

## **Dissemination and Implementation in Health Listserv**

**\*\* MAY 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](mailto: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](mailto:wynne.norton@gmail.com).

### **A. FUNDING ANNOUNCEMENTS**

#### **USAID**

The United States Agency for International Development (USAID) seeks to award up to two five-year cooperative agreements (combined total of \$50 million) to identify, develop, introduce, and support the scale-up of new health tools and technologies which are appropriate, affordable, and acceptable for distribution and use in low-resource settings, in order to accelerate reductions in mortality and morbidity in line with USAID health sector objectives. The Technologies for Health Program will play an important role in advancing USAID's leadership in health technology innovation by providing the Agency with access to leading technical and scientific expertise in the US and other countries devoted to health research, technology development, scientific research, and market development. In the course of this work, the Technologies for Health Program also will develop strong partnerships with the private sector, host countries, local organizations, private firms and other development partners in developing countries.

For complete information, please see

<http://www.grants.gov/search/search.do?mode=VIEW&oppId=92173>

### **B. WEBINARS**



**Enhancing Implementation Science  
Evaluation in Implementation Research: Examples and  
Challenges**

**By Hildi Hagedorn, Ph.D., LP  
Alex Young, M.D., MSHS**

**Thursday, May 12, 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 versions of the following July 2010 presentation prior to joining the Cyber Seminar: Panel: Evaluation Examples and Challenges (Hildi Hagedorn and Alex Young)

This sessions can be accessed from the July 2010 meeting website:  
<http://www.queri.research.va.gov/meetings/eis/>



**Modeling Impact: NCI's Cancer Intervention and Surveillance Modeling Network (CISNET)**

**Wednesday, May 18, 2011, 2:30 p.m. – 4:00 p.m. ET**



**CISNET** is a consortium of NCI-sponsored investigators that use statistical modeling to improve our understanding of cancer control interventions in prevention, screening, and treatment and their effects on population trends in incidence and mortality. With the support of a new CDC-funded initiative, CISNET modelers are looking to engage with cancer control planners on local and regional questions amenable to modeling.

This month's cyber-seminar will include a panel of the leaders from the five CISNET Coordinating Centers, each with a focus on a specific cancer site (Breast, Colorectal,

Esophageal, Lung and Prostate), as well as programmatic leaders from the NCI and CDC.

NCI's Dr. Eric (*Rocky*) Feuer, CISNET Director, will provide an overview of the CISNET Consortium.. CISNET modelers will then discuss how modeling tools and data can be used by cancer control practitioners and planners to drive evidence-based interventions and provide current examples of modeling applications. During the cyber-seminar, CDC 's Dr. Laura Seeff, will also announce a new exciting joint NCI-CDC opportunity for comprehensive cancer control practitioners to work with CISNET researchers in addressing public health problems relevant to their communities through modeling.

Some examples of questions that you could answer using modeling include:

- What is your region's anticipated need for colonoscopy and if that need was met how would it impact mortality?
- What is the comparative effectiveness of traditional mammogram vs. digital mammogram in your region?
- What would be the impact on lung cancer incidence given specific interventions?

Interested callers will be invited to follow up with the CISNET consortium members to outline possible questions for collaboration (proposal submission form available on [Research to Reality](#)).

Join us for this exciting discussion of the field of intervention and surveillance modeling and a new partnership opportunity!

#### Panelists:



**Ann Zauber, PhD**  
Memorial Sloan  
Kettering  
Cancer Center  
(*Colorectal  
Cancer*)



**Ruth Etzioni, PhD**  
Fred  
Hutchinson  
Cancer Center,  
University of  
Washington  
(*Prostate  
Cancer*)



**Jeanne Mandelblatt, MD, MPH**  
Georgetown  
University,  
Lombardi Cancer  
Center (*Breast  
Cancer*)



**Pam McMahon, PhD**  
Mass General  
Hospital,  
Harvard  
University  
(*Lung Cancer*)



**Chin Hur, MD**  
Mass General  
Hospital,  
*Harvard  
University  
(Esophageal  
Cancer)*

#### Register Now!

Please click on the following link to register for this event:

<https://researchtoreality.cancer.gov/cyber-seminars>.

Following registration, you will receive a confirmation email with the toll free number, web URL, and participant passcode. This cyber-seminar will be archived on Research to Reality web

site at <https://researchtoReality.cancer.gov> approximately one week following the presentation.

For more information on the cyber-seminar series please email [ResearchtoReality@mail.nih.gov](mailto:ResearchtoReality@mail.nih.gov).

## **\GLOBAL IMPLEMENTATION CONFERENCE**

<http://www.implementationconference.org/>

### *Join the GIC Network!*

One of the goals of the GIC is to create opportunities to form Practice Groups, or groups of common interest, that can share knowledge and best practices within specific areas related to implementation (researchers, purveyors, practitioners, policy makers, organization leadership). Practice groups will work to advance the practice and science of implementation, organization change and system transformation across disciplines, domains and nations. It is expected that these five Practice Groups will develop collaborative agendas for action that can be initiated and pursued over the next two years with progress reported at the 2013 Global Implementation Conference.

Between now and the **first biennial Global Implementation Conference**, each Practice Group will hold a series of virtual or in-person meetings to define and address issues related to implementation, organization change and system transformation. It is our intention to provide facilitation and support to the communications within and across Practice Groups. These groups will continue to facilitate a dialogue between each biennial conference, providing an ongoing forum for discussion and development. It is expected that this will be an emergent, self-organizing process that will be initiated in 2011, and continue over the years to develop implementation science, practice and policy. Over time, Practice Groups themselves will blossom, fade away, or transform into something different from the original group, all based on members' interests and momentum. Thus, the Practice Groups represent a starting point, and make no assumptions about where the participants may choose to take each group as issues, evidence, shared learning and solutions evolve.

Be a part of creating international dialogues around policies, frameworks and supports for implementation. [Register online today to select your practice group and begin participating!](#)

The inaugural Global Implementation Conference is all about networking and connecting to the work and world of implementation science and best practices. Each Practice Group area promises to be a terrific opportunity to learn from experts, share our own expertise, explore the thorny issues related to research, practice, policy, leadership and replication. The Practice Group experiences will allow us to bring our collective intelligence to bear on the challenges we face as we attempt to bring the best that science has to offer into the real world of service. Conversations and information exchanges are already occurring, setting the stage for the conference. I have so many questions for my colleagues and look forward to the rich discussions, problem-solving, and planning for the next stage of work in this Global Implementation Initiative. See you in August.

Karen A. Blase, Ph.D.  
Senior Scientist  
FPG Child Development Institute  
National Implementation Research Network

### C. ARTICLE TITLES

### D. ABSTRACTS

1. [Adm Policy Ment Health](#). 2011 May 1. [Epub ahead of print]  
**Therapist Perspectives on Community Mental Health Services for Children with Autism Spectrum Disorders.**  
[Brookman-Fraee L](#), [Drahota A](#), [Stadnick N](#), [Palinkas LA](#).

#### **Abstract**

This mixed methods study examined therapist perspectives on serving children with autism spectrum disorders (ASD) in community mental health (CMH) clinics. One hundred therapists completed a survey about their experiences with this population and 17 participated in subsequent focus groups to clarify and expand survey results. Results indicate that CMH therapists serve many children with ASD for behavior or other psychiatric problems and perceive serving this population as challenging and frustrating due to their limited training. Therapists are highly motivated for comprehensive ASD training on ASD characteristics and intervention strategies. These data were used to tailor and package evidence-based intervention strategies for delivery in CMH services.

2. [Adm Policy Ment Health](#). 2011 Apr 12. [Epub ahead of print]  
**Three Collaborative Models for Scaling Up Evidence-Based Practices.**  
[Chamberlain P](#), [Roberts R](#), [Jones H](#), [Marsenich L](#), [Sosna T](#), [Price JM](#).

#### **Source**

#### **Abstract**

The current paper describes three models of research-practice collaboration to scale-up evidence-based practices (EBP): (1) the Rolling Cohort model in England, (2) the Cascading Dissemination model in San Diego County, and (3) the Community Development Team model in 53 California and Ohio counties. Multidimensional Treatment Foster Care (MTFC) and KEEP are the focal evidence-based practices that are designed to improve outcomes for children and families in the child welfare, juvenile justice, and mental health systems. The three scale-up models each originated from collaboration between community partners and researchers with the shared goal of wide-spread implementation and sustainability of MTFC/KEEP. The three models were implemented in a variety of contexts; Rolling Cohort was implemented nationally, Cascading Dissemination was implemented within one county, and Community Development Team was targeted at the state level. The current paper presents an overview of the development of each model, the policy frameworks in which they are embedded, system challenges encountered during scale-up, and lessons learned. Common elements of successful scale-up efforts, barriers to success, factors relating to enduring practice relationships, and future research directions are discussed.

3. [BMC Fam Pract](#). 2011 Apr 19;12(1):21. [Epub ahead of print]

**Efficacy of a strategy for implementing a guideline for the control of cardiovascular risk in a primary healthcare setting: the SIRVA2 study a controlled, blinded community intervention trial randomised by clusters.**

[Rodriguez-Salvanes F](#), [Novella Arribas B](#), [Frenandez-Luque MJ](#), [Sanchez-Gomez LM](#), [Ruiz-Diaz L](#), [Sanchez-Alcalde R](#), [Sierra-Garcia B](#), [Mayayo-Vicente S](#), [Ruiz-Lopez M](#), [Loeches-Belinchon P](#), [Lopez-Gonzalez J](#), [Gonzalez-Gamarra A](#), [Group TS](#).

**Abstract**

**ABSTRACT:** This work describes the methodology used to assess a strategy for implementing clinical practice guidelines (CPG) for cardiovascular risk control in a health area of Madrid.

**BACKGROUND:** The results on clinical practice of introducing CPGs have been little studied in Spain. The strategy used to implement a CPG is known to influence its final use. Strategies based on the involvement of opinion leaders and that are easily executed appear to be among the most successful. **Aim.** The main aim of the present work was to compare the effectiveness of two strategies for implementing a CPG designed to reduce cardiovascular risk in the primary healthcare setting, measured in terms of improvements in the recording of calculated cardiovascular risk or specific risk factors in patients' medical records, the control of cardiovascular risk factors, and the incidence of cardiovascular events. **METHODS:** This study involved a controlled, blinded community intervention in which the 21 health centres of the Number 2 health Area of Madrid were randomly assigned by clusters to be involved in either a proposed CPG implementation strategy to reduce cardiovascular risk, or the normal dissemination strategy. The study subjects were patients > 45 years of age whose health cards showed them to belong to the studied health area. The main variable examined was the proportion of patients whose medical histories included the calculation of their cardiovascular risk or that explicitly mentioned the presence of variables necessary for its calculation. The sample size was calculated for a comparison of proportions with  $\alpha = 0.05$  and  $\beta = 0.20$ , and assuming that the intervention would lead to a 15% increase in the measured variables. Corrections were made for the design effect, assigning a sample size to each cluster proportional to the size of the population served by the corresponding health centre, and assuming losses of 20%. This demanded a final sample size of 620 patients. Data were analysed using summary measures for each cluster, both in making estimates and for hypothesis testing. Analysis of the variables was made on an intention-to-treat basis.

4. [J Eval Clin Pract](#). 2011 Apr 19. doi: 10.1111/j.1365-2753.2011.01681.x. [Epub ahead of print]

**Difficulties in the dissemination and implementation of clinical guidelines in government Neonatal Intensive Care Units in Brazil: how managers, medical and nursing, position themselves.**

[Magluta C](#), [de Sousa Mendes Gomes MA](#), [Wuillaume SM](#).

**Abstract**

**Rationale, aims and objectives** Clinical guidelines are tools that systematize scientific evidence and help to achieve proper care. Several difficulties are reported regarding the effective use, such as the shortcomings in the level of knowledge and attitudes by the professionals, the service structure and the preferences appointed by patients. An analysis of these difficulties was the objective of this study in the context of government Neonatal Intensive Care Units (NICU) in Brazil. **Method** A semi-structured survey was carried out with 53 managers (medical and nursing) of the 15 NICU in a convenient sample of two groups of government units in Brazil.

The managers chose their answers from a list of difficulties to implement the guidelines based on the analytical model of Cabana and graded the difficulties found on a 5-point scale with no reference to quality. Results Respondents have reported several difficulties with the following priority: lack of professionals to provide care, being perceived as more critical within the nursing and physiotherapy crews, minor participation of professionals in the discussion process and inadequate infrastructure. The lack of acquaintance with the guidelines by the professionals has been reported by few of the surveyed. Conclusion These findings show some common ground to literature pointing the importance of adequate infrastructure. Managers showed a low valuation of both the level of knowledge and the professionals' adherence to the guidelines.

5. [Adm Policy Ment Health](#). 2011 Apr 9. [Epub ahead of print]

**A Pilot Study Disseminating Cognitive Behavioral Therapy for Depression: Therapist Factors and Perceptions of Barriers to Implementation.**

[Lewis CC](#), [Simons AD](#).

**Source**

**Abstract**

This preliminary report on dissemination of Cognitive Behavioral Therapy (CBT) for depression assessed numerous therapist factors thought to influence implementation in a community setting. Participants were 24 therapists, aged 26-61 who participated in three, 1-day workshops and 8 months of ongoing group consultation. Attitudes toward empirically supported treatments (ESTs) and readiness to change were positively correlated whereas attitudes toward ESTs were negatively correlated with perceived client barriers to implementation. Therapists' report of client and setting factors were negatively associated with therapists' reports of implementation of CBT. Results are discussed in terms of implications and recommendations for dissemination and implementation of ESTs.

6. [J Adv Nurs](#). 2011 Apr 28. doi: 10.1111/j.1365-2648.2011.05655.x. [Epub ahead of print]

**Examination of the utility of the Promoting Action on Research Implementation in Health Services framework for implementation of evidence based practice in residential aged care settings.**

[Perry L](#), [Bellchambers H](#), [Howie A](#), [Moxey A](#), [Parkinson L](#), [Capra S](#), [Byles J](#).

**Source**

**Abstract**

perry l., bellchambers h., howie a., moxey a., parkinson l., capra s. & byles j. (2011) Examination of the utility of the Promoting Action on Research Implementation in Health Services framework for implementation of evidence based practice in residential aged care settings. Journal of Advanced Nursing. doi: 10.1111/j.1365-2648.2011.05655.x ABSTRACT: Aim. This study examined the relevance and fit of the PARIHS framework (Promoting Action on Research Implementation in Health Services) as an explanatory model for practice change in residential aged care. Background. Translation of research knowledge into routine practice is a complex matter in health and social care environments. Examination of the environment may identify factors likely to support and hinder practice change, inform strategy development, predict and explain successful uptake of new ways of working. Frameworks to enable this have been described but none has been tested in residential aged care. Methods. This paper reports preliminary qualitative analyses from the Encouraging Best Practice in Residential Aged Care Nutrition and Hydration project conducted in New South Wales in 2007-2009. We examined congruence with the PARIHS framework of factors staff described as influential for practice

change during 29 digitally recorded and transcribed staff interviews and meetings at three facilities. Findings. Unique features of the setting were flagged, with facilities simultaneously filling the roles of residents' home, staff's workplace and businesses. Participants discussed many of the same characteristics identified by the PARIHS framework, but in addition temporal dimensions of practice change were flagged. Conclusion. Overall factors described by staff as important for practice change in aged care settings showed good fit with those of the PARIHS framework. This framework can be recommended for use in this setting. Widespread adoption will enable cross-project and international synthesis of findings, a major step towards building a cumulative science of knowledge translation and practice change.

7. [Implement Sci](#). 2011 Apr 27;6(1):44. [Epub ahead of print]

**Disseminating quality improvement: study protocol for a large cluster randomized trial.** [Quanbeck AR](#), [Gustafson DH](#), [Ford JH 2nd](#), [Pulvermacher A](#), [French MT](#), [McConnell KJ](#), [McCarty D](#).

### **Abstract**

#### **BACKGROUND:**

Dissemination is a critical facet of implementing quality improvement in organizations. As a field, addiction treatment has produced effective interventions but disseminated them slowly and reached only a fraction of people needing treatment. This study investigates four methods of disseminating quality improvement (QI) to addiction treatment programs in the U.S. It is, to our knowledge, the largest study of organizational change ever conducted in healthcare. The trial seeks to determine the most cost-effective method of disseminating quality improvement in addiction treatment.

#### **METHODS:**

The study is evaluating the costs and effectiveness of different QI approaches by randomizing 201 addiction-treatment programs to four interventions. Each intervention used a web-based learning kit plus (1) monthly phone calls, (2) coaching, (3) face-to-face meetings, or (4) the combination of all three. Effectiveness is defined as reducing waiting time (days between first contact and treatment), increasing program admissions, and increasing continuation in treatment. Opportunity costs will be estimated for the resources associated with providing the services. Outcomes The study has three primary outcomes: waiting time, annual program admissions, and continuation in treatment. Secondary outcomes include: voluntary employee turnover, treatment completion, and operating margin. We are also seeking to understand the role of mediators, moderators, and other factors related to an organization's success in making changes. Analysis We are fitting a mixed-effect regression model to each program's average monthly waiting time and continuation rates (based on aggregated client records), including terms to isolate state and intervention effects. Admissions to treatment are aggregated to a yearly level to compensate for seasonality. We will order the interventions by cost to compare them pair-wise to the lowest cost intervention (monthly phone calls). All randomized sites with outcome data will be included in the analysis, following the intent-to-treat principle. Organizational covariates in the analysis include program size, management score, and state.

#### **DISCUSSION:**

The study offers seven recommendations for conducting a large-scale cluster-randomized trial: (1) provide valuable services, (2) have aims that are clear and important, (3) seek powerful allies, (4) understand the recruiting challenge, (5) cultivate commitment, (6) address turnover, and (7) encourage rigor and flexibility. Trial Registration: [ClinicalTrials.govNCT00934141](#).

8. [Implement Sci.](#) 2011 Apr 27;6(1):43. [Epub ahead of print]  
**Interventions Encouraging The Use of Systematic Reviews by Health Policymakers and Managers: A Systematic Review.**

[Perrier L](#), [Mrklas K](#), [Lavis JN](#), [Straus SE](#).

**Abstract**

**BACKGROUND:**

Systematic reviews have the potential to inform decisions made by health policymakers and managers, yet little is known about the impact of interventions to increase the use of systematic reviews by these groups in decision-making.

**METHODS:**

We systematically reviewed the evidence on the impact of interventions for seeking, appraising, and applying evidence from systematic reviews in decision-making by health policymakers or managers. Medline, EMBASE, CINAHL, Cochrane Central Register of Controlled Trials, Cochrane Methodology Register, Health Technology Assessment Database, and LISA were searched from the earliest date available until April 2010. Two independent reviewers selected studies for inclusion if the intervention intended to increase seeking, appraising, or applying evidence from systematic reviews by a health policymaker or manager. Minimum inclusion criteria were a description of the study population and availability of extractable data.

**RESULTS:**

11,297 titles and abstracts were reviewed leading to retrieval of 37 full-text articles for assessment; four of these articles met all inclusion criteria. Three articles described one study where five systematic reviews were mailed to public health officials and followed up with surveys at three months and two years. The articles reported from 23% to 63% of respondents declaring they had used systematic reviews in policymaking decisions. One randomised trial indicated that tailored messages combined with access to a registry of systematic reviews had a significant effect on policies made in the area of healthy body weight promotion in health departments.

**CONCLUSIONS:**

The limited empirical data renders the strength of evidence weak for the effectiveness and the types of interventions that encourage health policymakers and managers to use systematic reviews in decision making.

9. [Implement Sci.](#) 2011 Apr 23;6(1):42. [Epub ahead of print]

**The Behaviour Change Wheel: a new method for characterising and designing behaviour change interventions.**

[Michie S](#), [van Stralen MM](#), [West R](#).

**Abstract**

**BACKGROUND:**

Improving the design and implementation of evidence-based practice depends on successful behaviour change interventions. This requires an appropriate method for characterising interventions and linking them to an analysis of the targeted behaviour. There exists a plethora of frameworks of behaviour change interventions but it is not clear how well they serve this purpose. This paper evaluates these frameworks and develops and evaluates a new framework aimed at overcoming their limitations.

***METHODS:***

A systematic search of electronic databases and consultation with behaviour change experts were used to identify frameworks of behaviour change interventions. These were evaluated according to three criteria: comprehensiveness, coherence and a clear link to an overarching model of behaviour. A new framework was developed to meet these criteria. The reliability with which it could be applied was examined in two domains of behaviour change: tobacco control and obesity.

***RESULTS:***

Nineteen frameworks were identified covering nine intervention functions and seven policy categories that could enable those interventions. None of the frameworks reviewed covered the full range of intervention functions or policies, and only a minority met the criteria of coherence or linkage to a model of behaviour. At the centre of the new framework was a 'behaviour system' comprising three essential conditions: capability, opportunity and motivation (the 'COM-B system'). Around the hub of this 'Behaviour Change Wheel' (BCW) were positioned the nine intervention functions aimed at addressing deficits in one or more of these conditions; around this were placed seven categories of policy that could enable those interventions to occur. The BCW was used reliably to characterise interventions within the English Department of Health's 2010 tobacco control strategy and the National Institute of Health and Clinical Excellence's guidance on reducing obesity.

***CONCLUSIONS:***

Interventions and policies to change behaviour can be usefully characterised by means of a 'Behaviour Change Wheel' (BCW) comprising: a 'behaviour system' at the hub, encircled by intervention functions and then by policy categories. Research is needed to establish how far the BCW can lead to more efficient design of effective interventions.

10. [Implement Sci.](#) 2011 Apr 22;6(1):41. [Epub ahead of print]

***A hospital site controlled intervention using audit and feedback to implement guidelines concerning inappropriate treatment of catheter-associated asymptomatic bacteriuria.***

[Trautner BW](#), [Kelly PA](#), [Petersen N](#), [Hysong S](#), [Kell H](#), [Liao KS](#), [Patterson JE](#), [Naik AD](#).

**Abstract*****BACKGROUND:***

Catheter-associated urinary tract infection (CAUTI) is one of the most common hospital-acquired infections. However, many cases treated as hospital-acquired CAUTI are actually asymptomatic bacteriuria (ABU). Evidence-based guidelines recommend that providers neither screen for nor treat ABU in most catheterized patients, but there is a significant gap between these guidelines and clinical practice. Our objectives are (1) to evaluate the effectiveness of an audit and feedback intervention for increasing guideline-concordant care concerning catheter-associated ABU and (2) to measure improvements in healthcare providers' knowledge of and attitudes toward the practice guidelines associated with the intervention.

***METHODS:***

The study uses a controlled pre/post design to test an intervention using audit and feedback of healthcare providers to improve their compliance with ABU guidelines. The intervention and the control sites are two VA hospitals. For objective 1 we will review medical records to measure the clinical outcomes of inappropriate screening for and treatment of catheter-associated ABU. For objective 2 we will survey providers' knowledge and attitudes. Three phases of our protocol are proposed: the first 12-month phase will involve observation of the baseline incidence of

inappropriate screening for and treatment of ABU at both sites. This surveillance for clinical outcomes will continue at both sites throughout the study. Phase 2 consists of 12 months of individualized audit and feedback at the intervention site and guidelines distribution at both sites. The third phase, also over 12 months, will provide unit-level feedback at the intervention site to assess sustainability. Healthcare providers at the intervention site during phase 2 and at both sites during phase 3 will complete pre/post surveys of awareness and familiarity (knowledge), as well as of acceptance and outcome expectancy (attitudes) regarding the relevant practice guidelines.

***DISCUSSION:***

Our proposal to bring clinical practice in line with published guidelines has significant potential to decrease overdiagnosis of CAUTI and associated inappropriate antibiotic use. Our study will also provide information about how to maximize effectiveness of audit and feedback to achieve guideline adherence in the inpatient setting. Trial Registration: NCT01052545.

11. [Implement Sci](#). 2011 Apr 21;6(1):40. [Epub ahead of print]

**Shared communication processes within health care teams for rare diseases and their influence on health care professionals' innovative behavior and patient satisfaction.**

[Hannemann-Weber H](#), [Kessel M](#), [Budych K](#), [Schultz C](#).

**Abstract**

***BACKGROUND:***

A rare disease is a pattern of symptoms that afflicts less than 5 out of 10,000 patients. However, as about 6000 different rare disease patterns exist, they still have significant epidemiological relevance. We focus on rare diseases that affect multiple organs and thus demand that multidisciplinary health care professionals (HCPs) work together. In this context, standardized health care processes and concepts are mainly lacking, and a deficit of knowledge induces uncertainty and ambiguity. As such, individualized solutions for each patient are needed. This necessitates an intensive level of innovative individual behavior and thus, adequate idea generation and the final implementation of new health care concepts require the integration of the expertise of all health care team members, including that of the patients. Therefore, knowledge sharing between HCPs and shared decision making between HCPs and patients are important. The objective of this study is to assess the contribution of shared communication and decision making processes in patient-centered health care teams to the generation of innovative concepts and consequently to improvements in patient satisfaction.

***METHODS:***

A theoretical framework covering interaction processes and explorative outcomes and using patient satisfaction as a measure for operational performance was developed based on health care management, innovation and social science literature. This theoretical framework forms the basis for a three-phase, mixed-method study. Exploratory phase I will first involve collecting qualitative data to detect central interaction barriers within health care teams. The results are related back to theory, and testable hypotheses will be derived. Phase II then comprises the testing of hypotheses through a quantitative survey of patients and their HCPs in six different rare disease patterns. For each of the six diseases, the sample should comprise 30 patients with 6 HCP per patient-centered health care team on average. Finally, in phase III, qualitative data will be generated via semi-structured telephone interviews with patients to gain a deeper understanding of the communication processes and initiatives that generate innovative solutions.

***DISCUSSION:***

The findings of this proposed study will help to elucidate the necessity of individualized innovative solutions for patients with rare diseases. Therefore, this study will pinpoint the primary interaction and communication processes in multidisciplinary teams as well as the required interplay between exploratory outcomes and operational performance. Hence, this study will provide health care institutions and HCPs with results and information essential for elaborating and implementing individual care solutions through the establishment of appropriate interaction and communication structures and processes within patient-centered health care teams.

12. [Implement Sci.](#) 2011 Apr 16;6(1):39. [Epub ahead of print]

**Why don't hospital staff activate the Rapid Response System (RRS)? How frequently is it needed and can the process be improved?**

[Marshall SD](#), [Kitto S](#), [Shearer W](#), [Wilson SJ](#), [Finnigan MA](#), [Sturgess T](#), [Hore T](#), [Buist MD](#).

**Abstract**

**ABSTRACT: BACKGROUND:** The rapid response system (RRS) is a process of accessing help for health professionals when a patient under their care becomes severely ill. Recent studies and meta-analyses show a reduction in cardiac arrests by a one-third in hospitals that have introduced a rapid response team, although the effect on overall hospital mortality is less clear. It has been suggested that the difficulty in establishing the benefit of the RRS has been due to implementation difficulties and a reluctance of clinical staff to call for additional help. This assertion is supported by the observation that patients continue to have poor outcomes in our institution despite an established RRS being available. In many of these cases, the patient is often unstable for many hours or days without help being sought. These poor outcomes are often discovered in an ad hoc fashion, and the real numbers of patients who may benefit from the RRS is currently unknown. This study has been designed to answer three key questions to improve the RRS: estimate the scope of the problem in terms of numbers of patients requiring activation of the RRS; determine cognitive and socio-cultural barriers to calling the Rapid Response Team; and design and implement solutions to address the effectiveness of the RRS. **METHODS:** The extent of the problem will be addressed by establishing the incidence of patients who meet abnormal physiological criteria, as determined from a point prevalence investigation conducted across four hospitals. Follow-up review will determine if these patients subsequently require intensive care unit or critical care intervention. This study will be grounded in both cognitive and socio-cultural theoretical frameworks. The cognitive model of situation awareness will be used to determine psychological barriers to RRS activation, and socio-cultural models of interprofessional practice will be triangulated to inform further investigation. A multi-modal approach will be taken using reviews of clinical notes, structured interviews, and focus groups. Interventions will be designed using a human factors analysis approach. Ongoing surveillance of adverse outcomes and surveys of the safety climate in the clinical areas piloting the interventions will occur before and after implementation.

13. [Implement Sci.](#) 2011 Apr 11;6(1):38. [Epub ahead of print]

**A community based participatory approach to improving health in a Hispanic population.**

[Dulin MF](#), [Tapp H](#), [Smith HA](#), [Urquieta De Hernandez B](#), [Furusetth OJ](#).

**Abstract**

**ABSTRACT: BACKGROUND:** The Charlotte-Mecklenburg region has one of the fastest growing Hispanic communities in the country. This population has experienced disparities in

health outcomes and diminished ability to access healthcare services. This city is home to an established practice-based research network (PBRN) that includes community representatives, health services researchers, and primary care providers. The aims of this project are: (1) to use key principles of community-based participatory research (CBPR) within a Practice based research network (PBRN) to identify a single disease or condition that negatively affects the Charlotte Hispanic community; (2) to develop a community-based intervention that positively impacts the chosen condition and improves overall community health; and (3) to disseminate findings to all stakeholders. METHODS: This project is designed as CBPR. The CBPR process creates new social networks and connections between participants that can potentially alter patterns of healthcare utilization and other health related behaviors. The first step is the development of equitable partnerships between community representatives, providers, and researchers. This process is central to the CBPR process and will occur at 3 levels - community members trained as researchers and outreach workers, a community advisory board (CAB), and a community forum. Qualitative data on health issues facing the community - and possible solutions - will be collected at all 3 levels through focus groups, key informant interviews and surveys. The Community Advisory Board (CAB) will meet monthly to guide the project and oversee data collection, data analysis, participant recruitment, implementation of the community forum, and intervention deployment. The selection of the health condition and framework for the intervention will occur at the level of a community-wide forum. Outcomes of the study will be measured using indicators developed by the participants as well as geospatial modeling. On completion, this study will: determine the feasibility of the CBPR process to design interventions; demonstrate the feasibility of geographic models to monitor CBPR-derived interventions; and further establish mechanisms for implementation of the CBPR framework within a PBRN.

14. [Curr Opin HIV AIDS](#). 2011 Apr 30. [Epub ahead of print]

**Implementing operational research to scale-up access to antiretroviral therapy for HIV infection: lessons learned from the Cameroonian experience.**

[Boyer S](#), [Koulla-Shiro S](#), [Abé C](#), [Spire B](#), [Moatti JP](#).

**Source**

**Abstract**

**PURPOSE OF REVIEW:**

Given the lack of evidence on how to best design and implement antiretroviral therapy (ART) scaling-up policies, operational research has seen a surge in interest. There is, however, little published information on the contribution of operational research in ART programs' implementation or in improvement of associated outcomes. The article focuses therefore on how operational research may contribute to such improvements and what the key enabling factors are for its integration into program frameworks.

**RECENT FINDINGS:**

One of the most systematic operational research linked to a national ART program on the African continent was conducted in Cameroon between 2006 and 2010. Along with operational research carried out elsewhere in Africa, it helped demonstrate that a strategy of decentralizing HIV care can increase treatment coverage and improve early access to care, while maintaining good clinical outcomes. Multipartnership between local researchers, national authorities, healthcare professionals and the civil society is the key enabling factor for the relevance of operational research and the translation of its results into policy and practice.

**SUMMARY:**

In spite of a dramatic increase in access to ART during recent years in low-income countries, the fight against HIV remains a failure in terms of the goal of breaking the pandemic dynamic. Operational research is needed more than ever to face this challenge.

15. [Int J Qual Health Care](#). 2011 May 2. [Epub ahead of print]

**Widespread focused improvement: lessons from international health for spreading specific improvements to health services in high-income countries.**

[Ovretveit J](#).

**Source****Abstract**

Patients and citizens want more and better healthcare, and want to pay less for it. One way rapidly to respond to these demands is to spread proven or promising improvements in treatments or service delivery models. However, there is little research from high-income countries about effective ways to spread these improvements. In international health there is more experience and knowledge of scale-up, more variety in research approaches used to study the subject, and fewer resources and infrastructure for scaling-up improvements across a nation. This paper draws on reviews of research and experience in international health to contribute to conceptual and empirical knowledge as well as to practical strategies. It describes and illustrates three approaches: hierarchical control, participatory adaptation and facilitated evolution. It presents lessons from international health which could be of use to those studying, choosing, planning and progressing strategies to increase the uptake of proven or promising interventions to health services in high-income countries.

16. [BMC Public Health](#). 2011 Apr 13;11 Suppl 3:S32.

**Methods used in the Lives Saved Tool (LiST).**

[Winfrey W](#), [McKinnon R](#), [Stover J](#).

**Source****Abstract**

**BACKGROUND:** Choosing an optimum set of child health interventions for maximum mortality impact is important within resource poor policy environments. The Lives Saved Tool (LiST) is a computer model that estimates the mortality and stillbirth impact of scaling up proven maternal and child health interventions. This paper will describe the methods used to estimate the impact of scaling up interventions on neonatal and child mortality. **MODEL STRUCTURE AND ASSUMPTIONS:** LiST estimates mortality impact via five age bands 0 months, 1-5 months, 6-11 months, 12-23 months and 24 to 59 months. For each of these age bands reductions in cause specific mortality are estimated. Nutrition interventions can impact either nutritional statuses or directly impact mortality. In the former case, LiST acts as a cohort model where current nutritional statuses such as stunting impact the probability of stunting as the cohort ages. LiST links with a demographic projections model (DemProj) to estimate the deaths and deaths averted due to the reductions in mortality rates. **USING LIST:** LiST can be downloaded at <http://www.jhsph.edu/dept/ih/IIP/list/> where simple instructions are available for installation. LiST includes default values for coverage and effectiveness for many less developed countries obtained from credible sources. **CONCLUSIONS:** The development of LiST is a continuing process. Via technical inputs from the Child Health Epidemiological Group, effectiveness values are updated, interventions are adopted and new features added.

17. [Int J Qual Health Care](#). 2011 Apr 11. [Epub ahead of print]

**Seeking solutions: scaling-up audit as a quality improvement tool for infection control in Gujarat, India.**

[Anchalia MM](#), [D'Ambruoso L](#).

**Source**

**Abstract**

Quality problem or issue Surgical-site infections (SSIs) give rise to significant demands on the health systems as well as economic and social sequelae for patients. This article describes an audit for infection control developed in a surgical unit of a tertiary care setting in Gujarat state, India that was scaled-up to all state-owned hospitals in the district. Initial assessment A retrospective baseline assessment of surgical infection rates in a general surgical unit revealed an infection rate of 30%. Choice of solution An audit was implemented based on guidelines for SSI prevention published by the Centres of Disease Control. Implementation Surveillance and hospital epidemiology were established and practice reforms implemented. Monthly and annual meetings to review implementation were held. Evaluation After 12 months, an 88% decrease in the infection rate in the surgical unit was demonstrated. Thereafter, the process was replicated across the surgical department and for all cases undergoing surgery. After 12 months, a 67% reduction in the infection rate was detected. The process has since been applied across the state. Lessons learned A locally owned and team-led process embedded within routine working conditions can challenge widely held perceptions, inform low-cost and no-cost remedial actions, and improve cultures of practice, quality of care and health outcomes. As urban populations grow, methods that are capable of continuously identifying, and responding to, problems and sustaining quality of care in facilities are necessary. SSIs may be largely preventable. With careful implementation, audit has the potential to be a major contributor to their reduction.

18. [J Public Health Policy](#). 2011 May;32(2):211-8. Epub 2011 Feb 24.

**Commentary: Scaling up HIV treatment in resource-limited countries: The challenge of staff shortages.**

[Laurent C](#).

**Source**

**Abstract**

Scaling up antiretroviral therapy (ART) in resource-limited countries is a major challenge for health professionals and program managers due to the large number of patients and the severe shortage of health-care workers. The estimated number of patients in those settings requiring ART in 2009 was 14.6 million, of whom 64 per cent were not yet treated. The World Health Organization estimates that there is an overall deficit of more than 4 million physicians, nurses, midwives, and support workers for achieving the essential health interventions and the Millennium Development Goals (including the scaling up of HIV care). Strengthening the health systems through education, job-specific training, recruitment, and retention of health-care workers is imperative. In the meantime, task shifting is a key element of the response to the staff shortages, but further innovative models of care delivery are needed. Article JPHP.2011.4, available at <http://www.palgrave-journals.com/jphp/>, relates to this Commentary.

19. [J Autism Dev Disord](#). 2011 May;41(5):597-609.

**Bridging the Research-to-Practice Gap in Autism Intervention: An Application of Diffusion of Innovation Theory.**

[Dingfelder HE](#), [Mandell DS](#).

**Source****Abstract**

There is growing evidence that efficacious interventions for autism are rarely adopted or successfully implemented in public mental health and education systems. We propose applying diffusion of innovation theory to further our understanding of why this is the case. We pose a practical set of questions that administrators face as they decide about the use of interventions. Using literature from autism intervention and dissemination science, we describe reasons why efficacious interventions for autism are rarely adopted, implemented, and maintained in community settings, all revolving around the perceived fit between the intervention and the needs and capacities of the setting. Finally, we suggest strategies for intervention development that may increase the probability that these interventions will be used in real-world settings.

20. [Am J Infect Control](#). 2011 May;39(4):270-6.

**Hospital adoption of automated surveillance technology and the implementation of infection prevention and control programs.**

[Halpin H](#), [Shortell SM](#), [Milstein A](#), [Vanneman M](#).

**Source****Abstract****BACKGROUND:**

This research analyzes the relationship between hospital use of automated surveillance technology (AST) for identification and control of hospital-acquired infections (HAI) and implementation of evidence-based infection control practices. Our hypothesis is that hospitals that use AST have made more progress implementing infection control practices than hospitals that rely on manual surveillance.

**METHODS:**

A survey of all acute general care hospitals in California was conducted from October 2008 through January 2009. A structured computer-assisted telephone interview was conducted with the quality director of each hospital. The final sample includes 241 general acute care hospitals (response rate, 83%).

**RESULTS:**

Approximately one third (32.4%) of California's hospitals use AST for monitoring HAI. Adoption of AST is statistically significant and positively associated with the depth of implementation of evidence-based practices for methicillin-resistant *Staphylococcus aureus* and ventilator-associated pneumonia and adoption of contact precautions and surgical care infection practices. Use of AST is also statistically significantly associated with the breadth of hospital implementation of evidence-based practices across all 5 targeted HAI.

**CONCLUSION:**

Our findings suggest that hospitals using AST can achieve greater depth and breadth in implementing evidenced-based infection control practices.

21. [BMC Med](#). 2011 Apr 28;9(1):46. [Epub ahead of print]

**Comparison of user groups' perspectives of barriers and facilitators to implementing electronic health records: a systematic review.**

[McGinn CA](#), [Grenier S](#), [Duplantie J](#), [Shaw N](#), [Sicotte C](#), [Mathieu L](#), [Leduc Y](#), [Legare F](#), [Gagnon MP](#).

**Abstract**

***BACKGROUND:***

Electronic health record (EHR) implementation is currently underway in Canada, as in many other countries. These ambitious projects involve many stakeholders with unique perceptions of the implementation process. EHR users have an important role to play as they must integrate the EHR system into their work environments and use it in their everyday activities. Users hold valuable, first-hand knowledge of what can limit or contribute to the success of EHR implementation projects. A comprehensive synthesis of EHR users' perceptions is key to successful future implementation. This systematic literature review aimed to synthesize current knowledge of the barriers and facilitators influencing shared EHR implementation among its various users.

***METHODS:***

Covering a period from 1999 to 2009, a literature search was conducted on nine electronic databases. Studies were included if they reported on users' perceived barriers and facilitators to shared EHR implementation, in comparable healthcare settings to Canada. Studies in all languages with an empirical study design were included. Quality and relevance of the studies were assessed. Four EHR user groups were targeted: physicians, other health care professionals, managers, and patients/public. Content analysis was performed independently by two authors using a validated extraction grid with pre-established categorization of barriers and facilitators for each group of EHR users.

***RESULTS:***

Of a total of 5695 potentially relevant publications identified, 117 full text publications were obtained after screening titles and abstracts. After review of the full articles, 60 publications, corresponding to 52 studies, met the inclusion criteria. The most frequent adoption factors common to all user groups were design and technical concerns, ease of use, interoperability, privacy and security, costs, productivity, familiarity and ability with EHR, motivation to use EHR, patient and health professional interaction, and lack of time and workload. Each user group also identified factors specific to their professional and individual priorities.

***CONCLUSIONS:***

This systematic review presents innovative research on the barriers and facilitators to EHR implementation. While important similarities between user groups are highlighted, differences between them demonstrate that each user group also has a unique perspective of the implementation process that should be taken into account.

22. [PLoS Med.](#) 2011 Apr;8(4):e1001018. Epub 2011 Apr 5.

***A multifaceted intervention to implement guidelines and improve admission paediatric care in kenyan district hospitals: a cluster randomised trial.***

[Ayieko P](#), [Ntoburi S](#), [Wagai J](#), [Opondo C](#), [Opiyo N](#), [Migiro S](#), [Wamae A](#), [Mogoa W](#), [Were F](#), [Wasunna A](#), [Fegan G](#), [Irimu G](#), [English M](#).

**Abstract*****BACKGROUND:***

In developing countries referral of severely ill children from primary care to district hospitals is common, but hospital care is often of poor quality. However, strategies to change multiple paediatric care practices in rural hospitals have rarely been evaluated.

***METHODS AND FINDINGS:***

This cluster randomized trial was conducted in eight rural Kenyan district hospitals, four of which were randomly assigned to a full intervention aimed at improving quality of clinical care

(evidence-based guidelines, training, job aides, local facilitation, supervision, and face-to-face feedback; n=4) and the remaining four to control intervention (guidelines, didactic training, job aides, and written feedback; n=4). Prespecified structure, process, and outcome indicators were measured at baseline and during three and five 6-monthly surveys in control and intervention hospitals, respectively. Primary outcomes were process of care measures, assessed at 18 months postbaseline. In both groups performance improved from baseline. Completion of admission assessment tasks was higher in intervention sites at 18 months (mean=0.94 versus 0.65, adjusted difference 0.54 [95% confidence interval 0.05-0.29]). Uptake of guideline recommended therapeutic practices was also higher within intervention hospitals: adoption of once daily gentamicin (89.2% versus 74.4%; 17.1% [8.04%-26.1%]); loading dose quinine (91.9% versus 66.7%, 26.3% [-3.66% to 56.3%]); and adequate prescriptions of intravenous fluids for severe dehydration (67.2% versus 40.6%; 29.9% [10.9%-48.9%]). The proportion of children receiving inappropriate doses of drugs in intervention hospitals was lower (quinine dose >40 mg/kg/day; 1.0% versus 7.5%; -6.5% [-12.9% to 0.20%]), and inadequate gentamicin dose (2.2% versus 9.0%; -6.8% [-11.9% to -1.6%]).

### **CONCLUSIONS:**

Specific efforts are needed to improve hospital care in developing countries. A full, multifaceted intervention was associated with greater changes in practice spanning multiple, high mortality conditions in rural Kenyan hospitals than a partial intervention, providing one model for bridging the evidence to practice gap and improving admission care in similar settings.

23. [J Am Med Inform Assoc.](#) 2011 May 1;18(3):322-6. Epub 2011 Mar 21.

**Improving the utilization of admission order sets in a computerized physician order entry system by integrating modular disease specific order subsets into a general medicine admission order set.**

[Munasinghe RL](#), [Arsene C](#), [Abraham TK](#), [Zidan M](#), [Siddique M](#).

### **Source**

### **Abstract**

**Case description** We evaluated the effects of integrating order subsets for the most common medical diagnoses into a general medical admission order set of our electronic medical records (EMR) in order to improve order set integration by clinicians. **Methods of implementation** We identified the most common primary and secondary diagnoses for patients admitted to our medical service and developed order subsets comprising only of the orders necessary for the management of these individual diagnoses. Using the capabilities of our computerized physician order entry (CPOE), we nested these order subsets into the general order set and evaluated the resulting change in order set utilization by our clinicians. **Example and observations** The total number of order sets used by clinicians in all departments increased fivefold during the 16-month period following the implementation of the integrated order sets in July 2008. A before and after time series was used to analyze the trend in increased order set usage and showed an effect of the intervention (p=0.023). **Discussion** Integration of disease specific order subsets into a single general admission order set significantly improved the overall adoption of order sets by clinicians. This provides health care systems with the opportunity to improve patient safety and implement evidence based care in clinical practice.

24. [Adm Policy Ment Health.](#) 2011 May;38(3):193-202.

**A collaborative approach to identifying effective incentives for mental health clinicians to improve depression care in a large managed behavioral healthcare organization.**

[Meredith LS](#), [Branstrom RB](#), [Azocar F](#), [Fikes R](#), [Ettner SL](#).

**Source**

**Abstract**

This descriptive study used stakeholder input to prioritize evidence-based strategies for improving depression care and to select incentives for mental health clinicians to adopt those strategies, and to conduct a feasibility test of an incentive-based program in a managed behavioral healthcare organization (MBHO). In two rounds of interviews and a stakeholder meeting, MBHO administrators and clinicians selected increasing combination treatment (antidepressant plus psychotherapy) rates as the program goal; and paying a bonus for case reviews, clinician feedback, and clinician education as incentives. We assessed program feasibility with case review and clinician surveys from a large independent practice association that contracts with the MBHO. Findings suggest that providing incentives for mental health clinicians is feasible and the incentive program did increase awareness. However, adoption may be challenging because of administrative barriers and limited clinical data available to MBHOs.

25. [Am J Prev Med](#). 2011 May;40(5):561-5.

**Use of evidence-based strategies to promote mammography among medically underserved women.**

[Lobb R](#), [Opdyke KM](#), [McDonnell CJ](#), [Pagaduan MG](#), [Hurlbert M](#), [Gates-Ferris K](#), [Chi B](#), [Allen JD](#).

**Source**

**Abstract**

**BACKGROUND:**

Several web-based resources recommend effective intervention strategies to promote use of mammography but there is limited information on whether the strategies are used, particularly by organizations that serve medically underserved women.

**PURPOSE:**

In 2010, data collected by the Avon Breast Health Outreach Program (BHOP) were analyzed to examine the diffusion of evidence-based intervention strategies among funded organizations.

**METHODS:**

Data on intervention strategies were obtained from a 2009 survey of Avon BHOP organizations funded during 2006-2009. Self-reported use of mammography was reported from annual intake forms administered to medically underserved women aged  $\geq 40$  years, excluding those with a history of breast cancer or initial enrollees not exposed to the strategies. Strategies reflected interventions reviewed in the Guide to Community Preventive Services. Those recommended to increase demand and use of mammography included (1) client reminders; (2) small media; (3) one-to-one education; (4) removal of structural barriers to rescreening; and (5) group education- and one that lacked sufficient evidence to warrant a recommendation (6) client incentives.

**RESULTS:**

Among 86 organizations, 96% used three or more intervention strategies. The most common strategies were group education (91%) and client reminders (83%). The overall crude-percentage of recent mammography use was 84%. This percentage was similar for clinical sites and nonclinical sites, despite the disproportionate enrollment of medically underserved women in nonclinical sites.

**CONCLUSIONS:**

The wide use of evidence-based strategies among Avon BHOP-funded organizations and high percentage of recent mammography use among women exposed to the strategies suggests that medically underserved women are benefiting from effective interventions to increase use of mammography.

26. [Prev Chronic Dis](#). 2011 May;8(3):A65. Epub 2011 Feb 15.

**Training and technical assistance to enhance capacity building between prevention research centers and their partners.**

[Spadaro AJ](#), [Grunbaum JA](#), [Dawkins NU](#), [Wright DS](#), [Rubel SK](#), [Green DC](#), [Simoes EJ](#).

**Source****Abstract****INTRODUCTION:**

The Centers for Disease Control and Prevention has administered the Prevention Research Centers Program since 1986. We quantified the number and reach of training programs across all centers, determined whether the centers' outcomes varied by characteristics of the academic institution, and explored potential benefits of training and technical assistance for academic researchers and community partners. We characterized how these activities enhanced capacity building within Prevention Research Centers and the community.

**METHODS:**

The program office collected quantitative information on training across all 33 centers via its Internet-based system from April through December 2007. Qualitative data were collected from April through May 2007. We selected 9 centers each for 2 separate, semistructured, telephone interviews, 1 on training and 1 on technical assistance.

**RESULTS:**

Across 24 centers, 4,777 people were trained in 99 training programs in fiscal year 2007 (October 1, 2006-September 30, 2007). Nearly 30% of people trained were community members or agency representatives. Training and technical assistance activities provided opportunities to enhance community partners' capacity in areas such as conducting needs assessments and writing grants and to improve the centers' capacity for cultural competency.

**CONCLUSION:**

Both qualitative and quantitative data demonstrated that training and technical assistance activities can foster capacity building and provide a reciprocal venue to support researchers' and the community's research interests. Future evaluation could assess community and public health partners' perception of centers' training programs and technical assistance.

27. [Comput Inform Nurs](#). 2011 Apr 28. [Epub ahead of print]

**Exploring the Clinical Information System Implementation Readiness Activities to Support Nursing in Hospital Settings.**

[Piscotty RJ](#), [Tzeng HM](#).

**Abstract**

The implementation of clinical information systems can have a profound impact on nurses and their productivity. Poorly implemented systems can lead to unintended consequences that may have a negative impact on clinical processes and patient outcomes. Executives must have adequate knowledge to address nurses' concerns related to implementation. This study explored the clinical information system implementation readiness activities adopted by chief nurse

executives in hospital settings. A descriptive qualitative design was used, including interviews with six chief nurse executives, held from December 2003 through March 2004. The constant comparative method was used to analyze the interviews to extract readiness activity themes and compare these to the literature. The synthesized themes showed that the executives were knowledgeable about and engaged in several key areas, but not all, of the implementation readiness process. The majority of responses were classified into the thematic areas of champion support, staff preparation for change, training, organizational alignment, planning, and vendor support. The theme of a lack of vendor support was not identified in previous studies but was clear in the responses of the chief nurse executives interviewed.

28. [J Adv Nurs](#). 2011 Apr 20. doi: 10.1111/j.1365-2648.2011.05642.x. [Epub ahead of print] **The role of advanced practice nurses in knowledge brokering as a means of promoting evidence-based practice among clinical nurses.**

[Gerrish K](#), [McDonnell A](#), [Nolan M](#), [Guillaume L](#), [Kirshbaum M](#), [Tod A](#).

#### **Abstract**

gerrish k., mcdonnell a., nolan m., guillaume l., kirshbaum m. & tod a. (2011) The role of advanced practice nurses in knowledge brokering as a means of promoting evidence-based practice among clinical nurses. *Journal of Advanced Nursing* ABSTRACT: Aim. To identify approaches used by advanced practice nurses to promote evidence-based practice among clinical nurses. Background. Barriers encountered at individual and organizational levels hinder clinical nurses in their ability to deliver evidence-based practice. Advanced practice nurses are well placed to promote evidence-based practice through interactions with clinical nurses. However, little is understood about how advanced practice nurses might realize this potential. Method. A multiple instrumental case study of 23 advanced practice nurses from hospital and primary care settings across seven Strategic Health Authorities in England was undertaken in 2006. Data collection comprised interviews and observation of advanced practice nurses and interviews with clinical nurses and other healthcare professionals. Data were analysed using the Framework approach. Findings. Advanced practice nurses acted as knowledge brokers in promoting evidence-based practice among clinical nurses. Knowledge management and promoting the uptake of knowledge were key components of knowledge brokering. Knowledge management involved generating different types of evidence, accumulating evidence to act as a repository for clinical nurses, synthesizing different forms of evidence, translating evidence by evaluating, interpreting and distilling it for different audiences and disseminating evidence by formal and informal means. Advanced practice nurses promoted the uptake of evidence by developing the knowledge and skills of clinical nurses through role modelling, teaching, clinical problem-solving and facilitating change. Conclusion. The role of advanced practice nurses in knowledge brokering is complex and multi-faceted. It extends beyond the knowledge management, linkage and capacity building identified in the literature to include active processes of problem-solving and facilitating change.

29. [Am J Addict](#). 2011 May;20(3):271-84. doi: 10.1111/j.1521-0391.2011.00127.x. Epub 2011 Mar 31.

**Addiction treatment provider attitudes on staff capacity and evidence-based clinical training: results from a national study.**

[Lundgren L](#), [Amodeo M](#), [Krull I](#), [Chassler D](#), [Weidenfeld R](#), [de Saxe Zerden L](#), [Gowler R](#), [Lederer J](#), [Cohen A](#), [Beltrame C](#).

**Abstract**

This national study of addiction-treatment organizations' implementation of evidence-based practices examines: (1) organizational/leadership factors associated with director (n = 212) attitudes regarding staff resistance to organizational change, and (2) organizational/staff factors associated with staff (n = 312) attitudes regarding evidence-based clinical training. Linear regression analyses, controlling for type of treatment unit, leadership/staff characteristics and organizational readiness to change, identified that directors who perceived their organization needed more guidance and had less staff cohesion and autonomy rated staff resistance to organizational change significantly higher. Staff with higher levels of education and greater agreement that their organization supported change had greater preference for evidence-based trainings. Federal addiction treatment policy should both promote education and training of treatment staff and organizational development of treatment CBOs.

30. [J Eval Clin Pract.](#) 2011 Apr 19. doi: 10.1111/j.1365-2753.2011.01673.x. [Epub ahead of print]

**Achievement of a median door-to-balloon time of less than 90 minutes by implementation of organizational changes in the 'Emergency Department to Cath Lab' pathway: a 5-year analysis.**

[Comelli I](#), [Vignali L](#), [Rolli A](#), [Lippi G](#), [Cervellin G](#).

**Abstract**

**Rationale** At present, most patients presenting directly to emergency departments (EDs) do not meet the recommended door-to-balloon goal of less than 90 minutes for ST-elevation myocardial infarction (STEMI) patients. Until the year 2005, the goal of less than 90 minutes door-to-balloon time has been rarely achieved in our hospital (i.e. 17% of all cases). **Method** Some organizational changes - including immediate involvement of the cardiologist in ED - were established to improve our performance. To evaluate the results of these changes, we have measured the intervals pain-to-door, door-to-electrocardiogram (ECG) and ECG-to-balloon for all the consecutive STEMI patients (n = 206) observed in our hospital during three sample months (May to July) of the years 2005 to 2009. We have then calculated the times door-to-balloon and pain-to-balloon (total ischemic time). **Results** We have demonstrated that the door-to-balloon time has been progressively reduced to less than 90 minutes in 73% of patients. Only 4.5% of all patients still have a door-to-balloon time greater than 150 minutes (17% in 2005). It is also notable the 60% reduction (from 330 to 140 minutes) of the pain-to-door time, the so-called 'out of hospital avoidable delay', was achieved by a sensitization campaign directed to the whole population of the province. **Conclusion** Taken together, all these organizational changes have allowed to reduce the total ischemic time from 465 minutes in year 2005 to 232 minutes in year 2009, thereby demonstrating the effectiveness of our intervention.

31. [Adm Policy Ment Health.](#) 2011 May;38(3):203-10.

**Implementing Evidence-Based Practices for Youth in an HMO: The Roles of External Ratings and Market Share.**

[Hamilton J](#), [Daleiden E](#), [Dopson S](#).

**Abstract**

A qualitative study of child clinicians in a non-profit HMO examined implementation of evidence-based practices (EBPs) for anxiety and oppositional defiant disorders using interviews and focus groups with 33 clinicians (97% of participants), and ethnography of emails and

meetings. Analysis showed statistical measures of access and service-key elements of rating organizations' "report cards"- were central in creating "pressure" making transition to EBPs difficult. EBPs were secondary to access and service targets. "Research" and "statistics" were perceived as unrealistic, "literature" as lacking authority. Rating organizations should include outcome and fidelity metrics to align market share pressures with children's health.

32. [Trials](#). 2011 Apr 20;12(1):100. [Epub ahead of print]

**Ethical issues posed by cluster randomized trials in health research.**

[Weijer C](#), [Grimshaw JM](#), [Taljaard M](#), [Binik A](#), [Boruch R](#), [Brehaut JC](#), [Donner A](#), [Eccles MP](#), [Gallo A](#), [McRae AD](#), [Saginur R](#), [Zwarenstein M](#).

**Abstract**

ABSTRACT: The cluster randomized trial (CRT) is used increasingly in knowledge translation research, quality improvement research, community based intervention studies, public health research, and research in developing countries. However, cluster trials raise difficult ethical issues that challenge researchers, research ethics committees, regulators, and sponsors as they seek to fulfill responsibly their respective roles. Our project will provide a systematic analysis of the ethics of cluster trials. Here we have outlined a series of six areas of inquiry that must be addressed if the cluster trial is to be set on a firm ethical foundation: 1. Who is a research subject? 2. From whom, how, and when must informed consent be obtained? 3. Does clinical equipoise apply to CRTs? 4. How do we determine if the benefits outweigh the risks of CRTs? 5. How ought vulnerable groups be protected in CRTs? 6. Who are gatekeepers and what are their responsibilities? Subsequent papers in this series will address each of these areas, clarifying the ethical issues at stake and, where possible, arguing for a preferred solution. Our hope is that these papers will serve as the basis for the creation of international ethical guidelines for the design and conduct of cluster randomized trials.

33. [Health Promot Pract](#). 2011 May;12(3):361-9. Epub 2010 Feb 15.

**Knowledge translation strategies using the thinking about epilepsy program as a case study.**

[Martiniuk AL](#), [Secco M](#), [Speechley KN](#).

**Abstract**

In many areas of health promotion and health care there is a need to bring new knowledge from research into practice (knowledge translation). Relevant research alone is not usually sufficient to achieve the ultimate outcome(s) of interest. This study aims to address this gap by outlining practices and outcomes involved in moving research findings into action using the example of the Thinking About Epilepsy program. A case study approach is used to discuss evidence-based principles and steps taken to translate evidence about the Thinking About Epilepsy program into action. Data used to inform this process include organizational documents, observations, and stakeholder interviews. Partnerships and techniques used for knowledge translation are discussed. The process of moving research knowledge into action is discussed explicitly in terms of who the policy makers are, what action is desired, the role of partners, and funding. Using a case study approach the authors have illustrated the importance of starting knowledge translation at the beginning, not at the end, of the research project. The principles discussed in this article can be extended past epilepsy and applied to move research findings relevant to other health conditions, health promotion activities, products, and technologies into action.

34. [Psychol Health Med](#). 2011 May;16(3):291-303.

**Multiple outcome measures and mixed methods for evaluating the effectiveness of theory-based behaviour-change interventions: A case study targeting health professionals' adoption of a national suicide prevention guideline.**

[Hanbury A](#), [Wallace LM](#), [Clark M](#).

**Abstract**

Interest in behaviour-change interventions targeting health professionals' adoption of clinical guidelines is growing. Recommendations have been made for interventions to have a theoretical base, explore the local context and to use mixed and multiple methods of evaluation to establish intervention effectiveness. This article presents a case study of a behaviour-change intervention delivered to community mental health professionals in one Primary Care Trust, aimed at raising adherence to a national suicide prevention guideline. A discussion of how the theory-base was selected, the local context explored, and how the intervention was developed and delivered is provided. Time series analysis, mediational analysis and qualitative process evaluation were used to evaluate and explore intervention effectiveness. The time series analysis revealed that the intervention was not effective at increasing adherence to the guideline. The mediational analysis indicates that the intervention failed to successfully target the key barrier to adoption of the guidance, and the qualitative process evaluation identified certain intervention components that were well received by the health professionals, and also identified weaknesses in the delivery of the intervention. It is recommended that future research should seek to further develop the evidence-base for linking specific intervention strategies to specific behavioural barriers, explore the potential of theories that take into account broader social and organisational factors that influence health professionals' practice and focus on the process of data synthesis for identifying key factors to target with tailored interventions. Multiple and mixed evaluation techniques are recommended not only to explore whether an intervention is effective or not but also why it is effective or not.

35. [Intensive Crit Care Nurs](#). 2011 Apr 19. [Epub ahead of print]

**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.

36. [Adm Policy Ment Health](#). 2011 Apr 17. [Epub ahead of print]  
**Knowledge of and Attitudes Towards Evidence-Based Practices in Community Child Mental Health Practitioners.**

[Nakamura BJ](#), [Higa-McMillan CK](#), [Okamura KH](#), [Shimabukuro S](#).

**Abstract**

Research in the dissemination of evidence-based practices (EBPs) suggests that practitioners' knowledge of and attitudes towards EBPs influence their decisions to adopt such practices. This study investigated the relationships between practitioner background variables and EBP knowledge and attitudes, as well as the relationship between knowledge and attitudes among public sector youth direct service providers (n = 240). Findings suggest that knowledge and attitudes relate to practitioners' most advanced degree, practice setting, and licensure status. Additionally, lack of knowledge in the form of EBP under-identification was related to negative attitudes. Findings are discussed as they relate to the dissemination of EBPs.

37. [Am J Prev Med](#). 2011 May;40(5 Suppl 2):S134-43.

**Grid-enabled measures using science 2.0 to standardize measures and share data.**

[Moser RP](#), [Hesse BW](#), [Shaikh AR](#), [Courtney P](#), [Morgan G](#), [Augustson E](#), [Kobrin S](#), [Levin KY](#), [Helba C](#), [Garner D](#), [Dunn M](#), [Coa K](#).

**Abstract**

Scientists are taking advantage of the Internet and collaborative web technology to accelerate discovery in a massively connected, participative environment—a phenomenon referred to by some as Science 2.0. As a new way of doing science, this phenomenon has the potential to push science forward in a more efficient manner than was previously possible. The Grid-Enabled Measures (GEM) database has been conceptualized as an instantiation of Science 2.0 principles by the National Cancer Institute (NCI) with two overarching goals: (1) promote the use of standardized measures, which are tied to theoretically based constructs; and (2) facilitate the ability to share harmonized data resulting from the use of standardized measures. The first is accomplished by creating an online venue where a virtual community of researchers can collaborate together and come to consensus on measures by rating, commenting on, and viewing meta-data about the measures and associated constructs. The second is accomplished by connecting the constructs and measures to an ontological framework with data standards and common data elements such as the NCI Enterprise Vocabulary System (EVS) and the cancer Data Standards Repository (caDSR). This paper will describe the web 2.0 principles on which the GEM database is based, describe its functionality, and discuss some of the important issues involved with creating the GEM database, such as the role of mutually agreed-on ontologies (i.e., knowledge categories and the relationships among these categories—for data sharing).

38. [Health Educ Res](#). 2011 May 2. [Epub ahead of print]

**Taxonomy for strengthening the identification of core elements for evidence-based behavioral interventions for HIV/AIDS prevention.**

[Galbraith JS](#), [Herbst JH](#), [Whittier DK](#), [Jones PL](#), [Smith BD](#), [Uhl G](#), [Fisher HH](#).

**Source**

**Abstract**

The concept of core elements was developed to denote characteristics of an intervention, such as activities or delivery methods, presumed to be responsible for the efficacy of evidence-based behavioral interventions (EBIs) for HIV/AIDS prevention. This paper describes the development of a taxonomy of core elements based on a literature review of theoretical approaches and characteristics of EBIs. Sixty-one categories of core elements were identified from the literature and grouped into three distinct domains: implementation, content and pedagogy. The taxonomy was tested by categorizing core elements from 20 HIV prevention EBIs disseminated by Centers for Disease Control and Prevention. Results indicated that core elements represented all three domains but several were difficult to operationalize due to vague language or the inclusion of numerous activities or constructs. A process is proposed to describe core elements in a method that overcomes some of these challenges. The taxonomy of core elements can be used to identify core elements of EBIs, strengthen the translation of EBIs from research to practice and guide future research seeking to identify essential core elements in prevention interventions.

39. [Health Policy Plan](#). 2011 Apr 23. [Epub ahead of print]

**Does shortening the training on Integrated Management of Childhood Illness guidelines reduce its effectiveness? A systematic review.**

[Rowe AK](#), [Rowe SY](#), [Holloway KA](#), [Ivanovska V](#), [Muhe L](#), [Lambrechts T](#).

**Source****Abstract**

**OBJECTIVE** Implementation of the Integrated Management of Childhood Illness (IMCI) strategy with an 11-day training course for health workers improves care for ill children in outpatient settings in developing countries. The 11-day course duration is recommended by the World Health Organization, which developed IMCI. Our aim was to determine if shortening the training (to reduce cost) reduces its effectiveness. **METHODS** We conducted a systematic review to compare IMCI's effectiveness with standard training (duration  $\geq 11$  days) versus shortened training (5-10 days). Studies were identified from a search of MEDLINE, two existing systematic reviews, and by contacting investigators. We included published or unpublished studies that evaluated IMCI's effectiveness in developing countries and reported quantitative measures of health worker practices related to managing ill children under 5 years old in public or private health facilities. Summary measures were the median of effect sizes for all outcomes from a given study, and the percentage of patients needing oral antimicrobials or rehydration who were treated according to IMCI guidelines. **Findings** Twenty-nine studies were included. Direct comparisons from three studies showed little difference between standard and shortened training. Indirect comparisons from 26 studies revealed that effect sizes for standard training versus no IMCI were greater than shortened training versus no IMCI. Across all comparisons, differences ranged from -3 to +23 percentage-points, and our best estimate was a 2 to 16 percentage-point advantage for standard training. No result was statistically significant. After IMCI training (of any duration), 34% of ill children needing oral antimicrobials or rehydration were not receiving these treatments according to IMCI guidelines. **CONCLUSIONS** Based on limited evidence, standard IMCI training seemed more effective than shortened training, although the difference might be small. As sizable performance gaps often existed after IMCI training, countries should consider implementing other interventions to support health workers after training, regardless of training duration.

40. [J Gen Intern Med.](#) 2011 Apr 16. [Epub ahead of print]

**Pre-post Evaluation of Automated Reminders May Improve Detection and Management of Post-stroke Depression.**

[Williams LS](#), [Ofner S](#), [Yu Z](#), [Beyth RJ](#), [Plue L](#), [Damush T](#).

**Abstract**

**BACKGROUND:**

Post-stroke depression (PSD) occurs in at least one-third of stroke survivors, is associated with worse functional outcomes and increased mortality, and is frequently underdiagnosed and undertreated.

**OBJECTIVE:**

To evaluate the effectiveness of an electronic medical record-based system intervention to improve the proportion of veterans screened and treated for PSD.

**DESIGN:**

Quasi-experimental study comparing PSD screening and treatment among veterans receiving post-stroke outpatient care one year prior to the intervention (the control group) to those receiving outpatient care during the intervention period (the intervention group); contemporaneous data from non-study sites included to assess temporal trends in depression diagnosis and treatment.

**PARTICIPANTS:**

Veterans hospitalized for ischemic stroke and/or receiving primary care (PC) or neurology outpatient follow-up within six months post-stroke at two (Veterans Affairs) VA Medical Centers.

**INTERVENTIONS:**

We formed clinical improvement teams at both sites. Teams developed PSD screening and treatment reminders and designed tailored implementation strategies for reminder use in PC and neurology clinics.

**MAIN MEASURES:**

Proportion screened for PSD within 6 months post-stroke; proportion screening positive for PSD who received an appropriate treatment action within 6 months post-stroke.

**KEY RESULTS:**

In unadjusted analyses, PSD screening was performed within 6 months for 85% of intervention (N = 278) vs. 50% of control (N = 374) patients (OR 6.2,  $p < 0.001$ ), and treatment action was received by 83% of intervention vs. 73% of control patients who screened positive (OR 1.8,  $p = 0.13$ ). After adjusting for intervention, site and number of follow-up visits, intervention patients were more likely to be screened (OR 4.8,  $p < 0.001$ ) and to receive a treatment action if screened positive (OR 2.45,  $p = 0.05$ ). Analyses of temporal trends in non-study sites revealed no trend toward general increase in PSD detection or treatment.

**CONCLUSIONS:**

Automated depression screening in primary and specialty care can improve detection and treatment of PSD.

41. [Support Care Cancer.](#) 2011 Apr 15. [Epub ahead of print]

**Facilitating the implementation of empirically valid interventions in psychosocial oncology and supportive care.**

[Hack TF](#), [Carlson L](#), [Butler L](#), [Degner LF](#), [Jakulj F](#), [Pickles T](#), [Dean Ruether J](#), [Weir L](#).

**Abstract**

**PURPOSE:**

Over the past two decades, the fields of psychosocial oncology and supportive care have seen clinically effective tools as underutilized despite proven benefits to cancer patients and their families. The purpose of this paper is to discuss the reasons for the failure of psychosocial and supportive care interventions in oncology to realize broad clinical implementation and to demonstrate how a knowledge management framework offers several advantages for increasing the probability of successful implementation.

**METHODS:**

This paper is based on a systematic review of the literature pertaining to efforts to implement psychosocial oncology and supportive care interventions.

**RESULTS:**

The struggle to develop, implement, and evaluate promising psychosocial oncology and supportive care innovations has moved academic thought toward the development of models and theories concerning the best ways to move new knowledge into clinical practice. There are critical and common barriers to the successful transfer and implementation of promising interventions, and implementation efforts may be maximized by using knowledge management frameworks to systematically identify and address these barriers.

**CONCLUSIONS:**

The successful implementation of empirically promising interventions requires research networks and practice groups to work together in a concerted, theory-guided effort to identify and address the contextual factors most relevant to any particular intervention. The growing support of knowledge implementation activities by research funders, policy-makers, opinion leaders, and advocates of psychosocial and supportive care interventions is a positive move in this direction.

42. [BMJ Qual Saf](#). 2011 Apr 13. [Epub ahead of print]

**How does context affect interventions to improve patient safety? An assessment of evidence from studies of five patient safety practices and proposals for research.**

[Ovretveit JC](#), [Shekelle PG](#), [Dy SM](#), [McDonald KM](#), [Hempel S](#), [Pronovost P](#), [Rubenstein L](#), [Taylor SL](#), [Foy R](#), [Wachter RM](#).

**Abstract**

Background Logic and experience suggest that it is easier in some situations than in others to change behaviour and organisation to improve patient safety. Knowing which 'context factors' help and hinder implementation of different changes would help implementers, as well as managers, policy makers, regulators and purchasers of healthcare. It could help to judge the likely success of possible improvements, given the conditions that they have, and to decide which of these conditions could be modified to make implementation more effective. Methods The study presented in this paper examined research to discover any evidence reported about whether or how context factors influence the effectiveness of five patient safety interventions. Results The review found that, for these five diverse interventions, there was little strong evidence of the influence of different context factors. However, the research was not designed to investigate context influence. Conclusions The paper suggests that significant gaps in research exist and makes proposals for future research better to inform decision-making.

43. [BMJ Qual Saf](#). 2011 May;20(5):453-9. Epub 2011 Feb 11.

### **The role of theory in research to develop and evaluate the implementation of patient safety practices.**

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

#### **Abstract**

Theories provide a way of understanding and predicting the effects of patient safety practices (PSPs), interventions intended to prevent or mitigate harm caused by healthcare or risks of such harm. Yet most published evaluations make little or no explicit reference to theory, thereby hindering efforts to generalise findings from one context to another. Theories from a wide range of disciplines are potentially relevant to research on PSPs. Theory can be used in research to explain clinical and organisational behaviour, to guide the development and selection of PSPs, and in evaluating their implementation and mechanisms of action. One key recommendation from an expert consensus process is that researchers should describe the theoretical basis for chosen intervention components or provide an explicit logic model for 'why this PSP should work.' Future theory-driven evaluations would enhance generalisability and help build a cumulative understanding of the nature of change.

44. [J Clin Nurs](#). 2011 May;20(9-10):1329-1338. doi: 10.1111/j.1365-2702.2010.03590.x.

### **Implementation of clinical guidelines for adults with asthma and diabetes: a three-year follow-up evaluation of nursing care.**

[Higuchi KS](#), [Davies BL](#), [Edwards N](#), [Ploeg J](#), [Virani T](#).

#### **Abstract**

**Aims and objectives.** To report on a three-year follow-up evaluation in Canada of nursing care indicators following the implementation of the Adult Asthma Care Best Practice Guideline and the Reducing Foot Complications for People with Diabetes Best Practice Guideline and to describe the contextual changes in the clinical settings. **Background.** The Registered Nurses' Association of Ontario in Canada has developed and published more than 42 guidelines related to clinical nursing practice and healthy work environments. To date, evaluation has involved one-year studies of the impact of guideline implementation on the delivery of care in hospital and community settings, but little is known about whether changes in practice that were made during the initial implementation period have been sustained. **Design.** Longitudinal follow-up study. **Methods.** Site observations and interviews were conducted with key informants at two hospitals. Indicators of nursing care changes identified six months post-implementation were compared with indicators found during a retrospective chart audit at the same sites three years later. Fisher exact tests were used to compare outcomes for the two time periods. **Results.** Three out of 12 indicators related to asthma care remained consistently high ( $\geq 84\%$  of audited charts) and four indicators declined significantly ( $p < 0.01$ ). There were significant ( $p \leq 0.05$ ) improvements in nine out of 12 indicators related to diabetes foot care. Important contextual changes were made to better address the guideline recommendations for foot care in the out-patient program and the electronic documentation system. **Conclusions.** Sustainability of guideline implementation recommendations was enhanced with the use of an electronic documentation system. **Relevance to clinical practice.** Long-term follow-up of both clinical indicators and contextual factors are important to monitor to promote sustained implementation of guidelines.

45. [J Public Health \(Oxf\)](#). 2011 Apr 11. [Epub ahead of print]

**Population Impact Analysis: a framework for assessing the population impact of a risk or intervention.**

[Verma A](#), [Torun P](#), [Harris E](#), [Edwards R](#), [Gemmell I](#), [Harrison RA](#), [Buchan IE](#), [Davies L](#), [Patterson L](#), [Heller RF](#).

**Abstract****BACKGROUND:**

To describe an organizing framework, Population Impact Analysis, for applying the findings of systematic reviews of public health literature to estimating the impact on a local population, with the aim of implementing evidence-based decision-making.

**METHODS:**

A framework using population impact measures to demonstrate how resource allocation decisions may be influenced by using evidence-based medicine and local data. An example of influenza vaccination in the over 65s in Trafford to reduce hospital admissions for chronic obstructive pulmonary disease (COPD) is used.

**RESULTS:**

The number of COPD admissions due to non-vaccination of the over 65 in Trafford was 16.4 (95% confidence interval: 13.5; 19.5) and if vaccination rates were taken up to 90%, 11.5 (95% confidence interval: 9.3; 13.8) admissions could have been prevented. A total of 705 (95% confidence interval: 611; 861) people would have to be vaccinated against influenza to prevent one hospital admission.

**CONCLUSIONS:**

Population Impact Analysis can help the 'implementation' aspect of evidence for population health. It has been developed to support public health policy makers at both local and national/international levels in their role of commissioning services.

46. [J Public Health Manag Pract](#). 2011 May-Jun;17(3):242-7.

**Capacity of Diabetes Education Programs to Provide Both Diabetes Self-management Education and to Implement Diabetes Prevention Services.**

[Butcher MK](#), [Vanderwood KK](#), [Hall TO](#), [Gohdes D](#), [Helgerson SD](#), [Harwell TS](#).

**Abstract****OBJECTIVE:**

: The purpose of this study was to assess the capacity of diabetes self-management education (DSME) programs in urban and rural counties to provide services to patients with diagnosed diabetes, lifestyle services to persons at high risk for developing diabetes, and to assess the potential barriers to providing diabetes prevention services.

**METHODS:**

: In 2009, the Montana Department of Public Health and Human Services conducted an Internet-based survey of all DSME programs in Montana.

**RESULTS:**

: Thirty of the 39 (77%) DSME programs completed the survey. Seventy-seven percent of the urban programs and 50% of the rural programs reported a capacity to provide DSME to additional patients with diagnosed diabetes. More than 70% of the urban and the rural programs currently provide lifestyle services to patients with abnormal glucose tolerance but without diabetes. Eighty-four percent of the urban programs and 60% of the rural programs reported a capacity to provide lifestyle services to additional persons at high risk for diabetes. Eighty-five percent of the urban programs and 58% of the rural programs have already implemented or

intend to implement a lifestyle intervention service consistent with the Diabetes Prevention Program. Overall, the most frequently reported barriers to implementing a diabetes prevention services were lack of reimbursement (80%) and the lack of staff to provide the service (60%).

**CONCLUSION:**

: Urban and rural DSME programs in Montana have the capacity to implement both DSME for patients with diagnosed diabetes and diabetes prevention lifestyle services to additional people at high risk for diabetes. Reimbursement for diabetes prevention services is critical to ensure program development and implementation.

**47. Addictive Behavior 2011**

**Addicted to discovery: Does the quest for new knowledge hinder practice improvement?**

**Harold I. Perl**

**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.

48. [Adm Policy Ment Health](#). 2011 Apr 24. [Epub ahead of print]

**Use of the Breakthrough Series Collaborative to Support Broad and Sustained Use of Evidence-Based Trauma Treatment for Children in Community Practice Settings.**

[Ebert L](#), [Amaya-Jackson L](#), [Markiewicz JM](#), [Kisiel C](#), [Fairbank JA](#).

**Abstract**

Empirically supported treatments for posttraumatic stress reactions in children are not widely available. This observational study evaluates the feasibility and utility of adapting the Institute for Healthcare's Breakthrough Series Collaborative (BSC) to support the broad implementation and sustained use of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in community practice settings. Study findings indicated that agency staff in diverse roles viewed the BSC methodology as a valuable and practicable approach for facilitating skillful delivery of TF-CBT with fidelity. Use of TF-CBT increased over the course of the collaborative and findings from a

survey conducted one year later indicated that participating agencies were able to sustain and spread the practice.