DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Dissemination and Evaluation Center (DEC) Study Overview

Over the five-year course of the Dissemination of Evidence Informed Interventions initiative, the Boston University (BU) Dissemination and Evaluation Center (DEC) Team will achieve four goals:

1) Adapt four evidence-informed interventions from past SPNS initiatives (including creating an adapted intervention summary and an intervention plan which includes a staffing plan, logic model, budget, and three-year work plan);
2) Disseminate the adapted evidence-informed interventions to participating sites;
3) Conduct a rigorous multi-site evaluation of the evidence informed interventions; and
4) Disseminate four final enhanced, evidence-informed interventions.

Design

This is a longitudinal, prospective observational study. There are no control or comparison groups. This is a longitudinal, prospective study of a convenience sample of HIV-positive individuals. All study recruitment, enrollment, consent, or data collection activities will occur at the 12 demonstration sites (3 sites per intervention).

BU will serve as the data coordinating center for interview, chart, and intervention encounter data for study subjects that are consented into the national study. Local sites will enter data directly into BU's secure web-based system. Using a computer algorithm, the local ID will automatically be converted to a unique multi-site ID. All interview, chart, and intervention encounter data will be de-identified.

BU study staff will be responsible for audits of study files and chart review data to monitor and ensure the quality, accuracy, consistency, security, and privacy of multisite data that is collected at local sites. BU study staff will not gather the data directly from the medical chart for the record review. This is done by the local study staff. Audits of study files will be performed annually during site visits (years 2-5) on approximately 10% of the study site's sample (randomly generated).

Study Type

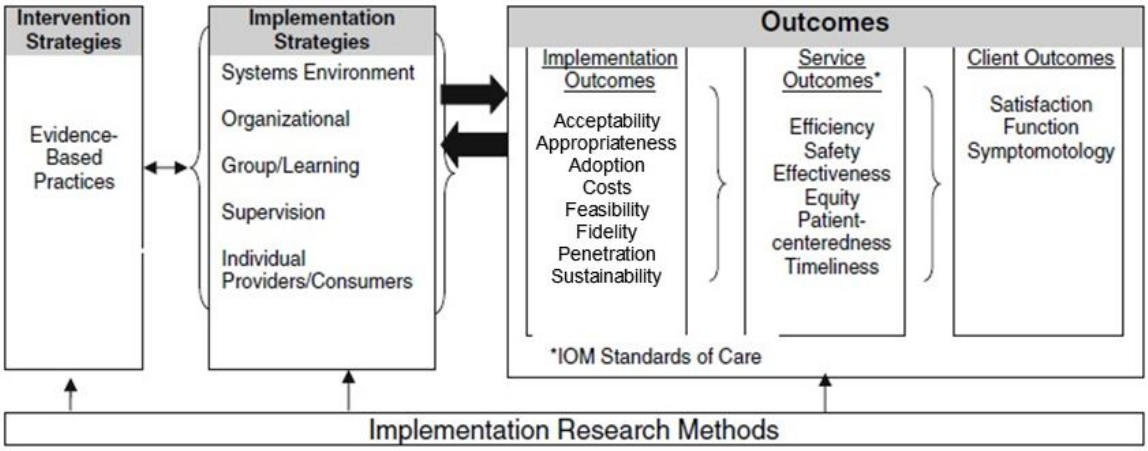
Drawing on the Proctor Model, the DEC Team will use hybrid implementation-effectiveness design (Curran et al., 2012). Hybrid designs have a dual focus with both implementation and effectiveness components. The rationale for the use of these designs is to move the study process more quickly from simply obtaining evidence to having an impact through understanding implementation.

Hybrid designs differ in the degree to which they focus on effectiveness or implementation. Because the primary goal of this initiative is the implementation evaluation, the DEC Team will use a Hybrid Type 3 study design. In a Hybrid Type 3, the goal is to test implementation strategies while also gathering information on the intervention outcomes, i.e. test the ability of the implementation strategy to enhance

the use of the evidence-based practice, but also collect health data. The Hybrid Type 3 provides insights into implementation barriers (which is a focus of the Dissemination of Evidence Informed Interventions). This is the appropriate model when effectiveness is established but it is unclear how robust the effects will be under implementation conditions. Additionally, the Hybrid Type 3 aligns with the Proctor Model, providing a coherent structure for the evaluation. Both are primarily focused on testing the implementation strategy, with a secondary aim of evaluating patient-level effects (what Proctor defines as the service and client-level outcomes).

Model

To ensure the multi-site evaluation is conducted with rigor and is based in a foundation of implementation science, the DEC team will use an established model of implementation research: the Proctor Model of Implementation Research (Proctor et al., 2009).



The Proctor Model, visually depicted above, posits that improvements in outcomes are dependent not only on the evidence-based interventions that are implemented but on the implementation strategies used to implement those interventions. The model distinguishes between the intervention strategy (evidence-based practice), different types of implementation strategies (e.g. environment or organizational setting), and three levels of outcomes (implementation, service, and client). Using the Proctor Model, one can infer that the quality and type of implementation strategies will affect implementation outcomes, and that successful implementation will result in improved service outcomes, which in turn should ultimately lead to better client outcomes. The appropriate outcome measures used in each category (implementation, service, and client) depend upon the specific evidence-based practice (in this case, the intervention model) and local context.

For more information, please contact Jane Fox (Principal Investigator, janefox@bu.edu) or Alexis Marbach (Senior Program Manager, amarbach@bu.edu).