TABI Code List - DRAFT

7/25/2018

1- Implementation Strategies – Use evaluative and iterative strategies
1a. Assess for readiness and identify barriers and facilitators
1b. Audit and provide feedback
1c. Purposefully reexamine the implementation
1d. Develop instruments to monitor and evaluate core components of the innovation/ new practice.
1e. Develop and organize quality monitoring systems
1f. Develop a detailed implementation plan or blueprint.
1g. Conduct local need assessment
1h. Stage implementation scale up
1i. Obtain and use patients/consumers and family feedback
1j. Conduct cyclical small tests of change
1k. Monitor the progress of the implementation effort
1l. None of the above

2-Implementation Strategies – Provider interactive assistance
2a. Facilitation
2b. Provide local technical assistance
2c. Provide clinical supervision
2d. Centralize technical assistance
2e. None of the above

3-Implementation Strategies – Adapt and tailor to context
3a. Tailor strategies
3b. Promote adaptability
3c. Use data experts
3d. Use data warehousing techniques
3e. Test-Drive and Select Practices. (pent_68)
3f. None of the above

4-Implementation Strategies – Develop stakeholder interrelationships
4a. Identify and prepare champions
4b. Organize school personnel implementation team meetings
4c. Recruit, designate, and train for leadership
4d. Inform local opinion leaders
4e. Build partnerships (i.e., coalitions) to support implementation.
4f. Obtain formal commitments
4g. Identify early adopters
4h. Conduct local consensus discussions
4i. Capture and share local knowledge
4j. Use advisory boards and workgroups
4k. Use an implementation advisor
4l. Model and simulate change
4m. Visit other sites
4n. Involve governing organizations
4o. Develop an implementation glossary
4p. Develop academic partnerships
4q. Promote network weaving
4r. Create new practice teams
4s. Peer-Assisted Learning
4t. None of the above

5-Implementation Strategies – Train and educate stakeholders
5a. Conduct ongoing training
5b. Provide ongoing consultation/coaching
5c. Develop educational materials
5d. Make training dynamic
5e. Distribute educational materials
5f. Use train-the-trainer strategies
5g. Conduct educational meetings with specific stakeholders
5h. Conduct educational outreach visits
5i. Create a professional learning collaborative
5j. Shadow other experts
5k. Work with educational institutions
5l. Improve implementers' buy-in
5m. Pre-correction prior to implementation
5n. None of the above

6- Implementation Strategies – Support school personnel
6a. Facilitate relay of intervention and student data to school personnel.
6b. Remind school personnel.
6c. Develop resource sharing agreements
6d. Revise professional roles
6e. Targeting/improving implementer wellbeing
6f. None of the above

7- Implementation Strategies – Engage consumers
7a. Involve students, family members, and other staff.
7b. Intervene/ communicate with students, families, and other staff to enhance uptake and fidelity
7c. Prepare families and students to be active participants
7d. Increase demand and expectations for implementation
7e. Use mass media
7f. None of the above

8- Implementation Strategies – Utilize financial strategies
8a. Fund and contract for the new practices.
8b. Access new funding
8c. Place innovation on fee for service lists/formularies
8d. Alter student or school personnel obligations to enhance participation in or delivery of new practice, respectively.
8e. Make billing easier
8f. Alter patient/consumer fees
8g. Use other payment schemes
8h. Develop disincentives
8i. Use capitated payments
8j. Provide system-level incentives
8k. None of the above

9- Implementation Strategies – Change infrastructure
9a. Mandate for change
9b. Change record systems
9c. Change/alter environment
9d. Create or change credentialing and/or professional development standards
9e. Change school or community sites
9f. Change accreditation or membership requirements
9g. Start a dissemination/implementation organization
9h. Change liability laws
9i. Change ethical and professional standards of conduct
9j. Develop local policy that supports implementation
9k. Make implementation easier by removing burdensome documentation tasks
9l. Pruning competing initiatives. (pent_60)
9m. None of the above

10- Stage of Implementation Completed
10a.Planning
10b. Budgeting
10c. Delivering services
10d. Sustained

11-Adaptation – By whom are modifications made?
11a. Individual practitioner/ facilitator
11b. Team
11c. Non-program staff
11d. Administration
11e. Program developer/ purveyor
11f. Researcher
11g. Coalition of stakeholders
11h. Unknown/ unspecified

12 – Adaptation – When did modification occur
12a. Pre-implementation/planning/pilot
12b. Implementation
12c. Scale up
12d. Maintenance/Sustainment

13-Adaptation – Were adaptations planned?
13a. Planned/Proactive (proactive adaptation)
13b. Planned/Reactive (reactive adaptation)
13c. Unplanned/Reactive (modification)
13d. Considered, unclear if implemented

14-Adaptation – Who participated in the decision to modify?
14a. Political leaders
14b. Program Leader
14c. Funder
14d. Administrator
14e. Program manager
14f. Intervention developer/ purveyor
14g. Researcher
14h. Treatment/Intervention team
14i. Individual Practitioners (those who deliver it)
14j. Community members
14k. Recipients

15-Adaptation – What is modified?
15a. Content
15b. Context
15c. Training and Evaluation

16-Adaptation - At what level of delivery (for whom/what are modifications made?)
16a. Individual patient level
16b. Group level
16c. Individual practitioner level
16d. Clinic/ unit level
16e. Hospital level
16f. Network level
16g. System level

17-Adaptation - Context modifications are made to which of the following?
17a. Format
17b. Setting
17c. Personnel
17d. Population

18-Adaptation - What is the nature of the content modifications?
18a. Tailoring/ tweaking/ refining
18b. Adding elements
18c. Removing/ skipping elements
18d. Shortening/ condensing (pacing/ timing)
18e. Lengthening/ extending (pacing/ timing)
18f. Substituting

18g. Reordering of intervention modules or segments

18h. Integrating the intervention into another framework (e.g., selecting elements)
18i. Integrating another treatment into EBP (not using the whole protocol and integrating other techniques into a general EBP approach)
18k. Repeating elements of modules
18l. Loosening structure
18m. Departing from the intervention ("drift")

19-Adaptation – Impact on fidelity/core elements
19a. Fidelity Consistent/Core elements preserved
19b. Fidelity Inconsistent/Core elements changed
19c. Unknown

20 – Activity information
20a. Activity
20b. Data Request
20c. Discreet
20d. Planned
20e. Enacted
20f. Not followed through
20g. Action

21 – Dose
21a. Dose – Ongoing
21b. Dose - Discreet
21c. If ongoing, how often
21d. Dose (additional details)
21e. Temporality

22 – Rational Information
22a. Justification
22b. Was the activity explicitly chosen to address a barrier identified during the needs assessment?
22c. Action target

23 – Outcomes
23a. Outcome
23b. Unit of Analysis

24. CFIR – Intervention Characteristics
24a. Intervention Source
24b. Evidence Strength & Quality
24c. Relative Advantage
24d. Adaptability
24e. Trialability
24f. Complexity
24g. Design Quality & Packaging
24h. Cost

25. CFIR – Outer Setting
25a. Patient Needs & Resources
25b. Cosmopolitanism
25c. Peer Pressure
25d. External Policy & Incentive

26. CFIR – Inner Setting
26a. Structural Characteristics
26b. Networks & Communications
26c. Culture
26d. Implementation Climate
26d.1 Tension for Change
26d.2 Compatibility
26d.3 Relative Priority
26d.4 Organizational Incentives & Rewards
26d.5 Goals & Feedback
26d.6 Learning Climate
26e. Readiness for Implementation
26e.1 Leadership Engagement
26e.2 Available Resources
26e.3 Access to Knowledge & Information

27. CFIR – Characteristics of Individuals
27a. Knowledge & Beliefs about the Intervention
27b. Self-efficacy
27c. Individual Stage of Change
27d. Individual Identification with Organization
27e. Other Personal Attributes

28. CFIR – Process
28a. Planning
28b. Engaging
28b.1 Opinion Leaders
28b.2 Formally Appointed Internal Implementation Leaders
28.b.3 Champions
28.b.4 External Change Agents
28.c Executing
28.d Reflecting & Evaluating

TABI Survey coding
Goal: Apply the same coding domains across all 3 survey types in order to a) determine if one type of survey elicits more actionable data than others, and b) allow for complete characterization of activities related to the Blues Program.

We are not interested in activities related to Action for Children. Any responses related to AfC and not NYF can be ignored. Do double check as some responses may include information about both.

Initial step: Determine if the survey response is reporting one of three domains a) an **implementation strategy**, b) a **treatment adaptation**, or c) a **barrier/facilitator**. Note: Depending on the survey type, the free text response may report on multiple types of activities. You will apply certain sets of codes depending upon the response type.

Coding is guided by the following published frameworks/compilations:

1. Proctor et al. (2013) Implementation strategies: recommendations for specifying and reporting
2. Powell et al. (2015) A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project
3. Damschroder et al. (2009) Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science (CFIR)
4. Wiltsey Stirman et al. (2013) Development of a framework and coding system for modifications and adaptations of evidence-based interventions

Implementation Strategy reporting requirements:

1. Name it
    a. Did the respondent name a specific strategy used – look for action verbs (e.g. met, planned)
    Dichotomous yes/no check box (check if yes)
    Free text: Enter the strategy label from the Powell compilation that best matched the strategy referred to in the survey response. Enter each discrete strategy on a new line; information about each unique strategy should be entered in separate lines in subsequent questions
    If strategy not named, put unknown in strategy definition free text box
2. Define it
    a. Did the respondent provide a conceptual definition of the strategy used? This is different than the operationalization of the strategy
    Dichotomous yes/no check box (check if yes)
    Free text: Copy and paste the strategy definition provided in the survey response.
    E.g. I assessed that there was a need for a "program champion." The program champion's role is to help supervisors support their staff to recruit for groups and address any barriers that present themselves during the implementation process
3. Actor specified
    a. Did the respondent indicate who enacted the strategy? Note: this should not receive a yes if the response only indicates who was involved in carrying out the strategy, but does not specify who initiated or led the enactment of the strategy
    Dichotomous yes/no check box (check if yes)
    Free text: Assign a standardized label using codes 14a. – 14k.
4. Action specified
    a. Did the respondent use active verb statements to specify the actions, processes, or steps taken
    Dichotomous yes/no check box (check if yes)
    Free text: Copy and paste the action described

5. Action target
    a. Did the respondent indicate the intended target of the strategy (e.g. individual provider, intervention characteristic, setting)
    Dichotomous yes/no check box (check if yes)
    Free text: Assign a standardized label whenever possible. Use codes 14a. – 14k. for an individual or group target, use parent CFIR codes 24-28 if the target is intervention characteristic, process, or setting Decide based on description, purpose, and outcome. If not clear, indicate unknown and track in excel for Cara consensus
6. Temporality
    a. Did the respondent indicate when the strategy is used? Look for specific dates, or in relation to a key event (e.g. one week before training)
    Dichotomous yes/no check box (check if yes)
    Free text: capture time (e.g. 1 hour, distinguish if prior to group start or while running groups)
7. Dose
    a. Did the respondent indicate the dose of the strategy? This is usually expressed in time and discrete or ongoing (e.g. a one-time training that spanned two half-days; met hourly once a week for the duration of the Blues Program)
    Dichotomous discrete/ongoing check box
    Free text: Copy & paste the dose information from the survey response
8. Implementation outcome affected
    a. Did the respondent identify the implementation outcome likely to be affected by the strategy? (e.g. participant recruitment aimed to increase **acceptability** of the Blues Program among students & families)
    Dichotomous yes/no check box (check if yes)
    Free text: Assign a standardized label based on the Proctor taxonomy of implementation outcomes. If the outcome does not match one of these outcomes, copy and paste from the survey response
9. Justification
    a. Did the respondent provide empirical, theoretical, or pragmatic justification for the choice of implementation strategies (e.g. strategy may have been used in the Blues efficacy trial, provider successfully used the same or similar strategy to implement another EBP)
    Dichotomous yes/no check box (check if yes)
    Free text: Copy & paste the justification provided in the survey response
10. Stage of Implementation Completed
    a. Select from one of four standardized responses to characterize at what stage the strategy is: Planning, Budgeting, Delivering services, Sustained

Barriers/Facilitators

1. For each barrier/facilitator reported in the survey response, provide the standardized label from the CFIR compilation to the response (codes 24-28); if more than one barrier/facilitator is reported, enter each unique CFIR label in a new line. You do not need to provide the CFIR category label If the response describes a facilitator, put (facilitator) after the CFIR label in order to distinguish from barriers.
2. Code temporality

Treatment Adaptation

1. By whom are modifications made?
    a. Provide a standardized code 11a. – 11h. to characterize who is responsible for enacting the treatment adaptation. Note: this is different from who directed the treatment adaptation be made (e.g. an individual practitioner may be the one who actually modifies the treatment, but their supervisor is the person who directed the modification be made. You would apply the code 11a. individual practitioner/facilitator
2. When did modification occur?
    a. Provide a standardized code 12a. – 12d. to characterize at what phase the modification is made. For example, an activity that indicates that a modification was discussed and the decision was made to modify in advance of a Blues Program session, this response would receive code 12a. If a modification was made during delivery of the Blues Program without prior planning, this response would receive code 12b.
3. Were adaptations planned?
    a. Provide a standardized code 13a. – 13c. to characterize if a modification was planned or not. For example, a modification that describes plans to offer the Blues Program to younger students due to the age range of students in the school would receive code 13a. because it anticipates a need. A response that describes a plan to modify the treatment in order to react to something that happened in a previous session would receive code 13b.
4. Who participated in the decision to modify?
    a. Provide a standardized code 14a. – 14h. to characterize who decided to make the modification. This may be multiple people such as the treatment developer (14f) and the Implementation support personnel at New York Foundling (14b). This may different from the person who enacts the adaptation; for example, an individual provider may enact the adaptation even if they did not participate in the decision to make the adaptation.
5. What is modified?
    a. Provide a standardized code 15a. – 15c. to characterize who what aspect of the treatment or its periphery are modified. For example, 15a. content would be applied to changes made to the treatment itself, such as changing the number of sessions, or tweaking content to make it more relatable to students. Context modifications (15b.) could include changes to the population to whom treatment is offered (e.g. younger students) or the setting (e.g. offered at a satellite clinic rather than in the school).
6. At what level of delivery (for whom/what are modifications made?)
    a. Provide a standardized code 16a. – 16g. to describe for whom or what the adaptations are made. For example, changes to a Blues Program session would be at the group level (16b.) because it is a group intervention. If exceptions were made for one student to allow them to complete homework assignments in a different manner, this would be at the individual patient level (16a.) Because only one group was run at a time in each school, we will likely only apply to the group level if it is reported by an individual practitioner. NYF or the treatment developer may have decided on treatment adaptations during training that would be applied to all groups, we could apply the code 16f. Network level.
7. Context modifications
    a. Provide a standardized code 17a. – 17d. to characterize the changes made to the context in which treatment adaptations are made
8. Content modifications
    a. Provide a standardized code 18a. – 18m. to characterize the changes made to the content of the Blues Program. Note that code 18m. for drift is only when the intervention is stopped for part of a session or if the treatment was discontinued altogether; this definition comes from the Wiltsey Stirman (2013) framework.
9. Impact on fidelity/core elements

a. Provide a standardized code 19a. – 19c. to characterize the impact on fidelity the changes had. This could at times be difficult without turning to the Blues Program Efficacy studies. Minor changes, such as lengthening or shortening sessions, changing the number of sessions offered would be fidelity consistent. Changes that are indicated to be outside what was tested in the efficacy trials would likely be fidelity inconsistent.