Implementing Collaborative Care for Co-Occurring Disorders

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September 13th, 2022

Acknowledgements

Funding: This work was supported by the National Institute of Mental Health (NIH/NIMH; grant U014289744). The statements presented in this work are solely the responsibility of the author(s) and do not necessarily represent the views of the National Institutes of Health.

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Disclosures: The authors do not have any personal, professional, or financial conflicts of interest to disclose for this work. The authors did not work with or were otherwise influenced by any external sponsors for this work. Dr. Saxon has received travel support from Alkermes, Inc., consulting fees from Indivior, Inc., and royalties from UpToDate, Inc. Anna Ratzliff, MD, PhD receives royalties from Wiley for her book on integrated care.

Learning Objectives

1) Describe barriers and facilitators to implementing CoCM for co-occurring opioid use disorder and behavioral conditions

2) Identify strategies to support primary care teams in integrating treatment for OUD into CoCM practice

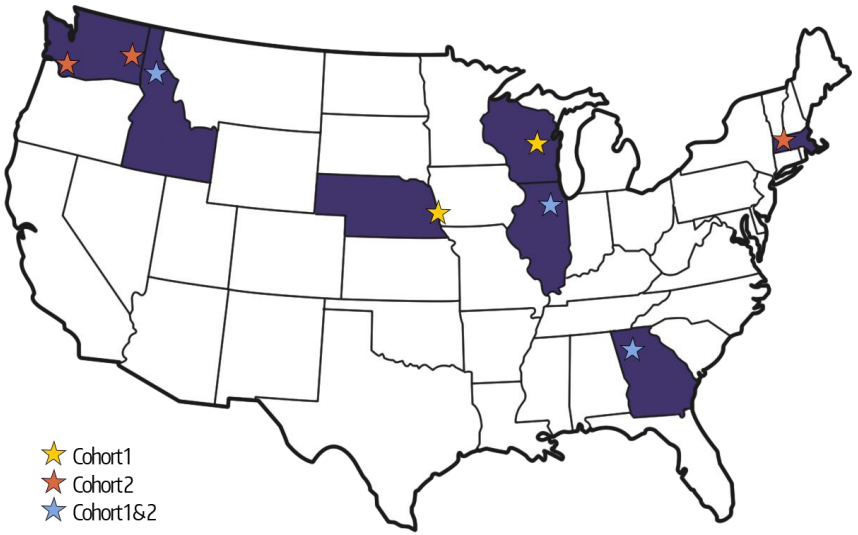
The Need to Expand OUD care

Study Setting

Study Aims:

- Evaluate the effectiveness of routine screening for OUD in primary care
- Evaluate the effectiveness of CoCM for co-occurring opioid use and mental health disorders
- Evaluate approaches to sustaining CoCM for co-occurring disorders

Collaborating to Heal Addiction and Mental Health in Primary Care (CHAMP)



Formative Evaluation Objectives

- Understand the experience of CHAMP implementation from the perspective of clinic staff and administrators
- Identify and document implementation barriers and facilitators
- Use data to inform adaptations to CHAMP implementation

CoCM Team Perspectives on the Integration of Care for Co-Occurring Disorders

Mixed Methods Evaluation

Mixed Methods Formative Evaluation

QUALITATIVE DATA

- **Sample**: Clinical implementation team (PCP champion, behavioral health care manager, psychiatric consultant, project lead, practice facilitator, support staff), n=10 practice sites
- **Data collection**: Participant observation
- **Timing**: Ongoing, monthly site calls for ~ 12 months following intervention launch
- **Guiding framework**: *Consolidated Framework for Implementation Research*
- **Analysis**: Rapid Assessment Process, thematic analysis

(Damschroder, 2009; Hamilton, 2020)

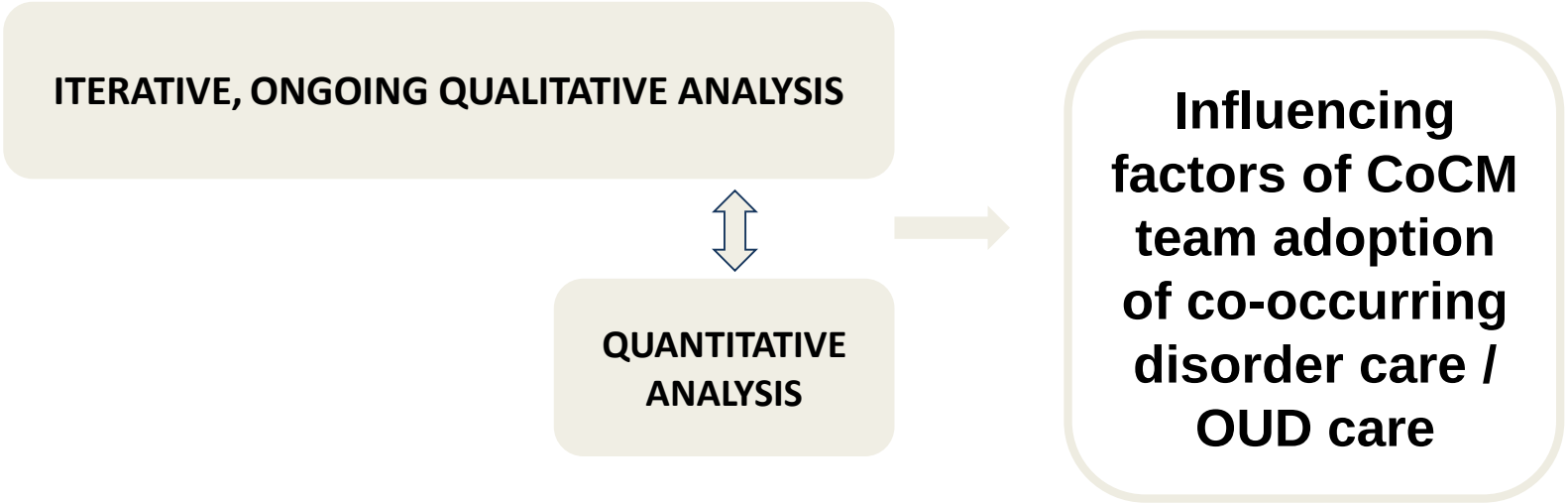
Mixed Methods Formative Evaluation

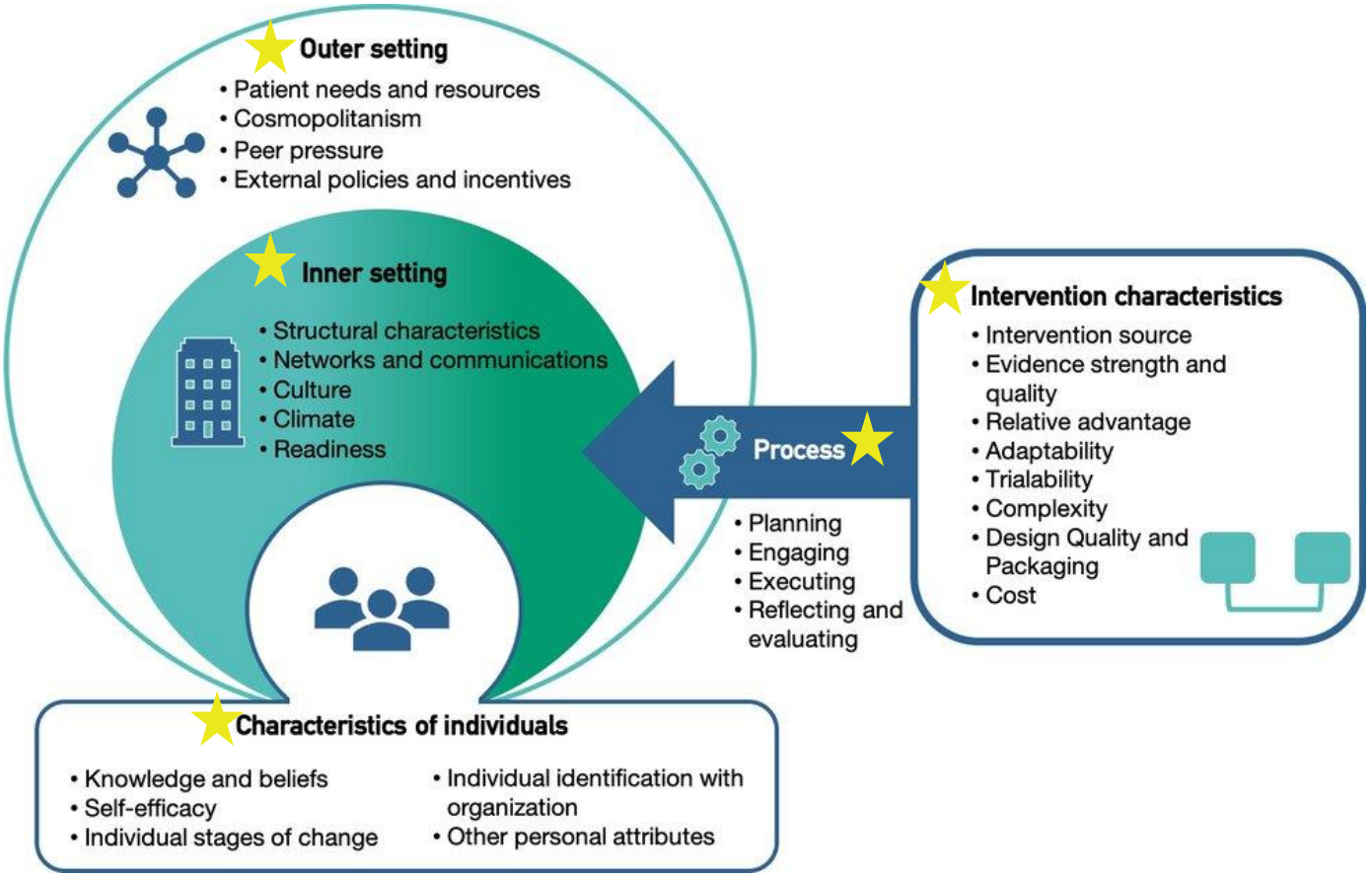
QUANTITATIVE DATA

- **Sample**: Primary care clinical staff (Primary care providers (PCPs), behavioral health care managers, psychiatrists), n=10 practice sites
- **Data collection**: Structured surveys
- **Timing**: At intervention launch
- **Measures**: *Organizational Readiness to Change Assessment, Drug Problems Perceptions Questionnaire, Evidence-based Practice Attitude Scale*
- **Analysis**: Descriptive statistics

(Helfrich, 2009; Watson, 2007; Rye, 2017)

Mixed Methods Formative Evaluation




Outer setting
• Patient needs and resources
• Cosmopolitanism
• Peer pressure
• External policies and incentives
Inner setting
• Structural characteristics
• Networks and communications
• Culture
• Climate
• Readiness
Process
• Planning
• Engaging
• Executing
• Reflecting and evaluating
Intervention characteristics
• Intervention source
• Evidence strength and quality
• Relative advantage
• Adaptability
• Trialability
• Complexity
• Design Quality and Packaging
• Cost
Characteristics of individuals
• Knowledge and beliefs
• Self-efficacy
• Individual stages of change
• Individual identification with organization
• Other personal attributes

Perspectives on implementing screening for OUD

Integrating Routine Screening for Opioid Use Disorder into Primary Care Settings: Experiences from a National Cohort of Clinics

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BACKGROUND: The U.S. Preventive Services Task Force recommends routine population-based screening for drug use, yet screening for opioid use disorder (OUD) in primary care occurs rarely, and little is known about barriers primary care teams face.

OBJECTIVE: As part of a multisite randomized trial to provide OUD and behavioral health treatment using the Collaborative Care Model, we supported 10 primary care clinics in implementing routine OUD screening and conducted formative evaluation to characterize early implementation experiences.

DESIGN: Qualitative formative evaluation.

APPROACH: Formative evaluation included taking detailed observation notes at implementation meetings with individual clinics and debriefings with external facilitators. Observation notes were analyzed weekly using a Rapid Assessment Process guided by the Consolidated Framework for Implementation Research, with iterative feedback from the study team. After clinics launched OUD screening, we conducted structured fidelity assessments via group interviews with each site to evaluate clinic experiences with routine OUD screening. Data from observation and structured fidelity assessments were combined into a matrix to compare across clinics and identify cross-cutting barriers and promising implementation strategies.

KEY RESULTS: While all clinics had the goal of implementing population-based OUD screening, barriers were experienced across intervention, individual, and clinic setting domains, with compounding effects for telehealth visits. Seven themes emerged characterizing barriers, including (1) challenges identifying who to screen, (2) complexity of the screening tool, (3) staff discomfort and/or hesitancies, (4) workflow barriers that decreased screening follow-up, (5) staffing shortages and turnover, (6) discouragement from low screening yield, and (7) stigma. Promising implementation strategies included utilizing a more universal screening approach, health information technology (HIT), audit and feedback, and repeated staff trainings.

CONCLUSIONS: Integrating population-based OUD screening in primary care is challenging but may be made feasible via implementation strategies and tailored practice facilitation that standardize workflows via HIT, decrease stigma, and increase staff confidence regarding OUD.

KEY WORDS: opioid use disorder; screening; primary care.

J Gen Intern Med
DOI: 10.1007/s11606-022-07675-2

BACKGROUND

With rising incidence of, associated mortality resulting from, and effective treatment for opioid use disorder (OUD), urgency exists to identify and link patients with OUD to evidence-based treatment.[1] In 2020, there were over 93,000 overdose-related deaths in the USA and a continued steady rise in new OUD diagnoses.[2] Effective medications to treat OUD (MOUD) reduce opioid-related mortality and improve quality of life.[1,3] Yet access to MOUD has been limited by prior federal policies requiring provider licensing (for buprenorphine) and/or supervised disbursement of medication (for methadone). As a result, only 21% of patients with diagnosed OUD nationally receive MOUD, with lower treatment access [4,5]

Table 1. Clinic Characteristics and Screening Practices	
Number of clinics represented	10
Number of health systems represented	9
Geographic setting of clinics*	
Urban	2
Suburban	6
Rural	2
Clinic setting characteristics	
FQHC	2
Trainee site (residents, interns)	3
Academic medical center affiliated	2
Existing SUD screening in place?	
Yes	3
No	7
Screening frequency	
Universal – every visit	2
Universal – annually	8
Screening visit formats	
In person visits only	8
Both in person & telehealth	2
Primary approach to OUD screening capture	
Patient completes on paper	8
Patient completes electronically (e.g., patient portal or third-party app)	2
Patients completes via verbal administration with clinic staff	0
***Based on clinic self-description**	

Table 2 Summary of Barriers and Promising Strategies for OUD Screening Implementation in Primary Care Settings

CFIR domain	Barriers experienced	Promising strategies
Intervention characteristics	• Identifying who, when, and how often to screen for OUD was complicated • The NIDA-Modified ASSIST (NMA) felt overly complex and challenging to administer	• Utilize a more universal OUD screening approach (e.g., every patient, every visit) to reduce workflow complexity • U enh • Id ad
Individual characteristics	• Staff expressed discomfort, hesitancy, and uncertainty with OUD screening administration and follow-up	all roles to reduce discomfort and hesitancy around OUD discussions with patients • Providing forums for staff to voice concerns about OUD screening and provision of OUD care • Provide clinical staff with access to OUD experts and/or mentors to a
Inner setting	• Clinics struggled to optimize workflow and ensure screening provided opportunity for follow-up of positive screens • The low yield from OUD screening felt discouraging • Screening felt burdensome to already-busy clinics	• Ir effe • C pro
Outer setting	• Stigma may deter patients from seeking OUD care in primary care settings	• U rela reducing wait times, offering alternative treatment approaches) • Advertise the availability of primary care-based OUD care to the broader community • Identify and reduce stigma within clinic policies and practices

"I mean, I kind of know what it's for, but **I don't know how to explain it in full detail**, like if a patient asks about it."

"MAs are just doing a push back… t**he MAs feel that they're overworked, you're just adding one more thing to their plate for them to do**, what does a positive screen mean, **what's in it for them**, what does it mean for them?"

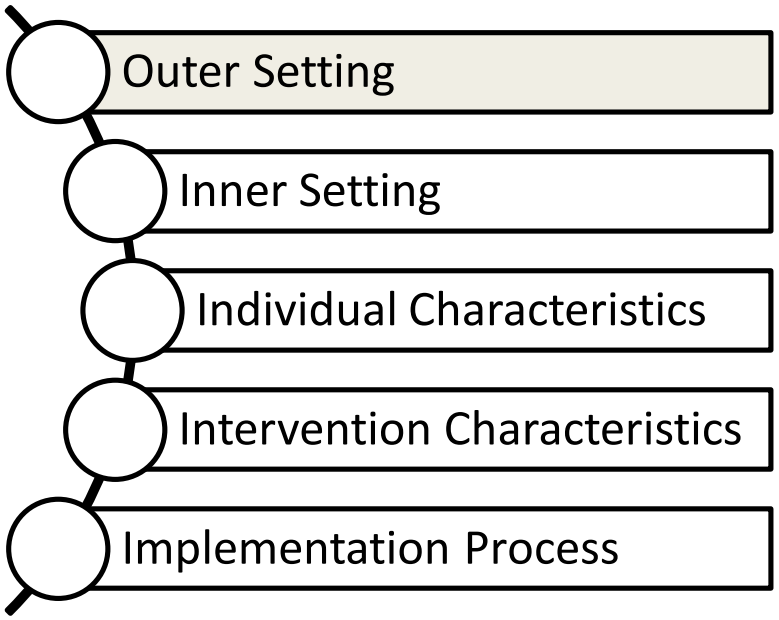
"Maybe some of our screening could actually come out differently **if people knew as part of our advertisement that we offer buprenorphine**."

Table 2 Summary of Barriers and Promising Strategies for OUD Screening Implementation in Primary Care Settings

CFIR domain	Barriers experienced	Promising strategies
Intervention characteristics	• Identifying who, when, and how often to screen for OUD was complicated • The NIDA-Modified ASSIST (NMA) felt overly complex and challenging to administer	• Utilize a more universal OUD screening approach (e.g., every patient, every visit) to reduce workflow complexity • Use health information technology (e.g., automated reminders) to enhance screening workflow consistency • Identify OUD screening tools that are brief and simple to administer
Individual characteristics	• Staff expressed discomfort, hesitancy, and uncertainty with OUD screening administration and follow-up	• Providing trainings, scripts, and 1:1 coaching for clinical staff of all roles to reduce discomfort and hesitancy around OUD discussions with patients • Providing forums for staff to voice concerns about OUD screening and provision of OUD care • Provide clinical staff with access to OUD experts and/or mentors to address knowledge gaps and provider self-efficacy
Inner setting	• Clinics struggled to optimize workflow and ensure screening provided opportunity for follow-up of positive screens • The low yield from OUD screening felt discouraging • Screening felt burdensome to already-busy clinics	• Incorporate audit and feedback strategies to increase workflow effectiveness • Clarify clinic goals for OUD screening and the importance of providing life-saving OUD care • Leverage clinical champions (e.g., a waivered primary care provider) to increase staff buy-in for OUD screening
Outer setting	• Stigma may deter patients from seeking OUD care in primary care settings	• Understand external (e.g., local, community) resources for OUD–related care; tailor care to be responsive to patient demand (e.g., reducing wait times, offering alternative treatment approaches) • Advertise the availability of primary care-based OUD care to the broader community • Identify and reduce stigma within clinic policies and practices

Perspectives on implementing collaborative care for OUD

Qualitative Themes



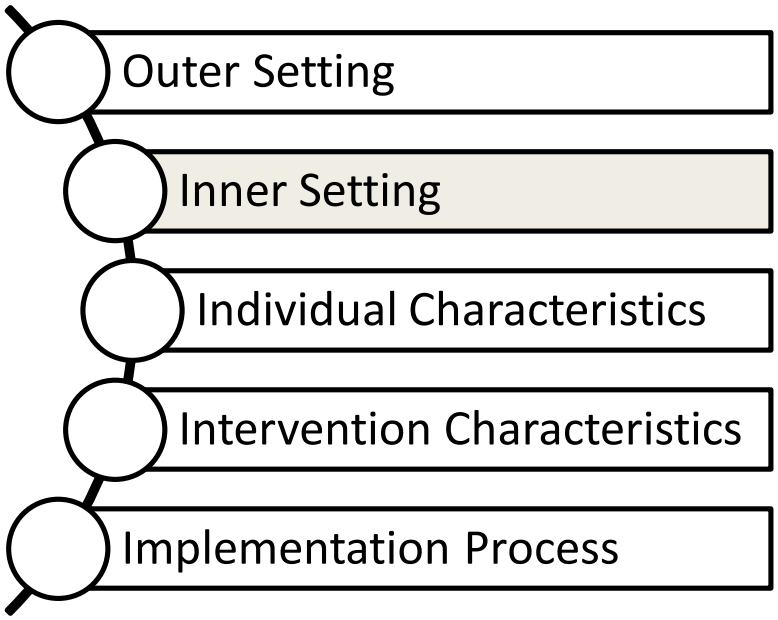
"I think there's **still a lot of lacking awareness in general in our area**, and even in the ERs and from all providers." [Site 8, PCP]

- Primary care is not perceived as the place for OUD care *(influenced by word of mouth, opioid safety initiatives, and stigma)*

"[City name] is pretty small, everybody knows that I will not give chronic opioids, **they will even say they don't want to see me** because they know I won't do that." [Site 2, PCP]

"It got out there, but it also got out there that I had a reputation of calling people out when following my directions. […] **[Patients with opioid use] are absolutely a community**." [Site 1, PCP]

Qualitative Themes



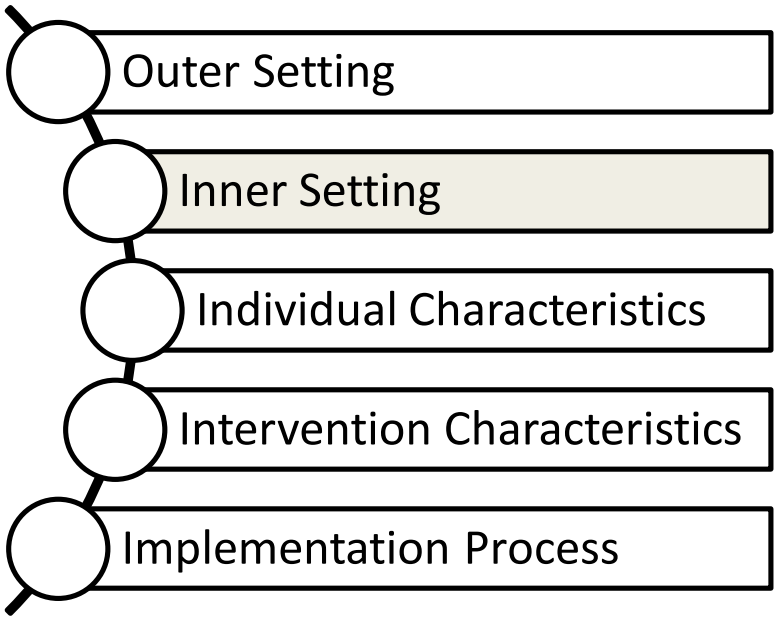
"My **practice has been *really* busy** right now … it's been tough to find openings for my current patients as it is." [Site 6, PCP]

- Limited clinic capacity to absorb new patients

"We just don't have the same capacity of patients, also I just don't have the capacity to see as many, you know **MOUD is not all that I do and I have a pretty full panel** . . . there's limits in what I can do." [Site 10, PCP]

"**It's not easy to get an appointment** as a new patient." [Site 1, PCP]

Qualitative Themes



"You really have to **strike when the iron's hot** and maybe **we're losing patients** that way." [Site 3, Psychiatrist]

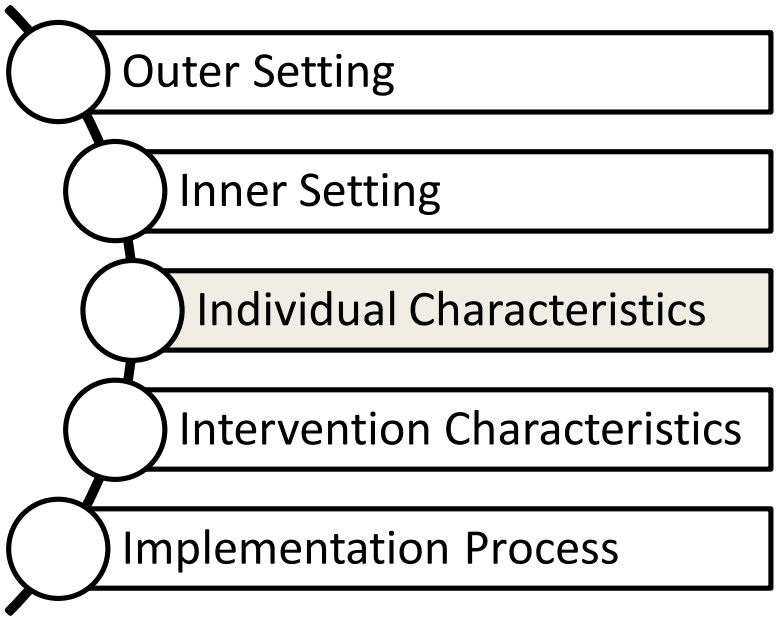
"The idea that they will leave an hour and a half open in my schedule every day or every other day knowing they may not be filled, **that's not cost effective.**" [Site 5, BHCM]

- Clinic appointment structures are not always responsive to OUD care delivery needs *(e.g., urgency, flexible formats)*

"It gets a little **bit cumbersome when your schedule is blocked**… Open access would be great it's just getting the hospital to buy in . . . that would be **nice to have a little bit of breathing space** there **instead of putting everyone else behind**, especially when they're withdrawing in the next room." [Site 2, PCP]

"You **just have to be flexible** because you just never know, I double book patients because sometimes they don't show up, sometimes they need an hour, **you just never know and you have to be flexible**." [Site 8, PCP]

Qualitative Themes



"Should I ask him? **Because I'm afraid to ask if he's selling it**. **I'm scared to breach the subject** of – 'well what is happening to the suboxone.' **I don't want to be so judgey**, I want to be open and not that way." [Site 8 PCP]

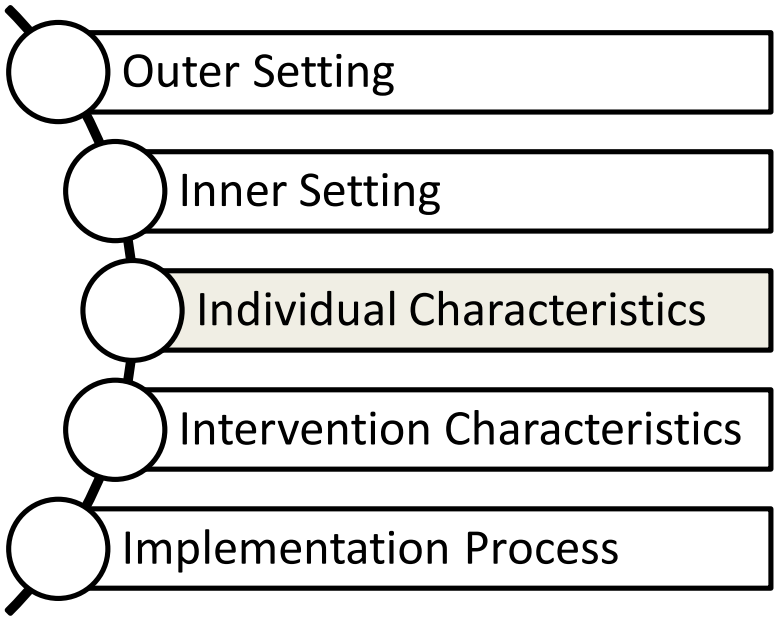
"Several providers **don't have experience or feel comfortable, or maybe don't understand** use disorder criteria." [Site 8, PCP]

- Low provider self-efficacy for OUD conversations *(e.g., diagnosis, polysubstance use, diversion)*

"It's a **struggle for us to feel empowered** to have those conversations since **we're so new**." [Site 2, PCP]

"I'll admit it's **a bit of a grey area** here, I have been pretty forgiving of patients that shared their meds . . . and all the time patients come in and say 'ya I started suboxone on the street and it worked great' I get that all the time . . . but **there's a difference between that and completely lying about selling it** ." [Site 4 PCP]

Qualitative Themes



"That's not my primary practice, and what happens is when you have a patient like that all of the sudden you have to schedule weekly appointments with them and **it's hard to fit these patients in and get them in the schedule, it overwhelms everyone**." [Site 2, PCP]

"We all know **these patients take a lot of resources and emotional capital from providers** and other staff as well." [Site 9, PCP]

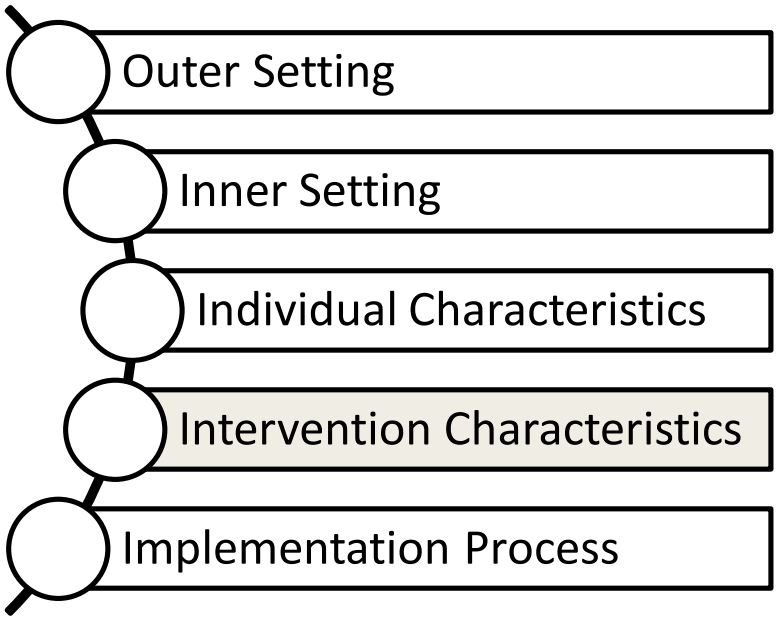
"At the end of the day **I'm fine adding them on**." [Site 2, PCP]

- Conflicting attitudes towards how MOUD impacts provider workload

"I do a lot of rearranging my schedule to make that work, when I see that they're in the clinic **I maneuver things around to make sure I get to see them**." [Site 9, BHCM]

"Our faculty group as whole has expressed that **that's not the direction they want for our clinic**, we already provide more psychiatric care and addiction medicine than other clinics, but **we can't be like *the* addiction medicine clinic in town either.**" [Site 9, PCP]

Qualitative Themes



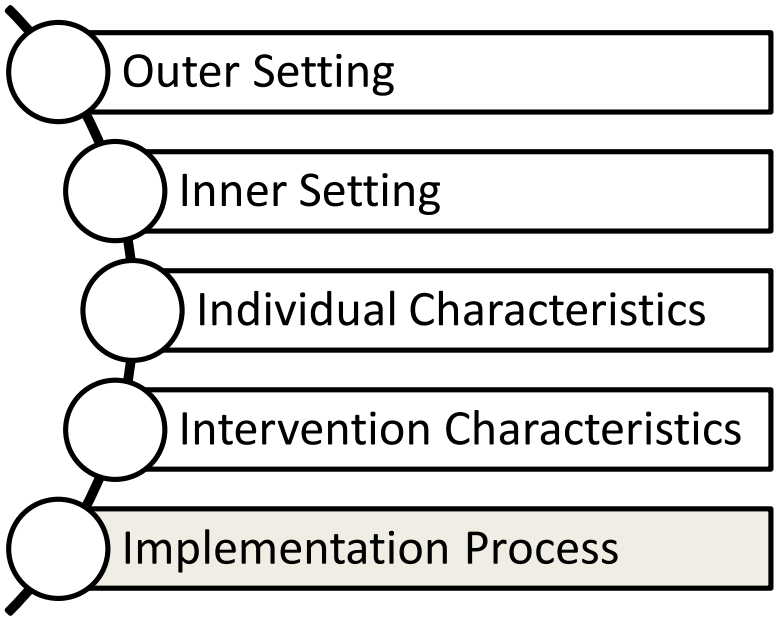
"I have my patients that have been using from street drugs where I don't have to explain any of that, versus my patients that are on prescribed opioids, I have to use visuals, I draw the little receptors. […] Explaining these ideas of **tolerance and withdrawal are not terms that my chronic pain patients are as familiar with** or comfortable with discussing." [Site 4, PCP]

"There's just an **iceberg of knowledge**." [Site 2, PCP]

- Patients with different histories of opioid use may require tailored strategies for OUD care delivery

"I swear **nobody's simple**, like can't someone just have straightforward depression and suboxone issues?" [Site 4, PCP]

Qualitative Themes



"**We don't have the opportunity to get together often enough, it just feels a little chaotic right now**." [Site 5, PCP]

"**We have not had an all staff meeting since we've been running at 25% capacity**." [Site 4, MA]

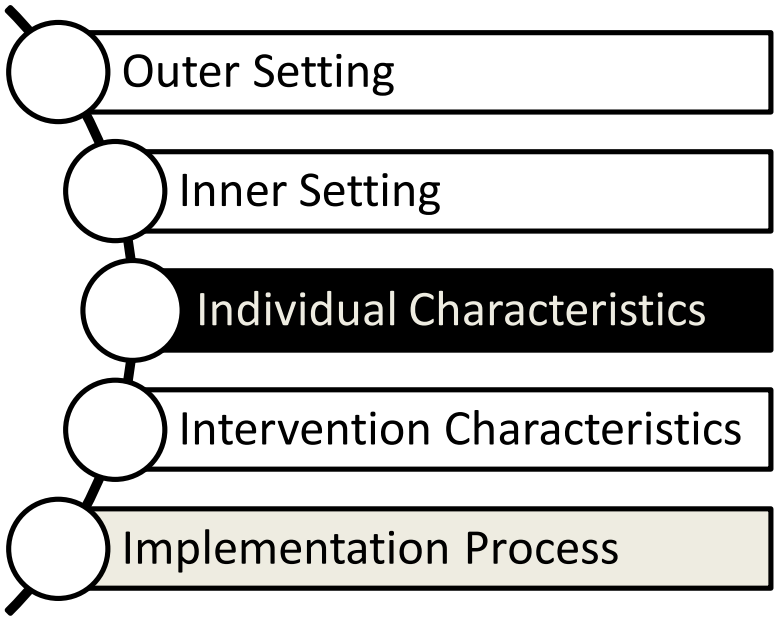
"**The issue that we have is that we have a ton of float people** – PSRs and such – I keep advocating that – 'get a ton of them in the room and I will happily train them' . . . **every time I go up to the front desk it's a new person** and I just cringe." [Site 2, BHCM]

- Repeated staff training is critical but difficult to implement during COVID

"**It's really just a matter of education and having the time to do this together**." [Site 5, PCP]

"**It's really really hard to do on Zoom**, when you speak it echoes and it's hard to see how people respond" [Site 8, PCP]

Qualitative Themes



"At the same time, we have active patients that we're treating, **we can't just find these people** for months and months. […] I'm spending 3 weeks, 4 weeks, trying to get them in but **at what point do I stop doing that because it isn't successful**." [Site 10, Care Manager]

"**It's frustrating when patients don't show up** when they have been referred." [Site 4, Care Manager]

- Feeling discouraged from low yield and/or variable patient engagement

Qualitative Themes - Facilitators

Facilitator / Promising Strategy	What we think is happening	What we need to understand
Clinical mentorship with OUD experts	• Increased provider skills and confidence via understanding lived experience of OUD care delivery	• How to support broader PCP access to mentors • Alternative formats to deliver mentoring
Use of EMR templates for OUD care delivery	• Increased provider confidence via template information • Increased consistency with staff turnover	• Best practices for template design • Impact of templates on provider adoption of OUD care delivery tasks
Modelling of MOUD by local champions	• Modelling of MOUD by local PCP champions improves willingness and attitudes of other PCPs	• What makes modelling effective in some settings, but in others encourages less involvement of PCPs
Patient education tools for MOUD	• Increased provider confidence in OUD discussions with patients	• Uptake and use of patient education resources • Need for tailored tools for prescription opioid use
Health system incentives for x-waiver training	• Health systems providing incentives to complete x-waiver training encourages PCP adoption	• Whether incentives are actually being offered • Impact of incentives on PCP x-waiver and provision of MOUD

EMR templates are helpful because "**[PCPs] don't have to diagnose [OUD] they just have to suspect it**" [Site 8, PCP]

"**I wouldn't have had to guts to do it, honestly, without a mentor**… it's just really refreshing and empowering to know that you can keep growing." [Site 2, PCP]

"**I appreciate the CHAMP handout** because I use that a lot. I think it'd be great to have a handout on 'why I should use suboxone.'" [Site 8, PCP]

Provider respondent demographics (n=51)

	N	***%***
Respondent Role at Clinic		
Healthcare Provider (medical)	25	49.1%
Psychiatric Consultant	12	23.6%
Behavioral Health Clinician	14	27.5%
Respondent Years of Practice		
Less than 5	6	11.8%
5-10	17	33.3%
11-20	18	35.3%
20+	10	19.6%
Respondent Age		
25-34	7	13.7%
35-44	22	43.1%
45-54	11	21.6%
55+	11	21.6%
Respondent Race		
Native Hawaiian or Other Pacific Islander	1	2.0%
Black or African American	4	7.8%
Asian	2	3.9%
White/Caucasian	44	86.3%
Gender Identity		
Female	35	68.6%

Provider beliefs about MOUD care delivery

The practice of delivering medications to treat OUD via a Collaborative Care Model … **(n=51)**	***Strongly Disagree***	***Disagree***	***Agree***	***Strongly Agree***
Is supported by randomized clinical trials or other scientific evidence	0	7 (13.7%)	30 (58.8%)	14 (27.5%)
Conforms to the opinions of clinical experts in my clinic	0	3 (5.9%)	32 (62.7%)	16 (31.4%)
Is consistent with clinical practices that have been accepted by patients	0	4 (7.8%)	37 (72.5%)	10 (19.6%)
Fills an important gap in the care my clinic provides	1 (2.0%)	4 (7.8%)	29 (56.9%)	17 (33.3%)
Can be integrated into my clinic's procedures and workflow	0	1 (2.0%)	32 (62.7%)	18 (35.3%)
Is compatible with the care provided by my clinic	0	2 (3.9%)	29 (56.9%)	20 (39.2%)
Is time consuming	2 (3.9%)	14 (27.5%)	28 (54.9%)	7 (13.7%)
Detracts from my clinical responsibilities	16 (31.4%)	29 (56.9%)	6 (11.8%)	0

(Helfrich, 2009)

Provider concerns about MOUD care integration

Are you concerned about being able to accommodate patients seeking OUD treatment at your clinic for any of the following reasons? (n=51)	
Waivered prescriber will not have DEA waiver capacity to meet demand	3 (5.9%)
Clinicians will not have caseload to accommodate patients seeking OUD care	18 (35.3%)
Clinic will experience an influx of new patients seeking OUD care	17 (33.3%)
Other:	10 (19.6%)
"Concerned PCP's may not feel confident in OUD prescribing towards taking on new patients" *"Lack of appropriate staff(we are short staffed)"* *"My schedule is full hard to accommodate new consults"* *"We do not desire to be the system referral clinic for OUD"*	

Provider attitudes towards patients with OUD

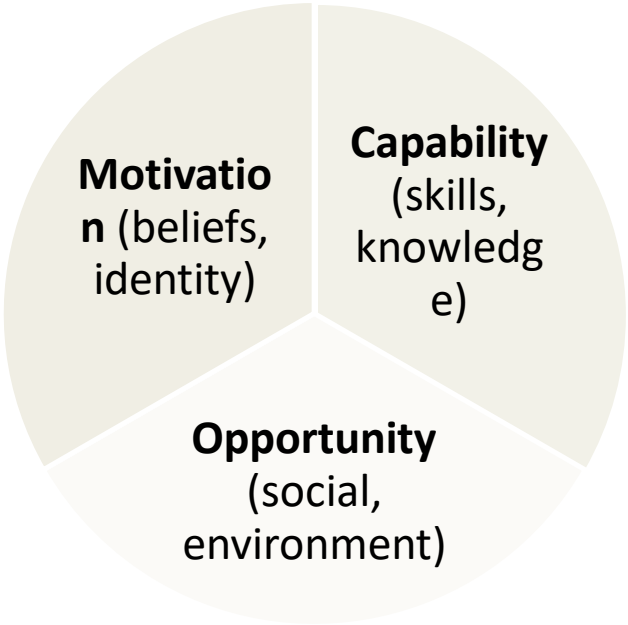
Selected Items from 'Drug Problems Perceptions Questionnaire (DPPQ)' (n=51)	***Strongly Disagree***	***Disagree***	***Slightly Disagree***	***Slightly Agree***	***Agree***	***Strongly Agree***
I feel I know how to counsel opioid users over the long-term	0	2 (3.9%)	7 (13.7%)	15 (29.4%)	17 (33.3%)	10 (19.6%)
If I felt the need when working with opioid users I could easily find someone with whom I could discuss any personal difficulties that I might encounter	0	4 (7.8%)	4 (7.8%)	4 (7.8%)	23 (45.1%)	16 (31.4%)
I feel I am able to work with opioid users as well as other patient groups	0	0	0	12 (23.5%)	19 (37.3%)	20 (39.2%)
In general, one can get satisfaction from working with opioid users	0	2 (3.9%)	0	7 (13.7%)	23 (45.1%)	19 (37.3%)
In general, it is rewarding to work with opioid users	0	0	2 (3.9%)	13 (25.5%)	23 (45.1%)	13 (25.5%)
In general, I feel I can understand opioid users	0	1 (2.0%)	4 (8.0%)	13 (25.5%)	22 (44.0%)	10 (20.0%)
I feel that there is little I can do to help opioid users	23 (45.1%)	23 (45.1%)	4 (7.8%)	0	0	1 (2.0%)
In general, I have less respect for opioid users than for most other patients I work with	31 (60.8%)	18 (35.3%)	0	2 (3.9%)	0	0
I often feel uncomfortable when working with opioid users	13 (25.5%)	19 (37.3%)	5 (9.8%)	12 (23.5%)	2 (3.9%)	0
All in all I am inclined to feel I am a failure with opioid users	26 (51.0%)	18 (35.3%)	5 (9.8%)	2 (3.9%)	0	0

(Watson, 2007)

Discussion

- Primary care teams experienced multilevel barriers to the implementation of CoCM for co-occurring disorders
- Implementation strategies should be tailored to clinic-level context of MOUD expertise, resources, & care integration approach
- Clinic structures and provider perspectives appear to be mutually reinforcing

Strategies to facilitate behavior change



(Michie et al, 2011)

Capability barriers

Potential barriers to provider delivery of OUD care
Primary care not perceived as place for OUD care
Limited clinic capacity to absorb new patients
Clinic structures not responsive to MOUD care delivery
Limited provider self-efficacy for OUD conversations
Conflicting attitudes around provider workload
Perceived complexity of OUD care by context of opioid use
Repeated staff training is challenging during COVID
Discouragement from low patient yield and engagement

Individual Strategies:

- **Training & Education** *(e.g., OUD diagnosis criteria, OUD conversations)*
- **Modeling** *(e.g., champions, mentors)*

Opportunity barriers

Potential barriers to provider delivery of OUD care
Primary care not perceived as place for OUD care
Limited clinic capacity to absorb new patients
Appointment structures not responsive to MOUD care
Limited provider self-efficacy for OUD conversations
Conflicting attitudes around provider workload
Perceived complexity of OUD care by context of opioid use
Repeated staff training is challenging during COVID
Discouragement from low patient yield and engagement

Inner Setting Strategies:

- **Enablement** *(e.g., panels, EMR tools)*
- **Environmental restructuring** *(e.g., appointment flexibility, outreach modalities)*

Motivation barriers

Potential barriers to provider delivery of OUD care
Primary care not perceived as place for OUD care
Limited clinic capacity to absorb new patients
Clinic structures not responsive to MOUD care delivery
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Discouragement from low patient yield and engagement

Outer Setting Strategies:

- **Incentives** *(e.g., organizational goals, productivity)*
- **Persuasion** *(e.g., community level messaging)*

Questions?

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