Washington; Suzanne E. Kerns, University of Washington; Nathaniel Jungbluth, University of Washington; Lucy Berliner, University of Washington; Kelly Thompson, University of Washington; Eliza Segell, University of Washington

Presenter: Shannon Dorsey
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Existing community-based supervisors (CBS) are an underutilized resource for supporting EBP in community mental health, despite the fact that CBS offer an efficient and affordable mechanism for strengthening the implementation of EBPs. We present data from a study of CBS involved in a state-supported EBT effort—the Washington State Trauma-focused CBT Initiative. This study provides the only examination, to our knowledge, of how supervision time is spent by CBS and clinicians trained in EBT. Supervisors (N = 42) and clinicians (N=167) report a high concordance of time spent on a variety of supervision topics, many of which are not clinically focused. Time spent on two EBT-critical activities—case conceptualization and treatment intervention—make up less than half of the supervision time. How much time was spent on these activities was associated with organizational climate—clinicians reporting higher stress and lower cohesion at their organization reported less time dedicated to these two activities. Notably, both supervisors (76.2%) and clinicians (74.8%) overwhelmingly report a desire for more time on case conceptualization and treatment intervention. We discuss implications of multiple demands on CBS for EBT implementation and present preliminary findings from a RCT designed to better integrate these two activities into supervision.

Notes:
From Theory to Practice: Conducting Implementation Facilitation Interventions in Clinical Settings

JoAnn E. Kirchner, VA Mental Health Quality Enhancement Research Initiative (QUERI), Central Arkansas Veterans Healthcare System, Department of Psychiatry, University of Arkansas for Medical Sciences; Jeffrey L. Smith, VA Mental Health Quality QUERI, Central Arkansas Veterans Healthcare System

Presenter: Sara J. Landes
Contact: sara.landes@va.gov

Implementing new practices and sustaining clinical practice change is challenging. Decades of organizational science research and more recent implementation science studies have identified limitations in both top-down mandates and bottom-up approaches to implementing practice change. The Promoting Action on Research Implementation in Health Services (PARIHS) framework suggests that successful implementation is a function of the dynamic interaction between context, evidence and facilitation. Implementation Facilitation (IF) has shown great promise as a strategy for implementing programs and practices, particularly at locations that would otherwise face significant challenges in conducting quality improvement efforts. IF strategies bundle discrete implementation interventions and focus on building relationships and partnering with clinical and administrative personnel. Facilitators use particular activities and techniques depending on the purpose of facilitation, stakeholder needs and the complexity of the clinical program or practice being implemented. This presentation will provide an overview of implementation facilitation, framed within PARIHS, and describe the development and evaluation of a highly partnered implementation facilitation model used within VHA.

Notes:
Establishment of a National Practice-Based Implementation Network to Accelerate Adoption of Evidence-Based and Best Practices

Pearl McGee-Vincent, National Center for PTSD, VA Palo Alto Health Care System; Nancy Liu, National Center for PTSD, VA Palo Alto Health Care System; Robyn Walser, National Center for PTSD, VA Palo Alto Health Care System, University of California, Berkeley; Jennifer Runnals, Durham VA Medical Center, VISN 6 MIRECC, Duke University School of Medicine; R. Keith Shaw, Mid-Atlantic (VISN 6) MIRECC, Durham VA Medical Center; Sara J. Landes, National Center for PTSD, VA Palo Alto Health Care System; Craig Rosen, National Center for PTSD, VA Palo Alto Health Care System, Stanford University; Janet Schmidt, National Center for PTSD, VA Palo Alto Health Care System; Patrick Calhoun, VA Mid-Atlantic Mental Illness Research Educational & Clinical Center

Presenter: Sara J. Landes
Contact: sara.landes@va.gov

Practice-Based Research Networks (PBRNs) are groups of providers and researchers working together to examine health care processes in broad populations of patients and settings in an effort to improve health care outcomes. We adapted this model and developed a Practice-Based Implementation Network in the U.S. Department of Veteran Affairs and Department of Defense. The goal of this national network is to facilitate ongoing and rapid implementation of mental health best practices including the treatment of PTSD. The network uses qualitative and quantitative methodologies to enable the efficient study of factors affecting adoption of practices. We have successfully applied two implementation strategies, technical assistance and external facilitation, with 18 VA clinics (including 151 providers from a range of disciplines) across different settings (e.g., specialty PTSD, general mental health, primary care clinics) in instituting mental health outcomes monitoring. Information sharing and collaboration among the network sites is facilitated with monthly champion calls, a network website, and activities geared at fostering peer support. This presentation will describe design, development, and operation of the network, as well as data on characteristics of sites and outcomes of the first practice change.

Notes:
Facilitation as a Mechanism of Implementation in a Practice-Based Implementation Network: Improving Care in a Veteran’s Affairs PTSD Outpatient Clinic

Ruth L. Varkovitzky, VA Puget Sound Health Care System – American Lake Division; University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences

Presenter: Ruth L. Varkovitzky
Contact: Ruth.Varkovitzky@va.gov

Facilitation is a problem-solving based method for supporting entities in the process of implementing a practice change. The purpose of a facilitation strategy is to speed adoption and reduce costs associated with systems change. Facilitation was the primary implementation process incorporated into the Practice-Based Implementation Network (“PBI Network”) created by the U.S. Department of Veteran Affairs and Department of Defense. The main goal of the first PBI Network project was to assist mental health professionals in adopting outcomes monitoring. In this presentation, we will describe how facilitation functioned within a PTSD Outpatient Clinic in the VA health care system. Step-by-step descriptions of the facilitation process will be described by an on-site EBP champion, responsible for implementation of an outcomes monitoring project within her clinic. The panelist will describe her experience working with facilitators, as well as the process of bringing a clinical team on board to a new project. Lessons learned from implementation barriers will also be shared. The effect of sites’ contextual variables such as workload, resourcing, experience with evidence-based practices, and management style on facilitation strategies will also be discussed.

Notes:
The ACT SMART Toolkit: An Implementation Strategy for Community-Based Agencies Providing Services to Children with Autism Spectrum Disorder

Amy Drahota, San Diego State University; Jonathan I. Martinez, San Diego State University; Brigitte Brikho, San Diego State University; Rosemary Meza, University of Washington; Aubyn C. Stahmer, University of California, Davis; Gregory A. Aarons, University of California, San Diego

Presenter: Amy Drahota
Contact: adrahota@mail.sdsu.edu

One in 68 U.S. children is diagnosed with Autism Spectrum Disorder (ASD), costing approximately $35 billion for services annually. Typically, ASD community providers (CPs) provide services to children with ASD using treatments with variable evidentiary support. Despite positive outcomes of EBP use, implementation practices have not been systematically studied in this setting. This study evaluated implementation practices used by community-based agencies providing ASD services to children. CPs (n=27) and agency leaders (ALs) (n=20) completed the Autism Model of Implementation Survey. ALs (n=10) participated in qualitative interviews. Data (Quan→QUAL) was converged for triangulation within and across methods. Results identified multiple challenges for implementing EBPs within ASD community agencies including: no existing systematic implementation strategies fitting this setting; lack of structure and consistency with implementation efforts; agency leader uncertainty; and organizational, provider, and treatment characteristics impacting implementation. Results indicate the need for the development of a comprehensive implementation strategy. The ACT SMART Toolkit is such a strategy to support agencies in successfully implementing new EBPs by assisting in identifying training/service delivery gaps, selecting effective treatments to meet needs, facilitating treatment adoption decisions, guiding the design of effective training and implementation strategies, and supporting efforts to sustain effective treatments.

Notes:
The Collaborative Intervention Planning Framework: An Approach to Engage Stakeholders in Preparing and Customizing Interventions for Implementation

Leopoldo J. Cabassa, Columbia University School of Social Work; Dianna Dragatsi, New York State Psychiatric Institute; Richard Younge, Columbia University; Roberto Lewis-Fernández, New York State Psychiatric Institute

Presenter: Leopoldo J. Cabassa
Contact: ljc2139@columbia.edu

Implementing health-care interventions in public mental health clinics is a pressing need since people with serious mental illness (SMI) face persistent health disparities. Few studies currently exist describing collaborative approaches that can be used to prepare healthcare interventions for routine practice in public mental health clinics. The aim of this NIMH-funded study is to describe the application of the collaborative intervention planning framework, an approach that combines community-based participatory research principles and intervention mapping procedures [3], to inform the adaptation of a health-care manager intervention to a new population (Hispanics) and provider group (social workers) to enhance its use in public mental health clinics. The framework included four steps: fostering collaborations between stakeholders (e.g., social workers, physicians, peer advocates) understanding the needs of the local population through a mixed-methods needs assessment, literature reviews, and group discussions; reviewing intervention objectives to identify targets for adaptation; and developing the adapted intervention. This process enabled stakeholders to identify a series of cultural and provider level-adaptations without compromising core intervention elements. This study illustrates one approach that can be used to engage stakeholders in the intervention adaptation process to enhance the transportability of interventions to address health disparities among people with SMI.

Notes:
Breakout E3 Partnering with EBT Champions Across Health Care Settings  
MC: Doyanne Darnell

**Community Capacity Building: Training Providers to Address the Psychological Health of Military Families through HomeFront Strong**

*Laura Neremberg, University of Michigan; Michelle Kees, University of Michigan; Adrian Blow, Michigan State University*

Presenter: Laura Supkoff Neremberg  
Contact: lneren@med.umich.edu

Since 9/11, the United States has relied significantly on the Reserve Component (RC) of the military, with deployments to high-risk war zones that have been frequent and lengthy. Though such deployments significantly impact military families, there are few services available to support the mental health and wellbeing of spouses, particularly in civilian communities where RC families are embedded. Our study seeks to address these unmet needs, by utilizing HomeFront Strong (HFS), an 8-week psychological health intervention for military spouses incorporating evidence based strategies from Cognitive Behavior Therapy, Dialectical Behavior Therapy, and Positive Psychology. Given promising Phase I findings coupled with a vital public health need for effective programs for this population, we are currently underway with an effectiveness-implementation hybrid design study that puts an emphasis on community capacity building and includes efforts to foster public-private partnerships for collaboration. Our design represents an effort to provide quality training that can be utilized by community practitioners in their current practices, while recruiting and training providers to implement HFS. Strategies and challenges around utility, acceptability, and sustainability of HFS provide a useful model for understanding the process of dissemination of knowledge and programming tailored for a population with particular challenges and needs.

**Notes:**
Many governments internationally have committed to better use of evidence from research in policy. Although many programs are directed at assisting agencies to better use research, there have been few tests of the effectiveness of such programs. This paper describes the protocol and early findings from SPIRIT (Supporting Policy In Health with Research: an Intervention Trial), a stepped wedge cluster randomised trial set in Sydney, Australia and designed to test the effectiveness of a multifaceted program to build organisational capacity for the use of research evidence in policy and program development. The primary aim is to determine whether SPIRIT results in an increase in the extent to which research and research expertise is sought, appraised, generated and used in the development of specific policy products produced by health policy agencies.
From EBP Initiatives to Infrastructure: Lessons Learned from a Public Behavioral Health System’s Efforts to Promote Evidence Based Practices

Ronnie M. Rubin, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services; Byron J. Powell, University of Pennsylvania; Matthew O. Hurford, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services; Shawna Weaver, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services; Rinad S. Beidas, University of Pennsylvania; David S. Mandell, University of Pennsylvania; Arthur C. Evans, Philadelphia Department of Behavioral Health and Intellectual Disabilities Services

Presenter: Ronnie M. Rubin
Contact: ronnie.rubin@phila.gov

Over the past decade, the field of implementation science has shifted from a focus on therapist knowledge, skills, and behavior to the inclusion of larger contextual and system factors that influence implementation and clinical outcomes. The Philadelphia Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) has undergone a similar shift in how evidence based practices (EBPs) are promoted from a system-level perspective. DBHIDS has supported several EBP initiatives, including Cognitive Behavioral Therapy, Prolonged Exposure, Trauma-focused CBT and Dialectical Behavior Therapy. These initiatives have included training, consultation, and implementation support to provider agencies. Implementing multiple EBPs simultaneously in a system has provided a unique vantage point to formulate lessons learned about community EBP implementation. We will present data on the training outcomes and sustainment of these practices, discuss key lessons learned, and describe how DBHIDS early experiences have shaped subsequent efforts to develop an infrastructure for EBP implementation by: 1) aligning system operations, 2) supporting the development of general organizational capacities, and 3) prioritizing the use of data driven decision making and outcome evaluation. Examples of specific strategies intended to support this infrastructure will be presented and future system and research directions will be discussed.

Notes:
Applying the Policy Ecology Model to Philadelphia’s Behavioral Health Transformation Efforts

Byron J. Powell, University of Pennsylvania; Rinad S. Beidas, University of Pennsylvania; Rebecca E. Stewart, University of Pennsylvania; Courtney Benjamin Wolk, University of Pennsylvania; Ronnie M. Rubin, Philadelphia Department of Behavioral Health and Intellectual disAbility Services; Samantha Matlin, Philadelphia Department of Behavioral Health and Intellectual disAbility Services; Arthur C. Evans, Philadelphia Department of Behavioral Health and disAbility Services; Trevor R. Hadley, University of Pennsylvania; David S. Mandell, University of Pennsylvania

Presenter: Byron J. Powell
Contact: bjpowell@email.unc.edu

Most implementation frameworks emphasize that increasing the use of evidence-based practice requires support at the intervention, individual, team, organizational, and broader system levels; however, most implementation strategies focus narrowly on educating and supporting clinicians. Raghavan et al. (2008) argued the importance of addressing the ‘policy ecology,’ which includes organizations, regulatory and purchasing agencies, political entities, and broader social forces. The present study applied Raghavan et al.’s (2008) policy ecology model to characterize the Philadelphia Department of Behavioral Health’s (DBH) efforts to implement evidence-based practices. Documents (e.g., published reports, white papers, and meeting notes) and semi-structured interviews with DBH leadership and treatment developers were analyzed using qualitative content analysis to identify implementation strategies and match them to the policy ecology levels specified by Raghavan et al. (2008). Results suggest that DBH has used strategies at each level of the policy ecology. We discuss strengths and weaknesses of DBH’s efforts, and suggest several implications for theory, research, and policy. This study contributes to the emerging literature on system-level implementation strategies, demonstrates how they can be used to promote the integration of effective practices, and broadens the scope of activities typically described or empirically tested in the implementation literature.

Notes:
A Model for Providing Methodological Expertise to Advance Dissemination and Implementation of Health Discoveries in Clinical and Translational Science Award (CTSA) Institutions

Donald Gerke, Washington University in St. Louis; Beth Prusaczyk, Washington University in St. Louis; Ana Baumann, Washington University in St. Louis; Ericka Lewis, Washington University in St. Louis; Enola K. Proctor, Washington University in St. Louis

Presenter: Donald Gerke
Contact: dgerke@wustl.edu

Background: Institutions supported by CTSAs are tasked with advancing translational science. The Dissemination and Implementation Research Core (DIRC) at Washington University’s CTSA provides methodological expertise to advance scientific agenda and grant writing to dissemination and implementation (D&I) of health discoveries.

Methods: Strategies employed by DIRC include: providing consultation to investigators during one-on-one appointments and weekly walk-in clinic; creating “toolkits” for each area of D&I to assist DIRC members during consultations and provide investigators with tools to strengthen their own capacity to conduct D&I research; working with a strong team comprising masters and doctoral-level research assistants, each with a focused area in D&I. DIRC team building activities include semi-monthly meetings for quality assurance and mentoring of each members’ own work in D&I research.

Results: Since its inception in 2011, the number of DIRC customers has steadily increased. In 2011, 19 investigators sought DIRC resources, followed by 29 in 2012 and 30 in 2013. Although there was a slight decrease in 2014 (N=24), as of February 2015, DIRC had assisted 50% more customers than were seen during the first two months of 2014.

Discussion: DIRC may serve as a model for other CTSAs supporting investigators in the development of translational research proposals.

Notes:
Establishing a Research Agenda for the Triple P Implementation Framework

Jenna McWilliam, Triple P International; Jacquie Brown, Triple P International

Presenter: Jenna McWilliam
Contact: jenna@triplep.net

The Triple P Implementation Framework supports communities to establish Community Implementation Systems to develop the capacity for effective, sustainable program implementation. This means that programs scale up at a pace that allows for maximum community benefit. The challenge now is how to evaluate the effectiveness of the Framework. This presentation focuses on two research projects that represent the beginning of a research agenda to evaluate the Framework. The first research project evaluated the impact on uptake and effective delivery of a key component of Triple P implementation support, the Pre-Accreditation Workshop. This workshop was introduced as a strategy to improve practitioner’s completion of the Triple P. This is a critical element of implementing Triple P, with previous research showing that practitioners who complete accreditation are more likely deliver the program. The second research project explored the implementation experiences of practitioners, examining the relationship between the practitioner’s implementation experience within their organisation, their perceptions of implementation climate and their use of Triple P in the last twelve months. Implications of these research findings will be discussed both in the context of supporting the implementation of evidence-based programs and developing a research agenda to evaluate the effectiveness of implementation strategies.

Notes:
Cheap and Fast, but What is “Best?” Examining Implementation Outcomes Across Sites in a State-Wide Scaled-Up Evidence-Based Walking Program

*Kathleen Conte, Oregon State University*

Presenter: Kathleen Conte  
Contact: kpconte@gmail.com

Scaling-up programs through established delivery systems can accelerate dissemination and reduce costs, however, research guiding best-practices for scaling-up and evaluating outcomes is lacking. This mixed-method study examines outcomes of a two-year state-wide scale-up of a simple, evidence-based walking program in relationship to cost, speed, and effectiveness of implementation.

To facilitate implementation and share resources, multi-sector community partnerships were established. Partners contributed volunteer/staff time to delivery in exchange for training and materials. Participant outcomes (n=598) were assessed via registration/satisfaction forms; scale-up outcomes were assessed via interviews with leaders (n=39), administrative reports and observations.

In-person leader trainings (versus online) accelerated leader recruitment and initiation. Scale-up outcomes (e.g. fidelity, leader recruitment and initiation, class size and participant retention) will be presented to describe variation in effectiveness by site type. Classes implemented by staff [OR=3.1, p<.05] and senior centers [OR=3.0, p<.05] best retained program participants. Interviews indicated implementation was enhanced in sites whose leaders who demonstrated clear understanding of program goals and saw the program as good fit.

Maximizing partnerships contributed to fast and cheap wide-scale implementation. By engaging volunteers in personal interaction via in-person trainings, scope, speed, and quality of implementation were improved. We discuss implications for managing and evaluating scaled-up program delivery.

**Notes:**
Which Treatments Does Our Agency Need and Which Do We Know Already?

Michael A. Southam-Gerow, Virginia Commonwealth University; Selamawit Hailu, Virginia Commonwealth University; Adam Bernstein, Practicewise, LLC

Presenter: Michael A. Southam-Gerow
Contact: MASouthamGer@vcu.edu

With increasingly limited budgets, public mental health agencies are charged with the delivery of high-quality mental health services to a population of clients with significant and diverse impairments. Evidence-based treatments (EBTs) offer one solution to this challenge. However, which EBTs are most appropriate for an agency given their client population (i.e., problems, age, ethnicity) and given what therapists already know?

We conducted a pilot study with two goals: 1) identify some best-fit EBTs for the agency given patient population characteristics and 2) determine which are currently used by therapists.

To accomplish these goals, we analyzed data from more than 300 clients who received services at the agency in the past 5 years, mapping their (a) problem, (b) age, (c) sex, and (d) ethnicity to the literature to identify the most efficient set of programs and practices. Second, we conducted therapist surveys using the Monthly Treatment Progress Summary (e.g., Orimoto et al., 2013) with current therapists, asking them to identify the practices they used with their current clients and what outcomes they had observed.

We present findings descriptively and identify a few possible solutions to the agency’s question of which treatments would make reasonable targets for a training initiative.

Notes:
Efficient Methodologies for Monitoring Fidelity in Routine Implementation: Lessons from the Allentown Social Emotional Learning Initiative

B.K. Elizabeth Kim, University of California, Berkeley; Valerie B. Shapiro, University of California, Berkeley; Jennifer L. Fleming, Devereux Center for Resilient Children; Paul LeBuffe, Devereux Center for Resilient Children

Presenter: B.K. Elizabeth Kim
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Monitoring implementation fidelity is essential to implementation success and intervention effectiveness. Ongoing monitoring, however, is challenging. The Promoting Alternative Thinking Strategies (PATHS) Curriculum is a school-based prevention program. Implementation guidelines suggest hiring PATHS coaches to monitor implementation fidelity of 20% of PATHS lessons (8-10 observations in grades K-2). In addition to self-monitoring of teacher fidelity, the district-wide Social Emotional Learning Initiative hired two Coaches to conduct observations in 170 classrooms across 15 schools. Coaches attempted to observe each classroom 8 times. Observations of teacher fidelity to PATHS were significantly correlated across time (e.g., r=.58-.80), but observations were not uniformly completed. 94% of classrooms were observed at Time 1. Only 35% of classrooms were observed at Time 8. Teacher fidelity to PATHS at Time 1, as observed by Coaches, was unrelated to the number of observations ultimately completed. However, the more the Coach at Time 1 perceived the teacher to be “committed to a high level of implementation of PATHS in their classroom”, the greater number of observations were ultimately completed (ES=.16). Findings suggest 1) fewer/briefer observations and 2) that teacher “buy-in”, detectable in the first month of implementation, is likely a requisite to implementation fidelity monitoring by technical assistance providers.

Notes:
Characterizing the Delivery of CBT for Youth Anxiety in Community Settings

Bryce D. McLeod, Virginia Commonwealth University; Michael A. Southam-Gerow, Virginia Commonwealth University; Bruce Chorpita, UCLA; Philip Kendall, Temple University; John R. Weisz, Harvard University

Presenter: Bryce D. McLeod
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Observational measures capable of assessing implementation integrity (the extent to which the components of an evidence-based treatment (EBT) are delivered as intended) of multiple EBTs are needed in implementation research. We evaluated the validity of the score interpretations for the Therapy Process Observational Coding System for Child Psychotherapy – Revised Strategies scale (TPOCS-RS) to assess implementation integrity. The TPOCS-RS includes five theory-based subscales (Cognitive, Behavioral, Psychodynamic, Client-Centered, and Family). Using the TPOCS-RS, coders independently rated 865 therapy sessions conducted with 68 children (M age = 9.93, SD = 1.79; 51.50% Caucasian) diagnosed with a primary anxiety disorder who received three different treatments (standard CBT, modular CBT, usual care) in community based mental health settings. The TPOCS-RS showed promise for assessing implementation integrity of multiple EBTs as the TPOCS-RS subscale scores, as hypothesized, discriminated between CBT and usual care delivered in community based service settings. The findings support the potential of the TPOCS-RS as a measure to assess implementation integrity.

Notes:
Measurement Feedback Systems in Mental Health: Initial Review of Capabilities and Characteristics

Aaron Lyon, University of Washington; Meredith Boyd, Indiana University; Abigail Melvin, Indiana University; Cara C. Lewis, Indiana University; Freda Liu, University of Washington; Nathaniel Jungbluth, University of Washington

Presenter: Aaron Lyon & Meredith Boyd
Contact: lyona@uw.edu

Measurement Feedback Systems (MFS) are emerging Health Information Technologies (HIT) that provide feedback to clinicians about client progress and outcomes, allowing for data-driven clinical decision-making. Moreover, HITs like MFS provide avenues for efficient methodological approaches to data collection in the context of implementation. Despite the existence of many MFS and strong evidence of benefits of their use, information about system functionality is fragmented, limiting uptake and utility. This project sought to identify every MFS available and document their specific features. 50 MFS were identified and coded for 56 capabilities and characteristics informed by relevant literature and feedback from experts and community stakeholders. Our review of systems suggests incredible variability in MFS. For example, 10 systems are highly customizable, allowing for the addition of new tools and measures. The remaining 40 offer a set library of measures that cannot be altered. Our findings emphasize the critical need for MFS information consolidation and comparison. Our methodology provides researchers and stakeholders with rich information supporting an efficient approach to MFS selection. Results will be discussed with respect to system capabilities, alignment with Feedback Intervention Theory (Kluger & Denisi, 1996), and the use of MFS as an efficient methodology for supporting implementation-related data collection.

Notes:
A Qualitative Investigation of Case Managers’ Attitudes Toward Implementation of a Measurement Feedback System in a Public Mental Health System for Youth

Amelia Kotte, University of Hawaii at Manoa; Kaitlin A. Hill, University of Hawaii at Manoa; Albert C. Mah, University of Hawaii at Manoa; Priya A. Korathu-Larson, University of Hawaii at Manoa; Janelle R. Au, University of Hawaii at Hilo; Sonia Izmirian, University of Hawaii at Manoa; Scott S. Keir, University of Hawaii at Manoa; Brad J. Nakamura, University of Hawaii at Manoa; Charmaine K. Higa-McMillan, University of Hawaii at Manoa

Presenter: Amelia Kotte
Contact: akotte@hawaii.edu

Hawaii’s Child and Adolescent Mental Health Division (CAMHD) initiated a state-wide quality improvement effort for administering the Ohio Scales (OS). The OS is a brief and free youth- and parent-report questionnaire administered on a monthly basis as part of a measurement feedback system (MFS). Surveys are collected by system case managers (CM). Reports are generated monthly to longitudinally track youth outcomes and increase client-level data-driven decision-making. This qualitative study seeks to understand barriers and facilitators associated with implementing an MFS. CMs received training on OS administration and MFS interpretation prior to implementation. They were interviewed on their experiences three months after training and implementation. Interviews were transcribed and coded by seven trained coders using an open inductive approach and an external auditor. Of the 24 completed interviews, 13 have been coded. Central themes related to facilitators of implementation included perceptions that the OS adds to clinical decision-making and facilitates good practices. Most common barriers were: perceptions that clinical leads do not support implementation by omission of OS/MFS in supervision and utilization management meetings, and that administration of the OS is too time consuming. All facilitator and barrier themes, as well as large scale MFS implementation recommendations will be discussed.

Notes:
Evidence-Based Quality Improvement to Reduce Information Delays

Steven E. Lindley, Stanford University/VA Palo Alto Health Care System; Dan Y. Wang, VA Palo Alto Health Care System; Maya Kopell, VA Palo Alto Health Care System; Lindsey E. Zimmerman, National Center for PTSD, Dissemination and Training Division; Eve B. Carlson, National Center for PTSD, Dissemination and Training Division; Ann Lefevre, VA Palo Alto Health Care System

Presenter: Steven E. Lindley
Contact: lindleys@stanford.edu

Most veterans from the wars in Afghanistan and Iraq (OEF/OIF) diagnosed with PTSD and/or depression currently do not receive an adequate course of an evidence-based treatment (EBT). This problem persists despite availability of Veterans Health Administration providers trained to deliver EBTs. Combining lean-design process improvement methods with rapid automated data extraction, we sought to reduce the time between an intake session and receiving of an EBT in a large mental health system with more than 15,000 patients treated each year. Analyses of administrative data identified our current state of EBT psychotherapy delivery. Utilizing A3 management processes and other quality improvement tools, a group of clinic providers developed a SMART goal, hypothesized potential key drivers, and specified countermeasures to improve timely access to EBTs. We then provided rapid feedback to system stakeholders on the progress of improvement. Initial implementation in one large clinic approximately doubled the proportion of new patients receiving timely EBT. Based on these preliminary results, we are adapting a measurement-based care software tool (COMMEND, Landes et al., 2015) to provide daily updates on process-improvement variables. Our goal is to sustain this quality improvement effort through ongoing, rapid presentation of feedback data to system decision makers, clinicians, and staff.

Notes:
Multiple Pathways to Sustainability: Using Qualitative Comparative Analysis to Uncover the Necessary and Sufficient Conditions for Successful Community-Based Implementation

Brittany Rhoades Cooper, Washington State University; Angie Funaiole, Washington State University; Eleanor Dizon, Washington State University

Presenter: Brittany Rhoades Cooper
Contact: brittany.cooper@wsu.edu

For prevention efforts to achieve public health impact requires a clear understanding of the conditions necessary and sufficient for successful program sustainability beyond initial seed funding. Existing sustainability research typically conceptualizes sustainability as a static, binary endpoint with a focus on simple, linear associations between predictors and outcomes within the context of controlled, research settings. To address these gaps, our paper presents findings from a mixed-method study of 16 diverse Strengthening Families Program for Parents and Youth 10-14 (SFP) sites across WA State (implemented under non-research conditions). SFP targets family processes in order to promote school success and to reduce youth aggression and substance use. Levels of sustainability for SFP in WA range from a single program to implementation of 53 programs over 10 years. Qualitative Comparative Analysis (QCA), is used to explore the community, organizational, and program factors associated with sustainability. QCA is based on the premise that different paths/processes can lead to the same outcome and uses Boolean logic to identify sets of conditions that are necessary, sufficient, or both to produce a categorical outcome. This innovative and efficient approach offers implementation researchers and stakeholders a more comprehensive picture of which combinations of factors promote successful sustainability.

Notes:
Evaluating a Medication Alert to Reduce Concurrent Opioid and Benzodiazepine Use at a Single VA Health Care System

Eric Hawkins, Center of Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System, University of Washington; Carol Malte, Center of Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System; Andrew Saxon, Center of Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System, University of Washington; George Sayre, VA Puget Sound Health Care System, University of Washington; Hildi Hagedorn, Minneapolis VA Health Care System; VA Substance Use Disorder QUERI; Douglas Berger, VA Puget Sound Health Care System, University of Washington; Carol Achtmeyer, Center of Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System; Anthony Mariano, VA Puget Sound Health Care System, University of Washington; Anissa Frank, Center of Excellence

Presenter: Eric Hawkins
Contact: Eric.Hawkins@va.gov

Despite clinical practice guidelines that recommend assessment of risk factors before prescribing opioids and benzodiazepines, these medications are often prescribed concurrently to Veterans with risk factors that pose serious safety concerns (e.g. age >65, comorbid substance use disorders, sleep apnea, or suicide risk). Medication alerts have been identified as interventions with significant potential to reduce errors and improve patient safety. This prospective mixed-methods quality improvement project used the Promoting Action on Research Implementation in Health Services model as the guiding framework for evaluating the implementation of an advanced medication alert developed through a partnership with key service line leaders. The project aims to identify the potential influence of evidence, contextual and facilitation factors on the implementation of an advanced medication alert at a single VA health care system. We will present data from 1) surveys of key leaders and prescribers assessing perspectives and attitudes on concurrent opioid and benzodiazepine use, 2) semi-structured qualitative interviews addressing contextual barriers and facilitators to use of advanced medication alerts and to modifying prescribing practices, and 3) pharmacy records to evaluate preliminary effectiveness of the medication alert on reducing concurrent use of opioids and benzodiazepines among Veterans with high-risk conditions.

Notes:
Usage of Promotional Media in Prolonged Exposure Therapy for PTSD: Current Practices and Practical Implications in VA Mental Healthcare

Lindsay Trent, National Center for PTSD, Palo Alto VA Health Care System; Brandy Smith, National Center for PTSD, Palo Alto VA Health Care System; Craig Rosen, National Center for PTSD, Palo Alto VA Health Care System; Jill Crowley, National Center for PTSD, Palo Alto VA Health Care System; Afsoon Eftekhari, National Center for PTSD, Palo Alto VA Health Care System; Eric Kuhn, National Center for PTSD, Palo Alto VA Health Care System; Joseph Ruzek, National Center for PTSD, Palo Alto VA Health Care System

Presenter: Lindsay Trent
Contact: lindsayraetrent@gmail.com

Using provider feedback the VA developed promotional media tools to market Prolonged Exposure (PE) therapy to potential patients and referral sources. To this point, however, there has been little research conducted on the penetration and perceived usefulness of promotional media tools developed to enhance the dissemination of Prolonged Exposure (PE) therapy for PTSD. Participants in the current study were licensed Veterans Health Administration (VHA) providers who completed the National Prolonged Exposure (PE) Training Program. Variables assessed included perceived characteristics of PE across several domains and use of PE. Analyses using data from a follow-up survey administered at six and eighteen months post-training identified self-efficacy to promote PE as the most significant predictor of sustained usage of PE. Coupled with the literature base describing provider concerns about negative patient reactions to exposure-based therapy approaches, these findings point to the need for enhancing providers’ confidence in their ability to “sell” the therapy approach to consumers and patient referral sources (i.e., other treatment providers). The current study examines the penetration, perceived usefulness, and implementation-relevant outcomes (e.g., barriers and facilitators) of a potentially useful tool for accomplishing this goal: promotional videos for PE that target treatment providers and patients through the presentation of psychoeducational information and testimonials. Quantitative and qualitative data were collected assessing variables related to perception of PE promotional videos and utilization. Descriptive data will be presented and relationship with clinician and system-level variables will be discussed. Practical implications will be offered including: increased treatment standardization/fidelity, sustainability, and decreasing training burden.

Notes:
A New Model for Training an Evidence-Based Practice for Suicidal Risk

David A. Jobes, The Catholic University of America

Presenter: David A. Jobes
Contact: jobes@cua.edu

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based clinical intervention for effectively treating suicidal risk (Comtois et al., 2011; Jobes, 2006; 2012). CAMS is best understood as a clinical framework that uses a multi-purpose assessment, treatment-planning, tracking, clinical outcome tool called the Suicide Status Form (SSF). CAMS is designed to establish a strong therapeutic alliance and patient motivation as the treatment dyad collaboratively develops a suicide-specific stabilization plan and the treatment of patient-defined suicidal “drivers” (problems that put the patient’s life in peril). After 20 years of training in CAMS (and the related use of the SSF), it has become clear that standard didactic training does not sufficiently change clinician behaviors to adherently use CAMS. To this end, a whole new CAMS training model has been developed and will be rigorously investigated in the years ahead. The new model includes: a highly interactive 4 hour foundational e-learning course on CAMS + 1.5 days of role-play training + 4-8 sessions of clinical case consultation. This presentation will review the evolution of training in CAMS and a program of research to understand how to best change clinician behaviors for using an evidence-based treatment that is designed to save lives.

Notes:
Adaptation of Coordinated Anxiety Learning and Management (CALM) for Comorbid Anxiety and Substance Use Disorders: Delivery of Evidence-Based Treatment for Anxiety in Addictions Treatment Centers

Kate Wolitzky-Taylor, University of Southern California; Richard Rawson, University of California, Los Angeles; Richard Ries, University of Washington; Peter Roy-Byrne, University of Washington; Michelle Craske, University of California, Los Angeles

Presenter: Kate Wolitzky-Taylor
Contact: kbtaylor@med.usc.edu

Introduction: The majority of individuals with comorbid anxiety and substance use disorders who receive treatment are treated for their addiction in specialty clinics but do not receive treatment for their anxiety disorders, which are associated with poorer substance use treatment outcomes and greater disability than those with substance use disorders only. The present study aimed to develop and evaluate an adaptation of a computerized, therapist-directed CBT program for anxiety disorders (CALM) to increase access to EBTs for anxiety in this comorbid population.

Methods: In the current effectiveness/implementation hybrid study, the CALM program was adapted to be suitable for delivery in addictions treatment centers. After training addictions treatment counselors to deliver the treatment, we conducted a randomized clinical trial comparing usual care at the addiction clinic (UC) to UC + CALM adaptation. Currently, 49 patients at the community clinic with comorbid anxiety and substance use disorders have been randomized. Outcomes (measured at baseline, post-treatment, and 6-mo follow-up) include measures of feasibility, acceptability, and anxiety and substance use symptom outcomes.

Results: Therapists demonstrated competency in delivering the treatment. At post-treatment, patients in CALM ARC report greater satisfaction with treatment, improvements in quality of life, fewer drinking days in the past month, and had greater percentages of negative urinalysis (66% v. 45% in UC). Contrary to hypothesis, the differences in anxiety symptoms do not attain statistical significance between groups.

Discussion: Although the study is still ongoing, findings thus far suggest (a) delivery of CBT for anxiety in addictions counseling centers is feasible and acceptable; and (b) benefits on a variety of outcomes have been observed at post-treatment. We await additional data to draw conclusions about our 6-month follow-up assessment.

Notes:
Opportunities and Challenges of Measuring Program Implementation with Online Surveys

Dena Simmons, Yale University; Catalina Torrente, Yale University; Lori Nathanson, Yale University; Grace Carroll, Yale University

Presenter: Dena Simmons
Contact: dena.simmons@yale.edu

We will present descriptive results from data collected to assess the implementation of RULER, a K-8th school-based approach to social and emotional learning. School implementation teams, consisting of counselors, teachers, and school leaders, attended RULER institutes in 2013 or 2014. Implementation data were collected 18, 12, or 6 months post-training. We used online surveys to reduce costs and to provide the RULER training department with timely information about progress and barriers to implementation. Seventy-three percent of eligible schools took the survey (n = 52; 76 educators, 42% response rate). Most respondents were principals/assistant principals (32%) or teachers (26%). Most schools (88%) implemented RULER since attending the training. On average, these schools implemented 6.7 out of 10 possible RULER activities. The most commonly endorsed activities were conducting at least one staff training (94%), teaching a lesson to students (89%), and scheduling staff trainings (89%). The least implemented activities were establishing a problem-solving process (28%) and scheduling an introductory meeting with families (44%). Generally, respondents perceived finding time for implementation as the most common barrier followed by a lack of a clear implementation plan. We will discuss how this data collection experience informed changes to our implementation support model.

Notes:
Observational Assessment of Fidelity to a Family-Centered Prevention Program: Differentiation and Predictive Validity

Justin D. Smith, Baylor University; Kimbree Brown, University of Oregon; Karina Ramos, University of Oregon; Nicole Thornton, Prevention Science Institute, University of Oregon; Thomas J. Dishion, REACH Institute, Arizona State University; Elizabeth A. Stormshak, Prevention Science Institute, University of Oregon; Daniel S. Shaw, University of Pittsburgh; Melvin N. Wilson, University of Virginia

Presenter: Justin D. Smith
Contact: jd_smith@baylor.edu

Assessing the fidelity with which evidence-based programs are implemented has critical implications for the validity of the findings and for translation and scale out of interventions. A breakdown in treatment fidelity inhibits the ability to draw valid inferences regarding the nature of a putative treatment effect. In this study, we conducted a randomized experiment to determine whether ratings of fidelity to the Family Check-Up (FCU) provided on the COACH rating system could differentiate levels of training in the model. Further, we evaluated the predictive validity of fidelity ratings on clinically meaningful outcomes. Trained coders observationally rated 75 intervention sessions for fidelity. Three groups of 25 sessions each were randomly selected from the intervention arms of an efficacy trial, an effectiveness trial, and from treatment as usual provided by licensed therapists with no training in the FCU model. Results indicated declining ratings of fidelity corresponding to the level of the therapists’ training in the FCU. Further, COACH ratings were predictive of child conduct problem ratings at posttreatment, controlling for baseline levels, for only those families who received the FCU; there was no relation between COACH scores and outcomes in the treatment as usual condition. These findings indicate that the COACH system reliably differentiates the level of fidelity to the FCU and that scores are predictive of child outcomes. Post hoc analyses indicates that conceptual accuracy to the FCU was the primary substantive difference between levels of training and also could explain the lack of predictive validity of the COACH score in the treatment as usual group. Future directions of fidelity assessment are discussed.

Notes:
Strategies and Challenges in Housing First Fidelity: A Multistate Qualitative Analysis

*Mimi Choy-Brown, Silver School of Social Work, New York University; Emmy Tiderington, Silver School of Social Work, New York University; Bikki Tran Smith, Silver School of Social Work, New York University; Deborah K. Padgett, Silver School of Social Work, New York University*

Presenter: Mimi Choy-Brown & Emmy Tiderington  
Contact: mimi.choybrown@nyu.edu

Pathways Housing First (PHF), an evidence-based model of permanent housing and supportive services for homeless adults, has been widely disseminated in the United States and internationally. However, model fidelity has varied widely across settings. Less understood are on-the-ground experiences of providers at different stages of implementation and organizational contextual factors influencing fidelity. Further knowledge of these provider experiences can inform more efficient and effective strategies to support fidelity in multiple contexts. The primary aim of this study was to understand the strategies and challenges providers encounter in the uptake and fidelity of PHF. Data were derived from a NIMH-funded study investigating perspectives of front-line staff and supervisors. Four focus groups were conducted with staff at PHF sites in two East Coast cities (total n=24). Thematic analysis (Boyatzis, 1991) was utilized to code and develop themes regarding challenges to model fidelity. Themes identified were 1) feasibility of the workload; 2) importance of supervision; 3) impact of technology; and 4) availability and types of training. Providers adapted limited resources to respond to barriers to fidelity (e.g. turnover) with some success. Qualitative focus groups were found to be an efficient method for assessment of proximal factors influencing model fidelity.

Notes:
Developing Treatment Fidelity Rating Systems for Psychotherapy Research: Recommendations and Lessons Learned

Kevin Hallgren, University of Washington; Shirley Crotwell, Boston Veteran Affairs Health Care System; Rosa Muñoz, University of New Mexico; Becky Gius, University of New Mexico; Benjamin Ladd, Reed College; Barbara McCrady, University of New Mexico; Elizabeth Epstein, University of Massachusetts Medical School in Worcester

Presenter: Kevin A. Hallgren
Contact: khallgre@u.washington.edu

Measuring fidelity to evidence-based treatments is a key component of dissemination and implementation research. However, developing reliable, valid, and clinically-relevant treatment fidelity measures remains a challenge. Although much of the literature has focused on theoretical and psychometric aspects of measure development, the literature often omits practical considerations for developing and using fidelity measures. The present study describes the development and testing of a treatment fidelity rating system used in couple-based alcoholism treatment. Over a three-year period, seven coders received extensive training and rated 74 components of treatment fidelity across 284 psychotherapy sessions. During this presentation, the theoretical model underlying the instrument and psychometric properties will be briefly described. However, a considerable portion of the presentation will focus on practical recommendations and lessons learned from our work, which we hope will inform future measure development. Major themes include challenges in (1) measure development (e.g., adapting existing fidelity measures for new treatments), (2) defining “treatment integrity” (e.g., conceptual and practical difficulties in rating various therapist behaviors), (3) process improvement (e.g., procedures for improving quality and efficiency of coder training and ongoing monitoring), and (4) inferring information from the ratings (e.g., improving clinical relevance and internal/external validity).

Notes:
Procurement and Contracting as an Implementation Strategy: Getting To Outcomes® Contracting

Ronnie M. Rubin, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services; Marilyn L. Ray, Finger Lakes Law and Social Policy Center; Abraham Wandersman, University of South Carolina; Andrea Lamont, University of South Carolina; Gordon Hannah, Gordon Hannah Consulting; Kassandra A. Alia, University of South Carolina; Matthew O. Hurford, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services; Arthur C. Evans, Philadelphia Department of Behavioral Health and Intellectual disAbilities Services

Presenter: Ronnie M. Rubin
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billions of dollars are spent each year on behavioral health services and there is a movement to require the use of evidence based practices (EBPs) in these services. Financing, contracting and regulatory strategies are proposed in several implementation science frameworks and many funders are moving toward performance based contracting. However, there are few systematic evaluations of how these strategies are deployed to ensure quality implementation of EBPs. Utilizing the Getting To Outcomes (GTO®) framework (Chinman, Imm & Wandersman, 2004), the Philadelphia Department of Behavioral Health and Intellectual Disabilities Services (DBHIDS) is engaged in an initiative to integrate accountability for the delivery of EBPs and the achievement of recovery and resilience outcomes into the procurement and contracting functions of its public behavioral health managed care organization. We will present an overview of the Getting To Outcomes Contracting (GTOC) Initiative, including how GTO was used to develop an RFP for co-occurring disorders, the training technical assistance efforts and strategies for scaling up. Data will be presented on the evaluation of this initiative, including comparisons of pre- and post-GTOC Initiative RFPs. This effort provides an example of how a behavioral health system can leverage implementation science strategies to procure evidence based services.

Notes:
Automated Feedback on Therapist Fidelity: Current Status and Future Directions

David C. Atkins, University of Washington; Zac E. Imel, University of Utah; Dogan Can, University of Southern California; Bo Xiao, University of Southern California; Panayiotis Georgiou, University of Southern California; Shrikanth Narayanan, University of Southern California

Presenter: David C. Atkins
Contact: datkins@u.washington.edu

Cognitive science on learning shows that specific, proximal feedback is critical to the development of expertise, and this is precisely what is lacking from training and quality monitoring with behavioral interventions such as psychotherapy. Particularly with an eye toward implementation and dissemination, research-based tools such as behavioral coding will never scale up to every-day practice. The current talk will present ongoing interdisciplinary research on developing tools for automated feedback to therapists learning and practicing motivational interviewing (MI). In collaboration with engineers and computer scientists, we have recently shown that a processing pipeline of tools – including voice activity detection, speaker segmentation, automated speech recognition, and text-based machine learning – can take an audiorecording of MI and yield accurate ratings of therapist empathy. Ongoing feasibility research will provide machine-generated feedback to therapists on their sessions, focusing on acceptability, perceived accuracy, and user-interface interpretability. In addition, we will comment on the opportunities, as well as possible pitfalls, of increased human-computer interaction in behavioral interventions. In our experiences, technology works best when it serves to support the human task, rather than trying to supplant it. In closing, we will discuss future plans for technology-augmented therapist training and supervision.

Notes:
Web-Based Feedback to Aid Successful Implementation: The Interactive Stages of Implementation Completion Tool

Lisa Saldana, Oregon Social Learning Center; Holle Schaper, Oregon Social Learning Center; Mark Campbell, Oregon Social Learning Center; Patricia Chamberlain, Oregon Social Learning Center

Presenter: Lisa Saldana
Contact: lisas@oslc.org

The Stages of Implementation Completion (SIC) is an 8-staged measure that was developed to evaluate the implementation of evidence-based practices (EBPs). Each of the stages maps onto three phases of implementation: pre-implementation, implementation, and sustainability. The SIC measures adopting sites’ implementation performance, as indicated by activity completion and duration. Early stage implementation performance has been shown to predict successful implementation outcomes and the measure has sound psychometrics. Subsequently, the Interactive SIC was developed to allow for real-time, web-based feedback to be delivered by purveyors to organizations. A purveyor can enter an organization’s data at the time of completion, and the prediction models for success are updated immediately to show the most up-to-date prediction for accomplishing key implementation milestones (e.g., successful program start-up, achievement of program competency/certification). This website functions on both Mac and PC platforms. The development of a tool that predicts outcomes by assessing implementation performance will help identify areas in need of intervention (e.g., through additional support/consultation) and strategies that best meet the needs of organizations. This project aims to provide efficient tools that will help increase the uptake of EBPs, thereby increasing the availability of services to vulnerable populations and decreasing wasted resources from failed implementation efforts.

Notes:
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Espresso - Monday-Friday 7:30 am to 2:00 pm  
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Open Everyday 7am to 10pm  
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**Ivar's Salmon House**  
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www.villagesushiseattle.com