Dissemination of an evidence-based telephone-delivered lifestyle intervention: factors associated with successful implementation and evaluation

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Abstract

To inform wider-scale dissemination efforts of health behavior change interventions, we need to better understand factors associated with successful implementation and evaluation in nonresearch settings. Using the experience of the Optimal Health Program dissemination (OHP), a 12-month evidence-based telephone-delivered intervention for physical activity, healthy eating, and weight loss, we provide a detailed account according to the reach, efficacy/effectiveness, adoption, implementation, and maintenance (RE-AIM) framework of the supports that were needed to facilitate the delivery and evaluation of the program in an applied community-based primary health care setting. Substantial initial research support including development of data collection procedures, staff training in intervention protocols, and ongoing support for fidelity of data collection and intervention delivery, as well as evaluation and reporting of outcomes was required. The RE-AIM framework can highlight common elements that will require attention from researchers to promote success of programs in applied settings.

Keywords

Dissemination, Translation, Weight loss, Physical activity, Diet, Intervention

INTRODUCTION

For telephone-delivered interventions targeting physical activity, healthy eating, and/or weight loss, there is a wealth of evidence from randomized controlled trials supporting their efficacy, in a range of target populations [1–4]. For such interventions to fulfill their potential for population health impact, it is imperative that they are successfully translated from research into applied community and health care settings [5, 6]. Promisingly, there are a small but growing number of reports of such dissemination studies which illustrate that telephone-delivered lifestyle interventions are both feasible to deliver and effective in “real-world” contexts [7–10]. In

Implications

Practice: Working in collaboration with research partners can help to ensure evidence-based implementation and rigorous evaluation.

Policy: Consideration of funding that supports the time required to establish and maintain research community/primary health care partnerships is required to enable larger-scale disseminations of evidence-based programs.

Research: Researchers need to be prepared to invest initial and ongoing time to help support the implementation and evaluation of evidence-based health behavior change interventions in applied nonresearch settings.

order to inform continued and wider-scale dissemination efforts, we need to better understand factors associated with successful implementation and evaluation in nonresearch settings.

While the broader translation and dissemination literature is replete with theories, models, and editorials [11, 12] describing factors hypothetically associated with bridging the “gap” between research and practice [5, 13, 14], there has been little systematic documentation and reporting of how the translation process actually unfolds in applied settings [15, 16]. In particular, there is limited reporting on the type of ongoing research support needed to underpin successful intervention implementation and evaluation in dissemination contexts [17].

In the case of the Optimal Health Program (OHP), an evidence-based telephone-delivered intervention targeting physical activity, healthy eating, and weight loss, successful dissemination was enabled by a strong research–primary health care partnership [18]. A “snapshot” evaluation conducted approximately 2.5 years following program initiation illustrated the program’s success in reaching disadvantaged groups and producing weight and associated behavior

changes [10]. To better understand factors associated with the success of the OHP dissemination, this paper uses the Reach, Efficacy/Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework to describe the supports provided by the research team in relation to program implementation and evaluation.

The RE-AIM framework [19] has been discussed and used extensively in the literature for guiding evaluations of health behavior interventions [16, 20, 21]. With its balanced focus on indicators of both internal and external validity, it helps to highlight factors particularly important to informing research translation (i.e., reach and representativeness of participants; feasibility and associated costs of intervention implementation) [13, 22, 23]. More recently, RE-AIM has been used to facilitate and evaluate the impact of dissemination efforts [13, 20, 23]. The aim of this paper is to highlight what is optimally involved on the part of researchers to drive and facilitate successful health behavior intervention implementation and evaluation in dissemination contexts. In the context of the OHP dissemination, we report on the use of the RE-AIM framework to identify appropriate program evaluation indices; for each RE-AIM domain, we also report on the role/activities of the research team in enhancing successful program implementation and evaluation.

METHODS AND RESULTS

Background of the study

The Optimal Health Program is the disseminated version of an evidence-based health behavior intervention, the Logan Healthy Living Program, evaluated in the context of a cluster-randomized controlled trial conducted in collaboration with the Greater Metro South Brisbane Medicare Local. Logan Healthy Living Program methods and outcomes have been described in detail elsewhere [24, 25]. In brief, it was a 12-month telephone-delivered physical activity and dietary intervention that resulted in significant behavioral change for primary care patients with type 2 diabetes or hypertension [25]. Systematic tracking of implementation enabled evaluation of dose-response [26] and cost-effectiveness [27]. Follow-up of participants 6-months after the end of intervention provided evidence for maintenance of behavior change [28].

As part of a State Health Department chronic disease prevention initiative developed to reduce the burden of disease on the State-funded health care system, dedicated funding was made available to try new and localized programs to better manage and prevent chronic illness within the community (for further details, see Goode et al. [18]). This dedicated funding provided the means for the Logan Healthy Living Program (rebadged as the OHP) to be taken up for delivery in 2009 by a community-based primary health care organization, now called the

Greater Metro South Brisbane Medicare Local (hereafter, Medicare Local). The Medicare Local is a not-for-profit organization that receives State and National funding to coordinate and integrate primary health care services to best meet the health needs of patients in surrounding local communities. All Australians are covered by a national Medicare system that provides universal free/highly subsidized medical coverage. At the time of uptake, the Medicare Local serviced 83 General Practices in Logan-Beaudesert, located in the state of Queensland, Australia. Three registered dietitians were hired by the Medicare Local to staff and deliver the OHP which was offered as a free program to primary care patients within the local area. Central to influencing the organizational readiness and decision by the Medicare Local to adopt the program was the commitment by the research team to provide intensive initial and ongoing support around implementation and evaluation.

Using the RE-AIM framework to guide evaluation

In collaboration with OHP staff, the research team developed an evaluation plan based on the RE-AIM framework. Table 1 includes a definition of the five RE-AIM domains and shows the data that were collected for each corresponding indicator. The table represents a simplified version of the detailed evaluation plan developed with the OHP staff, which included measurement tools (validated where available) and associated protocols for assessing each indicator.

What is not evident from Table 1 is the significant initial and ongoing support that was provided by the research team to maximize success of OHP program implementation and evaluation. This included development of data collection procedures, staff training in evaluation and intervention protocols, and ongoing support for fidelity of data collection and intervention delivery, each of which are described according to the relevant RE-AIM dimension below (and summarized in Table 2). The research team consisted of the principal investigator of the original randomized controlled trial (Professor level), two project managers from the original trial (both with Master's degree in Nutrition and Dietetics), and a postgraduate doctoral student whose dissertation centered on the translation and dissemination of the program. Support from the doctoral student formed a critical part of the resources drawn upon to drive implementation and evaluation of the OHP, and she became the main liaison for the Medicare Local. In general, contact was tapered, with more support provided initially whilst the program was being set up and our primary health care community partners were building capacity and expertise. Topics of focus or the areas that required more support changed as the program progressed, such that initial meetings were largely focused on recruitment pathways and later meetings focussed more on issues around evaluation of program out-

Table 1 | Data collected to enable evaluation according to the RE-AIM framework

RE-AIM dimension	Definition	Data collected to enable evaluation
Reach	An individual-level measure of patient participation and representativeness. Specifically, it is the absolute number, proportion of eligible people in the target population who take part in an intervention and the extent to which those participants are willing to participate and are representative of that population.	Number of patients referred Number of patients agreeing to participate Number of participant withdrawals and reasons for withdrawal Demographic characteristics of participants and nonparticipants
Effectiveness	The success rate of an intervention. Effectiveness is a measure of its performance under “real-world” conditions. In the context of dissemination, it is also the degree to which a program achieved success in terms of relevant outcomes when compared to the original more controlled evidence-based intervention [7, 16].	Objectively collected outcomes: weight, waist circumference, total, LDL and HDL cholesterol, blood pressure. Self-reported outcomes: physical activity, diet, sedentary behavior, adverse outcomes, collected at baseline, mid and end of program
Adoption	The proportion and representativeness of settings or program providers (e.g., worksites, health departments, general practitioners) that take up a program for delivery [19]. Adoption can be considered as an assessment of a program’s reach at the organizational level [29].	Number of practices and GPs contacted to participate Number of practices and GPs referring into the program
Implementation	Intervention fidelity or the extent to which a program is delivered as intended, or adheres to essential elements of the original evidence-based intervention [19].	Number of calls completed Duration of calls completed Participant use of program materials and satisfaction
Maintenance	Is a dimension that operates at both the individual and organizational levels; referring to the long-term effects of the program on its recipients and the extent to which a program becomes a routine part of an organization’s service delivery [29].	Objective and self-reported outcomes collected 6 months after the end of program; tracking of state health department funding for OHP

comes. Meetings were held fortnightly to monthly during the first year, bimonthly, and then quarterly in subsequent years, with the doctoral student available for weekly consultations via email or telephone when issues arose outside of scheduled meeting times.

Enhancing program reach

During initial consultations, the research team helped the OHP staff determine feasible recruitment rates and targets (i.e., a manageable and appropriate range of referrals received per week/month to aim for). During these initial planning consultations, the

research staff also helped plan recruitment strategies and protocols, including the development of user referral forms and pathways, designed to encourage referrals by time-poor practitioners. Monitoring of recruitment efforts and the rate of participants coming into the program was of central focus during initial meetings and was checked on an ongoing basis during scheduled support meetings.

Evaluating program effectiveness

At the outset of the OHP dissemination, an evaluation framework that considered both the adopting

Table 2 | Summary of research team activities to enhance success of the OHP across the RE-AIM dimensions

RE-AIM dimension	Key research team activity
Reach	Development and monitoring of participant recruitment strategies and targets
Effectiveness	Development of detailed evaluation plan Training staff in data collection procedures and monitoring of fidelity of data collection
Adoption	Development and monitoring of practice recruitment strategies and materials
Implementation	Training staff in program delivery Monitoring fidelity of intervention delivery
Maintenance	Assurance of ongoing research team support for implementation and evaluation

organization's key performance indicators and research needs was developed and agreed upon, as summarized in Table 1. The research staff were closely involved with initial database design, providing examples of previous databases and recommendations around data management and collection. The OHP staff received training in administering surveys and data tracking. In addition to scheduled support meetings, for the first 18 months of data collection (when the OHP staff were gaining expertise in data collection), approximately bimonthly reminders in the form of emails and telephone calls were put in place to encourage the OHP staff to collect participant outcomes at the required time points (i.e., as close to mid and end of intervention points as possible). Quarterly to biyearly checks by the research staff were made to ensure accuracy and completeness of data.

Enhancing OHP adoption by community primary care practices

The research staff provided advice on practice recruitment strategies, including how to advertise the program through appropriate network channels and how to approach primary care practices and practitioners about adopting the program (including program brochures and referral forms). Methods of follow-up (i.e., telephone calls with practice managers/nurses and practice visits) with adopting practices not subsequently referring patients into the program were also put in place with assistance from the researchers.

Supporting program implementation

The research team provided an initial 5-day (approx. 37 h) counselor training program covering program materials, core intervention elements including behavior change strategies (i.e., goal setting and self-monitoring), as well as program delivery and counseling approach (i.e., motivational interviewing). Examples of call scripts and checklist templates were provided. The research staff worked closely with the OHP staff to adapt and develop detailed counselor manuals and procedures, as well as the participant workbook and materials. Detailed description of the adaptations necessary to enhance "fit" of the program within the Medicare Local have been described elsewhere [18]. The research staff provided recommendations around monitoring of program delivery and process outcomes (to ensure that data tracking included number of call attempts, calls completed, and length of calls).

Initial fortnightly meetings with counselors to monitor intervention fidelity and intervention tracking and to address quality control were held for the first 6 months of program delivery. Monthly to bimonthly consultation meetings with counselors to discuss intervention updates, issues, and case conferencing were held for approximately the first year and a half. Regular phone and email contact to support imple-

mentation and troubleshoot was provided on an ongoing basis.

Enhancing the likelihood of OHP maintenance

Assurance of ongoing support and assistance in analyzing data and reporting of outcomes was important to the continuation of the OHP. Extraction, cleaning, analyzing, and reporting data were handled almost exclusively by the research team. Evaluation of the program formed a major component of the doctoral student's dissertation research; the level of support provided was necessary due to limited knowledge, skills, and infrastructure on the part of the Medicare Local, as well as the demands of the PhD. The ability to report on the success of the program was critical to helping the Medicare Local advocate for and secure continued funding for the program.

DISCUSSION

This account of the supports required to facilitate the successful dissemination of an evidence-based lifestyle intervention within the real-world is one of few within the literature [8, 17]. Using the RE-AIM model, we highlighted what is optimally involved on the part of the researchers to facilitate successful dissemination efforts. Evidence from our experience demonstrates the importance of substantial initial and ongoing research support around program uptake, delivery, and evaluation. After the initial effort in adapting research materials [18] and training staff in research protocols, it was necessary to provide intensive and ongoing support around implementation, evaluation, and related quality control. Indeed, it was evident that even after providing a highly detailed evaluation plan, training OHP staff in evaluation procedures (i.e., how to administer questionnaires and when to administer them), and supporting the development of a database to track and store outcomes, rigorous evaluation of the OHP would not have occurred without intensive research team support [10]. The focus of contacts and support changed over time; the Medicare Local largely gained independence in program delivery, such that support around aspects of referral and implementation became minimal. However, ongoing support around evaluation was required, with intensive support largely resourced by a postgraduate student whose dissertation focused on the evaluation of the disseminated program. Postgraduate support was also an integral part of the evaluation of the Get Healthy Service—a telephone-delivered lifestyle program currently being offered as a government health department-funded statewide service in three other Australian states [9].

Similar to other dissemination studies, one of the main challenges faced during the conduct of the OHP dissemination was the systematic collection and tracking of outcomes for evaluation [7, 30]. This

may have been due to the service delivery orientation of community primary health care staff (which often does not emphasize evaluation). Further, initial key performance indicators outlined by the funding body emphasized the importance of call delivery (i.e., to meet performance targets, the OHP staff were expected to deliver a minimum number of calls per week). Anecdotal evidence suggests that the time involved collecting and entering evaluation data “got in the way” of meeting program delivery targets. Regular support from the research team was needed to encourage the OHP staff to collect participant outcomes at the required time points, and to ensure accuracy and completeness of data collection and entry. When the program came up for formal funding renewal, the OHP staff were asked to provide evidence for program effectiveness; researcher support was necessary to abstract and analyze the required data, which helped to demonstrate the success of the program and secure recurrent funding. If the evaluation had shown the program to be unsuccessful, such evaluation support would have been central to making decisions to redistribute resources to more effective programs. This, in turn, highlighted not only the importance of systematically collecting participant outcomes, but also the potential need to pare down evaluation surveys to form a minimum and more manageable data set to enable reporting on key effectiveness outcomes without substantial assistance from the research staff. In future dissemination efforts, particularly during the early stages of development and capacity building, when adopting partners are likely to be less concerned with program evaluation (and the necessary structures such as a user-friendly database or data storage systems), involvement in and dedicated funding for database development and testing by researchers may require prioritization. In our experience, working with a less-than-ideal database was the most time-intensive component of evaluation support.

After approximately 3 years of operation, and the successful procurement of an additional 5 years of funding, issues of costs and cost-effectiveness became important in the context of the long-term sustainability of the OHP. The program is currently the most expensive of those offered by the Medicare Local, and ways to streamline program delivery to reduce costs and increase the number of participants successfully completing the program have become priorities. Examples from other dissemination studies show that adopting organizations are likely to change programs to make them more viable [30–33], including shortening their duration [8]. Similarly, the Medicare Local is considering offering the OHP as a 6-month (rather than 12-month) service. However, there is concern about the impact of this on the magnitude of weight loss and behavior change, as findings from the OHP suggest further improvement in outcomes between 6 and 12 months [10]. Similarly, related systematic reviews [1, 2]

support the need for longer-term interventions to enhance outcomes. Consultation from the research team will be needed to provide data to inform these decisions and ongoing involvement will be required to ensure that associated adaptations to implementation and evaluation protocols are evidence based.

In terms of informing the broader literature on dissemination of interventions, this study clearly illustrates the magnitude and ongoing nature of research team support needed to promote successful implementation and evaluation. Future studies would do well to systematically collect details concerning the nature of both scheduled and impromptu support meetings. If evidence-based interventions, when translated from research to practice, are to be sustainable, it will be important to set them up for long-term success. This involves training staff in adopting organizations in the ability to evaluate and report outcomes to show the benefits of such programs (which will likely be crucial to secure ongoing funding). Organizational level support for the associated time required to do this will be critical. Researchers will also need to view such support as “part and parcel” of dissemination research. This poses a unique challenge given that typical research funding mechanisms do not support ongoing researcher time in these contexts.

Recommendations

- To support wide-scale dissemination of evidence-based health behavior change interventions, researchers need to design such interventions with dissemination in mind [20]; this involves building strong research community/health care partnerships at the outset, as well as considering feasibility of intervention delivery in applied contexts.
- Increasing recognition and funding of dissemination research is needed; this would allow for the researcher time to work with community/health care partners to adapt evidence-based health behavior interventions for delivery in applied settings, and for ongoing research support for implementation and evaluation. An extra year of funding at the end of a randomized controlled trial and/or a year at the beginning of a dissemination study would provide concrete support for this.
- Research support for implementation and evaluation in dissemination contexts is one part of a broader dissemination research agenda. This broader agenda includes addressing questions important to further informing the translational evidence base, including the following: methods for improving adoption at the organizational level, methods for increasing participant reach, comparative effectiveness evaluations of interventions of different contact intensities and duration, and evaluation of cost-effectiveness means of promoting behavioral maintenance.

CONCLUSION

In this still emerging area of research, in order to enhance the translation and dissemination of evidence-based health behavior change interventions to practice, more attention to documenting and reporting of the supports required to facilitate success is needed. It may be that the process is largely idiosyncratic in each case, potentially making it difficult to generalize findings across studies. However, unless there are more published accounts of the process, similarities will remain unknown. The RE-AIM framework, applied in this example, highlights potentially common elements that will require attention from researchers to promote success of programs in applied settings.

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