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**Example Completed Project**

**D&I PROJECT TEMPLATE (for Intensive TA Projects)**

**Revision 9/21/20**

**Background**

This Dissemination & Implementation (D&I) project template was developed, piloted, and refined over the course of a year by the MHTTC Dissemination & Implementation Working Group. The structure is based on implementation science research, including the work of Powell and colleagues on implementation strategies (e.g., Powell et al., 2012) and the RE-AIM framework (e.g., Glasgow et al., 1999) for measuring implementation outcomes.

The template is a tool to assist in planning and tracking the progress of implementation projects (intensive TA) during the exploratory/planning (or pre-implementation), implementation, and sustainment phases.

* The MHTTC NCO is in the process of automating the form, such that TTC staff will be able to view their and other Centers forms on a secure portal.
* We will be able to summarize information across projects and reflect that information back to the Network(s) (e.g., what implementation strategies are used most frequently, what outcomes are being measured and how).
* This is meant to be voluntary, and is only applicable to some of the work completed by a TTC.

Having wide adoption of the template across the Network(s) can have the following benefits:

* As a learning health system, we want to be able to collect information/data, beyond GPRA, on the training and TA activities we provide.
* Summary information from forms completed across the Network/TTCs will inform us about how intensive TA projects are being conducted, and shed light on how we might better use implementation science findings to guide our work.
* The intention is not to compare Centers to each other. We want to learn how we are all developing TA services and how we can improve.

**Instructions**

There are three versions of the template. A version for exploration/planning, a version for implementation, and a version for sustainment. Each builds on the information entered previously. When the template is automated, the information from the previous form will pre-load into the next form (with ability to modify).

The following shows each form. The new data elements in each successive form are highlighted yellow.

**FORM #1 - Exploratory/Preparatory (or Planning) Phase**

 **D&I PROJECT TEMPLATE (for Intensive TA Projects)**

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|  | **Center:** (example) **Person Completing Form:** Heather Gotham**Dates of Project:** Jan 2019-Sept 2019**Title of project:** Motivational Interviewing for One State |
| **1** | **Evidence-Based Intervention/Program/Service Being Implemented (*WHAT)***: This project sought to assist behavioral health treatment providers in one state to implement motivational interviewing in their staff and supervisors. |
| **2** | **Target Audience for whom you are providing the project (*WHO*)** (e.g., behavioral health providers, prevention staff, educators):a) Describe the audience, including organizations and individuals:2 staff and 1 supervisor from each regional behavioral health treatment organizationb) Specify discipline(s) of individuals:counseling, social workc) Specify roles of individuals:2 frontline clinicians and 1 clinical supervisor per agencyd) Specify audience relationship to one another (Choose one):\_\_\_ Single individuals from multiple organizations\_\_\_ Multiple individuals within one organization\_x\_ Multiple individuals or teams from multiple organizations |
| **3** | **Implementation Strategy (*HOW*)** (Implementation strategies are the training and TA services you provide. Choose category based on list below; add or delete rows if needed)**:** |
|  | **Category** | **Description** | **Format** (e.g., meeting, phone, virtual, in person) | **Planned # of Units** (# times this will occur) | **Frequency** (how often this will occur) |
| Develop stakeholder relationships | Signed commitment letter from executive sponsor that included designation of change leader and implementation team | Written communication | **1** | **Once** |
| Interactive assistance | 2 virtual meetings with executive sponsors and change leaders to discuss project and implementation barriers | Virtual meeting | 2 | 3 months apart |
| Train/educate stakeholders | Initial online course for clinicians and supervisors | Online training | 1 6-hour course | Once  |
| Train/educate stakeholders | In-person 2-day advanced skills training for clinicians and supervisors | In-person | 2 days | Once  |
| Interactive assistance | Participants submitted a recorded session; coded by trainer; 1-hour individual meeting to review results; submitted up to 3 recordings until achieved competence via MITI rating scale | Session review; virtual meeting | 1-3 reviews | Up to 3 within 6 months |
| Interactive assistance | Monthly group coaching calls for 6 months | Virtual group coaching | 6 sessions | Monthly  |
| Train/educate stakeholders | In-person 2-day supervisor training | In-person | 2 days | Once  |
|  | **Describe the Planned Implementation Strategies, step by step:**Implementation strategies were planned in the sequence noted above. First, organizations will be contacted to sign letters of commitment. 2 virtual meetings will then be held with executive sponsors and change leaders to discuss project management and barriers while the clinicians and supervisors complete the online course. Following the course, a 2-day in person advanced MI training will be held. This will be followed by participants submitting recorded sessions to be coded by the trainer. The trainer will use the MITI rating scale, and provide feedback via coaching meeting. This will happen up to 3 times until the participant reaches competence. During this time, the trainer will provide monthly group coaching calls. After supervisors reach competence, they will attend a 2-day supervisor training. |
| **4** | **Contextual/determinant Considerations** (What facilitators are anticipated to aid implementation? What barriers could hinder implementation?):a) System factors--external to the organization (e.g., financing; mandates, community, culture): state pressure to implement EBPs; lingering beliefs in the culture that SUDs are a moral issue and MI is enabling; no financial benefit to implementing MI unless can show increase in retention ratesb) Organizational factors—internal to the organization (e.g., leadership; readiness): not observed yetc) Individual clinician/staff factors (e.g., alignment with existing practice; complexity): not observed yetd) How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)? Opinions of TTC staff; will conduct a readiness assessment with clinicians and supervisors after they are recruited |
| **5** | **Implementation Process:** a) How will your target audience/participants be recruited? Email through state provider association and state behavioral health authority. Email directly to providers on listserv. |
| **6** | **Implementation/Sustainment Measures** (see list for definitions and possible ways to measure)**:** |
| **Outcome** | **How will the outcome be measured?** |
| a) Reach (#/% of population of consumers receiving intervention)(Population = ) | Don’t plan to measure. |
| b) Effectiveness of intervention/program/services (w/consumers) | Don’t plan to measure. |
| c) Adoption (#/% of target audience/providers) | 3-month follow-up after the end of the strategies. |
| d) Implementation fidelity/adherence/quality | Whether participants reached competence via the MITI |
| e) Cost | Estimated cost of implementation strategies, including trainers, travel, etc., is $7,500 per participant (if purchased through regular national MI trainers). |
|  | f) Other? |  |
| **7** | **Other relevant issues?** |
|  |

**IMPLEMENTATION STRATEGY CATEGORIES**

**Determine which of the following best describe the implementation strategies used in your project. Use these categories in under #3 above.**

* Evaluative and iterative strategies (e.g., Assess for readiness; Identify barriers and facilitators; Audit and feedback)
* Interactive assistance (e.g., Facilitation; Technical assistance; Coaching; Clinical Supervision; Mentoring)
* Adapting and tailoring strategies (e.g., Based on barriers or facilitators; Stage of readiness; Characteristics of the Intervention; Baseline performance)
* Develop stakeholder relationships (e.g., Identify and prepare champions; Inform local opinion leaders; Build coalitions)
* Train/educate stakeholders (e.g., Conduct ongoing training; Develop educational materials; Learning Collaborative; Practice Improvement Collaborative)
* Support deliverers of the intervention/program/service (e.g. Reminders; Resource sharing agreements; Role revision)
* Engage consumers (e.g., Involve consumers and family members; Use mass media or public service announcements)
* Use financial strategies (e.g., Access new funding [time-limited grant or 3rd party insurance]; Provide incentives/allowance; Develop disincentives)
* Change infrastructure (e.g., Policy mandates; Alter physical environment)

**RE-AIM IMPLEMENTATION/SUSTAINMENT MEASURES**

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| --- | --- |
| Dimension | Level |
| Reach - Absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative (e.g., consumers who receive the intervention) | Individual |
| Effectiveness - The impact of an intervention on outcomes, including potential negative effects, quality of life, and economic outcomes (e.g., on consumers) | Individual |
| Adoption - the absolute number, proportion, and representativeness of settings an intervention agents who are willing to initiate a program (target audience/providers in an organization who adopt the intervention) | Organization |
| Implementation - Refers to the intervention agents Fidelity to the various elements of an interventions protocol. This includes consistency of delivery as intended, adaptations made, and the time and cost of the intervention (extent to which the intervention is implemented as intended in the real world) | Organization |
| Maintenance - the extent to which a program or policy it comes institutionalized or part of the routine organizational practices and policies. At the individual level, it is defined as the long term effects of a program on outcomes six or more months after the most recent intervention contact (extent to which a program is sustained over time) | Individual and organization |

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.

**FORM #2 - Implementation Phase**

**D&I PROJECT TEMPLATE (for Intensive TA Projects)**

Information from the exploration/preparatory phase will be auto-filled into the previously completed sections. The user can update based on what is occurring during the implementation phase. New content is highlighted in yellow.

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|  | **Center:** (example) **Person Completing Form:** Heather Gotham**Dates of Project:** Jan 2019-Sept 2019 |
| **1** | **Evidence-Based Intervention/Program/Service Being Implemented (*WHAT)***: This project sought to assist behavioral health treatment providers from 15 agencies in one state to implement motivational interviewing in their staff and supervisors. |
| **2** | **Target Audience for whom you are providing the project (*WHO*)** (e.g., behavioral health providers, prevention staff, educators):a) Describe the audience, including organizations and individuals:2 staff and 1 supervisor from each of 15 regional behavioral health treatment organizationb) Specify discipline(s) of individuals:counseling, social workc) Specify roles of individuals:2 frontline clinicians and 1 clinical supervisor per agencyd) Specify audience relationship to one another (Choose one):\_\_\_Single individuals from multiple organizations\_\_\_Multiple individuals within one organization\_x\_Multiple individuals or teams from multiple organizations |
| **3** | **Implementation Strategy (*HOW*)** (Implementation strategies are the training and TA services you provide. Choose category based on list; add or delete rows if needed)**:** |
|  | **Category** | **Description** | **Format** (e.g., meeting, phone, virtual, in person) | **Planned # of Units** (# times this will occur) | **Frequency** (how often this will occur) |
| Develop stakeholder relationships | Signed commitment letter from executive sponsor that included designation of change leader and implementation team | Written communication | **1** | **Once** |
| Interactive assistance | 2 virtual meetings with executive sponsors and change leaders to discuss project and implementation barriers | Virtual meeting | 2 | 3 months apart |
| Train/educate stakeholders | Initial online course for clinicians and supervisors | Online training | 1 6-hour course | Once  |
| Train/educate stakeholders | In-person 2-day advanced skills training for clinicians and supervisors | In-person | 2 days | Once  |
| Interactive assistance | Participants submitted a recorded session; coded by trainer; 1-hour individual meeting to review results; submitted up to 3 recordings until achieved competence via MITI rating scale | Session review; virtual meeting | 1-3 reviews | Up to 3 within 6 months |
| Interactive assistance | Monthly group coaching calls for 6 months | Virtual group coaching | 6 sessions | Monthly  |
| Train/educate stakeholders | In-person 2-day supervisor training | In-person | 2 days | Once  |
|  | **Describe the Implementation Strategies used, step by step:**Implementation strategies were planned in the sequence noted above. First, organizations were contacted to sign letters of commitment. 2 virtual meetings were then be held with executive sponsors and change leaders to discuss project management and barriers while the clinicians and supervisors completed the online course. Getting participants to complete the online course took longer than the anticipated 6 weeks (12 weeks). Following the course, a 2-day in person advanced MI training was held. This was followed by participants submitting recorded sessions to be coded by the trainer. The trainer used the MITI rating scale, and provided feedback via coaching meeting, up to 3 times until the participant reached competence (one participant needed 4 times). During this time, the trainer provided monthly group coaching calls. After supervisors reach competence, they will attend a 2-day supervisor training. |
| **4** | **Contextual/determinant Considerations** (What facilitators are present to aid implementation? What barriers have hindered implementation?):a) System factors--external to the organization (e.g., financing; mandates, community, culture): state pressure to implement EBPs; lingering beliefs in the culture that SUDs are a moral issue and MI is enabling; no financial benefit to implementing MI unless can show increase in retention ratesb) Organizational factors—internal to the organization (e.g., leadership; readiness): executive leadership was committed to implement; mixed readiness of staffc) Individual clinician factors (e.g., alignment with existing practice; complexity): most clinicians saw need for this model; clinicians initially unsure they would be given appropriate time off for training and recording sessions; most clinicians did not want to record and submit sessions for review;d) How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)? Readiness assessment with staff and supervisors; opinions of TTC staff |
| **5** | **Implementation Process:** a) How was your target audience/participants recruited?Email through state provider association and state behavioral health authority. Email directly to providers on listserv.b) # enrolled: \_\_15\_\_\_ organizations \_45\_\_\_ individualsc) # (%) initiating implementation strategy: \_15\_\_\_\_ organizations \_42 (93%)\_\_\_ individuals (2 staff dropped out due to job change) |
| **6** | **Implementation/Sustainment Measures being Collected** (see list for definitions)**:** |
| **Outcome** | **How measuring?** | **Results, if Available** |
| a) Reach (#/% of population of consumers receiving intervention)(Population = ) | Don’t plan to measure. |  |
| b) Effectiveness of intervention/program/services (w/consumers) | Don’t plan to measure. |  |
| c) Adoption (#/% of target audience) | 3-month follow-up after the end of the strategies. |  |
| d) Implementation fidelity/adherence/quality | Whether participants reached competence via the MITI |  |
| e) Cost | Estimated cost of implementation strategies, including trainers, travel, etc., is $7,500 per participant (if purchased through regular national MI trainers). |  |
|  | f) Other? |  |  |
| **7** | **Other relevant issues?** |
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**FORM #3 - Sustainment Phase**

 **D&I PROJECT TEMPLATE (for Intensive TA Projects)**

Information from the implementation phase will be auto-filled into the previously completed sections. The user can update based on what is occurring during the implementation phase. New content is highlighted in yellow.

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| --- | --- |
|  | **Center:** (example) **Person Completing Form:** Heather Gotham**Dates of Project:** Jan 2019-Sept 2019 |
| **1** | **Evidence-Based Intervention/Program/Service Being Implemented (*WHAT)***: This project sought to assist behavioral health treatment providers from 15 agencies in one state to implement motivational interviewing in their staff and supervisors. |
| **2** | **Target Audience for whom you are providing the project (*WHO*)** (e.g., behavioral health providers, prevention staff, educators):a) Describe the audience, including organizations and individuals:2 staff and 1 supervisor from each of 15 regional behavioral health treatment organizationb) Specify discipline(s) of individuals:counseling, social workc) Specify roles of individuals:2 frontline clinicians and 1 clinical supervisor per agencyd) Specify audience relationship to one another (Choose one):\_\_\_ Single individuals from multiple organizations\_\_\_ Multiple individuals within one organization\_x\_ Multiple individuals or teams from multiple organizations |
| **3** | **Implementation Strategy (*HOW*)** (Implementation strategies are the training and TA services you provide. Choose category based on list; add or delete rows if needed)**:** |
|  | **Category** | **Description** | **Format** (e.g., meeting, phone, virtual, in person) | **Planned # of Units** (# times this will occur) | **Frequency** (how often this will occur) |
| Develop stakeholder relationships | Signed commitment letter from executive sponsor that included designation of change leader and implementation team | Written communication | **1** | **Once** |
| Interactive assistance | 2 virtual meetings with executive sponsors and change leaders to discuss project and implementation barriers | Virtual meeting | 2 | 3 months apart |
| Train/educate stakeholders | Initial online course for clinicians and supervisors | Online training | 1 6-hour course | Once  |
| Train/educate stakeholders | In-person 2-day advanced skills training for clinicians and supervisors | In-person | 2 days | Once  |
| Interactive assistance | Participants submitted a recorded session; coded by trainer; 1-hour individual meeting to review results; submitted up to 3 recordings until achieved competence via MITI rating scale | Session review; virtual meeting | 1-3 reviews | Up to 3 within 6 months |
| Interactive assistance | Monthly group coaching calls for 6 months | Virtual group coaching | 9 sessions | Monthly  |
| Train/educate stakeholders | In-person 2-day supervisor training | In-person | 2 days | Once  |
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|  | **Describe the Implementation Strategies used, step by step:**Implementation strategies were planned in the sequence noted above. First, organizations were contacted to sign letters of commitment. 2 virtual meetings were then be held with executive sponsors and change leaders to discuss project management and barriers while the clinicians and supervisors completed the online course. Getting participants to complete the online course took longer than the anticipated 6 weeks (12 weeks). Following the course, a 2-day in person advanced MI training was held. This was followed by participants submitting recorded sessions to be coded by the trainer. The trainer used the MITI rating scale, and provided feedback via coaching meeting, up to 3 times until the participant reached competence (one participant needed 4 times). During this time, the trainer provided monthly group coaching calls; monthly coaching calls were extended due to more time taken then planned for participants to submit tapes. After supervisors reached competence, they attended a 2-day supervisor training. |
| **4** | **Contextual/determinant Considerations** (What facilitators were present to aid implementation? What barriers hindered implementation?):a) System factors--external to the organization (e.g., financing; mandates, community, culture): state pressure to implement EBPs; lingering beliefs in the culture that SUDs are a moral issue and MI is enabling; no financial benefit to implementing MI unless can show increase in retention ratesb) Organizational factors—internal to the organization (e.g., leadership; readiness): executive leadership was committed to implement; mixed readiness of staffc) Individual clinician factors (e.g., alignment with existing practice; complexity): most clinicians saw need for this model; clinicians initially unsure they would be given appropriate time off for training and recording sessions; most clinicians did not want to record and submit sessions for review;d) How were these considerations ascertained (e.g., formal evaluation, needs/readiness assessment)? Readiness assessment with staff and supervisors; opinions of TTC staffd) Sustainment strategies applied: Monthly coaching calls were extended to provide ongoing support to clinicians. |
| **5** | **Implementation Process:** a) How was your target audience/participants recruited?b) # enrolled: \_\_15\_\_\_ organizations \_45\_\_\_ individualsc) # (%) initiating implementation strategy: \_\_15\_ organizations \_42 (93%)\_ individuals (2 staff dropped out due to job change)d) # (%) completing 50% of implementation strategy activities: \_\_42 (100%) [made it through the 2-day advanced skills course]\_e) # (%) completing 80% or more of implementation strategy activities: \_\_37 (82%) achieved competence  |
| **6** | **Implementation/Sustainment Measures** (see list for definitions)**:** |
| **Outcome** | **How measured?** | **Results** |
| a) Reach (#/% of population of consumers receiving intervention)(Population = ) | Don’t plan to measure. |  |
| b) Effectiveness of intervention/program/services (w/consumers) | Don’t plan to measure. |  |
| c) Adoption (#/% of target audience) | 3-month follow-up after the end of the strategies. | Of the 37 who achieved competence, 20 reported that they were using MI in practice. |
| d) Implementation fidelity/adherence/quality | Whether participants reached competence via the MITI | 37 of the 42 achieved competence. |
| e) Cost  | Estimated cost of implementation strategies, including trainers, travel, etc., is $7,500 per participant. | TTC costs were approximately $2,000 per participant. |
| f) Maintenance/Sustainment |  | At 6 month follow-up, 15 reported that they were using MI in practice. |
|  | g) Other? |  |  |
| **7** | **Other relevant issues?** |
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