


Dissemination and Implementation in Health Listserv**** JUNE 2011****

Welcome to the **Dissemination and Implementation in Health Listserv**. The purpose of the listserv is to distribute information on late-breaking (*within past 30 days*) research, practice, and policy activities in the area of dissemination and implementation in medical care and public health, including publications, reports, conferences, meetings, program announcements, funding opportunities, and other various proceedings. The listserv is purposely broad in membership and scope, and encompasses the relevant areas of dissemination, implementation, capacity building, knowledge translation, scale-up/spread, quality improvement, research-to-practice, diffusion, knowledge transfer and exchange, adoption, complex interventions, implementation strategies, action research, translational research, and other related terms.

To subscribe to the listserv, send an email to listserv@listserv.uab.edu with the body of the message stating: Subscribe D-I-Health *your name*. You should receive a message from the listserv with instructions for how to complete your subscription. Archives for the listserv can be found at <http://listserv.uab.edu/D-I-Health.html>. Listserv information and archives are also posted on the Center for Health Dissemination and Implementation Research website: <http://www.research-practice.org/index.htm>

Questions and/or comments should be directed to Wynne E. Norton, PhD, Assistant Professor, School of Public Health, University of Alabama at Birmingham: wynne.norton@gmail.com.

A. WEBINARS

**Enhancing Implementation Science
Evaluation Examples and Guidance for Study Design
By Brian Mittman, Ph.D.
Carol VanDeusen Lukas, Ed.D.
Thursday, June 9, 12:00pm - 1:00pm ET**

Please note that this Cyber Seminar is a follow-up to the July 2010 CIPRS Implementation Science training meeting "Enhancing Implementation Science." If you did not attend the EIS training meeting, you are required to watch the archived version of the

following July 2010 presentation prior to joining the Cyber Seminar: "Panel: Evaluation Examples and Challenges (Carol Van Deusen Lukas)". This session can be accessed from the July 2010 meeting website: <http://www.queri.research.va.gov/meetings/eis/>.

The seminar also will feature an overview of the QUERI SDP (Service-Directed Project) Template, offering guidance for the design of evaluations of implementation programs and the content of QUERI and non-VA implementation research funding applications.

http://www.hsrd.research.va.gov/for_researchers/cyber_seminars.

B. ABSTRACTS

1. [N Engl J Med](#). 2011 May 26;364(21):1985-7. Epub 2011 May 18.

The \$640 billion question--why does cost-effective care diffuse so slowly?

[Fuchs VR](#), [Milstein A](#).

[No Abstract Provided]

2. [Am J Prev Med](#). 2011 Jun;40(6):637-44.

A proposal to speed translation of healthcare research into practice dramatic change is needed.

[Kessler R](#), [Glasgow RE](#).

Abstract

Efficacy trials have generated interventions to improve health behaviors and biomarkers. However, these efforts have had limited impact on practice and policy. It is suggested that key methodologic and contextual issues have contributed to this state of affairs. Current research paradigms generally have not provided the answers needed for more probable and more rapid translation. A major shift is proposed to produce research with more rapid clinical, public health, and policy impact.

3. [Int J Qual Health Care](#). 2011 May 16. [Epub ahead of print]

Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience.

[Luxford K](#), [Safran DG](#), [Delbanco T](#).

Abstract

OBJECTIVE:

/st> To investigate organizational facilitators and barriers to patient-centered care in US health care institutions renowned for improving the patient care experience.

DESIGN:

/st> A qualitative study involving interviews of senior staff and patient representatives. Semi-structured interviews focused on organizational processes, senior leadership, work environment, measurement and feedback mechanisms, patient engagement and information technology and access.

SETTING:

/st> Eight health care organizations across the USA with a reputation for successfully promoting patient-centered care.

PARTICIPANTS:

/st> Forty individuals, including chief executives, quality directors, chief medical officers, administrative directors and patient committee representatives.

RESULTS:

/st> Interviewees reported that several organizational attributes and processes are key facilitators for making care more patient-centered: (i) strong, committed senior leadership, (ii) clear communication of strategic vision, (iii) active engagement of patient and families throughout the institution, (iv) sustained focus on staff satisfaction, (v) active measurement and feedback reporting of patient experiences, (vi) adequate resourcing of care delivery redesign, (vii) staff capacity building, (viii) accountability and incentives and (ix) a culture strongly supportive of change and learning. Interviewees reported that changing the organizational culture from a 'provider-focus' to a 'patient-focus' and the length of time it took to transition toward such a focus were the principal barriers against transforming delivery for patient-centered care.

CONCLUSIONS:

/st> Organizations that have succeeded in fostering patient-centered care have gone beyond mainstream frameworks for quality improvement based on clinical measurement and audit and have adopted a strategic organizational approach to patient focus.

4. [J Subst Abuse Treat](#). 2011 Jun;40(4):405-13. Epub 2011 Feb 23.

Program, counselor, and patient variability in the alliance: A multilevel study of the alliance in relation to substance use outcomes.

[Crits-Christoph P](#), [Hamilton JL](#), [Ring-Kurtz S](#), [Gallop R](#), [McClure B](#), [Kulaga A](#), [Rotrosen J](#).

Abstract

We explored patient, therapist, and program variability in the alliance in relation to drug and alcohol use during treatment, and whether alliance mediates the relation of program characteristics to drug/alcohol use. Data (N = 1,613 patients) were drawn from a randomized clinical trial investigating the efficacy of an intervention that provided alliance and outcome feedback to 112 counselors across 20 community-based outpatient substance abuse treatment clinics in the northeast United States. Program characteristics were measured using the Organization Readiness for Change scale. Using multilevel modeling, we found that alliance was related to both drug and alcohol use during the past week at the patient and program levels of analysis, but not the counselor level. Several program characteristics were related to average drug and alcohol use. The alliance was not a mediator of these relationships. Program variability in the alliance is important to the alliance-outcome relationship in the treatment of substance abuse. Better outcomes can be achieved by improving both organizational functioning and the patient-counselor alliance.

5. [Health Serv Res.](#) 2011 Jun;46(3):691-711. doi: 10.1111/j.1475-6773.2010.01227.x. Epub 2011 Jan 6.

The Relationship between Organizational Climate and Quality of Chronic Disease Management.

[Benzer JK](#), [Young G](#), [Stolzmann K](#), [Osatuke K](#), [Meterko M](#), [Caso A](#), [White B](#), [Mohr DC](#).

Abstract

Objective. To test the utility of a two-dimensional model of organizational climate for explaining variation in diabetes care between primary care clinics. Data Sources/Study Setting. Secondary data were obtained from 223 primary care clinics in the Department of Veterans Affairs health care system. Study Design. Organizational climate was defined using the dimensions of task and relational climate. The association between primary care organizational climate and diabetes processes and intermediate outcomes were estimated for 4,539 patients in a cross-sectional study. Data Collection/Extraction Methods. All data were collected from administrative datasets. The climate data were drawn from the 2007 VA All Employee Survey, and the outcomes data were collected as part of the VA External Peer Review Program. Climate data were aggregated to the facility level of analysis and merged with patient-level data. Principal Findings. Relational climate was related to an increased likelihood of diabetes care process adherence, with significant but small effects for adherence to intermediate outcomes. Task climate was generally not shown to be related to adherence. Conclusions. The role of relational climate in predicting the quality of chronic care was supported. Future research should examine the mediators and moderators of relational climate and further investigate task climate.

6. [Health Serv Res.](#) 2011 May 24. doi: 10.1111/j.1475-6773.2011.01272.x. [Epub ahead of print]

Designing Payment for Collaborative Care for Depression in Primary Care.

[Bao Y](#), [Casalino LP](#), [Ettner SL](#), [Bruce ML](#), [Solberg LI](#), [Unützer J](#).

Abstract

Objective. To design a bundled case rate for Collaborative Care for Depression (CCD) that aligns incentives with evidence-based depression care in primary care. Data Sources. A clinical information system used by all care managers in a randomized controlled trial of CCD for older primary care patients. Study Design. We conducted an empirical investigation of factors accounting for variation in CCD resource use over time and across patients. CCD resource use at the patient-episode and patient-month levels was measured by number of care manager contacts and direct patient contact time and analyzed with count data (Poisson or negative binomial) models. Principal Findings. Episode-level resource use varies substantially with patient's time in the program. Monthly use declines sharply in the first 6 months regardless of treatment response or remission status, but it remains stable afterwards. An adjusted episode or monthly case rate design better matches payment with variation in resource use compared with a fixed design. Conclusions. Our findings lend support to an episode payment adjusted by number of months receiving CCD and a monthly payment adjusted by the ordinal month. Nonpayment tools including program certification and performance evaluation and reward systems are needed to fully align incentives.

7. [BMJ Qual Saf.](#) 2011 May 24. [Epub ahead of print]

A framework for classifying patient safety practices: results from an expert consensus process.

[Dy SM](#), [Taylor SL](#), [Carr LH](#), [Foy R](#), [Pronovost PJ](#), [Ovretveit J](#), [Wachter RM](#), [Rubenstein LV](#), [Hempel S](#), [McDonald KM](#), [Shekelle PG](#).

Abstract

Objective Development of a coherent literature evaluating patient safety practices has been hampered by the lack of an underlying conceptual framework. The authors describe issues and choices in describing and classifying diverse patient safety practices (PSPs). Methods The authors developed a framework to classify PSPs by identifying and synthesising existing conceptual frameworks, evaluating the draft framework by asking a group of experts to use it to classify a diverse set of PSPs and revising the framework through an expert-panel consensus process. Results The 11 classification dimensions in the framework include: regulatory versus voluntary; setting; feasibility; individual activity versus organisational change; temporal (one-time vs repeated/long-term); pervasive versus targeted; common versus rare events; PSP maturity; degree of controversy/conflicting evidence; degree of behavioural change required for implementation; and sensitivity to context. Conclusion This framework offers a way to classify and compare PSPs, and thereby to interpret the patient-safety literature. Further research is needed to develop understanding of these dimensions, how they evolve as the patient safety field matures, and their relative utilities in describing, evaluating and implementing PSPs.

8. [Community Ment Health J](#). 2011 Jun;47(3):361-3. Epub 2010 Sep 29.

Use of psychotropic medication guidelines at child-serving community mental health centers as assessed by clinic directors.

[Stevens J](#), [Kelleher KJ](#), [Wang W](#), [Schoenwald SK](#), [Hoagwood KE](#), [Landsverk J](#); [Research Network on Youth Mental Health](#).

Abstract

This study assessed the proportion of large, child-serving community mental health centers that used medication guidelines. Two hundred clinic directors from across the country completed an hour-long semi-structured interview, and 152 of these directors answered whether or not medication guidelines were used at their clinics. Half of these clinics' directors reported that their prescribers followed any form of medication guidelines. Governmental agencies and professional medical societies were among the most common sources of information regarding which specific guidelines to follow. Utilization of standardized child outcome measures, but not the employment of a child psychiatrist, was related to following medication guidelines. Despite the mental health field's recent emphasis on disseminating evidence-base practice, many directors reported their clinics did not use any pediatric medication guidelines.

9. Translational Behavioral Medicine
Practice, Policy, Research

The China Seven Cities Study (CSCS) consortium: adapting evidence-based prevention science from west to east

Paula H Palmer¹, Bin Xie¹, Liming Lee², Chih-Ping Chou³, Ping Sun³, Bree Hemingway¹ and C. Anderson Johnson¹

Abstract

Chronic, noncommunicable diseases (NCDs) have surpassed infectious diseases as the primary cause of death and disability in most developing nations. Nowhere is this more evident than in

China where NCDs account for 80% of all deaths and skyrocketing medical costs. Driving the escalation of NCDs are high rates of tobacco use, longer life spans, and changes in the traditional Chinese diet and lifestyle bolstered by unprecedented economic growth and the new global culture. Despite the epidemic of NCDs, few evidence-based interventions either to prevent or retard their progression exist in China. We present a case for the development and adoption of such strategies as effective tools to combat China's greatest health threat. Finally, we offer an example of a collaborative network linking Chinese public health and academic institutions with US researchers to promote the translation of western evidence-based interventions that fully incorporate local knowledge, culture, and capacity.

10. Translational Behavioral Medicine Practice, Policy, Research

Sustainability of evidence-based community-based physical activity programs for older adults: lessons from Active for Life

Paul A Estabrooks¹, Renae L Smith-Ray², David A Dzewaltowski³, Diane Dowdy⁴, Diana Lattimore⁵, Carol Rheume⁶, Marcia G Ory⁴, Terry Bazzarre⁷, Sarah F Griffin⁸ and Sara Wilcox⁶

Abstract

Program sustainability in community and healthcare settings is critical to realizing the translation of research into practice. The purpose of this study is to describe the implementation and assessment of an intervention to increase organizational maintenance of evidence-based physical activity programs and the factors that impede or facilitate sustainability. All organizations implemented a sustainability action plan that included identifying factors related to sustainability, examining resources available, identifying program modifications to enhance sustainability, and long-term action planning. A mixed methods approach was used. Organizational ($n = 12$ sites) ability to demonstrate program effectiveness, align priorities with the organizational mission, and integrate the program within the existing infrastructure were strengths related to sustainability. Sites were more optimistic about program sustainability when they had less reliance on internal financial, but more reliance on internal human resources to run the program post-funding. The study resulted in a number of tools that can help community organizations plan for sustainability of physical activity programs.

11. Translational Behavioral Medicine Practice, Policy, Research

Translating evidence to policy: urban interventions and physical activity promotion in Bogotá, Colombia and Curitiba, Brazil

Adriana Díaz del Castillo¹, Olga L Sarmiento¹, Rodrigo S Reis^{2,4} and Ross C Brownson^{3,5}

ABSTRACT

The growing evidence of the influence of urban environment on physical activity (PA) underscore the need for novel policy solutions to address the inequality, lack of space, and limited PA resources in rapidly growing Latin American cities. This study aims to better understand the PA policy process by conducting two case studies of Bogotá's *Ciclovía* and

Curitiba's *Curitiba*. Literature review of peer- and non-peer-reviewed documents and semi-structured interviews with stakeholders was conducted. In the cases of *Ciclovía* and *Curitiba*, most policies conducive to program development and sustainability were developed outside the health sector in sports and recreation, urban planning, environment, and transportation. Both programs were developed by governments as initiatives to overcome inequalities and provide quality of life. In both programs, multisectoral policies mainly from recreation and urban planning created a window of opportunity for the development and sustainability of the programs and environments supportive of PA.

12. Translational Behavioral Medicine Practice, Policy, Research

The many faces of translational research: a tale of two studies

Stephen M Weiss¹, Deborah L Jones¹, Maria Lopez¹, Olga Villar-Loubet¹ and Ndashi Chitalu²

ABSTRACT

Translational research can take many forms: bench to bedside, across cultural groups, across geographical boundaries, among others. This case study will share how we addressed all three “translational” issues using two evidence-based studies (USA, Zambia) to illustrate these “roads less traveled.” Our implementation and dissemination efforts were anchored by the “train the trainer” strategy, and the Glasgow RE-AIM model provided programmatic guideposts and direction. Keeping all stakeholders (scientific, community, political) involved in the implementation and dissemination process was an essential, perhaps determining factor in the success of the translation process.

13. [Ann Intern Med.](#) 2011 May 17;154(10):693-6.

Advancing the science of patient safety.

[Shekelle PG](#), [Pronovost PJ](#), [Wachter RM](#), [Taylor SL](#), [Dy SM](#), [Foy R](#), [Hempel S](#), [McDonald KM](#), [Ovretveit J](#), [Rubenstein LV](#), [Adams AS](#), [Angood PB](#), [Bates DW](#), [Bickman L](#), [Carayon P](#), [Donaldson L](#), [Duan N](#), [Farley DO](#), [Greenhalgh T](#), [Haughom J](#), [Lake ET](#), [Lilford R](#), [Lohr KN](#), [Meyer GS](#), [Miller MR](#), [Neuhauser DV](#), [Ryan G](#), [Saint S](#), [Shojania KG](#), [Shortell SM](#), [Stevens DP](#), [Walshe K](#).

Abstract

Despite a decade's worth of effort, patient safety has improved slowly, in part because of the limited evidence base for the development and widespread dissemination of successful patient safety practices. The Agency for Healthcare Research and Quality sponsored an international group of experts in patient safety and evaluation methods to develop criteria to improve the design, evaluation, and reporting of practice research in patient safety. This article reports the findings and recommendations of this group, which include greater use of theory and logic models, more detailed descriptions of interventions and their implementation, enhanced explanation of desired and unintended outcomes, and better description and measurement of context and of how context influences interventions. Using these criteria and measuring and reporting contexts will improve the science of patient safety.

14. [Inj Prev.](#) 2011 Jun;17(3):1-10. Epub 2011 Feb 22.

Towards a national sports safety strategy: addressing facilitators and barriers towards safety guideline uptake.

[Finch CF](#), [Gabbe BJ](#), [Lloyd DG](#), [Cook J](#), [Young W](#), [Nicholson M](#), [Seward H](#), [Donaldson A](#), [Doyle TL](#).

Abstract

Background Limited information exists about how best to conduct intervention implementation studies in community sport settings. Research should be directed towards understanding the context within which evidence-based injury prevention interventions are to be implemented, while continuing to build the evidence-base for the effectiveness of sports injury interventions. Objectives To identify factors that influence the translation of evidence-based injury prevention interventions into practice in community sport, and to provide specific evidence for the effectiveness of an evidence-based exercise training programme for lower limb injury prevention in community Australian football. Setting Community-level Australian football clubs, teams and players. Methods An exercise-based lower limb injury prevention programme will be developed and evaluated in terms of the implementation context, infrastructure and resources needed for its effective translation into community sport. Analysis of the community sports safety policy context will be undertaken to understand the barriers and facilitators to policy development and uptake. A randomised group-clustered ecological study will be conducted to compare the reach, effectiveness, adoption, implementation and maintenance (RE-AIM) of the intervention over 2 years. Outcome Measures The primary outcome will be evidence-based prevention guidelines that are fully supported by a comprehensively evaluated dissemination plan. The plan will detail the support structures and add-ons necessary to ensure sustainability and subsequent national implementation. Research outcomes will include new knowledge about how sports safety policy is set, how consensus is reached among sports safety experts in the community setting and how evidence-based safety guidelines are best developed, packaged and disseminated to community sport.

15. [Addict Behav.](#) 2011 Jun;36(6):566-9. Epub 2010 Dec 21.

Implementation research: Issues and prospects.

[Flynn PM](#), [Brown BS](#).

Abstract

The concern that addiction treatment be grounded in science has been recognized and enthusiastically endorsed in both the clinical and research communities. With recognition of the gap between knowledge development and application, there has been a recent emphasis on developing strategies for more effective application, i.e., for the incorporation of evidence-based practice in routine clinical programming. This has translated to a need to develop strategies designed to achieve organizational change and a field of study whose objective is to better understand how to expedite change in treatment organizations and their clinical practices. This paper focuses on the roles and responsibilities of researchers, practitioners, and the federal government in achieving changed practice and applying new knowledge to improve treatment. Even though great strides have been made to shift the emphasis from dissemination of knowledge to its application, much still remains to be done in the development and testing of additional application strategies specific to the substance abuse treatment field. Future considerations for implementation research are discussed.

16. [Int J Offender Ther Comp Criminol.](#) 2011 Jun;55(4):587-604. Epub 2010 Apr 28.

Implementation outcomes of multidimensional family therapy-detention to community: a reintegration program for drug-using juvenile detainees.

[Liddle HA](#), [Dakof GA](#), [Henderson C](#), [Rowe C](#).

Abstract

Responding to urgent calls for effective interventions to address young offenders' multiple and interconnected problems, a new variant of an existing empirically-validated intervention for drug-using adolescents, Multidimensional Family Therapy (MDFT)-Detention to Community (DTC) was tested in a two-site controlled trial. This article (a) outlines the rationale and protocol basics of the MDFT-DTC intervention, a program for substance-using juvenile offenders that links justice and substance abuse treatment systems to facilitate adolescents' postdetention community reintegration; (b) presents implementation outcomes, including fidelity, treatment engagement and retention rates, amount of services received, treatment satisfaction, and substance abuse-juvenile justice system collaboration outcomes; and (c) details the implementation and sustainability challenges in a cross-system (substance abuse treatment and juvenile justice) adolescent intervention. Findings support the effectiveness of the MDFT-DTC intervention, and the need to develop a full implementation model in which transfer and dissemination issues could be explored more fully, and tested experimentally.

17. [Prim Care Diabetes](#). 2011 May 24. [Epub ahead of print]

A model of translational research for diabetes prevention in low and middle-income countries: The Diabetes Community Lifestyle Improvement Program (D-CLIP) trial.

[Weber MB](#), [Harish R](#), [Meyers GC](#), [Mohan V](#), [Narayan KM](#).

Abstract

AIMS:

The Diabetes Community Lifestyle Improvement Program (D-CLIP) aims to implement and evaluate in a controlled, randomized trial the effectiveness, cost-effectiveness, and sustainability of a culturally appropriate, low-cost, and sustainable lifestyle intervention for the prevention of type 2 diabetes mellitus in India.

METHODS:

D-CLIP, a translational research project adapted from the methods and curriculum developed and tested for efficacy in the Diabetes Prevention Program, utilizes innovated methods (a step-wise model of diabetes prevention with lifestyle and metformin added when needed; inclusion of individuals with isolated glucose tolerance, impaired fasting glucose, and both; classes team-taught by professionals and trained community educators) with the goals of increasing diabetes prevention, community acceptability, and long-term dissemination and sustainability of the program. The study outcomes are: diabetes incidence (primary measure of effectiveness), cost-effectiveness, changes in anthropometric measures, plasma lipids, blood pressure, blood glucose, and HbA(1c.) Program acceptability and sustainability will be assessed using a mixed methods approach.

CONCLUSION:

D-CLIP, a low-cost, community-based, research program, addresses the key components of translational research and can be used as a model for prevention of chronic diseases in other low and middle-income country settings (clinicaltrials.gov number, NCT01283308).

18. [Health Expect](#). 2011 May 25. doi: 10.1111/j.1369-7625.2011.00681.x. [Epub ahead of print]

Close to the bench as well as at the bedside: involving service users in all phases of translational research.

[Callard F](#), [Rose D](#), [Wykes T](#).

Abstract

Aim The paper aims to develop a model of translational research in which service user and other stakeholder involvement are central to each phase. **Background** 'Translational' is the current medical buzzword: translational research has been termed 'bench to bedside' research and promises to fast-track biomedical advances in the service of patient benefit. Models usually conceive of translational research as a 'pipeline' that is divided into phases: the early phase is characterized as the province of basic scientists and laboratory-based clinical researchers; the later phases focus on the implementation, dissemination and diffusion of health applications. If service user involvement is mentioned, it is usually restricted to these later phases. **Methods** The paper critically reviews existing literature on translational research and medicine. The authors develop a theoretical argument that addresses why a reconceptualization of translational research is required on scientific, ethical and pragmatic grounds. **Results** The authors reconceptualize the model of translational research as an interlocking loop rather than as a pipeline, one in which service user and other stakeholder involvement feed into each of its elements. The authors demonstrate that for the 'interlocking loop' model of translational research to be materialized in practice will require changes in how health research is structured and organized. **Conclusion** The authors demonstrate the scientific, ethical and pragmatic benefits of involving service users in every phase of translational research. The authors' reconceptualized model of translational research contributes to theoretical and policy debates regarding both translational research and service user involvement.

19. [Trials](#). 2011 May 10;12:115.

Cluster randomised trial in the General Practice Research Database: 1. Electronic decision support to reduce antibiotic prescribing in primary care (eCRT study).

[Gulliford MC](#), [van Staa T](#), [McDermott L](#), [Dregan A](#), [McCann G](#), [Ashworth M](#), [Charlton J](#), [Grieve AP](#), [Little P](#), [Moore MV](#), [Yardley L](#); [electronic Cluster Randomised Trial Research Team eCRT Research Team](#).

Abstract

BACKGROUND:

The purpose of this research is to develop and evaluate methods for conducting cluster randomised trials in a primary care database that contains electronic patient records for large numbers of family practices. Cluster randomised trials are trials in which the units allocated represent groups of individuals, in this case family practices and their registered patients. Cluster randomised trials often suffer from the limitation that they include too few clusters, leading to problems of insufficient power and only imprecise estimation of the intraclass correlation coefficient, a key design parameter. This difficulty might be overcome by utilising databases that already hold electronic patient records for large numbers of practices. The protocol describes one application: a study of antibiotic prescribing for acute respiratory infection; a second protocol outlines an intervention in a less frequent chronic condition of public health importance, stroke.

METHODS/DESIGN:

The objective of the study is to implement a cluster randomised trial to test the effectiveness of an electronic record-based intervention at achieving a reduction in antibiotic prescribing at consultations for respiratory illness in patients aged 18 and 59 years old in intervention family

practices as compared with controls. Family practices will be recruited from the practices that presently contribute data to the UK General Practice Research Database (GPRD). Following randomisation, electronic prompts will be installed remotely at intervention practices to promote adherence with evidence-based standards of medical practice. The intervention was developed through qualitative research at non-intervention practices. Data for outcome assessment will be obtained from anonymised electronic patient records that are routinely collected into GPRD. This protocol outlines the proposed study designs, data sources, sample size requirements, analysis methods and dissemination plans. Ethical issues are also discussed.

DISCUSSION:

Results from this study will provide methodological evidence concerning the use of electronic patient records and databases for implementing cluster randomised trials in primary care. The study will also provide substantive findings in respect of electronic record-based interventions to reduce antibiotic prescribing in primary care.

20. [J Community Health](#). 2011 Jun;36(3):357-66.

Improving the alcohol retail environment to reduce youth access: a randomized community trial of a best practices toolkit intervention.

[Wolff LS](#), [El Ayadi AM](#), [Lyons NJ](#), [Herr-Zaya K](#), [Noll D](#), [Perfas F](#), [Rots G](#).

Abstract

Underage alcohol use remains a significant public health problem throughout the United States and has important consequences for the health of individuals and communities. The objective of this study was to assess the impact of distributing an alcohol retailer toolkit via direct mail on increasing positive alcohol retailer attitudes towards checking IDs, encouraging retail managers to formalize ID checking procedures with their employees, and promoting consumers to be prepared to show ID when purchasing alcohol. This community randomized study included five matched Massachusetts community pairs. Our analysis sample consisted of 209 retailers (77 intervention; 132 control). In models adjusted for baseline response and matching community and establishment characteristics, intervention communities reported posting, on average, one additional sign or wall decal in their establishments ($\beta = 0.937$, $P = 0.0069$), and a twofold higher odds of handing out written materials on ID checking to staff (OR: 2.074, 95%CI: 1.003-4.288) compared to control establishments. However, the intervention was not found to have an effect on changing establishment policies, retailer attitudes, or other establishment practices. Intervention retailers perceived all components of the toolkit to be very useful for their establishments, and nearly all reported having shared materials with their employees and customers. These results suggest that some significant changes in alcohol retailer establishment practices can be achieved among motivated owners or managers through the distribution of a toolkit targeting best retailer practices. We do, however, recommend that future program planners consider alternative dissemination and marketing strategies beyond direct mail to encourage greater utilization.

21. [Psychiatr Serv](#). 2011 Jun;62(6):670-4.

A comparison of phone-based and on-site assessment of fidelity for assertive community treatment in Indiana.

[McGrew JH](#), [Stull LG](#), [Rollins AL](#), [Salyers MP](#), [Hicks LJ](#).

Abstract

Objective: This study investigated the reliability and validity of a phone-administered fidelity assessment instrument based on the Dartmouth Assertive Community Treatment Scale (DACTS). **Methods:** An experienced rater paired with a research assistant without fidelity assessment experience or a consultant familiar with the treatment site conducted phone-based assessments of 23 teams providing assertive community treatment in Indiana. Using the DACTS, consultants conducted on-site evaluations of the programs. **Results:** The pairs of phone raters revealed high levels of consistency [intraclass correlation coefficient (ICC)=.92] and consensus (mean absolute difference of .07). Phone and on-site assessment showed strong agreement (ICC=.87) and consensus (mean absolute difference of .07) and agreed within .1 scale point, or 2% of the scoring range, for 83% of sites and within .15 scale point for 91% of sites. Results were unaffected by the expertise level of the rater. **Conclusions:** Phone-based assessment could help agencies monitor faithful implementation of evidence-based practices. (Psychiatric Services 62:670-674, 2011).

22. [Health Promot Pract.](#) 2011 May 31. [Epub ahead of print]

The Family-Centered Action Model of Intervention Layout and Implementation (FAMILI): The Example of Childhood Obesity.

[Davison KK](#), [Lawson HA](#), [Coatsworth JD](#).

Abstract

Parents play a fundamental role in shaping children's development, including their dietary and physical activity behaviors. Yet family-centered interventions are rarely used in obesity prevention research. Less than half of childhood obesity prevention programs include parents, and those that do include parents or a family component seldom focus on sustainable change at the level of the family. The general absence of a family-centered approach may be explained by persistent challenges in engaging parents and families and the absence of an intervention framework explicitly designed to foster family-centered programs. The Family-centered Action Model of Intervention Layout and Implementation, or FAMILI, was developed to address these needs. FAMILI draws on theories of family development to frame research and intervention design, uses a mixed-methods approach to conduct ecologically valid research, and positions family members as active participants in the development, implementation, and evaluation of family-centered obesity prevention programs. FAMILI is intended to facilitate the development of culturally responsive and sustainable prevention programs with the potential to improve outcomes. Although childhood obesity was used to illustrate the application of FAMILI, this model can be used to address a range of child health problems.

23. [BMC Public Health.](#) 2011 Jun 1;11(1):423. [Epub ahead of print]

Improving children's nutrition environments: A survey of adoption and implementation of nutrition guidelines in recreational facilities.

[Olstad DL](#), [Downs SM](#), [Raine KD](#), [Berry TR](#), [McCargar LJ](#).

ABSTRACT:

BACKGROUND:

Although the mandate of recreational facilities is to enhance well-being, many offer foods inconsistent with recommendations for healthy eating. Little is known regarding recreational facility food environments and how they might be improved, as few studies exist. The Alberta Nutrition Guidelines for Children and Youth (ANGCY) are intended to ensure access to healthy food choices in schools, childcare and recreational facilities. This study investigated awareness,

adoption and implementation of the ANGCY among recreational facilities in Alberta, Canada, one year following their release.

METHODS:

A cross-sectional telephone survey was conducted from June - December, 2009 (n=151) with managers of publicly funded recreational facilities that served food. The questionnaire included 10 closed and 7 open ended questions to assess the organizational priority for healthy eating, awareness, adoption and implementation of the ANGCY. Chi-squared tests examined quantitative variables, while qualitative data were analysed using directed content analysis. Greenhalgh's model of diffusion of complex innovations within health service organizations constituted the theoretical framework for the study.

RESULTS:

One half of respondents had heard of the ANGCY, however their knowledge of them was limited. Although 51% of facilities had made changes to improve the nutritional quality of foods offered in the past year, only a small fraction (11%) of these changes were motivated by the ANGCY. At the time of the survey, 14% of facilities had adopted the ANGCY and 6% had implemented them. Barriers to adoption and implementation were primarily related to perceived negative attributes of the ANGCY, the inner (organizational) context, and negative feedback received during the implementation process. Managers strongly perceived that implementing nutrition guidelines would limit their profit-making ability.

CONCLUSIONS:

If fully adopted and implemented, the ANGCY have the potential to make a significant and sustained contribution to improving the recreational facility food environment, however one year following their release, awareness, adoption and implementation of the ANGCY remained low. A mandated policy approach could offer an efficacious, cost-effective means of improving the food environment within recreational facilities.

24. [Implement Sci](#). 2011 Jun 1;6(1):57. [Epub ahead of print]

Exploring dietitians' salient beliefs about shared decision-making behaviors.

[Desroches S](#), [Lapointe A](#), [Deschenes SM](#), [Gagnon MP](#), [Legare F](#).

Abstract

BACKGROUND:

Shared decision making (SDM), a process by which health professionals and patients go through the decision-making process together to agree on treatment, is a promising strategy for promoting diet-related decisions that are informed and value-based and to which patients adhere well. The objective of the present study was to identify dietitians' salient beliefs regarding their exercise of two behaviors during the clinical encounter, both of which behaviors have been deemed essential for SDM to take place: 1) presenting patients with all dietary treatment options for a given health condition, and 2) helping patients clarify their values and preferences regarding the options.

METHODS:

Twenty-one dietitians were allocated to four focus groups. Facilitators conducted the focus groups using a semi-structured interview guide based on the Theory of Planned Behavior. Discussions were audiotaped, transcribed verbatim, coded and analyzed with NVivo8 software.

RESULTS:

Most participants stated that better patient adherence to treatment was an advantage of adopting the two SDM behaviors. Dietitians identified patients, physicians and the multidisciplinary team

as normative referents who would approve or disapprove of their adoption of the SDM behaviors. The most often reported barriers and facilitators for the behaviors concerned patients' characteristics, patients' clinical situation, and time.

CONCLUSIONS:

The implementation of SDM in nutrition clinical practice can be guided by addressing dietitians' salient beliefs. Identifying these beliefs also provides the theoretical framework needed for developing a quantitative survey questionnaire to further study the determinants of dietitians' adoption of SDM behaviors.

25. [J Clin Psychol Med Settings](#). 2011 May 28. [Epub ahead of print]

Implementation of a Suicide Nomenclature within Two VA Healthcare Settings.

[Brenner LA](#), [Breshears RE](#), [Betthausen LM](#), [Bellon KK](#), [Holman E](#), [Harwood JE](#), [Silverman MM](#), [Huggins J](#), [Nagamoto HT](#).

Abstract

Suicide and suicide attempts are significant issues for military, Veterans Affairs (VA), and civilian healthcare systems. The lack of uniform terms related to self-directed violence (SDV) has inhibited epidemiological surveillance efforts, limited the generalizability of empirical studies of suicide and non-lethal forms of SDV, and complicated the implementation of evidence-based assessment and treatment strategies for individuals with suicidal thoughts and/or behaviors. The Department of Veterans Affairs recently adopted the Centers for Disease Control and Prevention's (CDC) SDV Classification System (SDVCS). This paper describes an implementation study of the SDVCS in two VA Medical Centers. The Veterans Integrated Service Network (VISN) 19 Mental Illness Research, Education and Clinical Center (MIRECC) training program for the SDVCS, including the SDVCS Clinical Tool (CT), will be discussed. Although preliminary data suggest that the CT and SDVCS are generally perceived as being acceptable and useful, further work will likely be required to facilitate widespread adoption. Potential next steps in this process are presented.

26. [Implement Sci](#). 2011 May 29;6(1):56. [Epub ahead of print]

Social Networks, work and Network-Based Resources for the Management of Long Term Conditions: a framework and study protocol for developing self care support.

[Rogers A](#), [Vassilev I](#), [Sanders C](#), [Kirk S](#), [Chew-Graham C](#), [Kennedy A](#), [Protheroe J](#), [Bower P](#), [Blickem C](#), [Reeves D](#), [Kapadia D](#), [Brooks H](#), [Fullwood C](#), [Richardson G](#).

ABSTRACT:

BACKGROUND:

Increasing the effective targeting and promotion of self-care support for long-term conditions requires more of a focus on patient contexts and networks. The aim of this paper is to describe how within a programme of research and implementation, social networks are viewed as being centrally involved in the mobilisation and deployment of resources in the management of a chronic condition. This forms the basis of a novel approach to understanding, designing, and implementing new forms of self-management support.

METHODS:

Drawing on evidence syntheses about social networks and capital and the role of information in self-management, we build on four conceptual approaches to inform the design of our research on the implementation of self-care support for people with long-term conditions. Our approach takes into consideration the form and content of social networks, notions of chronic illness work,

normalisation process theory (NPT), and the whole systems informing self-management engagement (WISE) approach to self-care support.

DISCUSSION:

The translation and implementation of a self-care agenda in contemporary health and social context needs to acknowledge and incorporate the resources and networks operating in patients' domestic and social environments and everyday lives. The latter compliments the focus on healthcare settings for developing and delivering self-care support by viewing communities and networks, as well as people suffering from long-term conditions, as a key means of support for managing long-term conditions. By focusing on patient work and social-network provision, our aim is to open up a second frontier in implementation research, to translate knowledge into better chronic illness management, and to shift the emphasis towards support that takes place outside formal health services.

27. [BMJ Qual Saf](#). 2011 May 26. [Epub ahead of print]

What context features might be important determinants of the effectiveness of patient safety practice interventions?

[Taylor SL](#), [Dy S](#), [Foy R](#), [Hempel S](#), [McDonald KM](#), [Ovretveit J](#), [Pronovost PJ](#), [Rubenstein LV](#), [Wachter RM](#), [Shekelle PG](#).

Abstract

Background Differences in contexts (eg, policies, healthcare organisation characteristics) may explain variations in the effects of patient safety practice (PSP) implementations. However, knowledge of which contextual features are important determinants of PSP effectiveness is limited and consensus is lacking on a taxonomy of which contexts matter. Methods Iterative, formal discussions were held with a 22-member technical expert panel composed of experts or leaders in patient safety, healthcare systems, and methods. First, potentially important contextual features were identified, focusing on five PSPs. Then, two surveys were conducted to determine the context likely to influence PSP implementations. Results The panel reached a consensus on a taxonomy of four broad domains of contextual features important for PSP implementations: safety culture, teamwork and leadership involvement; structural organisational characteristics (eg, size, organisational complexity or financial status); external factors (eg, financial or performance incentives or PSP regulations); and availability of implementation and management tools (eg, training organisational incentives). Panelists also tended to rate specific patient safety culture, teamwork and leadership contexts as high priority for assessing their effects on PSP implementations, but tended to rate specific organisational characteristic contexts as high priority only for use in PSP evaluations. Panelists appeared split on whether specific external factors and implementation/management tools were important for assessment or only description.

Conclusion This work can guide research commissioners and evaluators on the contextual features of PSP implementations that are important to report or evaluate. It represents a first step towards developing guidelines on contexts in PSP implementation evaluations. However, the science of context measurement needs maturing.

28. [Implement Sci](#). 2011 May 26;6(1):50. [Epub ahead of print]

Assessing implementation difficulties in tobacco use prevention and cessation counselling among dental providers.

[Amemori M](#), [Michie S](#), [Korhonen T](#), [Murtomaa H](#), [Kinnunen TH](#).

Abstract

BACKGROUND:

Tobacco use adversely affects oral health. Clinical guidelines recommend that dental providers promote tobacco abstinence and provide patients who use tobacco with brief tobacco use cessation counselling. Research shows that these guidelines are seldom implemented, however. To improve guideline adherence and to develop effective interventions, it is essential to understand provider behaviour and challenges to implementation. This study aimed to develop a theoretically informed measure for assessing among dental providers implementation difficulties related to tobacco use prevention and cessation (TUPAC) counselling guidelines, to evaluate those difficulties among a sample of dental providers, and to investigate a possible underlying structure of applied theoretical domains.

METHODS:

A 35-item questionnaire was developed based on key theoretical domains relevant to the implementation behaviours of healthcare providers. Specific items were drawn mostly from the literature on TUPAC counselling studies of healthcare providers. The data were collected from dentists ($n = 73$) and dental hygienists ($n = 22$) in 36 dental clinics in Finland using a web-based survey. Of 95 providers, 73 participated (76.8%). We used Cronbach's alpha to ascertain the internal consistency of the questionnaire. Mean domain scores were calculated to assess different aspects of implementation difficulties and exploratory factor analysis to assess the theoretical domain structure. The authors agreed on the labels assigned to the factors on the basis of their component domains and the broader behavioural and theoretical literature.

RESULTS:

Internal consistency values for theoretical domains varied from 0.50 ('emotion') to 0.71 ('environmental context and resources'). The domain environmental context and resources had the lowest mean score (21.3%; 95% confidence interval [CI], 17.2 to 25.4) and was identified as a potential implementation difficulty. The domain emotion provided the highest mean score (60%; 95% CI, 55.0 to 65.0). Three factors were extracted that explain 70.8% of the variance: motivation (47.6% of variance, $\alpha = 0.86$), capability (13.3% of variance, $\alpha = 0.83$), and opportunity (10.0% of variance, $\alpha = 0.71$).

CONCLUSIONS:

This study demonstrated a theoretically informed approach to identifying possible implementation difficulties in TUPAC counselling among dental providers. This approach provides a method for moving from diagnosing implementation difficulties to designing and evaluating interventions.

29. [BMJ Qual Saf](#). 2011 May 23. [Epub ahead of print]

Opportunities and challenges in creating an international centralised knowledge base for clinical decision support systems in ePrescribing.

[Cresswell KM](#), [Bates DW](#), [Phansalkar S](#), [Sheikh A](#).

Abstract

Prescribing errors cause substantial potentially avoidable patient harm. There is increasing evidence that the implementation of clinical decision support systems to support prescribing may reduce the risk of such errors. Efforts have thus far concentrated on the implementation of these systems within local health communities. However, considerable potential benefit exists in sharing the content of these prescribing decision support systems across geographical boundaries, including the sharing of experiences and expertise and cost reduction, which could in turn potentially increase accessibility to low resource settings. Technical, commercial and

regulatory issues would however first need to be overcome in order to facilitate such a development. In this paper, the authors reflect on some of the opportunities and challenges inherent in trying to develop an internationally agreed and shared computerised decision support system aiming to enhance prescribing safety.

30. [Aust J Rural Health](#). 2011 Jun;19(3):125-34. doi: 10.1111/j.1440-1584.2011.01197.x. **Implementation of diabetes prevention programs in rural areas: Montana and south-eastern Australia compared.**

[Reddy P](#), [Hernan AL](#), [Vanderwood KK](#), [Arave D](#), [Niebylski ML](#), [Harwell TS](#), [Dunbar JA](#).

Abstract

Objective: To identify the key elements that enabled the Greater Green Triangle Diabetes Prevention Project (GGT DPP) and the Montana Cardiovascular Disease and Diabetes Prevention (CDDP) programs successful establishment and implementation in rural areas, as well as identifying specific challenges or barriers for implementation in rural communities.

Methods: Focus groups were held with the facilitators who delivered the GGT DPP in Australia and the Montana CDDP programs in the USA. Interview questions covered the facilitators' experiences with recruitment, establishing the program, the components and influence of rurality on the program, barriers and challenges to delivering the program, attributes of successful participants, and the influence of community resources and partnerships on the programs.

Results: Four main themes emerged from the focus groups: establishing and implementing the diabetes prevention program in the community; strategies for recruitment and retention of participants; what works in lifestyle intervention programs; and rural-centred issues.

Conclusions: The results from this study have assisted in determining the factors that contribute to developing, establishing and implementing successful diabetes prevention programs in two rural areas. Recommendations to increase the likelihood of success of programs in rural communities include: securing funding early for the program; establishing support from community leaders and developing positive relationships with health care providers; creating a professional team with passion for the program; encouraging participants to celebrate their small and big successes; and developing procedures for providing post-intervention support to help participants maintain their success.

31. [Implement Sci](#). 2011 May 20;6(1):48. [Epub ahead of print]

Study protocol: the DESPATCH study: Delivering stroke prevention for patients with atrial fibrillation - a cluster randomised controlled trial in primary healthcare.

[Gattellari M](#), [Leung DY](#), [Ukoumunne OC](#), [Zwar N](#), [Grimshaw J](#), [Worthington JM](#).

ABSTRACT:

BACKGROUND:

Compelling evidence shows that appropriate use of anticoagulation in patients with nonvalvular atrial fibrillation reduces the risk of ischaemic stroke by 67% and all-cause mortality by 26%.

Despite this evidence, anticoagulation is substantially underused, resulting in avoidable fatal and disabling strokes.

METHODS:

DESPATCH is a cluster randomised controlled trial with concealed allocation and blinded outcome assessment designed to evaluate a multifaceted and tailored implementation strategy for improving the uptake of anticoagulation in primary care. We have recruited general practices in South Western Sydney, Australia, and randomly allocated practices to receive the DESPATCH

intervention or evidence-based guidelines (control). The intervention comprises specialist decisional support via written feedback about patient-specific cases, three academic detailing sessions (delivered via telephone), practice resources, and evidence-based information. Data for outcome assessment will be obtained from a blinded, independent medical record audit. Our primary endpoint is the proportion of nonvalvular atrial fibrillation patients, over 65 years of age, who receive oral anticoagulation at any time during the 12-month posttest period.

DISCUSSION:

Successful translation of evidence into clinical practice can reduce avoidable stroke, death, and disability due to nonvalvular atrial fibrillation. If successful, DESPATCH will inform public policy, providing quality evidence for an effective implementation strategy to improve management of nonvalvular atrial fibrillation, to close an important evidence-practice gap. Trial Registration Australian Clinical Trials Registry Registration Number: ACTRN12608000074392.

32. [Health Aff \(Millwood\)](#). 2011 May 19. [Epub ahead of print]

How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts.

[James BC](#), [Savitz LA](#).

Abstract

It has been estimated that full implementation of the Affordable Care Act will extend coverage to thirty-two million previously uninsured Americans. However, rapidly rising health care costs could thwart that effort. Since 1988 Intermountain Healthcare has applied to health care delivery the insights of W. Edwards Deming's process management theory, which says that the best way to reduce costs is to improve quality. Intermountain achieved such quality-based savings through measuring, understanding, and managing variation among clinicians in providing care. Intermountain created data systems and management structures that increased accountability, drove improvement, and produced savings. For example, a new delivery protocol helped reduce rates of elective induced labor, unplanned cesarean sections, and admissions to newborn intensive care units. That one protocol saves an estimated \$50 million in Utah each year. If applied nationally, it would save about \$3.5 billion. "Organized care" along these lines may be central to the long-term success of health reform.

33. [J Behav Health Serv Res](#). 2011 May 19. [Epub ahead of print]

Community Characteristics and Implementation Factors Associated with Effective Systems of Care.

[Lunn LM](#), [Heflinger CA](#), [Wang W](#), [Greenbaum PE](#), [Kutash K](#), [Boothroyd RA](#), [Friedman RM](#).

Abstract

How are characteristics of communities associated with the implementation of the principles of systems of care (SOC)? This study uses multilevel modeling with a stratified random sample (N = 225) of US counties to explore community-level predictors of the implementation factors of the System of Care Implementation Survey. A model composed of community-level social indicators fits well with 5 of 14 factors identified as relevant for effective SOCs. As hypothesized, community disadvantage was negatively and residential stability positively associated with the implementation of SOC principles. Designation as a mental health professional shortage area was positively related to some implementation scores, as was the percentage of minority residents, while rurality was not significantly associated with any of the factors. Given the limitations of the study, the results should be interpreted with caution, but

suggest that further research is merited to clarify these relationships that could inform efforts directed at promoting SOCs.

34. [J Behav Health Serv Res](#). 2011 May 17. [Epub ahead of print]

Development of a Measure to Assess the Implementation of Children's Systems of Care: The Systems of Care Implementation Survey (SOCIS).

[Boothroyd RA](#), [Greenbaum PE](#), [Wang W](#), [Kutash K](#), [Friedman RM](#).

Abstract

The children's system of care framework has been extensively implemented in the U.S. Since its inception in 1993, the Comprehensive Community Mental Health Services for Children and Their Families Program has invested in excess of \$1 billion supporting the development of systems of care in 164 grantee sites across the country. Despite these efforts to implement children's systems of care nationally, little is known about the extent to which the principles and values actually have been put into practice outside of the funded grantee sites. This paper describes the development of the Systems of Care Implementation Survey, a measure designed specifically for the first ever study assessing the level of implementation of factors contributing to effective children's systems of care in a nationally representative sample of counties throughout the U.S.

35. [Int J Tuberc Lung Dis](#). 2011 Jun;15(6):715-21.

The role of health economics research in implementation research for health systems strengthening.

[Mann GH](#), [Thomson R](#), [Jin C](#), [Phiri M](#), [Vater MC](#), [Sinanovic E](#), [Squire SB](#).

Abstract

It has long been recognised that the health-related Millennium Development Goals cannot be achieved without strengthened health systems. This article presents the most recent World Health Organization framework for strengthening health systems and considers how health economics research can be used to measure achievements against each of the goals of the framework. Benefits to health systems strengthening of incorporating health economics tools into operational research are highlighted. Finally, health economic tools are placed within an impact assessment framework that facilitates the capture of health systems considerations in implementation research for innovations in tuberculosis diagnosis.

36. [BMC Health Serv Res](#). 2011 May 16;11(1):102. [Epub ahead of print]

What do primary care physicians and researchers consider the most important patient safety improvement strategies?

[Gaal S](#), [Verstappen W](#), [Wensing M](#).

Abstract

BACKGROUND:

Although it has been increasingly recognised that patient safety in primary care is important, little is known about the feasibility and effectiveness of different strategies to improve patient safety in primary care. In this study, we aimed to identify the most important strategies by consulting an international panel of primary care physicians and researchers.

METHODS:

A web-based survey was undertaken in an international panel of 58 individuals from eight countries with a strong primary care system. The questionnaire consisted of 38 strategies to

improve patient safety. We asked the respondents whether these strategies were currently used in their own country, and whether they felt them to be important.

RESULTS:

Most of the 38 presented strategies were seen as important by a majority of the participants, but the use of strategies in daily practice varied widely. Strategies that yielded the highest scores (>70%) regarding importance included a good medical record system (82% felt this was very important, while 83% said it was implemented in more than half of the practices), good telephone access (71% importance, 83% implementation), standards for record keeping (75% importance, 62% implementation), learning culture (74% importance, 10% implementation), vocational training on patient safety for GPs (81% importance, 24% implementation) and the presence of a patient safety guideline (81% importance, 15% implementation).

CONCLUSION:

An international panel of primary care physicians and researchers felt that many different strategies to improve patient safety were important. Highly important strategies with poor implementation included a culture that is positive for patient safety, education on patient safety for physicians, and the presence of a patient safety guideline.

37. [Adm Policy Ment Health](#). 2011 May 15. [Epub ahead of print]

Evidence-Based Practice Implementation in Community Mental Health Settings: The Relative Importance of Key Domains of Implementation Activity.

[Torrey WC](#), [Bond GR](#), [McHugo GJ](#), [Swain K](#).

Abstract

Implementation research has examined practice prioritization, implementation leadership, workforce development, workflow re-engineering, and practice reinforcement, but not addressed their relative importance as implementation drivers. This study investigated domains of implementation activities and correlated them to implementation success during a large national evidence-based practice implementation project. Implementation success was correlated with active leadership strategically devoted to redesigning the flow of work and reinforcing implementation through measurement and feedback. Relative attention to workforce development was negatively correlated with implementation. Active leaders should focus on redesigning the flow of work to support the implementation and on reinforcing program improvements.

38. [Health Promot Pract](#). 2011 May 13. [Epub ahead of print]

Implementing State Tobacco Treatment Services: Lessons From the Massachusetts Experience.

[Pbert L](#), [Zapka J](#), [Jolicoeur DG](#), [White MJ](#), [Valentine Goins K](#), [Reed G](#), [Ockene JK](#).

Abstract

This case study was conducted between 2000 and 2003 to examine the implementation of community based tobacco treatment programs funded by the Massachusetts Department of Public Health Tobacco Control Program (MTCP). Four dimensions of implementation, drawn from several models of program evaluation are explored: (a) quantity of services, (b) quality of services, (c) implementation/use of systems, and (d) sustainability. The quantity of services delivered was high, reflecting MTCP's focus on increasing availability of services, particularly in underserved populations. The quality of physician-delivered tobacco intervention did not meet national benchmarks for delivery of all 5As (Ask, Advise, Assess, Assist, Arrange follow-up)

and only about half of organizations reported routine systems for auditing tobacco use documentation. Implementation of systems to identify tobacco users and deliver tobacco treatment varied widely by community health settings, with low rates of tobacco use documentation found. Finally, in an era of greater competition for scarce prevention dollars, sustainability of services over time must be planned for from the outset, as indicated by the success of programs that sustained services by proactively and creatively incorporating tobacco treatment into their organizations. This case study can inform states' policies in their design of tobacco treatment services in community health settings.

39. [Health Educ Res.](#) 2011 May 13. [Epub ahead of print]

Vegetable and fruit breaks in Australian primary schools: prevalence, attitudes, barriers and implementation strategies.

[Nathan N](#), [Wolfenden L](#), [Butler M](#), [Bell AC](#), [Wyse R](#), [Campbell E](#), [Milat AJ](#), [Wiggers J](#).

Abstract

School-based vegetable and fruit programs can increase student consumption of vegetables and fruit and have been recommended for adoption by Australian schools since 2005. An understanding of the prevalence and predictors of and the barriers to the adoption of school-based vegetable and fruit programs is necessary to maximize their adoption by schools and ensure that the health benefits of such programs to children are realized. The aim of this study was to determine Australian primary school Principals' attitudes and barriers to the implementation of vegetable and fruit breaks; the prevalence of vegetable and fruit breaks in schools and the implementation strategies used and associated with their recommended adoption (daily in at least 80% of classes). A random sample of 384 school Principals completed a 20-min telephone interview. While Principals were highly supportive of vegetable and fruit breaks, only 44% were implementing these to a recommended level. When controlling for all school characteristics, recommended vegetable and fruit break adoption was 1.9 and 2.2 times greater, respectively, in schools that had parent communication strategies and teachers trained. A substantial opportunity exists to enhance the health of children through the adoption of vegetable and fruit breaks in schools.

40. [J Am Med Inform Assoc.](#) 2011 May 12. [Epub ahead of print]

The role of information technology in translating educational interventions into practice: an analysis using the PRECEDE/PROCEED model.

[Weir C](#), [McLeskey N](#), [Brunker C](#), [Brooks D](#), [Supiano MA](#).

Abstract

Objective The evidence base for information technology (IT) has been criticized, especially with the current emphasis on translational science. The purpose of this paper is to present an analysis of the role of IT in the implementation of a geriatric education and quality improvement (QI) intervention. **Design** A mixed-method three-group comparative design was used. The PRECEDE/PROCEED implementation model was used to qualitatively identify key factors in the implementation process. These results were further explored in a quantitative analysis. **Method** Thirty-three primary care clinics at three institutions (Intermountain Healthcare, VA Salt Lake City Health Care System, and University of Utah) participated. The program consisted of an onsite, didactic session, QI planning and 6 months of intense implementation support. **Results** Completion rate was 82% with an average improvement rate of 21%. Important predisposing factors for success included an established electronic record and a culture of quality. **The**

reinforcing and enabling factors included free continuing medical education credits, feedback, IT access, and flexible support. The relationship between IT and QI emerged as a central factor. Quantitative analysis found significant differences between institutions for pre-post changes even after the number and category of implementation strategies had been controlled for. Conclusions The analysis illustrates the complex dependence between IT interventions, institutional characteristics, and implementation practices. Access to IT tools and data by individual clinicians may be a key factor for the success of QI projects. Institutions vary widely in the degree of access to IT tools and support. This article suggests that more attention be paid to the QI and IT department relationship.

41. [Rev Calid Asist.](#) 2011 May 13. [Epub ahead of print]

[**The healthcare professional's perceptions on the implementation and usefulness of the surgical safety checklist.**]

[Article in Spanish]

[Rodrigo-Rincón MI](#), [Tirapu-León B](#), [Zabalza-López P](#), [Martín-Vizcaino MP](#), [de La Fuente-Calixto A](#), [Villalgorido-Ortín P](#), [Domench-Mañero L](#), [Gost-Garde J](#).

Abstract

OBJECTIVE:

To find out the perception of the health care professionals on the level of implementation and the usefulness of the surgical safety checklist (LVQ) after its introduction in a tertiary care hospital.

MATERIAL AND METHOD:

A descriptive cross-sectional study was conducted using a specially designed self-completion questionnaire. This consisted of 5 questions on the usefulness, 5 questions on the use of the LVQ, one open question and 4 control questions. The target population was hospital surgeons, anaesthetists, ward nurses, and surgical nurses.

RESULTS:

The response rate was 73%, ranking from 51% to 88% depending on the respondent profile. Almost all (95.7%) of the respondents declared they always or almost always used the LVQ when performing a surgical operation. The health care professionals rated the usefulness of the LVQ with a mean of 6.6 (scale, 1-10); 11.6% mentioned that actual errors had been avoided through the use of the LVQ; 32.5% considered the LVQ as a tool that improves communication between professionals; and 68% of the respondents declared they would like the LVQ to be used if they were surgical patients. Those respondents who answered that the LVQ had prevented errors gave higher usefulness scores, 1.4 above the mean. In this same group, 100% of the respondents would like the LVQ to be used on themselves and 63.2% considered that communication had improved. There were no differences in usefulness scores as regards professional experience or gender.

CONCLUSIONS:

The health care professionals use the LVQ very frequently, and consider that it has a moderate usefulness. Those professionals with experience of the LVQ preventing errors considered it to be more useful than those who did not experience an error being prevented.

42. [J Assoc Nurses AIDS Care.](#) 2011 May 11. [Epub ahead of print]

Barriers and Facilitators in Implementing "Prevention for Positives" Alcohol-Reduction Support: The Perspectives of Directors and Providers in Hospital-Based HIV Care Centers.

[Strauss SM](#), [Munoz-Plaza CE](#), [Tiburcio NJ](#), [Gwadz M](#).

Abstract

HIV-infected patients have considerable need for alcohol reduction support, and HIV care providers are strategically placed to implement a "prevention for positives" alcohol-reduction approach through alcohol screening and brief interventions (SBIs). To facilitate this approach, we provided alcohol SBI education and training to HIV care providers in four hospital-based, New York City HIV Care Centers in 2007. Interviews with the medical directors and 14 of the HIV care providers who attended the training identified barriers to implementing alcohol SBIs. These included limited time for alcohol screening, patients' incomplete disclosure of alcohol use, providers' perceptions that alcohol use is not a major problem for their patients, and provider specialization that assigns patients with problematic alcohol use to specifically designated providers. Identified facilitators for alcohol SBI implementation included adequate time to conduct the SBI; availability of information, tools, and key points to emphasize with HIV-infected patients; and use of a brief alcohol screening tool.

43. [BMC Med Inform Decis Mak](#). 2011 May 12;11(1):29. [Epub ahead of print]

Does the implementation of an electronic prescribing system create unintended medication errors? A study of the sociotechnical context through the analysis of reported medication incidents.

[Redwood S](#), [Rajakumar A](#), [Hodson J](#), [Coleman JJ](#).

Abstract

BACKGROUND:

Even though electronic prescribing systems are widely advocated as one of the most effective means of improving patient safety, they may also introduce new risks that are not immediately obvious. Through the study of specific incidents related to the processes involved in the administration of medication, we sought to find out if the prescribing system had unintended consequences in creating new errors. The focus of this study was a large acute hospital in the Midlands in the United Kingdom, which implemented a Prescribing, Information and Communication System (PICS).

METHODS:

This exploratory study was based on a survey of routinely collected medication incidents over five months. Data were independently reviewed by two of the investigators with a clinical pharmacology and nursing background respectively, and grouped into broad types: sociotechnical incidents (related to human interactions with the system) and non-sociotechnical incidents. Sociotechnical incidents were distinguished from the others because they occurred at the point where the system and the professional intersected and would not have occurred in the absence of the system. The day of the week and time of day that an incident occurred were tested using univariable and multivariable analyses. We acknowledge the limitations of conducting analyses of data extracted from incident reports as it is widely recognised that most medication errors are not reported and may contain inaccurate data. Interpretation of results must therefore be tentative.

RESULTS:

Out of a total of 485 incidents, a modest 15% (n= 73) were distinguished as sociotechnical issues and thus may be unique to hospitals that have such systems in place. These incidents were further analysed and subdivided into categories in order to identify aspects of the context which gave rise to adverse situations and possible risks to patient safety. The analysis of sociotechnical incidents by time of day and day of week indicated a trend for increased proportions of these types of incidents occurring on Sundays.

CONCLUSION:

Introducing an electronic prescribing system has the potential to give rise to new types of risks to patient safety. Being aware of these types of errors is important to the clinical and technical implementers of such systems in order to, where possible, design out unintended problems, highlight training requirements, and revise clinical practice protocols.

44. [BMC Public Health](#). 2011 May 11;11(1):299. [Epub ahead of print]

Integrating an Ecological Approach into an Aboriginal Community-Based Chronic Disease Prevention Program: A Longitudinal Process Evaluation.

[Cargo M](#), [Marks E](#), [Brimblecombe J](#), [Scarlett M](#), [Maypilama E](#), [Garnggulkpuy Dhurrkay J](#), [Daniel M](#).

Abstract

ABSTRACT: BACKGROUND: Public health promotes an ecological approach to chronic disease prevention, however, little research has been conducted to assess the integration of an ecological approach in community-based prevention programs. This study sought to contribute to the evidence base by assessing the extent to which an ecological approach was integrated into an Aboriginal community-based cardiovascular disease (CVD) and type 2 diabetes prevention program, across three-intervention years. **Methods:** Activity implementation forms were completed by interview with implementers and participant observation. A standardised ecological coding procedure was applied to assess participant recruitment settings, intervention targets, intervention strategy types, extent of ecologicalness and organisational partnering. Inter-rater reliability for two coders was assessed at Kappa = 0.76 (p <.0001), 95% CI (0.58, 0.94). **Results:** 215 activities were implemented across three intervention years by the health program (HP) with some activities implemented in multiple years. Participants were recruited most frequently through organisational settings in years 1 and 2, and organisational and community settings in year 3. The most commonly utilised intervention targets were the individual (IND) as a direct target, and interpersonal (INT) and organisational (ORG) environments as indirect targets; policy (POL), and community (COM) were targeted least. Direct (HP->IND) and indirect intervention strategies (i.e., HP->INT->IND) were used most often; networking strategies, which link at least two targets (i.e., HP->[ORG-ORG]->IND), were used the least. The program did not become more ecological over time. **Conclusions:** The quantity of activities with IND, INT and ORG targets and the proportion of participants recruited through informal cultural networking demonstrate community commitment to prevention. Integration of an ecological approach would have been facilitated by greater inter-organisational collaboration and centralised planning. The upfront time required for community stakeholders to develop their capacity to mobilise around chronic disease is at odds with short-term funding cycles that emphasise organisational accountability.

45. [BMC Health Serv Res](#). 2011 May 10;11(1):96. [Epub ahead of print]

An implementation study of the crisis resolution team model in Norway: Are crisis resolution teams fulfilling their role?

[Hasselberg N](#), [Grawe RW](#), [Johnson S](#), [Ruud T](#).

Abstract

BACKGROUND:

The establishment of crisis resolution teams (CRTs) is part of the national mental health policy in several Western countries. The purpose of the present study is to describe characteristics of CRTs and their patients, explore the differences between CRTs, and examine whether the CRTs in Norway is organized according to the international CRT model.

METHODS:

The study was a naturalistic study of eight CRTs and 680 patients referred to these teams in Norway. Mental health problems were assessed using the Health of the Nation Outcome Scales (HoNOS), Global Assessment of Functioning Scales (GAF) and the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

RESULTS:

None of the CRTs operated 24 hours a day, seven days a week (24/7 availability) or had gate-keeping functions for acute wards. The CRTs also treated patients who were not considered for hospital admission. Forty per cent of patients waited more than 24 hours for treatment. Fourteen per cent had psychotic symptoms, and 69% had affective symptoms. There were significant variations between teams in patients' total severity of symptoms and social problems, but no variations between teams with respect to patients' aggressive behaviour, non-accidental self-injury, substance abuse or psychotic symptoms. There was a tendency for teams operating extended hours to treat patients with more severe mental illnesses.

CONCLUSIONS:

The CRT model has been implemented in Norway without a rapid response, gate-keeping function and 24/7 availability. These findings indicate that the CRTs do not completely fulfil their intended role in the mental health system.

46. [Int J Clin Pharm](#). 2011 May 13. [Epub ahead of print]

Physicians' perception of CPOE implementation.

[Allenet B](#), [Bedouch P](#), [Bourget S](#), [Baudrant M](#), [Faroni L](#), [Calop J](#), [Bosson JL](#).

Abstract

Objective To identify perceptions held by physicians of the benefits of computerized physician order entry (CPOE) and factors influencing its successful implementation in the context of the increased presence of a clinical pharmacist on ward. **Setting** A 2000-bed University Hospital. **Method** A cross-section opinion survey was conducted of all permanent physicians of the hospital to determine their perception on the benefits, or otherwise, of CPOE. Questionnaires, built upon the analysis of 10 preliminary semi-structured interviews with physicians, were sent to physicians by electronic and paper mail. It comprised three sections with a 4 level Likert scale: general perception of CPOE benefits (items 1.1-1.8); opinion on the introduction of the CPOE system in the hospital (item 2); opinion on the presence of a pharmacist on ward (item 3). A fourth section recorded the respondent's profile. **Main outcome measures** Level of agreement on the items describing the general perception of CPOE benefits; opinion on the introduction of a CPOE system in the hospital; and opinion on the pharmacist's presence on ward. **A Principal Component Analysis (PCA)** was conducted on sections one and two. **Analysis of this PCA representation in terms of the respondents' profile** was performed. **Results** One hundred and one

physicians (18%) participated in the survey. Most (83%) physicians favoured the implementation of a CPOE (item 2). Among the advantages of CPOE, the greatest agreement concerned items related to safety and regulatory issues (from 80 to 76% agreement). Other items related to management issues were perceived as less tangible benefits (from 50 to 67% agreement). The increased presence of a pharmacist on the ward was supported by 94% of physicians. The PCA representation using profile items produced a 2-factor solution, accounting for 68% of the variance, with former experience of collaboration with a pharmacist ($P = 0.002$) and senior physician status ($P = 0.013$) positively influencing the perception of the CPOE. Conclusion Endorsement by senior physicians and the presence of a clinical pharmacist on ward promote a positive attitude towards CPOE and facilitate its implementation.

47. [Am J Infect Control](#). 2011 May 11. [Epub ahead of print]

Effectiveness of comprehensive implementation of individualized bundling infection control measures for prevention of health care-associated infections in general medical wards.

[Korbkitjaroen M](#), [Vaithayapichet S](#), [Kachintorn K](#), [Jintanothaitavorn D](#), [Wiruchkul N](#), [Thamlikitkul V](#).

Abstract

BACKGROUND:

The prevalence of health care-associated infections (HAIs) in general medical wards at Siriraj Hospital in Bangkok, Thailand remains at 10% even after infection control measures were launched. The present study aimed to determine the effectiveness of comprehensive individualized bundling infection control measures in reducing HAIs and to identify the lowest possible rate of HAIs in general medical wards.

METHODS:

This was a cluster randomized controlled study conducted in 8 general medical wards (4 control wards and 4 intervention wards) at Siriraj Hospital. The patients hospitalized in the control wards received regular health care, as well as regular measures for preventing HAIs. The patients hospitalized in the intervention wards received additional measures. Each patient in the intervention wards was visited by the infection control team once a day until he or she left the hospital. The infection control team identified risk factors for developing HAI in each patient, coordinated with the local health care team to eliminate or minimize such risk factors, and encouraged responsible personnel to comply with the appropriate infection control measures for each patient.

RESULTS:

Between January and April 2009, there were 954 patients (9,650 hospitalization-days) in the intervention wards and 920 patients (9,777 hospitalization-days) in the control wards. The patient characteristics were comparable in the 2 groups. The prevalence of HAI was significantly lower in the intervention wards compared with the control wards (5.6% vs 9.2%; $P = .003$). Six episodes of HAI in patients in the intervention wards could have been avoided.

CONCLUSION:

Comprehensive individualized bundling infection control measures were effective in reducing the prevalence of HAIs in general medical wards. The target overall prevalence of HAIs in general medical wards should not exceed 4.9%.

48. [Trop Med Int Health](#). 2011 May 12. doi: 10.1111/j.1365-3156.2011.02794.x. [Epub ahead of print]

Communities of practice: the missing link for knowledge management on implementation issues in low-income countries?

[Meessen B](#), [Kouanda S](#), [Musango L](#), [Richard F](#), [Ridde V](#), [Soucat A](#).

Abstract

The implementation of policies remains a huge challenge in many low-income countries. Several factors play a role in this, but improper management of existing knowledge is no doubt a major issue. In this article, we argue that new platforms should be created that gather all stakeholders who hold pieces of relevant knowledge for successful policies. To build our case, we capitalize on our experience in our domain of practice, health care financing in sub-Saharan Africa. We recently adopted a community of practice strategy in the region. More in general, we consider these platforms as the way forward for knowledge management of implementation issues.

49. [Lancet](#). 2011 May 28;377(9780):1863-76. Epub 2011 May 9.

Maternal and child health in Brazil: progress and challenges.

[Victora CG](#), [Aquino EM](#), [do Carmo Leal M](#), [Monteiro CA](#), [Barros FC](#), [Szwarcwald CL](#).

Abstract

In the past three decades, Brazil has undergone rapid changes in major social determinants of health and in the organisation of health services. In this report, we examine how these changes have affected indicators of maternal health, child health, and child nutrition. We use data from vital statistics, population censuses, demographic and health surveys, and published reports. In the past three decades, infant mortality rates have reduced substantially, decreasing by 5.5% a year in the 1980s and 1990s, and by 4.4% a year since 2000 to reach 20 deaths per 1000 livebirths in 2008. Neonatal deaths account for 68% of infant deaths. Stunting prevalence among children younger than 5 years decreased from 37% in 1974-75 to 7% in 2006-07. Regional differences in stunting and child mortality also decreased. Access to most maternal-health and child-health interventions increased sharply to almost universal coverage, and regional and socioeconomic inequalities in access to such interventions were notably reduced. The median duration of breastfeeding increased from 2.5 months in the 1970s to 14 months by 2006-07. Official statistics show stable maternal mortality ratios during the past 10 years, but modelled data indicate a yearly decrease of 4%, a trend which might not have been noticeable in official reports because of improvements in death registration and the increased number of investigations into deaths of women of reproductive age. The reasons behind Brazil's progress include: socioeconomic and demographic changes (economic growth, reduction in income disparities between the poorest and wealthiest populations, urbanisation, improved education of women, and decreased fertility rates), interventions outside the health sector (a conditional cash transfer programme and improvements in water and sanitation), vertical health programmes in the 1980s (promotion of breastfeeding, oral rehydration, and immunisations), creation of a tax-funded national health service in 1988 (coverage of which expanded to reach the poorest areas of the country through the Family Health Program in the mid-1990s); and implementation of many national and state-wide programmes to improve child health and child nutrition and, to a lesser extent, to promote women's health. Nevertheless, substantial challenges remain, including overmedicalisation of childbirth (nearly 50% of babies are delivered by caesarean section), maternal deaths caused by illegal abortions, and a high frequency of preterm deliveries.

50. [Health Educ Res](#). 2011 May 10. [Epub ahead of print]

A national survey of organizational transfer practices in chronic disease prevention in Canada.

[Hanusaik N](#), [O'Loughlin JL](#), [Paradis G](#), [Kishchuk N](#).

Abstract

Underuse of best practices in chronic disease prevention (CDP) represents missed opportunities to promote healthy living and prevent chronic disease. Better understanding of how CDP programs, practices and policies (PPPs) are transferred from 'resource' organizations that develop them to 'user' organizations that implement them is crucial. The objectives of this work were to develop psychometrically sound measures of transfer practices occurring within resource organizations; describe the use of these transfer practices and identify correlates of the transfer process. Cross-sectional data were collected in structured telephone interviews with the person most knowledgeable about PPP transfer in 77 Canadian organizations that develop PPPs. Independent correlates of transfer were identified using multiple linear regression. The transfer practices most commonly used included: identification of barriers to PPP adoption/implementation, tailoring transfer strategies and designing a transfer plan. Skill at planning/implementing transfer, external sources of funding specifically allocated for transfer, type of resource organization, attitude toward process of collaboration and user-centeredness were all positively associated with the transfer process. These factors represent possible targets for interventions to improve transfer of CDP PPPs.

51. [Health Policy Plan](#). 2011 May 10. [Epub ahead of print]

Influencing policy change: the experience of health think tanks in low- and middle-income countries.

[Bennett S](#), [Corluka A](#), [Doherty J](#), [Tangcharoensathien V](#), [Patcharanarumol W](#), [Jesani A](#), [Kyabaggu J](#), [Namaganda G](#), [Hussain AM](#), [de-Graft Aikins A](#).

Abstract

In recent years there has been a growth in the number of independent health policy analysis institutes in low- and middle-income countries which has occurred in response to the limitation of government analytical capacity and pressures associated with democratization. This study aimed to: (i) investigate the contribution made by health policy analysis institutes in low- and middle-income countries to health policy agenda setting, formulation, implementation and monitoring and evaluation; and (ii) assess which factors, including organizational form and structure, support the role of health policy analysis institutes in low- and middle-income countries in terms of positively contributing to health policy. Six case studies of health policy analysis institutes in Bangladesh, Ghana, India, South Africa, Uganda and Vietnam were conducted including two NGOs, two university and two government-owned policy analysis institutes. Case studies drew on document review, analysis of financial information, semi-structured interviews with staff and other stakeholders, and iterative feedback of draft findings. Some of the institutes had made major contributions to policy development in their respective countries. All of the institutes were actively engaged in providing policy advice and most undertook policy-relevant research. Relatively few were engaged in conducting policy dialogues, or systematic reviews, or commissioning research. Much of the work undertaken by institutes was driven by requests from government or donors, and the primary outputs for most institutes were research reports, frequently combined with verbal briefings. Several factors were critical in supporting effective policy engagement. These included a supportive policy environment, some degree of independence in governance and financing, and strong links to policy makers that

facilitate trust and influence. While the formal relationship of the institute to government was not found to be critical, units within government faced considerable difficulties.

52. [Best Pract Res Clin Anaesthesiol.](#) 2011 Jun;25(2):161-8.

The WHO surgical checklist.

[Mahajan RP.](#)

Abstract

Following the overwhelming evidence of adverse events in hospital practice, the World Health Organization (WHO)'s World Alliance for Patient Safety has launched the 'Safe Surgery Saves Lives' campaign, which has developed a surgical safety checklist aimed to improve patient safety. The implementation of this checklist has met with mixed reactions in different institutions. Many countries have still not adopted its use. In this article, a brief review is presented regarding the role of the WHO checklist, barriers to its implementation and strategies for successful adoption.

53. [J Eval Clin Pract.](#) 2011 May 5. doi: 10.1111/j.1365-2753.2011.01690.x. [Epub ahead of print]

Intentions and status prescribing: can the Theory of Planned Behaviour explain physician behaviour in following guideline recommendations?

[Rashidian A, Russell I.](#)

Abstract

Objectives Few studies have assessed the utility of the Theory of Planned Behaviour (TPB) in explaining physicians' behaviour. This study uses the TPB for explaining physicians' implementation of guidelines' prescribing recommendations. **Methods** We developed the questionnaire via conducting qualitative interviews and pilot study. A random sample of 155 general practitioners (GPs) in England participated in the study. Prescribing and practice data were collected from routine sources. We analysed the data using regression methods. **Results** TPB explained 48% of variation in reported intentions to follow guidelines' prescribing recommendations. Attitude and perceived controls, but not subjective norms, were predictors of variation in intentions. TPB belief variables significantly explained variation in effective and efficient prescribing indicators (14% and 12% respectively). Normative, control and behavioural beliefs contributed to the models. Only for efficient prescribing, the TPB items retained their significance in presence of demographic variables. We found no significant relationship between intention and prescribing. **Conclusions** TPB helped understanding of GPs prescribing behaviour and their intentions to implement a clinical guideline. Beliefs (e.g. normative beliefs) were better predictors of behaviour than the composite scores for their corresponding higher-level construct (e.g. indirect subjective norm). TPB models should be tested alongside randomized trials to test the assumption of causality that change in beliefs ultimately results in change in behaviour.

54. [Acad Med.](#) 2011 Jun;86(6):712-717.

Developing a Multidisciplinary Model of Comparative Effectiveness Research Within a Clinical and Translational Science Award.

[Marantz PR, Strelnick AH, Currie B, Bhalla R, Blank AE, Meissner P, Selwyn PA, Walker EA, Hsu DT, Shamoon H.](#)

Abstract

The Clinical and Translational Science Awards (CTSAs) were initiated to improve the conduct and impact of the National Institutes of Health's research portfolio, transforming training programs and research infrastructure at academic institutions and creating a nationwide consortium. They provide a model for translating research across disciplines and offer an efficient and powerful platform for comparative effectiveness research (CER), an effort that has long struggled but enjoys renewed hope under health care reform. CTSAs include study design and methods expertise, informatics, and regulatory support; programs in education, training, and career development in domains central to CER; and programs in community engagement. Albert Einstein College of Medicine of Yeshiva University and Montefiore Medical Center have entered a formal partnership that places their CTSA at a critical intersection for clinical and translational research. Their CTSA leaders were asked to develop a strategy for enhancing CER activities, and in 2010 they developed a model that encompasses four broadly defined "compartments" of research strength that must be coordinated for this enterprise to succeed: evaluation and health services research, biobehavioral research and prevention, efficacy studies and clinical trials, and social science and implementation research. This article provides historical context for CER, elucidates Einstein-Montefiore's CER model and strategic planning efforts, and illustrates how a CTSA can provide vision, leadership, coordination, and services to support an academic health center's collaborative efforts to develop a robust CER portfolio and thus contribute to the national effort to improve health and health care.

55. [Acad Med.](#) 2011 Jun;86(6):701-705.

[Integrating Economic Evaluation Methods Into Clinical and Translational Science Award Consortium Comparative Effectiveness Educational Goals.](#)

[Iribarne A](#), [Easterwood R](#), [Russo MJ](#), [Wang YC](#).

Abstract

With the ongoing debate over health care reform in the United States, public health and policy makers have paid growing attention to the need for comparative effectiveness research (CER). Recent allocation of federal funds for CER represents a significant move toward increased evidence-based practice and better-informed allocation of constrained health care resources; however, there is also heated debate on how, or whether, CER may contribute to controlling national health care expenditures. Economic evaluation, in the form of cost-effectiveness or cost-benefit analysis, is often an aspect of CER studies, yet there are no recommendations or guidelines for providing clinical investigators with the necessary skills to collect, analyze, and interpret economic data from clinical trials or observational studies. With an emphasis on multidisciplinary research, the Clinical and Translational Science Award (CTSA) consortium and institutional CTSA sites serve as an important resource for training researchers to engage in CER. In this article, the authors discuss the potential role of CTSA sites in integrating economic evaluation methods into their comparative effectiveness education goals, using the Columbia University Medical Center CTSA as an example. By allowing current and future generations of clinical investigators to become fully engaged not only in CER but also in the economic evaluations that result from such analyses, CTSA sites can help develop the necessary foundation for advancing research to guide clinical decision making and efficient use of limited resources.

56. [J Subst Abuse Treat.](#) 2011 May 30. [Epub ahead of print]

Frontline counselors in organizational contexts: A study of treatment practices in community settings.

[Smith BD](#), [Manfredo IT](#).

Abstract

This study addresses the challenge of implementing evidence-based treatment approaches in typical community settings. It identifies individual and organizational characteristics associated with two contrasting treatment approaches used by frontline practitioners. One treatment approach involves techniques supported by research; the other approach involves techniques primarily supported by experience and tradition. The study uses a nested probability sample of 45 organizations and 279 frontline practitioners. Multilevel (hierarchical linear modeling) regression models appropriately address the nested sample. The findings indicate that practitioner beliefs and components of organizational social contexts are associated with treatment approach. The use of an evidence-supported treatment approach is associated with opportunities to use training and with transformational leadership. A traditional treatment approach is more commonly used when practitioners have more positive perceptions of the organizational climate. The findings underscore the challenge of implementing evidence-based treatment techniques among counselors committed to traditional approaches.

57. [Addiction](#). 2011 Jun 1. doi: 10.1111/j.1360-0443.2011.03464.x. [Epub ahead of print]

A policy-oriented review of strategies for improving the outcomes of services for substance use disorder patients*

[Humphreys K](#), [McLellan AT](#).

Abstract

Aims To inform policy makers on available options for improving the effectiveness of treatments for substance use disorders and to stimulate debate about treatment improvement strategies among public officials, clinical providers, care managers, service users, families and researchers. **Methods** We draw on the scientific literature and our public policy experiences in two countries (the United Kingdom and the United States) to give an overview of policies which may improve care for individuals with substance use disorders. We divide such policies into 'process-focused quality improvement strategies' that attempt to change some aspect of treatment (e.g. increased retention, greater use of evidence-based practices) and 'patient-focused strategies' that attempt to reward outcomes directly (e.g. contingency management for patients, payment by results for providers). **Findings** Many policies of both types are poorly developed, have shown poor results, or both. The evidence is clear that process-focused quality improvement strategies can change what providers do and how treatment programs work, but such changes have thus far demonstrated only minimal impact on patient outcomes. Patient-focused strategies face challenges including treatment providers avoiding hard-to-treat patients or spending inordinate time relocating patients after treatment to assess outcome. However, policies that reward in-treatment outcomes and policies that allow the patient to purchase desired recovery support services show more promise. As policy makers go forward in this endeavor, they can do an enormous service to their countries and the field by embedding careful evaluation studies alongside new treatment outcome improvement initiatives.

58. [J Nurs Care Qual](#). 2011 May 26. [Epub ahead of print]

Evaluation of Emergency Department Evidence-Based Practices to Prevent the Incidence of Ventilator-Acquired Pneumonia.

[McCoy T](#), [Fields W](#), [Kent N](#).

Abstract

Pathogens in the oropharynx may be transported to the lung parenchyma during intubation and cause ventilator-acquired pneumonia. This project evaluated 3 post intubation evidence-based practices in the emergency department: oral care, head-of-bed elevation, and suctioning above the endotracheal tube balloon. Ventilator-acquired pneumonia cases decreased 83% after implementing these practices. There is no need to wait for the patient to be admitted to intensive care to begin these evidence-based practices.

59. [Qual Health Res.](#) 2011 Jun;21(6):757-70. Epub 2011 Feb 28.

The Influence of Context on Pain Practices in the NICU: Perceptions of Health Care Professionals.

[Stevens B](#), [Riahi S](#), [Cardoso R](#), [Ballantyne M](#), [Yamada J](#), [Beyene J](#), [Breau L](#), [Camfield C](#), [Finley GA](#), [Franck L](#), [Gibbins S](#), [Howlett A](#), [McGrath PJ](#), [McKeever P](#), [O'Brien K](#), [Ohlsson A](#).

Abstract

In this qualitative descriptive study, we explored health care professionals' perceptions of the influence of context (i.e., organizational culture, structure, resources, capabilities/competencies, and politics) on evidence-based pain practices. A total of 16 focus groups with 147 health care professionals were conducted in three neonatal intensive care units (NICUs) in central and eastern Canada. Three overarching themes emerged from the data, which captured influences on optimal pain practices in the NICU, including (a) a culture of collaboration and support for evidence-based practice, (b) threats to autonomous decision making, and (c) complexities in care delivery. These results were consistent with theoretical conceptualizations of how context influences practice, as well as recent empirical research findings. This study supports the importance of context in shaping evidence-based practices by health care professionals in the management of pain in the NICU.

60. [Addict Behav.](#) 2011 Jun;36(6):597-600. Epub 2011 Jan 21.

From Cat's Cradle to Beat the Reaper: getting evidence-based treatments into practice in spite of ourselves.

[Sorensen JL](#).

Abstract

Kurt Vonnegut was one of the most influential novelists of the late 20th Century. His wry views of people and organizations are applicable to the today's efforts to use science to improve the effectiveness of substance use treatment programs. His 1963 book, *Cat's Cradle* pointed to the potentially disastrous consequences of the development of science for science's sake. Moving to more current viewpoints, in 2009 the young writer and medical doctor Josh Bazell published *Beat the Reaper*, a novel that discusses modern medical care and pharmaceutical treatments with sarcasm and wit. Currently we are witnessing many developments to incorporate evidence-based practices into addiction treatment, ranging from Institute of Medicine overviews to the organization the Substance Abuse and Mental Health Services Administration, fielding the National Registry of Evidence-based Programs and Practices for preventing and treating substance abuse and mental health disorders, legislative initiatives, efforts to upgrade the treatment workforce and, most recently, health care reform. There are signs that

these and other efforts are upgrading the effectiveness of treatments for addiction. Yet the checks and balances of every effort to create change make for a field that shows halting and peripatetic development. "Top-down" reforms are watered down by "bottom-up" approaches, and vice-versa. Several concrete steps can be taken to improve the magnitude and speed of change in the field. We cannot change human nature, but we can improve addiction treatment.

61. [AIDS Behav.](#) 2011 May 14. [Epub ahead of print]

Evaluation of an HIV Prevention Intervention for African Americans and Hispanics: Findings from the VOICES/VOCES Community-Based Organization Behavioral Outcomes Project.

[Fisher HH](#), [Patel-Larson A](#), [Green K](#), [Shapatava E](#), [Uhl G](#), [Kalayil EJ](#), [Moore A](#), [Williams W](#), [Chen B](#).

Abstract

There is limited knowledge about whether the delivery of evidence-based, HIV prevention interventions in 'real world' settings will produce outcomes similar to efficacy trial outcomes. In this study, we describe longitudinal changes in sexual risk outcomes among African American and Hispanic participants in the Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) program at four CDC-funded agencies. VOICES/VOCES was delivered to 922 high-risk individuals in a variety of community settings such as substance abuse treatment centers, housing complex centers, private residences, shelters, clinics, and colleges. Significant risk reductions were consistently observed at 30- and 120-days post-intervention for all outcome measures (e.g., unprotected sex, self-reported STD infection). Risk reductions were strongest for African American participants, although Hispanic participants also reported reducing their risky behaviors. These results suggest that, over a decade after the first diffusion of VOICES/VOCES across the U.S. by CDC, this intervention remains an effective tool for reducing HIV risk behaviors among high-risk African American and Hispanic individuals.

62. [Surgery.](#) 2011 May 17. [Epub ahead of print]

Can a tailored knowledge translation strategy improve short term outcomes? A pilot study to increase compliance with bowel preparation recommendations in general surgery.

[Eskicioglu C](#), [Gagliardi A](#), [Fenech DS](#), [Victor CJ](#), [McLeod RS](#).

Abstract

BACKGROUND:

Previous studies have shown that practices supported by level I evidence may take up to 20 years before they are adopted. Although mechanical bowel preparation (MBP) has been a routine practice in colorectal surgery, there is strong evidence dating back to the early 1990s suggesting that in most patients MBP before elective colorectal surgery is not required. The objective of this study was to determine if surgical practices pertaining to bowel preparation could be altered using a tailored knowledge translation strategy.

METHODS:

A multi-faceted strategy including guideline development, consensus, education by opinion leaders, audit and feedback, and reminder cards was used in this before-after study. The primary outcome was compliance with the recommendations presented in the guideline regarding MBP, normal diet on the day prior to surgery, and enemas.

RESULTS:

Two-hundred eighty-two patients were enrolled in the study with 111 enrolled before the intervention and 171 enrolled after the intervention. Demographic and clinical characteristics between the 2 groups were similar. Overall, there was a 7.8% increase in compliance with MBP recommendations (81.1% vs 88.4%, $P = .038$), a 10.2% increase in compliance with diet recommendations (45.6% vs 55.8%, $P = .080$), and a 5.6% increase in compliance with enema recommendations (88.5% vs 94.2%, $P < .001$).

CONCLUSION:

The results of this study reveal that a tailored, multi-faceted knowledge translation strategy is effective in changing surgeon behavior.

63. [Am J Med.](#) 2011 Jun;124(6):549-56.

Use of a decision aid to improve treatment decisions in osteoporosis: the osteoporosis choice randomized trial.

[Montori VM](#), [Shah ND](#), [Pencille LJ](#), [Branda ME](#), [Van Houten HK](#), [Swiglo BA](#), [Kesman RL](#), [Tulledge-Scheitel SM](#), [Jaeger TM](#), [Johnson RE](#), [Bartel GA](#), [Melton LJ 3rd](#), [Wermers RA](#).

Abstract**OBJECTIVE:**

Poor adherence to therapy, perhaps related to unaddressed patient preferences, limits the effectiveness of osteoporosis treatment in at-risk women. A parallel patient-level randomized trial in primary care practices was performed.

METHODS:

Eligible postmenopausal women with bone mineral density T-scores less than -1.0 and not receiving bisphosphonate therapy were included. In addition to usual primary care, intervention patients received a decision aid (a tailored pictographic 10-year fracture risk estimate, absolute risk reduction with bisphosphonates, side effects, and out-of-pocket cost), and control patients received a standard brochure. Knowledge transfer, patient involvement in decision-making, and rates of bisphosphonate start and adherence were studied. Data came from medical records, post-visit written and 6-month phone surveys, video recordings of clinical encounters, and pharmacy prescription profiles.

RESULTS:

A total of 100 patients (range of 10-year fracture risk, 6%-60%) were allocated randomly to receive the decision aid ($n=52$) or usual care ($n=48$). Patients receiving the decision aid were 1.8 times more likely to correctly identify their 10-year fracture risk (49% vs 28%; 95% confidence interval [CI], 1.03-3.2) and 2.7 times more likely to identify their estimated risk reduction with bisphosphonates (43% vs 16%; 95% CI, 1.3-5.7). Patient involvement improved with the decision aid by 23% (95% CI, 13.6-31.4). Bisphosphonates were started by 44% of patients receiving the decision aid and 40% of patients receiving usual care. Adherence at 6 months was similarly high across both groups, but the proportion with more than 80% adherence was higher with the decision aid ($n=23$ [100%] vs $n=14$ [74%]; $P = .009$).

CONCLUSION:

A decision aid improved the quality of clinical decisions about bisphosphonate therapy in at-risk postmenopausal women, did not affect start rates, and may have improved adherence.

64. [Implement Sci.](#) 2011 May 28;6(1):55. [Epub ahead of print]

Applying psychological theories to evidence-based clinical practice: Identifying factors predictive of lumbar spine x-ray for low back pain in UK primary care practice.

[Grimshaw JM](#), [Eccles MP](#), [Steen N](#), [Johnston M](#), [Pitts NB](#), [Glidewell L](#), [Maclennan G](#), [Thomas R](#), [Bonetti D](#), [Walker A](#).

Abstract

BACKGROUND:

Psychological models predict behaviour in a wide range of settings. The aim of this study was to explore the usefulness of a range of psychological models to predict the health professional behaviour 'referral for lumbar spine x-ray in patients presenting with low back pain' by UK primary care physicians.

METHODS:

Psychological measures were collected by postal questionnaire survey from a random sample of primary care physicians in Scotland and north England. The outcome measures were clinical behaviour (referral rates for lumbar spine x-rays), behavioural simulation (lumbar spine x-ray referral decisions based upon scenarios), and behavioural intention (general intention to refer for lumbar spine x-rays in patients with low back pain). Explanatory variables were the constructs within the Theory of Planned Behaviour (TPB), Social Cognitive Theory (SCT), Common Sense Self-Regulation Model (CS-SRM), Operant Learning Theory (OLT), Implementation Intention (II), Weinstein's Stage Model termed the Precaution Adoption Process (PAP), and knowledge. For each of the outcome measures, a generalised linear model was used to examine the predictive value of each theory individually. Linear regression was used for the intention and simulation outcomes, and negative binomial regression was used for the behaviour outcome. Following this 'theory level' analysis, a 'cross-theoretical construct' analysis was conducted to investigate the combined predictive value of all individual constructs across theories.

RESULTS:

Constructs from TPB, SCT, CS-SRM, and OLT predicted behaviour; however, the theoretical models did not fit the data well. When predicting behavioural simulation, the proportion of variance explained by individual theories was TPB 11.6%, SCT 12.1%, OLT 8.1%, and II 1.5% of the variance, and in the cross-theory analysis constructs from TPB, CS-SRM and II explained 16.5% of the variance in simulated behaviours. When predicting intention, the proportion of variance explained by individual theories was TPB 25.0%, SCT 21.5%, CS-SRM 11.3%, OLT 26.3%, PAP 2.6%, and knowledge 2.3%, and in the cross-theory analysis constructs from TPB, SCT, CS-SRM, and OLT explained 33.5% variance in intention. Together these results suggest that physicians' beliefs about consequences and beliefs about capabilities are likely determinants of lumbar spine x-ray referrals.

CONCLUSIONS:

The study provides evidence that taking a theory-based approach enables the creation of a replicable methodology for identifying factors that predict clinical behaviour. However, a number of conceptual and methodological challenges remain.

65. [Implement Sci](#). 2011 May 28;6(1):54. [Epub ahead of print]

Community Capacity to Acquire, Assess, Adapt and Apply Research Evidence: A Survey of Ontario's HIV/AIDS Sector.

[Wilson MG](#), [Rourke SB](#), [Lavis JN](#), [Bacon J](#), [Travers R](#).

Abstract

BACKGROUND:

Community-based organizations (CBOs) are important stakeholders in health systems and are increasingly called upon to use research evidence to inform their advocacy, program planning, and service delivery. To better support CBOs to find and use research evidence, we sought to assess the capacity of CBOs in the HIV/AIDS sector to acquire, assess, adapt, and apply research evidence in their work.

METHODS:

We invited executive directors of HIV/AIDS CBOs in Ontario, Canada (n = 51) to complete the Canadian Health Services Research Foundation's "Is Research Working for You?" survey.

FINDINGS:

Based on responses from 25 organizations that collectively provide services to approximately 32,000 clients per year with 290 full-time equivalent staff, we found organizational capacity to acquire, assess, adapt, and apply research evidence to be low. CBO strengths include supporting a culture that rewards flexibility and quality improvement, exchanging information within their organization, and ensuring that their decision-making processes have a place for research. However, CBO Executive Directors indicated that they lacked the skills, time, resources, incentives, and links with experts to acquire research, assess its quality and reliability, and summarize it in a user-friendly way.

CONCLUSION:

Given the limited capacity to find and use research evidence, we recommend a capacity-building strategy for HIV/AIDS CBOs that focuses on providing the tools, resources, and skills needed to more consistently acquire, assess, adapt, and apply research evidence. Such a strategy may be appropriate in other sectors and jurisdictions as well given that CBO Executive Directors in the HIV/AIDS sector in Ontario report low capacity despite being in the enviable position of having stable government infrastructure in place to support them, benefiting from long-standing investment in capacity building, and being part of an active provincial network. CBOs in other sectors and jurisdictions that have fewer supports may have comparable or lower capacity. Future research should examine a larger sample of CBO Executive Directors from a range of sectors and jurisdictions.

66. [Implement Sci.](#) 2011 May 27;6(1):53. [Epub ahead of print]

Still too little qualitative research to shed light on results from reviews of effectiveness trials: A case study of a Cochrane review on the use of lay health workers.

[Glenton C](#), [Lewin S](#), [Scheel IB](#).

Abstract

ABSTRACT: BACKGROUND: Qualitative research is used increasingly alongside trials of complex interventions to explore processes, contextual factors or intervention characteristics that may have influenced trial outcomes. Qualitative research conducted alongside trials can also be used to shed light on the results of systematic reviews of effectiveness by looking for factors that can help explain heterogeneous results across trials. In a Cochrane review on the effects of using lay health workers on maternal and child health and infectious disease control, we identified 82 trials. These trials showed promising benefits but results were heterogeneous. **Objective:** To use qualitative studies conducted alongside these trials to explore factors and processes that might have influenced intervention outcomes. **Methods:** We attempted to identify qualitative research carried out alongside the trials by contacting trial authors; checking papers for references to qualitative research; searching Pubmed for related studies; and carrying out citation searches. For

those qualitative studies that we included, we extracted information regarding study objective; data collection and analysis methods; and key themes and categories. Results: For 52 (63%) of the trials, we found no qualitative research that had been conducted alongside the trials. For sixteen (20%) trials, some form of qualitative data collection had been done but was unavailable or had been done before the trial. For 14 (17%) trials, qualitative research had been done during or shortly after the trial, although descriptions of qualitative methods and results were often sparse. Most of these 14 studies aimed to elicit trial participants' perspectives and experiences of the intervention. A common theme was participants' appreciation of the lay health workers' shared circumstances, for instance with regard to social background or experience of the health condition. In six studies, researchers explored the experiences of the lay health workers themselves. Issues included the importance of regular supervision and health professionals' support or lack of support. Conclusions: Qualitative studies carried out alongside trials of complex interventions could offer opportunities to authors of systematic reviews of effectiveness wishing to understand the heterogeneity of trial results. For interventions of lay health worker programmes at least, too few such studies exist at present for these opportunities to be realised.

67. [Implement Sci](#). 2011 May 27;6(1):52. [Epub ahead of print]

Effects of an evidence service on community-based AIDS service organizations' use of research evidence: A protocol for a randomized controlled trial.

[Wilson MG](#), [Lavis JN](#), [Grimshaw JM](#), [Haynes RB](#), [Bekele T](#), [Rourke SB](#).

Abstract

ABSTRACT: BACKGROUND: To support the use of research evidence by community-based organizations (CBOs) we have developed 'Synthesized HIV/AIDS Research Evidence' (SHARE), which is an evidence service for those working in the HIV sector. SHARE consists of several components: an online searchable database of HIV-relevant systematic reviews (retrievable based on a taxonomy of topics related to HIV/AIDS and open text search); periodic email updates; access to user-friendly summaries; and peer relevance assessments. Our objective is to evaluate whether this 'full serve' evidence service increases the use of research evidence by CBOs as compared to a 'self-serve' evidence service. **Methods/design** We will conduct a two-arm randomized controlled trial (RCT), along with a follow-up qualitative process study to explore the findings in greater depth. All CBOs affiliated with Canadian AIDS Society (n = 120) will be invited to participate and will be randomized to receive either the 'full-serve' version of SHARE or the 'self-serve' version (a listing of relevant systematic reviews with links to records on PubMed and worksheets that help CBOs find and use research evidence) using a simple randomized design. All management and staff from each organization will be provided access to the version of SHARE that their organization is allocated to. The trial duration will be 10 months (two-month baseline period, six-month intervention period, and two month crossover period), the primary outcome measure will be the mean number of logins/month/organization (averaged across the number of users from each organization) between baseline and the end of the intervention period. The secondary outcome will be intention to use research evidence as measured by a survey administered to one key decision maker from each organization. For the qualitative study, one key organizational decision maker from 15 organizations in each trial arm (n = 30) will be purposively sampled. One-on-one semi-structured interviews will be conducted by telephone on their views about and their experiences with the evidence service they received, how helpful it was in their work, why it was helpful (or not helpful), what aspects were most and least helpful and why, and recommendations for next steps. **DISCUSSION:** To our knowledge,

this will be the first RCT to evaluate the effects of an evidence service specifically designed to support CBOs in finding and using research evidence. Trial registration: NCT01257724 (ClinicalTrials.gov).

68. [Implement Sci.](#) 2011 May 27;6(1):51. [Epub ahead of print]

Effects of an evidence service on health system policymakers' use of research evidence: A protocol for a randomized controlled trial.

[Lavis JN](#), [Wilson MG](#), [Grimshaw JM](#), [Haynes RB](#), [Hanna S](#), [Raina P](#), [Gruen R](#), [Ouimet M](#).

Abstract

ABSTRACT: **BACKGROUND:** Health-system policy makers need timely access to synthesised research evidence to inform the policy-making process. No efforts to address this need have been evaluated using an experimental quantitative design. We developed an evidence service that draws inputs from Health Systems Evidence, which is a database of policy-relevant systematic reviews. The reviews have been (a) categorised by topic and type of review; (b) coded by the last year searches for studies were conducted and by the countries in which included studies were conducted; (c) rated for quality; and (d) linked to available user-friendly summaries, scientific abstracts, and full-text reports. Our goal is to evaluate whether a "full-serve" evidence service increases the use of synthesised research evidence by policy analysts and advisors in the Ontario Ministry of Health and Long-Term Care (MOHLTC) as compared to a "self-serve" evidence service. **Methods/design** We will conduct a two-arm randomized controlled trial (RCT), along with a follow-up qualitative process study in order to explore the findings in greater depth. For the RCT, all policy analysts and policy advisors (n=168) in a single division of the MOHLTC will be invited to participate. Using a stratified randomized design, participants will be randomized to receive either the "full-serve" evidence service (database access, monthly e-mail alerts, and full-text article availability) or the "self-serve" evidence service (database access only). The trial duration will be ten months (two-month baseline period, six-month intervention period, and two month cross-over period). The primary outcome will be the mean number of site visits/month/user between baseline and the end of the intervention period. The secondary outcome will be participants' intention to use research evidence. For the qualitative study, 15 participants from each trial arm (n=30) will be purposively sampled. One-on-one semi-structured interviews will be conducted by telephone on their views about and their experiences with the evidence service they received, how helpful it was in their work, why it was helpful (or not helpful), what aspects were most and least helpful and why, and recommendations for next steps. **DISCUSSION:** To our knowledge, this will be the first RCT to evaluate the effects of an evidence service specifically designed to support health-system policy makers in finding and using research evidence.

69. [Implement Sci.](#) 2011 May 23;6(1):49. [Epub ahead of print]

A realist evaluation of the role of communities of practice in changing healthcare practice.

[Ranmuthugala G](#), [Cunningham FC](#), [Plumb JJ](#), [Long J](#), [Georgiou A](#), [Westbrook JI](#), [Braithwaite J](#).

Abstract

ABSTRACT:

BACKGROUND:

Healthcare organisations seeking to manage knowledge and improve organisational performance are increasingly investing in communities of practice (CoPs). Such investments are being made in the absence of empirical evidence demonstrating the impact of CoPs in improving the delivery

of healthcare. A realist evaluation is proposed to address this knowledge gap. Underpinned by the principle that outcomes are determined by the context in which an intervention is implemented, a realist evaluation is well suited to understand the role of CoPs in improving healthcare practice. By applying a realist approach, this study will explore the following questions: What outcomes do CoPs achieve in healthcare? Do these outcomes translate into improved practice in healthcare? What are the contexts and mechanisms by which CoPs improve healthcare?

METHODS:

The realist evaluation will be conducted by developing, testing, and refining theories on how, why, and when CoPs improve healthcare practice. When collecting data, context will be defined as the setting in which the CoP operates; mechanisms will be the factors and resources that the community offers to influence a change in behaviour or action; and outcomes will be defined as a change in behaviour or work practice that occurs as a result of accessing resources provided by the CoP.

DISCUSSION:

Realist evaluation is being used increasingly to study social interventions where context plays an important role in determining outcomes. This study further enhances the value of realist evaluations by incorporating a social network analysis component to quantify the structural context associated with CoPs. By identifying key mechanisms and contexts that optimise the effectiveness of CoPs, this study will contribute to creating a framework that will guide future establishment and evaluation of CoPs in healthcare.

70. [Implement Sci.](#) 2011 May 19;6(1):47. [Epub ahead of print]

How to develop a program to increase influenza vaccine uptake among workers in health care settings?

[Looijmans-van den Akker I](#), [Hulscher ME](#), [Verheij TJ](#), [Riphagen-Dalhuisen J](#), [van Delden JJ](#), [Hak E](#).

Abstract

ABSTRACT: Background Apart from direct protection and reduced productivity loss during epidemics, the main reason to immunize health care workers (HCWs) against influenza is to provide indirect protection of frail patients through reduced transmission in health care settings. Since the vaccine uptake among HCWs remains far below the health objectives, systematic programs are needed to take full advantage of such vaccination. In an earlier report we showed a mean 9% increase of vaccine uptake among HCWs in nursing homes that implemented a systematic program compared with control homes, with higher rates in those homes that implemented more program elements. Here we report in detail the process of the development of the implementation program to enable researchers and practitioners to develop intervention programs tailored to their setting. Methods We applied the intervention mapping (IM) method to develop a theory- and evidence-based intervention program to change vaccination behaviour among HCWs in nursing homes. Results After a comprehensive needs assessment we were able to specify proximal program objectives and selected methods and strategies for inducing behavioural change. By consensus, we decided on planning of three main program components, i.e. an outreach visit to all nursing homes, plenary information meetings and the appointment of a program coordinator, preferably a physician, in each home. Finally, we planned program adoption, implementation and evaluation. Conclusion The IM methodology resulted in a systematic, comprehensive and transparent procedure of program development. A potentially

effective intervention program to change influenza vaccination behaviour among HCWs was developed and its impact was assessed in a clustered randomised controlled trial.

71. [Implement Sci](#). 2011 May 10;6(1):46. [Epub ahead of print]

Developing a decision aid to guide public sector health policy decisions: A study protocol.
[Tso P](#), [Culyer AJ](#), [Brouwers M](#), [Dobrow MJ](#).

Abstract

ABSTRACT: BACKGROUND: Decision aids have been developed in a number of health disciplines to support evidence-informed decision making, including patient decision aids and clinical practice guidelines. However, policy contexts differ from clinical contexts in terms of complexity and uncertainty, requiring different approaches for identifying, interpreting, and applying many different types of evidence to support decisions. With few studies in the literature offering decision guidance specifically to health policymakers, the present study aims to facilitate the structured and systematic incorporation of research evidence and, where there is currently very little guidance, values and other non-research-based evidence, into the policy making process. The resulting decision aid is intended to help public sector health policy decision makers who are tasked with making evidence-informed decisions on behalf of populations. The intent is not to develop a decision aid that will yield uniform recommendations across jurisdictions, but rather to facilitate more transparent policy decisions that reflect a balanced consideration of all relevant factors. **Methods/design** The study comprises three phases: a modified meta-narrative review, the use of focus groups, and the application of a Delphi method. The modified meta-narrative review will inform the initial development of the decision aid by identifying as many policy decision factors as possible and other features of methodological guidance deemed to be desirable in the literatures of all relevant disciplines. The first of two focus groups will then seek to marry these findings with focus group members' own experience and expertise in public sector population-based health policy making and screening decisions. The second focus group will examine issues surrounding the application of the decision aid and act as a sounding board for initial feedback and refinement of the draft decision aid. Finally, the Delphi method will be used to further inform and refine the decision aid with a larger audience of potential end-users. **DISCUSSION:** The product of this research will be a working version of a decision aid to support policy makers in population-based health policy decisions. The decision aid will address the need for more structured and systematic ways of incorporating various evidentiary sources where applicable.

72. [Implement Sci](#). 2011 May 9;6(1):45. [Epub ahead of print]

Target for improvement: a cluster randomised trial of public involvement in quality-indicator prioritization (intervention development and study protocol).

[Boivin A](#), [Lehoux P](#), [Lacombe R](#), [Lacasse A](#), [Burgers J](#), [Grol R](#).

Abstract

BACKGROUND:

Public priorities for improvement often differ from those of clinicians and managers. Public involvement has been proposed as a way to bridge the gap between professional and public clinical care priorities but has not been studied in the context of quality-indicator choice. Our objective is to assess the feasibility and impact of public involvement on quality-indicator choice and agreement with public priorities.

METHODS:

We will conduct a cluster randomised controlled trial comparing quality-indicator prioritisation with and without public involvement. In preparation for the trial, we developed a 'menu' of quality indicators, based on a systematic review of existing validated indicator sets. Participants (public representatives, clinicians, and managers) will be recruited from six participating sites. In intervention sites, public representatives will be involved through direct participation (public representatives, clinicians, and managers will deliberate together to agree on quality-indicator choice and use) and consultation (individual public recommendations for improvement will be collected and presented to clinicians and managers). In control sites, only clinicians and managers will take part in the prioritisation process. Data on quality-indicator choice and intended use will be collected. Our primary outcome will compare quality-indicator choice and agreement with public priorities between intervention and control groups. A process evaluation based on direct observation, videorecording, and participants' assessment will be conducted to help explain the study's results. The marginal cost of public involvement will also be assessed.

DISCUSSION:

We identified 801 quality indicators that met our inclusion criteria. An expert panel agreed on a final set of 37 items containing validated quality indicators relevant for chronic disease prevention and management in primary care. We pilot tested our public-involvement intervention with 27 participants (11 public representatives and 16 professionals) and our study instruments with an additional 21 participants, which demonstrated the feasibility of the intervention and generated important insights and adaptations to engage public representatives more effectively. To our knowledge, this study is the first trial of public involvement in quality-indicator prioritisation, and its results could foster more effective upstream engagement of patients and the public in clinical practice improvement. Trial registration: NTR2496 (Netherlands National Trial Register, www.trialregister.nl).

73. [J Gen Intern Med](#). 2011 May 20. [Epub ahead of print]

Prevalence of Practice System Tools for Improving Depression Care Among Primary Care Clinics: The DIAMOND Initiative.

[Margolis KL](#), [Solberg LI](#), [Crain AL](#), [Whitebird RR](#), [Ohnsorg KA](#), [Jaekels N](#), [Ofstedahl G](#), [Glasgow RE](#).

Abstract***BACKGROUND:***

Practice system tools improve chronic disease care, but are generally lacking for the care of depression in most primary care settings.

OBJECTIVE:

To describe the frequency of various depression-related practice system tools among Minnesota primary care clinics interested in improving depression care.

DESIGN:

Cross-sectional survey.

PARTICIPANTS:

Physician leaders of 82 clinics in Minnesota.

MAIN MEASURES:

A survey including practice systems recommended for care of depression and chronic conditions, each scored on a 100-point scale, and the clinic's priority for improving depression care on a 10-point scale.

KEY RESULTS:

Fewer practice systems tools were present and functioning well for depression care (score = 24.4 [SD 1.6]) than for the care of chronic conditions in general (score = 43.9 [SD 1.6]), $p < 0.001$. The average priority for improving depression care was 5.8 (SD 2.3). There was not a significant correlation between the presence of practice systems for depression or chronic disease care and the priority for depression care except for a modest correlation with the depression Decision Support subscale ($r = 0.29$, $p = 0.008$). Certain staffing patterns, a metropolitan-area clinic location, and the presence of a fully functional electronic medical record were associated with the presence of more practice system tools.

CONCLUSIONS:

Few practice system tools are in place for improving depression care in Minnesota primary care clinics, and these are less well-developed than general chronic disease practice systems. Future research should focus on demonstrating whether implementing these tools for depression care results in much-needed improvements in care for patients with depression.

74. [Intensive Crit Care Nurs.](#) 2011 Jun;27(3):117-20. Epub 2011 Apr 20.

Implementing quality initiatives using a bundled approach.

[Dawson D](#), [Endacott R](#).

Abstract

Critical care has been criticised for its inconsistency in implementing and evaluating evidence based practice both at national and international level. A review of the critical care literature by Berenholtz et al. (2002) identified interventions that might help prevent morbidity or mortality in the intensive care unit; from this four elements were developed into the initial ventilator care bundle. The aim of this bundle was to improve the quality of care for mechanically ventilated patients by improving compliance with relevant evidence based practice; implementation of this or an adapted cluster of interventions has been shown consistently to reduce the incidence of ventilator-associated pneumonias across countries. There are now numerous care bundles and the bundle approach to quality improvement has been proven to be effective across a number of problems, international boundaries and in a wide variety of ICU's. The bundle approach recognises that core clinical interventions, are not always consistently applied across all appropriate patients, the range of interventions within a bundle tackles the problem from a variety of different angles. Other strengths include its adaptability to the wide variety of environments and working practices of intensive care units across the world. The bundle and the method of implementation can be adapted to suit individual teams and units; however, this can also be a weakness of this approach as it limits comparability across centres. The bundle approach to quality improvement requires significant multidisciplinary engagement and resources to be effective.

75. [Int J Qual Health Care.](#) 2011 Jun;23(3):309-16. Epub 2011 Apr 19.

An evidence-based, multidisciplinary process for implementation of potentially better practices using a computerized medical record.

[Pantoja AF](#), [Britton JR](#).

Abstract

Although the Institute of Medicine of the USA has recommended elements for healthcare reform, the optimal means for incorporation of these elements into a healthcare setting remain undefined. A process for the implementation of potentially better practices is described that incorporates a

computerized medical record into an evidence-based, multidisciplinary continuous quality improvement effort. Steps in the process include the following: fostering a culture change that incorporates key habits for improvement; identification of a potentially better practice; review of existing evidence and analysis of local experience; delineation of proposed outcomes and potential confounders; guideline formulation and implementation; monitoring of change effectiveness; ongoing multivariate data analyses; and policy formulation. Trainee education and family participation characterize all steps in the process. Consequently, the process incorporates all of the elements recommended by the Institute of Medicine of the USA for healthcare reform and may be adapted to any healthcare setting.

76. [Vaccine](#). 2011 May 23;29(23):3969-76. Epub 2011 Apr 6.

Evaluation of the implementation of the H1N1 pandemic influenza vaccine in local health departments (LHDs) in North Carolina.

[Dibiase LM](#), [Davis SE](#), [Rosselli R](#), [Horney J](#).

Abstract

INTRODUCTION:

Effective conduct of vaccination campaigns by public health authorities can reduce morbidity and mortality associated with influenza. The emergence of the pandemic H1N1 influenza in April 2009 resulted in an unprecedented vaccination campaign in the US during the 2009-2010 influenza season. The variety of methods local health departments (LHDs) utilized to cope with a mismatch between public demand and supply and ever-changing guidelines have gone unexamined thus far. The purpose of this research is to identify and share lessons learned related to H1N1 influenza vaccination activities at LHDs.

METHODS:

In April 2010, a comprehensive survey was developed to evaluate 2009-10 LHD H1N1 vaccination practices and document lessons learned. A stratified random sample was selected from NC's 85 LHDs. Interviews were conducted with key personnel involved in LHD vaccination campaigns. Results were analyzed to identify quantitative trends and qualitative themes.

RESULTS:

Twenty-five of 26 LHDs (96% response rate) participated in our survey. Each LHD utilized a different approach to address the challenges they faced during their H1N1 vaccination campaign. Variation between LHDs was found in terms of the types of vaccine-dispensing methods implemented and in the selection of outside organizations LHDs partnered with to assist with vaccinations.

CONCLUSION:

Having a Continuity of Operations Plan (COOP) and pandemic influenza plan, hiring temporary staff, building on existing community partnerships, implementing a variety of vaccination strategies and using a variety of sites are strategies that will help LHDs deal more effectively with challenges posed by future pandemics.

77. [Addict Behav](#). 2011 Jun;36(6):584-9. Epub 2011 Jan 27.

Using medication-assisted treatment for substance use disorders: evidence of barriers and facilitators of implementation.

[Roman PM](#), [Abraham AJ](#), [Knudsen HK](#).

Abstract

The use of medications to treat substance use disorders (SUDs) has emerged as a potentially central part of the treatment armamentarium. In this paper we present data from several recent US national surveys showing that despite the clinical promise of these medications, there has been limited adoption of pharmacotherapies in the treatment of SUDs. The data reveal variable patterns of use of disulfiram, buprenorphine, tablet naltrexone, acamprosate and injectable naltrexone. After examining the environmental and institutional context for the adoption of pharmacotherapies, the specific organizational facilitators and barriers of medication adoption are considered. The paper concludes with a discussion of the minimal clinical and administrative guidance available to enhance adoption, the lack of client and consumer knowledge of medications that puts a brake on their adoption and availability, and the difficulties that must be surmounted in bringing new medications to market.

78. [Addict Behav.](#) 2011 Jun;36(6):590-6. Epub 2011 Feb 1.

Addicted to discovery: Does the quest for new knowledge hinder practice improvement?
[Perl HI.](#)

Abstract

Despite the billions of dollars spent on health-focused research and the hundreds of billions spent on delivering health services each year, relatively little money and effort are directed toward investigating how best to connect the two. This results in missed opportunities to assure that research findings inform and improve quality across healthcare in general and for addiction prevention and treatment in particular. There is an asymmetrical focus that favors the identification of new interventions and neglects the implementation of science-based knowledge in actual practice. The consequences of that neglect are severe: significantly diminished progress in research on how to implement treatments that could improve the lives of persons with addiction problems, their families, and the rest of society. While the advancement of knowledge regarding effective implementation is lagging, it is clear that existing systemic incentives in the conduct of science inhibit rather than facilitate widespread adoption of evidence-based practices. This commentary proposes three interrelated strategies for improving the implementation process. First, develop scientific tools to understand implementation better, by expanding investigations on the science of implementation and broadening approaches to the design and execution of research. Second, nurture and support a collaborative implementation workforce comprised of scientists and on-the-ground practitioners, with an explicit focus on enhancing appropriate incentives for both. Third, pay closer attention to crafting research that seeks answers that are most relevant to clinicians' actual needs, primarily by ensuring that the anticipated users of the evidence-based practice are full partners in developing the questions right from the start.

79. [BMJ Qual Saf.](#) 2011 Jun;20(6):498-507. Epub 2011 Feb 23.

Infrastructure for quality transformation: measurement and reporting in veterans administration intensive care units.

[Render ML](#), [Freyberg RW](#), [Hasselbeck R](#), [Hofer TP](#), [Sales AE](#), [Deddens J](#), [Levesque O](#), [Almenoff PL](#).

Abstract

Background Veterans Health Administration (VA) intensive care units (ICUs) develop an infrastructure for quality improvement using information technology and recruiting leadership. Methods Setting Participation by the 183 ICUs in the quality improvement program is required. Infrastructure includes measurement (electronic data extraction, analysis), quarterly web-based

reporting and implementation support of evidence-based practices. Leaders prioritise measures based on quality improvement objectives. The electronic extraction is validated manually against the medical record, selecting hospitals whose data elements and measures fall at the extremes (10th, 90th percentile). Results are depicted in graphic, narrative and tabular reports benchmarked by type and complexity of ICU. Results The VA admits 103 689±1156 ICU patients/year. Variation in electronic business practices, data location and normal range of some laboratory tests affects data quality. A data management website captures data elements important to ICU performance and not available electronically. A dashboard manages the data overload (quarterly reports ranged 106-299 pages). More than 85% of ICU directors and nurse managers review their reports. Leadership interest is sustained by including ICU targets in executive performance contracts, identification of local improvement opportunities with analytic software, and focused reviews. Conclusion Lessons relevant to non-VA institutions include the: (1) need for ongoing data validation, (2) essential involvement of leadership at multiple levels, (3) supplementation of electronic data when key elements are absent, (4) utility of a good but not perfect electronic indicator to move practice while improving data elements and (5) value of a dashboard.

80. [Addict Behav.](#) 2011 Jun;36(6):601-7. Epub 2011 Jan 20.

Translating addictions research into evidence-based practice: the Polaris CD outcomes management system.

[Toche-Manley L](#), [Grissom G](#), [Dietzen L](#), [Sangslan S](#).

Abstract

Converting the findings from addictions studies into information actionable by (non-research) treatment programs is important to improving program outcomes. This paper describes the translation of the findings of studies on Patient-Services matching, prediction of patient response to treatment (Expected Treatment Response) and prediction of dropout to provide evidence-based decision support in routine treatment. The findings of the studies and their application to the development of an outcomes management system are described. Implementation issues in a network of addictions treatment programs are discussed. The work illustrates how outcomes management systems can play an important role in translating research into practice.

81. [Addict Behav.](#) 2011 Jun;36(6):630-5. Epub 2011 Jan 15.

Modifications of evidence-based practices in community-based addiction treatment organizations: a qualitative research study.

[Lundgren L](#), [Amodeo M](#), [Cohen A](#), [Chassler D](#), [Horowitz A](#).

Abstract

This qualitative research effort explored implementation of evidence-based practices (EBPs) in 100 community-based addiction treatment organizations (CBOs) nationwide. The study describes CBO program director attitudes on: (1) satisfaction with EBPs they were mandated to implement; (2) the extent to which their organization modified the EBPs; (3) reasons for modifications; and, (4) the standards they used for modifications. Findings indicate that program directors were highly positive both about EBPs implemented and the modifications made to those EBPs. A broad range of modifications were identified; most common were adding or deleting intervention sessions in efforts to serve the needs of a specific client population. Given the addiction treatment field's lack of standards for modifying EBPs, it is not surprising that little consistency occurred in modification efforts. As government funders of addiction treatments

require that CBOs implement EBPs, standards need to be created for modifying and adapting the EBPs while maintaining their fidelity.

82. [BMJ Qual Saf](#). 2011 Jun;20(6):527-33. Epub 2011 Feb 2.

From research to practice: factors affecting implementation of prospective targeted injury-detection systems.

[Sorensen AV](#), [Harrison MI](#), [Kane HL](#), [Roussel AE](#), [Halpern MT](#), [Bernard SL](#).

Abstract

Aim This paper describes key factors that shaped implementation of prospective targeted injury-detection systems (TIDS) for adverse drug events (ADEs) and nosocomial pressure ulcers (PrU). **Methods** Using case-study methodology, the authors conducted semistructured interviews with implementation champions and TIDS users at five hospitals. Interviews focused on implementation experiences, assessment of TIDS' effectiveness and utility, and plans for sustainability. The authors used content analysis techniques to compare implementation experiences within and across organisations and triangulated data for explanation and confirmation of common themes. **Findings** Participating hospitals were more successful in implementing the low-complexity PrU-TIDS, as compared with high-complexity ADE-TIDS. This pattern reflected the greater complexity of ADE-TIDS, its higher costs and poorer alignment with existing workflows. Complexity affected the innovations' perceived usability, the time needed to learn and install the trigger systems, and their costs. Local factors affecting implementation and sustainability of both innovations included turnover affecting champions and other staff, shifting organisational priorities, changing information infrastructures, and institutional constraints on adapting existing IT to the electronic TIDS. **Conclusions** To facilitate implementation of complex healthcare innovations such as ADE-TIDS, staff in adopting organisations should give high priority to innovation implementation; allocate sufficient resources; effectively communicate with and involve local champions and users; and align innovations with workflows and information systems. In addition, they should monitor local factors, such as changes in organisational priorities and IT, availability of implementation staff and champions, and external regulations and constraints that may pose barriers to innovation implementation and sustainability.

83. [Health Expect](#). 2011 Jun;14(2):133-146. doi: 10.1111/j.1369-7625.2010.00633.x. Epub 2010 Oct 28.

Clinicians' concerns about decision support interventions for patients facing breast cancer surgery options: understanding the challenge of implementing shared decision-making.

[Caldon LJ](#), [Collins KA](#), [Reed MW](#), [Sivell S](#), [Austoker J](#), [Clements AM](#), [Patnick J](#), [Elwyn G](#); [BresDex Group](#).

Abstract

Background There is interest in interventions that provide support for patients facing challenging decisions, such as the choice between mastectomy and breast conservation surgery for breast cancer. However, it is difficult to implement these interventions. One potential source of resistance is the attitudes of clinicians. **Objective** To examine specialist breast clinicians' opinions about the provision of decision support interventions (DesIs) for patients. **Methods** As part of the development of a web-based DesI (BresDex), semi-structured interviews were conducted with specialist clinicians [breast surgeons, breast care nurses (BCNs) and oncologists] from four breast units in a UK region, and speciality national opinion leaders. Interviews were

recorded, transcribed and analysed using the Framework approach. Results A majority of the 24 clinicians interviewed did not have a working knowledge of DesIs and were ambivalent or sceptical. Many expressed conflicting opinions: they noted the potential benefits, but at the same time expressed reservations about information overlap, overload and about content that they considered inappropriate. Many wanted access to DesIs to be always under clinical supervision. In particular, they were uncertain as regards how DeSIs could be tailored to individual patients' needs and also accommodate clinical practice variation. BCNs were particularly concerned that DesIs might induce patient anxiety and replace their role. Conclusions The concept of providing interventions to support patients in decision-making tasks generated concern, defensiveness and scepticism. These attitudes will be a significant barrier. Implementation efforts will need to recognize and address these issues if these interventions are to become embedded in clinical practice.

84. [Health Promot Int](#). 2011 Jun;26(2):136-47. Epub 2010 Oct 20.

Phases of school health promotion implementation through the lens of complexity theory: lessons learnt from an Austrian case study.

Abstract

The implementation of health promotion concepts in (school) settings is a complex undertaking on which little scientific knowledge exists. The purpose of this study was to better understand organizational influences on the implementation of school health promotion. An extended case study design that incorporated important insights from complexity science was used. This design influenced the focus of analysis and led to the use of multiple methods of data collection and analysis. A primary school in Vienna served as a case for observing and analysing the first year of implementing the health-promoting school concept. The study provided detailed insights into the implementation process. Results showed four chronologically overlapping implementation phases (starting health promotion, deciding what to do, planning health promotion projects, doing health promotion) on different system levels. In each phase, the original health-promoting school concept was adapted to the necessities and characteristics of each level and, therefore, changed considerably. Implications for possible adaptations of the health-promoting school concept to better fit the situation in schools are discussed.

85. [Health Policy](#). 2011 Jun;101(1):37-43. Epub 2010 Sep 19.

Capacity building in and for health promoting schools: Results from a qualitative study.
[Gugglberger L](#), [Dür W](#).

Abstract

OBJECTIVES:

Research has shown that schools have problems reaching the aim of becoming health promoting for many different reasons and that capacity building in and for schools is needed to develop necessary resources. We use the concept of capacity building as an analytical tool to answer the question of how the implementation of health promotion (HP) in schools can be supported.

METHODS:

As part of a wider qualitative study concerning capacity building in the Austrian school system 11 school heads were interviewed about their needs regarding the success of HP in schools. The interviews were analysed with qualitative content analysis.

RESULTS:

Schools can build several capacities themselves and are well informed about the requirements for implementing HP. The most important resource is institutionalisation of HP, which is not easy to reach. Concerning their environment, schools display a need for financial and human resources for HP, as well as knowledge management and quality control of HP service providers.

CONCLUSION:

Schools need support from their environment not only in building resources but also in taking the important step of institutionalising HP into their core and management processes. A concept of implementation, drawing attention to necessary but unforeseen capacities and resources, is needed.

86. [Patient Educ Couns.](#) 2011 May 23. [Epub ahead of print]

Changing practitioner behavior and building capacity in tobacco cessation treatment: The TEACH project.

[Herie M](#), [Connolly H](#), [Voci S](#), [Dragonetti R](#), [Selby P](#).

Abstract**OBJECTIVE:**

To facilitate interprofessional knowledge transfer to practice by increasing treatment capacity of health care practitioners to deliver evidence-informed smoking cessation counseling.

METHODS:

TEACH (Training Enhancement in Applied Cessation Counseling and Health) combines diffusion of innovations with principles of adult learning to address the lack of system capacity to implement evidence-based smoking cessation treatments. Participants were professionals from 15 disciplines with commitment from their supervisor to implement the intervention. Pre- and post-training course evaluation surveys assessed the extent to which learning objectives were achieved and guided a continuous quality improvement process.

RESULTS:

Evaluation of 741 participants that attended the three-day Core Course from June 2007 to January 2009 revealed significant increases in pre- to post-training ratings of feasibility, importance, and confidence in using the intervention. In addition to attitudinal changes, practitioners made changes to practice behavior. At six months post-training, 55% of professionals were implementing the intervention and 91% engaged in knowledge transfer activities in their organizations/communities.

CONCLUSION:

Findings suggest that TEACH impacted clinical practice and may serve as a model for knowledge translation initiatives in other health behavior domains.

PRACTICE IMPLICATIONS:

These data demonstrate that it is feasible to operationalize interprofessional knowledge translation models to transfer research findings into practice.

87. [Health Promot Int.](#) 2011 Jun;26(2):244-54. Epub 2010 Aug 25.

Evaluation of nationwide health promotion campaigns in the Netherlands: an exploration of practices, wishes and opportunities.

[Brug J](#), [Tak NI](#), [Te Velde SJ](#).

Abstract

Nationwide health promotion campaigns are an important part of government-funded health promotion efforts. Valid evaluation is important, but difficult because gold standard research designs are not applicable and the allocation of budget and time for evaluation is often very tight. In the Netherlands, Health Promotion Institutes (HPIs) are responsible for these campaigns. We conducted an exploratory study among the HPIs to gain better insight into goals, practices, conditions and perceived barriers regarding evaluation of these campaigns. Data were obtained through personal interviews with representatives of HPIs who had direct management responsibility for the evaluation of their campaigns. The HPIs typically made use of a pre-test-post-test design with single measurements before and after the campaign without a control group. In campaign preparations, HPIs used qualitative research to pre- and pilot-test some campaign materials, but true formative evaluation was rare. Besides, accountability to their sponsors, peers and the population at large, the most important reason to evaluate was to learn for future campaigns. In terms of the RE-AIM framework, evaluation was mostly restricted to Reach and Effects; hardly any evaluation of adoption, implementation or maintenance was reported. Budget and time constraints were reported as the main barriers for more extensive formative and effect evaluation. Evaluation of nationwide campaigns is standard procedure, but the applied research designs are weak, due to lack of time, budget and research methodology expertise. Next to additional budget and a longer-term planning, input from external experts regarding evaluation research designs are needed for evaluation improvement.