

HOW ARE IMPLEMENTATION AND ADAPTATION OF EVIDENCE-BASED INTERVENTIONS
APPLIED IN COMMUNITY PRACTICE SETTINGS?
LESSONS FROM THE MODELO DE INTERVENCIÓN PSICOMÉDICA

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ABSTRACT

GISELE CHARMION PEMBERTON: How are Implementation and Adaptation of Evidence-Based Interventions Applied in Community Practice Settings? Lessons from the Modelo de Intervención Psicomédica

(Under the direction of Suzanne Havala Hobbs, DrPH)

The use of evidence-based behavioral interventions to address the prevention and treatment needs of populations and communities is standard practice across the health professions. In the HIV prevention literature there is consensus that evidence-based interventions (EBIs), that have demonstrated efficacy in research trials, are likely to achieve similar positive outcomes when implemented with high levels of fidelity, consistency, and with similar clients and in cultural settings representative of those in controlled settings. Yet, best practice recommendations of EBIs are disconnected from the realities of community-based practice.

This research study describes the selection, implementation and adaptation experiences of three community-based organizations (CBOs) and nine community health practitioners with a specific HIV prevention EBI-The Modelo de Intervención Psicomédica (MIP). MIP is one of the 29 EBIs designated and endorsed by the Centers for Disease Control and Prevention (CDC) as suitable for community use through their Diffusion of Effective Behavioral Interventions project.

The goals of the study were to describe how CBOs approached the selection of MIP to meet local needs; identify the practices and strategies used to facilitate the implementation and adaptation of MIP; inform the development of user-friendly adaptation guidelines specifically for community practice settings; and provide health care leaders with a blueprint for adaptation.

A nonexperimental, descriptive design was used, characterized by triangulated research methods - purposeful sampling, semi-structured interviews and document review - to ensure validity. An iterative multi-step analysis of data consisted of data reduction and display, and conclusion drawing and verification.

The study revealed 16 key findings with significant implications for community based practitioners, funders and government partners. Recommendations and the Plan for Change address the leadership, resource, training and capacity building needs of funders and CBOs in the process of EBI implementation and adaptation. This plan outlines key steps necessary for health leaders and other stakeholders to invest in, adapt, and maximize existing evidence-based HIV behavioral interventions that can be “made to fit” targeted communities in a manner that maintains the integrity of EBIs; yet responds to the need for culturally competent and relevant HIV prevention interventions in community practice settings.

DEDICATION

This work is dedicated to the two people who represent my foundation and future.

For my desert rose:
Victoria Esle Pemberton

*Because you were my inspiration all along. Thank you!
I know you are watching from above with great delight.*

For my nephew Joaquin:
Because of the immeasurable joy you bring, the hope you inspire, and the future you represent

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBA	Capacity Building Assistance
CBOs	Community Based Organizations
CDC	Centers for Disease Control and Prevention
CDC- DHAP	Centers for Disease Control and Prevention- Division of HIV/AIDS Prevention
DEBIs	Diffusion of Evidence-Based Interventions
EBIs	Evidence-Based Interventions
HIV	Human Immunodeficiency Virus
HR	Human Resources
IRB	Institutional Review Board
MIP	Modelo de Intervención Psicomédica
MIP TOF	Modelo de Intervención Psicomédica -Training of Facilitators Curriculum
PI	Principal Investigator
SAMHSA	Substance Abuse and Mental Health Services Administration
TA	Technical Assistance
T/TA	Training and Technical Assistance
U.S.	United States

CHAPTER I. INTRODUCTION

Statement of the Issue

In the absence of a cure for HIV....the best available means for combating the epidemic involves widespread implementation of effective and sustainable HIV prevention behavioral interventions. (Norton, Amico, Cornman, Fisher & Fisher, 2009, p.424)

Despite significant gains in the prevention and treatment of Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS), the disease continues to pose a serious threat to the health and well-being of communities of color. Currently, prevention remains the most viable strategy for reducing the incidence of HIV/AIDS in the U.S (Center for AIDS Prevention Studies (CAPS), 2004; Centers for Disease Control and Prevention (CDC), 2011a; McKleroy et al., 2006; Norton, Amico, Cornman, Fisher & Fisher, 2009) and has been lauded for its effectiveness in averting more than 350,000 new HIV infections in the U.S. over the past 15 years (CDC, 2011a). For every HIV infection that is prevented, an estimated savings of \$360,000 is realized by the health care system from avoiding the lifetime cost of HIV treatment (CDC, 2011a).

The Centers for Disease Control and Prevention (CDC), the premier public health entity in the United States (U.S.) tasked with the responsibility of protecting the public's health has scaled-up HIV/AIDS prevention efforts through its *High Impact HIV Prevention* initiative– an approach to reducing new HIV infections that employs a combination of “scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographical areas ” (CDC, 2011a, p. 6). This approach focuses on maximizing the impact of HIV prevention efforts on populations at greatest

risk for HIV/AIDS through proven prevention strategies including HIV testing and linkage to care; antiretroviral therapy; access to condoms and sterile syringes; prevention programs for people living with HIV, their partners, and others at high risk for infection; and screening and treatment for sexually transmitted infections.

One component of High Impact Prevention is CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. DEBI is comprised of 29 science-based, effective HIV prevention interventions that incorporate one or more of the prevention strategies of High Impact HIV Prevention. Information on these interventions is readily available and accessible for community use via a CDC-supported website (<http://www.effectiveinterventions.org>). Although diverse in terms of target populations (race, gender, sexual orientation), intervention settings, and HIV risk behaviors addressed; the EBIs included in CDC's DEBI compendium only offer a limited representation of the plethora of situations, settings, conditions, and contexts in which HIV/AIDS occurs. For example, EBIs for specific sub-populations at highest risk for HIV/AIDS, such as transgender individuals and young men of color who have sex with men continue to be underrepresented in the compendium relative to HIV risk. Existing gaps in tailored HIV prevention strategies for particular sub-groups, an environment of competing public health priorities, and limited resources to address the distinct HIV prevention needs of specific populations and groups, has lead to the *adaptation* of existing evidence-based interventions as a viable strategy for maximizing this body of knowledge and increasing the reach to persons at risk for HIV.

In the HIV prevention literature, there is consensus that interventions that have demonstrated efficacy in research trials are likely to achieve similar (positive) outcomes when implemented in community practice settings with (1) high levels of fidelity to the original activities or services; (2) with the same duration, intensity, and formats; and (3) with similar clients and in cultural settings representative of those in the research trial (Solomon, Card and Malow, 2006). The increasingly

popular recommendation from federal entities such as CDC to use scientific and evidence-based HIV prevention interventions at the community level, rather than those identified as “home grown” poses a significant challenge for communities. The current EBIs assume a best case scenario for implementation at the community level and presume that optimal conditions exist to ensure that interventions are carried out with adequate resources and with fidelity. The reality for health professionals administering and implementing these EBIs is that there exist a multitude of environmental, resource, and contextual conditions that may require **adaptation** of interventions for local use. The issues of:

- 1) noticeable gaps in the types of HIV prevention EBIs that are available to meet the diverse HIV prevention needs and resource realities of communities (Lyles et al., 2007);
- 2) limited community capacity to select, implement and evaluate HIV prevention EBIs with fidelity (Collins, Harshbarger, Sawyer & Hamdallah, 2006); and
- 3) insufficient guidance for assisting communities with adapting existing EBIs to ensure cultural relevance within local communities have a deleterious effect on the implementation of EBI's.

Since many community level practitioners question the relevance, applicability, transferability, cultural appropriateness and effectiveness of “pre-packaged” EBIs when applied to their specific target populations and communities (Solomon et al., 2006), adaptation of these packaged evidence-based interventions must be seen as a viable option to meet local needs.

Issue Summary

A review of the health professions literature, reveals a paucity of information on how best to adapt evidence-based interventions designed for a specific population or setting to another population or setting in a manner that maintains the integrity and efficacy of the intervention, while at the same time accommodating the various cultural, environmental and contextual nuances that reflect the

realities of community-based practice. Since CDC-funded community-based organizations (CBOs) and health departments are encouraged to select high impact EBIs as part of their slate of HIV prevention services, the lack of existing guidelines or best practices on the implementation and adaptation of EBIs presents a significant deficit for those that must execute these interventions within their communities. As such, targeted research is needed to determine the implementation experiences and types of adaptations that are most common among community-based organizations, the effects of those adaptations, and the processes used by agencies to conduct and document adaptations. Since the processes for selecting, implementing and adapting EBIs is not an inherent skill, end-users of these pre-packaged HIV prevention EBIs must be allowed to own these interventions through a process of guided adaptation to ensure targeted, tailored, and culturally-appropriate interventions reflective of their community's HIV prevention needs.

This research study aims to broaden the scope of knowledge on the implementation and adaptation of EBIs within community practice settings. Findings will enable health leaders-- community practitioners, funders, and government partners-- to guide future dissemination and implementation of HIV prevention EBIs within our communities and provide the requisite support and technical assistance to ensure success and sustenance of these interventions at the community level.

Study Overview and Specific Aims

If the health professions and their sponsors want more widespread and consistent evidence-based practice, they will need to find ways to generate more practice-based evidence that explicitly addresses external validity and local realities. (Green & Glasgow, 2006. p. 3).

The focus of this research study is on the implementation and adaptation experiences of organizations and community health practitioners with one specific CDC designated EBI--The Modelo

de Intervención Psicomédica (MIP) (Robles et al., 2004). MIP is the only one of the 29 CDC EBIs specifically designed for, tested and validated with an exclusively Latino injection drug-using population (PROCEED Inc, 2011). This particular intervention was chosen as the focal EBI (over the other 28 EBIs) because of the Principal Investigator's (PIs) experience with the translation, packaging, and diffusion of MIP. For two years, the PI worked closely with the MIP diffusion team whose membership consisted of the primary researcher responsible for designing the research study protocol (Robles et al., 2004), the principal scientist who implemented MIP in the research setting, representatives from the CDC who provided overall guidance on research-to-practice translation, and colleagues from the community-based partner organization where the PI was employed. The PI had unique insight on the interventions' components, the training process for CBOs, and the expectations that both researchers and funders have of community-based organizations with regards to implementing MIP at the community level with fidelity.

MIP is a seven-session cognitive behavioral HIV prevention intervention for active injection drug users. It integrates community-based recruitment, individualized counseling, and comprehensive case management to reduce HIV risk behaviors among injection drug users while increasing patient access to, and use of health and social services, including drug treatment (PROCEED Inc., 2011). Initial research on MIP (Robles et al., 2004) tested the effectiveness of a combined counseling and case management model that incorporated motivational interviewing techniques and behavior change staging to engage injection drug users, facilitate their entry into healthcare, drug treatment, and family and social support systems, and increase their self-efficacy in modifying drug and sex-related HIV risk behaviors. MIP was shown to be effective in reducing both HIV risk behaviors among Latino injection drug users and increasing their utilization of social support and health services, including drug treatment (Robles et al., 2004).

In community practice settings, the implementation of CDC designated EBIs such as MIP requires a series of steps characterized by intervention selection and adoption, pre-implementation planning, program implementation and evaluation. Within each of these phases are processes related to EBI adaptation and intervention fidelity that are conducted to ensure “goodness of fit” and similarly positive outcomes for the targeted communities. MIP, like the other EBIs in CDC’s compendium of effective behavioral interventions has been packaged for community use through a shared partnership model between the original researchers, representatives from CDC and a community-based partner with experience in executing HIV/AIDS programs. These existing HIV EBIs must fulfill the multifaceted roles of being scientifically sound and effective, culturally competent, acceptable, and doable at the community level.

Research Aims

This dissertation study explores the selection, implementation, and adaptation processes of three community-based organizations implementing the Modelo de Intervención Psicomédica (MIP) in settings, populations, and/or contexts that differ from that which was prescribed in the MIP curriculum package developed by the original researchers/developers of MIP. The specific measurable aims of this research study are as follows:

1. Describe how organizations approached the selection of MIP to meet the needs of their local communities.
2. Identify the practices and strategies used to facilitate the successful adaptation of MIP in community settings;
3. Inform the development of user-friendly adaptation guidelines specifically for community practice settings.

Table 1 below displays the primary research question and supporting sub-questions intended to achieve these aims and further contribute to the field of dissemination and implementation research and adaptation of evidence-based interventions. It is anticipated that the information extracted on the implementation and adaptation experiences from MIP will be useful to other community-based practitioners implementing and adapting EBIs in their respective settings.

TABLE 1: Research Questions to Achieve Specific Study Aims	
<i>Primary Research Question</i>	How are Implementation and Adaptation of Evidence-Based Interventions Applied in Community Practice Settings? Lessons from the Modelo de Intervención Psicomédica.
<i>Study Aim 1</i>	Describe how organizations approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities.
<i>Supporting Sub-questions</i>	<ul style="list-style-type: none"> ▪ Which factors do organizations consider in their decisions to adopt a particular EBI such as MIP? Why? ▪ What pre-implementation planning activities did organizations conduct to prepare for the implementation of an EBI such as MIP? When were these activities conducted? With whom? Why? ▪ What barriers or challenges to adaptation did organizations perceive having prior to implementing MIP?
<i>Study Aim 2</i>	Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings.
<i>Supporting Sub-questions</i>	<ul style="list-style-type: none"> ▪ How do organizations define “adaptation?” Describe the process, direction, and scope of these changes. ▪ What types of challenges did organizations encounter while implementing MIP? What facilitators did they encounter? ▪ Which strategies, tools, and/or resources did organizations use to adapt EBIs such as MIP? Which were successful? Which were not? ▪ Which features of MIP required adaptation and which features did not? ▪ How were cultural considerations addressed in the adaptation process for MIP?
<i>Study Aim 3</i>	Inform the development of user-friendly adaptation guidelines specifically for community practice settings.
<i>Supporting Sub-questions</i>	<ul style="list-style-type: none"> ▪ What are the technical support needs of health service professionals in implementing and adapting EBIs? ▪ How can lessons learned through adaptation of EBIs be applied in future efforts to adapt and implement EBIs?

The information garnered from this research has the potential to increase the capacity of health leaders and service professionals to more effectively implement EBIs in community practice settings by revealing factors that inform intervention adoption and, subsequently, which strategies, tools and resources are used to effectively address challenges in implementing and adapting EBIs.

Historical Timeline

HIV/AIDS remains one of the most urgent global public health challenges of the 21st century. The Centers for Disease Control and Prevention (CDC, 2011a) has reported that in the U.S. alone approximately 50,000 Americans become infected with HIV annually and by the end of 2008 there were more than 1.2 million people living with HIV infection in this country. Although great strides have been made in the U.S. to prevent, diagnose and treat HIV/AIDS, certain populations still bear the brunt of the disease, particularly gay and bi-sexual men of all races African-Americans, Hispanics, and injection drug users (Prejean et al., 2011).

Gay and bisexual men of all races are the most disproportionately impacted by the epidemic accounting for 61% of all new infections in 2009 (CDC 2011b, Prejean et al., 2011). African-Americans and Hispanics continue to be the most affected racial/ethnic groups accounting for 64% of all persons living with HIV in 2009; but only comprising 14% and 16% of the U.S. population respectively (CDC 2011b, Prejean et al., 2011). During this same time period injection drug users (IDUs) represented 9% of all new infections, with African-American and Latino IDUs comprising 69% of these infections (CDC 2011b, Prejean et al., 2011). Racial and ethnic minorities in the U.S. represented the majority of new AIDS diagnoses, the majority of Americans living with AIDS, and the majority of deaths among persons with AIDS (Solomon et al., 2006).

Concurrently, population trend data indicate a demographic shift in the U.S. population from a majority white population to a largely non-white, racial/ethnic majority that is overwhelmingly Hispanic, foreign-born, and speak a language other than English at home (Motel, 2012). Based on current epidemiological and disease trends for HIV/AIDS, these population projections suggest that racial/ethnic minority communities will continue to be at high risk for HIV/AIDS and will require enhanced HIV testing, treatment, and culturally competent prevention strategies (CDC, 2011a). In response to these trends as well as the need to significantly reduce new HIV infections in the U.S. among all populations, the White House released a National HIV/AIDS Strategy (NHAS) in July 2010 to guide the nation's efforts to address HIV/AIDS across government agencies and public and private partners (CDC, 2011a). NHAS sets clear priorities for increasing the impact of HIV prevention, care and treatment efforts, and "emphasizes the central importance of reducing disparities in HIV prevention and care and in reducing the stigma and discrimination associated with HIV" (CDC, 2011a, p. 5). CDC's operationalization of NHAS is through High Impact HIV Prevention which directs prevention resources and interventions to populations and geographic locations most severely impacted by the disease in order to reduce HIV/AIDS disparities and facilitate health equity.

Focus on Prevention

HIV prevention programs, both in the U.S. and in developing countries have demonstrated that prevention works (CAPS, 2004; CDC, 2011a; Hawkins, Catalano, & Arthur, 2002; Lampthey, 2000). Prevention science is based on the assumption that poor health outcomes can be averted by reducing or eliminating risk factors and boosting the protective factors that safeguard individuals and their environments (Hawkins et al., 2002). HIV/AIDS is preventable; therefore, the primary modes for HIV infection-- unprotected sex, injection drug use, and a combination of the two unprotected sex and injection drug use — are also preventable when appropriate and effective HIV risk reduction and

behavior modification strategies are used. Since there is currently no cure for HIV/AIDS, prevention remains the most promising and effective strategy for reducing HIV risk among all groups and protecting communities of color from further deleterious effects.

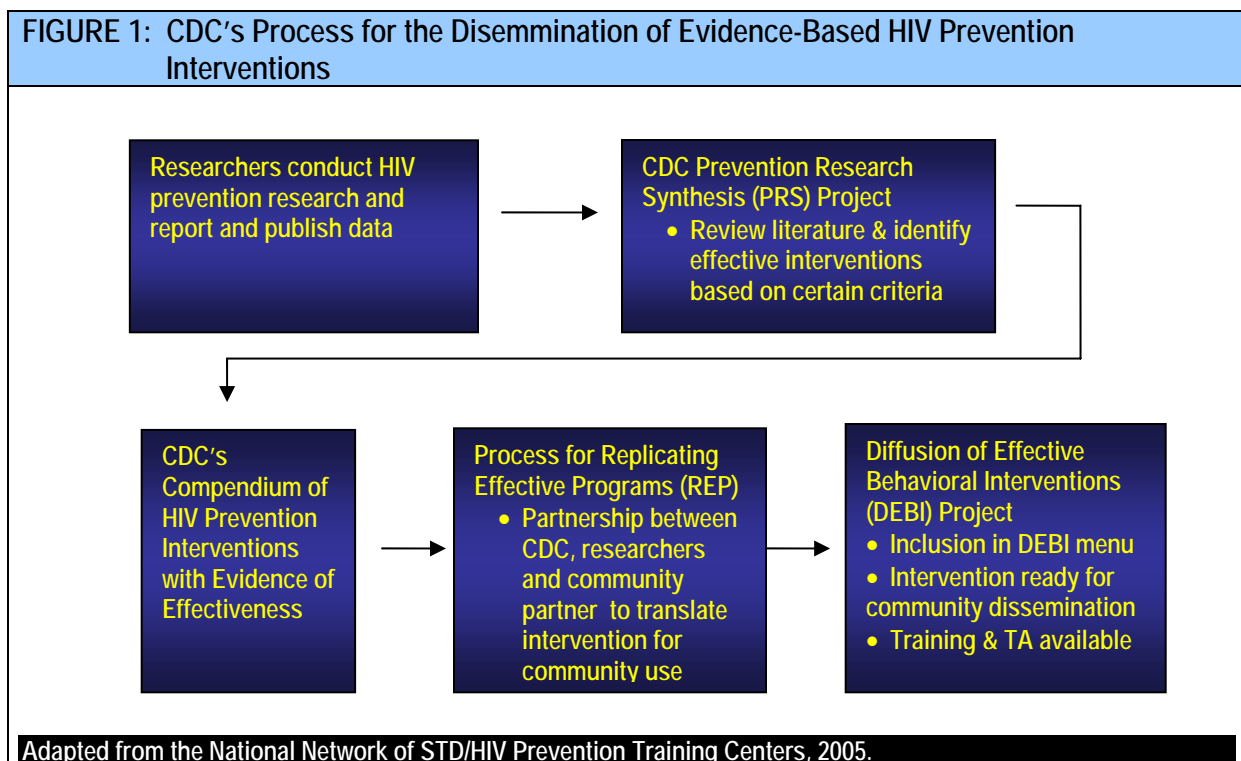
HIV prevention in community-based settings must be approached from a risk reduction/protection enhancement framework which considers and addresses the risk factors of greatest relevance to impacted communities (Hawkins et al., 2002). A comprehensive HIV prevention strategy calls for a multi-faceted and multi-layered plan which addresses the institutional, environmental, psychosocial, cultural and behavioral factors that contribute to, or protect against HIV/AIDS (CAPS, 2004). In communities where multiple health disparities already exist and resources are scarce, there is a need to maximize existing HIV prevention interventions that have already been proven effective in research settings. Such public health interventions must be made available for community use where the need is greatest, through information transfer and packaging, widespread diffusion, and technical assistance to support implementation of these interventions.

CDC - Diffusion of Effective Behavioral Interventions (DEBI) for HIV Prevention Project

The Centers for Disease Control - Division of HIV/AIDS Prevention (CDC-DHAP) has embraced the challenge of bringing best-evidence research to the community through its Diffusion of Effective Behavioral Interventions (DEBI) for HIV Prevention Project, which makes a connection between promising research conducted in a contained setting and evidence-based practice conducted in the field (Collins et al., 2006; Solomon et al., 2006). DEBI was launched in 2002 in response to an Institute of Medicine (IOM) Report (2001) calling for the increased use of HIV prevention research at the community level through greater access to state-of-the-art prevention research and on-going technical support to implement, adapt, and evaluate HIV prevention programs (Collins et al., 2006; IOM, 2001). The DEBI project has been a significant component of CDC's larger HIV prevention efforts

to ensure that best evidence HIV prevention interventions reach community practitioners and are put to use with specific target populations at risk for, and living with HIV/AIDS.

CDC's research translation process has included reviewing the research, packaging it for community consumption, and creating field-tested curricula, materials and products that assist community-based practitioners with implementing these evidence-based interventions in their respective settings (Solomon et al., 2006). **Figure 1** below depicts CDC's process for identifying and making available evidence-based HIV prevention interventions to the community.



The DEBI project comprises a significant component of CDC's national HIV prevention strategy. Almost three-quarters of the 29 EBIs in CDC's compendium have been tested. Data demonstrate that minority participants in communities are most disproportionately affected by HIV/AIDS (Lyles et al., 2007). The target populations for EBIs include persons at high risk for, and living with HIV/AIDS, including gay and bisexual men who have sex with men, heterosexual women, injection

drug users, youth, persons living with HIV, and others (Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008). These EBIs are delivered either one-on-one between an individual and community practitioner, through a group, or at the community level (Dworkin et al., 2008). Through the DEBI project, entities directly funded by CDC-DHAP, such as state and local health departments and community-based organizations are required to implement one or more of the available EBI packages appropriate for use with their constituents, and grantees of these health departments have been encouraged to follow suit (Collins et al., 2006; Dworkin et al., 2008; Norton et al., 2009). The DEBI diffusion site, (<http://www.effectiveinterventions.org>) thus serves as an information and resource clearinghouse for potential and actual implementers of these EBIs and a management and monitoring site for the CDC to track interest in, and activities related to, DEBI dissemination and implementation. MIP, as one of the 29 interventions in the DEBI compendium, is readily accessible for adoption and implementation by the numerous entities and stakeholders in a variety of community practice settings interested in HIV prevention, diagnosis, and treatment for injection drug users.

Chapter Summary

HIV/AIDS continues to disproportionately affect communities of color, thus establishing the need for population specific, community-centered, culturally competent evidence based HIV prevention strategies. This research study will elucidate many of the issues that emerged in the experiences of community partners who implemented and adapted the Modelo de Intervención Psicomédica (MIP). It is also expected that the information derived from this inquiry will help community-based organizations, health departments, government funders, and foundations, invest in, adapt, and maximize existing evidence-based HIV behavioral interventions that can be “made to fit” targeted communities in a manner that maintains the integrity of the intervention; yet responds to the need for culturally competent and relevant HIV prevention interventions.

Definition of Terms

To provide a common framework for discussing the literature, conducting the research, and interpreting and analyzing its findings, operational definitions for the terms used most frequently throughout this study are provided. For purposes of this research, an “EBI” is an effective behavioral intervention that has been identified by CDC as meeting specific “evidence of effectiveness” in formal research settings. “DEBI” refers to a collection of EBIs that have been selected by the CDC through a formal review process, “translated” into prevention intervention packages for community use, and diffused to community-based organizations and health departments for use with specific target populations at high risk for HIV/AIDS. **Table 2** provides a list of frequently used terms with accompanying definitions and definition sources.

TABLE 2: Operational Definitions of Key Terms

Key Terms	Definition	Source
Adaptation	The process of modifying key characteristics of an intervention, recommended activities and delivery methods, without competing with or contradicting the core elements, theory, and internal logic of the intervention thought most likely to produce the intervention's main effects.	McKleroy et al., 2006 p. 62
	The degree to which an innovation is changed or modified by a user in the process of its adoption or implementation.	Rogers, 1995
Capacity	The necessary motivation and ability to identify, select, implement, evaluate and sustain effective interventions.	Durlak & DuPre, 2008
Community	A group of people or organizations defined by function, geography, shared interests or characteristics, or by a combination of these dimensions in which members share some sense of identity or connection.	Mendel, Meredith, Sherbourne, & Wells, et al., 2008
Context	The environmentin which participants exist or reside, which filters the usability and applicability of the treatment intervention. It may encompass (a) sociostructural factors.; (b) economic factors.; (c) political factors; and (d) spiritual factors including religious practices/rituals and concepts of the supernatural.	Divieux, Malow, Rosenberg, &Dyer, 2004. Pg. 51

TABLE 2 continued		
Core elements	Required elements that represent the intent, theory, and internal logic of the intervention and most likely produce the intervention's main effects. Core elements define an intervention and must be implemented with fidelity to increase the likelihood that program outcomes in community settings will be similar to those demonstrated in the original research.	Mc Kelroy et al., 2006 p. 62
Dissemination	The spreading of innovations from the originators or developers to the intended users.	Saul et al., 2008a
	The targeted distribution of intervention information or materials to a specific public health or clinical practice audience.	Norton et al., 2009
Effectiveness	The extent to which an intervention works in a real world.	Lyles, Crepaz, Herbst, & Kay, 2006, pg. 26
Efficacy	The extent to which an intervention works in a highly controlled setting.	Lyles, et al., 2006, pg. 26
Implementation	A specified set of activities designed to put into practice an activity of known dimensions.	Fixsen, Naoom, Blase, Friedman, Wallace, 2005
	The use of strategies to adopt and integrate evidence-based health interventions and change practice patters within specific settings.	Norton et al., 2009
Innovation	New knowledge or information that can be useful to prevention efforts in the field. Such innovations are usually categorized as programs, processes, policies and principles.	Saul et al., 2008b
Key characteristics	Key characteristics are important, but not essential attributes of an intervention's recommended activities and delivery methods. They may be modified to be culturally appropriate and fit the risk factors, behavioral determinants, and risk behaviors of the target population and the unique circumstances of the venue, agency, and other stakeholders. Modification of key characteristics' should not compete with or contradict the core elements, theory, and internal logic of the intervention.	Mc Kelroy et al., 2006 p. 62
Translation	The process of converting (translating) scientific knowledge into practitioner friendly products to be used for implementation.	Wandersman et al (2008) p. 175

CHAPTER II. LITERATURE REVIEW

Chapter II provides a review of the literature and is organized into six major sections as follows: Section one presents an overview of the **research-to-practice dilemma** as an overarching theme in the process of information transfer from science to practice. Section two introduces **adaptation** as a focal area of interest for this study and as a critical element of the research-to-practice continuum. Section three is characterized by discussion of the **implementation** of evidence-based interventions in community-practice settings which serve as the hub for most program adaptations. Section four presents examples of **adaptation successes** identified in the literature which is followed by a discussion (Section 5) of the **cultural, capacity, content and community** factors most frequently cited in the literature to **impact program implementation and adaptation**. Section six presents a discussion of the **challenges and barriers** inherent in program implementation and adaptation and Section seven points to the limitations of current models and the implications for future research.

The Research-to-Practice Dilemma

Science can develop important new knowledge about prevention, but if that knowledge is not synthesized and translated, it will be accessible only to other scientists; it will not be user-friendly, and it is not likely to be widely adopted in prevention practice. (Wandersman et al., 2008, p.178)

The gap between science and practice is well-documented in the literature as an enduring challenge to public health practice and has been grappled with by almost every sector of the health and

human services field, including violence prevention (Guerra & Knox, 2008; Saul et al., 2008a), mental health and psychiatric rehabilitation (Miller & Shin, 2005; Mowbray, Gutierrez, Bellamy, Szilvagi, & Strauss, 2003a), physical fitness (Brownson et al., 2007; Brownson & Jones, 2009); occupational therapy (Sudsawad, 2005), substance abuse (Hawkins et al., 2002; Kumpfer, Pinyuchon, Teixeira de Melo, & Whiteside, 2008; Substance Abuse and Mental Health Services [SAMHSA], 2002) and HIV/AIDS (Bell et al., 2007; Galbraith et al., 2009; McKleroy et al., 2006; Somerville, Diaz, Davis, Coleman, & Taveras, 2006).

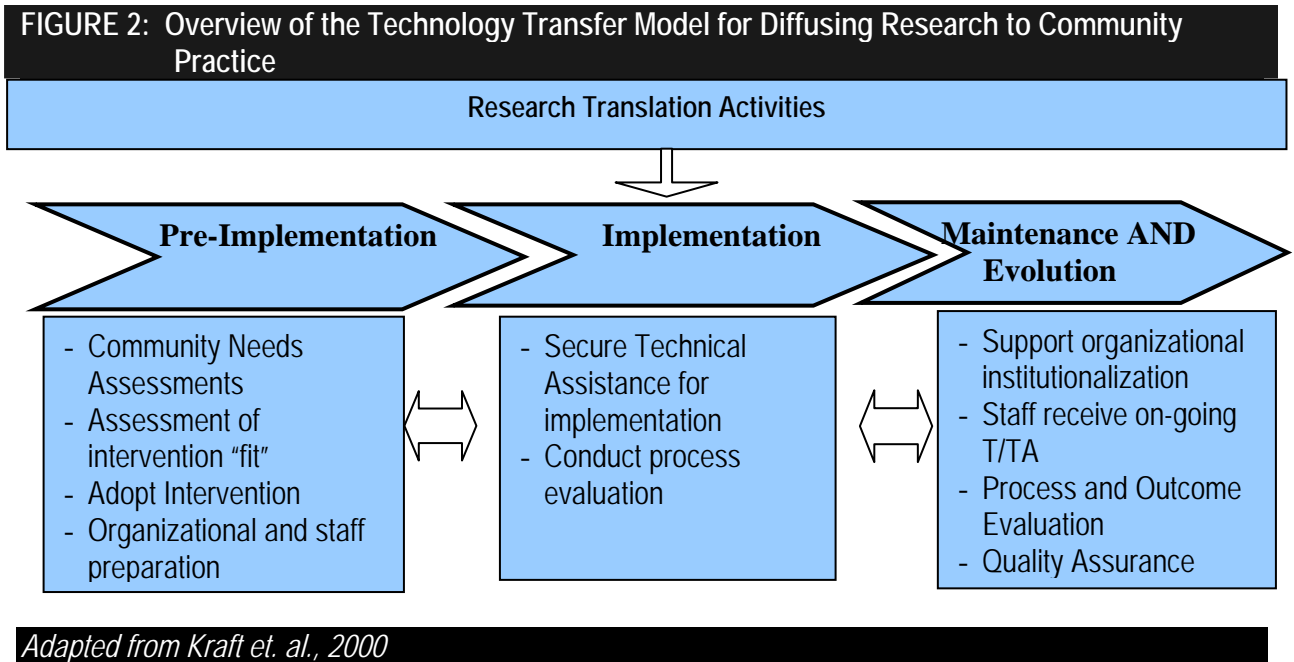
Support for the use of evidence-based strategies in community practice settings has increasingly gained momentum with funders, policy makers, and researchers as a means of enhancing investments in communities, expanding the utility of research beyond academia, and increasing the likelihood that proven strategies will be implemented, thus leading to successful program outcomes (SAMHSA, 2002). This enthusiasm for evidence-based practice at the community level has been simultaneously met with concern from community-based practitioners, program developers and researchers alike regarding the feasibility, compatibility, and usefulness of evidence-based research when applied at the community level (SAMHSA, 2002). The process of research translation, defined by Wandersman and colleagues (2008) as “the conversion of scientific knowledge into user-friendly products to be used by practitioners for program implementation” (p. 175), is the means by which evidence-based interventions (EBIs) transcend the research domain to become available to the community.

Several researchers (Emshoff, 2008; Lee, Altschul, & Mowbray, 2008; Miller & Shinn, 2005; Saul et al., 2008a; Saul et al., 2008b; Wandersman et al., 2008) have criticized this definition of research translation as over simplistic for not taking into account the priorities and needs of the community, the benefits and risks of the intervention to the community, and the resources available to implement EBIs with fidelity. Others point to the time gap between research conclusion and community

uptake of an innovation as a major impediment to putting evidence-based research into practice (Davis, Jamison, Brumley & Enguidanos, 2006). The consensus among these researchers is that the research translation process is resource-intensive and fraught with barriers, including environmental and situational circumstances that can negatively impact the acceptance, implementation and effectiveness of the EBI at the community level (Davis et al., 2006; McKleroy et al., 2006; Saul, 2008a; Wandersman et al., 2008). To abate these concerns, Saul and colleagues (2008b) have proposed that prior to undertaking the research translation process for any EBI that those involved consider, “what should be disseminated, at what cost, to whom, through what types of mechanisms, and what efforts should be put in place to support those activities?” (p. 197).

The technology transfer model used by CDC to disseminate EBIs considers these questions in its three-tiered approach to the dissemination of science to community practice settings. Pre-implementation activities, implementation and maintenance are the cornerstones of the model (Kraft, Mezoff, Sogolow, Neumann, & Thomas, 2000). Each phase is associated with specific activities and actions that allow for the planning, implementation and evaluation of the intervention in order to ensure effective service delivery (Kraft et al., 2000). Each phase also targets the participation of specific groupings of stakeholders inclusive of prevention practitioners and researchers, community planning groups, advisory boards, linking and external organizations, members of the target population, trainers and technical assistance providers.

Figure 2 below depicts the Technology Transfer Model, the activities associated with each phase of the model and adaptation as an on-going process within this model.



The HIV prevention interventions that are currently endorsed by CDC and recommended for community use has been disseminated through the DEBI Project (McKleroy et al., 2006) where research translation has already occurred and activities to encourage program dissemination, implementation, and maintenance at the community level are on-going. It is well recognized that although many EBIs in their translated form are “manualized” for immediate use within community practice settings, significant gaps still remain. For some populations, particularly those that are most marginalized and for whom few behavioral interventions exist, and in certain settings, particularly those that are rural and more isolated — the current menu of EBIs lack immediate application and relevance and therefore **must be adapted** to meet local needs (Lyles et al., 2007; Lyles, Crepaz, Herbst, & Kay, 2006; McKleroy et al., 2006; Saleh-Onoya et al., 2008). The need for **Adaptation** in such instances is underlined by the need for EBIs for populations most disproportionately impacted by the disease surpassing the availability of these interventions for the most vulnerable populations.

The most often cited definition for *adaptation* comes from the work of Rogers (1995) around the **Diffusion of Innovations theory** and reads “the degree to which an innovation is changed or

modified by a user in the process of its adoption and implementation.” In HIV prevention, researchers such as McKleroy and colleagues (2006) have added elements of fidelity to the definition of adaptation as:

the process of modifying key characteristics of an intervention, recommended activities and delivery methods, without competing with or contradicting the core elements, theory, and internal logic of the intervention thought most likely to produce the intervention's main effects. (p. 62)

Since concerns of **fidelity and effectiveness** are present whenever an EBI is selected for community implementation, adaptation becomes an integral part of the research translation-dissemination-practice continuum. Within this continuum “**adaptation**” is viewed as a strategic tool that can help support community practitioners and other stakeholders with the dissemination and implementation of EBIs that they are encouraged to implement within their respective settings.

Fidelity and Adaptation of Evidence Based Interventions in Public Health Practice

Delivery science is as important as 'discovery science' despite the former being overshadowed by the latter in most programs of research to date. (Norton et al., 2009, p. 424).

There is much discrepancy in the literature and in the practice settings as to what is considered an adaptation and when adaptation occurs (Castro, Barerra, & Martinez, 2004; Cohen et al., 2008; McKleroy et al., 2006; Saul et al., 2008b). In a series of articles related to program fidelity and adaptation, O'Connor, Small and Cooney (2007) note that in recent years dialogue has shifted from whether adaptation of EBIs was an acceptable practice to the types of program adaptation that are most acceptable and least likely to jeopardize fidelity. According to Castro and colleagues (2004) adaptation occurs when there is discrepancy between the activities of the intervention and local needs. Others conclude (Mowbray, Holter, Teague, & Bybee, 2003b) that adaptation is often “legitimate” when used to tailor programs to local circumstances and resources and to the social and cultural needs of the targeted communities. In conversations with the head of the Science Application Team at CDC’s-

DHAP, C. Collins (2007) notes that “adaptation occurs anytime a change is made to the prescribed intervention” (personal communication, July 27, 2007). O’Connor et al., (2007) suggest that adaptation logically occurs during program implementation, whether or not it is intentional, and Norton et al. (2009) points out that despite messages to the contrary, community-based organizations often alter interventions to compensate for resource restrictions or differences with the target population. These findings suggest that adaptation is done to accommodate the needs of the practitioner, agency, target population or community in an attempt to make an intervention more relevant, user-friendly, and effective in a situation, setting or context other than that which has been prescribed.

In the context of EBI implementation, several studies emphasize organizational factors (Castro et al. 2004; Dobbins, Cockerill, Barnsley & Ciliska, 2001; Durlak & DuPre, 2008; Mendel et al., 2008; Norton et al., 2009; Wandersman et al., 2008), environmental/community factors (Dobbins et al., 2001; Dworkin et al., 2008; Mowbray et al., 2003a; Wandersman et al., 2008), intervention characteristics (Castro et al., 2004; Glasgow & Emmons, 2007; Sudsawad, 2005), and individual characteristics (Brownson et al., 2007; Dobbins et al., 2001; Durlak & DuPre, 2008), as influencing variables that facilitate the need for adaptations in order to ensure implementation success and sustenance at the community level. Adaptation in such instances is viewed as all-encompassing and inclusive of additions, deletions, and modifications to program components, changes in the manner and intensity of intervention delivery, and cultural or other modifications necessary for increasing the relevance of EBIs for the target population; it also includes providing organizational support in implementation, and boosting community ownership and acceptance of these interventions (McKleroy, 2006; SAMHSA, 2002).

Although there is support for adaptation of EBIs in practice settings, there is also concern about “the boundaries”-- that is the nature, scope, and extent of an adaptation-- before it begins to dilute or jeopardize the anticipated positive outcomes expected from evidence-based interventions. As

a rule, interventions undergoing adaptation should be monitored to determine how and to what extent original core program components are changed in order to determine whether these changes facilitate or undermine intervention effectiveness (Backer, 2001; Durlak & DuPre, 2008; Rohrbach, Grana, Sussman & Valente, 2006). In their work on adaptation and program fidelity, Mowbray and colleagues (2003b) note that “populations in different locations have different strengths and needs; service systems have different goals and objectives; and communities often differ widely in availability of and access to resources” (p.335), thus warranting adaptation. The authors also acknowledge that when key elements of an intervention have been neglected or abandoned, contradictory or less positive outcomes have resulted, largely due to implementation failure (Mowbray, 2003b).

Researchers like Castro et al. (2004) have coined the term “fidelity-adaptation tension” to describe the disconnect between the scripted implementation guidelines provided to community practitioners as a blueprint for the implementation of evidence-based interventions in practice settings and the actual program modifications that are needed in order to meet the needs of local communities. These researchers endorse what they refer to as “hybrid prevention programs” that “build-in” adaptations in order to enhance intervention acceptability and implementation at the community level while still maintaining fidelity and program effectiveness (Castro et al., 2004; Lee et al., 2008). Conversely, others such as Rohrbach et al. (2006) object that even when adaptability is “built-in” to EBI implementation, this very feature makes fidelity even harder to achieve. Durlak & DuPre (2008) draw attention to the inappropriateness of the “either-or” debate surrounding fidelity and adaptation and instead suggests finding the right mix of both. According to Backer (2001) “attention to both program fidelity and adaptation during the complex process of program implementation is critical to successful, sustained implementation of science-based...prevention programs” (p. 2). Backer (2001) adds to the discourse by proposing a set of program implementation guidelines that attempt to address the “fidelity-implementation tension”. These guidelines are characterized by 12 steps:

(1) define the fidelity/adaptation balance; (2) assess community concerns; (3) review targeted program to determine fidelity/adaptation issues; (4) examine that program's theory of change, logic model, and core components; (5) determine the needed resources; (6) consider available training; (7) consider how to document adaptation efforts; (8) consult with the program developer; (9) involve the community; (10) integrate all prior steps into a plan; (11) include fidelity/adaptation issues into the program evaluation; and (12) conduct an ongoing analysis of fidelity/adaptation issues.

Ideally, these guidelines would be used by stakeholders (funders, practitioners, researchers) prior to performing program adaptations. Although these guidelines represent only one of the many perspectives offered in the literature on how to “solve” the fidelity-adaptation gap, it speaks to the level of complexity and skills required to conduct an adaptation, much of which appears beyond the scope of expertise of community-based organizations and the practitioners that implement the EBIs in those settings.

In a state-of-the-art review on program fidelity and adaptation in mental health and substance abuse prevention, SAMHSA (2002), acknowledged that “efforts to promote fidelity and engage in adaptation happen all the time, but of course not strategically or effectively as would be possible with better guidance” (p. 3). The review also maintained that over the years numerous studies have shown that “programs simply are not implemented with full fidelity no matter what exhortations or claims have been made” (p.21). Thus, “absolute fidelity” to original research protocol of EBIs is viewed by many (Backer, 2001; Castro et al., 2004; Lee et al., 2008; Miller & Shinn, 2005; Rorhbach et al., 2006; SAMHSA, 2002,) as an unrealistic goal for real-world implementation, which if one embraces, gives “permission” for program adaptation.

Among researchers who accept adaptation as a routine part of the research-to-practice continuum and not in conflict with it, the consensus is that program adaptation is appropriate as long as adaptations do not contradict underlying program theories, core elements or key activities and are reflective of local realities (Bell et al., 2007; McKleroy et al., 2006; Norton et al., 2009). In actuality, it

has been established that many of the EBIs implemented in community practice settings undergo some degree of intervention adaptation (Castro et al., 2004). Admittedly, confusion exists as to where the distinctions lie between “core” versus “adaptable” elements of an intervention (Dworkin et al., 2008). Hence, communities must be offered science-based adaptation strategies that provide guidance in the process and prevent questionable adaptations that may compromise the effectiveness of the EBIs that community practitioners are mandated to implement. Informing the best strategies and tools to assist practitioners and other stakeholders with the implementation and adaptation of EBIs is the focus of this research.

Program Implementation along the Research-to-Practice Continuum

Implementation is a process, not an event. Implementation will not happen all at once or proceed smoothly, at least not at first. (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, p.15)

To understand “adaptation” within the context of the research-to-practice continuum and the delivery of evidence-based interventions (DEBI), one must first identify the point at which organizations are first introduced to this concept. Although it is ideal for community members to be involved in the research translation process prior to dissemination and implementation, the reality is that with the exception of a few community-based representatives, organizations are initiated into the world of EBIs only after EBIs become available for community use, and usually through funder or policy mandates/recommendations to use evidence-based programs and practices. Such is the case with the CDC DEBI project which is the largest centralized effort by a U.S. federal entity to diffuse HIV prevention EBIs to communities (Dworkin et al., 2008). It is at the point of program adoption and subsequent implementation that most organizations become aware of the need for adaptation as they consider how best to implement EBIs within their respective populations and settings so that the benefits of the intervention can be realized. It is also during program implementation that fidelity issues

arise and adherence to intervention protocols become more challenging to monitor and secure (Cohen et al., 2008). The study of:

the methods, interventions (strategies), and variables that influence adoption of evidence-based healthcare practices by individuals and organizations to improve clinical and operational decision-making, [and the] testing and effectiveness of the interventions to promote and sustain [their use] is referred to as **implementation science**. (Titler, Everett, & Adams, 2007 p. s53).

Implementation science is viewed as considerably lagging behind the science of program development in research settings (Chambers, 2008; Fixsen et al., 2005; Rohrbach et al., 2006). According to SAMHSA (2002), the implementation process for evidence-based interventions is comprised of two main stages: program adoption and program implementation. Program adoption is the initial decision to implement a specific EBI based on needs, asset assessments and organizational readiness. Program implementation, the second stage, is multi-dimensional and includes a series of steps required for program execution including balancing program fidelity and adaptation, and ensuring “fit” between intervention and organizational characteristics; characteristics of the populations to be served; and the larger environmental context (i.e. support for the issue) where the program will be implemented.

Durlak & DuPre (2008) identified eight aspects to program implementations that combines the work of various researchers and include the following characteristics: 1) fidelity, 2) dosage, 3) quality of program delivery, 4) participant responsiveness, 5) program differentiation, 6) program monitoring of control/comparison conditions, 7) program reach, and 8) program adaptation. Durlak & DuPre’s (2008) inclusion of “adaptation” as an actual component of program implementation was among the few identified in the literature (Rohrbach et al., 2006; Solomon et al., 2006) directly linking adaptation to implementation of EBIs rather than as an external phenomenon necessary for program adoption, implementation, and evaluation, but not inevitably a part of these processes.

In one particular study examining the implementation of ten health promotion EBIs in primary care practices, Cohen et al. (2008) found that all interventions required changes as they were integrated into practice. Often, these changes were unanticipated and adaptation took place *during* program implementation as teams worked to accommodate various practice and patient circumstances while attempting to balance fidelity and flexibility of the intervention in a practice setting (Cohen et al., 2008). In another large-scale review of over 500 implementation studies evaluated in five meta-analyses, Durlak & DuPre (2008) confirmed that the level to which programs are implemented with fidelity is an important determinant of program outcomes. Moreover, the magnitude of differences in outcomes between mediocre implementation and robust implementation was profound, in that mean program effect was two to three times higher in carefully implemented programs (Durlak & DuPre, 2008). This finding thus supports the conclusion that high quality program implementation is essential for realizing the effectiveness of an EBI in a new setting or for a new population (Fagan, Hanson, Hawkins and Arthur, 2008).

Chambers (2008) summarized the constructs related to implementation research that resulted from a workshop sponsored by the National Institute of Mental Health (NIMH) to address the dearth of knowledge around implementation science. Multi-disciplinary teams of researchers, clinicians and community practitioners, theorists, and other stakeholders articulated several recommendations to further the implementation science agenda including:

- 1) developing organizational measurements to assess readiness for change, organizational culture, leadership and management support, and competing demands;
- 2) conducting social network analyses to examine relationships between and among individuals, organizations and the systems in which they are embedded;
- 3) infusing implementation constructs into research designs and approaches to ensure alignment between the research and the needs of influencing stakeholders, and

- 4) increasing fit between the intervention and the service settings selected for implementation (Chambers, 2008).

Many of the recommendations presented by Chambers (2008) appear to correspond with the earlier work of Fixsen and colleagues (2005) of the National Implementation Research Network (<http://www.fpg.unc.edu/~nirn/>) in one of the few conceptual frameworks for EBI implementation identified in the literature. The Framework for Implementation of Defined Programs and Practices (Fixsen et al., 2005) is comprised of six non-linear and overlapping stages: Exploration and Adoption, Program Installation, Initial Implementation, Full Operation, Innovation, and Sustainability-- all of which comprise an "implementation process". These stages are congruent to the key attributes and characteristics of the technology transfer model presented earlier (Figure 2), but with greater emphasis on **program implementation**. Although this model provided further insight on program implementation of EBIs, its limitation was in excluding adaptation and how it fit into the system, at what levels, through what mechanisms, and by whom. Thus, the study of implementation science remains underdeveloped in the literature indicating a need for further exploration on this particular phase of the research-to-practice continuum and the ensuing adaptations that are likely to occur in this phase.

Successes in Adaptation

A critical predictor of effectiveness is adaptability. If an efficacious intervention cannot be adapted to local contexts, it is highly unlikely that the intervention will be demonstrated as effective. (Collins, C.B., 2009, p. 416)

There are examples in the literature, albeit limited, of successful adaptations of HIV prevention EBIs from one population or setting to another. Somerville and colleagues (2006) for instance, reported on the adaptation of Population Opinion Leader, an HIV prevention intervention designed for white gay men which was subsequently modified for use with young Latino migrant men who have sex

with men (MSM) by taking into account the language needs, literacy skills, healthcare access, high mobility, and dearth of knowledge about HIV and STIs, as well as the poverty, racism, and homophobia experienced by this target population. Wainberg et al. (2007) identified HIV prevention interventions demonstrating effectiveness with U.S. psychiatric patients and conducted cultural adaptations of these interventions to specifically meet the needs of local Brazilian practitioners and their Brazilian patients with severe mental illness. The authors provided detailed accounts of the processes used to guide adaptation and pilot the changes with input from interdisciplinary and intercultural groups (Wainberg et al., 2007), thus contributing to the field of knowledge around guided adaptation of EBIs in settings and contexts different from its original form.

Cornelius, Moneyham & LeGrand (2008) adapted and validated SISTA-- Sisters Informing Sisters on Topics about AIDS-- an HIV Prevention EBI targeting young African-American women involved in heterosexual relationships for older African-American women in church settings. Based on input from a sample of women recruited from the target population, the authors modified content to be more inclusive of, and relevant to, older African-American women. Some noted changes included changing the name of the curriculum from SISTA to WIWTA - Women Informing Women on Topics about AIDS, updating the statistics and visuals for relevance to the population and modifying words and language to reflect the experiences of older African-American women.

Saleh-Onoya and colleagues (2008) also adapted the SISTA EBI to Black isiXhosa women in the Western Cape Province of South Africa with successful outcomes. The adaptation process involved participation from isiXhosa and English-speaking researchers, local stakeholders, clinicians, community practitioners, and members of the targeted population. This community approach to adaptation helped to secure local-buy-in and made the intervention more relevant to both the women targeted for the intervention and the intervention setting. Examples of adaption included replacing poems written by African-American women with isiXhosa poems, condensing the original five 2-hour

sessions to three 3-hour sessions, closing with local songs or beading activities, and translating the intervention into isiXhosa for implementation. The authors concluded that the core elements of the intervention remained intact but that cultural elements and themes regarding HIV risk among South African isiXhosa women were infused without compromising fidelity (Saleh-Onoya et al., 2008).

Considerations for Program Implementation and Adaptation: Culture, Capacity, Content, Community

The dominant themes that have been identified in the literature and highlighted in the previous examples as influencing program implementation and the subsequent adaptations that occur can be grouped into four major categories- **culture, capacity, content, and community**. These influencing variables have included leadership and administrative support at the organizational level (Davis et al., 2006; Fagan et al., 2008; Mowbray, 2003a; Rohrbach et al., 2006), intervention compatibility with the values and philosophy of implementing organization (Mowbray et al., 2003a; Rohrbach et al., 2006), provision of training and technical assistance to providers (Davis et al., 2006; Durlak & DuPre, 2008; Fagan et al., 2008; Rohrbach et al., 2006), proactive monitoring and evaluation (Fagan et al., 2008; Rohrbach et al., 2006), favorable program characteristics (eg., ease of implementation, flexibility) (Durlak & DuPre, 2008; Fagan et al., 2008; Rohrbach et al., 2006), favorable characteristics of program providers (Davis et al., 2006; Rohrbach et al., 2006), organizational structure (Greenhalgh et al., 2004; Rohrbach et al., 2006), and community support for intervention (Durlak & DuPre, 2008; Fagan et al., 2008; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004).

These broad-based themes--**culture, capacity, content and community**--have been reported as both facilitators and barriers to successful program implementation and adaptation. "Success" in program adaptation is largely defined as adaptations that have retained fidelity and demonstrated positive outcomes in implementation (community practice) settings. "Barriers" to

adaptation are discussed in the context of program implementation challenges which often warrant adaptation in order to enhance program relevance and effectiveness in community practice settings. Each major theme is discussed below in detail as per findings in the literature.

Cultural Considerations

Cultural adaptations, more so than any other type of adaptation, are labeled in the literature as “more acceptable” because they are known to have little to no impact on intervention effectiveness (Kumpfer et al., 2008; O’Connor et al., 2007), yet yield significant returns on relevance and applicability to targeted groups. In cultural adaptations, the goal is to enhance intervention validity by addressing the cultural influences that impact health, illness and health behaviors so that interventions can be tailored to specific cultural contexts thus increasing acceptance and effectiveness at the community level (Divieux, Malow, Rosenbergg, & Dyer, 2004). These types of adaptations usually occur during research translation and/or implementation as a means of attending to the needs and realities of the cultural groups slated to receive the intervention.

An example of a successful cultural adaptation was the *Strengthening Families Program*, a well-established EBI for substance abuse prevention that was first developed in the 1980’s. The Program which was adapted for use with racial/ethnic minority populations in the U.S in the 1990s, was further disseminated and adapted for international use in the 2000’s, and to date has been implemented in 17 countries with marked success. The authors reported that the “overriding principle” to fidelity within these cultural adaptations was to keep program components intact (Kumpfer et al., 2008). Changes to the timing, dosage of the intervention, topic lessons, and session flow and content was deemed unacceptable and found to reduce effectiveness. On the other hand, the addition of culturally appropriate materials such as welcomes, blessings, stories, videos, songs, exercises and

examples to the intervention was shown to increase participant engagement and retention in the program (Kumpfer et al., 2008).

In implementing a youth violence prevention EBI with immigrant Latino youth, Guerra & Knox (2008) found that both the culture of the target population *and* the culture of the implementing organization were equally influential in determining intervention effectiveness. Researchers and community practitioners worked together to select an appropriate EBI based on intervention content, agency capacity, and local culture. Training then commenced and adaptations were conducted to mediate the cultural nuances of the target population and ensure “fit” with the practices and protocols of the implementing organization. The authors surmised that although most EBIs were designed to be generalizable across diverse populations, more attention needs to be placed on the cultural, historical, social, psychological and environmental factors influencing uptake at the community level (Devieux et al., 2005; Guerra & Knox, 2008).

Cultural considerations are considered even more relevant when it comes to the implementation of HIV prevention EBIs. Because HIV/AIDS has reached epidemic proportions in the U.S. and worldwide, and because there are fewer EBIs than the extent of the epidemic warrants, cultural adaptations of existing EBIs takes on new urgency in HIV prevention (Solomon et al., 2006). In their work with low literacy and minority individuals at increased risk for HIV infection, Devieux et al., (2005) noted that the cultural practices and social and structural barriers that increased HIV risk among culturally diverse populations were the same factors that impeded intervention effectiveness when not addressed. As such, the authors recommended integrating culturally relevant materials into the research translation and implementation processes to ensure the appropriateness and acceptability of the intervention for the target audiences (Devieux et al, 2005).

Other researchers have affirmed that cultural adaptations, when conducted to address differences between the original research and current target populations/cultural settings, often make

programs as effective or even more effective than what had previously been reported in the original research (Kelly et al., 2000; Solomon et al., 2006). Specifically in the HIV prevention field, adaptations that are tailored to the linguistic needs, developmental levels, and cultural backgrounds of its target audiences have been shown to enhance community support, client participation, program satisfaction and outcomes, and program institutionalization (Solomon et al., 2006). These findings suggest that the HIV prevention interventions that are adopted by communities need to be a “good” cultural fit in that the theories, assumptions, activities, and values of the intervention must be congruent to those of the implementing organization, the community practitioners who work there, and the consumers who seek services from these organizations.

Capacity Considerations

“Building capacity is an important part of the process of promoting effective prevention.” This assertion by Wandersman et al. (2008, p.176), is indicative of the widespread agreement in the literature that there is the need for strong infrastructure and systems to carry out the functions of evidence-based prevention practice (Fixsen et al., 2005; Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Guerra & Knox, 2008; Norton et al., 2009; Wandersman et al., 2008). According to Flaspohler et al. (2008) capacity is the intersection between research and practice and is distinguished by level (individual, organization, and community), and by type (general capacity or capacity specific to the intervention). General capacity building is based on the notion that well-functioning organizations are better equipped to implement EBIs. General capacity activities focus on enhancing the skills and characteristics of individuals and the infrastructure, abilities, and motivation of organizations and communities to implement EBIs. Innovation-specific capacity refers to the motivation, skills, and human, technical and fiscal conditions necessary to implement a specific intervention.

Both types of capacities are applicable at the individual, organizational and community levels (Flaspohler et al., 2008). At the individual level, perceptions related to the need for and benefit of the innovation all influence implementation. As well as provider knowledge, skill set, values and attitudes toward the intervention and their motivation to implement the intervention (Durlak & DuPre, 2008, Guerra & Knox, 2008). At the organizational level, leadership structure and management style, resource availability, staff capacity, external linkages, and compatibility between intervention “fit” and organizational climate were all found to impact implementation (Guerra & Knox, 2008). Finally, at the community level, factors that increase implementation success included community awareness of problem and the readiness, resources, social capital and leadership required to address the problem (Guerra & Knox, 2008).

Wandersman et al. (2008) recognized that organizations, individuals, and communities have varying levels of capacity to implement prevention interventions. As such, gaps between the requirements of prevention programs and capacity to meet them in any of the three areas (individual, organizational or community) can lead to dissemination or implementation failure (Flaspohler et al., 2008; Miller & Shinn, 2005). Implementation failure is known to occur when there is discrepancy between the characteristics and resources required to execute an intervention and the availability of those resources and/or capacity to obtain them in applied settings (Glasgow & Emmons, 2007). Miller & Shinn (2005) also point out that when the capacity gap is large, organizational performance is adversely impacted due to the burden placed on the human and other resources within the organization.

The CDC's Science Application Team has attempted to address the deficit in the literature with regard to the elements of capacity most related to EBI implementation success by proposing a model comprised of six domains of organizational capacity for EBI implementation consisting of: 1) organizational environment, governance and programmatic infrastructure, 2) workforce and

professional development, 3) resources and support, 4) motivational forces and readiness, 5) learning from experience, and 6) adjusting to the external environment (Collins et al., 2007). From the perspective of funders attempting to identify agencies with the capacity to implement new interventions, these categorizations can assist in decision-making. Organizations demonstrating high levels of capacity in these areas are funded to implement EBIs in their respective settings with the expectation that implementation will be conducted with fidelity and positive outcomes achieved. Likewise, these criteria can also be used by community-based organizations (CBOs) as a benchmark for gauging their own capacity to implement EBIs and identifying capacity building needs in areas where they may have fallen short.

Content Considerations

The characteristics of an intervention, that is, the content, flow, dosage, number, frequency and length of sessions, method of delivery, and activities and exercises, all influence the adoption and implementation of an intervention at the community level. Characteristics of an intervention such as its adaptability, flexibility, and compatibility with the organization's current mission, priorities, and existing practices also influence implementation (Durlak & DuPre, 2008). The literature suggests that modifications to standardized intervention content are among the riskiest of adaptations since they often threaten the effectiveness of interventions in the setting in which they are being implemented (O'Connor et al, 2007; SAMHSA, 2002). Content adaptations have often been blamed for the "unexplained" program outcomes reported by CBOs and for failure of interventions to "work" in their respective settings. In the literature, the gold standard for guiding EBI implementation and adaptation is to define and adhere to the core elements (sometimes referred to as core intervention components) of an intervention (Bell et al., 2007; Dworkin et al., 2008; McKleroy et al., 2006).

Several researchers (Miller & Shinn, 2005; Norton et al., 2009) have noted that many EBIs lack clearly identified core elements, and even when they are defined, they are still subject to adaptation. Core elements are considered the “untouchables,” whereas, the key characteristics of an intervention are allowed to be tweaked (within reason) to better accommodate the needs of community practitioners in their respective implementation settings. Galbraith et al. (2009) concluded that although adherence to an intervention's core elements is essential to maintaining intervention effectiveness and fidelity, the processes for identifying core elements of EBIs continues to be underdeveloped, thus making it difficult to adhere to ambiguous or incomplete guidelines around program implementation and adaptation of EBIs. Durlak & DuPre (2008) support this assertion by pointing to the lack of information in implementation studies regarding the specific intervention components that were either reproduced faithfully or altered to a new context. These deficits indicate that basing adaptation on adherence to core elements still leaves community practitioners with the task of figuring out how much and what types of adaptation are most feasible without compromising intervention efficacy. Norton et al. (2009) assert that although the identification of core elements is a great start in addressing fidelity-adaptation tensions, more research is needed to determine the extent to which different core intervention components impact behavior change, both individually and collectively.

The most noted content adaptations that have been reported in the literature as acceptable include use of updated statistics (Cornelius et al., 2008; Fagan et al., 2008), infusing culture into program content (See “Cultural Considerations” above), and language or word changes (Cornelius et al., 2008; Saleh-Onoya et al., 2008). Adaptations noted as most detrimental to intervention fidelity included significant deviation from the interventions' theoretical bases and recommended practices, including adding or deleting session content, activities or exercises, decreasing time spent on specific activities (Fagan et al., 2008; SAMHSA, 2002) and changing core elements (O'Connor et al., 2007; SAMHSA, 2002).

Community/Environmental Considerations

The adoption, implementation and sustainability of EBIs in community practice settings is influenced as much by the characteristics of an intervention and the capacity of implementing organizations as it is by the larger community and environmental context in which these interventions are implemented. For purposes of this discussion “community” embodies an ecological perspective which refers to interpersonal, institutional, and community issues. A community perspective allows one to observe the interaction and behavior of policy-makers, community practitioners, organizations and consumers of services within an organized setting characterized by identifiable norms, routines, policies, social and professional networks and systems of support (Mendel et al., 2008). These factors, in turn, influence how well EBIs are disseminated, accepted, adopted, implemented and sustained within communities. The range of skills required to operationalize EBIs in community practice settings goes far beyond the scope of research institutions or any single organization or individual, and requires the advocacy, acceptance and buy-in of the larger community (Haines, Kuruvilla & Borchet, 2004) within an overarching cultural and socioeconomic environment. Further, the capacity of communities is inextricably linked to the capacity of the health and human service organizations that operate within these settings (Flaspohler et al., 2008) and the social capital of consumers accessing services from these entities.

Researchers such as Dworkin and colleagues (2008) have expressed concern regarding the lack of attention given to community capacity and preparedness to adopt and implement EBIs. The authors contend that prior to dissemination, the community’s knowledge and understanding of the presenting issue and readiness to address the issue must be assessed. The authors suggest that information on the community’s perception of the research processes and products be examined in order to address misconceptions or concerns that may hamper acceptance in that setting (Dworkin et al., 2008). Durlak & DuPre (2008) have also recognized community context as a major influencing

factor for effective program dissemination and implementation. In a review of 81 studies examining program implementation, the most common community factors identified as influencing implementation included politics, funding, policy and prevention research and theory (Durlak & Dupre, 2008). These factors were reported to either enhance or impede the implementation and success of programs at the community level. For example, Greenhalgh et al. (2004) found that external mandates or policies could influence intervention adoption and ensuing success, especially when funding was directed toward implementing a particular intervention. Haines et al. (2004) and Mendel et al. (2008) have both cited the media and social marketing initiatives as additional community/environmental factors that help engage and shape the larger public's perception of an intervention, thus influencing the potential acceptance and adoption of an EBI in that practice setting or community. In several studies where the adaptation of EBIs from one population or setting were the focus (Saleh-Onoya 2008; Wainberg et al., 2007; Wingood & DiClemente, 2008), the researchers reported securing larger community-wide participation in intervention dissemination and adoption in order to increase community-wide acceptance of the intervention and address any community context issues. However, almost all studies failed at ensuring the same level of stakeholder involvement in the implementation of the research findings (Haines et al., 2004).

Despite this lack of empirical evidence supporting the role of community capacity in predicting improved prevention implementation, the overwhelming assumption is that communities with greater capacity have the ability to identify and address problems and leverage the resources and support necessary to sustain best practices and promising interventions in their respective settings (Flaspohler et al., 2008).

Adaptation Challenges and Pending Issues

Build it – and they will never know about it...
Build it –and they will find it irrelevant to their needs
Build it—and they won't be able to afford to come
Build it –and they will come and rebuild it as something unrecognizable....
(Emshoff, 2008, p. 393)

The above commentary by Emshoff (2008) captures the disassociation that often occurs in the translation of promising research to sound practices used in the field. It is a sentiment articulated by other researchers who affirm that that diffusion of EBIs is necessary but not sufficient to the success of technology transfer to communities (Dworkin et al., 2008) and in fact, yields diminishing returns as the process unfolds (Durlak & DuPre, 2008). Even with the few reported adaptation successes that were identified in the literature, the implementation and adaptation of EBIs with fidelity continues to pose a challenge for stakeholders across the research-to-practice discourse (Haines et al., 2004; Rotheram-Borus et al., 2009).

A review of the research revealed that the barriers to program adaptation have not always been explicit, but instead are often discussed in the context of program implementation. Although the conceptual models and theories used to explain the research-to-practice continuum consider adaptation a part of the process, when successful program implementation is discussed it is often done by emphasizing the lack of modification to a prescribed program, or the lack of adaptation. The literature also tends to distinguish between adaptations that are considered "intentional" and therefore more mindful of fidelity, and those that are unintentional and likely to compromise fidelity (Lee et al., 2008; O'Connor et al., 2007). Norton et al. (2009) warns that the dissemination of interventions with rigid adherence demands or those that are prohibitive of adaptation will lead to resistance from organizations and community practitioners, thus resulting in poor uptake. Such resistance to the adoption and implementation of EBIs in community practice settings is often the result of real and

perceived inconsistencies with local values, cultures, and capacity that takes precedence over the scientific backing of the intervention (Emshoff, 2008).

As the literature demonstrates it is also possible to adapt a program in ways that undermine the positive outcomes of an intervention, even when attempting to increase relevance and applicability in local settings. In one of only a handful of studies identified in the literature examining the adaptation of HIV prevention EBIs in community practice settings, Galbraith et al. (2009) found that of the 34 organizations implementing the *Focus on Youth* HIV prevention intervention, none implemented all core elements of the intervention with fidelity. As many as half of the implementing organizations deleted or changed recommended activities or added additional activities. Reasons cited for deletions included time constraints and lack of resources. Curriculum changes, including additions to the curriculum, were explained as necessary for increasing suitability for targeted audiences (Galbraith et al., 2009).

Veniegas, Kao, Rosales, & Arellanes, (2009) similarly examined the implementation of several different HIV prevention EBIs at 34 community-based organizations in Los Angeles County and yielded findings comparable to those reported by Galbraith et al. (2009). In the study, half of all participants reported “inadequate fit” between the interventions they selected and the populations targeted to receive services. Participants also reported having to modify key characteristics of EBIs either on their own accord or based on the request of a funder, but always with inadequate or contradictory guidance from their funder or designated technical assistance provider (Veniegas et al., 2009). Other identified barriers to intervention adoption and implementation in this study included lack of information about and access to materials for certain EBIs, limited agency resources to support EBI implementation, and under-guided or misguided adaptations (Veniegas et al., 2009).

In their discussion of implementation fidelity for various EBIs across multiple settings, Fagan et al. (2008) concluded that even with an awareness of the benefits of what they termed “implementation

integrity," community-based organizations still did not fully adhere to program implementation guidelines. The authors surmised that the overwhelming lack of fidelity in the delivery of EBIs in community practice settings could best be improved through training, technical assistance and program monitoring (Fagan et al., 2008).

In documenting the experiences of CBOs in adapting six different HIV prevention EBIs for adolescents, Bell et al. (2007) found that both structural and cultural barriers were encountered by program implementers. Changes to the interventions occurred for two main reasons: 1) to accommodate local constraints and realities in practice settings, including organizational capacity to implement the intervention and community support for the intervention, and 2) to address unmet needs among the target population inclusive of cultural and environmental considerations. The authors noted that the process of adaptation proved to be a struggle among participating organizations, even when the original researchers were involved in these adaptations (Bell et al., 2007)--most likely due to the lack of standardized guidelines regarding how to adapt and what to adapt without compromising EBI fidelity and anticipated positive outcomes for the targeted populations.

Discussions of the numerous challenges that occur along the research-to-practice continuum were abundant in the reviewed literature, and these examples illustrate that the path from research translation to community practice is not a linear route, but one with multiple twists and turns. Major themes and challenges are summarized in **Table 3**. In following the earlier categorizations on adaptation, barriers to **program implementation** are categorized according to the same themes – **culture, capacity, content, and community/environmental factors**, with an additional focus on the **research translation process** prior to EBIs becoming available to communities.

TABLE 3: Barriers to Program Adoption and Implementation along the Research-to-Practice Continuum

Research translation process

- Timing of information transfer from research-to-practice (Davis et al., 2006; Lee et al., 2008).
- Relevance of the research to the priorities in the field (Glasgow & Emmons, 2007; Shriver, deBurger, Brown, Simpson, & Myerson, 1998; Sudsawad, 2005).
- Expectation for interventions to be replicable, applicable, and easily scaled up for widespread use (Bell, et al., 2007; Glasgow & Emmons, 2007; Shriver et al., 1998).
- Tension between generalizability and fidelity (Bell et al., 2007; Fagan et al., 2008; Sudsawad, 2005).
- Information on intervention not easily available and accessible to community (Saul et al., 2008; Shriver et al., 1998; Veniegas et al., 2009).

Organizational contexts in which interventions are implemented

- Organizational readiness and preparedness for new innovation; competing demands (Flaspohler et al., 2008; Glasgow & Emmons, 2007; Norton et al., 2009).
- Ideological values, norms, inconsistent with research evidence (Haines et al., 2004; Miller & Shinn, 2005; Norton et al., 2009).
- Mismatch between research design and what communities have the capacity to implement (Glasgow & Emmons, 2007; Miller & Shinn, 2005).
- Inadequate infrastructure including human, financial, structural resources (Bell et al., 2007; Fixsen et al., 2005; Flaspohler et al., 2008; Glasgow & Emmons, 2007; Haines et al., 2004; Mendel et al., 2008; Solomon et al., 2006; Veniegas et al., 2009).
- Organizational culture, climate and work attitudes that enhance or obstruct implementation (Fixsen et al., 2005; Flaspohler et al., 2008; Glasgow & Emmons, 2007; Mendel et al., 2008; Miller & Shinn, 2005; Norton et al., 2009).
- Organizational linkages, relationships and reputation within community (Chambers, 2008; Greenhalgh et al., 2004; Flaspohler et al., 2008; Mendel et al., 2008).
- Organizational leadership and administrative support (Chambers, 2008; Davis et al., 2006; Flaspohler et al., 2008).

Characteristics and content of the interventions

- Efficacious programs tested with specific target population in a single cultural context (Glasgow & Emmons, 2007; Solomon et al., 2006).
- Intervention intensive and demanding on staff, organization and participants; require elaborate set-up, costly, and time and resource-intensive (Glasgow & Emmons, 2007; Sudsawad, 2005).
- Cultural mismatch between intervention and CBO target population (Bell et al., 2007; Kumpfer et al., 2007; Solomon et al., 2006; Veniegas et al., 2009).
- Not understandable or useable; not developed, packaged, “manualized” with end-user in mind; not customizable (Glasgow & Emmons, 2007; Shriver et al., 1998).
- Intervention does not address emergent needs of the target population (Bell et al., 2007).

Macro-level factors at the Community level – Health Systems, Politics, Policy, Economics

- Limited community involvement and participation in research-to-practice processes (Flaspohler et al., 2008).
- Lack of community support for the intervention (Bell et al., 2007; Dworkin et al., 2008; Wandersman et al., 2008).
- Limited social capital – power, relationships, resources (Chambers, 2008; Flaspohler et al., 2008).
- Health policies that fail to promote and support prevention activities (Haines et al., 2004).
- Political climate and influence of social fads and trends for particular health issues (Haines et al., 2004; Mendel et al., 2008)
- Support System ill-prepared to provide the level of training, technical assistance and capacity building support needed (Fagan et al., 2008; Flaspohler et al., 2008; Lee et al., 2008; Norton, et al., 2009; Saul et al., 2008a; Veniegas et al., 2009).
- Limited guidance and lack of in-depth information on adaptation and transportability of innovations (Davis et al., 2006; Fixsen et al., 2005; Saul et al., 2008b; Veniegas et al., 2009).

Limitations of Existing Adaptation Models and Future Research Directions

Although there is widespread consensus in the literature that adaptation “naturally occurs” during program adoption and implementation, the “act” of adaptation with fidelity is still presented as a skill or process beyond community reach to be undertaken only with guidance from the experts. The reported successes in the literature were almost always researcher-driven (Kumpfer et al., 2007; Saleh-Onoya et al., 2008; Wainberg et al., 2007; Wingood & DiClemente, 2008) but with significant participation from the individuals and organizations within the community where the intervention was being implemented. The underlying problem though is that if community-based organizations either choose or are mandated to implement EBIs, there should be an “expectation of adaptation” that occurs along with that task; yet, the limited adaptation “guidelines” that were found were: 1) in the academic literature which has limited circulation in community practice settings, 2) focused on “what to do,” rather than the “how to do it” that community-based practitioners need, 3) mostly directed at pre-

implementation activities of selection and adoption, instead of the full spectrum inclusive of implementation and sustainability, and 4) comprised of complex steps requiring high skill levels and input or participation from original research development teams.

The CDC (McKleroy et al., 2006) has proposed a systematic approach for adaptation of EBIs through its map of the adaptation process developed to assist CBOs with the selection, implementation, adaptation and evaluation of EBIs. The model which occurs in five steps emphasizes community and implementing agency input via feedback loops built into the adaptation process. The steps include an assessment of the target population, EBI choices, and agency capacity to implement an EBI. The completion of these steps is followed by the selection of an EBI and a decision about whether to adopt the intervention or conduct an adaptation. If an organization chooses to adapt the intervention, materials are then modified and preparation begins for program implementation. Finally, the agency pilots the new intervention and then conducts the intervention routinely without modification. There is overlap throughout the process of adaptation so that feedback is easily applied to the process and program implementation remains on-course (McKleroy et al., 2006).

Other than entities such as the CDC, Wingood & DiClemente (2008) were among the few researchers to have proposed an adaptation model specific to HIV-related EBIs. The "ADAPT-ITT" model consists of eight sequential phases that guide HIV prevention providers and researchers in adapting EBIs.

Phase 1 includes an assessment of new populations/populations of interest;

Phase 2 involves the review and selection of an EBI for adoption or adaptation;

Phase 3 focuses on adaptation, and entails pre-testing the intervention with new target populations; production characterizes;

Phase 4 refers to the development of the first draft of the adapted EBI;

Phase 5 involves the identification of topical experts to supplement the content of adapted EBI;

Phase 6 which centers on integration requires developing second and third drafts of the EBI with input from content experts and after testing for readability;

Phase 7 includes training all personnel involved in the implementation of the new EBI on the intervention, including facilitators, and administrative and data management staff; and,

Phase 8- involves testing the adapted EBI to gauge success in achieving short-term outcomes and conducting a second randomized study with the adapted intervention (Wingood & DiClemente, 2008).

Solomon et al. (2006) offered the most straightforward proposal for undertaking program adaptation from the perspective of community practitioners tasked with adapting EBIs to meet local needs. These predominantly practitioner driven steps included:

- knowing the target population and community context;
- selecting the programs that best match the population and context;
- retaining fidelity to core program components;
- systematically reducing mismatches between the program and its new context;
- documenting the adaptation process; and
- evaluating process and outcomes of the adapted intervention.

The issue with both the CDC model (McKleroy et al., 2006) and the ADAPT-ITT model (Wingood and Di-Clemente, 2008) is that they were both heavily researcher-focused with a top-down approach and required specific skills sets in order to apply the intricate steps that were part of each phase. Depending on capacity, a CBO may or may not be able to implement these steps or have the time and resources to do so; yet, they are still either encouraged or mandated to use and/or adapt existing EBIs within their respective settings. Although Wingood and DiClemente (2008) are critical of the complexity of the CDC's model, they present the ADAPT-ITT model which is as researcher-focused and involved, and even more intricate, resource-intensive, and time-consuming than the CDC model.

Although Solomon and colleagues (2006) and Lee et al. (2006) attempt to offer a more simplistic model, it lacks the detailed guidance needed to implement these steps in a real-world setting. Consequently, community-based practitioners are ill-equipped to serve their constituents and left with a major conundrum perhaps best described by Rotheram-Borus et al. (2009):

HIV is a moving target and we have not achieved our prevention goals. It should not take years to get new programs into the field or to address evolving needs. Current practices for the dissemination and adaptation of EBI rely on a complex set of logic models and a locked step sequence of repeat testing, adaptation and implementation. These practices pre-suppose a level of expertise unavailable to the CBOs who do not have the time or funding to invest in the capacities necessary to ensure adaptation with fidelity of a specific intervention to a new target population. (p. 406).

Based on the adaptation models that have been identified to guide community based practitioners in program implementation and adaptation, the questions that appear pertinent to the chasm between what is recommended and what one has the capacity to do, is:

- How does adaptation as a practice tool become more feasible, accessible and within reach of CBOs?
- Are there basics steps or strategies an “average” CBO can use to adapt EBIs with fidelity?
- Can CBOs conduct adaptation on their own or do they require certain expertise, and if so, what support should be provided to CBOs to facilitate the implementation and adaptation of EBIs?

Questions such as these, prompt several researchers (Brownson & Jones, 2009; Durlak & DuPre, 2008; Fixsen et al., 2005; Glasgow & Emmons, 2007; Mendel et al., 2008; Norton et al., 2009; Wandersman, et al., 2008) to focus their inquiries on the implementation and sustainability of evidence-based interventions within community and health care settings. For instance, Norton et al. (2009) called for more targeted research to “determine how much and what type of adaptation to core intervention components is tolerable, non-consequential to demonstrated efficacy and...even an improvement to

the intervention" (p. 427). Mendel and colleagues (2008) note that while several studies have been successful in establishing models of care, they have not provided enough information and guidance on how best to sustain multi-level, multi-modal interventions involving multiple stakeholders in settings within various locales and systems of care. As such, they have delineated the following set of research questions specifically intended to close the research-to-practice gap, especially as it pertains to implementation of EBIs in community practice settings.

- *How best to understand and assess the relevant contextual factors and dynamics affecting the dissemination, implementation, and sustainability of interventions within community and healthcare settings,*
- *How to effectively identify, develop, and evaluate new strategies for tailoring, disseminating, and implementing relatively complex interventions across a variety of healthcare and community stakeholders and contexts,*
- *How to provide useful formative feedback to investigators and other partners to guide the dissemination and implementation of interventions without jeopardizing evaluation objectives,*
- *How to build capacity among academic and other stakeholders both for dissemination and evaluation of interventions in healthcare and community settings, and*
- *How to meaningfully generalize findings and pool results across varied dissemination and implementation studies? (Mendel et al., 2008, p. 23)*

These questions present a large undertaking for the research-to-practice discourse that is both beyond the scope of this research study and what currently exists in the literature on implementation science and adaptation in particular. However; it elevates the currency and relevancy of the question of how community-based organizations approach and address the implementation and adaptation of EBIs. In relation to the broader research framework proposed by Mendel et al. (2008) this dissertation research will shed light on the above questions by examining the experiences of community-based organizations with the implementation and adaptation of MIP in their respective settings in the following ways:

- 1) Explore the relevant contextual factors and dynamics affecting the implementation of EBIs within community practice settings;
- 2) Provide insight as to the strategies used in community practice settings to implement and adapt complex EBIs;
- 3) Identify the capacity building needs of organizations and practitioners implementing EBIs in community practice settings; and
- 4) Provide feedback and results to various stakeholders that will inevitably help guide the dissemination and implementation of EBIs in community practice settings.

The proposed methods that were used to undertake this inquiry are presented in detail in the next chapter.

CHAPTER III. METHODS

Conceptual Framework

Research-to-practice models begin with the researchers and research, while community-practice models begin with the world of practice. (Wandersman et al., 2008, p. 173)

Based on the literature reviewed and the aims of this study, the conceptual framework used to explore *how implementation and adaptation of evidence-based interventions are applied in community practice settings using lessons learned from the Modelo de Intervención Psicomédica* is the **Integrated Systems Framework (ISF) for Dissemination and Implementation** developed by Wandersman et al. (2008). ISF is one of the few *community-centered* models identified in the literature that focuses on dissemination *and* implementation processes, rather than solely on the former. The most commonly cited theoretical framework offered in the literature to explain the journey from research translation to adoption and application at the community level is Rogers' (1995) Diffusion of Innovations (DI) which features a series of linear steps in which ideas, practices, or products are transferred from the source (research settings) to the user (community). The focus of DI is on the dissemination and adoption of new "innovations" among members of a social system (Rogers, 1995), more so than on the pre-implementation and implementation processes of EBI application or the infrastructure or systems needed to carry out these functions (Wandersman et al., 2008). Several authors (Fixsen et al. 2005; Flaspohler et al., 2008; Guerra & Knox, 2008) maintain that DI provides guidance up to the point of adoption of an innovation but falls short on providing direction on the actual implementation of an innovation with fidelity. They further conclude that although the adoption process

lends itself to supporting implementation and maintenance of an EBI, such support does not substitute for the actual functions and processes implicit in implementation. The ISF model includes the research translation and adoption processes that are defined within DI theory but also focuses on intervention implementation and sustainability at the community level, including the role of adaptation along the research-to-practice continuum (Wandersman et al., 2008).

ISF follows a community-centered model which purports to consider community needs in the context of the resources and capacity (individual, organizational, and community) required to respond to those needs (Flaspohler et al., 2008; Wandersman et al., 2008). ISF is defined by three major dimensions that span the research-to-practice continuum; each differentiated by specific yet interacting functions resulting in the application of evidence-based interventions in community practice settings. Dimensions include: 1) prevention research and synthesis (dimension 1), prevention support systems (dimension, 2) and prevention delivery systems (dimension 3).

- **Prevention research and synthesis** refers to the development, evaluation, synthesis and translation of research and scholarly literature to prepare it for dissemination and implementation (Guerra & Knox, 2008; Lee et al., 2008; Saul et al., 2008a; Wandersman et al., 2008)
- **Prevention support systems** focus on supporting and building the capacity of the “system”; that is practitioners, organizations and communities, to deliver the interventions. This building is done via two mechanisms: 1) innovation-specific support which refers to capacity building specifically related to the adoption, adaptation, implementation of an EBI, and 2) general capacity-building which refers to the provision of technical assistance to enhance the broader organizational infrastructure, skills, and motivation, without emphasis on a particular EBI. (Lee et al., 2008; Saul et al., 2008a Wandersman et al., 2008).

- **Prevention delivery systems** refer to the practice settings in which interventions are implemented with target populations and the actions taken by individuals, organizations and communities to execute these interventions (Lee et al., 2008; Saul et al., 2008a; Wandersman et al., 2008).

The nucleus of the ISF model is on the infrastructure and systems needed to perform the functions necessary for the dissemination and implementation of EBIs. Interaction between all three systems is viewed as critical to the functioning of the model. In the ISF model, “innovations” from prevention synthesis and translation (dimension 1) are made available to communities for implementation (dimension 3) through strong prevention support systems (dimension 2) that focus on capacity building for individuals, organizations, and communities to facilitate the connection from science to practice (Guerra & Knox, 2008).

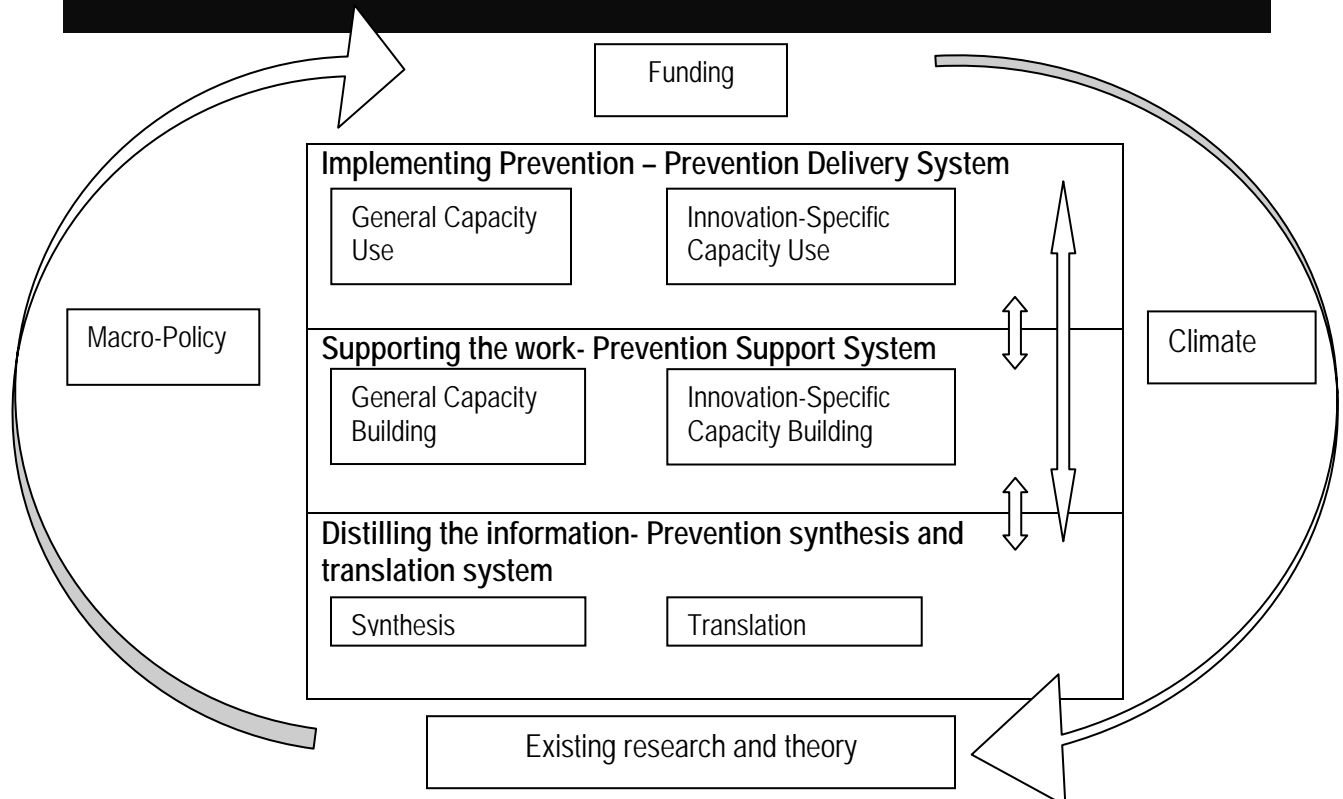
ISF also explicitly mentions ***adaptation*** as a major component of the model that can occur at any time within all three dimensions of the system. Specifically embedded in dimension 2 (Prevention support systems) is what Lee et al. (2008) refer to as “planned adaptation”.

Planned adaptation [as a tool for community practitioners] serves to orient the provider to the intervention and its theoretical underpinnings; it helps providers identify the usefulness of an intervention model for a particular setting; it serves as a framework to orient practitioners to important issues inherent in implementing and adapting EBPs; in addition, it provides some initial direction in developing evaluation strategies. (Lee et al., 2008, p. 291-292)

According to the ISF model Planned Adaptation works best when accompanied by training, technical assistance, and coaching that encompass the functions of the prevention support systems. ISF presents adaptation as an integral part of the research-to-practice continuum and as a non-linear, interactive and dynamic process that considers the perspectives of multiple stakeholders (such as funders, researchers, practitioners, and technical assistance providers) each requiring various levels of support to ensure the relevance, applicability, and success of the intervention in the field. Adaptation in

the context of ISF is viewed as a tool to be used by community practitioners with caution to support the dissemination and implementation of the EBIs recommended for implementation within their respective settings. **Figure 3** illustrates the Interactive Systems Framework as conceptualized by Wandersman et al. (2008).

FIGURE 3: The Interactive Systems Framework (ISF) for Dissemination and Implementation



Excerpted from Wandersman et al., (2008) p. 174

In applying the ISF model to this research inquiry, two components of the model are highlighted, 1) the prevention support systems (dimension 2) which speaks to the capacity of health practitioners and implementing organizations; and 2) prevention delivery systems (dimension 3) which includes the activities conducted to execute and deliver EBIs in community practice settings.

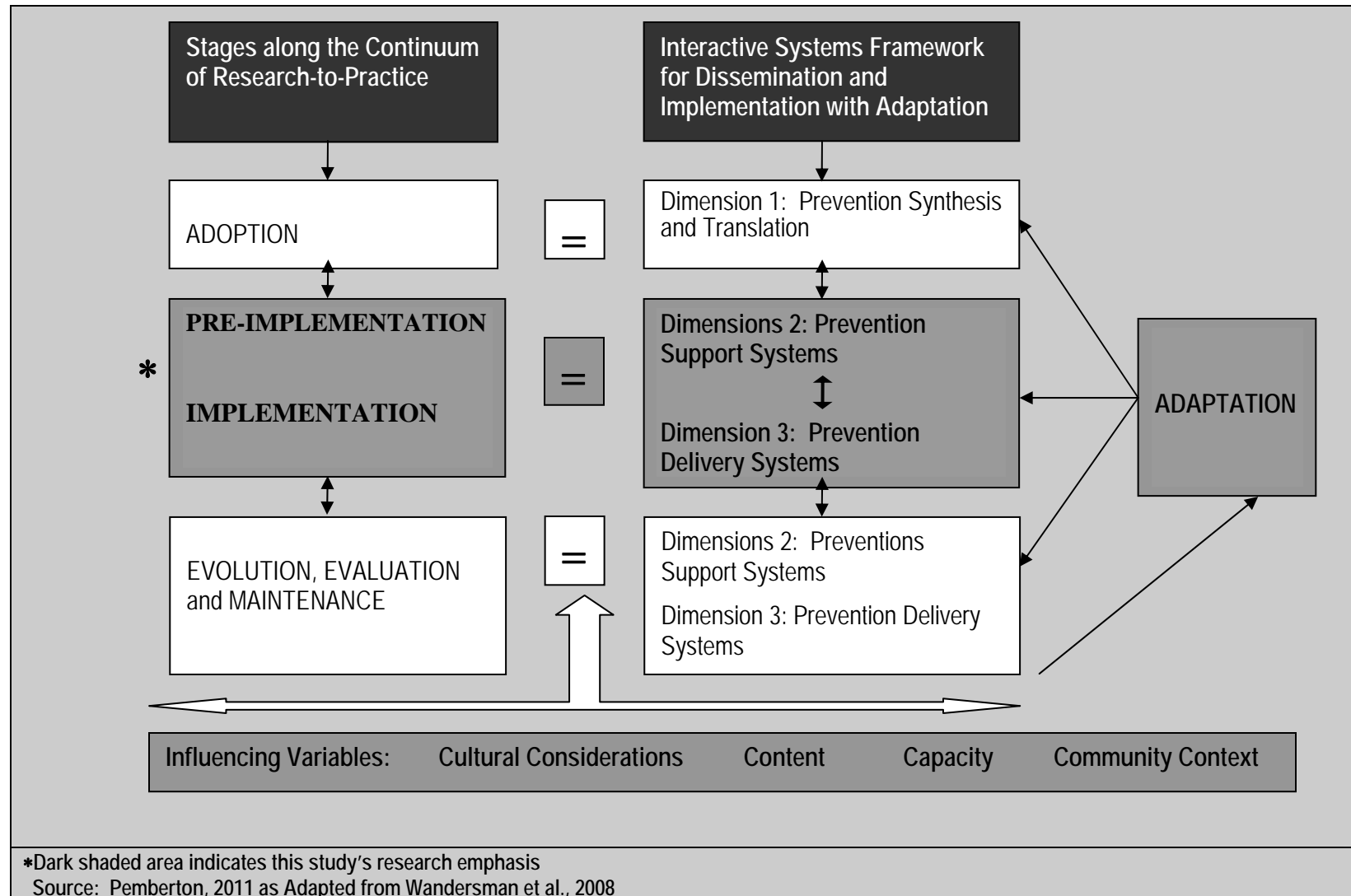
Dimension 1- Prevention research and synthesis, although relevant to the research-to-practice process, is not a focal point of this research study. As the focus of this research is on the

implementation phase of the research-to-practice continuum and the adaptations that occur along the continuum especially in the implementation phase, the emphasis on ISF's prevention support and prevention delivery systems is understandable.

Building on ISF, the influencing factors of culture, content, capacity and community identified in the literature as impacting intervention adoption, implementation and adaptation in community practice settings also influenced the research approach and the development of the research questionnaire. As such, the research inquiry was organized across four major areas -- pre-implementation, implementation, adaptation, and technical assistance—compatible with the tasks, activities and capacities outlined in the prevention support and prevention delivery systems and the implementation stage along the research-to-practice continuum. Combined, these components extracted from various models and knowledge sources manifested into an enhanced conceptual framework grounded in ISF, to address the research question: *How are Implementation and Adaptation of Evidence-Based Interventions Applied in Community Practice Settings?*

Figure 4 below depicts the PI's concept of such an enhanced framework for ISF, inclusive of the other contributing factors identified in the literature as impacting the research-to-practice continuum; and presents the four basic stages of the research-to-practice continuum —adoption, pre-implementation, implementation and evaluation/maintenance and the ISF dimension to which each phase best relates. Although there is overlap in the applicability of ISF's three dimensions to the various stages along the continuum, the focal areas for this research are highlighted in a darker shade to distinguish relevant components of the model. Adaptation is also included as a component of ISF along all three dimensions, as has been explained but not illustrated in the ISF depiction from Wandersman and colleagues (2008) presented earlier in this section. Lastly, the influencing variables impacting all stages along the research-to-practice continuum, including adaptation is incorporated into this enhanced ISF framework.

Figure 4: Enhanced Interactive Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions in Community Practice Settings.



Study Design and Sampling

In public health, qualitative research findings provide insights about “why” individuals and populations engage in specific behaviors, promote understanding of social processes that result in positive health outcomes and facilitate identification of contextual influences, including historical, social, political or cultural factors that influence the success or failure of an intervention, program or policy (Jack, 2006, p. 279).

Study Design

A non experimental, descriptive qualitative research design was most compatible with exploring the primary research question: ***How are Implementation and Adaptation of Evidence-Based Interventions Applied in Community Practice Settings?*** According to various literature sources (Bradley, Curry, & Devers, 2007; Creswell, 2003; Jack, 2006), a qualitative research design is best suited for exploring a phenomenon of interest that has never been studied or for which little information exists, for providing a new perspective on an existing situation or issue, for generating or refining theory, or for understanding the contextual factors that influence and determine health, including cultural, social and political influences. Qualitative research is especially valuable when attempting to convey to policy makers, funders, administrators, and other decision makers, the processes and factors that contribute to the success or failure of interventions or policies through the identification of the facilitators, barriers, and contextual issues that impact the program of focus (Jack, 2006).

The selected research design is also compatible with the conceptual model developed to guide this research. The **Enhanced Interactive Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions** (discussed and depicted in the previous section) considers various systems dimensions and influencing factors to predict success or failure of adopted evidence-based interventions in community practice settings. Given the research question posed, the social, political and historical nature of HIV/AIDS, its disparate

impact on communities of color and traditionally marginalized groups, and the need for new or adapted EBIs to be made available and accessible to communities, a qualitative research design provides the best approach for responding to these complex and interacting issues.

Sampling

A purposeful sample of three community-based organizations (CBOs) was employed. CBO's were identified and recruited to participate in this dissertation research study. In purposeful sampling, "information rich" cases are selected to provide the greatest insight into the phenomenon in question (Devers & Frankel, 2000). A sample size of three agencies allowed for some cross-comparisons in the implementation/adaptation processes of MIP. Because MIP was new to CDC's DEBI compendium at the time of this research, the selection pool of eligible organizations implementing MIP (approximately 6 across the U.S. and Puerto Rico) was fairly small. CBOs receiving funding from any source to implement MIP were identified via the following sources:

- CDC-DHAP was asked to identify organizations known to be either directly or indirectly funded to implement MIP. At the time of this research, only three (3) organizations received funding from the CDC to implement MIP; however, only two met the eligibility criteria of having implemented the intervention for six months or more.
- PROCEED Inc., a national provider of training and capacity building assistance in select EBIs including MIP, and the worksite of the Principal Investigator, had access to information on two additional community-based sites that were funded to implement MIP by non-CDC sources. These agencies had been trained in MIP by PROCEED and had contacted the agency for further technical assistance on MIP implementation.

- PI accessed the members of the original MIP research team to inquire as to whether they knew of any organizations implementing MIP, or had been contacted for information or technical assistance on MIP by any entity. An additional agency was identified through this source, however, it was unable to determine whether or not the organization had initiated implementation of MIP by the beginning of this research.

It is possible but unlikely that other organizations were implementing MIP without the knowledge of the CDC, the “gatekeepers” of these EBI intervention packages, or the original research team, as any implementing agency would have had at least some information and guidance on the intervention components and processes in order to actually qualify as having implemented MIP.

Sites were approached as potential participants for this research study prioritizing CBOs with current capacity to implement MIP with injection drug users. Following a suggested protocol outlined by Devers and Frankel (2000), the Principal Investigator (PI) first telephoned the agency Executive Directors, or other designated officials, at the identified sites to request and secure participation in the study and initiate relationships. Calls were followed up with formal recruitment letters outlining the purpose of the research, the role, responsibilities, and obligations of the researcher and participating organization, the expected organizational commitment, the risks involved with participation in the study, and the potential benefits of the research to the organization and larger public. This correspondence included informed consent forms that required the signature of an organizational official to indicate an understanding of the terms, full agreement to participate in the study, and permission to obtain and review case files of clients currently enrolled in or having completed a cycle of MIP, with all identifiers removed. All recruitment correspondence was available to organizations in both Spanish and English. See **Appendices A and B** for copies of the Invitation Letter and Consent forms.

Study Exclusion and Inclusion Criteria

The exclusion criteria for this study were organizations that had been implementing MIP for 6 months or less and agencies implementing MIP with staff that had not completed the CDC-endorsed MIP Training of Facilitators. These specifications reduced the potential pool of participants to four organizations; one of which was unable to participate in the study due to a fire at the agency's headquarters. Three CBOs met all of the following inclusion criteria and were cleared for participation in the study:

- CBOs must have been implementing the MIP intervention with injecting drug users for at least six months.
- CBO must have signed informed consent forms to commit to participation in the study and agreed to hold employees harmless from study results.
- CBO must have had in place dedicated staff to implement MIP and to serve as a lead contact to this project.
- CBO staff must have participated in, and completed, a CDC-endorsed MIP Training of Facilitators (TOF) prior to implementing the intervention.

The latter requirement, the Training of Facilitators are CDC-mandated prerequisite courses that agency staff must attend prior to implementing EBIs such as MIP. These courses train community-based practitioners and administrators on the interventions' theoretical underpinnings, and main components and strategies, including how to conduct the intervention with the target population using scripted curricula to help support practice in the field. The TOF also provides organizations with detailed guidance around intervention implementation, especially with regard to the identification of core elements and key characteristics that must remain stable in order to maintain fidelity and thus, effectiveness in field settings. As part of the TOF, an MIP program implementation manual, inclusive of sample documentation and data collection forms and a mock

client file are provided to training participants to further support program implementation post-training. The MIP curriculum was available to practitioners in both English and Spanish.

Data Sources and Collection

Case study can be seen to satisfy the three tenets of the qualitative method: describing, understanding, and explaining. (Tellis, 1997, p. 3)

A case study approach using semi-structured interviews and document review was used to collect data for this research study. Although the study encompassed a predominantly qualitative approach, some objective data were collected to inform the creation of individual and organizational demographic profiles. A case study is *"known as a triangulated research strateg[ies]"* (Tellis, 1997, p.6) because it often uses multiple data sources to establish the validity of its processes. For purposes of this study a case is defined as a participating organization with multiple respondents affiliated with each case.

Table 4 summarizes the data collection methods used to answer the research question and accomplish the study's research aims. Each aim is presented, followed by the methods and data sources used to address that aim. The data collection methods presented in the table are described in greater detail in the subsequent paragraph, including the justification for selecting a particular method and the strengths and limitation of each method chosen for this research study.

TABLE 4: Research Aims, Methods and Data Sources

Research Aim	Methods	Data Sources
1. Describe how agencies approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities.	Semi- structured Interview Document Review	Key informant interviews- management and front-line staff Two most recent reports to funder; Organizational brochures/ and/or description of services.
2. Identify the practices and strategies used to facilitate the successful adaptation of MIP in community settings;	Semi- structured Interview Document Review	Key informant interviews- management and front-line staff Behavioral Risk Assessment and/or Behavioral Staging Forms, Progress Notes; (2) most recent reports to funder.
3. Inform the development of user-friendly adaptation guidelines specifically for community practice settings.	Semi-structured interview Document Review	Key informant interviews - management and front-line staff Progress notes

Data Collection

▪ Semi-Structured Interviews

The semi-structured interview served as the primary strategy of inquiry used in this research study as it is one of the most important sources of case study information (Tellis, 1997). As noted by Creswell (2003), this type of methodology is useful for gaining a historical perspective, yet it allows the researcher to drive the questioning and provide structure to the conversations. Semi-structured interview questions were derived from the conceptual model (Enhanced Interactive Systems Framework for the Implementation and Adaptation of Evidence-Based Interventions), as well as the literature on the adaptation and implementation of EBIs. Semi-structured interview questions were developed by the PI, and then reviewed for clarity by both

members of the dissertation committee and community practitioners familiar with the administration and/or implementation of EBIs in community-based settings.

To maintain a degree of consistency in the manner and sequence in which questions were asked, a semi-structured interview guide was developed. In anticipation of the need to conduct semi-structured interviews in Spanish to accommodate staff where Spanish was their principle language, the PI trained a bi-lingual research assistant familiar with the HIV prevention EBIs and MIP in particular to facilitate the semi-structured interviews and to conduct the document review using the same protocol outlined for English-speaking participants. The PI and research assistant completed two training sessions; one of which focused on a “practice run” following the scripts and the types of prompts appropriate to further the dialogue but not lead the participant. Prior to conducting any interviews, the research assistant was required to sign a confidentiality agreement to further safeguard agency information. All interviews occurred face-to-face at the agency administrative offices or other program site. Consent forms for participation in the study were made available in both languages to accommodate the preferences of interviewees. Copies of the semi-structured interview questionnaires (in Spanish and English) are included in **Appendices C and D**.

Limitations noted in the literature (Creswell, 2003) involving the use of semi-structured interviews include: 1) varying levels of articulation and perception from interviewees, 2) researcher presence biasing responses, and 3) indirect information based on the views of the interviewee. These limitations were addressed by using the same interview protocol with all participant interviews and establishing rapport with agency staff so that open and candid conversation was encouraged.

- **Document Review**

Document review was used as a “second methodology” to corroborate the data obtained from semi-structured interviews. As stated by Solomon et al. (2006):

A discipline of documentation is essential to advancing the science and practice of program adaptation.....conducting process and outcome evaluation of the intervention as implemented is essential to determining the effectiveness of the adapted intervention in a new context. These findings, along with careful documentation of the process that was used to alter the original intervention, also permit an assessment of the utility of the specific adaptation procedures. (p. 178)

The benefit to including document review in the methodology was that it provided written “evidence” to capture the authentic words and processes used by staff in conducting the intervention. Much of the processes involved in the implementation and adaptation of MIP was expected to be captured in the administrative and case files kept by the agency staff. Once signed consent was received from participating sites, the PI requested copies of the forms used by each site to document the activities and benchmarks of the MIP intervention. In preparation for the review of these documents, the PI reviewed the entire CDC-endorsed MIP Curriculum Package which is comprised of the original MIP research article, program implementation manual, training manual, PowerPoint workbook, and mock client file, so as to capture the “intent” of the intervention and identify potential variation from the interventions’ guidelines . Since the MIP Curriculum package includes several sample data collection forms for use by CBOs implementing the intervention, the PI selected three recommended forms germane to the implementation of MIP with members of the target population for extraction and review from client case files. These forms, available to CBOs in both English and Spanish included:

- Behavioral risk assessment which collects baseline and post-intervention data on a client’s overall health and sex/drug related HIV risk behaviors.

- Behavioral staging forms which are recommended for use during each MIP session to assess client readiness to take meaningful action, change risk behaviors, enter drug treatment, and obtain health care and social services.
- Progress notes which document a client's "movement" from one MIP session to the next and/or the referrals provided to support behavior change efforts.

These documents capture significant activities that support adherence to the "core elements" of the MIP intervention and serve as benchmarks for discussing fidelity and adaptation experiences with the three implementing organizations.

According to Creswell (2003) the limitations of document review include having materials that may be incomplete, inaccurate, inauthentic, or illegible, and having difficulty "finding" the relevant data within the documents provided. As previously mentioned, these limitations were addressed by using the two data sources rather than information from any one source.

Data Collection Timeline

Primary data collection occurred from January through April 2011. This 4-month time span was due to the limited availability of participating organizations and their MIP program staff, the logistics of traveling to the various site locations across the country, and delays in collecting the MIP program documentation as delineated in the proposal. A site visit was conducted with each of the three participating CBOs; each of which yielded three interviews for a total of nine interviews with management (3) and front-line staff (6). These face-to-face visits helped establish rapport with agency staff, thus setting the tone for conducting the semi-structured interviews. These visits also allowed the PI and research assistant to view the agency's facilities, thus providing a better sense of the agency's operations scope, size and general operations. A second round of data verification occurred in September 2011 with the three agencies' lead contacts to clarify information obtained

from the semi-structured interviews and document review.

Data Management and Analysis

There is no singularly appropriate way to conduct qualitative data analysis, although there is general agreement that analysis is an on-going, iterative process that begins in the early stages of data collection and continues throughout the study. (Bradley et al., 2007. p. 1760)

Data Management

Throughout the study implementation (January–April 2011) and data management and analysis (July–December 2011) phases, the PI managed data from the semi-structured interviews and document review through a process of note-taking, tape recordings, verbatim transcription and coding. All case-related information for each participating organization was assigned a unique identification number and kept in secured files that were physically locked (hard copies) or password protected (computer files). Semi-structured interview data were simultaneously captured through note-taking and tape recordings for which explicit consent was sought and obtained from each participant (See Consent to tape-record form included in **Appendices C and D**). For the document review, a master grid of the forms and reports collected from each agency was organized and listed by that agency's unique identifier.

All semi-structured interview data was transcribed and checked against written responses and notes taken during the interview. The first round of transcriptions was conducted verbatim. A second review of the audio-taped interviews was conducted to further verify the data retrieved. For the two interviews that were conducted in Spanish, a third review took place upon examination of the second round of transcribed and translated data. This step was added as additional verification and to ensure clarity and the accuracy of the translations. A simple Microsoft Word application was used to store the raw data prior to coding and data analysis.

Data Analysis

The PI followed an iterative multi-step process in the analysis of study data which was heavily influenced by the work of Miles and Huberman (1994) and other reliable sources (Bradley et al., 2007; Powell & Renner, 2003) and inclusive of the following steps: **1) Data reduction**, which helps to sort, focus, simplify, abstract and summarize raw data; **2) Data display**, where data are organized and displayed logically so that conclusions can be drawn, and; **3) Conclusion drawing and verification**, which marks the final analytical activity where patterns, themes, explanations, and casual relationships are noted and these conclusions verified.

To become familiar with the data and learn the nuances of the complete data set, the PI first organized raw data from the nine interviews by agency “case”, then by role within the organization (management status or front line staff status), and finally, as one complete data set due to the similarity of participant responses. Data were then coded to extract relevant categories and themes. This process was guided by 1) key themes expressed within the research questions/sub-questions being asked, 2) findings from the literature review, 3) the semi-structured interview categories- pre-implementation, implementation/adaptation, and training and technical assistance needs; and 4) the semi-structured interview questions.

Coding and categorization of data were conducted multiple times to ensure that all relevant themes and categories were captured for further analysis. An Excel spreadsheet with the coded categories and themes was then developed to capture individual interview data as per the established codes. This step allowed the PI to begin to decipher similarities, differences and “other” themes within the data set that were not previously extracted. During this period of analysis, the PI consulted with dissertation committee members to obtain guidance and information resources on data coding. The PI recruited one committee member to examine the data collection

instrument and coded spreadsheet to ascertain whether the categories were logical detailed and comprehensive enough. Based on feedback received, the PI examined portions of the data sets to further explore and extract additional themes. **Table 5** captures the PI's five-step approach to data analysis and the major "benchmarks" yielded from each step, which in turn comprises the study results presented in Chapter 4.

TABLE 5: Data Analysis Approach for MIP Qualitative Research

Steps in Data Analysis	Yield
I. Data Reduction	
a. Learn data ; read and re-read content for overall understanding and comprehension of complete data set.	<ul style="list-style-type: none"> ▪ Familiarity with Data ▪ Comprehension of the raw data obtained ▪ Impressions on data quality and limitations
b. Sort data by case, question, topic other relevant distinction or similarity.	<ul style="list-style-type: none"> ▪ Question/topic across respondents. ▪ Begin to identify consistencies and differences across/within cases ▪ Overall picture of an organization or 'case'.
II. Data Display	
c. Categorize and Code data by identifying themes or patterns through an iterative process, assigning codes, and organizing data into well-defined categories.	<ul style="list-style-type: none"> ▪ Include pre-set themes and categories from existing sources (ie. literature, concept models) ▪ Extract emergent themes and categories from data obtained. ▪ Identity key constructs, categories, and sub-categories identified.
III. Conclusion Drawing and Verification	
d. Identify, compare and contrast within case and across cases. "Within case" analysis refers to the findings from a single "whole" case. Cross-case analysis compares one cases' findings to others.	<ul style="list-style-type: none"> ▪ Themes, patterns, and constructs for "within-case" and "cross-case" analysis identified. ▪ Capture relationships between questions, topics, and cases ▪ Similarities and differences in responses across individuals and organizations
e. Coalesce, interpret and present data. Once the data is coded and summarized, the connections, relationships, or differences that become apparent should be noted and comparisons made to support data interpretation	<ul style="list-style-type: none"> ▪ Significant themes, concepts and relationships explained. ▪ Details what was learned and major lessons. ▪ Reveals remaining gaps in knowledge and future research needs. ▪ Suggests how information/findings can be used.

Sources: Miles & Huberman, 1994; Bradley et al., 2007; Powell & Renner, 2003

Ethics and Confidentiality

Institutional Review Board approval for this research study was sought from the Office of Human Research Ethics at the University of North Carolina (UNC) in October 2010, obtained in November 2010, and renewed in October 2011 to allow for ongoing data analysis. All reasonable measures were taken to ensure adherence to UNC research standards, protect confidentiality, and minimize risks to participants. As such, three forms of consent were sought:

1. **Organizational consent to participate in research study.** This consent form secured organizational participation in this research study from an authorized agency official and documented the time commitment, activities, and other requirements of agency participation. It also addressed any potential risk of retaliation against staff at participating organizations for providing information to the PI that could have been deemed inappropriate or unfavorable by management. Please refer to **Appendices A & B**.
2. **Consent to participate in the research study- Adult Participants.** This form sought explicit consent for participation in the research study from individual staff members within organizations. The consent made clear that participation was voluntary, that refusal to participate in this study would not affect the individuals' employment, and that the individual was free from coercion. Please refer to **Appendices E and F**.
3. **Written consent to record the semi-structured interview.** Upon agreeing to participate in the research study, individual participants were informed about what to expect in the semi-structured interview, including their right to end the interview or pass on questions. Consent was sought to record the interview prior to beginning the process. Please refer to **Appendices C and D**.

Protecting confidentiality was also of utmost priority and measures were built into the research process to reflect this concern. First, the research assistant was required to sign a confidentiality agreement with regard to all study data as an additional safeguard for participating agencies and their staff. Also, identifiers were used solely for contacting participating organizations. Rather, unique codes were assigned to each participating organization and individual staff and any identifiers or potential identifiers found in the data set were removed by the PI and replaced with these unique codes. In addition to using locked files to store hard copy materials, raw data on laptops was password protected. Upon the verification, analysis, and write up of the data, all recorded interviews and organizational documents were destroyed as per study protocol. The results presented in the next section do not reference organizational or individual names. Data are reported in "case" format or in aggregate form.

CHAPTER IV. RESULTS

This chapter reports the results from the semi-structured interviews and document review so as to answer the primary research question: *How are Implementation and Adaptation of Evidence-based Interventions Applied in Community Practice Settings using lessons from the Modelo de Intervención Psicomédica*. First, an overall profile of the three participating agencies is provided, followed by a case description of each organization. Next, data from the semi-structured interviews is organized and presented according to the focal areas of inquiry of this research -- pre-implementation, implementation, adaptation, and technical assistance needs-- and by the research aims directly related to each phase. Finally, findings from the document review are presented in relation to the implementation and adaptation practices of agencies. Document review findings verify semi-structured interview data and help to further elucidate research aims two and three of this study.

This study's research aims are to:

- Aim 1: Describe how organizations approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities.
- Aim 2: Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings.
- Aim 3: Inform the development of user-friendly adaptation guidelines specifically for community practice settings

To provide a comprehensive and well-informed report that captures the experiences of MIP health practitioners within agencies implementing HIV/AIDS prevention programs, each aim is explored

within the context of its accompanying sub-questions. It is important to note that within this reporting and discussion framework, the research aims and phases of inquiry are not mutually exclusive and often overlap in applicability. Even within the phases of inquiry, pre-implementation and implementation are not mutually exclusive from adaptation and technical assistance; rather, the latter two are often conducted and required across the research-to-practice continuum.

Although there were two sets of semi-structured interview instruments, one for management and the other for front-line staff, data were combined as the majority of the questions on both questionnaires overlapped, and upon coding and preliminary analysis few differences were found in responses between groups. Questions specific to management staff focused on agency infrastructure, including annual agency budgets, range of services provided, agency staff size, MIP program budget and funder(s), MIP staff credentials, types of EBIs implemented and number of staff trained in EBIs from the DEBI compendium (www.effectiveinterventions.org). This information was largely used to develop the agency case descriptions. Questions asked solely of front-line staff were specific to the actual field implementation of MIP such as characteristics of the target population, outreach and recruitment strategies, implementation challenges and adaptations conducted. In cases where questions were answered by only one group, most of the key findings reflect a full data set that includes all study participants irrespective of their role within the organization.

Case Descriptions

Key Finding 1: A history of service, demonstrated experience with diverse communities, and high organizational capacity are characteristic of the community-based organizations funded to implement HIV prevention evidence-based interventions with highly vulnerable populations.

Overall Sample

Three community-based organizations were recruited to participate in the study. All participating agencies met study eligibility criteria and had been implementing MIP for six or more months at the time of data collection. One management staff member and two front-line staff members from each agency were interviewed for a total of nine (9) interviews across organizations. Implementing organizations represented three distinct regions-- the Northeast, Caribbean, and West Coast—and all had been operational an average of 40 years with current budgets at or exceeding 14 million dollars. The longstanding presence of these organizations is best demonstrated by the full range of health, human, and social service programs (beyond HIV/AIDS) offered by these agencies. Two of the three agencies offered a full range of primary health care services, including medical and dental care and obstetrics/gynecological services. HIV/AIDS programs across agencies were also well-established, averaging 17 years of operation and staff sizes ranging from 10 – 25 people. Services offered within these programs included counseling, testing and referral (CTR), and prevention education for various at-risk populations. All three organizations had previous experience in implementing evidence-based interventions from the CDC DEBI compendium (www.effectiveinterventions.org) and had significant experience working with injection drug users.

Based on size, funding diversity, total annual budgets, and the variety of health, education, and human services offered, all three organizations were determined to be high capacity. Across agencies, funding amounts for MIP varied from \$180,000 to \$500,000 annually from diverse funding streams such as the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Agency, and a local health department. All agencies used MIP with its intended target audience-- male and female injection drug users 18 years and older recruited from the community. However, two of the three agencies either expanded or further streamlined client eligibility criteria for MIP participation. Agency 1 expanded criteria to include other substance users and Agency 3 added a

specification of “sharing drug paraphernalia in the past 12 months” to further streamline the injection drug use criteria. MIP client profiles across agencies were similar in that all enrolled clients had health and behavioral issues that either contributed to, or resulted from their substance use. Also, staff from each agency indicated co-occurrence of mental illness among their MIP clientele.

Reflective of funding amounts, the numbers of staff dedicated to the implementation of MIP varied from 2 to 6 full-time staff. Educational levels also varied. Management staff within these agencies and in particular the MIP program were well-educated. Supervising staff held Bachelor’s, Masters and Ph.D degrees, whereas front-line staff education ranged from a high school diploma or equivalent to a Masters level degree. Across agencies, most (90%) of the existing staff had been trained on MIP and had attended the CDC MIP Training of Facilitators (TOF) course which prepares organizations to implement the intervention in local settings. All staff participating in the study were required to have attended a CDC MIP TOF. **Table 6** provides a snapshot of participating organizations and **Table 7** presents a profile of study participants.

TABLE 6: Profile of Participating Agencies						
	Year Established	Geographic Location	Annual Budget	MIP Budget	Funder	Year Funded
Agency 1	1970	Northeast	14 million	500K	Federal- SAMHSA	Sept. 2007
Agency 2	1971	Caribbean	16 million	210K	Federal- CDC	July 2008
Agency 3	1970	West	>20 million	180K	State- Local Health Dept.	Oct. 2009

TABLE 7: Profile of Study Participants (N=9)				
Position – Management	Education	Agency Tenure	Yrs. in current position	Yrs. in field of HIV/AIDS
1. Clinical Director	Ph.D, MSW, LCSW	21 yrs	20 yrs	15 yrs
2. Special Projects Director	MA (pursuing PhD)	8 yrs	4 months	8 yrs
3. HIV Prevention Coordinator	BA	5 yrs	4 yrs	5 yrs
Position: Front-Line Staff	Education	Agency Tenure	Yrs. in current position	Yrs. in field of HIV/AIDS
4. Outreach Worker/ Case Manager	Various certifications	3.5 yrs	3.5 yrs	4 yrs
5. Outreach Worker/ Case Manager	LPN, Various certifications	10 yrs	4 yrs	10 yrs
6. MIP Counselor/Case Manager	BA	6 yrs	1 yr	14 yrs
7. Case Manager	BA	4.5 yrs	6 months	7 yrs
8. Health Educator/ Risk Reduction Counselor	BA	20 yrs	2 yrs	20 yrs
9. Health Educator/ Case Manager	Various certifications	4 yrs	4 yrs	20 yrs
<i>* Note: One Supervisor and two(2) front-line staff from each participating agency were interviewed</i>				

Agency 1 Profile

Agency 1 is a health and human services organization that has been in existence for 41 years and has a budget of approximately 14 million dollars. The agency is located within an economically and socially disenfranchised urban community characterized by a number of social ills including poverty, unemployment, homelessness, child abuse and neglect, crime, gang violence, substance abuse and high rates of HIV/AIDS and sexually transmitted infections (STIs). This agency provides health, education, counseling, and support services that cover *“the life cycle of community members from preschool to senior services.”* Unlike its two counterparts, Agency 1 does not offer medical care or mental health services. Agency 1 has the most funding for the MIP program. In September 2007

the agency was awarded a 5-year grant from SAMHSA in the amount of \$500,000 annually to serve up to 135 substance users annually, inclusive of injection drug users.

The client profile for Agency 1 include IDUs and other individuals with substance abuse problems, predominantly male (80% men; 20% women), and Hispanic/Latino (50%) or African-American (40%), with the other 10% of clients representing other racial/ethnic groups. Approximately 90% of MIP clients have criminal backgrounds, 70% lack a high school diploma, and 75% have mild to severe mental health issues.

MIP is supervised by a Clinical Director with agency tenure of over 20 years and 15 years of experience in the field of HIV/AIDS. Agency 1 staff had received two trainings on MIP; one in 2008 and another in March 2010, however, only four of the current six staff had participated in the CDC MIP Training of Facilitators. All three staff interviewed for this research study (the MIP Supervisor and the two front-line workers) had attended the two MIP trainings. Although the front-line staff interviewed held no formal degrees, both were certified as HIV Counselors and were in the process of pursuing certifications as Alcohol and Drug Addiction Counselors. At the time of the interview, the agency had been conducting MIP for 3.5 years.

Agency 2 Profile

Agency 2 is a full-scale health center located in a semi-rural setting within the heart of an impoverished community challenged by significant injection and other drug use and a flourishing sex trade industry. The agency has been a stable source of community health support for 40 years, addressing issues of domestic violence, homelessness, mental health, and substance abuse, in addition to offering primary health care and psychological services and specialty health care such as obstetrics/gynecology, pediatric care, internal and family medicine, and a full laboratory and pharmacy. Agency 2 also has a needle exchange program which is in direct response to the plethora of injection

drug use that fuels the HIV/AIDS epidemic in that region. The agency has an annual budget of approximately 16 million dollars and owns all of its eleven centers; an accomplishment the agency says provides them with the autonomy to continue to serve the most disenfranchised and stigmatized populations in that region.

Right now we bought all of our centers....We projected that we [were] paying \$7- 8000 per house [monthly], so we are paying more [in rent] than what we would pay with a mortgage...more than \$600K in 15 years. Some landlords [also] have issues with the target population, so it was another reason to purchase. (Agency 2 Director)

In July 2008, Agency 2 secured a five-year cooperative agreement from CDC in the amount of \$210,000 annually to implement MIP with 15 active injection drug users yearly. The MIP client profile for Agency 2 are 100% active injecting drug users, 18 years and older, equally male and female, and almost exclusively Hispanic/Latino (98%). Most of these clients are at increased risk for HIV due to commercial sex work and have mental health issues. Domestic violence is also typical for the women enrolled in the MIP program. Histories of unemployment and homelessness are also typical among this target population.

MIP is staffed by two full-time persons and a part-time Director of Special Projects. On average MIP staff have been with the agency for 5 years or more, and have had a minimum of 7 years experience providing HIV/AIDS services. All three MIP program staff participating in this research study participated in the CDC MIP Training of Facilitators in January 2009. At the time of this research, Agency 2 had been implementing MIP for two years.

Agency 3 Profile

Agency 3 is a well-established health center that has provided comprehensive health care and health education services to low-income and under-served residents across eleven towns for the past 23 years. Services include general medical, dental, obstetrics/gynecological services, a food pantry,

and a host of other health education and prevention programs aimed at promoting health and well-being. Agency 3 has an organizational budget of approximately 15 million and 250 staff to execute the agencies' mission: To provide quality and accessible comprehensive healthcare and health education services to the low-income and underserved populations. Staff tenure within the organization ranges from 5- 20 years, as does the accompanying experience in the field of HIV/AIDS. HIV/AIDS programs include counseling and testing, mobile unit testing, and several prevention programs from the DEBI compendium.

The MIP program was funded by the local health department in October 2009 for a three-year grant cycle in the amount of \$180,000 annually, the smallest of the three funding awards, to serve up to 60 IDUs who share drug paraphernalia per year. MIP participants were equally male and female, all over 18 years, and predominantly Hispanic/Latino. These clients often had co-morbidities of severe mental illness and substance abuse, conducted commercial sex work, were unemployed, and had been incarcerated. Many of these clients also had histories of sexual abuse or other trauma, had been involved in narcotics sales and had been separated from their children. This agency conducts MIP within various methadone maintenance programs in the agency's geographic service region from where injection drug using/sharing clients are also directly recruited.

MIP is staffed by two full-time persons and an HIV Prevention Coordinator who provides supervision and ensures that program deliverables are met. MIP team members were trained in MIP in September 2009, prior to implementing the intervention. All three MIP program staff provided key informant interviews for this research study. At the time semi-structured interviews occurred, Agency 3 had been implementing MIP for 1.5 years.

A: Pre-implementation
Research Aim 1: Describe how organizations approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities.

The pre-implementation phase--characterized as the process of EBI selection and preparation activities conducted by an agency prior to the launch of an EBI-- directly correlates with Study Aim 1 which seeks to elucidate how organizations approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities. Pre-implementation phase explores the activities conducted by organizations to prepare for MIP implementation, the factors contributing to the selection of MIP as the EBI of choice for organizations, and staff perceptions of the intervention.

Key Finding 2: Community-based organizations expend significant time, energy, preparation, and planning into the selection of appropriate evidence-based interventions that complement existing agency services and meet the needs of their constituents.

A series of questions were asked of both management staff and front-line workers to assess agencies' perceived levels of preparedness to conduct MIP and the pre-implementation activities executed by organizations to launch the intervention. Across the board, study participants were asked to rank on a scale of 1-5 (with 1 being the lowest and 5 the highest) their level of preparedness for implementing MIP prior to actual implementation. Two of the three agencies ranked themselves 4 or higher; whereas staff from one agency ranked themselves lower with a score of 2.2. Across all three agencies, implementation preparedness was associated with 1) experience with and knowledge of the target population of injecting drug users (IDU), and 2) having had prior experience implementing evidence-based interventions. The two agencies which self-ranked highly on preparedness noted

"being trained in MIP prior to its implementation" as one of the main reasons for a higher self-rating. Other reasons associated with perceived higher levels of preparedness included agency buy-in for the intervention, access to the IDU population, established trust between the agency and the IDU population, and the ability to link IDU clients to other in-house health, education, and social service programs. Although the agency that self-ranked lower on preparedness (2.2/5) had significant experience working with the IDU population and with implementing other EBIs, they felt less prepared for two reasons: 1) agency staff had not yet received the MIP Training of Facilitators (TOF) which prepares healthcare providers to implement the intervention locally, and 2) staff anticipated having a learning curve after completing the TOF and before achieving mastery with the implementation of program components.

In preparation for the implementation of MIP, 100% of study participants reported that needs assessments had been conducted by their respective organizations via a combination of methods including focus groups, community mapping activities, and consultations with key informants and stakeholders.

[Agency] held focus groups with former clients to discuss the possibility of implementing MIP. [Agency] discussed length of the sessions, incentives etc.

The agency had meetings to discuss what the potential of implementing MIP was. We decided to just go for it and select MIP.

Across agencies, other activities included staff training (n=5/9), protocol and/or policy development or modification (n=4/9), recruitment and outreach to the target population (n=3/9) and the development of memoranda of agreements to facilitate client linkages to other health and support services (n=2/9). Across agencies these pre-implementation activities included a combination of management staff, front-line staff and current or prospective clients. In one case, community partner agencies were involved in pre-implementation and assessment activities for MIP.

Factors in Selecting MIP

Key Finding 3: The most influential factors in community-based organizations' decision-making processes for selecting appropriate evidence-based interventions for agency implementation included the needs of, experiences with, and the content, structure, and suitability of the intervention for the target population.

In order to gauge the extent of forethought and decision-making that went into the selection of MIP as the evidence-based intervention of choice, agency staff were asked about the factors that contributed to their selection of MIP for their organizations. In a series of open and close-ended questions, 7 of the 9 participants stated that the needs and service gaps of the target population were key considerations in the selection of MIP. Six stated that experience with the target population was also a consideration and almost half (5) stated that the content of MIP played into its selection as an EBI of choice for their agency. The comprehensive nature of MIP was also noted by (4) participants as a key determining factor in its selection.

Another one-third of those interviewed expressed that the values/norms promoted by MIP and staff expertise to implement the intervention played a role in its selection as the EBI of choice for their respective organizations. For two of the three agencies, existing trust established between the target population and the implementing agency was a factor in the selection of MIP for IDUs. In the case of one agency, staff felt that MIP had "local applicability," and therefore would be a better fit than other EBIs within the compendium. Other influencing factors included the availability of resources, cost, client interest, community support, and "newness" of the intervention. **Table 8** presents the most dominant factors noted in selecting MIP for agency implementation and offers participant quotes which further highlight these factors.

TABLE 8: Key Factors Considered in the Selection of EBI- MIP	
Dominant Factors	Supporting Participant Quotes on Key Factors
Needs/Service Gaps of the target population (IDU)	<i>MIP coincided with the community mapping conducted by [agency]. The MIP intervention seemed like a really good fit for [agency]. [We] used mapping data to direct our program efforts.</i>
Previous experience with the target population. MIP “offers more”/ MIP more comprehensive	<i>We were already working with IDU and had some success with the target population. We were up for the challenge of taking on the new program. I saw MIP as more a benefit to the population we were going to be targeting because we were providing more services; we were offering more to them.</i>
Content/Structure/Suitability of MIP for IDU.	<i>Before [MIP] there was not a lot of case management, but in substance abuse you need a lot of case management b/c for instance if you have substance abuse and you are homeless you have to address the homelessness first....All the programs should have case management component. MIP brought the case management piece</i> <i>MIP is the best model that is being implemented to work with drug users....</i>
Individualized and client centered nature of MIP	<i>[MIP is a] good match with agency because it is more client-centered. I thought they [IDUs] would be more inclined to try the intervention because we would be picking up their needs. [We] saw MIP as being more of a benefit to population we are targeting; offering more to them.</i>
Trust established between IDU clients and agency	<i>IDU clients already feel comfortable with [agency] as they have participated in other agency programs and events.</i> <i>We had the trust of the clients--no intervention goes out effectively if the client doesn't trust you.</i>

Perception of Intervention Compatibility or “Fit”

Overall, 100% of study participants believed MIP to be a “good fit” for their organizations. Many of the factors that informed an agency’s decision to select MIP as the intervention of choice also shaped staff perceptions of the intervention. Reasons provided by study participants regarding MIP’s compatibility with their agency’s current menu of services included:

- Experience with/knowledge of IDU population (n=4/9)

- More comprehensive than other EBIs (n=3/9)
- Harm reduction philosophy of MIP (n=2/9)
- Local applicability/creation/context (n=2/9)
- MIP is client-centered n=(2/9)
- MIP is individualized and provides “more” to client (n=2/9)
- MIP is structured (n=2/9)
- Ability to provide wrap-around services to MIP clients through internal referrals to other in-house programs and services (n=2/9)
- Previous experience with other EBIs (n=1/9)
- Better match for the IDU population than other EBIs (n=1/9).

Across all three agencies, staff perceived MIP as an intervention that agencies had the capacity to do well and that would greatly benefit the IDU population and larger community. These perceptions aligned with the dominant factors reported by staff as influencing their agencies’ decision to select MIP as the EBI of choice for their organizations.

Upon implementation, initial perceptions that MIP fit seamlessly into existing agency services was challenged by a third of the study participants who felt that MIP was still a good fit for their organizations but simultaneously “a bad fit”. While none of the participants categorized MIP as a solely “bad fit”, once implementation began, supervising/management staff were able to identify characteristics associated with MIP that made seamless integration into existing agency services challenging, thus compromising “fit.”

- One agency indicated that the harm-reduction philosophy of MIP conflicted with the abstinence-based philosophy of other substance abuse programs within the organization that targeted the IDU population. As such there was confusion in the community about the

services provided by the agency, and hesitation to access services from some clients who preferred not to mix with active drug users, especially if they were in recovery.

- Staff across agencies articulated that MIP was too long and intensive an intervention for the IDU population. It was pointed out that due to drug use; IDUs are often unstable and inconsistent with appointments, thus making it difficult to retain them long enough to complete the MIP intervention. One Supervisor commented: *“IDUs need a quicker intervention focused on treatment and primary and secondary prevention.”*

Another agency felt that MIP’s “fit” with their organization was compromised due to a lack of knowledge by the funder of MIP’s philosophy, components, and how the intervention actually works in the field. As a result, this staff member felt that the expectations of the funder clashed with the goals of MIP as well as the agency.

Other implementation successes and challenges are discussed in the next section- Phase II, Implementation of MIP.

B: Implementation of MIP
Research Aim 2: Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings

The actions taken by organizations during each phase of implementation of EBIs often overlap in practice. The **implementation** of an evidence based intervention builds upon the pre-implementation activities conducted by an organization with an emphasis on the day-to-day effort required to reach out to, engage, and retain the target population; and identify and resolve implementation challenges and barriers that negatively impact the EBI program so that success can be realized. The **implementation phase** also marks the most common period where significant

adaptations occur. This phase of inquiry is related to the second study aim which explores the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings, including the successes and challenges experienced by implementing agencies. First, the role of agency leadership in support for the intervention is discussed, then perceived and real barriers to implementation is presented, followed by testimonies of implementation successes and challenges experienced by the staff of agencies implementing MIP.

Agency Leadership Support

Key Finding 4: Agency leadership support and staff buy-in on all levels is an important facilitator for proactive planning and successful implementation of an evidence-based intervention.

On the whole, staff within the three participating organizations found their agency's leadership teams to be supportive of MIP planning and implementation efforts. Two participants from different agencies noted impressive support for MIP from all levels of staff within their agency.

Staff have [a] strong commitment to MIP clients. There is adequate supervision and support of MIP staff. Upper management is open to staff ideas to ensure program effectiveness....The Executive Director [is] attentive to staff needs and our suggestions to improve agency services.

We get a lot of support from each other and from the Supervisor. We also have support from the Medical Director. We do both individual and group case conference two times a month. We discuss cases individually and as a group.

When asked about the type of support that was provided by agency leadership, 7 of the 9 participants responded that agency leadership was supportive of staff training. Five (5) participants responded that they received adequate supervision, inclusive of staff meetings, case conferences, and "general support." Three (3) front-line workers mentioned open communication and the ability to express ideas or concerns as indicative of support from agency leadership, including their immediate

supervisors; whereas 2 of 3 MIP Supervisors noted autonomy in running the MIP program as a measure of “support” provided by their superiors. Two participants also mentioned the accessibility of funds to support MIP program activities as a show of support from agency leadership.

Our Team has free range to do what is needed for the intervention. The agency allows funds to be spent as needed and assume that they will get it back to us. Finance is never a barrier in that area.

In one case, however, a participant voiced concern that although immediate supervision was adequate, there was a need for greater support from agency leaders.

Administration needs to learn more about MIP, what it entails, and the work conducted by staff. Lack of knowledge results in limits and less support. The organization's leadership doesn't place a lot of importance to MIP...there should be more orientation in this area [with] the Directors and Administration. [They] should be knowledgeable about MIP program goals and be able to understand the humanistic work that is being done.

Barriers to Successful Implementation of MIP: Perceived -vs- Real Barriers

Key Finding 5: Barriers to the implementation of EBIs, whether perceived or real, fall into four major categories- culture, capacity, content, and community. Few barriers exist outside the realm of these overarching themes.

Significant and varied responses were provided by participants with regard to the barriers and challenges in implementing MIP, both prior to the implementation (perceived) and since implementation (real) of the intervention. Almost an equal number of “perceived barriers” and “real barriers” in implementing MIP were provided by study participants. **Table 9** depicts the major barriers identified by participants, categorized under one of the four dominant themes to which it is most applicable. Table 9 also indicates whether the barriers or challenges identified were “perceived” prior to implementation or were actual barriers experienced with implementation.

TABLE 9: Perceived and Real Barriers to MIP Implementation and Adaptation by Theme-- Culture, Capacity, Content, Community		
Barriers	Perceived	Real
Culture		
Culture of drug use--competing with the "high" (client commitment to program vs. addiction (pull of drugs)	√	√
Nature/consequences of substance abuse (withdrawal, shakes, need for a fix).	√	√
Inconsistency with IDUs in keeping appointments, completing sessions, etc.		√
Capacity		
Program staffing levels – limited staff and competing agency demands	√	√
Staff lacking clinical expertise to implement MIP as intended	√	√
Staff lacking understanding and mastery of the program and techniques/ Lack of confidence with implementation of MIP	√	√
Recruitment of target population	√	√
Retention of clients	√	√
Adequate space for MIP counseling/case management sessions	√	√
Establishing trust with IDUs	√	
Ensuring confidentiality of clients	√	
Limited/inadequate supervision		√
Limited quality assurance checks		√
Meeting levels of service		√
Content		
Time constraints- Length and intensity of MIP for IDU population	√	√
MIP's program philosophy different from other agency programs	√	√
Switching from one EBI to another (MIP)/ Transitioning from a group-level intervention (other EBI) to an individual level intervention (MIP).	√	
Team approach to implementation as prescribed by MIP (Counselor/Case Manager dyad)	√	
Challenge with implementing "as recommended"		√
Community (inclusive of Health Systems, Politics, Policy, Economics)		
Funder requirements on client eligibility for MIP	√	√
Continued community support	√	
Loss of collaborators (working with IDU population)	√	
Referral wait times for MIP client		√
Lack of mental health and housing resources		√
Funding levels do not support program requirements and extent of services		√
Multiple Categories (two or more themes)		
Inability to provide clients with all the services they need (community/capacity)		√
Securing external partnerships/Memoranda of understanding (capacity/ community)	√	√
Inability to provide monetary incentives (capacity/content/ community)	√	√
Client retention (capacity/culture of drug use)	√	
Client receptiveness to program (content/capacity/culture/community)	√	

Culture

The “*culture of drug use*,” inclusive of the nature of drug abuse (cravings and withdrawals) and its consequences (incarceration, memory loss, self-medication, dislocation, mental health issues) was perceived as a significant barrier. Agency staff implementing MIP felt that they were “competing with the high” when working with active IDUs and noted the difficulties in keeping IDUs engaged and committed to MIP due to the physical, psychological, and behavioral effects of the drugs. One MIP Supervisor noted these difficulties in working with IDUs,

Even though my staff has been working with IDUs for over 8-10 years and they have expertise in terms of sitting down with a client and getting him to work through his risk-reduction goals. For the client--the main importance ... is the drug and getting the drug—that's a major barrier. I guess the other agency will tell you the same thing”.

As predicted by the above quote, staff across agencies implementing MIP noted the inconsistency of IDU clients keeping up with the session appointments required to successfully complete MIP and with referral follow-up for other identified needs and services. According to front-line staff, co-occurring conditions of mental illness and homelessness also contributed to client inconsistency with MIP.

They [MIP clients] will disappear but they will always come back. They may not be as structured as other people because of the drugs, but they always come back to us. MIP is client centered so you cannot make them do anything; you work with them little by little and motivate them to do better.”

Activities/referrals do not always go as planned. MIP is time-consuming because of who we are working with[IDUs]. The flow from one session to the next does not always happen as planned.

Capacity

The most responses regarding barriers and challenges both perceived and real, were under the broad theme of “**Capacity**” (See **Table 9**). It is also under this category that there was the most

correlation between perceived/anticipated barriers prior to implementation of MIP and the reality of implementation. Capacity barriers/challenges found to be both perceived and real are highlighted:

1. Human Resource Constraints –Staffing, Supervision, and Skill Deficits.

a. Inadequate or limited program staffing levels.

Human resource capacity across agencies varied with approximately half the participants (5) stating that staffing was adequate; whereas other participants viewed staffing and supervision issues as among their “greatest challenge” with implementing MIP. Supervisors and front-line staff both expressed concern with current staffing. Limited staffing meant that current MIP staff were stretched and redeployed to fulfill other tasks within the agency.

[Agency] requires more staff to run the program as intended--maybe one more staff because I need at least two outreach staff on the streets...Then I need a Counselor and Case Manager to work with MIP because that is one of the core elements of the intervention.

Although case conferences are conducted and there is some mentoring with writing clinical notes, “staging” clients, etc., staff definitely need more supervision.

A front-line staff member at one of the implementing agencies, identified the current staff pattern at the agency as being in direct conflict with the recommendations provided in the MIP TOF implementation manual, and thus, posing a burden for existing staff.

[Agency] model is different from what is recommended in the MIP curriculum. Each staff member does both counseling and case management—using the recommended MIP model would ease the burden.

The staffing model recommended in the MIP TOF includes at a minimum, a Counselor, a Case Manager and a Supervisor; however the recommendations also encourage cross-training between positions to ensure that the MIP client can always be served in the event of staff turn-over or staff unavailability.

b. Staff Skill Deficits

An agency supervisor strongly believed that among existing staff the lack of clinical expertise presented as a major challenge. This Supervisor felt strongly, that the counseling and case management components of MIP required staff with strong clinical backgrounds rather than the use of non-clinical staff to implement these functions.

I am still convinced that MIP is better implemented by clinical staff. For example, even in how you respond to clients, there is a clinical response. I believe MIP would be more effective if implemented by people with a stronger clinical background.

In another case, program staff lacked understanding and mastery of the MIP program techniques. Two front-line staff members noted a level of discomfort with MIP and lack of confidence in implementing the intervention both before implementation and soon thereafter.

[I was] "learning as I go." I would go out with my manual (MIP Implementation Manual) wherever I went and would be flipping through the pages. Am I doing this correctly? Have I covered everything? Then I gained my confidence. I still have that thing in my trunk....

2. Recruitment and Retention of target population

Identified as both a perceived and real threat, the recruitment and retention of MIP clients was among the most common challenge across implementing agencies. For two of the three agencies, continuing to find IDU clients that meet MIP eligibility criteria-- and in the case of one agency, funder criteria—proved difficult. Even when clients were recruited, the challenge of keeping them engaged and committed to the entire MIP intervention remained.

3. Adequate space for MIP counseling/case management sessions.

For one of the three agencies, a lack of adequate space to conduct MIP counseling and case management sessions was foreseen as a barrier to implementation and remained a barrier upon implementation. Staff from this agency indicated that because they conducted MIP sessions off-site at partner locations, they often had to "find" available space to implement MIP and ensure confidentiality.

Content

Content barriers specifically highlighted challenges with the design, structure and input of the MIP intervention. Two most significant content barriers impacting implementation are as follows:

1. Meeting Program Fidelity - Time Constraints, Quality, Levels of Service.

Especially for front-line staff, the greatest challenge encountered with MIP implementation has been to deliver the intervention as intended, within a recommended time-frame and in a structured and client-driven manner that retains fidelity. Although the client-centered nature of MIP was viewed as contributing to its success; the flexibility of the intervention, its intensity, and the time needed to implement MIP as intended, was equally perceived as a major barrier by some agency staff.

[MIP] is a tough intervention to implement because each component can break down into multiple sessions. It is good, but it is long. When you work with IDUs you need to have an intervention that is more direct-- short --and can address all those components in a less amount of time.

We have an intervention that has 7 sessions and every session can be broken into 5-6 meetings--other sessions. Then you have a client who has a big substance abuse problem and he may not comply with the meetings that have been established. So basically...we can work with a client over 6 month period [as per MIP guidance]. During that time, let's say the client was attending nicely and complying nicely for three months and something happens and then he disappears and the work that we have done in 3-4 months...and we are close to the end... it just disassembles in our face—so that's a major barrier.

This balance of time, quality, and fidelity impacted at least one agency's ability to meet their levels of service with the funder.

Meeting target number of clients as indicated in the program contract is a challenge. Some clients take 10 minutes to get through a session, and others take 3 days;

2. Implementing MIP “as recommended”

Another major “content” barrier highlighted by agency staff was the expectation from certain funders to implement MIP “as recommended.” Supervisors from two of the agencies noted **the disconnect** between the MIP implementation recommendations and the reality of community-based

practice. One Supervisor pointed to the discrepancy between program expectations and outcomes, and staffing and funding levels within CBOs.

When [original researchers] performed the study, they had a lot of case managers and staff to implement it. Now the reality of any agency working with HIV is that they don't have a big staff; it is a few staff with various responsibilities...that is the reality in HIV[programs]—maximize the staff. When you work with an intervention as structured as this, you have to take the client to another level to really complete it....we want to really be effective; we want to create an impact, so you have to do it right, and when you do things right it takes a little bit more time. So that's the thing.

Other study participants expressed similar sentiments related to the gap between research and practice related to the content of MIP:

MIP is challenging to implement structurally. All sessions are not conducted with all clients. This is because [the] client does not follow a schedule or session flow;

MIP is challenging in terms of doing it as is....Client attendance is not reliable. If clients are no shows for over a month, you have to go back again and start from the beginning.

[We] considered the intervention presented as opposed to how it is in practice. For example, the intervention says 7 sessions but each session can take multiple contacts and run for as long as 6 months

Community

The theme of “**Community**” was inclusive of the health systems, politics, policies, and economic realities that can impact programs within communities. Community-level barriers included: 1) Funder specifications on client eligibility for MIP; 2) inadequate community support/structural systems to support MIP clients; and 3) in inadequate funding levels to support MIP program requirements and optimal service delivery.

1. Funder specifications on client eligibility for MIP

An agency-specific issue identified as the “greatest challenge” for staff was a mandate from the funder to change the client eligibility criteria for MIP from “persons who injected drugs in the past 90 days” to persons who have “shared drug paraphernalia in the past 12 months.” According to staff, this

specification posed a challenge to the MIP program because IDUs were less likely to disclose to “sharing works” than injecting drugs due to stigma associated with sharing. Agency staff also felt that the “sharing” specification had further reduced the pool the eligible clients thus making recruitment of participants into the MIP program more challenging.

The fact that qualifying MIP participants must have shared within the last 12 months has been a huge challenge. MIP staff has had to turn away individuals because of this clause.

In this particular case, the implementing agency felt that the funder lacked knowledge and understanding of the MIP program components, philosophy and overall goals, thus further compromising agency success with implementation of MIP.

2. Inadequate community support/structural systems to support MIP clients.

The lack of mental health and housing services to support the MIP client was a recurrent theme among front-line staff. These two factors were viewed as compromising the retention of clients in the MIP program. One organization also identified the lack of a needle exchange program in the immediate vicinity of the agency’s service area as a major structural barrier in reducing HIV/AIDS risk among IDUs.

So far the great challenge we have encountered is the lack of mental health programs that will take clients. It is very hard to link them for psychiatric evaluations.

Until basic needs are met client will not commit to recovery. We do not directly work on substance abuse but work with their top issues....housing, food, urgent care, etc. That is beauty of MIP.

Even when resources were identified for other critical services needed by the MIP client, the wait time from referral to actual service delivery was lengthy and cumbersome, thus compromising client follow-through and retention.

Also, because the clientele served by MIP were highly stigmatized, overall support from the community, including other health, human and social service programs varied from lukewarm to complete marginalization, as is described in the quotes below.

While the community is not directly involved, they are not opposed to the MIP program either. [Agency] has a commitment to the community and is open to ideas to facilitate the effectiveness of the MIP program.

The community does not buy in as much...community has more important priorities on their plates than MIP. Also, the addiction community is transient.

[The] community sees population in a very negative way; so there is not much community support.

Multiple Categories

To account for identified barriers, either real or perceived, that could not be solely categorized under one of the four dominant themes, a “multiple category” theme was developed. Responses in this category spanning two or more themes and manifesting as a current implementation barrier are as follows:

Two study participants noted the “inability to provide clients with all the services they need” as a current barrier; yet it was difficult to discern whether this barrier was structural and thus belonging to the category of “Community,” or whether the “inability” described was a “capacity” issue within the organization and reflective of internal shortcomings in facilitating linkages and referrals. Adequate mental health resources and temporary and permanent housing were two service gaps identified by several staff as lacking within their respective communities. One front-line worker described the challenge of meeting all client needs as a community-level and resource issue.

Sometimes clients come because they have a lot of case management needs—housing, food supplies, employment—things that need to be attended quickly...and that's part of the challenge because sometimes you cannot really resolve as you wish—because you are calling other agencies and they do not have an opening for the client—then the client may feel frustrated and he may feel that you are not really doing enough for them. Of course you try to

explain to them....we always make it clear to the client that we don't promise anything. What we can promise is that we will work with them and we are going to try our best. We never tell the clients that we are going to give them this and that because that is not a good thing. When it comes to mental health it is challenging as well to find some referrals for clients with mental health [needs].

Another front-line worker felt that ineffective cooperative agreements with external partners hindered MIP clients' access to services outside that of the implementing agency and advocated for enhancing relationships with external organizations to "go beyond the paper."

[Agency] could improve on relationships with other agencies. Agreements are done but there is no "warm connection" with other agencies. MOA's are on paper but the relationships are not always there or work out as intended. Sometimes we go to agencies that we know that we have agreements with and we do not have anything in common.

Staff at two agencies also identified the "inability to provide clients with monetary incentives" as a current barrier to the successful implementation of MIP. It was unclear whether this limitation was based on internal agency policies which would indicate a "capacity," issue, or prohibited by intervention guidelines (content issue), or funders (community/policy issue), or simply a lack of innovation on behalf of implementing agencies to find other means to support client retention in the MIP program. Two participants felt that cash incentives would increase retention; whereas another participant looked at cash incentives as a way to directly support clients with accomplishing the goals and objectives of MIP.

I would like to see incentives used for certain unobligated things. For instance, money to supplement costs for receiving certain services where there is a small fee. For example, if you [provide] a referral for a client to seek medical care or a medical examination but they do not have the \$20.00 co-pay, then they don't go—[I]would like to see incentives used like that.

If clients do not have identification in a lot of places they cannot receive services—it is like they don't exist—clients have to have a picture id....especially since 9-11. Clients need monetary help to get id's.

"Client receptiveness" and "client commitment" to the program were also perceived barriers that did not fit into single categories. It is difficult to ascertain whether receptiveness or commitment is

a manifestation of intervention content, or an agency's inability to engage and retain a client, or a result of the nature, culture and consequences of drug use, thus, these two barriers "fit" multiple themes.

Major Successes with MIP Implementation

Key Finding 6: Overall, implementing agencies believe in utility and value of MIP. Although agencies have, and continue to face implementation challenges, they have also experienced significant successes with MIP.

The implementation of MIP brought with it significant successes and challenges for each implementing organization. When asked about the successes experienced with the implementation of MIP, four major themes emerged from the responses of one-half (n=5) or more of study participants and are as follows:

1. **Positive client-level changes.** The majority (n=7) of study participants commented on the success of MIP in changing the lives of clients for the better through positive behavioral changes to reduce sexual and drug-related HIV risks, as well as improve overall wellness and quality of life. Several examples attesting to the success of MIP were provided:

A great success has been seeing clients stabilize as a result of the intervention.

MIP helps client realize health is important. When clients are using drugs they forgot about themselves, so MIP helps raise awareness of needs. Eventually there are rewards. for example—when clients report that they have reduced their intake of drugs or that they are using condoms to protect themselves during intercourse, or when they say they are taking medication as mandated--things that they did not do before—to me that is an accomplishment.

What has worked well with MIP implementation is that participants are empowered and see that they have the capacity to improve their lives. MIP participants have increased self confidence.

In one case a client survived a domestic violence incident after being violently physically hurt. The participant did not relapse; she filed a police report and continued with MIP. [She] received medical and mental health services through MIP and is doing well.

2. **MIP staff capacity, commitment, and teamwork.** Six (6) study participants commented on the commitment and cohesiveness of MIP staff as contributing to program implementation success. Participants noted staff skills in working with IDUs, their willingness to accompany clients to referral appointments, and the teamwork and support among agency MIP staff as examples.

There was a lot that went into implementing the program-- putting a great team together, being able to fully understand the intervention, and being committed to the fidelity.... The team did so successfully.

MIP staff work really well and [as] a unit. We are a close knit group. We have a great Coordinator that advocates for MIP staff.

We do whatever it takes. The client gets the complete service. Staff work overtime if need be and staff hours are settled later. Many times clients are accompanied to medical and service appointments. This proves to the client that [agency] has a strong commitment to assist them and will not defraud or deceive them in any way.

3. **Effective intervention components benefit participants.** Across agencies study participants (n=6) viewed the client-centered nature of MIP as contributing to its success with IDU population. The structure of the intervention, its case management component, and its acceptability among IDUs were all noted.

I've had a lot of successes in MIP. I honestly believe it is the case management piece [in MIP] because you can get counseling anywhere.....

Participants are "pleasantly surprised" with all of the MIP services that they are offered and seem to appear more secure and calmer with the process once the program is thoroughly explained to them.

It is good to know that MIP is something that we can use and that it is really working... I think that they [clients] respond to what they have been given...at different times, at different levels. [MIP] meets the client at their pace.

MIP is excellent. The participants accept it. MIP is tremendous.

4. **Use of incentives aid in retention.** Five participants mentioned the use of incentives as a success strategy and valuable tool in facilitating the recruitment and retention of clients in the MIP program. Staff viewed incentives as both monetary (gift cards), and supportive in the form of easy, readily available access to other health, social and support services offered within and outside the implementing agency. The participant quotes below attest to the many ways in which incentives are strategically used to facilitate MIP program participation and completion.

The incentives have worked well in terms of recruitment and retention of clients.

[Agency] offers significant incentives at the beginning of the program and even better at the end. [MIP clients] get gift cards of \$ 20 for the 1st session (Induction session), \$10 per subsequent sessions and \$50 for the booster session. We give gift cards that have been suggested by participants and gift certificates to restaurants.

Clients are offered incentives for a referral; persons are screened to see if eligible for the [MIP] program. We screen them when we test them for HIV.

[Agency] sets aside weekly medical appointments for MIP participants (free of charge services). [They] receive on-site medical services--family planning, screening and testing for HIV, comprehensive care clinic, mental health services, OB/GYN, youth services, pediatrics and dental care.

Other factors identified by study participants (fewer than 50%) as “successes” with MIP implementation included:

5. **HIV testing success.** MIP staff across agencies encourage testing and are certified to conduct on-demand HIV tests for MIP clients and all other clients;
6. **Ability to recruit and retain IDU clients** that are commonly classified as “hard to reach” and “difficult” to work with; and.
7. **Having received the MIP Training of Facilitators** prior to implementation to get staff prepared to execute the program.

MIP Program Implementation Support

Key Finding 7: Program Implementation Support varies by funder with regard to the extent of involvement, input, and technical assistance provided around EBI implementation. The value implementing agencies place on such support is related to whether implementation support is perceived as a need by agency staff.

Based on their funding awards, implementing agencies have certain levels of service they are contracted to meet. Only one of the three agencies reported meeting their levels of service without any major challenges; while the other two agencies reported having issues with the recruitment and retention of clients for various reasons. When asked about the “helpfulness of the funder” with providing adequate technical assistance around program implementation, staff (n=6/9) from the three agencies reported significantly different experiences. On a scale of 1-5 (with 1 being the lowest level of “helpfulness” and 5 being the highest) among the six respondents providing a rating, the average rating was “2.3,” with a rating of “5” (n=1) as an outlier. Two of the three (n=2/3) staff unable to respond to this question noted that they were not privy to funder support and therefore would not comment on “helpfulness.” Also important to note was that a low rating of funder “helpfulness” did not necessarily indicate a negative experience with the funder, but in one case, a lack of need for help with implementation. For staff at another agency, lower ratings of funder “helpfulness” were indeed indicative of a lack of support. **Table 10** provides the ratings and study participant justifications for these ratings.

TABLE 10: Funder “Helpfulness” with MIP Implementation- Ratings and Justifications		
Note: Scale of 1-5; 1= low; 5 = high		
N=9	Rating-Funder Helpfulness	Justification for rating
N=1	5	<i>Project Officers are always there to provide assistance every time I call. [They] always have a response and a way to help me see things or suggest ways to help me solve the issue. [The] tools are out there and the people I have had the opportunity to work with have guided me and helped me."</i>
N=4	2	<i>We have no need for assistance; site visits were conducted and the funder is pleased with program results.</i>
		<i>MIP TOF was provided but no additional trainings or refreshers have been offered by the funder. We are working with what we know.</i>
		<i>[Funder] has not been very helpful on MIP implementation and adaptation. [Funder] has not received any MIP training.</i>
		<i>MIP TOF training, materials and documents provided by the [funder] was helpful. Since then no refresher training or new strategies have been offered to MIP staff.</i>
N=1	1	<i>Funder is not trained in intervention- "Technically I don't know they can assist because of their own lack of knowledge. [Funder] relies on us— the implementing agency."</i>
N=1	No rating	<i>[Funder] lacks knowledge and understanding of the intervention and therefore cannot provide guidance on implementation of MIP.</i>
N=2	No rating	<i>Staff not privvy to information regarding funder support</i>

When asked about their *primary sources of implementation support*, the few (n=5/9) study participants responding to this question accessed support through diverse sources. Only one participant noted the funder (n=1/5) as a provider of implementation support; whereas two (n=2/9) participants referenced a Capacity Building Assistance Provider with expertise in the particular EBI (MIP) as a source of implementation support that was made available through the funder. Another participant (n=1/5) accessed program implementation support through collaborations with various external agencies, and yet another participant (n=1/5) found support for program implementation through the shared knowledge and experiences of internal staff.

C: Adaptation of MIP
Research Aim 2: Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings

The exploration of Adaptation in the context of program implementation is compatible with the second aim in this research study which is to identify the practices and strategies used to facilitate the successful adaptation of MIP in community settings. First, agency staff understanding of adaptation as part of the EBI implementation process is presented along with the inherent messages received by staff regarding adaptation. Second, support for adaptation of EBIs from the community's perspective is discussed, followed by an account of staff experiences with the adaptation of MIP and the strategies and resources accessed and used to facilitate these adaptations.

Adaptation Concepts: Definitions, Examples, Nature, and Scope

Key Finding 8: Adaptation “in concept” is well-understood by community-based practitioners. It is viewed as a necessary part of the EBI implementation process warranted by the variations between the realities of community-based practice and researcher/funder implementation recommendations.

The knowledge and understanding of adaptation and what it entails varied among study participants. Whereas some staff were able to effortlessly provide definitions of adaptation in their own words; others preferred to provide examples to communicate understanding of what adaptation entails. Key concepts communicated in the *definitions* provided by study participants (n=4) included “maintenance of core program elements,” “tailoring program components” and “making it fit,” indicating sufficient awareness and understanding of the process of adaptation.

Other study participants (n= 4) provided *examples* to explain adaptation rather than providing a definition. The key concepts communicated in these examples were “making changes” or “doing something else.”

Adaptation is making changes; adjusting the terminology of the documentation to terms that the client is more familiar with.

For example, MIP was assigned to a specific population and we have been using it with other populations. That is an adaptation.

Adaptation includes things to help make the program run better. [Agency]...adapted some forms (documentation) and eliminated certain terminology.

One front-line staff member was particularly uncomfortable with the concept of adaptation and felt ill-equipped to define it or provide an example; yet, was able to articulate the value and necessity of adaptation for community based practice.

MIP has a lot. Everything is comprehensive, but [it] certainly needs to be adapted depending on all of these factors—geography, social and cultural [issues]—all of them.

Similarly, the majority (n=5) of study participants expressed that adaptation of EBIs was necessary to ensure relevance and applicability in local community practice settings. Respondents understood that multiple factors needed to be considered in undertaking an adaptation including funder requirements, organizational level factors, EBI content, and client-level factors such as variations in population targeted, language/ethnicity, geography, and clients' drug of choice.

Adaptation is absolutely necessary. Adaptation takes advantage of the intervention to get more out of the curriculum to meet the needs of more diverse groups. My feeling is that the way it [MIP] was done—the target population, the geographical location, all of it was good, but now, it needs to be adapted. To me it [MIP] needs to be dynamic.

Adaptation is necessary because you need to consider all factors such as cultural differences, language, ethnicity...and other client and organizational factors.

Study participants also surmised that adaptations were necessary especially upon implementation of an EBI and the realization that “in practice” most EBIs required some modification from the implementation recommendations and guidelines presented in order to work well for the organization and/or population being targeted.

Interventions are designed to be implemented on a daily basis but organizations cannot do these interventions on a daily basis. Adaptation is needed.

Adaptation is necessary due to organization and program issues. The intervention “as is” does not mirror practice.

[I] think [adaptation] is necessary because the actual training may not be how agencies are actually implementing. Adaptation can make the difference in whether intervention is successful or not.

Another study participant indicated that the adaptation of an EBI was dependent on how long the intervention has been around and whether or not the target populations were the same in the original research and at the community level.

Adaptation depends on the age of the intervention and whether the intervention was specifically made to serve the actual target population that you are intending to serve.

Taken together, these responses demonstrated that there is a general degree of understanding among CBO staff regarding adaptation and its role in EBI implementation. Such was not the case for staff knowledge regarding *how* to conduct an adaptation of an EBI.

Adaptation “Know- How” and Support

Key Finding 9: There is a lack of information and guidance available to community-based practitioners on how to conduct adaptations of EBIs. This lack of information is perceived as purposeful and indicative of a lack of funder support for adaptations being undertaken at the community level.

Across agencies, staff reported a paucity of information on *how to adapt* an EBI. Even with the overwhelming belief that adaptations were a necessary part of the EBI implementation process, participant responses to questions regarding the nature and extent of EBI adaptations before efficacy and fit was compromised, were wide-ranging. Three (n=3/9) respondents were very clear on the limitations in conducting adaptations of EBIs.

The message for everyone trained has been that there are certain elements of the intervention that cannot be changed. You must follow the curriculum otherwise the efficacy/validity is compromised.

Depends on the core elements of the intervention. Use core elements as your rules on what is allowed with adaptation.

The core items need to be in place and not changed. There needs to be flexibility, but the essence must remain or else it becomes a totally new program.

Two (n=2/9) study participants understood that adaptations were allowed, but only “up to a point” before compromising efficacy/fidelity.

[I] believe interventions needs to be tailored and changed "to a point." You can only change some things. For example, a previous intervention designed for African-American IDUs had to be done for rural Latinos. You have to be careful...

Sometimes adaptation changes a program completely so that it is no longer the way it was done originally. It is not the same anymore, it is an entire new program....

The remaining (n=4/9) study participants had little to no information as to the extent of changes that would be allowed or prohibited during the adaptation of an EBI. The following quote from one of these four participants captures this gap in knowledge.

*[It is] hard to say what features can be adapted. I was told the intervention could be adapted, but not **how to** adapt. For example, how to use MIP for clients with diverse substance abuse problems... Many of the [MIP] sessions apply to anybody. .*

Study participants also expressed a general lack of guidance on conducting an adaptation of an EBI in their respective settings. Only five of the nine (n=5/9) participants had ever received any

form of guidance on adaptation, and according to these participants most of the guidance received was general in nature and not specific to the adaptation of MIP. Front-line staff persons were less likely than Supervisors to report having received guidance on adaptation and those that had been exposed to adaptation had learned about adaptation processes through a capacity building assistance provider or their Supervisor. The prevailing sentiment from front-line staff was that little to no guidance was provided on adaptation.

A lot of what I learned in the DEBI workshops is that the core of the program cannot be adapted—that there can be variations.. but certain things that cannot be changed.

[The] guidance is general with a focus on keeping core elements. It is not specific to populations. We are always told “don’t touch the core elements.”

Some guidance on adaptation was received through trainings, but not specific to MIP. .

Two study participants that reported having received guidance on adaptation did so from the funder (n=1) or through a capacity building assistance provider (n=1). In the first case, a front-line staff member reported the agency having received permission from the funder to expand the target population for MIP to include other substance using clients, thus indicating an “approved” adaptation. This information was later verified with the agency Supervisor.

We have adapted MIP to no-IDUs and I think it has worked very well. Because personally I think MIP should be implemented with all clients/populations not strictly IDU. Most of our clients put themselves at risk for HIV.

From the perspective of study participants, the general information and guidance received on adaptation, whether from training workshops, funders, or CBA providers, had varying levels of value. On a scale of 1-5, three (n=3/9) participants ranked the information received on adaptation as “5--very helpful” due to the usefulness of the information and technical assistance received (n=2/3), and because of having received permission from the funder to expand the target population for MIP (n=1/3). One participant in a Management/Supervisory capacity provided a rating of “2” due to a previously

unsatisfactory experience in obtaining guidance and materials from the funder to help facilitate the adaption of another EBI within the organization. In recalling this experience, the participant noted difficulty and resistance with obtaining this information from the funder.

It was more just guidelines for adapting an intervention, but you still have to go back and get a hold of the original curriculum which isn't easy to do. They [Funder] do not make it easy. because they don't want to release it that much...

Another management/supervising staff member provided a rating of "0" for the overall lack of guidance that exists on adaptation and the perceived resistance to adaptation coming from the funder.

When [funder] is told about adaptation they do not necessarily support it. They want agencies to implement the intervention as is. Really, every time you tell [funder] that you are going to adapt, they get crazy about it. They don't want you to touch their intervention.

Similarly, three (n=3/9) participants felt that they could not provide ratings on "helpfulness of information received on adaptation of EBIs" because although it had been communicated that adaptations could be done, there had been no guidance provided from any entity on how to adapt an EBI.

[I was] told we can adapt but not "how" to adapt.

No guidance was received on adaptation. All modifications—the terminology and forms—were done by agency staff without guidance.

Although a third of study participants (n=3/9) experienced positive outcomes in seeking and receiving guidance on adaptation from a funder, supervisor, or capacity building assistance provider, the experiences of the other five individuals indicate that support, especially from the funder was either non-existent, limited, difficult to access, or unwelcoming. A few (n=2/9) study participants noted having to depend on other staff for assistance with adaptations or had to use their own counseling and case management skills to "figure out" adaptation.

Adaptation Experiences with MIP

Key Finding 10: Agencies implementing MIP have conducted major and minor adaptations; however they are reluctant to classify these changes as “adaptations.” Adaptations conducted align with the four major themes of culture, capacity, content, and community.

Whether or not study participants had been exposed to or had received information or guidance on adaptation of EBIs did not hinder adaptations from occurring. Management staff were asked to describe how the agency had approached the need for adaptation. Across agencies, the immediate responses provided by Supervisors were that none or few adaptations of MIP had taken place. Front-line staff, perhaps because of their role and experiences as implementers, were more forthcoming and detailed in their recollection of “some” adaptations having occurred.

[We] tried to stay close to the original research. [We] adapted a bit but [stayed] very close to original intervention, as it was taught to us. The essence of it is still there but we made little changes.

Very little adaptation was done. MIP runs itself, we didn't have to do much to it.

At one agency, management initiated adaptations included changes in staffing structure for the MIP program as well as the decision to expand MIP to other substance using clients including alcohol abusers. However, it was solely front-line staff who disclosed these significant adaptations although the Supervisor was asked multiple times about program adaptations conducted and provided with examples. It was only after direct questioning about these two adaptations that the Supervisor confirmed and verified that adaptation had occurred.

Our agency model is different from curriculum recommendations. Each staff does both counseling and Case Management; I believe that using the recommended MIP model would ease the burden on staff.

At first we targeted mostly IDU, then we became flexible and began targeting people in high-risk situations—not just IDU or their partners but clients that are using some type of substance. We expanded because there was so much need in other areas.

Types of Adaptations Conducted: Culture, Capacity, Content, Community

Across agencies and staffing roles, the MIP adaptations that were conducted aligned with the four major themes of culture, capacity, content, and community; and as such have been organized according to those themes as presented in **Table 11**.

The most commonly reported adaptations were modifications to the sample MIP forms provided in the MIP TOF to assist CBOs with implementation. Two Supervisors and four front-line staff members all reported form modification as an adaptation. The second most common adaptation reported across agencies and staff were language modifications, specifically the replacement of terms to include less complex language or more local terminology. Staff from all three agencies also reported having to conduct Spanish language translations of MIP sessions in order to accommodate Spanish-Speaking clients. It should be noted that the MIP curriculum is available in both Spanish and English; however only one implementing agency knew of and used the Spanish language MIP curriculum as its predominant implementation tool. For the two other agencies many more “on-demand” translations were conducted.

Other adaptations reported by the implementers of MIP, the front-line staff, focused on intervention content and cultural factors. Front-line staff members described having to shorten, lengthen, or condense MIP sessions to meet the needs of MIP clients and also reported having to alter intervention content to accommodate cultural values and beliefs and increase cultural relevance and competency for particular groups. The experiences of front-line staff members with cultural and content adaptations of MIP are captured below in the following quotes. By far, **content** adaptations were the most prevalent among front-line staff across agencies and varied from minor adaptations to more significant ones, and are documented in that order.

We adapted terminology and forms for variation in local terminology.

Some sessions will go longer than others or shorter, depending on what the session is and what is going on with the client.

We condense sessions on the street. We condense when we don't have the forms or the same structure as the curriculum.

We added information on coping skills and add activities such as journaling.

We have used curriculum with non-IDUs and conducted translations to Spanish. Also, not all sessions have been done. We sometimes skip.

In the latter example of skipping or eliminating sessions, reported by staff from a single agency, the Supervisor recognized this "adaptation" as a **capacity** issue for the organization:

Seven sessions are not conducted. The staff report that the client is not interested in some topic areas covered in the MIP curriculum; Counselor reports the client does not have a need for certain sessions. I'm not sure if this is the Counselor's issue or really the choice of the client. I believe that if you have the counseling skills you can encourage the client and cover all the topics.

Adaptations related to **culture and cultural competencies** were also revealed. For front-line staff members at two different agencies issues of machismo came up in the context of cultural adaptations. These staff reported having to change their approach, language, questioning, and examples, in order to remain unthreatening and keep the clients engaged.

Every client is different. I may need to probe more with some clients based on cultural issues--for example, machismo. Spanish males choose not to disclose certain things. Also clients may think some drugs [are] better or worse than others and we have to tell them all drug use has consequences. All cultural factors need to be considered. Everyone has their own story. The interventions are intended to help a lot of people, but every case is different.

Another cultural adaptation articulated by a front-line staff member was with regard to the drug using culture for specific drugs. It was noted that the existing MIP content had to be modified to include language and examples directly related to drug use for the particular drug of choice.

We have tailored MIP to everybody--not just injection drug users. Content and language has been modified to be specific to "drug of choice" because MIP is not just for IDUs, so we change activities and examples.

Community driven adaptations of MIP included two policy decisions made by a funder: First, a decision was made not to require the implementing agency to conduct the Booster session of MIP—which is the last session of MIP and a core element. The agency has continued to conduct the Booster on its own in order to maintain the integrity of the MIP intervention; however, this work is not recognized by the funder. Secondly, the funder instructed the implementing agency to modify client eligibility for MIP by changing criteria from “injecting” drugs within the past 90 days to “sharing” injecting drug paraphernalia within the past 12 months.

TABLE 11: Types of MIP Adaptations Conducted by Theme – Culture, Capacity, Content , Community		
Theme	Type of Adaptations Conducted	Supporting Comments
Culture		
	Alter intervention content to address the cultural values, beliefs, and nuances of clients and increase cultural relevance and competency; <ul style="list-style-type: none"> - Machismo - Sexual health - Drug using culture of other substance users (non-IDU). 	N=3
Capacity		
	Agency staffing model different from recommendation; One individual conducts both case management and counseling tasks.	N=1
	Agency staff skip/eliminate MIP sessions due to shortcomings in counseling skills	N=1
Content		
	Modify forms provided in the MIP TOF	N=6
	Simplify language and terminology; Use local terms.	N=4
	Conduct Spanish language translations	N=4
	Shorten, lengthen, condense sessions	N=3
	Modifying target population of MIP to include: <ul style="list-style-type: none"> - non- IDUs (other substance users) - needle and paraphernalia sharing IDUs 	N=3
	Skippping over or eliminating sessions	N=2
	Add content (coping skills; journaling activities)	N=1
Community	Health Systems, Politics, Policy, Economics	
	Policy --MIP Booster Session not required as per funder	N=1
	Policy—Funder specification that MIP eligibility criteria be changed from “injecting” drugs within the past 90 days to “sharing” injecting drug paraphernalia within the past 12 months.	N=1

With the exception of the agency that sought permission from the funder to expand the target population of MIP to include non-IDUs, almost all other adaptations occurred autonomously within agencies. Few external resources or tools were used to undertake these adaptations; however, three (n=3/9) study participants recognized the contributions of Capacity Building Assistance (CBA) Providers in helping to address the training and technical assistance needs within their organizations with regard to the implementation and adaptation of MIP. In the other cases, participants either noted that no adaptation guidance was provided or that the guidance provided was subpar or not very useful.

D: Technical Assistance Needs
Research Aim 3: Inform the development of user-friendly adaptation guidelines specifically for community practice settings

The third aim of this research study, which entails the development of user-friendly adaptation guidelines for community practice settings, is informed by the fourth phase of inquiry: Technical Assistance needs draws on the experiences of those most closely involved with adaptation and implementation of EBIs—the management and front-line staff of CBOs. Overall, there were no clear distinctions between staff TA needs for pre-implementation, implementation, or adaptation, thus the support needs identified by study participants cover all phases of EBI implementation.

Implementation and Adaptation Technical Assistance (TA) Needs

Key Finding 11: The Technical Assistance support needs of staff implementing EBIs cover three main categories: Training, Capacity, and Resource Support.

To gauge the technical assistance needs of implementing agencies with regard to the implementation and adaptation of EBIs, all study participants were asked about their current TA and

support needs. Three major themes emerged from responses: 1) Training Support, 2) Capacity Support, and 3) Resource Needs. The most commonly identified TA needs fell into the category of “Training Support” in the form of skills-based trainings, peer-to-peer learning opportunities, and MIP Refresher trainings. TA needs related to any type of adaptation of MIP was categorized as a “capacity” issue for implementing agencies, as was all other TA needs directly influencing an agency’s capacity to implement and adapt MIP effectively. Finally, TA needs directly related to funding was categorized as “Resource” related. **Table 12** lists the TA needs of study participants categorized according to whether the identified need was training, capacity, or resource related. The table is followed by a detailed summary of the TA support needs identified under each major category/theme.

TABLE 12: Technical Assistance Support Needs Identified by Staff of Agencies Implementing MIP	
Training Support	
<ul style="list-style-type: none"> • Peer to Peer Learning --Provision of opportunities to dialogue with other agencies that implement MIP to discuss strategies, successes, challenges and resolution of issues. • Refresher trainings on MIP • Skill-Building training on various topics including: <ul style="list-style-type: none"> √ Enhanced recruitment and retention strategies √ Motivational interviewing/Advanced motivational interviewing, √ Mental health issues and co-occurring disorders √ Strategies for working effectively with IDUs √ Training on psychosocial issues. √ Evaluation of EBI Programs √ Program Documentation/Use of Forms • Strategies on accessing “limited” external health, social and support services such as substance abuse treatment, mental health and housing. 	
Capacity Support	
<ul style="list-style-type: none"> • Support to adapt MIP other populations • Adaptation support to enhance content of MIP to make more comprehensive • Materials development support for MIP implementation • Flexibility from funder with levels of service; • Increased funder understanding and knowledge of the MIP intervention and the difficulties working with the IDU population. 	
Resource Support	
<ul style="list-style-type: none"> • Additional funding to directly and indirectly support implementation and adaptation of MIP • Provision of additional incentives to support MIP clients. 	

Training Support Needs

- **Offer Peer Exchange Learning and Problem-Solving Opportunities on EBI implementation and adaptation.** A majority (66%) of management and front-line staff desired T/TA opportunities that encouraged the exchange of information among implementing agencies about their experiences, challenges, and successes with EBI implementation and adaptation so that staff could learn from each other and use “best practices” to resolve challenges and enhance program implementation. One Supervising staff member suggested the implementation of EBI specific forums which would allow for questions around implementation and adaptation to be raised by implementing agencies and answered by the original researchers based on their unique knowledge and expertise with the intervention.
- **Conduct MIP Refresher Trainings.** All study participants completed the MIP training course at least a year prior to this research study and felt that a “refresher” course on MIP would be greatly beneficial. According to participants, a refresher course should focus on MIP program components, innovative implementation strategies and resolving barriers to implementation.
- **Offer Skills-Based Training.** Across roles, 100% of staff identified the need for skills-based trainings aimed at enhancing competencies for EBI adaptation and implementation. Strategies to enhance recruitment and/or retention of clients was identified as a top training need by more-than half (n=5/9) of the study participants involved with implementing and adapting EBIs. This identification was followed by requests for motivational interviewing trainings (n=4/9) and training on EBI program evaluation (n=3/9). Other areas of training requested included psychosocial issues, including mental health and co-occurring disorders, strategies for working with IDUs, strategies for accessing “limited” external health and social support services such

as substance abuse treatment, mental health and housing, and training in program documentation, with emphasis on writing progress notes and usage of MIP program forms.

Capacity- Related TA Needs

- **Adapt MIP for other populations.** Three quarters of study participants expressed the need for guidance on how to adapt MIP to other target populations, including sex workers, transgender persons, persons in out-patient drug-free treatment programs, persons who abuse other non-injecting substances, and women at sexual risk whose partners share injection drug paraphernalia. The need for guidance on how to adapt MIP for “new” populations emerged as high on the list of TA support needs across agency staff.
- **Enhance MIP Curriculum with added content.** Another type of adaptation that front-line staff were interested in receiving guidance on was the enhancement of the MIP Curriculum to include modules on mental health, vocational and job training and domestic violence and prevention.
- **Provide materials development support.** Assistance with the development of resource materials and support tools to facilitate program implementation and adaptation of MIP was identified as a need among a third (n=3) of the respondents. One front-line staff member was especially interested in learning how to develop recruitment and marketing videos that *“document participant successes and can be used for recruitment and graduation ceremonies.”* Other materials development needs identified by MIP front-line staff included making the MIP forms and curriculum available in Spanish and producing fact sheets on various illicit substances with an explanation of the bio-psychosocial impact of these drugs on the people who use them.

- **Increased funder knowledge and understanding of EBI and Flexibility with Levels of Service:** For one agency, help to renegotiate the agency's contracted levels of service with the funder was identified as a TA need by a staff member, as was the need for increased funder understanding and knowledge of MIP and the difficulties in working with the IDU population.

Resource Support Needs

- **Provide Additional Funding to Support MIP Implementation at the Agency and Health Systems levels.** Funding to support and supplement the health, human, and social services infrastructure to adequately respond to the needs of clients in the MIP program was articulated as a TA need by a little more than one half (n=5/9) of study participants. Two Management/Supervising staff members felt that additional funding for MIP could help strengthen the agency's capacity to more efficiently and effectively run MIP program by supporting the hiring of additional highly skilled staff. A front-line staff member expressed the need for additional funding to expand program incentives for MIP clients as a way of improving program retention.

Other study participants identifying "funding" as a TA issue believed that additional resources allocated to service areas outside of MIP could significantly assist in program retention and the ultimate success of the MIP client. Programs identified as needing additional funding to support the MIP client included needle access and exchange programs, housing and homelessness programs, mobile health units that conduct HIV and STD testing, transportation support, and mental health support services.

Key Finding 12: The role of the funder in the implementation and adaptation of EBIs needs to expand beyond the provision of monetary support. Community based organizations want funders to act as information and knowledge brokers, TA facilitators, Client and agency advocates, and subject-matter experts in EBI program implementation and adaptation.

Since funders have a unique relationship with CBOs as the providers of monetary support to facilitate EBI implementation at the community level, study participants were asked about other ways besides funding, that leading agencies such as federal, state, and local funders could support community-based organizations in the implementation and adaptation of EBIs. Responses were varied and ranged from the expected, such requests for enhanced training and TA, to more broad-based and systems focused recommendations, such as policy advocacy for changing criminalization laws on carrying needles that adversely affect MIP clients. The responses below capture the expanded role that agency staff envision for funders.

One agency Supervisor felt that funders were doing all that they could to support EBI implementing agencies and felt it was up to organizations to take advantage of these offerings.

TA is adequate; to be honest, I can't think of anything else [funder] can do. Funders] have so many webinars, articles, resources to support program implementation and adaptation. The information is there, it is a matter of using it.

Other staff ideas for enhanced TA and support from the funder included having access to EBI researchers and subject-matter experts for consultations, and building funders' knowledge and capacity to provide adequate guidance to CBOs on EBI implementation and adaptation .

In past [we] have contracted with an evaluator to work with [agency], but it is not the same—I don't want any evaluator--I want one of them-- an evaluator that actually created and did the initial research to work with us. [I want] an expert in the subject; not someone that is going to learn with us..

I think that number one thing they [funder] can do is to know the intervention..... There should be mandatory trainings for local funders on the DEBIs they are funding.

[Funder] should be coming in and listen to CBOs about current implementation and what the challenges are and offer help on how to resolve them.

One front-line staff member articulated a broader role for funders to include a policy advocacy component. This participant also articulated a need for greater flexibility from the funder to allow agencies to successfully fulfill the goals and aims of MIP.

[Funder] should provided funding for other support services....They should also support policies that are pro-client -- for example getting clean needles without a prescription and non-criminalization of having needles in [one's] possession....so important. [we] also need more flexibility from the funder to allow for a variety of incentives. For example, meal tickets, hotel vouchers for homeless clients, etc. that would really benefit the client.

For another front-line staff member, the most effective form of support funders could provide CBOs was simply to “renew contracts” to ensure continuity with the HIV prevention efforts of community-based organizations.

Key Finding 13: Program progress notes and funder progress reports provide unique insight into the operations of agencies implementing EBIs and are valuable resources for assessing and verifying the EBI implementation and adaptation practices of community-based organizations and their staff.

Progress Notes Findings

Progress notes from all three agencies provided unparalleled insight as to how the MIP program is implemented at individual agencies, the adaptations that accompany implementation, and the barriers and challenges that are presented. These notes provided documentation of client progress through the MIP program and the case management services received during the course of engagement. In one particular case, an agency submitted progress notes clearly demonstrating the teamwork between the MIP Counselor and Case Manager in supporting the client through the program.

Through this documentation the intensity of the intervention and the time it takes to administer MIP to clients was also revealed. The recommendation in the MIP TOF is that a client is first seen by the Counselor to receive the applicable MIP session and then is referred to the Case Manager for services. This agency's progress notes demonstrated that at almost every encounter the client was seen by both the Counselor and Case Manager and indicated the date and time of each contact with the client. The notes also included the session focus, the staff member(s) seen, the counseling and case management services provided, including referrals, follow-up with past referrals, and pending needs. What also became evident in reviewing these notes was that a single MIP session sometimes required multiple contacts with the client, thus significantly expanding the duration of the intervention. For example, one client file documented six separate contacts with the MIP team, ranging from 15 minutes to one hour on a single session before the client was prepared to move on to the next session topic. Since MIP is comprised of seven sessions, clients requiring multiple contacts to complete a session must be engaged and retained in the program for a longer period of time.

Progress notes from the other two agencies also confirmed the intensity of support required from the MIP team to attend to the case management needs of clients while simultaneously addressing their sexual and drug related HIV risks. These notes provided documentation on session content, client readiness to change specific behaviors, the case management needs identified and attended to, the support items provided to the client (e.g. Male and female condoms) and plans for the next MIP counseling/case management session. For another agency, progress notes verified the fact that case management and counseling tasks were conducted by one person, as was revealed in the semi-structured interviews. Based on a complete review of client files for this agency it was also confirmed that MIP was being used with substance using clients other than those who solely inject drugs, and that very few of these clients had completed three or more MIP sessions. It was difficult to ascertain from the files the reason for limited documentation of sessions. Conflicting positions on whether the client

was still actively involved with MIP, or whether sessions had been skipped or eliminated by agency staff members who perceived that clients did not need or want to participate in certain sessions, was an issue reported in semi-structured interviews and later verified by this agency's Supervisor.

Two of the three agencies also included Action Plan Forms in clients' case files. These forms state the presenting problem to be addressed in a particular session, documents the clients' goal for that session (for example sexual risk reduction), notes the clients reason or motivation for change, and delineates the objective(s)/action step(s) the client will take to accomplish his/her goal, as well as the action step the agency will take to assist the client. Documentation of case management services provided to support the client in accomplishing his/her goal, including referrals dates were also provided on this form which served as "value-added" documentation.

Funder Progress Reports

Funder progress reports were supplied by two of the three agencies and provided a secondary source of data from which to verify MIP client demographics and characteristics, location of services, and program highlights and challenges. For example, a review of one agency's progress report to the funder revealed challenges with client retention and noted the instability of the target population. This revelation was followed with concern about meeting projected levels of services and the steps being taken by the agency to expand recruitment efforts and increase retention. These reports also documented the types and amounts of materials such as male condoms, dental dams and safer sex kits distributed to clients to support them in the MIP program.

A review of funder progress reports and a continuation application for funding provided by the second agency revealed that MIP was only one part of larger, more comprehensive program to reduce substance abuse prevalence in the community. This finding , , provided valuable insight as to why this particular agency chose to implement MIP not only with IDUs, who comprised half of the population

served, but also with other substance users. The agency appeared to have had the support of the funder for this informal “adaptation.” These reports also verified the occurrence of on-going staff training for MIP staff; recorded the types of substances used/abused by clients, and documented program challenges and successes, including changes in drug and sexual risk behavior of MIP clients at baseline and follow-up.

Funder Progress reports from both agencies provided the only reference to technical assistance needs that was available from any of the documentation provided. One agency reported needing assistance with modifying their scope of work as a result of the difficulties presented with reaching levels of service and recruiting and retaining clients for MIP. Another agency noted in their progress report that they were behind in reaching their projected number of clients in a previous quarter but had every intention to achieve projected levels of service in forthcoming months.

Chapter Summary

The depth of the information that emerged from the semi-structured interviews and documentation review provided significant insight into the implementation and adaptation practices of community-based organizations in their deliveries of EBIs, particularly MIP. Each of the four phases of inquiry summarized as 16 key findings revealed substantial information in support of the study’s research aims. The implications of these findings, generated from both from the semi-structured interviews and document review, are discussed in the next chapter.

CHAPTER V. DISCUSSION

This chapter discusses the results from the two research study components-- semi-structured interviews and document review—organized and presented in the same manner as the previous chapter and according to the focal areas of inquiry of this research — pre-implementation, implementation, adaptation and technical assistance needs--- and the research aim(s) associated with each phase. The implications of the key research findings are summarized and an explanation of the limitations of this study are also provided. Conclusions drawn from the discussions also provide the impetus for the study's recommendations and plan for change that is the focus of Chapter 6.

In order to provide a reference point for this discussion on the pre-implementation, implementation and adaptation experiences of the three participating agencies, an overview of the MIP HIV prevention intervention is provided below in **Figure 5**. It includes information on MIP's core elements, key characteristics and intervention content. The discussions that follow on CBOs implementation successes and challenges with MIP, and the adaptations that are conducted as part of the EBI implementation process should be considered in the context of this model and the changes that seem to be inevitable in order to bring best evidence-research to community practice settings.

FIGURE 5: MIP Core Elements, Key Characteristics, and Intervention Sessions

<p>Core Elements</p> <ol style="list-style-type: none"> 1. Community Assessment and Outreach 2. Induction 3. Motivational Interviewing Technique and Underlying theories 4. Continuous Stages of Readiness Assessment 5. Counselor-Case Manager/Community Educator Interaction 6. Minimum Number of Flexible Sessions and Scheduling 7. Booster Session 	<p>Key Characteristics</p> <ul style="list-style-type: none"> ■ Cultural Competence and Sensitivity ■ Team Structure and Training ■ Counseling and Testing for HIV/ viral hepatitis and other Transmittable Diseases ■ Counseling Team Interaction and the Bonding Process 	<p>MIP Intervention: Fixed and Flexible Sessions</p> <p>* Session 1: Induction Session 2: Taking Care of your Health Session 3: Readiness for Entering Drug Treatment Session 4: Relapse Prevention Session 5: Reducing Drug-Related HIV Risk Session 6: Reducing Sex-Related HIV Risk * Session 7: Booster</p> <p>*Note: Sessions 1&7 are fixed; they must occur first and last, respectively. All other sessions are flexible and can occur in any order based on client need.</p>
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Source: PROCEED Inc., 2011-- Modelo de Intervención Psicomédica (MIP) Implementation Manual,

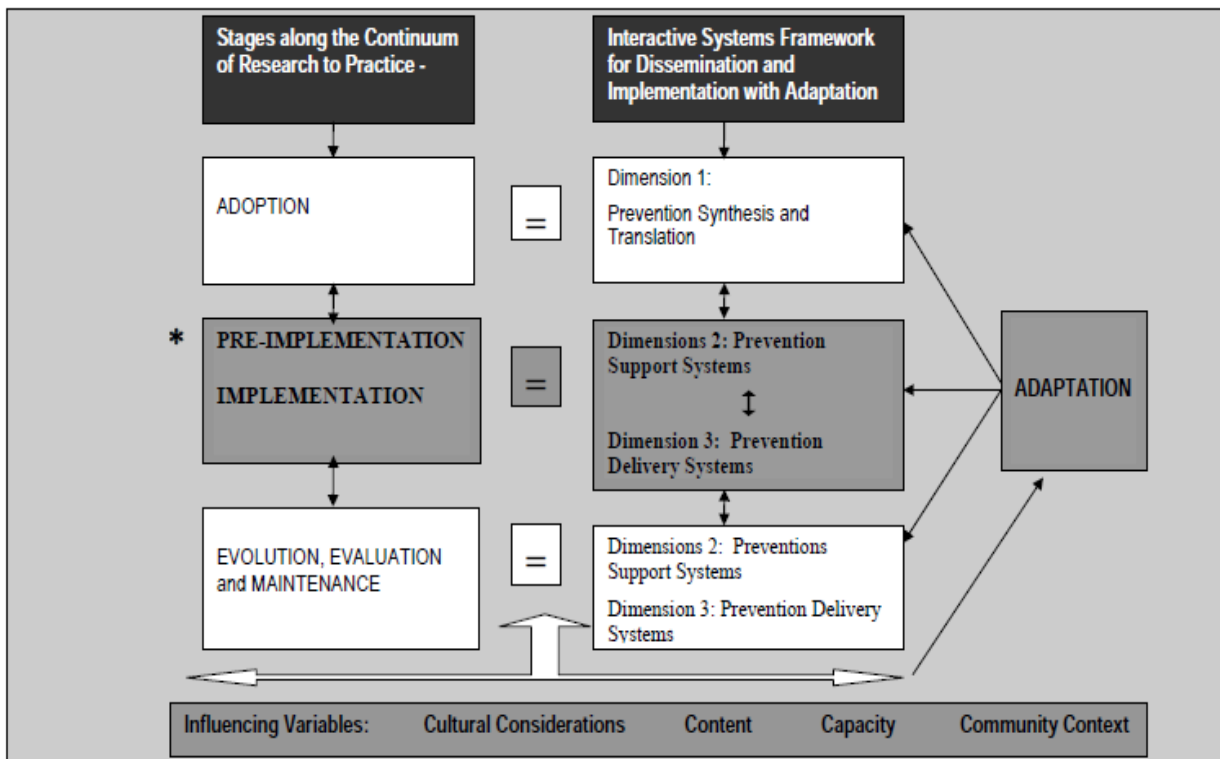
Reflections on Organizational Profiles and Agency Staff

Key Finding 1: A history of service, demonstrated experience with diverse communities, and high organizational capacity are characteristics of the community-based organizations funded to implement HIV prevention evidence-based interventions with highly vulnerable populations.

The first note-worthy trend in the study results is the high capacity of the community-based organizations that were funded by the various sources to implement MIP. Based on the profiles of the three participating agencies it appears that the *first strategic move* in the diffusion of research to community-based practice comes from the *funders* in their selection of well-established community-based organizations with solid organizational infrastructures, experienced, credentialed leadership and staff, and strong histories of providing HIV/AIDS services to communities to introduce and implement new innovations such as MIP.

In the conceptual model supporting this research study—the **Enhanced Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions** (See Figure 4) below)-- this “step” of providing resources to support the diffusion of new innovations, follows Dimension 1- Prevention Synthesis and Translation when funders often take on a lead role of dissemination, as is the case with CDC’s Diffusion of Effective Behavioral Interventions (DEBI), to ensure that new technologies are made available to community practitioners where their impact can be best leveraged. Thus, the “adoption” of EBIs such as MIP by CBOs is facilitated by the availability of monetary support to see the innovation to fruition. Because funding awards to implement MIP ranged from three to five years, it allowed for a full process of program planning, implementation, evaluation, and enhancement to unfold, and for organizations to build on their successes and address challenges over an extended period of time.

Figure 4: Enhanced Interactive Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions in Community Practice Settings.



The characteristics of agencies funded to implement MIP are in line with the six domains identified by Collins et al. (2007), for aiding in the selection of best-prepared agencies with the capacity to implement EBIs. The domains include organizational environment, governance and programmatic infrastructure; workforce and professional development; resources and support; motivational forces and readiness; learning from experience; and adjusting to the external environment. Although agency profile descriptions immediately spoke to three of these six dimensions (organizational and program infrastructure, workforce capacity, and resources and support) , the other dimensions are captured in the pre-implementation, implementation and adaptation practices of these CBOs in their experiences with MIP.

A: Pre-implementation
Research Aim 1: Describe how organizations approached the selection of an evidence-based intervention such as MIP to meet the needs of their local communities.

Key Finding 2: Community-based organizations place significant time, energy, preparation, and planning into the selection of appropriate evidence-based interventions that complement existing agency services and meet the needs of their constituents

In line with Key Finding #2, all agencies placed significant time and effort into planning and preparing for the implementation of MIP. Preparatory activities focused on building individual and agency level competencies through staff training, policy and protocol development, recruitment and outreach to the target population, and the development of memoranda of understanding with key agencies to facilitate a continuum of care and services for the MIP client. These capacity building efforts conducted by the three agencies are in line with activities conducted in Dimension 2- Prevention

Support Systems of the ISF Framework (depicted in Figure 4 above) which focuses on both “innovation specific capacity-building ” or “general capacity building” and is usually facilitated by the funder, an intermediary organization, or both. In these cases, staff completion of the MIP Training of Facilitators, development of intervention specific policies and protocols, and recruitment and outreach to the target population would be considered innovation specific capacity building activities; whereas strengthening the linkages and service agreements between the implementing agency and others could be considered a “general capacity building activity” as the entire agency system would potentially benefit from this accomplishment. These CBOs also prepared for potential opportunities to serve their target populations by conducting needs assessments and community mapping activities with the target population.

On the whole, agencies were cognizant and insightful about what needed to be done in the pre-implementation phase of the research-to-practice continuum to prepare for launching of an EBI and were at ease with the associated tasks. Preparatory tasks primarily focused on building individual staff and agency capacity to facilitate a smooth transition from pre-implementation to implementation of the EBI with the target population. Whereas two agencies felt highly prepared to implement MIP; one agency felt at a disadvantage. This feeling was due to the fact that at the time of funding, staff at this agency had yet to be trained on the MIP intervention and felt at a disadvantage in knowing the full scope and requirements of the intervention.

Agencies were also secure in their selection of MIP as an EBI of choice and were clear about the reasons they viewed the intervention favorably: value to the target population, agency capacity to implement, and self-efficacy to implement with success. This level of comfort demonstrated by participating agencies with regard to the “pre-implementation” phase along the research-to-practice continuum is encouraging, and may be indicative of a mastery that is achieved by well-established organizations that have a history of offering new types of programs to the community and therefore are

adept in the planning it takes to launch a new intervention, whether it be for an HIV prevention EBI or any other type of program.

Key Finding 3: The most influential factors in community-based organizations' decision-making processes for selecting appropriate evidence-based interventions for agency implementation included the needs of, experiences with, and the content, structure, and suitability of the intervention for the target population.

Based on the reported considerations that went into the selection of the MIP, staff perceptions of the intervention, and the pre-implementation activities conducted, it was evident that organizational readiness and motivation to implement MIP was high across agencies. The construct of "readiness" on both the individual and organizational levels is highlighted in the literature (Collins et al., 2007; Durlak & DuPre, 2008; Flaspohler et al., 2008; Norton et al., 2009) as a positive factor influencing program implementation of EBIs. Agency staff perceived MIP as a more comprehensive and valuable intervention for the target population and expressed strong self-efficacy with regard to their abilities to conduct the intervention with the target population based on previous experience with IDUs.

Staff also perceived the components of MIP to have "value congruence" with existing agency philosophies, services and programs. "Value congruence" is defined by Miller and Shin (2005) as: "the fundamental ideology of the organization [including the] values about what its members believe it ought to accomplish in the world and also about what its members think is good, local prevention practice for its target population" (p. 172). Elements of value congruence are captured in the responses of staff in their beliefs regarding MIP's compatibility with the agency's current services milieu, as well as their overwhelming support of MIP as the EBI of choice for the target population of IDUs. It is likely that

these positive perceptions about MIP set a more conducive “tone” for its selection and implementation, as individual and organizational buy-in appeared to be a non-issue.

Although it is unclear whether staff perceptions of MIP influenced its selection as an EBI of choice for organizations, or whether these perceptions were formed after MIP had already been adopted by the organization, there was significant alignment between how staff perceived the intervention and the considerations that went into the actual selection of MIP. For instance, the most significant considerations in agency selection of MIP were the desire to meet the needs of IDU clients and bridge existing service gaps, followed by agency and staff expertise, knowledge of, and experience with the target population of IDUs.

Another aligned “key consideration” and “perception” was the suitability of MIP- that being, the content, structure, and relevance of the intervention-- for IDU clients. All three agencies prior experience with implementing other EBIs for IDUs also factored into the decision to select MIP, thus facilitating a “continuation” of services for this population, albeit the introduction of a new EBI. For two of the three agencies the existence of “trust” between this highly stigmatized and vulnerable population and the implementing agency also influenced agency decision to select MIP as the HIV prevention EBI to ensure that IDUs could continue to rely on these agencies for much needed HIV prevention and related services.

In the case of all three agencies, the congruity between staff perceptions of MIP and the key factors considered in the selection of MIP as an EBI of choice for these organizations demonstrates a level of validity in research findings which suggests that beliefs and perceptions related to an EBI, whether perceived or real, influences its adoption and uptake at the agency level, and thus the “motivation and readiness” of organizations and their staff to implement these EBIs within their respective settings.

B: Implementation
Research Aim 2: Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings

The activities that occur as part of program implementation, including adaptation, correspond to the actions taken within the Interactive Systems Framework—Dimension 3-- Prevention Delivery Systems (PDS). PDS focuses on the overall prevention infrastructure and the ongoing capacity needs of individuals, organizations and communities to implement EBIs with high quality and sustain their use over time in the world of practice. The successes, barriers and challenges discussed thus far comprise the PDS milieu. For CBOs to progress from initial funding (Dimension 1) to implementation, evolution and maintenance of EBIs in community practice settings (Dimension 3), support must be provided. Such support is the role of the Prevention Support System (Dimension 2) which serves as the “hub” for addressing the training and technical assistance needs of staff, organizations, and communities as they implement EBIs.

Key Finding 4: Agency leadership support and staff buy-in on all levels is an important facilitator for proactive planning and successful implementation of an evidence-based intervention.

Agencies implementing MIP had done so for an average of 2.5 years with a range from 1.5 to 3.5 years at the time of this research. Tenure with implementation indicates that the three participating agencies had the opportunity to conduct full cycles of the MIP program and experience first-hand the successes and barriers to implementation. For the most part, agency staff felt well-supported by agency leadership in their planning and implementation efforts for MIP. In the literature (Collins et al., 2007; Flaspohler et al., 2008), elements of buy-in and support for an intervention, both at the individual (staff-level) and organizational level is indicative of agency capacity to implement the innovation. In

the case of the three participating organizations, favorability and acceptance for MIP transcended beyond both management and front-line staff and was reflected in the actions of agency leadership through the provision of general administrative support to facilitate program functioning, including approval for staff trainings relevant to MIP implementation, fiscal management and oversight, and the autonomy granted to Supervisors to manage the day-to-day implementation of MIP. Front-line staff viewed leadership support as more directly related to the supervision, guidance, feedback, and “advocacy with the big bosses” provided by their immediate Supervisors on all aspects of MIP program implementation. Hence, in line with Key finding #4, it can be surmised that agency leadership support and buy-in for MIP on all levels within the implementing agency facilitates proactive planning and implementation efforts for an evidence-based intervention.

Key Finding 5: Barriers to the implementation of EBIs, whether perceived or real, fall into four major categories- culture, capacity, content, and community. Few barriers exist outside the realm of these overarching themes.

In the discussion on pre-implementation, it was pointed out that agency staff typically felt confident in their selection of MIP as an EBI of choice for their organization and the IDU population. These agency staff also anticipated challenges with MIP implementation that were found to coincide with actual existing barriers once implementation commenced. Similarities existed between real and perceived barriers and were organized according to one or more of the four dominant themes identified in the literature as influencing the research-to-practice continuum. These similarities can be attributed to participant recollection, that being the merging of past occurrences (perceptions of barriers) with current occurrences (real barriers), or may be reflective of the collective experiences of these agencies in implementing other programs for IDUs and knowing the strengths and limitations of the target

population, their agencies, and the larger community health system. The four themes, **culture**, **capacity**, **content**, and **community** have influence with all steps along the research-to-practice continuum.

Along the theme of **culture**, the “culture of drug use” was identified as both a perceived barrier and an actual barrier to implementation largely due to agencies experience in having provided services to IDUs prior to MIP. The specific occurrence that was identified as a barrier only after implementation commenced was the level of inconsistency IDU clients demonstrated in keeping appointments, following up with referrals, or completing MIP sessions. This barrier may be because MIP is a structured intervention and calls for certain steps to be followed and actions completed; whereas other programs and services previously offered to IDUs by these agencies did not require a similar level of structure, attendance, or consistency from the IDU client.

Research on how culture impacts dissemination and implementation of innovations (Castro et al., 2004; Devieux et al., 2004; Emshoff, 2008; Guerra & Knox, 2008) support these findings in that culture is viewed as a key moderator of intervention effectiveness where both the “*culture of clients*” and the “*culture of the agencies*” impact science to practice, as was the case with the MIP case examples provided. This moderation of effectiveness implies that CBOs may need to look more closely at an intervention’s *design* as well as its *content*, to ensure cultural compatibility with the target population. In the case of IDUs, less intensive, more rapid interventions may be better suited for this transient and unpredictable population; more so than a structured, comprehensive intervention such as MIP. Even though the latter may “offer more” to clients, a benefit of MIP noted by agency staff, these benefits can only be realized if the client is present, and attends and completes the intervention.

The **capacity** of individuals and organizations to implement EBIs was a dominant theme throughout this research and the source of the most identified barriers or challenges to implementation, both perceived and real. Issues of capacity in the literature is the focus of most implementation

science documentation (Durlak & DuPre, 2008; Flaspohler et al., 2008; Miller & Shin, 2005; Wandersman et al., 2008) and is also a core component of the **Enhanced Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions** that frames this research. Specifically, staffing challenges, whether in the form of competencies and skill, or a lack of adequate staff to run the program to scale, was a significant and on-going barrier for implementing agencies that was identified both before and after implementation.

Other issues pertaining to agency and individual capacity including the recruitment and retention of clients, limited and inadequate supervision, lack of quality assurance checks during implementation and failure to meet levels of service, could all be traced back to “staffing challenges” that either directly caused or hastened other identified capacity barriers. Since the MIP Implementation Manual (made available to CBOs completing the MIP TOF) recommends a minimal staffing plan comprised of a Supervisor, Counselor and Case Manager, deviations from this plan, or having too few staff, or staff without the capacity to fulfill these functions, manifests as a major challenge for implementing organizations. O'Connor et al., (2007) suggest that *“using fewer staff members than recommended”* is a “risky or unacceptable” adaptation that agencies implementing EBIs must be mindful of, if the goal is to implement with fidelity and obtain the effectiveness that EBIs promise to yield.

These identified capacity barriers imply that in addition to the staff training, marketing, and protocol development activities that CBOs conduct in the pre-implementation stage, more attention needs to be given to the staffing and supervisory needs of EBI programs, including the credentials and skill sets of those who run the program, and a program budget which supports a solid staffing plan to ensure that staffing is a top priority. As staff capacity directly impacts agency capacity, an investment in staffing on the agency's behalf, is an investment in the potential success of the EBI in the community practice setting. CBOs must also be attuned to other types of capacity challenges that may be related

to overall agency infrastructure, such as having adequate space or securing strong partnerships and linkages that may impact EBI implementation and client retention in these programs.

The **content** barriers that were identified by agency staff directly interface with the cultural concerns discussed in the aforementioned section. The prevailing content barrier for implementing organizations was the time it took to implement MIP due to the length and intensity of the intervention. Even though MIP is presented as a seven-session intervention (www.effectiveinterventions.org), the “fine print” in the implementation manual states that a client can have “multiple encounters” within the context of any one session until the goals of the session have been accomplished and the client is prepared to move on to another session. This requirement, followed more so by some agencies than others depending on their commitment to fidelity, became extremely difficult to manage when combined with the drug-using “culture of clients” and their inconsistent attendance at session appointments.

Another content barrier specific to one agency but closely intertwined with “culture” was the discrepancy between the agency’s existing abstinence-based only programs for IDUs and the harm-reduction philosophy that MIP espouses which allows for reduced use of drugs. In this case, the “value *incongruence*,” as has been described by Miller and Shin (2005), between MIP’s content and that of other agency programs presented as a barrier for the larger client community seeking services from the agency. Internally, agency staff were oriented to MIP through training. As a result, the agency prepared materials to inform clients that both types of programs were available to them depending on need.

The third content barrier identified by agencies, “challenges with implementing MIP as recommended”, speaks to the “fidelity-adaptation tension” noted in the literature by several researchers (Bell et al., 2007; Emshoff, 2008; Lee et al., 2008; O’Connor et al., 2007; Saul et al., 2008a; Wandersman et al., 2008) as a major obstacle to operationalizing best evidence research in a practice setting. Agency staff noted difficulties implementing MIP exactly as recommended due to the

realities of implementation “in practice” and felt that some degree of flexibility was needed in order for the intervention to be successfully executed at the agency level and with the target population. It is often at this juncture of implementation that agencies realize that the EBI “as is” requires modification in order to succeed at the community level, and that adaptation, whether done consciously or not, becomes a necessity and reality for implementing organizations. The adaptation experiences of the three MIP cohort organizations, largely due to this realization are discussed in the next section.

According to Flaspohler and colleagues (2008) **community-level** capacity to accommodate EBIs can be gauged by assessing factors such as leadership, resources, stakeholder participation or opportunities for participation, connections within and beyond the community, shared norms and values, and a sense of community. **Community-level** barriers identified by agency staff revealed community resource deficits and a weak health systems infrastructure to support the MIP client in his/her efforts to reduce drug and sex-related HIV risk. Across agencies, staff identified service gaps in the areas of housing and mental health services as a support need for MIP clients that went unmet due to having too few resources in the community to accommodate the level of need. When services external to those offered by the implementing agency were available, referral wait times posed a major barrier, especially for the MIP client possibly dealing with the physical and emotional manifestations of their drug use.

Inadequate funding to support the implementation of MIP “as it was intended,” was also identified as a community-level barrier specific to funders that may be an indication of their own economic and political challenges that indirectly influence funding support for CBOs. The role of the funder, as a leader, stakeholder, influencing agent, and provider of monetary support imparts great power over the agencies whom they choose to fund; hence a funder’s recommendation to implement “as is” or to modify or adapt an EBI in any way, could signify the difference between an intervention’s success and failure in the field. As such, this finding suggests the imperative for funders to understand

the intent and components of the EBIs they fund, and work in partnerships with agencies to figure out what allowances are needed to ensure EBI success in the community.

Key Finding 6: Overall, implementing agencies believe in utility and value of MIP. Although agencies have, and continue to face implementation challenges, they have also experienced significant successes with MIP.

Even with the numerous implementation barriers that were identified by agency staff in Key Finding 5, the general perception of MIP as a valuable and relevant intervention for IDUs did not waiver and program successes were easily identified. According to the testimonials from agency staff, IDU clients that were able to commit to MIP reaped the benefits of the intervention to various degrees. The benefits they gained were dependent upon their particular circumstances as well as their goals for the program and the behavior changes adopted to reduce their drug and sex related HIV risks. In fact, the *content* of MIP was viewed by the agencies as directly responsible for these changes because of its individualized client-centered focus, strong case management component, and suitability for the IDU population. Since the evaluation of MIP and its effectiveness was not a focus of this study, these reported “successes” must be taken at face value until further research is conducted to evaluate the impact of the interventions’ components and overall efficacy with the IDU client base.

Also, although staffing challenges were conveyed as a principal barrier across agencies, the capacity, commitment, and teamwork demonstrated by MIP staff was simultaneously identified as an implementation “success” across all three agencies. This apparent contradiction is in fact explainable, in that although there are staffing shortages or shortcomings with preferred skill levels, the staff that currently implement MIP are in fact skilled in working with the IDU population, are committed to the MIP

program and IDU clients, and work well as a team to provide a range of counseling and case management services to MIP clients to support them through the program.

Lastly, success with the MIP program was attributed to the use of incentives to retain clients. Strategically, the use of incentives can have a huge positive or negative impact on program outcomes. Because client retention was such a significant challenge across all agencies and incentives are usually used to aid in recruitment and retention, it is not surprising that agency staff, particularly front-line staff, viewed incentives as contributing to the program's successes.

Incentives for MIP clients varied across agencies. The two agencies reporting fewer issues with client recruitment or retention strategically chose and distributed incentives to facilitate relationship and rapport building to ensure program completion. In those cases, incentives not only included monetary support (cash gift cards, phone cards, fast food/restaurant vouchers, etc), but also included services support to address other health, economic, and social support needs of the MIP client (for example, hot meals, immigration services, dental services, medical care, etc.). Staff made a point of noting that the incentives provided to clients had to be appropriate to the circumstances of the client; otherwise the "appeal" of the incentive would be surpassed by the appeal of having free time, using drugs, or any other circumstance. As such, incentives for IDU clients in MIP focused on both cash gifts and support/wellness incentives that would further the aims of the HIV prevention program. Other agencies implementing EBIs such as MIP may benefit from using this dual approach to incentives as a strategic tool and means of expanding the appeal to clients by covering all of their basic needs as well as their need for monetary support.

The salient message to be garnered from both the barriers to MIP (Key finding 5) and MIP's successes (key finding 6) is that what worked well for one implementing agency, may in fact have been the most significant challenge of another implementing agency. The three most prominent barriers to MIP implementation identified by organizations were: 1) human resource constraints, 2) program

fidelity concerns and time constraints, 3) and inadequate community and health support systems. These covered the overarching themes of capacity, content, and community, respectively. As such, the very factors that were identified as integral to the success of MIP were also the same factors that presented the greatest challenges.

Where staff from one agency spoke of the strengths, talents, and cohesiveness of their MIP team, others spoke of the skill deficits of existing staff or the staffing shortages that hindered optimal implementation of the MIP EBI. Where Supervisors may have praised the individualized, client-centered nature of MIP, front-line staff saw this “benefit” as a double edge sword. Disadvantages of the MIP made it almost impossible to implement the intervention with fidelity within the recommended time-frame, move the client from one session to another within these parameters, and retain the client long enough to complete the MIP intervention in its entirety.

Inadequate community resources to address the additional needs of the MIP client were also viewed as a major impediment to implementation success. Specifically a shortage of mental health and housing services within each of these communities stymied the ability of MIP team members to stabilize the client and continue the MIP intervention. Because most MIP clients have co-morbidities of mental illness, the inability to address this need in particular made it more difficult for the MIP client to remain committed to MIP and ultimately realize its benefits.

Key Finding 7: Program Implementation Support varies by funder with regard to the extent of involvement, input, and technical assistance provided around EBI implementation. The value implementing agencies place on such support is related to whether implementation support is perceived as a need by agency staff.

Once agencies are funded to implement an EBI questions arise as to the level and type of support that should be provided or expected from the funder to facilitate program implementation. The three funders of MIP tended to be involved with the planning and implementation processes of EBIs to varying degrees. This may be due to the fact that each funder has their own work culture, processes, and priorities in place that may or may not encourage significant involvement, input, and support of the work of their grantees or contractors, depending on the “culture” within the agency.

One funder, the CDC, appeared to be the most active in its involvement with CBO implementation efforts of EBIs by providing access to information, training, and technical assistance opportunities to better prepare agencies for implementation. One local health department was moderately involved in CBO implementation and used the larger CDC DEBI diffusion network to support their grantee; whereas, the third entity, SAMSHA provided the least guidance and most autonomy in terms of training requirements and decision-making about how best to implement the intervention and with whom, and looked to the expertise of staff to guide implementation.

Under all three scenarios, agency staff were generally disappointed by the level of support provided by the funders (with the exception of one supervisor). This indicates a weakness within the conceptual framework- **Enhanced Interactive Systems Framework for the Implementation and Adaptation of EBIs in Community Practice Settings**- discernible by a gap between Dimension 1 which marks the funder role in research synthesis, translation and funding and Dimension 3, the Prevention Delivery System where CBOs implement EBIs. By strengthening Dimension 2- the Prevention Support System—which links the two, this gap could be easily mitigated.

Staff from the health department funded agency were determined to be most disappointed and disillusioned with the lack of support and guidance provided by the funder due to a general lack of knowledge and understanding about the MIP intervention. Front-line staff were more inclined to report seeking implementation support from their immediate supervisors or other agency staff than accessing

help via the funder. In the case of one agency, TA was accessed from a CDC designated Capacity Building Assistance Provider for MIP to offer consultation around acceptable case loads and recruitment and retention of eligible MIP clients. TA support from a source other than the funder was deemed as highly satisfactory to the CBO and thus, may indicate a funder “best practice” in providing monetary support to external agencies to serve as the “prevention support systems” link to address the guidance, training and technical assistance needs of organizations implementing EBIs. Implications from this finding include:

- 1) Funders need to offer a minimal level of support to grantees or contractors, or consider funding external agencies to respond to their training and TA needs;
- 2) CBOs must feel comfortable to ask for and access help, and must be aware of the resources available to them, whether that be the Funder, an external TA provider, a website, listserv or other resource;
- 3) CBOs must be proactive in seeking implementation support to address barriers and challenges that do arise so that the MIP and other EBIs can be successfully implemented with the target population in community practice settings.

C: Adaptation
Research Aim 2: Identify the practices and strategies used to facilitate the successful implementation and adaptation of MIP in community settings

Key Finding 8: Adaptation “in concept” is well-understood by community-based practitioners. It is viewed as a necessary part of the EBI implementation process warranted by the variations between the realities of community-based practice and researcher/funder implementation recommendations.

The concept of adaptation was familiar to staff as each agency in this cohort had previous experience with implementing other EBIs prior to MIP. Although agency Supervisors were more adept at defining adaptation and articulating its purpose, all staff understood adaptation as an action taken to change an intervention to some degree, either to improve “fit” with the target population or to accommodate organizational resources and local realities. For agency staff, adaptation was regarded as intrinsic to EBI implementation because it was recognized that even with the best efforts to adhere to EBI intervention guidelines, some level of modification was destined to occur due to variations in context, target population, geography, or other circumstance impacting the delivery of the intervention.

Agency staff also recognized that evidence-based interventions were “evidence-based” for a reason. Some agency staff understood the concept of “core elements” and specifically used that language in discussing adaptations, whereas other staff acknowledged that there were components or characteristics of an intervention that could not be changed without compromising its efficacy. Staff comprehension of adaptation, its necessity, and what it entails was a positive finding in this research. However, where comprehension ended and uncertainty began was in the “*how to*” of conducting adaptations, and the nature, extent, and scope of allowable adaptations as is discussed in the next key finding (#9)

Key Finding 9: There is a lack of information and guidance available to community-based practitioners on how to conduct adaptations of EBIs. This lack of information is perceived as purposeful and indicative of a lack of funder support for adaptations being undertaken at the community level.

Across agencies, MIP Supervisors and front-line staff had little knowledge on how to conduct adaptations or the extent of adaptations that are allowable with an EBI. This chasm between

knowledge and practice—that being the understanding of adaptation as a concept, and having the confidence or skills to actually conduct an adaptation—was a noticeable gap among agency staff irrespective of roles. The primary messages heard and reiterated by CBO staff, mostly from HIV prevention EBI trainings through the CDC DEBI program, were that 1) adaptations of EBIs were feasible and allowable, and 2) “core elements” were sacred and needed to remain intact. These two messages, seemingly related but vague, left staff without any concrete guidance to draw from and resulted in a knowledge gap subject to interpretation, and a skill gap subject to random acts of adaptation by CBO staff implementing EBIs. As one front-line staff member succinctly articulated *“I was told that the intervention could be adapted, but not **how** to adapt...”*

From their work on the scale-up of EBIs in communities and adaptation issues with CDC DEBIs in particular, Dworkin and colleagues (2008) confirmed *“at CDC trainings, facilitators are provided with guidelines for adapting interventions that include the requirement of adherence to ‘core elements’ of the interventions”* (p. 53). The authors further specified that *“some”* flexibility is allowed as long as adherence to core elements is not affected. Other researchers (Bell et al., (2007; Dworkin et al., 2008; Norton et al., 2009) cautioned about vague messages regarding core elements and adaptation and have concluded that additional targeted research is needed to explore the aspects of an intervention that are truly essential and the extent and types of adaptations that core intervention components can have without sacrificing efficacy.

Yet, the reality for agency staff in this cohort was that very little guidance related to adaptation was received or readily accessible to them, even though it had been communicated through the mandated EBI-specific trainings that adaptations were permissible. When information on adaptation was provided, it was typically general in nature and lacked specific applicability to any EBI. In fact, when two agencies sought information on adaptation from funders, their inquiries were met with resistance as was made evident in the testimonies from two supervising staff recounted here to

demonstrate the perceived magnitude of opposition from funders with regard to community adaptations of EBIs:

They get crazy about it [adaptation]; they don't want you to touch their intervention (Supervisor A).

They do not make it easy..... they do not want to release it that much (Supervisor B)

Clearly, the levels of perceived or experienced opposition to adaptation by EBI implementing agencies poses a larger issue about what steps do agencies take when they want or need to adapt an EBI in their practice setting.

Key finding 10: Agencies implementing MIP have conducted major and minor adaptations; however they are reluctant to classify these changes as “adaptations.” Adaptations conducted align with the four major themes of culture, capacity, content, and community.

Irrespective of the barriers to adaptation that were encountered by the implementing agencies in this cohort, **adaptations of MIP transpired**. Neither the reported lack of available and accessible information on adaptation, nor the perceived lack of support for adaptation from funders prevented adaptations from occurring. Researchers studying the process from research-to-practice have long acknowledged that adaptations will happen, whether or not guidance is provided (Lee et al., 2008; SAMSHA, 2002; Wandersman et al., 2008), and that expectations of near perfect implementation is unrealistic (Durlak & DuPre, 2008; Norton et al., 2009), and will ultimately fail in community practice settings. As Norton et al., (2008) notes:

Despite recommendations against making substantial changes to pre-packaged interventions, community-based organizations frequently adapt, alter or delete intervention content, scope, focus, and /or delivery methods (Norton et al., 2009. p. 426).

In fact, the three implementing agencies conducted adaptations that included all of the above noted adjustments; yet most agency staff, especially those in management/supervisory positions expressed hesitancy in categorizing EBI modifications as “adaptations.” This resistance was an interesting discovery because as Finding 8 indicates, agency staff understood adaptation and what it involved, including the necessity of it as part of the EBI implementation process.

With the exception of one front-line worker, the first response from agency staff with regard to their experiences adapting MIP was one of hesitation and indecisiveness. Statements alluding to not adapting “that much”, or adapting “a bit,” did not capture the *scope or extent* of adaptations that were initiated or executed by agency staff to meet levels of service, accommodate resource limitations, and ensure service delivery to the target population of IDUs. Such hesitancy could be based on the previous finding (#9) and the perceived lack of funder support for adaptations that had probably been conducted but not necessarily approved by the funder; or on indecisiveness as to whether modifications to the MIP qualified as adaptations. Nevertheless the implications of this research finding are far-reaching and important for the following reasons.

1. If agency staff conduct adaptations but cannot account for them or “admit” to them, there is no way of truly gauging implementation effectiveness of EBIs in the practice setting.
2. If agency staff believe that the adaptations they conduct will be frowned upon or reprimanded in a way, especially by the funder, they will be much less likely be forthcoming about the need for adaptation of an EBI or the adaptations that have already been conducted.
3. If agency staff have little knowledge, information, or confidence as to what activities, changes or modifications constitute an adaptation, they will likely do too much or not enough to achieve the expected impact on EBI service delivery.

This finding also suggests that the general environment for “adaptation” among the CBO community may need to be revisited and replaced with a new orientation that specifically encourages communities in their adaptation efforts, provides guidance on adaptation, and truly embraces adaptation as yet another activity in the implementation process of EBIs that ultimately leads to success at the community level.

It should be noted that in the case of one agency, resistance to adaptation from the funder was reported to be non-existent and in fact supported; yet two of the three interviewed agency staff were reluctant to discuss the adaptations conducted. What was interesting about this particular case was that the agency supervisor still articulated throughout the interview that *“We have not adapted. We have been providing the intervention following the core elements,”* even though this agency conducted the most significant adaptations, including changes to several of core elements and expanding the target population of MIP from solely IDU to other substance-using clients. It was only after the PI re-verified whether certain adaptations had been conducted due to conflicting data from the other interviewed agency staff that the agency Supervisor discussed these adaptations and justified why they had been necessary for implementation.

Types of Adaptations Conducted: Culture, Capacity, Content, Community

The types of adaptations conducted by agency staff vary in scope from those that would be considered “minor,” and hence allowable, and those that are major and for which further guidance and professional technical assistance is recommended. These adaptations all address one or more of the influencing variables – culture, capacity, content, and community—that were found to impact the diffusion, implementation and adaptation of EBIs along the research-to-practice continuum. According to an article by O'Connor, Small, and Cooney (2007) on program fidelity and adaptation, the types of adaptation that are considered acceptable include:

- language changes such as translations or vocabulary replacements;
- image replacement to reflect the target audience;
- replacement of cultural references;
- modification of certain aspects of activities such as physical contact; and
- addition of evidence based content [such as statistics] to make the program more appealing to participants (p. 2).

Likewise, adaptations that could potentially undermine fidelity and program effectiveness and would be considered “risky” or unacceptable include:

- reducing the number or length of sessions or the length of time participants are involved;
- lowering levels of participant engagement;
- eliminating key messages and activities that promote skills-building;
- removing topics;
- changing the theoretical approach;
- using staff or volunteers who are not adequately trained or qualified to implement the intervention; and
- using fewer staff members than recommended.

Based on the above lists, “benign” adaptations were the most common types of adaptations conducted across the three agencies and primarily included modifications to MIP documentation forms, changes in vocabulary and terminology to reflect local norms; and language translations to accommodate Spanish speaking MIP clients; all of which either related to the **cultural aspects** of the intervention, its content, or both.

Another “safe” adaptation that was reported by staff from two agencies related to the “culture of clients” was the “machismo” of some Latino male clients which required staff to modify their language,

approach and questioning to effectively engage the client in the MIP sessions, especially with regard to the session on sexual health which requires clients to disclose very intimate, personal information on sexual practices and behaviors. The infusion of terms related to clients' "drug of choice" and local terms for these drugs was also among the cultural adaptations conducted.

Other adaptations were more questionable; particularly those that were more **content-based** and/or funding-source driven (**community**). In fact, content-based adaptations were the most frequently conducted adaptations within the culture-content-capacity-community framework, although they are considered among the most precarious (O'Connor et al., 2007). Front-line staff across the three agencies reported various combinations of condensing, lengthening, or eliminating MIP sessions. Reasons for these adaptations included:

- 1) accommodating MIP clients' priority needs, interests, and time commitment to the program given their inconsistency and unreliability with keeping appointments;
- 2) adjusting for agency staffing challenges and time constraints to accomplish the work; and
- 3) managing the circumstance of delivery (for example, street contacts vs. office contacts with a client).

One front-line worker also noted adding content and activities to MIP sessions to increase the relevance of the intervention for that particular MIP client. The most extensive content adaptation was performed by a single agency in their funder-supported decision to expand the target population of MIP from solely injection drug users to other substance using clients, including alcohol users. According to agency front-line staff, the community's need for an intervention that could address the individual counseling and case management needs of all substance abusing clients made MIP an obvious choice, especially since it was currently being implemented with success with the IDU population from the community. Staff made the point of noting that most of the content within MIP's seven sessions (See Figure 5 referenced at the beginning of this Chapter, p. 118) was relevant to almost any person

at risk for HIV through drug use, with the exception of the session on Reducing Drug Related HIV risk with its focus on cleaning needles and other drug paraphernalia, in which case the content would be modified to reflect the clients' drug of choice.

This agency's staff believed that the individualized nature of MIP, and its strong counseling and case management components made the intervention attractive for use and relevant to other populations besides IDUs; yet it remains to be seen whether this particular adaptation for MIP had the same positive impact with non-IDU substance using clients. Another factor that also should be considered in this adaptation is that although the MIP implementation manual acknowledges that the intervention is adaptable to other drug users, it specifically excludes alcohol users for this intervention due to differences in the physiological and psychological impact of alcohol versus other drugs. The inclusion of alcohol users in the expanded target population may be an example of going beyond the parameters of "acceptable" adaptations and into unknown territory where appropriateness and effectiveness becomes even more questionable.

Among all the content adaptations reported, cause for concern was greatest for the complete elimination of MIP sessions reported by front-line staff at one particular agency which was justified as having occurred due to lack of client interest in particular curriculum topics. Although the Supervisor at this agency was aware that these types of adaptations had occurred and had counseled and cautioned staff against it; conversations with front-line staff confirmed that sessions were still "skipped," if either the MIP staff member or client felt they mastered the information and skills discussed in certain sessions.

This lack of enforcement of adherence to the seven MIP sessions indicates two things: first, it indicates an organizational **capacity issue** which calls for greater oversight, supervision and quality assurance measures of the MIP program, a need duly noted and confirmed by this Agency's supervisor; or second, it indicates a level of flexibility on the part of the funder with the delivery of MIP

that allows for such “customizations” as long levels of service are met. Yet, without the appropriate “dosage” or combination of topics, it is likely that intervention effectiveness would be greatly compromised and that neither positive nor negative results could be attributed to the MIP EBI. Most importantly, this adaptation goes against a core element of MIP which calls for a minimum of five (5) flexible sessions and two (2) fixed sessions, as shown in **Figure 5** (p. 118).

Another capacity related adaptation conducted by this same agency was in modifying the recommended MIP Program Staffing Plan comprised of at least a Supervisor, Counselor, and Case Manager/Community Educator and combining the tasks of the Counselor, and Case Manager/Community Educator into one position. Hence, instead of the MIP client interacting with at least two staff members for their counseling and case management needs, only one person saw and interacted with the MIP client. Not only did this capacity-related adaptation place a burden on staff, but it also eliminated the team approach or *“critical role of the dyad”* that is purported to be one of the strengths of the MIP intervention related to its success with the IDU population and as such is one of the core elements of the intervention (See Figure 5, p. 118).

Other adaptation concerns originated from the two reported **community-level** adaptations dictated by a specific funder in the form of two implementation mandates. When mandates are introduced organizations often feel they must adhere to them or lose funds (Dworkin et al., 2008), even when they may directly conflict with various components of the EBI. First, the agency was instructed to modify the client eligibility criteria for MIP from “persons who have injected drugs in the past 90 days” to “persons who have shared injection drug paraphernalia within the past 12 months.” It can be assumed that the specification from simply “injecting drugs” to “sharing drug paraphernalia” is more in line with actual HIV risk since a person who injects drugs but uses his/her own equipment would be no more at risk for HIV from that specific act, than a non-drug user. However the expansion

of the time-frame for use or sharing from the recommended 90 days to *12 months* is one that requires additional questioning directly with the funder and is beyond the scope of this research, although it may reflect epidemiological trends in that particular area which warrant such as expansion.

The second funded dictated adaptation in direct conflict with a core element of MIP was the allowance made for agencies to only conduct six of the seven MIP sessions and exclude the last session, the Booster, as it would not be counted toward program deliverables. The reasoning behind this funder-initiated adaptation is unknown, but to the benefit of this particular organization, agency staff made the decision to continue to conduct the Booster session *because it was a core element* of MIP, because the *messages regarding adherence to core elements* had been so clearly heard and received, and because agency staff wanted to implement the intervention with as much fidelity as possible even though these efforts were not “counted” by the funder.

In the cases of the community adaptations conducted, a funder dictated two major adaptations; one of which was in direct conflict with a stated core element of the MIP EBI, and the other which changed eligibility criteria for the intervention. Yet, it is the CBO initiated adaptations that appear to cause the most concern among researchers and funders and are the least supported even though staff within these settings are the key conduits for getting evidence-based research to the community. This double standard warrants a second look at the messages regarding adaptation that have been communicated thus far to all levels of stakeholders, and dictates that a singular consistent message be promoted irrespective of role within the research-to-practice continuum to ensure a minimum standard for conducting adaptations.

Finally, it is important to note that few external resources or tools were used to undertake these adaptations, many of which had not been previously planned but had occurred spontaneously with implementation of MIP. Staff primarily depended on their own internal expertise—from each other and their Supervisor's-- to obtain the necessary support for these adaptations and in rare cases sought

counsel from a CDC funded Capacity Building Assistance Provider or the funder. The overarching approach to adaptation was much more random than planned, and much looser than structured and measurable. As such, there lies the opportunity to build community capacity to conduct adaptations through training and technical assistance from “prevention support entities” that understand the need for agencies to have some autonomy on how best to adapt EBIs and still maintain intervention integrity.

D: Technical Assistance Needs
Research Aim 3: Inform the development of user-friendly adaptation guidelines specifically for community practice settings

Key Finding 11: The Technical Assistance support needs of staff implementing EBIs cover three main categories: training, capacity, and resource support.

Much of the technical assistance needs identified by MIP agency staff focused on training support to increase individual and organizational competencies to implement and adapt MIP and other EBIs, capacity support to strengthen organizational infrastructure and capabilities, and resource support to increase the scope, reach and effectiveness of the MIP program. In the conceptual model for this research—the **Enhanced Systems Framework for Exploring the Implementation and Adaptation of Evidence-Based Interventions** (See Figure 4- p.119), the availability of training and technical assistance in all of these areas is a function of Dimension 2- Prevention Support Systems-- that supports individuals, organizations and communities throughout EBI implementation until the EBI is well embedded and sustainable at the community level. Thus, the TA needs of staff implementing EBIs has the potential to be met by this system through opportunities such as funder supported capacity building and training activities.

Agency staff training support needs were closely aligned with the barriers and challenges identified during the implementation and adaptation phases of MIP, as if to note that skill deficits had been realized and opportunities to improve individual competencies welcomed. For example, requests for skills-based trainings on topics such as recruitment and retention, mental health issues, or effective strategies for working with IDUs addressed key implementation issues reported by agency staff. These practitioners were also keenly aware of the need to refresh their skills in the underlying theories and techniques used in MIP such as Motivational Interviewing.

Surpassing these skills-based training needs, the leading request for TA from agency staff was to be provided with opportunities to participate in shared learning activities with other agencies implementing the same EBIs. These forums would allow for exploration and comparison of implementation and adaptation experiences, sharing of best practices and problem-solving strategies and provide opportunities for learning on equal footing. The importance of the peer-to-peer experience for MIP agency staff was at first surprising; however as this research unfolded, it was easier to understand this TA need within the context of the unfavorable reactions some staff articulated having experienced in accessing “sensitive” information from the funder, or the low value in general that was attributed to such assistance when it did occur.

Capacity support needs articulated by agency staff focused on building adaptation skills and competencies to better prepare and enable community level practitioners to conduct appropriate adaptations within the parameters of sound science. Staff were especially interested in how to adapt MIP for use with other populations including transgender persons, sex workers, persons in recovery and women at sexual risk due to their IDU partners. Given the adaptations that are already taking place within organizations implementing EBIs and the on-going need for appropriate and relevant EBIs that respond to the particular needs of communities, adaptation training and guidance for community-based practitioners must become a priority for researchers, funders, and the training and technical

assistance providers that comprise the Prevention Support Systems that support the diffusion of training and technical assistance to the community.

Lastly, agency staff “need” focused on resource support in the form of expanded funding to support the MIP program’s infrastructure and client services *and* to support the larger health systems infrastructure. Because mental health and housing issues were so prominent among MIP clients, and because these two issues often circumvented HIV or substance abuse problems as a priority for the client, agency staff wanted solutions to help mitigate these barriers in order to help stabilize the client, move them toward the completion of MIP, and support them in achieving overall wellness and a better quality of life. Additional funding of the larger health systems infrastructure in particular was viewed as a meaningful way to invest in communities and clients and truly make a difference.

Key Finding 12: The role of the funder in the implementation and adaptation of EBIs needs to expand beyond the provision of monetary support. Community based organizations want funders to act as information and knowledge brokers, technical assistance facilitators, Client and agency advocates, and subject-matter experts in EBI program implementation and adaptation.

Collectively, the testimonies provided by agency staff imply that there is room for enhancing the relationships between funders and their grantees/contractors. This implication was especially true for a Supervisor and most of the front-line staff across agencies who perceived funders as being responsible for many of the added “pressures” and burdens placed on the EBI program other than those directly related to client services. Two other agency Supervisors acknowledged positive relationships with their respective funders, with the exception of a negative experience with an adaptation inquiry reported by one.

The relationships that are in place between the EBI implementing agency and the funder is a rather important one in that both parties support the ultimate outcome of HIV free, healthier communities; but is not an equal relationship due to the imbalance of power from one source (CBO) depending on the other (funder) for monetary support for what CBOs deem as critical public health for their communities. As such, in this position of power, funders have a unique role that expands beyond providers of monetary support, as some may see themselves.

Because funders are influential on so many levels, CBO staff view their roles in an expanded capacity—as information and knowledge brokers, technical assistance facilitators, client and agency advocates, and subject-matter experts in EBI program implementation and adaptation. When funders cannot or do not live up to these expectations, CBO staff often become disappointed and disillusioned because they want to feel supported in their efforts and want to have access to expertise they feel will help make their programs stronger and more efficient.

Even though funders cannot be all things to all CBOs, there is an expanded role for them which may simply start with creating an environment for honest exchange through improved communication between agency staff and funder contacts. These improved relationships have the potential to mitigate many of the identified issues faced with EBI implementation at the community level, because many of them have to do with flexibility and strategy that will allow for enhanced, or more efficient services to the target population. Funders may also consider using a strategy similar to that of the CDC which is to fund external agencies to serve as their “brokers” for training, support and technical assistance; thereby releasing them from that particular task while simultaneously meeting the support needs of the grantees and contractors funded to implement EBIs in the community.

Key Finding 13: Progress Notes and Funder Progress Reports provide unique insight into the operations of agencies implementing EBIs and are valuable resources for assessing and verifying the EBI implementation and adaptation practices of community-based organizations and their staff.

Although agencies pre-selected the client case files and reports to be reviewed by the PI, the document review process provided the opportunity to obtain information on the processes and practices of CBOs in implementing and adapting EBIs from a source other than self-report through semi-structured interviews. Progress notes and funder reports provided a missing link between the staff accounts and the implementation realities. The elements of MIP—meaning its counseling and case management components, the timing required to conduct the sessions, the teamwork of the MIP staff, and the intensity of the resources and support provided to MIP clients—all the elements that were reported as contributing to the success of MIP were captured in the Progress notes of implementing agencies. Also captured were the barriers—the length and intensity of MIP; the inconsistency of IDU clients with keeping appointments, the retention issues, the attempts to link clients to mental health and housing services—were all documented in client case files and progress notes.

Progress reports to the funder, submitted by only two of the three agencies were also useful in providing a more comprehensive picture of the MIP intervention. These reports often noted the contracted levels of services and agency progress toward meeting those levels; included information on the internal and external barriers/challenges to implementation, and in some cases inquired about the TA support needs of agency staff to enhance implementation or resolve program challenges. It was from progress reports that the PI noted one agency's on-going struggle with meeting levels of service, and another's shift in focus from solely serving IDUs to serving all substance-using clients in the community including alcohol users – the only “forbidden” population for MIP.

The trend for agency's to highlight their accomplishments but downplay implementation challenges, may be attributed to agencies viewing themselves as experts who should know how to solve problems, or maybe it was because performance is often tied to support for continued funding and admission of issues might jeopardize funding. While this dynamic of reporting "good over the bad" to funders is quite common and may not change, what it does imply is that in order to get the full picture of the status of an HIV prevention EBI, progress reports alone will not suffice. As such, funders may wish to consider intermittent case file reviews to supplement progress report data; however, the most beneficial strategy would be to enhance and improve relationships with CBO staff so that a true partnership, rather than a "powership," can be established that will encourage joint solutions to address barriers to successful EBI implementation and adaptation.

Limitations of this Research Study

Taken together, the 16 key findings from this research study provides a compelling account of the experiences of CBOs and their staff with implementing and adapting EBIs within their respective communities. These findings inform the Plan for Change presented in the next Chapter that is intended to guide both community based practitioners and their funders in creating more optimal conditions for the implementation of EBIs in community practice settings. Prior to presenting this plan, the limitations of this research study should be noted and taken into consideration.

First, selection bias may have been introduced into the study as a result of the small sample size and purposeful selection of community-based organizations and participating agency staff. This bias implies that the findings from this research may be skewed in a certain direction since neither all MIP funded organizations nor staff within those organizations were represented in the sample. It also means that even among the selected sample of CBOs some staff members working on MIP were more

likely to be recruited to participate in this study than others for one reason or another. Selection bias with individual agency staff was kept to a minimum since only one agency had a greater number of MIP staff than was interviewed for this study. However, given the small sample size, caution should be exercised in generalizing the findings of this research to the larger group of CBOs that implement HIV prevention evidence-based interventions every day.

Second, because parts of this research were retrospective and characterized by participant recollection of activities or incidents that occurred during pre-implementation, implementation or adaptation of MIP, the study may have been subject to recall bias. Although all three participating agencies and interviewed staff were currently implementing MIP the timeline from initial funding to current implementation varied sufficiently among agencies so that for some staff, interview questions were more retrospective in nature than for others, thus producing the potential for recall bias.

Third, the majority of these research findings were generated from staff self-report during the semi-structured interviews. Hence subjectivity could have existed on participants' accounts of the implementation and adaptation activities conducted within their organizations that were either in line with or against implementation recommendations. Also, although participants were assured that there were no right or wrong answers, social desirability bias may have been introduced due to the line of questioning that asked participants to recall both their successes and challenges with EBI implementation and adaptation.

Fourth, since agencies self-selected files for the document review there is the possibility that the case files that were reviewed were among the best and most complete and not representative of the larger set of case files for MIP clients within the organization.

Finally, given the qualitative nature of this study, researcher bias was wittingly introduced given the PI's experience and interest in the topic area, the choice of methods selected for use, and the interpretation and analysis of study findings based on the PIs orientation to the diffusion, selection,

implementation and adaptation of HIV prevention EBIs. As a CDC supported Capacity Building Assistance Provider and public health professional working in the field of HIV/AIDS for over 15years, the PI could be considered a “participant observer” in this case.

In spite of these limitations, the findings from this research make a significant contribution to the field, especially in the area of “delivery science” which focuses on implementation in real world settings. As Norton et al. (2009) so succinctly put it:

In order for our effective interventions to truly have an impact on curbing the epidemic worldwide, we must approach ‘delivery science’ with the same scientific rigor, dedication, and urgency that has characterized ‘discovery science’ to date. In doing so, we can begin to identify empirically guided strategies that are essential for supporting the widespread and effective implementation of HIV prevention in everyday settings (p. 428).

By anticipating the barriers, challenges, and training and technical assistance needs of the implementers of EBIs, that being public health practitioners within CBOs, we can help facilitate implementation or “delivery science” by encouraging the development of recommendations and practices that allow CBOs to adapt EBIs to the needs and circumstances of their local communities without compromising efficacy. The next chapter presents such recommendations.

CHAPTER VI. PLAN FOR CHANGE AND RECOMMENDATIONS

The findings from this research study verify the widespread practice of adaptation in implementing EBIs. Consequently, support is needed to facilitate the smooth transition of evidence-based interventions from researcher controlled settings to practical application at the community level. As underscored by Fixsen and colleagues (2005) implementation is not a single act but a process consisting of various stages. Implementation begins with initial application and continues through “practice,” inclusive of adaptation. This process is further characterized by a level of maturity and evolution which marks maintenance and sustainability of the EBI in that particular setting and for that specific community.

This study has revealed that agencies want and need support in implementing and adapting EBIs in order to overcome the challenges inherent in implementation. These are predominantly related to cultural relevance, intervention content, individual and organizational capacities, and community context inclusive of the larger health systems structure and the stakeholders, policies, politics, and finances that influence the system. The proposed plan for change seeks to address the identified knowledge, skill, resource, and system gaps and requires effective leadership at various levels.

In developing a plan for change, each key finding from the semi-structured interviews and document review was considered then shaped into concrete recommendations. These recommendations aim to shift the current dynamic between CBOs and funders to create a more supportive environment which facilitates optimal implementation and adaptation of EBIs in community

practice settings. Achieving this aim will require robust leadership and employment of targeted strategies from two distinct groups: 1) Funders, and 2) Community-Based Organizations. Other stakeholders such as researchers, technical assistance providers, and policy makers also have significant roles along the research-to-practice continuum and can impact EBI implementation and adaption in the field. However, in this research study, their involvement was noticeably linked to either the funder, the CBO, or both, and therefore, their inclusion are within the context of these two main entities. Also, it should be noted that recommendations pertaining to CBOs are intertwined with those pertaining to health practitioners since people comprise organizations and the two are inextricably linked.

Table 13 below presents the recommendations generated from the study findings which provide a basis for change. These recommendations echo two categories of leadership actions identified by leading expert Gary Yukl (2006) as critical to the change process: 1) political and organizational actions and 2) people oriented actions, which often overlap. In planning for change and for maximum impact, the recommendations presented should be considered in their entirety and not as distinct parts operating in silos.

Each funder recommendation is accompanied by a related CBO recommendation to demonstrate the dual approach to building the capacity of the “system” to more effectively implement and adapt EBIs in communities. The leadership principles and competencies required to implement these recommendations are included in the descriptions of each recommendation. Where appropriate, concrete action steps are provided to help operationalize these recommendations in the world of practice. The chapter closes with a discussion of “Implementing Change” as part of leadership practice, and concludes with a Final Word which summarizes this research study.

TABLE 13: Recommendations for Funders and Community Based Organizations to Enhance Implementation and Adaptation of HIV Prevention EBIs in Community Practice Settings

Funder	Community Based Organization
1. Continue to fund high performing community-based organizations that present with a balance of infrastructure, experience and access to the community.	*1. Invest in enhancing organizational and programmatic infrastructure and staff capacity to implement and adapt EBIs.
2. Invest in the relationship; strengthen the partnership.	2. Invest in the relationship; strengthen the partnership
3. Invest in an intermediary “support system” that is equipped to respond to the training and technical assistance needs of individuals, agencies, and communities.	3. Create or reinforce a “culture of learning” which encourages training and technical assistance for overall quality improvement.
4. Create a new environment in support of adaptation of EBIs in community practice settings.	4. Build internal capacity to conduct adaptations of EBIs.
5. Collaborate and coordinate across federal and/or state health, human and social service entities to create a stronger, more coordinated public health system.	*(Collaboration and coordination inclusive in CBO recommendation #1)

Funder Recommendations

Research findings support an expanded role for funders as leaders in the change process. This role is especially important because of their considerable power and influence in prioritizing community health issues and providing monetary support to address those issues. Having such influence is viewed as the “essence of leadership” by the foremost experts in leadership discourse (Kotter, 1996, Maxwell, 1993; Yukl, 2006). Funder recommendations fall within the category of “political/organizational actions” prescribed by Yukl (2006) which focuses on building support for change, recruiting competent change agents, making symbolic changes that influence the work, and

monitoring the progress of change. These recommendations also incorporate “people oriented actions” that provide individuals with the necessary support and guidance to enact change.

Recommendation 1: Continue to fund high performing community-based organizations that present with a balance of infrastructure, experience and access to the community.

The capacity of organizations or lack thereof, is indeed a predictor of performance (C. Collins et al., 2007). It is imperative that funders invest in organizations that meet certain capacity criteria to increase the likelihood of EBI implementation success at the community level. CBOs that demonstrate a strong organizational infrastructure, solid track record for performance, and the presence of skilled, experienced staff at all levels within the organization with competencies to reach and serve the target population appear to be the most prepared to implement EBIs. However, criteria should also take into account the agency’s credibility with the target population and larger community as well the agency’s client demographic base in order to assess who has been seen and served by the agency.

It is recommended that “criteria for capacity” be inclusive of:

1. Strong governance and programmatic infrastructure including a clear agency vision and mission;
2. Defined organizational structure, including lines of authority and accountability;
3. Demonstrated leadership; solid staff capacity; collective staff capability; supervision and management;
4. Availability of additional resources and support via other agency programs; partnerships, linkages etc. that can supplement and leverage the impact of program funds;
5. Competence in managing funds to support community programs and meet program deliverables.

6. Expertise in area of focus of funding (e.g. HIV, substance abuse, and other health and human service topic areas);
7. History of serving the target population or serving similarly highly vulnerable or disenfranchised groups;
8. A track record of success and being well-established within the community;
9. Credibility/perception of agency within the community; and
10. Evidence of investment in staff training and evaluation of programs.

While there may be additional considerations depending on the specific goals of the funder, combined, these ten criteria provide a starting point for gauging the capacity of organizations to implement EBIs and can assist funders in making the best informed decisions based on available data. It should be noted that these criteria should be considered as a collective in order to avoid the pitfalls of: a) funding organizations that have high capacity and present well on paper but fail to have the respect of, or connection to, the community; and b) passing over organizations that may not have a history of providing a specific service to the community, but otherwise have the infrastructure (organizational, programmatic, staffing) and ties to the target population or community that enable them to expand their services milieu and readily access the community to provide a much needed service.

As resources become more scarce and monetary support for public health programs becomes more competitive, these criteria can help funders secure more “bang for their buck” by funding strategically and informatively to ensure that resources are maximized to the ultimate benefit of the community and to protect the public’s health.

Recommendation 2: Invest in the relationship; strengthen the partnership.

This recommendation for funders is comprised of three action steps: a) conduct what has been coined by the PI as an “internal values clarification” scan; b) provide support through communication, monitoring, and oversight; and c) provide support through training and technical assistance.

a. Conduct an “internal values clarification.”

“Internal values clarification” refers to the internal operations of the funder with regard to the goals and objectives for the funding provided, the expected outcomes that are to result from this funding, and the relationship of this funding to the funders’ other funding streams and reporting and accountability requirements. It also includes assessing the funders’ infrastructure and resources to be able to better define (at least internally) how much and to what extent the funder will be involved in the work of its contractors/grantees. This exercise of values clarification is an important first step in “investing in the relationship; strengthening the partnership”. These actions are also congruent to the leadership practice of **articulating a vision and communicating that vision effectively** (Kotter, 1996), both internally and externally. Values clarification defines the priorities of the funder, determines why and how they invest in the community, and better prepares those who provide oversight and monitoring to communicate these values to the CBO grantees and other funded entities to do the job of implementation in real world settings. In clarifying these values funders should consider the following questions:

- What are we funding and why?
- What are the components of evidence that makes this model work? Who needs to have this information?
- What does it truly take to run a program like this effectively?

- What are reasonable levels of service given the requirements of this intervention/program?
- What outcome would we like to see?
- What should funding awards look like to achieve these outcomes?
- How can we best support our grantees given our own resource constraints?

The answers to questions such as these will help funders define their vision and values, notwithstanding the popularity or unpopularity of each and help educate funder personnel about the intervention being funded, its components, and the required levels of skill and effort needed to achieve outcomes. Attention to details such as staff knowledge and understanding of the programs being funded and program components could potentially make all the difference in building the relationship, including the type of guidance and TA provided to grantees/contractors and the value of such guidance as it applies to community practice.

Finally, the information generated from these questions will provide guidance for setting levels of services that are realistic and achievable for grantees or contractors based on the design, components and intensity of the intervention, and will help inform the funding levels that should be awarded to achieve the expected outcomes. Even if fewer organizations were funded at higher levels to provide a service to the community, the impact of such efforts would still be more generous than would be accomplished with multiple “watered down” awards that inhibited organizations from executing programs at full capacity and in the manner in which they were intended.

b. Provide support through enhanced communication, monitoring, and oversight

Often, funders take the lead in “setting the tone” for communicating with their grantees/contractors. The “values clarification” exercise (explained above) is a significant first step toward improved communication between the two parties as it allows for transparency and the ability of

funder personnel to communicate the overall vision, goals, objectives, priorities and expectations of the funder to CBO staff from the beginning. It is recommended that funder personnel establish a platform for open dialogue with grantees that allows for disclosure of both program successes and challenges. This “people oriented action” (Yukl, 2006) provides a forum for motivating, supporting and guiding those that do the work. This step becomes especially important in the first program year when both parties are becoming acquainted with each other and CBOs are learning the “culture of communication” of a specific funder or its personnel. It is also during this period that many agencies face initial implementation and adaptation challenges and may “test out” the type of feedback and input they receive from the funder in response to their disclosed challenge which ultimately “sets the tone” for future communication. Thus, during the initial funding period training and technical assistance support becomes even more critical and funder personnel must be especially careful to create an environment of trust and collaboration that will help facilitate open dialogue through the duration of the relationship.

Findings from this research study revealed that implementation barriers and challenges faced were rarely unique to any one CBO. In fact, since CBOs had similar experiences and challenges with implementation and adaptation of EBIs, it is likely that many of them also resolved these challenges through the use of innovative strategies, or training and technical support from an external source. As the “gatekeepers” of the activities conducted by grantees, it is likely that funder personnel possess unique insight into the problem-solving strategies that have worked for CBOs facing implementation barriers. However without dialogue and disclosure, this information remains untapped at the expense of the community being served. Consequently, by opening up the dialogue and encouraging CBO staff to be forthright in their challenges, a joint partnership can be established where successes are celebrated and challenges are addressed from multiple perspectives. This partnership enables “broad based action” for change that is part of Kotter’s (1996) eight-stage process for creating change, characterized by removing obstacles and encouraging nontraditional ideas, activities and actions.

One suggestion for operationalizing this recommendation is for funder personnel to establish a mutually beneficial time (whether bi-weekly, monthly, or more or less frequently) with grantees or contractors, between scheduled progress reports, for conference call updates on programs' progress and barriers . This would help facilitate accountability and enable an exchange of information that would prove equally beneficial to both parties. In the case of the funder, it would ensure that there were no surprises with regard to agency progress on meeting deliverables and achieving objectives. In the case of the grantee or contractor, check-ins would provide opportunities to highlight successes, disclose barriers and challenges, and come up with sage solutions informed by the knowledge and insight of two separate entities working together to achieve a similar goal.

Another suggestion for increasing monitoring and oversight, especially in the first year of program implementation when grantees first embark on executing new initiatives, is for funders to establish feedback loops at multiple benchmarks of implementation of EBIs. These feedback loops would signify change or challenges within the system of implementation, indicating the need for greater support to address or correct imbalances, and potentially point to the EBI adaptation needs of agencies, or facilitate a dialogue about such needs, and serve as a forum for the development of jointly agreed upon strategies.

Recommendation 3: Invest in an intermediary “support system” that is equipped to respond to the training and technical assistance needs of individuals, agencies, and communities.

According to Maxwell (1993) *“the growth and development of people is the highest calling of leadership”* (p. 179). Findings from this research demonstrate that CBO staff view their funders as much more than conduits of monetary funds. Funders are considered the experts, and this leads to an expectation funders will provide useful guidance to advance the work of grantees/contractors. In order to *“invest in the relationship; strengthen the partnership”* it is recommended that funders offer

opportunities for training and technical assistance (T/TA) to CBOs, whether directly or indirectly through other external entities.

Since funder capacity to provide grantees or contractors with the necessary guidance and support is often limited due to sheer volume, internal human resource constraints, or other value priorities (see recommendation 2a. internal values scan), an alternative is for funders to delegate this responsibility to qualified external agencies that can meet both the volume demand and time-sensitive nature of these requests. By using a model that uses external partners as TA facilitators, funders will directly impact the “Prevention Support System” (Dimension 2) within the Enhanced Interactive Systems Framework for the Implementation and Adaptation of EBIs (see **Figure 5** pg. 118), which serves as the hub for T/TA support activities and serves as the “linking agent” between Dimension 1- Prevention Synthesis and Translation where the funder plays a dominant role and Dimension 3- Prevention Delivery systems which is the nexus for community-based application of EBIs. By operationalizing this recommendation the entire support system for EBI application in community-based settings will be strengthened and the needs of both funders and CBOs met.

For example, as part of its larger High Impact HIV Prevention Initiative, CDC funds a cadre of Capacity Building Assistance (CBA) Providers primarily to tend to the training and technical assistance needs of their grantees, with extended support to state and local health departments and their local grantees. Although access and availability of training has been a barrier for some CBOs (Veneigas et al., 2009) others, such as two of the three CBOs participating in this research study, benefitted from the T/TA services of CBA providers. In these cases, CBA providers comprised the “prevention support system” and served as a bridge between the two main entities (funders and CBOs) to ensure that the vision and quality concerns of the funder transcended to the practice arena and that the information, skills, and support needs of CBOs were attended to in a responsive, timely manner. Other public and private funders should consider adopting CDCs model of using external T/TA sources in order to

enhance the availability and accessibility of support mechanisms for grantees or contractors and reduce stigma associated with seeking help.

In any case, as communication, monitoring and oversight improves (recommendation 2b), funder personnel will be in an exceptional position to identify the T/TA needs of CBO grantees or contractors and will more readily receive requests for T/TA from agency staff. With this information in hand, funders and their designated TA representatives must be prepared to respond to the learning and performance improvement needs of CBOs.

It is further recommended that funders or their TA designee(s) take leading roles in facilitating opportunities for peer learning among grantees focused on best practices and problem solving. A feasible option would be to “add-on” peer-exchange forums to required funder meetings or conferences, or to offer web-based opportunities that serve the same purpose. Funders and/or their designees may also want to consider conducting short annual surveys of grantee/contractor training needs for program implementation and adaptation since those needs change often as new developments in HIV prevention emerge or as staff turnover occurs at the CBO level.

Recommendation 4: Create a new environment in support of adaptation of EBIs in community practice settings.

As investors in HIV prevention and gatekeepers of EBIs, funders have an important role to play in building community capacity to adapt EBIs. This research confirmed that adaptations are being conducted in varying degrees by staff within CBOs, but with little to no external guidance. As such, concerns have emerged as to whether program results can be attributed to the intervention, depending on the level and/or type of adaptations conducted. Such concerns underline the need for funders to assume a more active role in adaptation, extending beyond the message of “keeping the core elements intact” to providing hands-on leadership and support to re-frame the issue.

This recommendation signals the need for a paradigm shift from how adaptation is currently perceived and experienced (as a process predominantly controlled by researchers and funders) to one that is inclusive of community input and expertise. Such a shift requires the use of transformational leadership practices to bring about environmental change. Transformational leadership is strategic and facilitates change by adapting to established systems (Sternberg, 2007). This model of leadership is typified by engaging and motivating followers, encouraging participation and innovation, developing people, taking calculated risks, and leading by example (Firth-Cozens & Mowbray, 2001; Leatt & Porter, 2003). Transformational leadership practices are known to positively impact organizational and individual outcomes, including organizational commitment, employee performance, and employee satisfaction with leadership (Kelloway, Mullen & Francis, 2006). As such, funders, with their unparalleled influence and power, can incorporate principles and practices of transformational leadership to implement the following recommendations.

- a. **Develop a policy statement and synopsis on adaptation and its purpose, and parameters for all stakeholders working in the field of HIV/AIDS.**

As a first step to shifting the current negative paradigm on adaptation in community practice settings to one of funder-supported adaptation, it is recommended that a leading public health entity such as the CDC- Division of HIV/AIDS Prevention (CDC-DHAP) assume responsibility for the development of a guidance/policy statement supporting “guided” adaptations of HIV prevention EBIs in community practices settings. This policy statement should include details on why CDC supports adaptation as part of a larger goal of HIV prevention, its necessity and role in implementation, and provide information on the types of adaptations that are most benign or hazardous to fidelity. The statement should conclude with information on adaptation-specific trainings (see point c below), resources, and tools that can be accessed by organizations and staff considering adaptations in their local settings.

To facilitate this major change, the CDC should **organize a taskforce or a “guiding coalition”** with representatives from key stakeholder groups (CBOs, researchers, health departments, other federal agencies, private sector funders) to develop a comprehensive policy statement. Leadership within CDC should ensure that the workgroup is comprised of competent change agents (Yukl, 2006) with the power, expertise, credibility, and leadership to influence change in their respective domains and with their constituents (Kotter, 1996). As leadership expert Jim Collins (2005) asserts, the aim is to *“get the right people are on the bus, the wrong people off the bus, and the right people into the right seats”* (p. 14), in order to develop a statement policy that reflects the needs and perspectives of the multiple stakeholders involved in bringing best evidence research-to-practice and ensure their buy-in and commitment to upholding the decided upon policy.

A guidance/ policy statement such as this would have widespread influence over other state, local, and private HIV prevention funders who often take their cue from CDC- DHAP, as a leader in the field. Such a statement would serve to **articulate and communicate a new vision for adaptation** and reframe the funder environment from adaptation-phobic to adaptation-acceptable. It would also “alert” CBOs that adaptations were allowable, and that acceptable adaptations could be conducted with guidance in order to promote a “better fit” for either the target population or agency, as needed. The emphasis on “guided” adaptation in this recommendation should not diminish the need for CBOs to be held accountable for the adaptations that they do take on; nor should it discourage them seeking appropriate guidance so that the fidelity of the intervention is retained and the community benefits.

b. Create written support materials to facilitate adaptation at the community level.

In line with the goal of changing the environment around adaptation of EBIs, funders should proactively invest in developing tools that will assist CBOs with conducting adaptations. These tools may include assessments to identify adaptation needs, considerations prior to undertaking an adaptation, and guidance on when adaptations can be conducted “in-house” versus when CBOs

should seek professional external assistance to guide adaptation plans (See Adaptation Decision Tree on pg. 178).

The development of such tools should be informed by both the taskforce and community practitioners implementing these EBIs in the field. It should be on going and evolve according to the support needs of community practitioners. Although the actual content of these support materials are beyond the scope of this research, it indicates an area for further exploration that will further the cause of implementation and adaptation of EBIs in community practice settings.

c. Provide adaptation-specific trainings for community health practitioners.

Recommendation 4, *"creating a new environment in support of adaptation of EBIs in community practice settings"* requires funders to invest in training CBO staff. In addition to having adaptation policy statements in place and access to support tools to facilitate adaptations, providing needed training is a key factor in facilitating change (Kotter, 1996) and empowering CBO staff to uphold the standards and recommendations set forth. As such, a change implementation step would be to "strongly encourage" CBO staff to participate in training on how to conduct adaptations. As much as funders have diffused DEBI trainings and required CBOs to attend them prior to implementing EBIs, the same should happen for adaptation-related trainings. To this end, it is recommended that funders consider adding a requirement for adaptation-specific training as a condition of receiving a funding award or contract, especially in light of the fact that CBOs already conduct adaptations of EBIs even without the formal know how.

These adaptation trainings should be offered on-line, in self-taught forums, and face-to face so that they are readily accessible to community members. These trainings should focus on assessment skills (the need for adaptation), management skills related to the process (documentation of the adaptations conducted), practical skills, which includes guidance and practice in conducting adaptations, and direction on how to evaluate the adaptation effort (did the adaptation have the

expected effect of EBI delivery). The content of these trainings should be further informed by “experts” in the field, such as the researchers and program developers involved in the translation and synthesis of the EBI for use within the community. Upon completion of such trainings, certificates of completion should be provided to participants as evidence that the necessary training was sought and acquired by the CBO.

Recommendation 5: Collaborate and coordinate across federal and/or state health, human and social service entities to create a stronger, more coordinated public health system.

The resource deficits that now characterize the national public health system drive this recommendation for increased collaboration and coordination across large funding entities to optimize health care service delivery. Just as CBOs are asked to establish linkages and partnerships with health and human service organizations that can support their clients in achieving their goals, so should funders coordinate and collaborate their efforts to ensure: 1) their policies are supportive of each other, 2) resources are well allocated and not duplicated, and 3) CBOs are supported in their efforts to improve community health and wellness.

Although the literature suggests increased communication over the years among the major providers of public health services in the U.S., there appears to be significant room to increase *coordination* of services and *collaboration* on public health initiatives. Because deficits do exist in the system and have such a deleterious impact on the broader effort of keeping communities HIV-free, and because no single funder can fund all things for all people, the need for coordination and collaboration across these major entities becomes all the more urgent and beneficial to all parties. The following steps can be taken to achieve this change:

1. **Create a cross-agency workgroup** with key representatives from federal and state health and human service groups.

2. To obtain participation, **increase the urgency level** (Kotter, 1996) so that the matter can be prioritized and given due attention. In this case, the “urgency” is driven by financial losses experienced across agencies and the reality of having to continue to address the needs of the community with fewer resources.
3. Once the group has been established, the work should focus on **articulating a vision** to help direct the change process and include **strategies** (Kotter, 1996, Yukl, 2006) for facilitating cross agency collaboration and coordination.
4. The vision and strategies should be communicated by representatives in their respective agencies and **put into practice immediately**. At least initially, cross agency collaborations should be **made highly visible** (Kotter, 1996, Yukl, 2006) to demonstrate the change. These accomplishments should be made known both internally, within agencies, and externally with the larger public via the use of media.
5. Once initial change is established, the workgroup should continue to **produce more change** in systems, structures and policies (Kotter, 1996) and **monitor progress with change** (Yukl, 2006) until it is well integrated; all while keeping the vision central to the cause.

As with the adaptation of EBIs, it is believed that if the leaders set the tone for working together on the federal level, the next tier of leaders will follow suit. In time, with such modeling, coordination and collaboration will become the norm in local HIV prevention settings and clients will be able to receive the continuum of services that will further support their efforts to either remain HIV negative or to live healthier lives and prevent transmission if they are HIV positive.

CBO Recommendations

CBOs are critical partners in the research-to-practice process, and therefore, have an equally important role to play in ensuring that the communities they serve receive the best and most effective HIV prevention and other health-related services. The recommendations outlined for CBOs require leadership at the organizational level to institute changes that will strengthen the capacity of both individual staff and the agency to implement and adapt EBIs in their respective settings.

Recommendation 1: Invest in enhancing organizational and programmatic infrastructure and staff capacity to implement and adapt EBIs.

To be a high functioning CBO or maintain the status as one, agencies need to continually invest in their overall infrastructure to ensure that programs and services are well aligned with the agency's mission and vision, and are well managed and implemented. This assertion is supported by the leadership literature, which endorses continuous learning and quality improvement as a means of "keeping an edge" on the competition.

The environment of most organizations is becoming increasingly dynamic and competitive. Competition is becoming more intense.... To succeed in this turbulent environment, organizations need to have people at every level who are oriented toward learning and continuous improvement. (Yukl, 2006, p. 308).

As such, agency staff need to be knowledgeable, skilled, and competent in their proposed work areas of focus. This recommendation speaks to the need for agencies to become more sustainable by building up their attractiveness to diverse funders as well as their client base, and calls for actions steps in several key areas:

a. Assess human resources (HR) capacity and develop a plan to address limitations.

The most appreciable asset of any organizations is people (J. Collins, 2005; Maxwell, 1993), and the selection of people will largely determine an organization's success or failure (Maxwell, 1993). The preeminent investment organizations can make to strengthen internal capacity is to secure competent, effective, ethical people in management and front-line positions. To do so, it is recommended that both prior to and during the course of program implementation, agencies assess current staffing capacity and evaluate existing staff for "goodness of fit" with agency philosophy, culture, and programs. This can be done by implementing the following action steps generated from the work of Maxwell (1993) for building team capacity:

- Map out the mission and vision of team (in this case the HIV prevention team);
- Define the role of each player and identify what strengths and gaps exist;
- Develop a plan to address identified deficiencies;
- Know what kind of person is needed and what the job requires;
- Find out the motivations of potential staff members;
- If the best cannot be hired; hire the young who are going to be the best.

The process of assessment and investment in the people who comprise the team continues even after the team is established, goals and objectives are communicated, and the work is underway.

Since many of the implementation barriers and adaptation challenges identified in this research relate to HR issues such as staffing shortages, inadequate oversight and supervision (see Recommendation 2b below), and skill deficiencies, the focus on human resource capacity, especially EBI team capacity, can eliminate many of the identified barriers once properly addressed.

- b. Prepare purposefully for EBI implementation--budget wisely; project levels of services cautiously.**

As agencies consider their human resource capacity and program support needs for EBI implementation, such considerations should automatically translate into budget recommendations. CBOs are advised to ensure that program budgets support EBI implementation and that human resource support needs, in particular, are not sacrificed for other direct programmatic support needs.

To truly gauge HR support needs and project reasonable levels of service, CBOs must consider the components of an EBI, including design (individual vs. group level), components (how many sessions), intensity (what is required in each session), and the time required to recruit and retain clients for the duration of the program. It is recommended that agencies project levels of services based on this specific factual information rather than on past experience with other EBIs or programs that may be designed much differently from the EBI for which they are seeking funding. As a best practice, leadership within the organization should instill a culture whereby CBO program staff and fiscal personnel collaboratively prepare budgets so as to avoid the pitfalls brought on by too little human resource support and too large projections for services on the client end.

- c. Establish strong linkages and partnerships to support overall client needs.**

Few organizations have the ability to stand on their own to address the gamut of health, human, educational and social support needs of a given client. It is recommended that CBOs establish linkages and partnerships with other agencies within their communities to supplement the client services being provided at the agency. To lead this change, agency leadership should first conduct an environmental scan to determine the resource assets and service gaps within their communities.

Next, agency leaders should **invest the time to convene stakeholders** and **establish or enhance relationships** with key community services providers (similar to that which was proposed for coordination and collaboration at the funder level) across fields and disciplines in order to establish a

network of care for clients at high risk for, and living with HIV/AIDS. These linkages become especially important for services in high demand that are sparse within a community, but critical to a clients' overall well-being and capacity to complete the HIV prevention EBI. In this research, such service areas included substance abuse treatment and housing and mental health services, but services could also include a range of other support and health services including job training, general and specialty medical care, remedial educational services, and immigration services.

A key implementation step for agencies conducting MIP is to establish formal memoranda of agreement (MOAs) with substance abuse, mental health and housing providers for a number of slots which are supported through program funding, or include partial support for a mental health practitioner in the MIP program budget. This would ensure that MIP clients receive some level of mental health care. Another solution for organizations is to explore additional streams of funding to support these services outside of HIV prevention in order to have greater capacity to provide wrap-around services to the MIP client.

In general, it is also recommended that agencies "go beyond" having MOAs and conduct outreach to the point(s) of contact at partnering agencies to facilitate a relationship that will support the referral process. A best practice would also be to obtain information on a partnering agency's eligibility and intake processes so that clients can be properly referred and prepared to receive services with as little delay as possible. Another best practice would be to develop a tracking mechanism to capture successful referrals between parties to gauge clients' use of referral services as well as agency service provision to referred clients.

Recommendation 2: Invest in the relationship; strengthen the partnership.

CBOs have an equally valuable stake in establishing a relationship with the funder as the funder has in doing the same with the CBO grantee or contractor. The recommendation for CBOs with

regard to *"investing in the relationship and strengthening the partnership"* is two-pronged: a) establish open communication and honest dialogue with funder and; b) institute a culture of accountability with formal and informal quality assurance and reporting mechanisms.

a. Establish open communication and honest dialogue with Funder.

CBOs must be vigilant in establishing productive relationships with funders. Open communication and dialogue built on honesty and trust can immensely benefit the CBO by providing an unsolicited champion or advocate for the CBO in the form of funder personnel. Communication as a leadership practice helps to articulate the vision, clarify priorities, champion solutions and strategies, and energize commitment to goals (Baker, 2003). It also helps to attract supporters and fosters ownership of the process. Recommended strategies that CBO staff may wish to implement to initiate and establish a culture of open communication with the funder include:

- Inquire about the funder's goals, objectives, priorities, and expectations for the funded program. If the funder has done its part in conducting an internal values clarification scan, then these questions are easily answered; if not, the funder may need additional time to ensure that accurate information is communicated.
- Inquire about preferred communication style. Are emails preferred over telephone calls? Are certain times of the day or certain days better than others for discussions? What type of turn around is expected in responding to emails? How are urgent inquiries to be handled?
- Share program successes, challenges and barriers informally and ask for feedback, guidance, and opinions on the information disclosed.
- Ask questions to clarify feedback and guidance received.

- Incorporate as much or as little of the feedback/guidance provided by the funder in terms of what makes sense for the given situation or circumstance.
- Inform the funder of how suggestions have been incorporated.
- Express gratitude for a mutually conducive working relationship.

As there are often other personal factors that can readily impact the dynamics of a relationship, these steps are meant to provide a foundation from which CBOs can build or enhance the relationship and strengthen the partnership with funders. The above strategies apply not only to newly funded CBOs, but also to those that have long established relationships with funders and for which the relationship requires a boost. The value and usefulness of these strategies is that they transcend time and tenure and can be used by an agency at any moment in time to “pick up” the dialogue and enhance communication between parties.

Recommendation 3: Create or reinforce a “culture of learning and accountability” which encourages training and technical assistance for overall quality improvement.

A commitment to continuous learning coupled with monitoring, evaluation, and continuous quality improvement are key leadership competencies that community-based leaders must command in order to continually improve operations and provide quality services to their constituents (Baker, 2003). CBOs have the responsibility to ensure that the services they provide to the community are of high quality and value. Internally, CBOs must establish a “culture of learning and accountability” among staff that reinforces professional development, principled management and quality service delivery. The internal work that must first be done to further this goal requires leadership to create an environment that models learning and accountability through the behaviors and practices of management. Steps that agency leaders can take toward achieving this goal include:

- Instituting formal supervisory mechanisms for both group and individual supervision;
- Developing and supporting both individual and team (MIP) professional development goals;
- Establishing quality assurance checks and benchmarks within various stages of program implementation to identify opportunities for improvement;
- Prioritizing and investing in open, honest dialogue with funder;
- Prioritizing accurate reporting; and,
- Establishing accountability as a core organizational value.

Prior to seeking assistance from external parties, CBOs should first assess and determine their strengths and areas for improvement, including the learning needs of staff. Adequate monitoring, supervision and program oversight will yield such information before an issue or skill deficit becomes a major impediment to program operations. Once a Supervisor is equipped with the “full picture” including both program successes and challenges, this information should be communicated to the funder via both formal reports and the informal dialogue and communication that occurs as part of the agency’s management strategy or “investment in the relationship.”

The key action step for CBOs within this recommendation is to communicate training needs as well as challenges and barriers to the funders as they arise so that joint solutions can be developed and strategies put in place to move beyond the challenge(s). The alternatives of “waiting it through” or “covering up” challenges is a detrimental practice that leaves one side blindsided and the other without the necessary support and technical assistance to move beyond the issue.

Supervision also serves as the gateway for identifying staff training and support needs. A “culture of accountability” requires agencies to respond to staff development needs to ensure that staff are well informed and equipped to do their jobs. Support for training opportunities that build

professional skills, provide networking opportunities, and facilitate peer-to-peer learning is an additional way agencies can facilitate a learning culture within their organizations that reinforces the values of quality and accountability.

Recommendation 4: Build internal capacity to conduct adaptations of EBIs.

To build CBO capacity for adaptation, the “implementation practice culture” for EBIs at the community level also needs to shift. CBOs must invest in training staff on the processes and practices related to adapting an EBI, including identifying when there is a *need* for adaptation. It is recommended that all levels of staff involved with implementing EBIs be required to attend training on adaptation so as to understand the significance of adaptation, including its scope and parameters, as well as the need to plan and execute adaptation in a systematic manner and track and evaluate the adaptations conducted. Although all EBI-implementing staff should be educated on adaptation as an option for enhancing the relevance and applicability of an intervention for a target population, it should be communicated that not all trained staff will be authorized to conduct adaptations, as there is a process to be followed to protect the integrity of the EBI. As such, agency leadership should designate select staff trained in adaptation and having management skills and competencies to serve as adaptation “specialists” for the agency. In this role, these staff would be consulted on all adaptations and would provide the necessary oversight and support on the adaptation processes being undertaken by the agency. Ideally, agency Adaptation Specialists would be supported by agency leadership and provided with opportunities for further training and consultation on adaptation of EBIs.

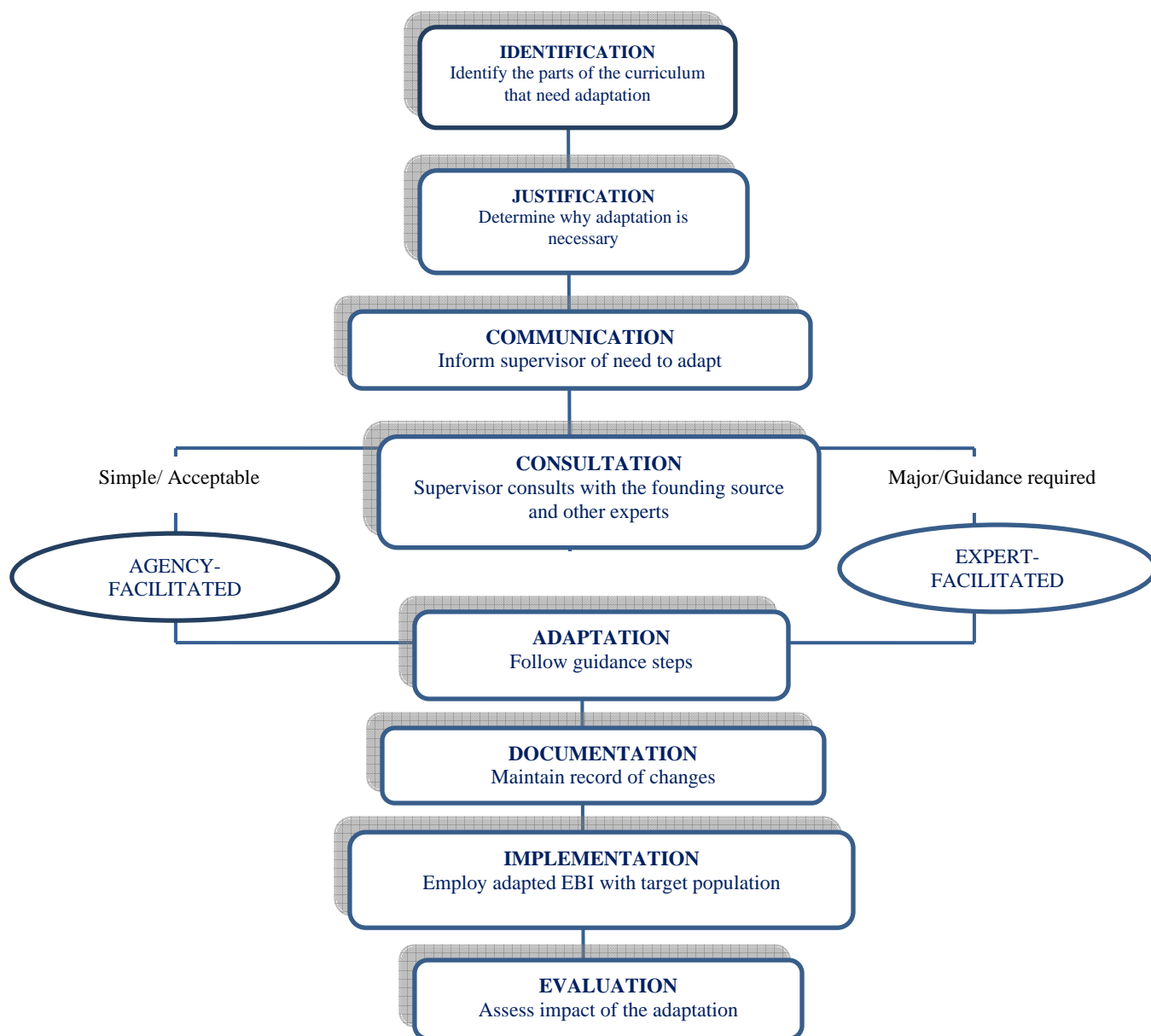
As agencies move toward building their capacity for conducting adaptations, as a best practice CBOs should establish internal protocols for embarking on adaptations similar to the implementation protocols that routinely exist for EBI service delivery. The existence of such a protocol would convey an agency’s commitment to conducting adaptations with integrity, and dissuade random and impromptu

acts of adaptation. An example of an internal agency protocol on adaptation would include a series of simple steps to guide the adaptation process as has been conceptualized by the PI and listed below:

- Identify the parts of the curriculum that needs to be adapted;
- Determine why the adaptation is necessary;
- Inform supervisor of need to adapt;
- Ensure supervisor consults with funder and/or another external “expert” on the feasibility and scope of the proposed adaptation;
 - If determined to be simple and acceptable, agency conducts adaptation under the supervision of an staff person trained in adaptation;
 - If determined to be major, supervisor seeks professional guidance to facilitate the adaptation;
- Follow guidance on the steps to be taken to conduct the proposed adaptation;
- Maintain documentation of the changes made, especially those related to culture or content of the intervention;
- Implement the adapted EBI with the target population;
- Evaluate the impact of the adaptation.

This proposed flow of events is further conceptualized in **Figure 6- Adaptation Decision Tree**, which can be used by CBOs to strategically think about adaptation and initiate the process from a community-based perspective that is both user-friendly and easily followed.

FIGURE 6: Adaptation Decision Tree



Pemberton, 2012

This type of internal agency protocol would serve to reinforce the notion of adaptation as a tool that is available and accessible to organizations, but which requires forethought, planning, and skill to ensure that EBIs remain as effective or more effective in their adapted form as they were in their

original form. To ensure adaptations are conducted with fidelity, implementation of this protocol could potentially be managed by the agency Adaptation Specialist, with the support of agency leadership.

Implementing Change

The application of the proposed recommendations warrants change. Leading change is one of the most important and difficult leadership responsibilities (Kotter, 1996; Maxwell, 1993; Yukl, 2006) and requires concerted effort and thoughtful action. For both funders and CBOs these recommendations can only become reality if leadership practice takes center stage. Although there is consensus that more and better leadership is needed in order to respond to today's demands on both public and private healthcare systems (Baker, 2003; J. Collins, 2005; Maxwell 1993), the means by which to translate this knowledge to action remains a constant challenge. Although there are various schools of thought on leadership, what remains constant are the competencies required of leaders to facilitate change toward better quality healthcare and optimal health of individuals and communities into the 21st century.

The National Center for Healthcare Leadership (as cited in Baker, 2003) offers six overarching leadership and management competencies for health leaders that subsume three levels: individual development, organizational improvement, and health system redesign and performance. These themes (as cited in Baker, 2003) offer a best practice guide for leaders within CBOs and funding agencies to follow to build their own capacity to lead and implement change on both a broad and smaller scale. The six areas of leadership competency are as follows:

1. *Leadership:* Create and communicate a shared vision, champion solutions for organizational and community challenges and energize commitment to the goals.
2. *Collaboration and Communication:* Develop cooperative relationships and effective information exchanges within the organizations and broader communities served.

3. *Management Practice:* Identify, evaluate and implement strategies and processes designed to yield effective, efficient, and high quality customer-oriented healthcare.
4. *Learning and Performance Improvement:* Continuously assess and improve the quality, safety and value of health care.
5. *Professionalism:* Demonstrate ethics, values, and professional practices; stimulate social accountability and community stewardship; and commit to personal and institutional development.
6. *Personal and Community Health Systems:* Integrate the needs of individuals with those of the community, optimizing opportunities to improve the health of the populations served within the context of the healthcare environment and policy. (Baker, 2003, pg. 52-53)

Each of these competencies includes specific action steps to be executed by the leader to “achieve” a given competency. These action steps are in line with the current literature on leading change (Kotter, 1996; Maxwell, 1993, and Yukl, 2006), which calls for building momentum or urgency for change, getting the right people onboard to support change, defining and articulating a vision and strategy for change, empowering action for change, implementing change, getting change efforts recognized, and sticking with change with the same passion until the vision is a reality. In order to accomplish the proposed recommendations, a similar commitment and passion must be harnessed from the leaders within CBOs and funding agencies so that followers are inspired and empowered to do the work and make the necessary changes to improve the overall delivery of HIV prevention to those who are most in highly impacted by the disease and in need of good, sound, public health and support services.

Final Word

Taken together, these recommendations provide a point of continuation from which CBOs and funders can continue the critical service of providing best evidence HIV prevention

interventions to the most impacted and disenfranchised communities. Even though the road from research-to-practice may be fraught with challenges, these challenges can be overcome when leaders both facilitate and join efforts to improve and enhance capacity on all levels of the research-to-practice continuum and encourage their staff to follow. While the literature on the implementation phase of the continuum remains underdeveloped and there is a lack of community-centered adaptation guidelines, this research offers insights into the implementation and adaptation experiences that currently exist in community practice settings and offers recommendations to address challenges and create a better environment for “delivery science” progress.

APPENDIX A.
Organization Invitation and Consent to Participate in the Research Project (English)

DATE

Name of Executive

Title

Address 1

Address 2

Dear _____

As the Executive Director of Organization Name, I would like to invite your organization to participate in a research study on the implementation and adaptation of Evidence-Based Interventions in Community Practice Settings using the experiences of community-based organizations that are currently implementing the Modelo de Intervención Psicomédica (MIP).

Organization Name was targeted as a potential site for this research study as one of only a handful of organizations nationwide that is known to have been implementing MIP for at least six months.

Although your organization is being asked to join this study, participation is fully voluntary and you may refuse to participate or may withdraw consent to be in the study, for any reason, without penalty.

The purpose of this research study is to expand the knowledge base of the processes used by community-based organizations to select, implement, and adapt HIV prevention evidence based interventions in local settings so that strategies can be identified to facilitate future dissemination and implementation of efficacious HIV prevention interventions in community practice settings. Your organization's participation in this study will further this goal and provide useful information to funders, researchers, community practitioners, and stakeholders on how best to support organizations such as yours in your efforts to successfully implement and sustain HIV prevention efforts locally.

Should you agree to participate in this study, participation will entail approximately five contacts over a three-month period for up to 14 hours of agency staff time. We will require that you designate a lead staff member for this study as a point of contact for coordinating research activities. Contacts with estimated time-frames would include the following:

- Site visit to organization (up to 2 hours)
- Semi-structured interview with at least two but up to four members of the MIP team with at least one staff representing administrative/management team and the other a front-line staff person involved in the implementation of MIP) (up to 8 hours estimated at 2 hours/interview for up to 4 people)
- Data gathering to facilitate review of select MIP program implementation forms (without client identifiers). Forms may include 1) behavior risk assessment, progress notes, documentation of sessions completed by client) (up to 2 hours)
- Participation in follow-up, as needed. (up to 2 hours)

At least two other organizations from different regions of the country (U.S. and its territories) will be selected for participation in this study. I will speak to at least five more staff members within these organizations to ask them to share their experiences with regard to the implementation and adaptation of MIP. All information obtained from this research study will be reported in general descriptions and group summaries unless otherwise explicitly specified with verbal and written consent. This means that neither the name of your organization nor participating staff will be connected to the data. Although I may use a direct quote from a staff member in the final write-up of this research to reinforce a particular point, names and identifiers will never be used. Instead "mock" or "pseudo" names such as "participant 3" will be used.

Finally, there is no payment for participating in this study. Upon completion of the study, all participating organizations will receive an executive summary of research findings including recommendations around the implementation and adaptation of HIV prevention evidence-based interventions. It is my hope that the information generated from this research study will reveal the issues, challenges, key strategies and best practices surrounding the implementation and adaptation of evidence based interventions so that community-based practitioners such as yourself can use this information to guide current and future delivery of HIV prevention programs.

If you have any questions related to this research study at any point in time, please feel free to contact Gisele Pemberton, Primary Investigator and Student Researcher at:

In writing: 111 Orchard Road, Maplewood, NJ 07040

Via Email: gpembert@email.unc.edu or giselepemberton@yahoo.com

Voice: 973-202-1367

Fax: 908-353-5185

Your organization's consent to participate in this study will be confirmed by completing the attached consent form. Please sign and date the form as indicated below, and email or fax back to Gisele Pemberton (see above contact information). Please maintain a copy of this letter and the signed and dated consent form for your records.

Sincerely,

Gisele Pemberton, MPH, CHES
Doctoral Student, Principal Investigator, Student Researcher
University of North Carolina-Chapel Hill
School of Public Health-Health Policy and Management

CONSENT TO PARTICIPATE IN RESEARCH STUDY

How do Community Practice Settings Approach the Implementation and Adaptation of Evidence-based Interventions? Lessons from the Modelo de Intervención Psicomédica"

As an official representative of AGENCY NAME, I, NAME OF AGENCY OFFICIAL, voluntarily agree to AGENCY NAME participation in the research study entitled "How do Community Practice Settings Approach the Implementation and Adaptation of Evidence-based Interventions? Lessons from the Modelo de Intervención Psicomédica" and agree to the terms and conditions for participation described in this letter of invitation and consent.

I understand that participation in this study may take up to 14 hours of agency staff time and will require:

- On-site visit
- Interviews with key staff
- Document review of MIP data collection/documentation forms

On behalf of AGENCY NAME, I also agree to "hold harmless" all staff participating in this study from any cost, loss, or retaliation due to their participation in this study.

I also agree to designate the following persons to serve as lead agency contact(s) for this study:

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Email: _____	Email: _____

My signature below provides full consent for participation. I am aware that if I have any questions or concerns, these may be addressed to Gisele Pemberton, Principal Investigator, at gpembert@email.unc.edu or 973-202-1367.

Print Name: _____

Title: _____

Signature: _____ Date: _____

Thank you.

Please return this signed consent form to Gisele Pemberton
Via mail: 111 Orchard Road, Maplewood, NJ or
Via fax: 908-353-5185 Attn: Gisele Pemberton
Scan and Email: gpembert@email.unc.edu

APPENDIX B.
Invitación para la Organización y Consentimiento para Participar en el Proyecto de Investigación (Spanish)

FECHA

Nombre del Ejecutivo

Título

Dirección 1

Dirección 2

Estimado _____

Como el Director Ejecutivo del **Nombre de la organización** me gustaría invitar a su organización a participar en un estudio de investigación sobre la implementación y adaptación de intervenciones basadas en la investigación mediante las experiencias de las organizaciones basadas en la comunidad que actualmente están implementando el Modelo de Intervención Psicomédica (MIP).

Nombre de la organización fue seleccionado como un sitio potencial para esta investigación como una de sólo unas cuantas organizaciones en todo el país que han estado implementado MIP por seis meses o más. Aunque le estamos pidiendo participar en este estudio, la participación es totalmente voluntaria y no tiene que participar o puede retirarse del proyecto de investigación en cualquier momento y por cualquier motivo, sin sufrir sanciones.

El propósito de este estudio de investigación es ampliar la base de conocimiento sobre los procesos utilizados por las organizaciones basadas en la comunidad para seleccionar, implementar y adaptar las intervenciones basadas en la evidencia para la prevención de VIH. Y para identificar estrategias para facilitar la futura difusión y aplicación de estas intervenciones de prevención del VIH en un contexto comunitario. La participación de su organización en este estudio nos ayudará a realizar esta meta y proporcionará información útil a los financiadores, investigadores, profesionales de la comunidad sobre la mejor forma de apoyar a las organizaciones como la suya en sus esfuerzos para exitosamente implementar y sustentar la prevención de VIH localmente.

Si acepta participar en este estudio, esto significaría participar en cinco contactos durante un periodo de tres meses por lo máximo de 14 horas de tiempo de algunos empleados de la agencia. Vamos a requerir designar un miembro del personal como un punto de contacto para coordinar las actividades de investigación. Actividades con el tiempo estimado que durarán son:

- Visita a la organización (hasta 2 horas)
- Entrevista semi-estructurada con al menos dos pero hasta cuatro miembros del equipo de MIP con al menos un empleado que representa la gerencia o personal administrativo y una persona del personal de alcance comunitario que están implementando MIP (hasta 8 horas, estimadas en 2 horas cada una/Entrevista para hasta 4 personas).

- Recopilación de datos para facilitar la revisión de algunos de los formularios de implementación del programa de MIP (sin identificadores de cliente). Las formas pueden incluir 1) evaluación de los riesgos de comportamiento, notas de progreso, documentación de sesiones completado por cliente) (2 horas).
- Participación en seguimiento, según sea necesario (2 horas).

Por lo menos dos otras organizaciones de diferentes regiones del país (Estados Unidos y sus territorios) serán seleccionados para participar en este estudio. Voy a hablar con por lo menos cinco personas dentro de estas organizaciones para pedirles que compartan sus experiencias con respecto a la implementación y adaptación de MIP.

Toda la información obtenida en este estudio de investigación se reportará en descripciones generales y resúmenes de grupo a menos que sea explícitamente por escrito y con consentimiento. Esto significa que ni el nombre de su organización ni los de los participantes se conectarán a los datos recopilados. Aunque utilice una frase de un miembro del personal en el reporte final no se utilizara su nombre sino un nombre ficticio. Por ejemplo, "participante #3".

Por último, no hay ningún pago por su participación en este estudio. Al finalizar el estudio, todas las organizaciones participantes recibirán un resumen de los resultados de la investigación incluyendo recomendaciones para la implementación y adaptación de las intervenciones basadas en la investigación para la prevención de VIH. Espero que la información que se generará de este estudio de investigación revelará los problemas, retos, estrategias claves y las mejores prácticas en la implementación y adaptación de intervenciones para que profesionales como usted puedan usar esta información para guiar la implementación de los programas de prevención de VIH actualmente y en el futuro.

Si tiene alguna pregunta relacionada con este estudio de investigación en cualquier momento, no dude en ponerse en contacto con Gisele Pemberton, investigadora principal y estudiante de doctorado en:

Por escrito: 111 Orchard Road, Maplewood, NJ 07040

A través de correo electrónico: Gpembert@email.unc.edu o giselepemberton@yahoo.com

Por teléfono: 973-202-1367

Fax: 908-353-5185

Su consentimiento de su organización a participar en este estudio se puede confirmar al completar el formulario de consentimiento adjunto. Por favor poner su firma y la fecha en la página siguiente y mandarla de vuelta por correo electrónico o fax a Gisele Pemberton (véa la información de contacto). Por favor, mantener una copia de esta carta y el formulario de consentimiento firmado y fechado para sus archivos.

Atentamente,

Gisele Pemberton, MPH, CHES
Estudiante de doctorado, investigadora principal,
Universidad de Carolina del Norte- Chapel Hill
Escuela de Salud Pública – Departamento de Póliza y Administración de Salud

CONSENTIMIENTO PARA PARTICIPAR EN EL ESTUDIO DE INVESTIGACIÓN

¿Cómo organizaciones basadas en la comunidad implementan y adaptan las intervenciones basadas en la investigación (EBIs)? Lecciones del Modelo de Intervención Psicomédica.

¿Como representante oficial de **Nombre de la organización** Yo, **Nombre** voluntariamente estoy de acuerdo en la participación **del Nombre de la organización** en el estudio de investigación titulado "¿Cómo organizaciones basadas en la comunidad implementan y adaptan las intervenciones basadas en la investigación (EBIs)? Lecciones del Modelo de Intervención Psicomédica" y de acuerdo a los términos y condiciones de participación que se describe en la carta de invitación.

Tengo entendido que la participación en este estudio puede requerir hasta 14 horas de tiempo de la agencia y como mínimo, incluye las siguientes actividades:

- Visita a la organización
- Entrevistas con personal clave
- Revisión de la documentación - formas de colección/documentación de datos de MIP

También estoy de acuerdo en designar a la persona o personas siguientes para servir como puntos de contacto para la agencia refiriéndose a este estudio de investigación:

Nombre: _____

Nombre: _____

Dirección: _____

Dirección: _____

Teléfono: _____

Teléfono: _____

Email: _____

Email: _____

Nombre de la organización, le asegura mantener todo personal que participe en esta investigación "libre de daños", gasto, pérdida, o retaliación por su participación en la misma.

Mi firma a continuación proporciona pleno consentimiento para la participación. Soy consciente de que si tengo alguna pregunta o inquietud, estas las puedo dirigir a Gisele Pemberton, investigadora principal, en gpembert@email.unc.edu o 973-202-1367.

Nombre (en letras imprenta): _____

Título: _____

Firma: _____

Fecha: _____

Gracias por su cooperación y participación.

Devuelva este formulario de consentimiento firmado a Gisele Pemberton

A través de correo electrónico: 111 Orchard Road, Maplewood, NJ o

Por fax 908-353-5185 Attn: Gisele Pemberton

Correo electrónico: gpembert@email.unc.edu

APPENDIX C.
Interview Guide, Consent, and Questions for Dissertation Research Study:
How do Community Practice Settings Approach the Implementation and Adaptation of
Evidence-based Interventions? Lessons from the Modelo de Intervención Psicomédica
(English)

Introduction:

Thank you so much for agreeing to participate in this interview. The purpose of this interview is to learn more about how you and your organization are implementing the Modelo de Intervención Psicomédica (MIP) evidence-based intervention. I will be asking you a series of questions to help me understand how you have approached the selection, adaptation and implementation of MIP and which factors have facilitated or hindered this process for you or your organization. It is my hope that the information obtained from these interviews will reveal the issues, challenges, key strategies and best practices surrounding the implementation and adaptation of evidence based interventions so that community-based practitioners such as yourself can use this information to guide your practice the next time around.

This interview will last about two hours and it is completely confidential. **You can stop the interview at any time should you choose to do so or pass on (not answer) any question that you do not want to respond to.** Please be aware that the information obtained in this interview will be reported in group summaries and that neither your name nor that of your organization will be connected to your responses to these questions.

Finally, there is no payment for participating in this study. I will now ask your permission to record our interview so that I can be sure to capture your responses accurately and listen while you talk. Upon completion of this research, all documentation related to this work, including these tape recordings and any transcriptions will be destroyed.

Do you have any questions or concerns with regard to what I just said?

May I have your written consent to record this interview? Please check off "Yes" or "No" here and initial.

<input type="checkbox"/> Yes	Initial _____	Date: _____
<input type="checkbox"/> No	Initial _____	Date: _____

This will be the only time I will ask you to use your initials on any documents. This page will be filed away and kept separate from the rest of this interview to further protect your confidentiality.

Thank you. Now let's begin, and remember I am more than happy to repeat or reword any question I ask that is not clear to you.

Part I : Demographic Information-Organizations

This section for management/administrative staff interviews only

- When was your organization first established?
- What types of programs and services does your agency offer?
- Approximately how many staff does your agency have?
- For how many years has your organization been providing HIV/AIDS services?
 - How many staff do you have in your HIV/AIDS department?
 - How many staff do you have working on MIP?
 - What are their background/credentials?
- What types of HIV/AIDS services do you offer?
 - Which DEBIs or other EBIs do you implement?
 - Who are your target populations for each of these interventions? Please describe by both race/ethnicity and risk category/behavior (for eg. MSM, IDU).
- What is the total annual budget of your organization? Would you say:

<input type="checkbox"/> < \$99,000	<input type="checkbox"/> \$700,000 - \$1 Million
<input type="checkbox"/> \$100,000- \$249,000	<input type="checkbox"/> \$1 Million-\$3 Million
<input type="checkbox"/> \$250,000-\$499,000	<input type="checkbox"/> \$4 Million-7 Million
<input type="checkbox"/> \$500,000 - \$700,000	<input type="checkbox"/> \$7 Million-\$10 Million
<input type="checkbox"/> <\$10 Million	
- What is your approximate budget for implementing the MIP intervention?
- Who is your funder(s) for MIP?
- Who within your agency been trained on a CDC evidence-based intervention from the DEBI compendium(www.effectiveinterventions.org) ?
 - Who within your agency has been specifically trained on MIP?
 - Did this individual(s) attend the CDC-sponsored training or another type of training?
- How is MIP a "good" or 'bad" fit for your organization? Why?
 - If a "bad fit" what other DEBI you would have chosen? Why?
- What type of support does the agency leadership provide with regard to the planning and implementation of EBIs such as MIP?
 - (Probe for program support, fiscal support, staff training, etc.)

Part I: Demographic Information- Personal

This section for both management/administrative staff and front line staff interviews:

- How long have you been working for this agency?
- What is your title/position here?
- How would you describe your role?
- How long have you been working in the field of HIV/AIDS?
- How long have you been held your title/position of _____ at this agency?
- What is your educational background/training?
 - What degrees do you hold?
 - In what area(s)?
- What type of training, if any, have you received on CDC DEBIs?
 - Probe: Ask about training in any of the 26 DEBIs, Motivational Interviewing, HIV Counseling, Testing, and Referral or other public health strategies.
- What training, if any, have you received in MIP? How long ago were you trained?
 - Probes- For front line staff, ask about training in Motivational Interviewing, Stages of Change, Outreach and Community Mapping, HIV Counseling, Testing and Referral)

Part II: General Questions: Administrative/Management Staff

This section for management/administrative staff interviews only

Implementation Experiences:

- On a scale of 1-5 with 1 being the lowest and 5 being the highest, how would you rate your agency's level of preparedness for implementing MIP prior to implementation? Why that rating?
- Which factors did you or your agency consider in your selection of MIP as an evidence-based intervention to implement within your agency? Why?
Probe with these questions, as needed: Did you consider
 - Needs/service gaps of your target population?
 - Agency access/experience with target population?
 - Content of the intervention?
 - Length of the intervention?
 - Values and norms promoted for MIP?
 - Staff expertise to implement intervention?
 - Community support for intervention
 - Available resources?
 - Costs?
 - Client interest?
- What pre-implementation planning activities did you or your organization conduct to prepare for implementing MIP?
 - Probe (For example, such activities may include: conducting a needs assessment, consultation with clients, sending staff for training on MIP or another supportive skill area, seeking additional funding to support MIP, delegating private counseling space, changing/modifying existing policies and procedures, hiring a supervisor/consultant, promotion and marketing of MIP for target audience, discussions with funder on how best to implement, seeking technical assistance from an "expert.")
 - When were these activities conducted?
 - With whom?
- What type of barriers or challenges did you expect having prior to actually implementing the MIP intervention?
 - Probe (For example, inadequate funding, recruiting participants, retaining participants, time to implement intervention and/or conduct follow-up, identifying and hiring experienced staff, opposition or resistance from staff/community, outdated internal policies/ procedures, lack of guidance from funder, lack of interest among clients, lack of T/TA opportunities)

- What types of barriers or challenges have you actually had in implementing MIP?
- What has worked well with implementation? Why?
- Think about the financial, human and structural resources that are needed to successfully implement MIP. How then would you describe your agency's capacity to implement MIP as it relates to:
 - Human Resources (Staffing? Supervision? Supportive policies/procedures)
 - Financial resources (enough money to run the program effectively/ enough money to offer incentives)?
 - Adequate structural resources (space to conduct counseling and case management sessions)?
 - Buy in (from staff, clients, community)
 - What else?
- What can you tell me about how MIP is being implemented at your agency?
 (Probe: With whom is it implemented?
 Who conducts the counseling sessions?
 Who conducts Case management sessions?
 How is it organized?
 Where does it take place?
 How often do you see clients to deliver MIP?
- In your opinion, what would you say has been the greatest challenge related to the implementation of MIP?
 - What is your greatest success with implementation thus far?
- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing you with enough guidance around program implementation for MIP? Why that rating?
- In your opinion, what person/group/entity has been your primary source of support for implementing MIP?

Adaptation Experiences

- What do you know about adaptation of EBIs? *Probe:*
 - How do you define adaptation?
 - What things do you consider allowable or unallowable during adaptation?(for instance, changes in content, target population, activities, number of sessions etc.)
 - Why do you think adaptation is necessary or unnecessary?
- What kind of guidance, if any, have you received with regard to adapting EBIs?
 - From whom did you receive this information?(Eg. Funder, Article, CBA provider, Website)
 - On a scale of 1-5 with 5 being the highest and 1 the lowest, how helpful was the information you received on adaptation of EBIs to your work with MIP?
- How has your agency dealt with the need for adaptation of EBIs such as MIP?
 - What adaptations have taken place?
 - Which strategies, tools, and/or resources did you or your agency use to adapt MIP?(Eg. Funder, CBA Provider, Website, Technical Assistance, Use of Consultant Expert)
 - Have you sought Information? Training? Technical assistance? around adaptation?
 - Which did you find successful?
 - Which were not?
- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing adequate guidance around program adaptation for MIP? Why that rating?

Technical Assistance Needs:

- What type of assistance do you think your staff is in need of NOW to support the implementation and/or adaptation of MIP?
- What are your technical support needs with regard to implementing and adapting EBIs such as MIP? *Probe:* Do you require assistance with:
 - Determining/negotiating levels of service with funder?
 - Recruitment and retention of clients?
 - Adapting MIP to another population or setting?
 - Documentation of program activities/use of forms etc.
 - On-going training and supervision?
 - Evaluation of intervention?
 - Human resource issues (staffing, training, etc)
 - Additional funding to support program activities/
 - What else?

- In addition to funding, in what other ways can agencies such as the CDC best support community-based organizations in the implementation and adaptation of EBIs such as MIP?
- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing with adequate technical assistance around program implementation and adaptation of EBIs such as MIP? Why that rating?
- What types of resources would be helpful in supporting the implementation and adaptation of EBIs such as MIP?
 - Probe (more training, guidance document, more funding, more flexibility from funder, more technical assistance?)
- What else would you like me to know with regard to your experiences around adaptation and implementation of MIP?

Thank you for participating in this interview.

Do you have any questions for me?

Part II: General Questions: Front line Staff

This section for front-line staff interviews only

Implementation Experiences of MIP

- On a scale of 1-5 with 1 being the lowest and 5 being the highest, how would you rate your agency's level of preparedness for implementing MIP prior to implementation? Why that rating?
- Which factors did you or your agency consider in your selection of MIP as an evidence-based intervention to implement within your agency? Why?
Probe with these questions, as needed: Did you consider
 - Needs/service gaps of your target population?
 - Agency access/experience with target population?
 - Content of the intervention?
 - Length of the intervention?
 - Values and norms promoted for MIP?
 - Staff expertise to implement intervention?
 - Community support for intervention
 - Available resources?
 - Costs?
 - Client interest?
- What pre-implementation planning activities did you or your organization conduct to prepare for carrying out MIP?
 - Probe (For example, such activities may include: conducting a needs assessment, sending staff for training on MIP or another supportive skill area, seeking additional funding to support MIP, delegating private counseling space, hiring a supervisor/consultant, promotion and marketing of MIP for target audience, discussions with funder on how best to implement, seeking technical assistance from an "expert.")
 - When were these activities conducted?
 - With whom?
- What type of barriers or challenges did you expect prior to actually implementing MIP?
 - Probe(For example, inadequate funding, recruiting participants, retaining participants, time to implement intervention and/or conduct follow-up, identifying and hiring experienced staff, opposition or resistance from staff/community, outdated internal policies/ procedures, lack of guidance from funder, lack of T/TA opportunities)

- How would you describe the population for whom you implement MIP?
 - Race/ethnicity
 - Risk behavior
 - Geographic location
 - Other defining characteristics

- From where do you recruit participants for the MIP intervention?

- Where do you conduct your MIP sessions?
 - Counseling sessions?
 - Case management sessions?
 - Outreach?

- What types of barrier or challenges have you encountered or are currently encountering now that you are implementing MIP? For example, inadequate funding, recruiting participants, retaining participants, time to implement intervention and/or conduct follow-up, identifying and hiring experienced staff, opposition or resistance from staff/community, outdated internal policies/ procedures, lack of guidance from funder, lack of T/TA opportunities)
 - In your opinion, what has been the greatest challenge in implementing MIP?

- What factors help to facilitate the implementation of MIP?
(Probe: training/TA, supervision, outreach/ access to clients, incentives provided etc)
 - What has worked well with implementation?
 - What has been your success(es)?

- Think about the financial, human and structural resources that are needed to successful implement MIP. How would you describe your agency's capacity to implement MIP as it relates to:
 - Human Resources (Staffing? Supervision? policies/procedures)
 - Financial resources (enough money to run the program effectively/ enough money to offer incentives)?
 - Adequate structural resources (space to conduct counseling and case management sessions)?
 - Commitment and Buy-in from all?
 - What else?

- How would you describe the support provided by agency leadership (management/administrative staff) in planning for and implementing MIP?
 - Probe: Do you feel you have adequate training? Supervision? Resources? Support?

- On a scale of 1-5 with 1 being the lowest and 5 the highest, as an evidence-based intervention (EBI) how well of a “match” or “fit” would you say MIP is for your organization compared to other interventions?
 - Probe: Think of MIP in terms of content, values, resources, organizational capacity to implement MIP etc.) Why that rating?
- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing with adequate technical assistance around program implementation and adaptation of EBIs such as MIP? Why that rating?
- What type of assistance are you in need of now to further support the implementation of MIP?

Adaptation Experiences:

- What do you know about adaptation of EBIs? *Probe:*
 - How do you define adaptation?
 - What things do you consider allowable or unallowable during adaptation?(for instance, changes in content, target population, activities, number of sessions etc.)
 - Why so you think is adaptation necessary or unnecessary?
- What kind of guidance, if any, have you received with regard to adapting EBIs?
 - From whom did you receive this information?(Eg. Funder, Article, CBA provider, Website)
 - On a scale of 1-5 with 5 being the highest and 1 the lowest, how helpful was the information you received on adaptation of EBIs to your work with MIP?
- What has been your experience with adaptation of EBIs? What types of adaptations have you made to the MIP Curriculum?
 - Probe: Have you even had to:
 - Shorten, lengthen, or condense sessions?
 - Change an activity/exercise?
 - Change any content?
 - Change language in the curriculum?
 - Exclude or Add an activity/exercise?
 - Use the curriculum with someone other than an IDU?
 - Conduct translations from English to another language?
 - Probe: Which features of MIP required adaptation and which features did not?
 - Probe on Core elements: (Community assessment/outreach, Induction, Motivational Interviewing, Continuous stages of readiness, Case

- Manager/Counselor interaction, session flexibility and scheduling, booster session)
 - Cultural elements: (conduct intervention for non-IDU, make more gender specific, integrate information for specific racial/ethnic group etc.)
- What cultural issues came up in implementing/adapting MIP?
 - Probe on what specific issues related to the target population were missing? Needed to be addressed? (drug use? Issues of racial/ethnic/sexual minorities/ gender issues?)
 - How were cultural considerations addressed in the adaptation process for MIP?
- Which strategies, tools, and/or resources did you or your agency use to adapt MIP? (Eg. Funder, CBA Provider, Website, Technical Assistance, Use of Consultant Expert)
 - Have you sought Information? Training? Technical assistance? around adaptation?
 - Which did you find successful?
 - Which were not?
- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing adequate guidance around program adaptation for MIP? Why that rating?
- What type of assistance are you in need of now to further support the adaptation of MIP?

Technical Assistance Needs:

- On a scale of 1-5 with 1 being the lowest and 5 the highest, how helpful has the funder been with providing you/your agency with adequate technical assistance around program implementation and adaptation of EBIs such as MIP? Why that rating?
- What are your technical support needs with regard to implementing and adapting EBIs such as MIP? Probe: Do you require assistance with:
 - Determining/negotiating levels of service with funder?
 - Recruitment and retention of clients?
 - Adapting MIP to another population or setting?
 - Documentation of program activities/use of forms etc.
 - On-going training and supervision?
 - Evaluation of intervention?
 - Human resource issues (staffing, training, etc)
 - Additional funding to support program activities/
 - What else?

- In addition to funding, in what other ways can agencies such as the CDC best support community-based organizations in the implementation and adaptation of EBIs such as MIP?
- What types of resources would be helpful in supporting the implementation and adaptation of EBIs such as MIP?
 - Probe (more training, guidance document, more funding, more flexibility from funder, more technical assistance?)
- What else would you like me to know with regard to your experiences around adaptation and implementation of MIP?

Thank you for participating in this interview.

Do you have any questions for me?

APPENDIX D.

Consentimiento y Cuestionario para la Tesis y Estudio de Investigación: ¿Cómo organizaciones basadas en la comunidad implementan y adaptan las intervenciones basadas en la investigación (EBIs)? Lecciones del Modelo de Intervención Psicomédica.

Introducción:

Muchas gracias por aceptar participar en esta entrevista. El objetivo de esta entrevista es aprender más sobre cómo usted y su organización están implementando la intervención basada en la investigación Modelo de Intervención Psicomédica (MIP). Preguntare una serie de preguntas que me ayudarán a comprender cómo se han dirigido a la selección, adaptación y implementación de MIP y los factores que han facilitado o dificultado este proceso para usted o su organización. Espero que la información obtenida en estas entrevistas revela los problemas, retos, estrategias claves y las mejores prácticas relacionadas con la implementación y adaptación de intervenciones basadas en la investigación para que los profesionales en la comunidad como usted pueden utilizar esta información para orientar sus programas la próxima vez.

Esta entrevista durará cerca de dos horas y es completamente confidencial. **Usted puede parar la entrevista en cualquier momento o no responder a cualquier pregunta.** Por favor, tenga en cuenta que la información obtenida en esta entrevista se reportara en resúmenes de grupo y que ni su nombre ni el de su organización se conectarán a sus respuestas a estas preguntas.

Por último, no hay ningún pago por su participación en este estudio. Ahora voy a pedir su permiso para grabar nuestra entrevista, para asegurarme que capturé sus respuestas con precisión y escuchar mientras usted habla. Al finalizar esta investigación, toda la documentación relacionada con este trabajo, incluyendo estas grabaciones y las transcripciones se destruirán.

¿Tiene alguna pregunta o inquietud con respecto a lo que he dicho?

¿Puedo tener su consentimiento por escrito para grabar esta entrevista? Por favor marcar "Sí" o "no" aquí y ponga sus iniciales.

____Yes Iniciales____ fecha: _____
____No Iniciales____ fecha: _____

Se trata de la única vez que le preguntaré utilizar sus iniciales en un documento. Esta página se mantendrá separada del resto de esta entrevista para proteger aún más su confidencialidad.

Gracias. Ahora vamos a comenzar y recuerde que puedo repetir o formular en otra manera cualquier pregunta.

Parte I: Información Demográfica - Organizaciones

Esta sección es solo para las entrevistas del personal administrativas y de gestión

- ¿Cuándo se estableció su organización?
- ¿Qué tipos de programas y servicios ofrece su agencia?
- ¿Aproximadamente cuántos empleados tiene su agencia?
- ¿Cuántos años su organización ofrece servicios de VIH/SIDA?
 - ¿Cuántos empleados tiene en su departamento de VIH/SIDA?
 - ¿Cuántos empleados trabajan en MIP?
 - ¿Cuáles son sus credenciales?
- ¿Qué tipos de servicios de VIH/SIDA ofrecen?
 - ¿Que DEBIs o otros EBIs implementan?
 - ¿Quiénes son sus poblaciones objetivo para cada una de estas intervenciones? Por favor, describa por raza/origen étnico y el riesgo de categoría/comportamiento (por ej. MSM-hombres que tienen relaciones con hombres, IDU).
- ¿Cuál es el presupuesto anual total de su organización? ¿Diría:

< \$99.000	700,000 dólares-\$1Million
\$100.000-\$249.000	\$1 Millón-\$ 3 millones
\$250.000-499,000	4 Millones de dólares-7 millones
500.000 Dólares - 700.000 dólares	7 millones de dólares, US \$10 millones
< 10 millones de dólares	
- ¿Cuál es su presupuesto aproximado para la implementación de la intervención MIP?
- ¿Quién es su fuente (s) de financiación para MIP?
- ¿Quién dentro de su agencia ha sido capacitado en una intervención basada en la evidencia de CDC del compendio DEBI (www.effectiveinterventions.org)?
 - ¿Quién dentro de su agencia ha sido específicamente capacitado en MIP?
 - ¿Este individuo o individuos asistieron una capacitación patrocinada por CDC u otro tipo de capacitación?
- ¿Cómo es el MIP una "buena" o "mala" elección para su organización? ¿Por qué?
 - Si fue una "mala elección" o "no encaja bien" ¿qué otro DEBI habría elegido? ¿Por qué?
- ¿Qué tipo de apoyo ofrece la directiva o jefes de la agencia con respecto a la planificación y ejecución de EBIs como el MIP?
 - (Sondear para: apoyo a nivel del programa, apoyo fiscal, capacitación del personal, etc.).

Parte I: Información demográfica - personal

En esta sección es para las entrevistas del personal de gestión o administrativos tanto como el personal implementando los programas:

- ¿Cuánto tiempo ha estado trabajando para esta agencia?
- ¿Cuál es su título/posición?
- ¿Cómo describiría su función?
- ¿Cuánto tiempo ha estado trabajando en el campo del VIH/SIDA?
- ¿Cuánto tiempo ha tenido su título/posición _____ en esta Agencia?
- ¿Cuáles son sus antecedentes educativos?
 - ¿Qué títulos tiene?
 - ¿En qué áreas?
- ¿Qué tipo de capacitación ha tenido en DEBIs de CDC?
 - Sondear: Pregunte sobre la capacitación en cualquiera de las 26 DEBIs, entrevista motivacional, Consejería, Pruebas y Referidos del VIH u otras estrategias de salud pública.
- ¿Qué capacitación ha recibido en MIP? ¿Cómo hace cuanto tiempo asistió a la capacitación?
 - Sondear-para el personal implementando programas, pregunte sobre la capacitación en la entrevista motivacional, etapas de cambio, mapeo de la comunidad y outreach o alcance comunitario, y Consejería, Pruebas y Referidos del VIH.)

Parte II: Preguntas Generales: personal administrativo y de la gerencia

Esta sección es solo para personal administrativo y de la gerencia

Experiencias sobre la implementación:

- En una escala del 1-5, con 1 es lo más bajo y 5, siendo lo más alto, ¿cómo calificaría el nivel de preparación de su agencia para la implementación del MIP antes a la implementación? ¿Por qué esa calificación?
- ¿Que factores usted o su agencia consideraron en su selección de MIP una intervención basada en la evidencia para implementar dentro de su agencia? ¿Por qué?
 - Sondear con estas preguntas, según sea necesario: Ud. consideró
 - ¿Necesidades de la población objetivo?
 - ¿Acceso de la agencia/experiencia con población de destino?
 - ¿Contenido de la intervención?
 - ¿Duración de la intervención?
 - ¿Valores y normas promovidas por MIP?
 - ¿Experiencia personal para implementar la intervención?
 - Apoyo de la comunidad para la intervención
 - ¿Recursos disponibles?
 - ¿Los costos?
 - Interés de los clientes?
- ¿Qué actividades de planificación previa hicieron usted o su organización para prepararse para implementar MIP?
 - o Sondear (por ejemplo, estas actividades pueden incluir: una evaluación de las necesidades, consulta con los clientes, envío de personal para capacitación sobre MIP o de otra área de apoyo, buscando financiación adicional para apoyar el MIP, conseguir espacio privado para la consejería privada, cambiar y modificar las pólizas y procedimientos existentes, contratar a un supervisor/consultor, promoción y de MIP para la población objetivo, conversaciones con fuentes de fondos sobre la mejor manera de implementar, solicitar asistencia técnica de un "experto".)
 - o ¿Cuándo se realizaron estas actividades?
 - o ¿Con quién?
- ¿Qué tipo de barreras o desafíos se pudieron anticipar antes de la implementación de la intervención de MIP?
 - o Sondear (por ejemplo, financiación insuficiente, reclutamiento de participantes, retención de los participantes, tiempo implementar la intervención o realizar el seguimiento, identificación y contratación de personal, oposición o resistencia de personal/comunidad, las políticas internas y procedimientos, falta de orientación de su fuente de financiación, falta de interés entre clientes, falta de oportunidades de T/TA)

- ¿Qué tipos de barreras o desafíos tuvieron en la implementación MIP?
- ¿Qué ha funcionado bien con la implementación? ¿Por qué?
- Piense acerca de los recursos financieros, humanos, y estructurales que son necesarias para implementar con éxito MIP. ¿Cómo describirías la capacidad de la agencia para implementar MIP, lo que se refiere a:
 - o ¿Recursos humanos (personal? ¿Supervisión? Apoyo de las políticas y procedimientos)
 - o ¿Recursos financieros (dinero suficiente para ejecutar el programa de manera eficaz y suficiente dinero para ofrecer incentivos)?
 - o ¿Suficientes recursos estructurales (espacio para llevar a cabo sesiones de administración, de consejería, y caso)?
 - o Apoyo (personal, clientes, comunidad)
 - o ¿Qué otra cosa?
- ¿Qué puede usted decirme sobre cómo MIP se está implementando en su agencia?
 - o ¿(Sondear: con quien es implementado?
 - o ¿Quién lleva a cabo las sesiones de consejería?
 - o ¿Quién lleva a cabo sesiones de administración de casos?
 - o ¿Cómo está organizada?
 - o ¿Dónde toma lugar?
 - o ¿Con qué frecuencia ve clientes para ofrecer MIP?
- En su opinión, ¿qué diría ha sido el mayor reto relacionado a la implementación de MIP?
 - o ¿Cuál es su mayor éxito con la implementación hasta la fecha?
- En una escala del 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿Qué útil ha sido la fuente de financiación proporcionando suficiente orientación alrededor de la ejecución del programa de MIP? ¿Por qué esa calificación?
- En su opinión, ¿qué persona/grupo/entidad ha sido la principal fuente de apoyo para la implementación de MIP?

Experiencias de adaptación

- ¿Qué sabe sobre la adaptación de EBIs? *Sondear:*
 - ¿Cómo se define la adaptación?
 - ¿Qué cosas ¿considera admisible o no durante la adaptación? (por ejemplo, cambios en el contenido, población objetivo, actividades, número de sesiones etc..)
 - ¿Por qué crees adaptación es necesario o innecesario?
- ¿Qué tipo de orientación, ha recibido con respecto a la adaptación de EBIs?
 - ¿De quien recibió esta información? (Ej. Proveedor de fuente de fondos, artículo, CBA, sitio Web)
 - ¿En una escala de 1 a 5, con 5 siendo lo más alto y 1 siendo lo más bajo, que útil fue la información que ha recibido sobre la adaptación de EBIs a su trabajo con MIP?
- ¿Qué ha hecho su agencia con la necesidad de adaptación de EBIs como el MIP?
 - o ¿Qué adaptaciones han tenido?
 - o ¿Qué estrategias, herramientas y recursos hicieron usted o su agencia para adaptar el MIP? (Ej. Fuente de fondos, proveedor de CBA, sitio Web, asistencia técnica, uso de un consultor experto)
 - o ¿Han buscado información? ¿Formación? ¿Asistencia técnica? Con la adaptación?
 - o ¿Que fue exitoso?
 - o ¿Que no lo fue?
- En una escala de 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿Qué útil ha sido la fuente de financiación proporcionando asistencia y orientación acerca de adaptación del programa MIP?
¿Por qué esa calificación?

Necesidades de asistencia técnica:

- ¿Qué tipo de asistencia cree usted que su personal está en necesidad AHORA MISMO para apoyar la implementación y la adaptación de MIP?
- ¿Cuáles son sus necesidades de asistencia técnica con respecto a la implementación y adaptación de EBIs como el MIP? *Sondear: Necesita asistencia con:*
 - o ¿Determinar y negociar los niveles de servicio con la fuente de financiación?
 - o ¿Reclutamiento y retención de clientes?
 - o ¿Adaptación de MIP a otra población o configuración?
 - o Documentación de las actividades del programa/uso de formas etc..
 - o ¿Capacitación y la supervisión en curso?
 - o ¿Evaluación de la intervención?
 - o Cuestiones de recursos humanos (personal, formación, etc.)
 - o Fondos adicionales para apoyar las actividades de programa?
 - ¿Qué otra cosa?

- ¿Además de financiación, en que otras maneras puede organizaciones tales como los CDC mejor apoyar a organizaciones basadas en la comunidad en la aplicación y adaptación de EBIs como el MIP?
- En una escala de 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿qué útil ha sido la fuente de financiación proporcionando una asistencia técnica adecuada alrededor de ejecución del programa y la adaptación de EBIs como el MIP? ¿Por qué esa calificación?
- ¿Qué tipos de recursos podrían ser útil en el apoyo a la implementación y adaptación de EBIs como el MIP?
 - Sondear (más formación, documento de orientación, más fondos, más flexibilidad de fuente de financiación, más asistencia técnica?)
- ¿Qué más quiere que yo sepa con respecto a sus experiencias alrededor de adaptación y aplicación de MIP?

Gracias por participar en esta entrevista.

¿Tiene alguna pregunta para mí?

Preguntas generales de la parte II: Personal de atención al cliente

Esta sección es solo para las entrevistas del personal de atención al cliente

Experiencias de implementación del MIP

- En una escala del 1-5, con 1 es lo más bajo y 5, siendo lo más alto, ¿cómo calificaría el nivel de preparación de su agencia para la implementación del MIP antes a la implementación? ¿Por qué esa calificación?
- ¿Qué factores usted o su agencia consideraron en su selección de MIP una intervención basada en la evidencia para implementar dentro de su agencia? ¿Por qué?
Sondear con estas preguntas, según sea necesario: Ud. consideró
 - ¿Necesidades de la población objetivo?
 - ¿Acceso de la agencia/experiencia con población de destino?
 - ¿Contenido de la intervención?
 - ¿Duración de la intervención?
 - ¿Valores y normas promovidas por MIP?
 - ¿Experiencia personal para implementar la intervención?
 - Apoyo de la comunidad para la intervención
 - ¿Recursos disponibles?
 - ¿Los costos?
 - Interés de los clientes?
- ¿Qué actividades de planificación previa hicieron usted o su organización para prepararse a implementar MIP?
 - o Sondear (por ejemplo, estas actividades pueden incluir: una evaluación de las necesidades, consulta con los clientes, envío de personal para capacitación sobre MIP o de otra área de apoyo, buscando financiación adicional para apoyar el MIP, conseguir espacio privado para la consejería privada, cambiar y modificar las políticas y procedimientos existentes, contratar a un supervisor/consultor, promoción y de MIP para la población objetivo, conversaciones con fuentes de fondos sobre la mejor manera de implementar, solicitar asistencia técnica de un "experto".)
 - o ¿Cuándo se realizaron estas actividades?
 - o ¿Con quién?
- ¿Qué tipo de barreras o desafíos se pudieron anticipar antes de la implementación de la intervención de MIP?
 - o Sondear (por ejemplo, financiación insuficiente, reclutamiento de participantes, retención de los participantes, tiempo implementar la intervención o realizar el

seguimiento, identificación y contratación de personal, oposición o resistencia de personal/comunidad, las políticas internas y procedimientos, falta de orientación de su fuente de financiación, falta de interés entre clientes, falta de oportunidades de T/TA)

- ¿Cómo describiría la población para que implemente MIP?
 - Raza/etnia
 - Comportamiento de riesgo
 - Ubicación geográfica
 - Otras características

- ¿Dónde recluto participantes para la intervención de MIP?

- ¿Dónde se realizaron las sesiones de MIP?
 - ¿Sesiones de asesoramiento?
 - ¿Las sesiones de la administración de casos?
 - ¿Alcance comunitario?

- ¿Qué tipos de barreras o desafíos encontró o están enfrentando en este momento al implementar MIP? Por ejemplo, financiación insuficiente, reclutamiento de participantes, retención de los participantes, tiempo para implementar la intervención o realizar el seguimiento, la identificación y la contratación de personal, la oposición o la resistencia del personal y la Comunidad, las políticas internas, falta de orientación de la fuente de financiación, falta de oportunidades de T/TA)
 - En su opinión, ¿cuál ha sido el mayor desafío en la implementación de MIP?

- ¿Qué factores ayudan a facilitar la implementación de MIP?
(Sondear: capacitación/TA, supervisión, alcance comunitario / acceso a los clientes, proporcionar incentivos etc.)
 - ¿Qué ha funcionado bien con la implementación?
 - ¿Cuál ha sido sus logros o éxitos?

- Piense acerca de los recursos financieros, humanos, y estructurales que son necesarias para implementar con éxito MIP. ¿Cómo describirías la capacidad de la agencia para implementar MIP, lo que se refiere a:
 - ¿Recursos humanos (personal? ¿Supervisión? Apoyo de las políticas y procedimientos)
 - ¿Recursos financieros (dinero suficiente para ejecutar el programa de manera eficaz y suficiente dinero para ofrecer incentivos)?
 - ¿Suficientes recursos estructurales (espacio para llevar a cabo sesiones de administración, de consejería, y caso)?
 - Apoyo (personal, clientes, comunidad)
 - ¿Qué otra cosa?

- ¿Cómo describiría el apoyo prestado por el liderazgo/jefes de la Agencia (personal administrativas y de gestión) en la planificación y la ejecución de MIP?
 - ¿Sondear: sientes que te tiene una capacitación adecuada? ¿Supervisión? ¿Recursos? ¿Apoyo?
- En una escala de 1-5 con 1 es lo más bajo y 5 lo más alto como una intervención basada en la evidencia (EBI) qué tan bien “apropiado” dicen que MIP es para su organización en comparación con otras intervenciones?
 - Sondear: Piense en MIP en términos de contenido, valores, recursos, capacidad de la organización para implementar MIP etc.) ¿Por qué esa calificación?
- En una escala de 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿qué útil ha sido la fuente de financiación al proporcionar una asistencia técnica adecuada alrededor de la ejecución del programa y la adaptación de EBIs como el MIP? ¿Por qué esa calificación?
- ¿Qué tipo de asistencia necesita ahora para apoyar la implementación de MIP?

Experiencias de adaptación:

- ¿Qué sabe sobre la adaptación de EBIs? *Sondear:*
 - ¿Cómo se define la adaptación?
 - ¿Qué cosas ¿considera admisible o no durante la adaptación? (por ejemplo, cambios en el contenido, población objetivo, actividades, número de sesiones etc..)
 - ¿Por qué crees adaptación es necesario o innecesario?
- ¿Qué tipo de orientación, ha recibido con respecto a la adaptación de EBIs?
 - ¿De quien recibió esta información? (Ej. Proveedor de fuente de fondos, artículo, CBA, sitio Web)
 - ¿En una escala de 1 a 5, con 5 siendo lo más alto y 1 siendo lo más bajo, que útil fue la información que ha recibido sobre la adaptación de EBIs a su trabajo con MIP?
- ¿Cuál ha sido su experiencia con la adaptación de EBIs? ¿Qué tipos de adaptaciones ha realizado en el plan de estudios o currículo de MIP?
 - Sondear: Tuvieron que:
 - ¿Acortar, prolongar o condensar las sesiones?
 - ¿Cambiar un ejercicio o actividad?
 - ¿Cambiar cualquier contenido?
 - ¿Cambiar el idioma en el plan de estudios?
 - ¿Excluir o agregar un ejercicio o actividad?
 - ¿Utilizar el plan de estudios con alguien que no sea un IDU usuario de drogas inyectables?
 - ¿Llevar a cabo traducciones del inglés a otro idioma?

- ¿Sondear: Qué características de MIP requieren adaptación y cuales no?
 - Sondear sobre los elementos centrales: (evaluación y alcance comunitario, inducción, entrevista motivacional, continuas etapas de preparación para el cambio, interacción del Case Manager/consejero, flexibilidad del período de sesiones y programación, sesiones de refuerzo)
 - Elementos culturales: (realizar la intervención para no usuarios de drogas inyectables, concretar el género, integrar la información para el grupo racial/étnico específico etc.).
- ¿Qué aspectos culturales surgieron en la implementación/adaptación MIP?
 - Sondear - sobre qué cuestiones concretas relacionadas con la población objetivo? uso de drogas? Cuestiones de las minorías raciales y etnias/sexual / cuestiones de género?)
 - ¿Qué consideraciones culturales abordaron en el proceso de adaptación de MIP?
- ¿Qué ha hecho su agencia con la necesidad de adaptación de EBIs como el MIP?
 - ¿Qué adaptaciones han tenido?
 - ¿Qué estrategias, herramientas y recursos hicieron usted o su agencia para adaptar el MIP? (*Ej. Fuente de fondos, proveedor de CBA, sitio Web, asistencia técnica, uso de un consultor experto*)
 - ¿Han buscado información? Capacitación? ¿Asistencia técnica? Con la adaptación?
 - ¿Que fue exitoso?
 - ¿Que no lo fue?
- En una escala de 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿qué útil ha sido la fuente de financiación proviniendo asistencia y orientación acerca de adaptación del programa MIP? ¿Por qué esa calificación?
- ¿Qué tipo de asistencia necesita ahora para apoyar la adaptación de MIP?

Necesidades de asistencia técnica:

- En una escala de 1 a 5, siendo 1 lo más bajo y 5 lo más alto, ¿qué útil ha sido la fuente de financiación proporcionando una asistencia técnica adecuada alrededor de la ejecución del programa y la adaptación de EBIs como el MIP? ¿Por qué esa calificación?
- ¿Cuáles son sus necesidades de asistencia técnica con respecto a la implementación y adaptación de EBIs como el MIP? Sondear: Necesita asistencia con:
 - ¿Determinar y negociar los niveles de servicio con la fuente de financiación?
 - ¿Reclutamiento y retención de clientes?
 - ¿Adaptación de MIP a otra población o configuración?

- o Documentación de las actividades del programa/uso de formas etc..
 - o ¿Capacitación y la supervisión en curso?
 - o ¿Evaluación de la intervención?
 - o Cuestiones de recursos humanos (personal, formación, etc.)
 - o Fondos adicionales para apoyar las actividades de programa?
 - ¿Qué otra cosa?
- ¿Además de financiación, en que otras maneras puede organizaciones tales como los CDC mejor apoyar las organizaciones basadas en la comunidad en la implementación y adaptación de EBIs como el MIP?
 - ¿Qué tipos de recursos podrían ser útil en el apoyo a la implementación y adaptación de EBIs como el MIP?
 - o Sondear (más formación, documento de orientación, más fondos, más flexibilidad de fuente de financiación, más asistencia técnica?)
 - ¿Qué más quiere que yo sepa con respecto a sus experiencias alrededor de adaptación y aplicación de MIP?

Gracias por participar en esta entrevista.

¿Tienes alguna pregunta para mí?

APPENDIX E.
Adult Consent to Participate in the Research Study (Individual) - English

University of North Carolina-Chapel Hill
Consent to Participate in a Research Study
Adult Participants
Social Behavioral Form

IRB Study # 10-1885
Consent Form Version Date: 10/27/2010

Title of Study: How do Community Practice Settings Approach the Implementation and Adaptation of Evidence-based Interventions? Lessons from the Modelo de Intervención Psicomédica

Principal Investigator: Gisele Pemberton

UNC-Chapel Hill Department: School of Public Health- Department of Health Policy and Management

UNC-Chapel Hill Phone number: N/A

Email Address: gpembert@email.unc.edu

Co-Investigators: N/A

Faculty Advisor: Suzanne Havala-Hobbs, DrPH, MS, RD, FADA

Funder and/or Sponsor: None

Study Contact telephone number: 973-202-1367

Study Contact email: gpembert@email.unc.edu

What are some general things you should know about research studies?

You are being asked to take part in a research study. To join the study is voluntary.

You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

You will be given a copy of this consent form. You should ask the researchers named above, or staff members who may assist them, any questions you have about this study at any time.

What is the purpose of this study?

The purpose of this research study is to learn more about the experiences that community-based organizations (CBOs) have in selecting, implementing and adapting HIV prevention evidence based interventions in local settings so that strategies can be identified to help support CBOs and health providers in their implementation and adaptation of efficacious HIV prevention interventions.

Specifically, this study is interested in how the HIV prevention evidence-based intervention- Modelo de Intervención Psicomédica (MIP)- has been implemented and adapted at your agency.

Your organization was specifically targeted as a research study site because it is among a handful of organizations nationwide that have been implementing MIP for at least six months. You are being approached to participate in this study because you have been identified as a member of the MIP implementation team.

Are there any reasons you should not be in this study?

You should not be in this study if you do not have a specific role or responsibilities within the MIP program. Also, you should not be in this study if you are a front-line staff member (Counselor, Case Manager, Coordinator, Outreach Worker) currently implementing MIP at your organization, but have **not** taken the Centers for Disease Control's (CDC) MIP Training of Facilitators Course.

How many people will take part in this study?

If you decide to be in this study, you will be one of approximately seven (7) individual participants. At least two other organizations from different regions of the country (U.S. and its territories) will be selected for participation in this study. I will speak to at least five more staff members within these organizations to ask them to share their experiences with regard to the implementation and adaptation of MIP.

How long will your part in this study last?

Your participation in this study will last approximately three months and will require about 3-4 contacts totaling up to 8 hours of your time. Contacts with estimated time-frame include:

- Participation in organizational site visit (up to 2 hours)
- Participation in a semi-structured interview (up to 2 hours)
- Data gathering of select MIP program implementation forms (without client identifiers). Forms may include 1) behavior risk assessment, progress notes, documentation of sessions completed by client) (up to 2 hours)
- Participation in follow-up, as needed. (up to 2 hours)

What will happen if you take part in the study?

As mentioned in the previous question, it is anticipated that your involvement will span three months but will take up no more than a total of 8 hours of individual time. If you choose to take part in this study after receiving and reading this consent form, you will be asked to:

- 1) Sign this consent form noting your voluntary participation in the study.

- 2) Participate in a site-visit at your organization where you will meet the researcher(s) to learn more about the study and ask any questions you may have.
- 3) Participate in an interview where you will be asked a series of questions about how you have approached the implementation and adaptation of MIP and which factors have facilitated or hindered this process for you or your organization. This interview will last about two hours and will be audio-taped with your permission. Once the interview has been transcribed, you will be given the opportunity to review and edit your interview transcript before it is reported in any form.
- 4) You will also be asked to gather and share with the researcher(s) some of the forms that you use to document the implementation of MIP. You will be provided with guidance from the researchers and your organization about the exact forms to collect but it will be no more than 3 types of forms. Prior to sharing any forms, you will be asked to remove any client identifiers that may appear on the forms by either deleting the data or erasing with dark markers.
- 5) During the course of the study you may also be contacted by the researcher with follow-up questions. These questions may include providing more information about your work in the MIP program, clarifying something you said during the interview, or requesting additional forms used during MIP implementation.
- 6) Once the study is completed, you will only be contacted by the researcher to share an executive summary of research findings. Similarly, all study data with identifiers will be discarded.

What are the possible benefits from being in this study?

Research is designed to benefit society by gaining new knowledge. As a health provider of HIV prevention services, you may also expect to benefit from being in this study by using the results of the research to gain insight as to the facilitators, challenges, and barriers surrounding the implementation and adaptation of HIV prevention evidence-based interventions (EBI), and the strategies, tools, and resources that can be used to alleviate some of those challenges and ensure EBI success at your own agency. Additionally, you may be able to leverage study findings to:

- Advocate for intensified training and/or technical assistance on EBI adaptation.
- Advocate for funding to support partnerships with researchers and community to adapt existing EBIs to other populations and/or setting with high levels of fidelity, and,
- Identify the strengths and weaknesses of your organization in order to build your infrastructure to support the successful implementation and adaptation of EBIs.

What are the possible risks or discomforts involved with being in this study?

The proposed study poses a minimal risk to participants; however there are some risks of which you should be aware of and know the steps taken by the researchers to minimize these risks.

1. Breach of Confidentiality refers to the unauthorized disclosure of the personal information that a person would not wish others to know without prior authorization. To guard against such risks, you will be assigned a unique identifier so that your responses remain confidential and is not associated with your name. Further, all data will be secured in locked files which will only be accessible to the researcher(s).
2. Deductive Disclosure is the discerning of an individual respondent's identity and responses through the reporting of certain characteristics that makes it possible to identify the person. This means that one may be able to "figure out" that a person responded in a certain way even though that individual was not identified by name.

To safeguard against deductive disclosure, data will be de-identified to protect the identity of both individuals and organizations and will be reported as group summaries wherever possible. Additionally, you will be given the option to review your interview notes and/or transcripts prior to any reporting or publication.

3. There is also a small risk of retaliation against staff at participating organizations for providing information to the researcher(s) that is deemed inappropriate or unfavorable by management. To minimize this risk a clause has been built into the organizations' consent to participate in the study that staff members be "held harmless" without retaliation for any data provided or study outcomes revealed in the final reports. This consent will also provide explicit language on the voluntary nature of this study and your right to terminate participation at any point during the study.

Also, there may be uncommon or previously unknown risks. You should report any problems to the researcher.

How will your privacy be protected?

Every effort will be made to protect your privacy and confidentiality in this research study. During the course of the study you will be assigned a unique identifier that will be known only to the researcher(s) so that the information you provide is not directly associated with your name or that of your organization. You *will not* be identified in any report or publication about this study. All information obtained from this research study will be reported in a general descriptions and group summaries unless otherwise explicitly specified by the researcher(s) with additional verbal and written consent. Although a direct quote from you may be used in the final write-up of this research to reinforce a particular point, your name will never be used. Instead a "mock" or "pseudo" name such as "participant 3" will be used. Additionally, the following steps will be taken to further protect your privacy and confidentiality:

- Interviews will take place in private rooms where participants can talk freely.
- All data will be reviewed by the PI and any identifiers or potential identifies found will be removed and replaced with your special identification code, so as to prevent deductive disclosure.
- Locked cabinets/files will be used to secure written data.
- Data on laptops will be double password protected. A password will be needed to access the laptop and another password to access the study research data.
- Access to research data will be limited to the principal investigator, research assistant, and dissertation committee chair, as appropriate.
- Upon completion of the study, hard-copy research data will be discarded via a professional shredding machine. Electronic data will be "trashed" and emptied so that data cannot be retrieved.
- Audio-taped interviews will be kept in a secure locked file cabinet until the data is transcribed. Once transcribed, written data will be kept in a secure locked file cabinet and/or password protected laptop. Audio transcriptions will be kept secured until the end of the research study or for up to 2 years of the date on this form (whichever comes first) and upon which time audio recording and transcriptions will be erased and destroyed.

Please indicate your willingness to be audio-taped during the interview portion of this research study.

- ☐ OK to record me during the study
☐ Not OK to record me during the study

NOTE that at any point during the interview you may choose to STOP the audio-taped, even if you may have agreed to being recorded here.

What if you want to stop before your part in the study is complete?

You can withdraw from this study at any time, without penalty. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

Will you receive anything for being in this study?

You will be receiving an executive summary of research findings for taking part in this study. Upon completion of the study, an executive summary of the research findings will be sent to you which will include recommendations around the implementation and adaptation of HIV prevention evidence-based interventions in community practice settings.

Will it cost you anything to be in this study?

There is no monetary cost for being in the study; however there is a time commitment of up to 8 hours that will be expected in order to ensure your full participation in this study.

What if you have questions about this study?

You have the right to ask, and have answered, any questions you may have about this research. If you have questions, complaints, concerns, or if a research-related injury occurs, you should contact the researchers listed on the first page of this form.

What if you have questions about your rights as a research participant?

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject, or if you would like to obtain information or offer input, you may contact the Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

Title of Study: How do Community Practice Settings Approach the Implementation and Adaptation of Evidence-based Interventions? Lessons from the Modelo de Intervención Psicomédica

Principal Investigator: Gisele Pemberton

Contact: gpembert@email.unc.edu or (973) 202-1367

Participant's Agreement:

I understand that this study is completely voluntary. I understand that refusal to participate in this study will not affect my employment in anyway. I am not being coerced by the researcher or my employer to participate in this study.

I also understand that I can choose to end my participation at any point during the course of this study.

I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Signature of Research Participant

Date

Printed Name of Research Participant

Signature of Research Team Member Obtaining Consent

Date

Printed Name of Research Team Member Obtaining Consent

APPENDIX F.
Adult Consent to Participate in the Research Study (Individual) - Spanish

Universidad de Carolina del Norte-Chapel Hill
Consentimiento para participar en un estudio de investigación
Participantes adultos Formulario de conducta social

Nº de estudio del IRB 10-1885

Fecha de la versión del formulario de consentimiento: 10/26/2010

Título del estudio: ¿Cómo organizaciones basadas en la comunidad implementan y adaptan las intervenciones basadas en la investigación (EBIs)? Lecciones del Modelo de Intervención Psicomédica.

Investigador principal: Gisele Pemberton

Departamento de la UNC-Chapel Hill: Escuela de Salud Pública – Departamento de Póliza y Administración de Salud

Número telefónico de la UNC-Chapel Hill: N/A

Dirección de correo electrónico: *gpembert@email.unc.edu*

Co-Investigadores: N/A

Asesor facultativo: Suzanne Havala-Hobbs, DrPH, MS, RD, FADA

Origen del financiamiento: Ninguno

Número telefónico del contacto del estudio: 973-202-1367

Correo electrónico del contacto del estudio: gpembert@email.UNC.edu

¿Cuáles son algunas de las cuestiones generales que usted debe saber sobre los estudios de investigación?

Se le solicita que participe en un estudio de investigación. La participación en este estudio es voluntaria. Puede negarse a participar, o puede retirar su consentimiento para participar en el estudio, por cualquier motivo, sin sufrir sanciones.

Los estudios de investigación están diseñados para obtener nueva información. Es posible que esta nueva información ayude a las personas en el futuro. Es posible que no reciba ningún beneficio directo por participar en este estudio de investigación. También pueden existir riesgos asociados con la participación en estudios de investigación.

Los detalles sobre este estudio se analizan a continuación. Es importante que entienda esta información de modo que pueda decidir en forma fundamentada acerca de la participación en este estudio de investigación.

Se le entregará una copia de este formulario de consentimiento. Debe preguntar a los investigadores mencionados anteriormente, o a los miembros del personal que los asisten, cualquier consulta que tenga acerca de este estudio en cualquier momento.

¿Cuál es el objetivo de este estudio?

El propósito de este estudio de investigación es aprender más sobre las experiencias que las organizaciones de base comunitaria (CBOs) en la selección, implementación y adaptación de intervenciones basadas en la investigación para la prevención del VIH para identificar estrategias para apoyar estas organizaciones y los proveedores de salud en su implementación y adaptación de las intervenciones eficaces de prevención de VIH. Específicamente, este estudio está interesada en cómo la intervención Modelo de Intervención Psicomédica (MIP) - se ha implementado en su agencia.

Su organización fue específicamente elegida como un sitio de estudio de investigación porque es una de pocas organizaciones en el país que han estado implementado MIP por seis meses o más. Le estamos pidiendo participar en este estudio, porque ha sido identificado como un miembro del equipo de implementación de MIP.

¿Existe algún motivo por el que usted no deba participar en este estudio?

No debe participar en este estudio si no tiene una función específica o responsabilidades dentro del programa de MIP. Usted no debe participar en este estudio si es parte del equipo de implementación de MIP (consejero, administrador de caso, coordinador, trabajadores de alcance comunitario) actualmente implementando MIP en su organización, pero no ha tomado la capacitación de MIP patrocinado por los Centros de Control y Prevención de Enfermedades.

¿Cuántas personas participarán en este estudio?

Si decide participar en este estudio, será uno de entre aproximadamente siete participantes individuales. Al menos dos otras organizaciones de diferentes regiones del país (Estados Unidos y sus territorios) serán elegidos para participar en este estudio. Voy a hablar con por lo menos cinco empleados dentro de estas organizaciones para pedirles que compartan sus experiencias con respecto a la implementación y adaptación de MIP.

¿Cuánto tiempo participará en este estudio?

Su participación en este estudio durará aproximadamente tres meses y requerirá entre 3-4 contactos con un total de 8 horas de su tiempo. Actividades con el tiempo estimado que durarán son:

- Participación en la visita a la organización (hasta 2 horas)
- Participación en una entrevista semi-estructurada (hasta 2 horas)
- Recopilación de datos para facilitar la revisión de algunos de los formularios de implementación del programa de MIP (sin identificadores de cliente). Las formas pueden incluir 1) evaluación de los riesgos de comportamiento, notas de progreso, documentación de sesiones completado por cliente) (2 horas).
- Participación en seguimiento, según sea necesario (2 horas).

¿Qué ocurrirá si participa en este estudio?

Como se ha mencionado en la pregunta anterior, se anticipa que su participación durará tres meses, pero no le tomará más que un total de 8 horas de tiempo individual. Si opta por participar en este estudio, después de recibir y leer este formulario de consentimiento, se le pedirá:

- 1) Firmar este formulario de consentimiento indicando su participación voluntaria en el estudio.
- 2) Participar en una visita a su organización, donde se reunirá con la investigadora(s) para aprender más sobre el estudio y hacer cualquier pregunta.
- 3) Participar en una entrevista donde se le preguntará una serie de preguntas sobre cómo se ha dirigido a la implementación y adaptación de MIP y los factores que han facilitado o dificultado este proceso para usted o su organización. Esta entrevista durará dos horas y se grabará con su permiso. Una vez que la entrevista ha sido transcrita, se le dará la oportunidad de revisar y editar su transcripción antes de que se haga cualquier reporte.
- 4) También se le pedirá recopilar y compartir con el investigador(es) algunas de los formularios que se utilizan para implementar MIP. Se proporcionará con la orientación de los investigadores y su organización acerca de los documentos exactos para recopilar, pero va a ser no más de 3 tipos de formularios. Antes de compartir cualquier documento, se le pedirá borrar cualquier identificador del cliente que puede aparecer en los documentos formas por borrar los datos con un borrador o cubrirlos con marcadores oscuros.
- 5) En el transcurso del estudio usted también puede ser contactado por el investigador con preguntas de seguimiento. Estas preguntas pueden incluir ofrecer más información acerca de su trabajo en el programa de MIP, aclarar algo que dijo durante la entrevista o solicitar formularios adicionales utilizados durante la implementación del MIP.
- 6) Una vez en el estudio se haya completado, sólo se comunicará con usted por el investigador para compartir un resumen de los resultados de la investigación. Del mismo modo, se todos los datos de estudio con identificadores serán destruidos.

¿Cuáles son los posibles beneficios por participar en este estudio?

La investigación está diseñada para beneficiar a la sociedad mediante la obtención de nuevos conocimientos. Como proveedor de servicios preventivos de VIH puede esperar además beneficiarse por su participación en este estudio mediante el uso de los resultados de la investigación para

entender los logros, los retos y las barreras que rodean la implementación y adaptación de intervenciones basadas en la investigación para la prevención del VIH (EBI), y las estrategias, herramientas y recursos que pueden utilizarse para sobrellevar algunos de los desafíos y garantizar el éxito de la EBI en su agencia. Además, es posible que pueden utilizar los resultados del estudio para:

- Abogar para conseguir más capacitación y asistencia técnica sobre la adaptación de EBI.
- Promover la financiación para apoyar las asociaciones con los investigadores y la comunidad para adaptar EBIs existentes a otras poblaciones y/o otros entornos en la comunidad asegurándose en tener altos niveles de fidelidad y,
- Identificar las fortalezas y debilidades de su organización con el fin de desarrollar su infraestructura para apoyar el éxito en la implementación y adaptación de EBIs.

¿Cuáles son los posibles riesgos o molestias que implica la participación en este estudio?

El estudio propuesto supone un riesgo mínimo para los participantes; sin embargo, existen algunos riesgos que deben ser nombrados y conocer las medidas adoptadas por los investigadores para minimizar estos riesgos.

1. Violación de confidencialidad se refiere a la divulgación no autorizada de la información personal que una persona no desearía otros saber sin autorización previa. Para protegerse de estos riesgos, se le asignará un identificador único para que sus respuestas permanezcan confidenciales y no sean asociadas con su nombre. Además, todos los datos se guardarán en archivos bajo llave y solo serán accesibles a la investigadora(s).

2. Divulgación deductivo es cuando la identidad de un individuo se percibe a través de las respuestas presentadas de informes de ciertas características que hace posible identificar a la persona. Esto significa que uno puede ser capaz de "averiguar" lo que una persona respondió en cierto modo, a pesar de que ese individuo no fue identificado por su nombre.

Para proteger contra divulgación deductivo, a los datos se le quitarán los identificadores para proteger la identidad de las personas y organizaciones y se hará resúmenes de grupo siempre que sea posible. Además, se le dará la opción de revisar sus notas de la entrevista o transcripciones antes de cualquier reporte o publicación.

3. También hay un pequeño riesgo de represalias contra el personal de las organizaciones participantes para proporcionar información a la investigadora(s) que es considerado inadecuado o desfavorable por la directiva o jefes. Para minimizar este riesgo hay una cláusula en el consentimiento de las organizaciones que participen el estudio que los miembros del personal no tendrán ninguna "represalia" por cualquier dato proporcionado o resultado que se reveló en los informes finales. Este consentimiento también proporcionará lenguaje explícito sobre el carácter voluntario de este estudio y su derecho de terminar su participación en cualquier momento durante el estudio.

¿De qué manera se protegerá su privacidad?

Se hará todo lo posible para proteger su privacidad y la confidencialidad en este estudio de investigación. En el transcurso del estudio se le asignará un identificador único que se conocerá sólo a los investigador(es) para que la información que usted proporciona no está directamente asociada con su nombre o el de su organización. Usted no será identificado en cualquier informe o publicación sobre este estudio. Toda la información obtenida en este estudio de investigación se informará en las descripciones generales y resúmenes de grupo a menos que se indique lo contrario explícitamente por el investigador(es) con consentimiento verbal y escrito adicional. Aunque utilice una frase de un

miembro del personal en el reporte final no se utilizara su nombre sino un nombre ficticio. Por ejemplo, "participante #3". Además, los siguientes pasos se seguirán para proteger aún más su privacidad y confidencialidad:

- Entrevistas se llevarán a cabo en habitaciones privadas donde los participantes pueden hablar libremente.
- Todos los datos serán examinados por la IP y cualquier identificadores o potencial identificadores van a ser eliminados y reemplazados con su código de identificación especial, a fin de evitar divulgación deductiva.
- Los archivos se van a guardar bajo llave para proteger datos escritos.
- Datos en computadoras portátiles serán protegidos por contraseña doble. Se necesitará una contraseña para acceder a la computadora portátil y otra contraseña para acceder a los datos de investigación de estudio.
- Acceso a los datos de la investigación se limitará al investigador principal, Asistente de investigación y Presidente del Comité de tesis, según corresponda.
- Al finalizar el estudio, se destruirán los datos de investigación por una trituradora profesional. Datos electrónicos serán destruidos y eliminados para que no se pueden recuperar.
- Entrevistas grabadas en cintas de audio se mantendrán en un gabinete seguro bajo llave hasta que se transcriban los datos. Una vez que se transcriban, los datos escritos se mantendrán en un gabinete seguro bajo llave o en una computadora portátil protegida con una contraseña. Transcripciones de audio se mantendrá seguras hasta el final del estudio de investigación o hasta 2 años de la fecha en este formulario (lo que pase primero) y en ese momento las grabaciones y transcripciones serán borradas y destruidas.

Por favor indicar su deseo de ser grabado (audio) durante la parte de la entrevista de este estudio de investigación.

_____ Acepto ser grabado durante el estudio

_____ No acepto ser grabado durante el estudio

Nota en algún momento durante la entrevista usted puede elegir detener la grabación, incluso si antes estuvo de acuerdo.

¿Qué sucede si desea salirse del estudio antes de completar lo acordado?

Puede retirarse de este estudio en cualquier momento, sin sufrir sanciones. Los investigadores también tienen derecho a detener su participación en cualquier momento. Esto podría ser debido a que usted ha tenido una reacción inesperada o no siguió las instrucciones, o porque el estudio se ha detenido.

¿Recibirá algo por participar en este estudio?

Usted recibirá un resumen de los resultados de la investigación por participar en este estudio. Al finalizar el estudio, se enviará un resumen de los resultados que incluirá recomendaciones sobre la implementación y adaptación de las intervenciones basadas en pruebas de prevención de VIH en entornos de práctica comunitarios.

¿Le costará algo la participación en este estudio?

No existirá ningún costo por participar en este estudio pero si hay compromiso de tiempo de 8 horas para completar el estudio y tener completa participación.

¿Qué sucede si desea formular preguntas sobre este estudio?

Tiene el derecho de preguntar, y que le respondan, cualquier duda que tenga acerca de esta investigación. Si tiene preguntas o inquietudes, debe ponerse en contacto con los investigadores mencionados en la primera página de este formulario.

¿Qué sucede si usted desea formular preguntas sobre sus derechos como participante de una investigación?

Toda investigación realizada con voluntarios humanos es examinada por un comité que trabaja para proteger sus derechos y su bienestar. Si tiene preguntas o inquietudes acerca de sus derechos como sujeto de una investigación, puede ponerse en contacto, de manera anónima si lo desea, con el Institutional Review Board (Comité de revisión institucional, IRB por sus siglas en inglés) al 919-966-3113 o por correo electrónico a IRB_subjects@unc.edu.

Título del estudio: ¿Cómo organizaciones basadas en la comunidad implementan y adaptan las intervenciones basadas en la investigación (EBIs)? Lecciones de la Modelo de Intervención Psicomédica.

Investigador principal: Gisele Pemberton
Contacto: gpembert@email.unc.edu or (973) 202-1367

Acuerdo del participante:

Entiendo que este estudio es totalmente voluntario. Yo puedo rechazar participar en este estudio y no afectará mi empleo en cualquier manera. No estoy siendo obligado por el investigador o mi empleador para participar en este estudio.

También entiendo que puedo elegir poner fin a mi participación en cualquier momento durante este estudio.

He leído la información proporcionada más arriba. He realizado todas las preguntas que tengo en este momento. Acepto voluntariamente participar en este estudio de investigación.

Firma del participante de la investigación

Fecha

Nombre del participante de la investigación en imprenta

Firma de la persona que obtiene el consentimiento

Fecha

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