FLORIDA MATERNAL, INFANT, & EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM EVALUATION

COORDINATED INTAKE & REFERRAL LEARNING COLLABORATIVE, SPRING 2016

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Florida Maternal, Infant & Early Childhood Home Visiting Initiative

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University of South Florida College of Public Health

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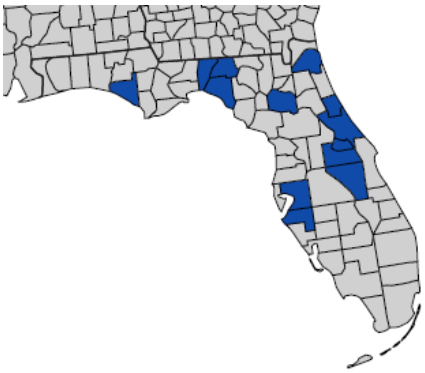
This project was supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant numbers D89MC28265 and D90MC25705, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.

INTRODUCTION

THE COORDINATED INTAKE & REFERRAL LEARNING COLLABORATIVE

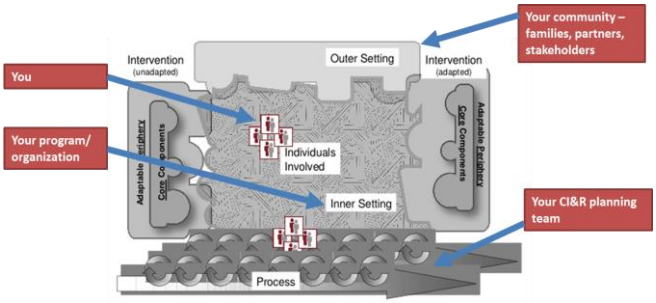
During the Spring of 2016, the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative partnered with the State Title V agency to develop and test Coordinated Intake and Referral (CI&R) models with a group of Florida's Healthy Start Coalitions using the state's universal prenatal and infant risk screens. The prenatal and infant risk screens provide a foundation for local maternal and child health systems, affording universal access to appropriate care and services. The purpose of a CI&R system is to streamline an oftentimes complex process by minimizing duplication of services, utilizing community resources effectively, determining the best services for the needs of families, and following what family participation and referrals collectively. Community collaborations are integral to this process because they form the foundation and extent to which services are available to families and may also help to expedite community referrals.



This project was implemented using a learning collaborative approach with participation from eight Healthy Start Coalition teams who self-selected in response to a request for proposals (RFP) sent to all of the 32 coalitions. Per the RFP participating coalitions were required to include specific organizations on their local teams, including at a minimum: Healthy Start Coalition, local Health Department responsible for processing screening forms, Healthy Families Florida, Federal Healthy Start, Early Head Start, MIECHV-funded project, Early Steps, additional care coordination, education and support programs, and other key stakeholders. They had the flexibility of selecting any five members to serve on the travel team to attend in-person learning sessions. Florida MIECHV Initiative provided the participating coalitions with financial support ($90,000 - $120,000 for the 21-month project period, depending on number of births in their area) to design and implement system changes as part of the learning collaborative. These eight coalition teams all started in different places - from no CI&R experience to implementing CI&R in some fashion – and all are early adopters, with leadership that sees the value added by participating in this learning collaborative.

PARTICIPATING HEALTHY START COALITION (HSC)	COUNTY/ COUNTIES	ANNUAL NUMBER OF BIRTHS 2014-2015
HSC of North Central Florida	Alachua	2,914
Bay, Franklin, Gulf HSC	Bay	2,389
HSC of Flagler & Volusia	Flagler, Volusia	5,609
HSC of Hillsborough	Hillsborough	17,238
HSC of Jefferson, Madison & Taylor	Jefferson, Madison, Taylor	558
Northeast Florida HSC	Duval	12,761
HSCs of Orange, Osceola & Seminole	Orange, Osceola, Seminole	25,067
HSC of Manatee	Manatee	3,549
Total	13 Counties	70,085

EVALUATION FRAMEWORK



The University of South Florida (USF) evaluation team utilizes the Consolidated Framework for Implementation Research (CFIR) to describe the characteristics of the learning collaborative and will document the successes and challenges faced by the learning collaborative in integrating CI&R models into local systems of care, particularly in the context of Florida's universal prenatal and infant risk screens. This framework is a useful guide for formative evaluation research, as it provides an organizational framework for synthesizing and building knowledge about what works in multiple settings.[1] As explained by Kilbourne et al., this model is useful for implementation research, "Adaptive implementation designs consisting of a sequence of decision rules that are tailored based on a site's uptake of an effective program may produce more relevant, rapid, and generalizable results by more quickly validating or rejecting new implementation strategies, thus enhancing the efficiency and sustainability of implementation research and potentially leading to the rollout of more cost-efficient implementation strategies."[2] The evaluation primarily focuses on the organizational-level (community teams) collaborative characteristics, perceptions, and processes.

CONSOLIDATED FRAMEWORK FOR IMPLEMENTATION RESEARCH3 (CFIR)

Implementation

Characteristics of the intervention	Inner Setting	Outer setting	Individuals involved	Learning Collaborative Group Dynamics	Implementation process
▪ Intervention source ▪ Evidence strength and quality ▪ Relative advantage ▪ Adaptability ▪ Trialability ▪ Complexity ▪ Design quality ▪ Cost	▪ Structural characteristic ▪ Network and communication ▪ Culture ▪ Implementation climate	▪ Patient need and resources ▪ Cosmopolitanism ▪ Peer pressure ▪ External policies and incentives	▪ Knowledge and beliefs about the intervention ▪ Self-efficacy ▪ Individual stage of change ▪ Individual identification with organization ▪ Other personal attributes	▪ Leadership and participation ▪ Communication ▪ Conflict resolution ▪ Decision making ▪ Problem solving ▪ Influence ▪ Trust ▪ Agenda setting ▪ Accomplishment ▪ Satisfaction ▪ Benefits of participation ▪ Attendance ▪ Cohesion ▪ Empowerment	▪ Planning ▪ Engaging ▪ Executing ▪ Reflecting and evaluating

CI&R LEARNING SESSIONS

The first meeting of the learning collaborative took place in Jacksonville, Florida March 10-11, 2016. Representatives from each of the eight participating Healthy Start Coalitions attended the event. The two-day meeting included guest speakers, break-out sessions, and team poster presentations. These activities were designed to encourage information sharing among the different Healthy Start Coalition travel teams regarding their community CI&R systems and provide an opportunity for networking.

As part of the MIECHV program evaluation, a baseline comprehensive CI&R readiness survey was distributed to all learning collaborative participants electronically before the meeting to examine: their respective community's CI&R system characteristics and perceptions of system changes; the inner setting of the organization; the outer setting and community partners; their involvement in their community's CI&R system changes; group dynamics of their CI&R teams; and their impressions of the CI&R implementation process in their community. There were open-ended questions in the survey for

participants to enter their responses regarding their personal/professional CI&R knowledge, as well as their organization's CI&R knowledge.

Three separate focus groups were then conducted by the MIECHV evaluation team during the second day of the learning collaborative meeting. Focus group discussions were based on CFIR constructs: perceptions of opportunities and challenges of CI&R system change within the context of individual, organizational, and community characteristics; perceptions of system changes; and learning collaborative group dynamics. Discussions were audio recorded and professionally transcribed verbatim. Transcripts were reviewed for accuracy by the MIECHV evaluation team.

CI & R TEAM MEMBER DEMOGRAPHICS

BASELINE READINESS SURVEY – INDIVIDUAL TEAM MEMBER DEMOGRAPHICS

51 CI&R team members completed the baseline survey. Most survey respondents (66%) described their organization as a home visiting program, 12% did not identify a predetermined category, and 4% and 1% described their organizations as healthcare and early childhood care/ education, respectively. Almost half of all team members identified as administrators or directors in their organizations. Respondents' experience in their professional field ranged from 0 to 46 years, averaging 17 years of experience. A minority (10%) of respondents identified as Hispanic, while the majority (72%) were White and 20% Black. The largest group of participants (56%) had professional or graduate degrees, and 26% had a bachelors, 6% an associate degree, and 10% some college without a degree.

BASELINE PRE-COLLABORATIVE READINESS SURVEY

CI & R SYSTEM CHARACTERISTICS

In the pre-collaborative readiness survey distributed before the meeting, CI&R team members were asked to rate the strength of evidence that is available in implementing CI&R systems changes. When asked how they perceived the strength of evidence in the CI&R system to meaningfully impact family outcomes, 38% felt there was very strong evidence, 48% felt there was slightly strong evidence, 10% felt neutral, and 2% there was slightly or very weak evidence. Team members responded similarly when asked how they thought that respected officials within the organization would rate the strength of evidence for CI&R systems change to meaningfully impact family outcomes; 18 (38%) felt officials would rate the evidence as very strong and 23 (48%) as slightly strong, four (8%) neutral, two (4%) as slightly weak, and one (2%) who felt officials would rate the evidence as very weak.

INNER SETTING OF THE ORGANIZATION

Team members were posed a series of statements in the survey that dealt with how they perceived that the inner setting of their organization might have an influence on the CI&R system changes. Most agreed or strongly agreed when asked if: CI&R system changes within the organization take into account the needs and preferences of families; management/leadership have clearly defined areas of responsibility to implement CI&R system changes; management/leadership promote communication among community partners to implement CI&R system changes; communication will be maintained with regular project meetings; and staff members are receptive to the CI&R system changes. Most participants however strongly disagreed/disagreed that the current CI&R system is intolerable and needs to be changed. Nonetheless, about 21% of participants agreed that the current system was either intolerable or needed to be changed.

Additional comments on the organizational setting were:

"Our CI&R is still in the planning phase. I will be going to Jacksonville this Thursday to learn more."

"We are still in the formative stage of our C I & R project and many of the previous questions were not applicable at this time. We have not yet begun the work to develop our design and implementation plan."

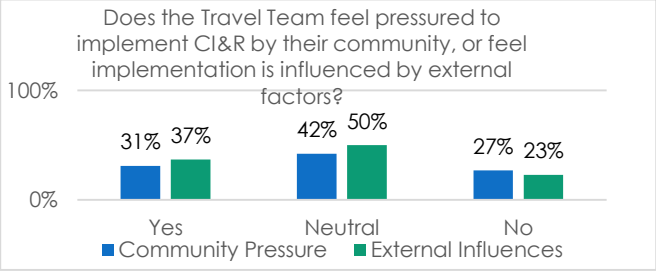
"I am sure there are areas of improvement and opportunities to take it to the next level."

"The lead is very knowledgeable and capable to move forward with CI & R."

"I'm concerned that historical animosity may impact our ability to move forward as quickly as could be possible."

OUTER SETTING - COMMUNITY PARTNERS

Team members were presented with six different statements to gauge their insights on how community partners might influence the CI&R system changes. For the statements rating the extent to which their community took into consideration the needs and preferences of families, and of partner agencies, a large proportion - 72% and 79% team members agreed with the statements, respectively. Regarding whether they felt that those on the CI&R system change team were networked with other community organizations, 81% agreed, 13% felt neutral, and 8% disagreed. Regarding whether team members felt that there was peer pressure by their respective communities to implement CI&R system changes, the responses were somewhat evenly distributed. There were 15 (31%) who agreed that there was peer pressure, 20 (42%) who felt neutral, and 13 (27%) who disagreed. Responses followed a similar pattern when team members were presented with the statement of whether implementation of CI&R system changes was influenced by external policy and incentives. There were 13 (37%) who agreed that their CI&R system changes were influenced, 24 (50%) who felt neutral, and 11 (23%) who disagreed. There was no difference, based on whether the respondents felt pressured, in whether they felt that the current system was intolerable or needed to be changed.



INVOLVEMENT IN CI&R SYSTEM CHANGES

Team members were also asked about the extent of their personal involvement in CI&R system changes. Nearly all team members agreed that their attitude towards the value placed on CI&R system changes was positive, with 96% agreeing and only 4% reporting neutral. Similarly, all team members (100%) felt that their degree of commitment to the CI&R system changes was positive. Regarding whether team members believed in their own capabilities to execute courses of action to achieve implementation goals for the CI&R system changes, 90% agreed this was true and 10% were neutral.

Two statements were posed to team members with respect to the planning and implementation process of CI&R system changes. For the first statement of whether team members were *actively planning* to implement CI&R changes, there were 43 (90%) who agreed, three (6%) who felt neutral, and two (4%) who disagreed. The second statement inquired whether team members were *already working on* CI&R system changes. There were 34 (71%) who agreed that they were already working on changes, 11 (23%) who felt neutral, and three (6%) who disagreed, meaning they were not already working on the changes. Ten respondents (71%) of those not currently working on or neutral are actively planning to implement system changes.

CI&R team members were also asked if they had any additional comments about their personal/professional centralized intake & referral knowledge or practices:

"Beginning stage - Need time." *"We are just beginning this process."* *"… just recently developed our team."*

"We are just beginning and haven't delved into the details yet. We were waiting for the initial meeting in order to gage a better idea of action steps."

"We are still in the early formative stage of our CI&R project and many of the previous questions were not applicable at this time. Our organization is extremely committed to working to develop community minded thought and effective change to our CI&R system."

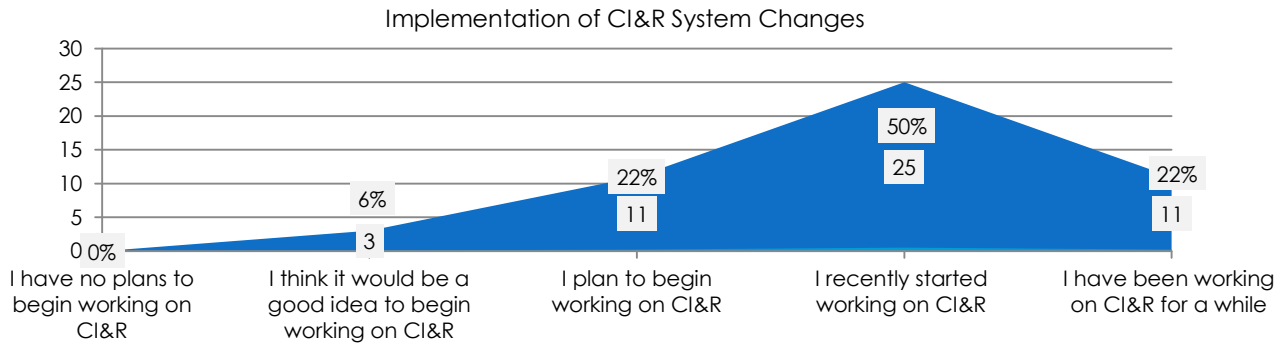
"I am willing to be a part of local community team that will be using CI&R. I was recently introduced to the system and looking forward to receive more knowledge."

"We have been implementing a centralized I&R for a while in [our county] and have a fluid process."

"We are past the planning stage and we are in our second year after implementation."

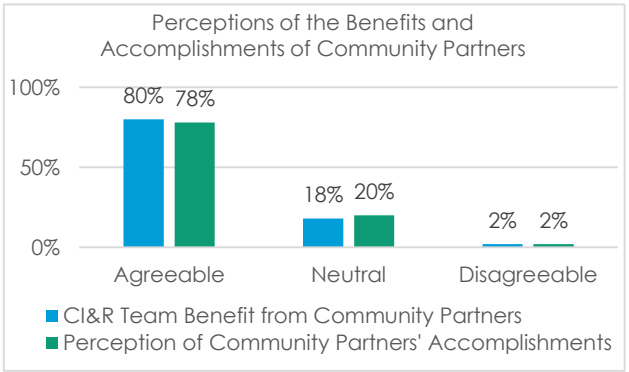
"Integrating assessment processes and data collection have been key for the progress we have made so far. We would really like to use technology more to our advantage by giving participants more access to services through 'apps' and self-assessment/screening."

"I do believe that our involvement and participation with the CI&R learning collaborative will assist us in enhancing our processes and improve services for families in our community."



CI&R GROUP DYNAMICS

A series of statements were posed to team members to evaluate the group dynamics of their respective CI&R teams. There were 41 (85%) team members who believed that there was leadership and participation among community partners, whereas 4 (8%) and 3 (6%) felt neutral and disagreed respectively. Similarly, there were 42 (88%) team members who felt that there was communication between community partners, with 3 (6%) who felt each neutral and 3 (6%) who disagreed with the statement, and 39 (80%) reported acceptable levels of decision making capabilities among community partners. Regarding whether there was adequate conflict resolution among community partners, 32 (67%) team members who agreed, 13 (27%) felt neutral, and 3 (6%) disagreed. Finally, 39 (80%) team members felt that there was trust among community partners, with 7 (14%) team members reporting neutral and 3 (6%) who disagreed.

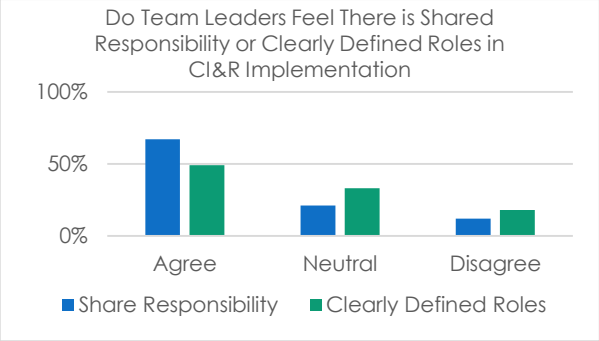


Team members were also asked whether their CI&R teams benefit from their participation with community

partners. There were 39 (80%) team members who agreed, 9 (18%) who reported neutral, and 1 (2%) who disagreed. Their perception of the accomplishments of community partners followed a similar trend, with 38 (78%) feeling as though the level of accomplishments were agreeable, 10 (20%) feeling neutral, and 1 (2%) who reported the level was disagreeable. Satisfaction among community members was found agreeable by 32 (65%) and neutral by 16 (33%) team members, with 1 (2%) team leader finding it disagreeable.

CI&R IMPLEMENTATION

Team members validated statements related to the implementation process for CI&R system changes. Statements indicated whether the organization had a staff participation/satisfaction survey (51% agreed) or a dissemination plan in place (47% agreed) for performance measures as the CI&R system changes unfold. There were 6 (12%) who answered each question by disagreeing, indicating that neither surveys nor a dissemination plan were part of the CI&R system changes. Regarding provider buy-in, 28 (57%) team members indicated that they had provider buy-in, and 5 (10%) team members reported they did not. Statements were presented as to whether team members were expected to share the responsibility of the CI&R system changes leading to success of the program; and whether team members have clearly defined roles and responsibilities. 67% of team members agreed that team members share the responsibility, but only 49% identified that team members have clearly defined roles and responsibilities. There were 6 (12%) and 9 (18%) who indicated that their teams did not have shared responsibility and clearly defined roles and responsibilities, respectively. Additionally, 33 (67%) believed they had a systems team in place and 4 (8%) indicated they did not, with the remainder feeling neutral. Those who disagreed or were neutral about clearly defined roles were more likely to feel that the system needed to be changed or was intolerable than those who agreed. There however is not a linear relationship between low values of agreement on most of the implementation variables with feelings about the need to change the system.



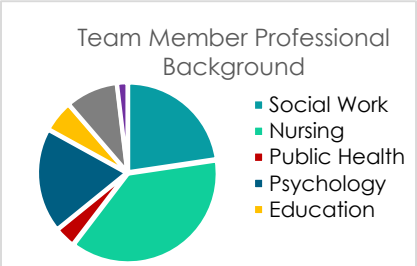
FOCUS GROUP RESULTS

Three separate, simultaneous focus groups were moderated by members of the USF evaluation team during the learning collaborative. CI&R travel team members were asked a series of questions to gain insight into: how their teams came into fruition; the decision process for taking part in the CI&R intervention; determining the informal leaders or champions taking the lead in the CI&R initiatives; reasons for deciding to implement the CI&R system changes in their communities; and how essential the CI&R intervention is to families in their communities.

TRAVEL TEAM MEMBER DEMOGRAPHICS

In total, 31 CI&R travel team members attended the learning collaborative in Jacksonville. The characteristics of the group who attended the learning collaborative were fairly representative of the baseline readiness respondents. The representation at the meeting was nearly balanced: of the participants, Alachua and Volusia/Flagler counties each had five leaders in attendance; Bay, Duval, and Hillsborough counties each had four; and Jefferson/Madison/Taylor, Manatee, and Orange/Osceola/ Seminole counties had three each. In terms of service sectors of the organization, 55% of travel team

members identified their organization as maternal and/or newborn health focus, 35% identified as a home visiting organization, 6% as a school readiness program, and 3% as a child maltreatment program. Within these organizations, most individuals (58%) self-identified as an administrator/director, 10% as a family support worker, and 3% as a supervisor. The remaining nine participants (29%) selected 'other,' which included: community relations, Healthy Families program manager, a program coordinator or program specialist, a CI&R project manager, a training specialist, program improvement, and a peer breastfeeding specialist. Experience in the current role ranged from zero to 18 years, with an average duration of 4.8 years (standard deviation of 5.5 years). Additionally, 40% of participants and 16% of participants had more than five and ten years of experience in the current role, respectively.



The majority of travel team members self-identified as 35 or older (77%), non-Hispanic (90%), and White (61%). Educational background was quite diverse; 17 (55%) participants held a graduate degree, 10 (32%) held a college degree, and 3 (10%) had some college experience, with public health (29%), social work (16%), and education (16%) being the most common fields. The selection of 'other' was selected 35% of the time, and included a wide range of answers such as sociology, English, economics, and recreation/tourism.

HOW WAS THIS CI&R LEADERSHIP GROUP OR TEAM FORMED?

When asked how their respective CI&R leadership group formed, some of the travel team members responded that most of the group was already in place before the CI&R initiative, having to add a few people to the team when they found out about the CI&R grant opportunity. Other travel team members reflected on the team recruiting and building process because there was no prior team in place.

"For [our county], since we're so large, we've actually had a kind of meeting going for the last couple of years that we've called [name] and it was our one place to come once a month. We'd invite Healthy Families, any other potential partners in the community. So, it's developed prior to – even with coordinated intake."

"A lot of the folks on our team have been working together on other collaborative initiatives. So, basically, I just called everybody… 'We have another opportunity to apply for some funding. We'd like you at the table. It's really important to have the whole continuum.' Pretty much everybody said yes."

"We've only really had one collective team meeting where all the members came to the table. There's been e-mails, different things like that, that just kind of the understanding. We weren't sure; our thing was basically when you get to this meeting. These guys are going to bring back what we're really supposed to do. So, there wasn't like a road map."

"In [our county], we already had a home visiting coalition that met monthly with all the home visiting programs in the county. This was something that we had talked about wanting to do before this RFP ever came out."

HOW WAS IT DECIDED TO PARTICIPATE IN THE CI&R INTERVENTION?

Much like the formation of teams, the decision to participate in the CI&R intervention varied between already having an ad hoc CI&R system in place, and making the decision with little previously

established. One sentiment that was shared among all teams, however, was how the decision was made based on what they perceived as the best choice for the families they served.

"Since for the last couple of years we've been meeting and we realized that there needs to be a process put into place within our community…We're in like a – working [on the] fly because it's something that we had been wanting to do, but it takes time, it takes money, it takes commitment, and it takes guidance, and that's kind of what we're all here together…versus trying to do our own things."

"We do have the advisory board, we just meet quarterly and we probably need to meet more often - so we have a structure in place but know that we're at the point where we could really provide services to many more families."

"The part I'm looking forward to is just to having one system where each agency can go in and look up and see what they provided for each family, so there won't be a duplication of services; because you can very well get a car seat for one service, come over to another and get another car seat, and we just need to have that. All the agencies needs to be viewing one thing ."

"I think what really stood out for me is when [partner agencies] talked about families having to share their story over and over. It's not respectful to them…"

WHO ARE THE INFORMAL LEADERS IN THE CI&R INTERVENTION?

Travel team members were asked to identify those who were the informal leaders, or champions of the CI&R intervention. These were people or organizations who leaders reported had gone above and beyond in their support efforts. In every focus group, Healthy Families identified as a key leader in the respective community's intervention. Other leaders that the teams mentioned ranged from MIECHV, non-profit organizations, the government, to the parents who use the CI&R services.

"I would say for us it's all the leadership and staff at the Community Coalition and are also managers at the health departments that do use services."

"I think the leaders of all the home visiting programs are really involved and really onboard to really create this collaborative approach. So, I think we're kind of ahead of the curve just because the provider meetings and the relationships we've established…"

"Yes. I think that's been the key for us, as really – I think as we've been really discussing this, we've been trying to figure out who exactly do we have to have buy-in from, which is really everybody, but really, key is actual parents that would use our services."

"I think that's the thing I'm taking away from this [learning collaborative] the most is that we think we know best…and we've been doing this and so of course, why wouldn't we be the best. But I think we do lose sight sometimes of that [family] and we need to actually be thinking the most about what their input could be in this process."

WHAT ARE THE DRIVING FACTORS FOR A CI&R INTERVENTION?

Travel team members were asked to explain why they thought the CI&R intervention was being implemented in their respective communities. In every focus group, leaders expressed similar notions of how much easier it is for the organizations in a community to be quite literally coordinated so that services are streamlined for families. Oftentimes there are overlaps in services provided to families, and there are also different qualifications for different services that organizations may not be aware of upon

referral. Travel team members talked about how both of these situations can be discouraging for families and their organizations alike because it creates extra barriers to resource delivery.

"Competing against each other, too, has led to negative outcomes. I mean if we have multiple programs coming into a home, it overwhelms the family sometimes. They don't want any of us there. So, maybe coordinating those efforts helps us all to better serve the families."

"I think just having us get to know the programs so we don't send people on a witch hunt because we'd love to tell families, 'Oh girl, can I help you?', and then we give them a number and then they found out that they didn't wear the red shoes so they can't participate in the program. If we knew that they had to wear red shoes we could have told them up front."

"Actually, we have both. We have families where two and three agencies are coming in to do home visits and not coordinating."

" So, when we looked at that data a few years back and saw the disparity in certain communities we said we have to do something. So, it's been a conversation for a really, really, really long time and this was an opportunity that allowed us to start where we should be starting, at the beginning."

HOW ESSENTIAL IS CI&R IN MEETING THE NEEDS OF FAMILIES?

Travel team members were asked how essential they felt that the CI&R intervention would be in meeting the needs of the families served. The responses from leaders ranged from the intervention being so essential that it would change the community forever and that it should be legislatively mandated in all states, to the intervention being essential although communities cannot possibly know what they need if they are not aware of the particular needs of their families.

"So, they're [communities] unassuming as a whole right now. They don't know what they don't know. So, we have bits and pieces that we'll have to educate them that this could work, oh, so much better if we all came together."

"…meaningful services and the outcomes of moving because the needs of family is met. Those families that just need a little bit of services or help them to through health outcomes. The really low birth weight children or the babies that have other medical issues and they don't have all these risk factors that is associated with child abuse".

"…because how many times have we given someone a referral and then you saw them in the street. They call back and say, 'That lady never called me', and you think all this time that she's getting these services over here at ABC and no one has ever called her."

"So, their family's support, we'll meet moms that – they're just nervous because they don't have a sister here, or a mama here, or a mother-in-law here. They had been sent to our area with their husband who's deployed many times or TDY and they're kind of by themselves. So, we call them sometimes. They just want help with breastfeeding or education that just somebody that I can call that knows the area, kind of thing"

"We have strong participation from all the home visiting programs within our community. All of them are represented and there's a buy-in from everybody that it would be the best for the families. We've talked about being able to track the families; if they graduated from one program or like some of the programs that we have in there are short term programs but they may feel like they need continued support so the we can refer them back, and they can go into like a parent-teacher program or something else that continues with that care."

CONCLUSION

Both the CI&R readiness survey and the three separate focus groups unveiled predominantly positive feedback from the CI&R team leaders regarding how helpful they perceive the intervention will be for their communities. Many of the leaders who participated in the learning collaborative had already been involved in CI&R implementation for some time in their respective communities; however, there were also some leaders whose communities had not yet started implementation activities. This mix of experienced and inexperienced participants in CI&R learning collaborative proved to be instrumental in the exchange of information and knowledge of how to approach the implementation of such a complex intervention. The next CI&R learning collaborative will be held in September 2016. With each subsequent learning collaborative, the USF evaluation team will continue to assess the perceptions of team members and their communities with respect to CI&R implementation in their communities.

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