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Mental Health Technology Transfer Center Network

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MAKING IT STICK: A GUIDE TO USING DISSEMINATION AND IMPLEMENTATION SCIENCE IN PLANNING HIGH-IMPACT TRAINING AND TECHNICAL ASSISTANCE

SAMHSA

Substance Abuse and Mental Health Services Administration

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Introduction: Why Dissemination and Implementation Science?

As **technical assistance (TA) purveyors** (see **Appendix 1 – Glossary**), we seek to address challenges in the behavioral health treatment system by increasing the workforce's knowledge about and organization's ability to implement evidence-based practices. We provide training and technical assistance activities to raise awareness, build skills, and accelerate practice change.

Dissemination and Implementation (D&I) Science is the study of how one gets evidence-based practices spread widely and incorporated into routine practice settings so that more people can receive the best care possible, and how one keeps the practice in place.

This guide was developed from a three-session learning community held for the Technology Transfer Centers in Summer 2022. The purpose of this guide is to demonstrate how TA purveyors can use D&I science findings, models, and frameworks to provide the most effective training and technical assistance to accelerate practice change. The guide includes real-world TA examples, exercises that can be used by TA purveyor teams to learn about how to apply D&I science to their work, and an implementation project template that helps a TA purveyor plan and track an intensive TA activity.

Challenges in Behavioral Health Services Delivery

The US behavioral health care service system suffers from challenges and gaps related to lack of access to treatment, lack of treatment equity, lack of access to effective treatments, and lack of access to effective treatments delivered effectively (see **Box 1**).

Box 1: 4 Challenges to Behavioral Health Services Delivery

1. **Lack of access to treatment**
    a. 55.2% of adults with any mental illness and 89.2% of adolescents/adults with substance use disorders do not receive treatment.[1]
2. **Lack of equity in diagnosis and treatment**
    a. Racial/ethnic minority groups are over- and underdiagnosed with serious mental illness and typically have less access to effective services.[1,2,3]
3. **Lack of access to effective treatments**
    a. Of people who receive services through state mental health systems: 1/3 receive medication management, 1/5 receive illness self-management, and less than 1/10 receive other treatments (e.g., illness self-management, dual-diagnosis treatment, assertive community treatment [ACT], supported employment/housing).[4]
4. **Lack of access to effective treatments delivered effectively (with high fidelity to the original model)**
    a. Individuals served by high-fidelity ACT teams have better outcomes compared to those served by low-fidelity ACT teams.[5]
    b. Youth and families engaged in average fidelity wraparound processes have better outcomes compared to those engaged in low-fidelity processes.

The identified challenges and **Figure 1**, adapted from Bertram and colleagues (2008),[6] illustrate implementation gaps. Implementation gaps occur when we have an evidence-based practice (EBP), but it is not available to the individuals who would benefit from it, or when it is available but not implemented well, meaning implemented in a way that will lead to the expected outcomes.

Effective Intervention	X	**Not Implemented**	=	**Poor Patient Outcomes**			
Effective Intervention	X	**Ineffective or Insufficient Implementation**	=	**Inconsistent, Not Sustainable, Poor Outcomes**		***aka "Voltage Drop"**	

Figure 1: Implementation gaps can lead to poor individual outcomes, through lack of or ineffective implementation.

As TA purveyors, we are positioned to address implementation gaps that may occur when implementing an evidence-based practice. Our role is to assist the behavioral health prevention, treatment, and recovery systems and workforces to provide the most effective services to people in need. We can use D&I science to make sure we are delivering the most effective training/technical assistance (TTA) to decrease implementation gaps, thereby addressing challenges to behavioral health services delivery.

Levels of Technical Assistance

Let's start building a bridge to D&I science by talking about the typical activities that a TA purveyor or TTA center engages in. A framework developed by the Technology Transfer Center (TTC) Networks differentiates among three levels of TA: basic, targeted, and intensive (**Figure 2**).[7]

Basic TA: information dissemination or the provision of brief consultations. Goal: raise awareness and disseminate information. Impact: raise awareness of new information, but relatively limited impact, generally unlikely to result in behavior change.[8]

Targeted TA: directed training or support to specific groups (e.g., clinical supervisors) or organizations (e.g., prevention coalitions) focused on building skill and promoting behavior change. Goal: raise awareness and build knowledge. Impact: "train and hope" usually has short-term gains and does not result in changes in skills or practices.

Intensive TA: ongoing, customized consultation to specific sites, communities, or systems. Goal: support full incorporation of a new

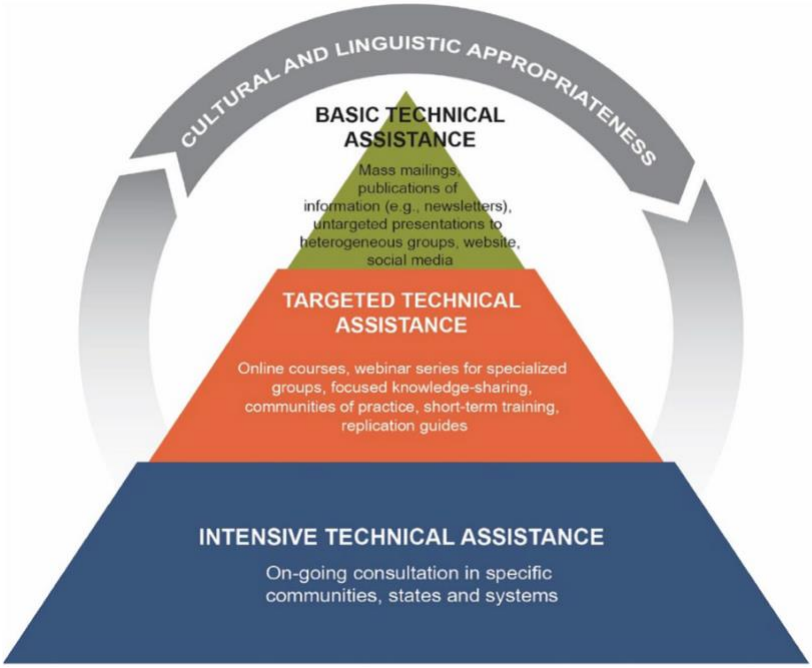


Figure 2: Technology Transfer Center Network's conceptual framework of TA.[7]

practice or innovation into real-world settings. Impact: intensive TA strategies show promise in changing organizational practices and implementing evidence-based practices.

Here are a few examples of how intensive TA has more impact on practice change than basic or targeted TA.

Example: Training alone doesn't lead to practice change

Figure 3 highlights the implementation gap—or how we, as TA providers, may not do enough, or enough of the right things, to change practice. Joyce and Showers (2002)[9] looked at knowledge, skill, and practice change outcomes based on different training and TA components. When training only included theory and discussion, very few participants showed changes in knowledge or skills. Even when the training included demonstration, practice, and feedback, it did not translate to changes in the classroom. **Only when coaching in the classroom was provided did practice change.**

	OUTCOMES (% of Participants)		
TRAINING COMPONENTS	Knowledge	Skill Demonstration	Use in the Classroom
Theory and Discussion	10%	5%	0%
…+Demonstration in Training	30%	20%	0%
…+ Practice & Feedback in Training	60%	60%	5%
…+ Coaching in Classroom	95%	95%	95%

Figure 3: Adding coaching to other components led to increased participant outcomes.

Example: Follow-up support leads to improved patient outcomes

Another example is from the Northwest MHTTC (**Figure 4**),[10] which observed decreases in participants' intentions to collaborate with other organizations and address and understand problems and needs after following up in four to six weeks without further training. When participants were supported through follow-up training or consultation, there were increases in all measures.

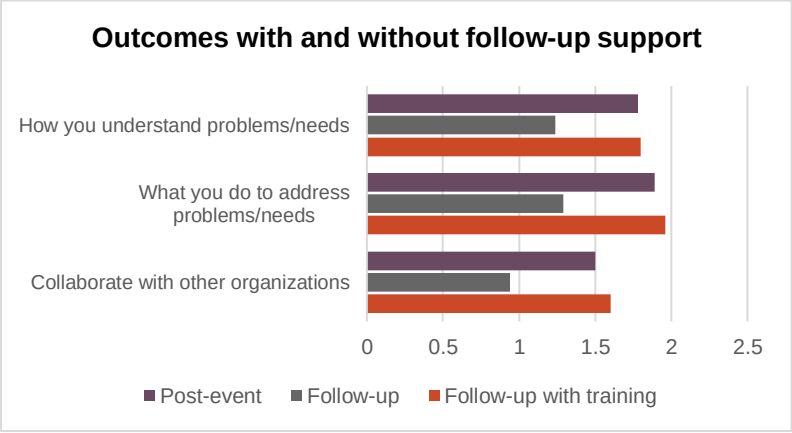


Figure 4: Follow-up consultation improved participant outcomes.

While basic TA and targeted TA can help set the stage for implementation, intensive TA is where the work really occurs to make changes in existing practices.

Exercise: What TA has the most impact?

Use this exercise with your colleagues to reflect on previous TA that you provided or participated in.

1. Talk about the best TA or training you were involved in:
    a. What level of TA was it?
    b. What was the secret sauce that made it work?
    c. How might we apply the findings in the examples above to the TA and training that we typically provide?

Here is an example response:

1. The best TA I was involved in was a project we conducted for Classroom WISE, a three-part training package to help educators and school staff promote student well-being.
    a. Intensive TA
    b. The "secret sauce" was sharing sessions we held with schools, who talked about difficulties they faced in implementing Classroom WISE and how they addressed those difficulties. Learning from their peers during sharing sessions gave the schools new ideas for overcoming barriers.
    c. Those findings make sense in the context of our TA project. Twenty-eight percent of schools that received only an orientation webinar and implementation guide started adopting Classroom WISE, while 50% that also received an individual facilitation session and sharing sessions started adopting Classroom WISE. Having more intensive TA helped individuals understand and gave them confidence and skills to implement evidence-based practices.

The Levels of TA framework is helpful in showing that TTA has different goals. For example, information dissemination, raising awareness, building skills, and fully implementing a new practice are all important and necessary components in moving toward practice change. Yet, it is important to recognize the limitations of basic and targeted TA if the actual goal is embedding a new evidence-based, promising, or community-defined practice.

Research evidence from D&I science has shown that basic and targeted TA, such as journal articles, treatment manuals, and one-time workshops, do not provide enough support to a behavioral health prevention, treatment, or recovery organization to elicit real practice change.[8,9] As TA purveyors, we should build our understanding of D&I science to help us design the most effective TTA for the specific context and goals of the project.

Dissemination and Implementation (D&I) Science

D&I science draws from fields such as public health, communications, organizational change, and evidence-based medicine. It is not the same as process or quality improvement. Improvement science aims to improve the quality, safety, and value of health care.[11] D&I science studies the uptake and use of evidence-based interventions. **Box 2** includes a number of commonly used terms.

Box 2: D&I Terms*

Dissemination: An active approach of spreading evidence-based interventions to the target audience via determined channels using planned strategies.

Implementation: The process of putting to use or integrating evidence-based interventions within a setting.

Implementation strategy: "The stuff we do to try to help people and places"[12] change; training and technical assistance activities.

Sustainment: The process of maintaining or continuing the intervention within a setting, beyond a more active implementation period.

*See Appendix 1 for more terms.

Throughout this guide, we'll present four D&I science concepts that TA purveyors can use to help them plan more effective TTA.

D&I Science Concept #1: Implementation Stages

Change is hard and can feel overwhelming. Thinking about an implementation project in stages can help structure your planning and manage participants' and leadership expectations.

One D&I stage model is EPIS (Exploration, Preparation, Implementation, and Sustainment), developed by Aarons and colleagues (2011).[13]

Implementation Stages of EPIS Model

Let's examine each stage in the model.

Exploration: the awareness of a patient/consumer/community need or a change in practice, including a decision to adopt a new practice after examining options.

Preparation: building buy-in and support for change to get ready to implement the new practice, such as through staff training and changing protocols and policies.

Implementation: when an organization is beginning to provide or use the new practice. Note that initial implementation does not usually go smoothly. It is an "awkward teenager" phase, when difficulties arise and flexibility is important to address them. By full implementation, the program should be operating effectively.

Sustainment: maintenance of the practice over time and with fidelity. In the sustainment stage, programs must address issues such as how to provide resources, supervision, and training over the long term to maintain and support the program.

Stages vary in length, depending on factors such as the complexity of the new practice, the readiness of the team or organization to enact the change, and the context in which the change is occurring. It may take several years to fully implement and sustain an effective program or intervention. Stages are not necessarily linear, as it may be necessary to revisit an earlier stage due to a change in organizational context, like staff departures or new regulations. However, knowing a project's stage can help in setting expectations with leadership or staff and decision-making around which technical assistance/implementation strategies to use.

Example: Using implementation stages to frame a TA project

An example of the EPIS Model's application comes from Gotham and colleagues (2008), including Chestnut Health Systems as the primary TA purveyor, who assisted the State of Missouri in implementing a standardized assessment across 15 adolescent addiction treatment programs.[14]

Exploration began with a SAMHSA-funded adolescent addiction system of care grant. At the time, the 15 state-funded adolescent addiction programs were using a homegrown brief rating scale. Although the state and some providers wanted an evidence-based assessment, most wanted to retain the rating scale. Through the SAMHSA grant, one provider began using the GAIN,[15] a standardized, evidence-based clinical assessment. Over the next two years, that program director reported to the statewide adolescent provider group about progress in piloting the GAIN, answering questions and concerns about the assessment's length, presenting data showing that clients did not deny or underreport substance use, and generally building consensus. The exploration process ended with a decision to adopt the GAIN assessment statewide.

Preparation included Chestnut Health System providing training and monitoring and feedback on the GAIN, as well as consultation with the programs and state staff on the implementation process. A strength of the GAIN was the ability to upload data into a state-level reporting system. State policies and procedures were changed to extend the time frame and requirements for implementation, revise billing policies, and customize the GAIN assessment.

In the initial **implementation** stage, Chestnut continued consultation. Several agencies asked for an extension to accommodate staff training and make programmatic changes. More time

was needed to fully install the state reporting system. There were still concerns about the length of the assessment; however, once the programs got through this “awkward teenager” phase, they did not want to delete any items.

In Missouri, the seeds of **sustainment** were planted throughout the implementation process. Policy changed to increase reimbursement and time for staff training, a local trainer model assured training of new staff when turnover occurred, and the state kept trained staff to manage the reporting system.

This example shows how using the EPIS Model helped frame the project, including that naming the implementation stages for the addiction treatment organizations assisted them in waiting until after the early implementation stage to finalize the evidence-based assessment, and that the TA purveyor timed the TA strategies per stage.

Exercise: Apply the EPIS Model to an MI Project

This exercise can help you apply the EPIS Model to a real-world case example from the Northeast and Caribbean MHTTC. We recommend completing this exercise with your colleagues.

The Northeast and Caribbean MHTTC developed a project in response to requests from providers in HHS Region 2 to implement and sustain Motivational Interviewing (MI) with all levels of staff, including administrators, supervisors, and direct service providers. The target audience included behavioral health-care providers who worked in residential or outpatient services or assertive community treatment teams.

They recruited organizations through an application process in which organizations committed the time and staffing to participate. These applicants also indicated their needs and how they planned to support implementation. The chosen organizations represented rural, suburban, and urban areas. Initial communication with leaders allowed for further discussion of questions and clarification of the time commitment.

1. Thinking about Northeast & Caribbean MHTTC's Motivational Interviewing project:
    a. What stage do you think this project is in?
    b. What are the implications for how you would move forward with this project?
    c. What might you do differently, depending on implementation stage?

How to Decide What TTA to Provide

Practice change is not a smooth process, for the provider or the TA purveyor. See if any of these resonate for you:

- At a training event, the participants were not sure why they were there or what they were supposed to do with the information.
- Training participants shared that the provider organization had strict rules around productivity that would not allow the practice being taught to actually be delivered.
- Six months into an implementation project, only a few providers remain in the cohort because of staff turnover.

While we cannot totally prevent these issues from happening, we can try to minimize them and make sure that we are investing our intensive TA resources wisely. See **Box 3** for engagement strategies you can use for organizations and individuals.

Box 3: Engagement Strategies for Organizations and Individuals

1. **Organizational Engagement Strategies**
    a. Have each agency convene an implementation team.
    b. Require an application to assess readiness and commitment.
    c. Conduct a readiness assessment (e.g., staff survey) to get a sense of the audience.
    d. Examine facilitators to implementation, such as policies and funding.
    e. Anticipate challenges by examining and reducing implementation barriers.
    f. Assess willingness to make a financial commitment (e.g., making resources available to facilitate staff development).
2. **Individual Engagement Strategies**
    a. Use an application process to identify providers that should participate.
        i. Engage your target audience strategically by tailoring questions (e.g., assessing beliefs about evidence-based practices).
    b. Require participation in teams so colleagues can discuss ideas and hold each other accountable.
    c. Provide pre-work to build readiness (e.g., participation in training module).
    d. Assess participants' readiness and adapt the training to it.
    e. Enhance commitment intentionally (e.g., certification, financial incentives).
    f. Create staged training to identify participants best suited for intensive TA.

Example: Engagement strategies

An example from the South Southwest MHTTC highlights engagement strategies. They provided intensive TA on the evidence-based practice Stress Management and Resilience Training (SMART). Since SMART had not been used in their region, first they offered webinars to expose people to the SMART Model, and then offered workshops so providers could understand the model. After this, they required interested organizations and providers to complete an application to participate in their Tier 3 training, after which attendees would become certified trainers. The most well-equipped organizations and providers were selected to participate.

Exercise: Apply engagement strategies to an MI project

Continuing from the previous exercise, the Northeast and Caribbean MHTTC sent their mailing list a call for applications for the MI project that included an overview and expectations and asked interested organizations to complete an application. The application asked organizations to summarize their agency's needs regarding implementing MI, describe expectations for participation, and reviewed eligibility criteria (i.e., behavioral health organization wanting to integrate MI in all aspects of service delivery, committing to implementation with two administrators and three to five clinical supervisors, and designating 15 to 20 direct service staff to develop necessary skills to deliver MI). Upon acceptance, agencies scheduled an intensive discussion to assess organizational readiness with administrators, clinical supervisors, and direct service staff. This discussion included how the organization planned to integrate MI, potential barriers, and challenges MI would address within their agency.

1. Considering how the Northeast & Caribbean MHTTC engaged their audience:
    a. What does your organization do similarly and/or differently when engaging an intensive TA audience?
    b. Is there one thing in your engagement toolbox that is a must-have? Why?

D&I Science Concept #2: Three Levels of Context for Implementation

At the simplest level, we can think of three levels of context for implementation: the **individual** level, the **organizational** level, and the **systems** level. Let's consider this using the popular TV show *Mister Rogers' Neighborhood* as an analogy.

Mr. Rogers is surrounded by friendly neighbors who are committed to helping children learn and gain positive experiences (i.e., **individual** level).

The individuals within Mr. Rogers' neighborhood are embedded within a cozy house that includes a creative world of make-believe filled with resources including puppets, props, and educational materials (i.e., **inner setting**).

Mr. Rogers' house is embedded within a resource-filled community that includes specialty shops, museums, a library, a post office, and a bakery, among many other community assets. The community appears safe and provides a supportive environment that enables Mr. Rogers' efforts to support young people (i.e., **outer setting**).

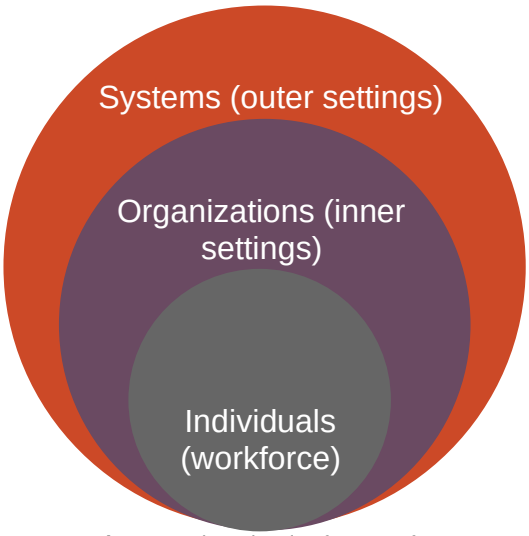


Figure 5: Three levels of context for implementation.

Figure 5 illustrates how the analogy applies to your organization. **Individual level:** members of the workforce, or the people and teams that you train and support. **Organizational level:** organizations and agencies in which TTA participants work, with their own cultures, leadership styles, resources, and readiness for change. **Systems level:** the systems in which your participants' workplaces are embedded, including financing structures, policies, public attitudes, and more.

Context in D&I Frameworks

High-quality implementation needs to take context into consideration (e.g., Consolidated Framework for Implementation Research [CFIR]),[16] including processes that are supported by the inner and outer settings, individuals, and the characteristics of the practice that will be implemented. The EPIS Model also takes these inner and outer settings into account.

How Can We Incorporate Context Into Our Work?

Historically, TTA focuses at the individual level, as we develop the workforce by targeting knowledge gains and skill development. However, considering context helps promote practice change and implementation outcomes, as systems and organizations influence individual practitioner behavior. **Figure 6** illustrates examples of barriers and facilitators at each of the three levels of context, and **Box 4** showcases examples of questions you can ask to incorporate context in your work.

Figure 6: Examples of implementation barriers and facilitators at the three levels of context.

Box 4: How Can You Incorporate Context Into Your Work?

1. **Choose TTA Topics**
    a. Is implementation realistic in light of barriers and facilitators?
    b. What level of support is needed for successful implementation?
2. **Target a Particular Audience**
    a. Who will benefit most from the training/TA (e.g., practitioners, supervisors)?
3. **Select Speakers**
    a. Who can connect with the target audience?
4. **Design an Evaluation**
    a. How can concepts from D&I theory and research inform evaluation design?

Example: Barriers and facilitators to implementation in an MI project

Through questions in the application process, surveys, and discussions with organizational participant teams, the Northeast and Caribbean MHTTC identified barriers and facilitators unique to their MI project (**Figure 7)**.

System-Level Barriers:	Organization-Level Barriers:	Individual-Level Barriers:
• COVID-19 led to crisis-oriented mode of service to meet basic needs	• Direct service staff turnover	• Low readiness among clinical supervisors and direct service staff

System-Level Facilitators:	Organization-Level Facilitators:	Individual-Level Facilitators:
• None identified at the time	• High readiness among administrators • Administrator interest in implementing MI in all parts of their agency	• Clinically licensed supervisors • Relatively recent MI training

Figure 7: Implementation barriers and facilitators at the three levels of context for the Northeast and Caribbean MHTTC's MI project.

D&I Science Concept #3: Implementation Strategies (TA Activities)

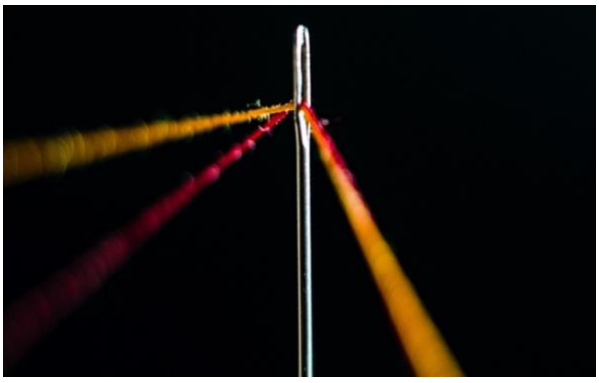
Implementation strategies are the TA activities and actions that we do to try to install, scale up, or scale out an evidence-based practice. "Scale up" refers to expanding an EBP to similar settings and populations as those in the original research, while "scale-out" efforts expand the intervention to different settings/sub-populations. In this section, we will talk about what implementation strategies are, how to categorize them, and a few ways to decide which to offer, referring back to the D&I frameworks we have already discussed.

Powell and colleagues[17]have classified implementation strategies into six categories (**Figure 8)**.

Category	Examples
Plan	Conduct local needs assessment; assess for readiness and identify barriers; develop implementation plan; build local consensus; mandate change.
Educate	Develop effective educational materials; conduct ongoing training; inform local opinions leaders; prepare patients/consumers to be active participants.
Finance	Alter incentives; place on formularies; access new funding; make billing easier.
Restructure	Create new clinical teams; change service sites; change physical structure and equipment; change records systems.
Manage Quality	Develop and organize quality monitoring systems; audit and feedback; obtain and use patient/consumer/family feedback; provide clinical supervision; conduct cyclical small tests of change (PDSA cycles).
Attend to Policy	Encourage the promotion of programs and practices through accrediting bodies, licensing boards, and legal systems.

Figure 8: Six categories of implementation strategies: planning, education, finance, restructuring, managing quality, and attending to policy.[20]

Choosing an Implementation Strategy: Precision Implementation



How we decide which implementation strategies to provide in a TA project is very important. As we have learned, commonly used strategies are not necessarily the most effective to change clinical practice or meet the goals of a given project. For example, “train and pray,” where we provide a training and hope participants then start using a new practice, does not work. Other examples include “throwing in everything and the kitchen sink” (i.e., using different implementation strategies to make sure something sticks), having a one-size-fits-all approach (i.e., using the same set of strategies, regardless of the setting or context of implementation), and the “it seemed like a good idea at the time” approach.[18,19,20]

Let’s move toward **precision implementation,** where we choose implementation strategies/TA activities after considering stage of implementation and assessing the context (barriers or facilitators) of the audience.

Choosing an Implementation Strategy: Stage of Implementation

Implementation strategies can be tailored to the stage of implementation. See **Box 5** for example strategies using the EPIS Model.

Box 5: Implementation Strategies by EPIS Model Stage

1. **Exploration**
    a. Form an implementation team.
    b. Identify the problem.
    c. Conduct a needs assessment.
    d. Identify potential solutions.
    e. Determine program fit.
2. **Preparation**
    a. Ensure leadership buy-in.
    b. Develop an implementation plan.
    c. Educate and train staff/stakeholders.
    d. Identify viable funding streams.
    e. Change policies and procedures.
3. **Implementation**
    a. Verify buy-in.
    b. Complete training.
    c. Manage expectations.
    d. Monitor fidelity to the EBP.
    e. Collect and evaluate outcomes.
4. **Sustainment**
    a. Continue funding and support.
    b. Continue ongoing training and fidelity monitoring.
    c. Make refinements.

Example: Matching implementation strategies to stage

An example from Finnerty and colleagues (2019)[21] looked at the implementation strategies that would be useful at each stage for a web-based shared decision-making system in two specialty mental health clinics (**Figure 9**).

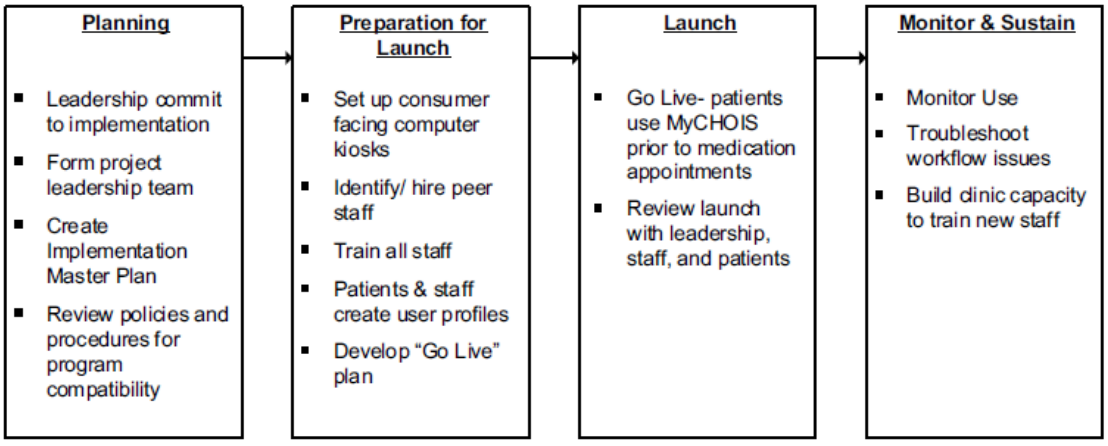


Figure 9: The implementation strategies used to implement a web-based shared decision-making system in two specialty mental health clinics, from planning to sustainment stages.

Choosing an Implementation Strategy: Barriers and Facilitators

Implementation strategies can also be matched to barriers/facilitators. For example, if there is a lack of knowledge about the evidence-based practice, then one would use interactive education sessions, or staff lack of motivation to change could be matched with incentives or sanctions.

Example: Barriers and facilitators affect implementation

An example from Kilbourne and colleagues (2014; 2015)[22,23] and Smith and colleagues (2018)[24] shows the value of both **adaptive implementation**, or understanding how intensive implementation strategies must be for organizations to adopt a program that re-engages veterans with serious mental illness into VA care, and choosing strategies based on barriers and facilitators. They found that organizations with more positive organizational culture and climate were more likely to adopt the program when they received enhanced TA. However, with less positive organizational culture and climate, program adoption rates were similar across standard and enhanced TA groups.

Exercise: Choose implementation strategies for the MI project

This exercise can help you practice how to consider context in deciding on implementation strategies for the real-world case example from the Northeast and Caribbean MHTTC. We recommend completing this exercise with your colleagues.

Recall the barriers and facilitators experienced during the Northeast and Caribbean MHTTC's MI project in **Figure 8**. Considering those barriers and facilitators, what implementation strategies/TA activities would you use (or which ones wouldn't you choose)?

Example: An array of implementation strategies for the MI project

Before beginning their MI project, the Northeast and Caribbean MHTTC used evaluative and iterative strategies. They called administrators to answer initial questions upon acceptance and scheduled a more intensive discussion to assess organizational readiness with administrators, clinical supervisors, and direct service staff. They also developed an implementation plan with agencies by reviewing agency responsibilities (e.g., providing cameras and tech support), implementation goals and objectives, and project outcomes.

For educational strategies, skilled MI trainers conducted an in-person six-hour training for direct service staff and clinical supervisors and two 90-minute virtual trainings for administrators.

Interactive assistance was also provided. For each agency, all staff received bimonthly group coaching calls, and direct service staff and clinical supervisors each received an in-person three-hour coaching session. After a pause due to COVID-19, clinical supervisors and direct service staff received a virtual three-hour booster training. Finally, agency staff received a virtual one-hour consultation to assist with implementation and sustainment.

How Can We Evaluate Our Work?

In the next few pages, we will discuss how D&I frameworks can help us evaluate our work.

D&I Concept #4: Evaluating Our Implementation

One implementation evaluation framework is **RE-AIM**. RE-AIM includes evaluation of the intervention/program/practice and the effect of implementation strategies. See **Box 6** for a breakdown of the model.

Box 6: RE-AIM Model[25]

1. **Reach**
    a. Absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative/intervention/program (e.g., consumers receiving the intervention; is the target population receiving the intervention?)
2. **Effectiveness**
    a. Impact of an intervention on individual outcomes, including potential negative effects, quality of life, cultural, and economic outcomes on consumers (e.g., is the intervention effective?)
3. **Adoption**
    a. Absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program (e.g., are staff and programs using the intervention?)
4. **Implementation**
    a. The intervention agents' fidelity to the various elements of an intervention's protocol, including consistency of delivery as intended, adaptations made, and the time and cost of the intervention (e.g., is the intervention being delivered properly?)
5. **Maintenance (e.g., is the intervention delivered over the long term?)**
    a. Individual level: Long-term effects of a program on participant outcomes 6+ months after the most recent intervention contact
    b. Organizational level: Extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies

An implementation/TA project's funding level and scope may not allow for the evaluation of intervention outcomes; however, the RE-AIM framework keeps the focus on the full range of evaluation targets.

You may have to decide which outcomes are most important to measure, and you may be wondering how you can creatively assess each part of this framework. Let's look at some examples.

Reach

If you wanted to measure reach among individuals in care or consumers, you might consider using administrative, medical, or interview records.

Effectiveness, Adoption, and Implementation

We can examine effectiveness, adoption, and implementation through the lens of the CFIR (see **Figure 10**, adapted from Smith et al., 2014)[26] Although we are interested in outcomes for our

target audience, we need to implement an evidence-based practice with fidelity to reach them. As TA purveyors, we support the implementation process, which can be influenced by the three contexts of implementation we described earlier.

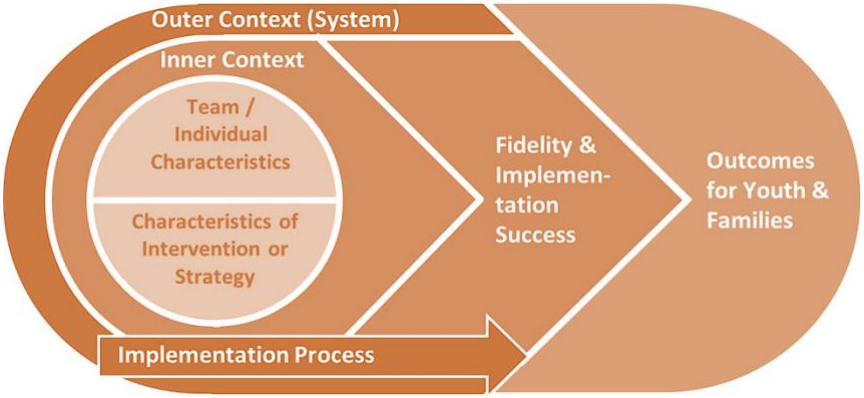


Figure 10: Graphic representation of the Consolidated Framework for Implementation Research.

There are several ways to evaluate the different components that make up the CFIR. **Box 7** provides a list that, while not exhaustive, offers some measures that can be used to assess implementation context, process, fidelity, and outcomes.

Box 7: Evaluating the CFIR's Components

1. **Intervention Characteristics**
   a. Intervention Usability Scale (IUS)[27]
   b. Intervention Acceptability, Appropriateness, and Feasibility measures (AIM, IAM, FIM)[28]
2. **Individual/Team Characteristics**
   a. SAMHSA's training and technical assistance surveys (e.g., GPRA)[29]
   b. Knowledge quizzes
   c. Impact of Training and Technical Assistance (IOTTA) (measures of competence)[30]
   d. EBP Attitudes Scale (EBPAS)[31]
   e. Customized practitioner attitude and behavior measures
3. **Inner Setting**
   a. Implementation Climate Scale (ICS)[32]
   b. Implementation Leadership Scale (ILS)[33]
   c. Custom readiness measure
4. **Outer Setting**
   a. Stage of Implementation Completion (SIC)[34]
   b. Public records
   c. Administrative structures, policies, and procedures
5. **Implementation Process**
   a. IOTTA measure
   b. Stage of Implementation Completion (SIC)
6. **Implementation Fidelity**
   a. Fidelity checklists
   b. Observations of implementation
   c. Interviews
7. **Outcomes**
   a. Behavior change checklists
   b. Health indicators
   c. Self-report measures
   d. Interviews

Maintenance

By measuring each of the different pieces of the RE-AIM framework over time, we work toward measuring the maintenance of an evidence-based practice.

Example: Evaluating across RE-AIM

Figure 11 illustrates a Northwest MHTTC evaluation of intensive TA that consisted of a virtual pre-training session, in-person training, and intensive follow-up consultation. Note the various time points at which implementation and outcomes are measured (see Box 7 for a complete list of measures referenced in Figure 12).

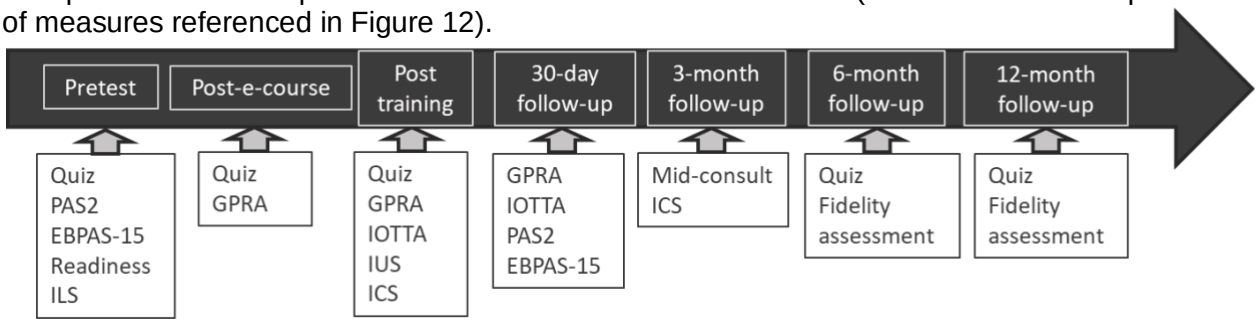


Figure 11: Graphic representation of an evaluation of intensive TA activities from the Northwest MHTTC, ranging from pre-test to post-training and 12-month follow-up.

Example: Evaluation measures across RE-AIM for the MI project

Here's how the Northeast and Caribbean MHTTC applied the RE-AIM framework to their MI project. While they did not measure reach, there were measures for effectiveness, adoption, implementation, and maintenance; see **Figure 12**.

Construct	Measure	Results
Reach	Did not measure	N/A
Effectiveness	Training satisfaction for all agency staff	**Administrators:** 100% would recommend the TA to a colleague and agreed they would use the information gained in their current practice **Direct service staff:** 100% would recommend the TA to a colleague and 90% agreed they would use the information gained in their current practice **Clinical supervisors:** 100% would recommend the TA to a colleague and agreed they expect the information to benefit their professional practice or development
Adoption	Survey measured how helpful participants found the TTA, what was most/least helpful	100% of respondents found the MI trainings helpful. When asked what was most helpful about the MI trainings, participants reported: "It was thought provoking and created useful conversation between my colleagues re: our services, practice and approaches."

		"Practicing MI skills, regular meetings to reinforce practice, getting the chance to have relevant questions answered." "The Community of Practice sessions."
Implementation	Focus groups for administrators and direct service staff to assess and assist with implementation adherence	"Having a common framework has been very helpful. We have people from different backgrounds and so the common framework has been helpful. Conversations are more coherent." "We're very good at providing new staff orientation/one off training, but to have the BA level staff have the ongoing learning community – how do I put it into practice? Helped bring it all together."
Maintenance	Changes to organization and sustained MI implementation	No data at the time of publication

Figure 12: Evaluation of the Northeast and Caribbean MHTTC's MI project, using the RE-AIM framework.

Exercise: Thinking about evaluation across RE-AIM

This exercise can help you reflect on a real-world case example from the Northeast and Caribbean MHTTC. We recommend completing this exercise with your colleagues.

Now, consider your own experiences with a TA project:

1. What is an ITA/TA project example where you were able to measure one or more of the RE-AIM dimensions? How did you achieve it?
2. Is there a particular dimension you have desired to measure but it was difficult to achieve? Has anyone in the group dealt with this? If so, what did you learn?

Next Steps to Using D&I Science in Your Work

This guide introduced D&I science and four D&I concepts that can help you design more effective TA. The examples and exercises offered an opportunity to think about implementation stages, how you can engage your audience in TA, how you may tailor implementation strategies based on your target audience's needs, and how you can evaluate the impact of your work beyond satisfaction with your services.

Implementation Project Template

The MHTTC D&I Working Group, with input from the ATTCs and PTTCs, developed the Implementation Project Template (**Appendix 2**). The template is based on the D&I concepts explored in this guide. Use the Implementation Project Template to plan and track the progress of intensive TA projects. We recommend meeting with your team to complete the template prior to starting a project, as it can help you think through project components, information you may want to gather from participants, and which implementation strategies/TA activities fit with the specific practice and its context.

For More Information

In Summer 2022, the MHTTC Dissemination and Implementation Working Group held a three-session internal learning community for the TTCs, using a curriculum that served as the basis for this guide. The learning community included the didactics found in this guide, as well as examples and exercises. You can access the recordings, slide decks, and more information on the MHTTC website. The materials can be used with your TA purveyor team as professional development to learn more about D&I science and how to use it in your work.

Go forth and accelerate change!

Appendix 1 – Glossary of D&I Terms

Here are terms commonly used in D&I science. For a more complete list, see Rabin and Brownson (2018).[35]

D&I science: The scientific study of processes and factors associated with successful integration of evidence-based interventions within a particular setting (e.g., how one gets evidence-based practices into routine practice settings so that more people can receive the best care possible, how one keeps the practice in place).

Diffusion: A passive, untargeted, unplanned, and uncontrolled spread of new interventions.[35]

Dissemination: An active approach of spreading evidence-based interventions to the target audience via determined channels using planned strategies.

Exploration: The awareness of a patient/consumer/community need or a change in practice, including the decision to adopt a new practice after examining options that might meet the need.

Implementation: The process of putting to use or integrating evidence-based interventions within a setting.

Implementation strategy: "The stuff we do to try to help people and places"[12] change; training and technical assistance activities.

Preparation: Building buy-in and support for change to get ready to implement new practices.

Sustainment: The process of maintaining or continuing the intervention within a setting, beyond a more active implementation period.

TA purveyor or intermediary/purveyor organization: Organizations that disseminate EBPs, train individuals and organizations in EBPs, and provide implementation support.[36]

Appendix 2 – Implementation Project Template

Introduction/Background
The Implementation Project Template was developed by the Mental Health Technology Transfer Center (MHTTC) Dissemination & Implementation (D&I) Working Group, with feedback from the ATTC and PTTC Networks.

The template is a tool to assist in planning and tracking the progress of implementation support/technical assistance projects that have the goal of implementing an intervention/program/practice (versus those focused on awareness raising or training only).

The template is based on key frameworks from D&I research:

- *Implementation Stages*: Implementation of a new practice or an intensive TA project proceeds via stages or phases, one model of which is the Exploration, Planning, Implementation, and Sustainment (EPIS) Framework (Aarons et al., 2012). Exploration—awareness of a patient/consumer/community need or a change in practice. Preparation—tasks needed to get ready to implement the new practice. Implementation—beginning to provide or use the new practice. Sustainment—maintenance of the practice over time.
- *Implementation strategies* are TA activities or "methods to enhance the adoption, implementation sustainment, and scale-up of an innovation" (Kirchner et al., 2018, p. 245). This template uses the nine categories of implementation strategies formulated by Waltz, Powell, and colleagues (e.g., Powell et al., 2012; Waltz et al., 2015).
- The *RE-AIM Framework* (reach, effectiveness, adoption, implementation, maintenance; e.g., Glasgow et al., 1999) is a model for evaluating intervention/program/practice outcomes, as well as the effect of the implementation strategies (implementation outcomes). This template uses the RE-AIM Framework to organize reporting on planned and completed evaluation components. Although TA purveyor funding and scope do not always allow for full evaluation, TA purveyors should strive to evaluate across the range of evaluation targets (e.g., can participant organizations track and report some outcomes?).

Instructions
This template consists of three iterative forms: Exploration/Preparation, Implementation, and Sustainment. Each builds on the information entered previously, with several new fields that appear in the latter two forms. The new data elements in each successive form are highlighted yellow.

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(Questions? Contact Heather Gotham, gothamh@stanford.edu, MHTTC NCO Director).

IMPLEMENTATION PROJECT TEMPLATE
FORM #1 – Exploration/Preparation (Planning) Phase

This version of the form can be used when planning the project, or when the project is in the exploration/preparation phase.

	Organization: **Name & Title of Person Completing Form:** **Dates of Project:** **Date Completing Form:** **Project Title:**
1	**Describe your evidence-based intervention/program/service being implemented (WHAT):**
2	**What is the need/rationale for this project? Why/how did you decide to do this project?**
3	**Target audience/TA recipients (*WHO and WHERE*)** (e.g., behavioral health providers, prevention staff, educators): a) Describe the audience (including organizations, individuals, and cultural considerations): b) Specify discipline(s) of individuals: c) Specify the audience's setting (e.g., emergency departments, schools, opioid treatment programs): d) Specify roles of individuals: e) Specify audience relationship to one another (Choose one): ___Single individuals from multiple organizations ___Multiple individuals within one organization ___Multiple individuals or teams from multiple organizations f) How will your target audience/TA recipients be recruited?
4	**Contextual/determinant considerations** (What facilitators are anticipated to aid implementation? What barriers could hinder implementation? Include cultural considerations for each category): *Facilitators:* a) System factors—external to the organization (e.g., financing, mandates, community, culture): b) Organizational factors—internal to the organization (e.g., leadership, readiness): c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity): *Barriers:* a) System factors—external to the organization (e.g., financing, mandates, community, culture): b) Organizational factors—internal to the organization (e.g., leadership, readiness): c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity): How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)?
5	**Implementation Strategies (*HOW*)** Implementation strategies are the training and technical assistance services that you provide as part of the project. The following list includes specific implementation strategies in 9 categories. Determine which implementation strategies were used in your project, and then fill in the table ***Determine which implementation strategies were used in your project.**

Category	**Implementation Strategy**
Use evaluative and iterative strategies.	Assess for readiness.
	Identify barriers and facilitators.

	Audit and provide feedback.
	Implement quality monitoring tools/programs.
	Develop a formal implementation blueprint/plan.
	Conduct local needs assessment.
	Conduct cyclical small tests of change.
Provide interactive assistance.	Provide facilitation (interactive problem-solving and support for implementation of an intervention).
	Provide technical assistance (negotiated series of activities designed to reach a valued outcome).
	Provide coaching (person with specific training in coaching guides and provides feedback).
	Provide consultation (on clinician practice by external consultant).
	Conduct mentoring (matching experienced person with less experienced person).
Adapt and tailor to context.	Use data experts.
Develop stakeholder relationships.	Identify and prepare champions.
	Inform local opinion leaders.
	Build a coalition.
	Recruit, designate, and train leadership.
	Obtain formal commitments.
	Involve executive boards.
	Involve patients/consumers and family members.
	Visit other sites.
Train and educate stakeholders.	Develop educational materials (e.g., guidelines, manuals, toolkits).
	Distribute educational materials (e.g., in person, electronically, via mail).
	Conduct educational meetings (with stakeholders to learn about the intervention).
	Conduct ongoing training.
	Conduct a train-the-trainer.
	Create a learning collaborative.
	Conduct a practice improvement collaborative.
	Create a community of practice or learning community.
Support deliverers of the intervention/program/service.	Set up clinical reminders.
	Develop resource sharing agreements.
Use financial strategies.	Provide incentives/allowance.
Change infrastructure.	Suggest policy mandates.
	Change records systems.

Adapted from Waltz, T. J., Powell, B. J., Matthieu, M. M., Damschroder, L. J., Chinman, M. J., Smith, J. L., Proctor, E. K., & Kirchner, J. E. (2015). Use of concept mapping to characterize relationships among implementation strategies and assess their feasibility and importance: results from the Expert Recommendations for Implementing Change (ERIC) study. *Implementation Science*, *10*, 109. https://doi.org/10.1186/s13012-015-0295-0

For each strategy:

- Choose strategy from list above (dropdown in the online version) (if it really does not fit any of the strategies listed, choose Other)
- Describe the strategy briefly (including if it was tailored for specific/cultural groups)
- Enter information about:
  - Format – choose from dropdown: email/mail, in person, phone, virtual/video, website
  - # of units – how many times was strategy offered (number)
  - Frequency – how often was strategy offered
- Add or delete rows if needed:

Implementation Strategy* (from the list)	**Format** (email/mail, in person, phone,	**Planned # of Units** (# times this will occur)	**Frequency** (how often this will occur)	**Brief Description**

		virtual/video, website)			

Describe the timeline/sequence of the planned Implementation Strategies, step by step:

6 Evaluation

a) Target audience/TA participants

planned enrollment: _____ organizations ____ individuals

b) Proximal Training/TA Outcomes: List how you will measure proximal/short-term training outcomes such as knowledge, skills, confidence, and attitudes.

Outcome	**How will the outcome be measured?**

c) Implementation/Sustainment Measures. The *RE-AIM Framework* is a model for evaluating intervention/program/practice outcomes, as well as the effect of the implementation strategies (implementation outcomes). Review the following for definitions and possible ways to measure outcomes, including culturally focused measures. Then complete the table.

****RE-AIM FRAMEWORK**

Outcomes are measured either at the patients/consumers/participants level (intervention/program/practice outcomes in patients/consumers/participants) or the target audience/TA recipients/organization/setting level (outcomes in the staff/providers or organization).

Dimension	**Level**
Reach: Absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative/intervention/program (e.g., consumers who receive the intervention). This includes: (# of individuals receiving intervention)/(# of individuals needing the intervention). *Are the people receiving the intervention?*	Patients/consumers/participants
Effectiveness: The impact of an intervention on individual outcomes, including potential negative effects, quality of life, cultural, and economic outcomes (e.g., on consumers). *Is the intervention effective?*	Patients/consumers/participants
Adoption: The absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program (e.g., target audience/providers in an organization who adopt the intervention). *Are staff and programs using my intervention?*	Target audience/TA recipients/organization /setting
Implementation: The intervention agents' fidelity to the various elements of an intervention's protocol. This includes consistency of delivery as intended, adaptations made, and the time and cost of the intervention. *Is the intervention being delivered properly?*	Target audience/TA recipients/organization /setting
Maintenance: • Patients/consumers/participants level: The long-term effects of a program on participant's outcomes six or more months after the most recent intervention contact. • Target audience/TA recipients/organization/setting level: The extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies. • Is the intervention delivered over the long-term?	Both

Adapted from Gaglio, B., & Glasgow, R. E. (2018). Evaluation approaches for dissemination and implementation research. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds.), *Dissemination and implementation research in health: Translating science to practice* (2nd ed.). New York: Oxford University Press. Glasgow, R. E., Harden, S. M., Gaglio, B., Rabin, B., Smith, M. L., Porter, G. C., Ory, M. G., & Estabrooks, P. A. (2019). RE-AIM planning and evaluation framework: Adapting to new science and practice with a 20-year review. *Frontiers in Public Health*, *7*, 64. https://doi.org/10.3389/fpubh.2019.00064

	Outcome	**How will the outcome be measured?**
	a) Reach of intervention/program/service (# of individuals receiving intervention)/(# of individuals needing the intervention)	
	b) Effectiveness of intervention/program/service (with individuals)	
	c) Adoption (#/% of target audience/TA recipients using intervention)	
	d) Implementation fidelity/adherence/quality, cost	
	e) Maintenance (individual effectiveness; target audience/TA recipients' using intervention)	
	f) Other?	
7	**Other relevant issues?**	

IMPLEMENTATION PROJECT TEMPLATE
FORM #2 – Implementation Phase

This version of the form can be used when the project is in the implementation phase. New content is highlighted in **bold orange font**.

<table>
<tr><td></td><td colspan="5">Organization: Name & Title of Person Completing Form:
Dates of Project: Date Completing Form:
Project Title:</td></tr>
<tr><td>1</td><td colspan="5">Describe your evidence-based intervention/program/service being implemented (WHAT):</td></tr>
<tr><td>2</td><td colspan="5">What is the need/rationale for this project? Why/how did you decide to do this project? Did anything change from the previous phase to impact the project?</td></tr>
<tr><td>3</td><td colspan="5">Target audience/TA recipients (WHO and WHERE) (e.g., behavioral health providers, prevention staff, educators):
a) Describe the audience (including organizations, individuals, and cultural considerations):

b) Specify discipline(s) of individuals:

c) Specify what setting the audience is from (e.g., emergency departments, schools, opioid treatment programs):

d) Specify roles of individuals:

e) Specify audience relationship to one another (Choose one):
___Single individuals from multiple organizations
___Multiple individuals within one organization
___Multiple individuals or teams from multiple organizations

f) How were your target audience/TA recipients recruited?</td></tr>
<tr><td>4</td><td colspan="5">Contextual/determinant considerations (What facilitators are aiding implementation? What barriers are hindering implementation? Include cultural considerations for each category. Update as needed.):

Facilitators:
a) System factors—external to the organization (e.g., financing, mandates, community, culture):

b) Organizational factors—internal to the organization (e.g., leadership, readiness):

c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity):

Barriers:
a) System factors—external to the organization (e.g., financing, mandates, community, culture):

b) Organizational factors—internal to the organization (e.g., leadership, readiness):

c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity):

How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)?</td></tr>
<tr><td>5</td><td colspan="5">Implementation strategies (HOW) (For each strategy, describe the strategy briefly [including if it was tailored for specific/cultural groups], and provide information about the format, # of units, and frequency. Note if the strategy was tailored for specific/cultural groups. Add or delete rows if needed):</td></tr>
<tr><td></td><td>Implementation Strategy* (from the list)</td><td>Format (email/mail, in person, phone, virtual/video, website)</td><td>Planned # of Units (# of times this will occur)</td><td>Frequency (how often this will occur)</td><td>Brief Description</td></tr>
</table>

	Describe the sequence of the implementation strategies, step by step (edit from previous if the plan changed):				
6	**Evaluation** **a) Target audience/TA participants** # planned enrollment: _____ organizations ____ individuals **# enrolled: _____ organizations ____ individuals** **# (%) initiating implementation strategy: _____ organizations ____ individuals**				
	b) Proximal training/TA outcomes: List how you will measure proximal/short-term training outcomes such as knowledge, skills, confidence, and attitudes.				
	Outcome		**How Measuring?**		**Results, if Available**
	c) Implementation/Sustainment Measures** The *RE-AIM Framework* is a model for evaluating intervention/program/practice outcomes, as well as the effect of the implementation strategies (implementation outcomes). Review the following for definitions and possible ways to measure outcomes, including culturally focused measures. Then complete the table below.				
	Outcome		**How Measuring?**		**Results, if Available**
	a) Reach of intervention/program/service (# of individuals receiving intervention)/(# of individuals needing the intervention)				
	b) Effectiveness of intervention/program/service (with individuals)				
	c) Adoption (#/% of target audience/TA recipients using intervention)				
	d) Implementation fidelity/adherence/quality, cost				
	e) Maintenance (individual effectiveness; target audience/TA recipients using intervention)				
	f) Other?				
7	**Other relevant issues?**				

IMPLEMENTATION PROJECT TEMPLATE
FORM #3 – Sustainment Phase

This version of the form can be used when the project is in the Sustainment Phase. New content is in **bold orange font.**

	Organization: **Name & Title of Person Completing Form:** **Dates of Project:** **Date Completing Form:** **Project Title:**
1	**Describe your evidence-based intervention/program/service being implemented (WHAT):**
2	**What is the need/rationale for this project? Why/how did you decide to do this project? Did anything change from the previous phase to impact the project?**
3	**Target audience/TA recipients (*WHO and WHERE*)** (e.g., behavioral health providers, prevention staff, educators): a) Describe the audience (including organizations, individuals, and cultural considerations): b) Specify discipline(s) of individuals: c) Specify what setting the audience is from (e.g., emergency departments, schools, opioid treatment programs): d) Specify roles of individuals: e) Specify audience relationship to one another (Choose one): ___Single individuals from multiple organizations ___Multiple individuals within one organization ___Multiple individuals or teams from multiple organizations f) How were your target audience/TA recipients recruited?
4	**Contextual/Determinant Considerations** (What facilitators aided implementation? What barriers hindered implementation? Include cultural considerations for each category. **Update as needed.**): **Facilitators:** a) System factors—external to the organization (e.g., **policy,** financing, mandates, community, culture): b) Organizational factors—internal to the organization (e.g., leadership, readiness): c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity): **Barriers:** a) System factors—external to the organization (e.g., financing, mandates, community, culture): b) Organizational factors—internal to the organization (e.g., leadership, readiness): c) Individual clinician/staff factors (e.g., alignment with existing practice, complexity): How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)?
5	**Implementation Strategies (*HOW*)** (For each strategy, describe the strategy briefly [including if it was tailored for specific/cultural groups], and provide information about the format, # of units, and frequency. Note if strategy was tailored for specific/cultural groups. Add or delete rows if needed):

	Implementation Strategy* (from the list)	**Format** (email/mail, in person, phone, virtual/video, website)	**Planned # of Units** (# of times this will occur)	**Frequency** (how often this will occur)	**Brief Description**

	Describe the sequence of the implementation strategies, step by step (edit from previous if the plan changed):				
6	**Evaluation** **a) Target audience/TA participants** # planned enrollment: _____ organizations ____ individuals # enrolled: _____ organizations ____ individuals # (%) initiating implementation strategy: _____ organizations ____ individuals **# (%) completing 50% of implementation strategy activities:** ____ organizations ____ individuals **# (%) completing 80% or more of implementation strategy activities:** _____ organizations ____ individuals _____				
	b) Proximal training/TA outcomes: List how you will measure proximal/short-term training outcomes such as knowledge, skills, confidence, and attitudes.				
	Outcome		**How Measured?**		**Results**
	c) Implementation/sustainment measures** The *RE-AIM Framework* is a model for evaluating intervention/program/practice outcomes, as well as the effect of the implementation strategies (implementation outcomes). Review the following for definitions and possible ways to measure outcomes, including culturally focused measures. Then complete the table below.				
	Outcome		**How Measured?**		**Results**
	a) Reach of intervention/program/service (# of individuals receiving intervention)/(# of individuals needing the intervention)				
	b) Effectiveness of intervention/program/service (with individuals)				
	c) Adoption (#/% of target audience/TA recipients using intervention)				
	d) Implementation fidelity/adherence/quality, cost				
	e) Maintenance (individual effectiveness; target audience/TA recipients using intervention)				
	f) Other?				
7	**Other relevant issues?**				

Appendix 3 – References

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