Measuring Fidelity of a Feedback Informed Treatment Pilot Program: A Quality Improvement Project

Elizabeth Frost, BSN RN

Oregon Health & Science University School of Nursing

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Submitted to: Kasey McCracken DNP, PMHNP- Chair

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Background: Progress feedback models, including Feedback informed treatment (FIT), are evidence-based models for using client feedback to improve progress toward therapeutic goals in the behavioral health setting. These models are effective only when implemented with fidelity to the model. **Local problem:** A private Outpatient Clinic (OPC), with 23 clinicians serving over 1,000 clients, is in the process of implementing FIT, including a small pilot program of five clinicians. OPC did not have a systematic means of evaluating fidelity to the FIT model during this pilot program. **Methods**: This project uses the Conceptual Framework for Implementation Fidelity (CFIF) in conjunction with Plan-Do-Study-Act (PDSA) cycles of iterative improvement, as described by the Institute for Healthcare Improvement Model approach to Quality Improvement (IHI-QI). A process for evaluating and describing fidelity implementation of FIT during the pilot program, as well as eliciting clinician feedback on barriers to fidelity is described. **Interventions:** A mixed-methods approach was used to collect quantitative data describing use of FIT tools over time with identified client population, and qualitative data from structured group interviews with participating clinicians. These data describe execution of the key fidelity components identified in this project. Evaluation included a description of fidelity to FIT at this early implementation stage and identified opportunities to improve fidelity moving forward.

Problem Description

In the last several decades, the field of mental health has seen an increased effort to integrate progress feedback models into therapeutic practice. This effort occurs in the context of both national and local mental health crises; at 731,000 adults in Oregon with a mental health condition in 2021, Oregon has one of the highest rates of mental illness in the U.S. (National Alliance on Mental Illness [NAMI], 2021; Oregon Health Authority [OHA], 2024). Psychotherapy is a key intervention for mental health disorders, widely recommended as a first-line treatment by practice standards and guidelines (Leichsenring et al., 2022). As a result, high-quality and evidence-based treatment is a foundational component of addressing the mental health crisis. Unfortunately, it has been found that therapeutic practitioners are unlikely to improve their patient outcomes after entering practice (Germer et al., 2022). In other words, experience alone does not increase clinician efficacy.

It is in this context that progress feedback models, including Feedback Informed Treatment (FIT), have increased in use, and been established as an evidence-based means for clinicians to improve patient outcomes (de Jong et al., 2024). Progress feedback models use longitudinal metrics over the course of treatment to assess progress toward treatment goals and inform the treatment plan (de Jong et al., 2024). FIT is a progress feedback model, for which the evidence-base is well established, including by previous Doctor of Nursing Practice (DNP) projects (Delgadillo et al., 2022; Pierpont, 2024; Thelin, 2021). Briefly, FIT utilizes surveys to collect real-time client feedback, which the clinician uses to adjust treatment (Appendix A) (Bertolino et al., 2012). The efficacy of FIT and other progress feedback models is dependent on fidelity of implementation; their evidence as effective interventions is demonstrated only when these models are utilized to fidelity (O'Leary et al., 2021; Wolk et al., 2022).

The outpatient clinic (OPC) where this project takes place is in process with implementation of FIT. Currently, the clinic is poised to initiate a small pilot program of several clinicians to begin utilizing FIT with select clients. In this pilot, selected clients complete two surveys each session: the Outcome Rating Scale (ORS) administered at the beginning of the session and the Session Rating Scale (SRS) administered at the end (Appendix B). As clinical sites consistently struggle to implement progress feedback to fidelity, it was anticipated for the OPC to encounter barriers and challenges to fidelity implementation (de Jong et al., 2024). In particular, the pilot program lacked systematic means of evaluating utilization of FIT by clinicians. This quality improvement project seeks to support the implementation fidelity of FIT by gathering these data so that the OPC may better address barriers to fidelity.

Available knowledge

FIT is an evidence-based model for improving the quality of therapeutic treatment, as summarized by a meta-analysis by Delgadillo et al. (2022), which found that use of FIT reduced the gap in outcomes between more and less effective therapists. Randomized control trials have found that clients treated with FIT had less severe symptoms and were less likely to drop out of treatment (Delgadillo et al., 2018; Janse et al., 2020). These recent findings are consistent with the last decade of literature, which Tam et al. (2017) summarized in a systematic review concluding that FIT increases beneficial outcomes for youth clients.

There is relatively little literature, however, examining the impact of implementation fidelity on the outcomes provided by FIT as a specific model. Due to this gap, this literature review was expanded to include other progress feedback models. In a narrative review on the use of progress feedback, de Jong et al. (2024) describe a substantial reduction in the effect size of the intervention when clinicians do not use feedback as intended. In a systematic review of

measurement feedback systems, Rognstad et al. (2023) describe inconsistent outcomes across studies, which the authors attribute in large part to a widespread lack of fidelity implementation and fidelity measurement. In their JAMA Psychiatry narrative review of Measure-Based Care, Lewis et al. (2019) describe fidelity to the model as a key implementation outcome and provide guidance on criteria and techniques to operationalize fidelity monitoring. In summary, the literature is clear that progress feedback models, like FIT, only produce consistent benefit when implemented to fidelity. At the same time, clinical sites that adopt progress feedback models consistently face barriers to fidelity implementation (de Jong et al., 2024; Rognstad et al., 2023).

Fidelity can be understood as the extent to which interventions are delivered as planned (O'Leary et al, 2021; Toomey et al., 2020; Walton et al., 2020). The measurement of fidelity is a critical and often overlooked element of adopting a new intervention (Walton, 2017). Measuring fidelity helps to increase efficacy of an intervention by ensuring that it remains true to its evidence-based design (Walton et al., 2020; Toomey et al., 2020). The Feedback Readiness Index and Fidelity Measure (FRIFM) model emphasizes the importance of slow adoption and fidelity to FIT, but does not provide a tool for measuring implementation fidelity. While the gold standard in implementation fidelity is to record and review all sessions, this was determined to be impractical for this project. Instead, a tool for measurement of fidelity implementation was identified; developed by Carroll et al. in 2007, the Conceptual Framework for Implementation Fidelity (CFIF) is one of the most commonly used frameworks in implementation science (Appendix C) (McGee et al., 2018). Based on this review, FIT is an evidence-based progress feedback model, which improves therapy outcomes. Its successful adoption depends on fidelity to the FIT model during implementation, which may be measured using the CFIF.

Rational

In this project, the definition of fidelity to FIT will be understood as the utilization of results from the ORS and SRS surveys to inform treatment decisions (Bertolino et al., 2012). This definition was found by utilizing the Conceptual Framework for Implementation Fidelity (CFIF) (Appendix C) (Carrol et al., 2007). The CFIF is an implementation fidelity framework that is widely used in improvement science (Swindle et al., 2022; Toomey et al., 2020). The CFIF framework as applied to this project highlights key Adherence Components of consistently completed ORS/SRS surveys, regular review of survey results, and use of survey results by the clinician to inform treatment (Appendix D).

This DNP project's focus is fidelity of implementation of an existing, evidence-based QI model. As such, this project stands on the shoulders of the clinic's organizational work and the work of two previous DNP projects. Important contextual frameworks include understanding Feedback Informed Treatment (FIT) as an evidence-based progress feedback model for the delivery of quality mental health care; developed by the International Center for Clinical Excellence (ICCE) (Bertolino et al., 2012). ICCE provides a six-sigma quality improvement process to accompany adoption of FIT, as outlined in their implementation tool the Feedback Readiness Index and Fidelity Measures (FRIFM). The FRIFM includes five stages for an organization to follow while adopting FIT: exploration, installation, initial implementation, full implementation, and sustainment (Appendix E). The clinic is currently in the installation phase of the FRIFM QI framework, which includes a small pilot program.

Considering the focused nature of this project, the Institute for Healthcare Improvement-Quality Improvement (IHI-QI) model was used to best provide a targeted QI improvement process. The IHI-QI model was developed for projects in healthcare settings specifically, it is data-based and focused on continuous change over time (Scoville et al., 2014). The project

consisted of one Plan-Do-Study-Act (PDSA) cycle, as the iterative PDSA model is effective in structuring quality improvement with small sample sizes, such as the group of pilot program clinicians (Etchells et al., 2018; McNicholas et al., 2019).

Specific Aims

The final adjusted AIM for this project was developed after an initial round of data collection: This project aims to evaluate the fidelity of implementation of FIT by pilot program clinicians, with the goal that each client who is introduced to FIT will complete minimum one FIT survey(s), for at least 75% of the sessions that client attends during one PDSA cycle.

Context

OPC is a private mental health care organization, consisting of 23 clinicians who provide outpatient-level care to clients of all ages. Clinical staff is comprised of 11 PMHNPs, nine LPCs, two LMFTs, and one LCSW. Two comprise the leadership team: a PMHNP is the director of the organization, and an LPC is the head of operations. Operational and administrative expertise are provided by four administrative specialists, one operations specialist, one operations coordinator, and one billing specialist.

Services include individual and group treatment modalities, with clients ranging from school-age children to older adults. The OPC serves over 1,000 clients in Oregon. Clinicians represent a wide range of specializations, and work on a commission basis with personal discretion regarding caseload and scheduling. The clinic is in-network with numerous private insurance companies and Medicaid coordinated care organizations (CCOs). Two of these CCOs are providing incentive payment and consultation for the implementation of FIT.

The FIT working group consists of three members, the two-person leadership team and DNP student. The working group was originally planned to add three additional pilot program

clinicians, ultimately there were five pilot program clinicians; two PMHNPS, two LPCs, one LMFT. These clinicians were volunteer participants who had either previously attended FIT training or attended the ICCE FIT training in November. The POC is engaged in additional installation efforts, including hosting client focus groups, ongoing consultation with a CCO FIT consultant, and integrating use of OpenFIT into their operation.

Interventions

The OPC's primary QI goal is the adoption of FIT, specifically executing the installation phase of the FRIFM adoption process. This project supported this goal by working to improve fidelity of implementation of the FIT model in the OPC pilot program. The pilot program follows the FRIFM recommendations for the installation phase of FIT adoption; it consists of five volunteer clinicians who began utilizing FIT by administering the ORS and SRS surveys in session and using the results of these surveys. The ORS measures progress toward treatment goals with subjective ratings for client distress and functioning and is administered prior to or at the beginning of each session. Results are charted into a line graph to measure patient progress, which is reviewed with the client. The ICCE does not provide specific guidance for frequency of reviewing results, instead encouraging clinicians to integrate survey results into treatment planning conversations (Miller et al., 2011). The SRS is used in tandem with the ORS and is administered at the end of each session; it provides subjective rating scales to capture the strength of therapeutic alliance. FIT recommends that clinicians score the SRS in real time at the end of session to allow discussion of any rupture in therapeutic alliance (Miller et al., 2011).

Pilot program clinicians selected clients to participate in FIT, with emphasis on new clients as FIT is demonstrated to be most effective in the first six months of treatment (Miller et al., 2011). The selected clients were identified by clinicians upon initiation of the pilot program and

provided to the DNP student as the target population. The duration of this project is one PDSA cycle, consisting of 12 to 17 weeks, depending on the clinician's pilot start date (Appendix F)

Efforts to promote fidelity to the FIT model include attending the ICCE provider training session on the FIT model prior to pilot program initiation, as well as access to ICCE materials for the implementation of FIT. Clinicians were advised of the importance of fidelity to successful implementation, as well as the working definition of fidelity. Administrative supports were provided by Head of Operations, who onboarded clinicians to OpenFIT, an online FIT program.

Study of Interventions

The project follows a mixed-methods approach, designed to capture process data to determine the rate of survey utilization, as well as qualitative measures meant to capture pilot program clinician experience of fidelity utilization of FIT. Data collection methods for rate of survey implementation included review in OpenFIT of identified client appointments for completion of ORS and SRS surveys. Pre- and post- intervention Likert surveys were originally planned to capture outcome data, this was discarded in favor of two structured interviews at weeks seven and week 18 of the pilot program. The interviews provided longitudinal, qualitative outcome measures of integration of FIT surveys into client treatment.

Measures

The primary outcome measure of this project is the fidelity of utilization of FIT surveys during the pilot program portion of the FRIFM installation phase of FIT adoption. Using the applied CFIF model (Appendix D), this project was originally designed to measure the Essential Component of "using survey results to inform treatment". The Adherence Components of coverage and frequency, i.e. survey completion rates, were conceptualized as secondary process measures. As the pilot progressed, however, it became clear that the collection of sufficient

longitudinal survey data is a prerequisite for fidelity use of FIT and the measures were adjusted to reflect this new understanding. Furthermore, the originally planned pre-post clinician surveys were discarded due to the heterogeneity of clinician start times, techniques for FIT introduction, and small number of clients (n=1 to n=6 per clinician). Instead, two structured interviews were conducted in week seven and week 18 to collect longitudinal, qualitative data.

The data review of OpenFit was conducted to address the outcome measure of 'percent of sessions attended by each target client where they completed one or both surveys during the PDSA cycle'. These data were collected by reviewing the completion of ORS and SRS surveys in OpenFit and sessions attended on clinician's schedule. Outcome measures produced include: percent sessions with no FIT surveys completed (out of sessions attended by client), percent of sessions with just SRS or ORS completed (out of sessions attended by client), and percent of sessions with both ORS and SRS completed (out of sessions attended by client). Completion was measured as yes/no, because all surveys administered had 100% of items answered.

The relationship between these quantitative data and the applied CFIF Essential Component (Appendix D) of 'survey results informing treatment' was captured by qualitative data collected in two structured group interviews with clinicians [N=5] (Appendix G). Interview questions asked clinicians to describe their use of FIT in session and in making treatment decisions. Data from these interviews was de-identified and organized by themes.

Process measures were calculated using the same quantitative dataset. These include: the percent of all possible surveys completed by each clinician, how long FIT participation was sustained per client for each clinician, and the percent of clients who completed surveys at more than one session, compared to the number of clients to be introduced to FIT and the number of

clients originally selected for FIT. Balancing measures were captured qualitatively in the structured interviewed to identify the barriers and challenges to FIT implementation.

Analysis

The outcome and process measures were analyzed by examining completion rates by clinician (Appendix H), creating run charts of completion rates over time (Appendix I), and creating crosstabs of number of surveys completed by client (Appendix J). Finally, qualitative data is summarized with relevant quotations representing themes identified (Appendix K).

Ethical Considerations

Data gathering in this project protects client information by focusing on clinician experience, using de-identified data, and storing data on a secure server. The data collection process did not entail viewing any client clinical information, and recorded data did not include any identifying client information or survey data beyond completion. Data collection was completed with access to OpenFit. Structured group interviews were scheduled in advance and integrated into existing FIT meetings to avoid disruption to clinic operations. Individual clinician ORS/SRS survey completion rates were de-identified before being shared with the OPC. This project was submitted to the OHSU Institutional Review Board (IRB) and it was deemed "not research"; the IRB study number for this project is STUDY00027660.

Results

As shown in Appendix L, of the total clients originally identified for FIT, 61% were introduced to FIT (from n=34 to n=12). Of those, 41% (n=5) completed surveys in more than one session. From the group of 12 clients introduced to FIT, 25% of selected clients (n=3), completed FIT survey(s) at ≥75% of their sessions (Appendix J). Clinicians One, Three, and Four all had a single FIT client who completed at least one survey at 75% to 100% of sessions,

over seven to 12 weeks, respectively. Clinicians Two and Five had more than one client, but almost no longitudinal data. Of the six clients that Clinician Two had complete initial FIT surveys, only one client completed a follow-up set of surveys. Clinician Five was similar, administering initial surveys to three clients and completing only one set of follow-up surveys.

As shown in Appendix H, 37% of all possible surveys (n=152) were completed across all pilot clinicians. By clinician, those clinicians with only one FIT client had 75% to 100% surveys completed of all possible, the two clinicians with multiple FIT clients had 17% and 20% surveys completed of all possible (Appendix H). The PDSA cycle varied in length by clinician, based on their earliest client start date as shown in Appendix F. Each client's pilot start date was determined by the date that their OpenFIT account was created. Time between their 1st FIT survey completed and last FIT survey completed is displayed in Appendix J. The clinicians with one client only had FIT participation durations of seven weeks, 10 weeks, and 11 weeks. Of the multiple FIT clients for clinicians Two and Five, the longest FIT participation duration was one week. Clinician survey completion over time for all clients is shown in Appendix I. As displayed there, Clinician One's client left care after week nine, Clinician Two's survey completion drops to 0% after week 11, Clinician Three's survey completion fluctuates but was ongoing at the end of the project, Clinician Four had 100% survey completion and was ongoing at the end of the project, and Clinician Five's survey completion dropped to 0% at week 10.

Key themes emerged from the structured interviews as summarized in Appendix K. The first structured interview at week seven highlighted the challenges that clinicians faced in navigating the logistical/administrative challenges of administering surveys via OpenFIT, integrating the surveys into sessions with already limited time, and navigating the interpersonal awkwardness of introducing feedback surveys to their clients. As summarized by one pilot

clinician, “It’s ideologically and abstractly useful, but in practice it’s a little more stressful”. Themes also emerged based on two primary implementation philosophies, three clinicians (One, Three and Four) selected one client based on specific treatment challenges they hoped to address with FIT. Clinicians Two and Five focused on the pilot primarily as an implementation process and rolled it out with multiple clients. The difference was summarized by Clinician Two; “The thing I’m hearing from y’all that’s making me shift—because I’ve been focusing on ‘bear with me, this is a pilot program,’— is making sure than I’m tying it in with something related to our work specifically, which might make it more like it’s not a waste of time.”

The second structured interview was completed at the end of the PDSA cycle, with the pilot planning to continue after this project. In this interview, the challenges described previously (OpenFIT logistics, time, awkwardness) were ongoing. Clinicians with more than one client cited overwhelm from these factors, and both described stopping administering the surveys with a plan to resume after problem solving with other FIT clinicians: “over the past month as I have lost admin time . . . I have been telling myself, I’m not dealing with this until the FIT meeting, so I came into this with the expectation of problem solving”. Clinicians Three and Four continued to use FIT with their client and described its application to specific treatment goals, Clinician Two decided to transfer their client’s care, partly based on reflections from FIT results. Clinicians described their own attitudes toward FIT as informing client engagement and FIT adherence: “I still have this barrier of a digitization of therapy . . . I know it’s my own reaction, and I feel like when I present it, I have a double signal and that gets picked up”. Finally, all clinicians described the structured interviews as a resource for collaborative learning and requested more frequent group consultation going forward, “I think the consult would keep me more consistent, keep it at the forefront and about what the data means”.

Summary

Relevant to the specific aims of this project include the key finding that three of 12 (25%) of selected clients completed FIT survey(s) at ≥75% of their sessions during this PDSA cycle (Appendix J). As shown in the applied CFIF (Appendix D), the generation of longitudinal data by regular completion of surveys over time is necessary for the fidelity use of FIT. Aligned with these quantitative findings, the clinicians with survey completion in 75% or more of their sessions with FIT clients qualitatively described integration of treatment goals with use of FIT surveys, and their process measures demonstrated more sustained use of FIT. Of note, the clinicians with only one FIT client all had the highest survey completion rates, longest FIT participation, and most clearly described integration of FIT use and client treatment. In contrast, the clinicians who described themselves as eager to dive in and focus on widespread roll-out of FIT reported the significant challenges of survey administration logistics, limited session time, and interpersonal awkwardness as prohibitive to sustained participation despite their personal investment in FIT as a model. Overall, the particular strengths of this project include integrating qualitative data to provide narrative understanding of the quantitative data.

Interpretation

The identified challenges—administrative burden in administering surveys, limited session time, and navigating the interpersonal introduction of FIT to clients—were consistent with barriers identified in the literature (O'Leary et al., 2021). What's more, the connection between these challenges and inconsistent survey completion is consistent with the implementation science literature, which describes most clinical sites struggling with fidelity use of evidence-based care models during implementation processes (Wolk et al., 2022).

By measuring fidelity to FIT during the very early stages of implementation, this project was able to identify key learnings for implementation of FIT at the OPC. The first recommendation is to start small; clinicians should be encouraged to start by selecting one client to integrate FIT into their treatment. Based on the findings of this project, this change will support the prioritization of generating longitudinal data over sporadic use of surveys across many clients. Generation of longitudinal data is fundamental to progress feedback models like FIT, which depend on measure of client progress over time (Rognstad et al., 2023). Reducing administrative burden is another benefit for clinicians starting with one initial client. Finally, selecting a single initial client encourages consideration of their treatment needs and the integration of treatment goals with FIT. This finding aligns with the clear connection the literature outlines between FIT and treatment planning for fidelity (Janse et al., 2020).

The second recommendation is to provide more opportunities for collaborative learning between pilot clinicians. During the structured interviews, it quickly became clear that part of the value of that time was in collectively sharing experiences, problem solving, and encouragement. Per the ICCE manuals, regular supervision is a component to the fidelity use of FIT that was originally planned by the OPC to be rolled out later in the installation process (Bertolino et al. 2012). Based on the findings of this project and the request of pilot clinicians, regular group consultation would provide great benefit from the start of future pilot programs.

Limitations:

Limitations to this quality improvement project include its ungeneralizable nature, due to the small number of participating clinicians (n=5) and subsequently participating clients (n=12). Further limitations include the imprecise design of the intervention, especially the variability of clinician start times, techniques for FIT introduction, and administration methods of FIT surveys.

In addition, the imprecise design of the structured group interviews led to challenges with gathering each clinician's experience in equal measure. Efforts to minimize these limitations included a long PDSA cycle so that even the clinicians who started last participated for 12 weeks. Although the small number of participating clients impacts this project's generalizability, it also contributed to the project's findings based on number of participating clients per clinician. Finally, the use of qualitative data was designed to capture nuances not otherwise shown.

Conclusions

This QI project used a mixed-methods approach to measure the fidelity to FIT by participating clinicians during the OPC's first pilot program. The project was collaboratively designed with the OPC to support FIT implementation per FIFRM criteria and to measure fidelity as defined by the applied CFIF. Future PDSA cycles may include utilizing a similar study design to concurrently measure the fidelity of the same five clinician pilot program and the second pilot program, planned to begin in March 2025. It is anticipated that recommendations from this project will encourage regular collaborative learning via monthly group consultations and a shift in clinician approach to focus on longitudinal data for one initial client before expanding to include multiple clients. On the systems level, the measurement of fidelity to evidence-based models like FIT is a critical element of quality improvement, and further exploration is needed to increase the feasibility of fidelity measurement across care settings.

Appendix A: FIT One-Pager (CareOregon, 2024)

CareOregon

Feedback Informed Treatment

What is FIT?

Feedback Informed Treatment, or "FIT", is an evidence-based approach that involves regularly measuring client-rated outcomes and client feedback on the provider alliance through the use of client-rated outcomes tools. FIT can be used across modalities, in a variety of settings, and has been successfully implemented internationally in diverse cultures.

Although there is overlap between FIT and measurement-based care, FIT is more than just the use of an outcomes tool. Organizationally, it is a transformative initiative, which creates a culture and way of being that centers feedback and authenticity. From a client perspective, it is a collaborative process between client and practitioner that centers client worldview, culture, needs, and preferences. Client feedback and outcomes data is then used in session and consultation to inform care, and aggregate data is used to inform both individual professional development and larger improvement initiatives.

Why FIT?

Organizations choose to implement FIT for a variety of reasons. FIT operationalizes client-centered care by firmly anchoring services in client voice, and supports the equity-related work of ensuring clients are empowered and respected while receiving services.

There are decades of research to support the use of FIT, showing that implementing FIT can improve client outcomes, reduce attrition rates, and shorten length of care. In a time when need for services outpaces supply, FIT can help ensure that care is as effective as possible for clients to reach their goals.

Successful FIT Implementation

FIT is implemented through a staged process, beginning with exploring how FIT aligns with your organizational mission, vision, and values, and ending with FIT becoming a fully integrated part of organizational practice and culture.

FIT implementation can take 3-7 years to complete, and data has shown that the quality of implementation is a key factor in both sustainability and measurable benefits to consumers. CareOregon offers a multitude of supports related to FIT implementation designed to help organizations in this process – we'll help you learn more and be successful!

Want to learn more?

- **CareOregon** provides training, database support, and consultation free of charge to Mental Health Providers with Jackson Care Connect and those contracted through Health Share - CareOregon. For more information or to get involved, please contact FIT@CareOregon.org
- **The International Center for Clinical Excellent (ICCE)** is an international organization dedicated to FIT, and their website includes a variety of resources and research about FIT and FIT implementation: http://centerforclinicalexcellence.com
- The ICCE also has a YouTube channel with tips, practitioner interviews, and more: https://www.youtube.com/@ICCETV

Appendix B: Outcome Rating Scale (ORS) and Session Rating Scale (SRS)

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

The Heart and Soul of Change Project

https://heartandsoulofchange.com

(DeSantis et al., 2016)

Session Rating Scale (SRS V.3.0)

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard by the therapist, understood, and respected.	I----------I	I felt heard by the therapist, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.	I----------I	We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.	I----------I	The therapist's approach is a good fit for me.

Overall

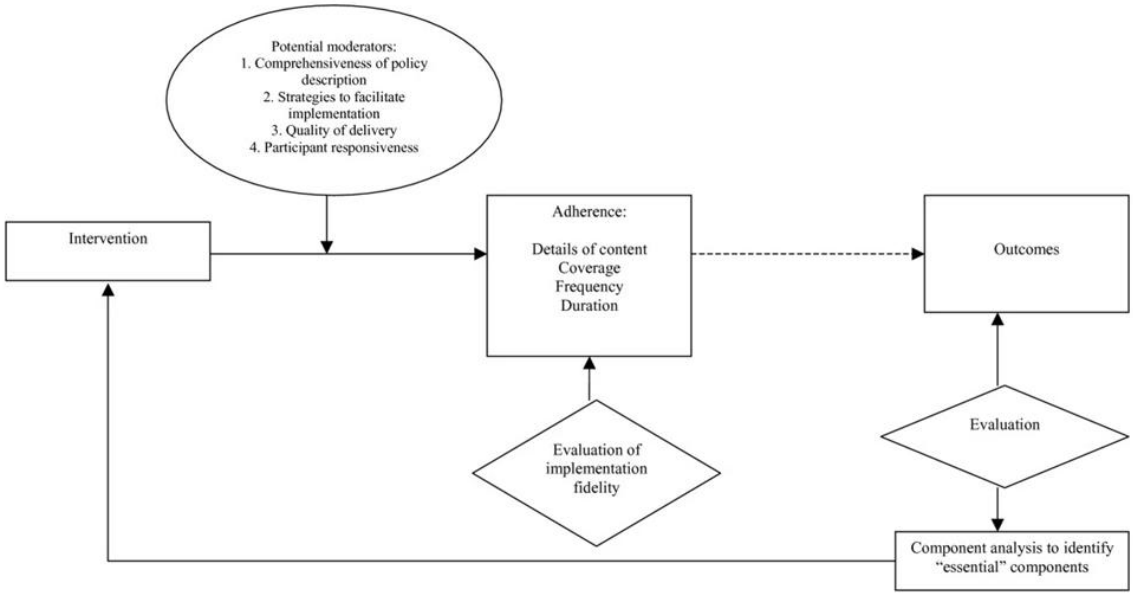
There was something missing in the session today.	I----------I	Overall, today's session was right for me.

Institute for the Study of Therapeutic Change

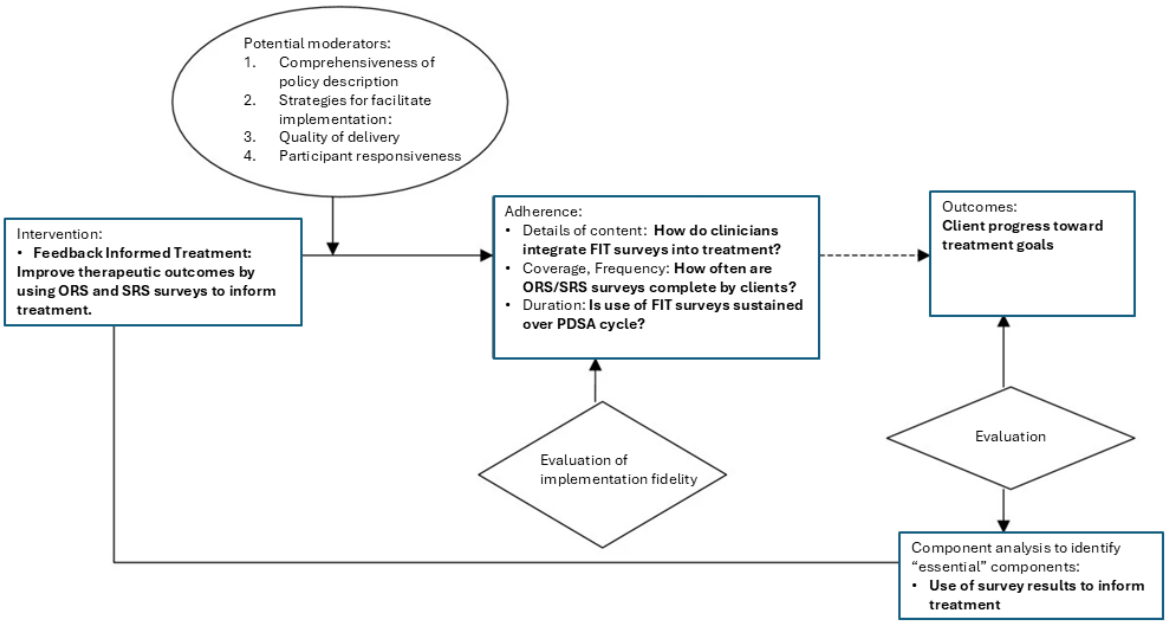
www.talkingcure.com

(Murphy et al., 2020)

Appendix C: Conceptual Framework for Implementation Fidelity (CFIF); (Carrol et al, 2017)



Appendix D: Applied CFIF: Fidelity to FIT during Pilot Program



Appendix E: FRIFM Installation Phase Description from ICCE; (CareOregon, 2024)

CareOregon Outcomes Based Care

FIT Incentive Program
Installation Stage

1. Exploration Stage	2. Installation Stage	3. Initial Implementation Stage	4. Full Implementation Stage

Overview

The **Installation Stage** is focused on developing infrastructure, running small pilots, getting feedback from pilot staff and clients, and developing the supports necessary for long-term implementation to be successful. Key tasks include the development of training materials, policies and procedures, and workflows for FIT processes. At the conclusion of the pilot, a decision is made to either continue to expand FIT beyond the pilot and throughout the organization or to stop the implementation process.

FIT eligible providers who choose to participate in the FIT Incentive Program and are in the **Installation Stage** of implementation are incentivized to complete the following elements.

☐	**Element 1**	**SOI Checklist** Attest to current Stage of Implementation using the **FIT SOI Checklist**	10% of total score
☐	**Element 2**	**FRIFM Worksheet** Complete and submit the **FIT FRIFM Worksheet**	15% of total score
☐	**Element 3**	**Implementation Plan** Submit a FIT implementation plan	30% of total score
☐	**Element 4**	**Infrastructure Documents** Submit two documents demonstrating development of FIT implementation infrastructure	25% of total score
☐	**Element 5**	**Consultations** Participate in one or more one-hour, agency specific, consultation sessions with a CareOregon Outcomes Specialist every 6 months for a total of two consultations per calendar year	20% of total score

Detailed instructions for the **Installation Stage** elements follow.

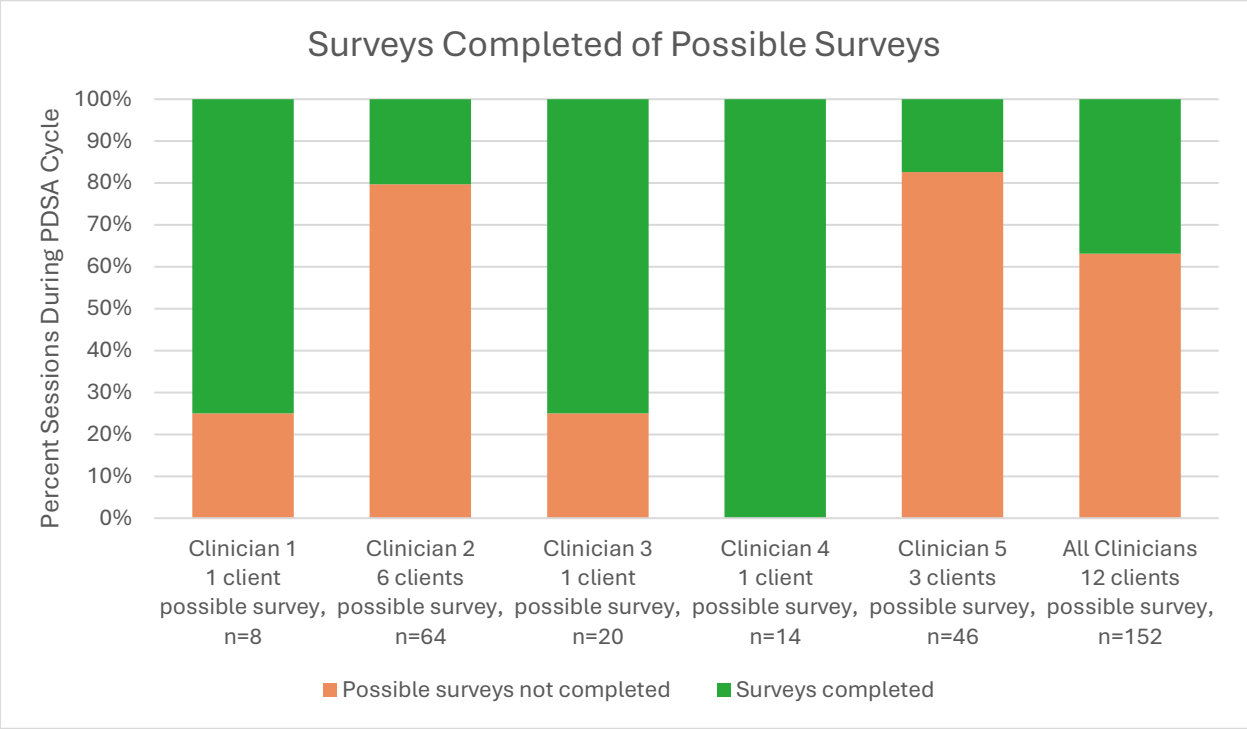
Appendix F: Timeline

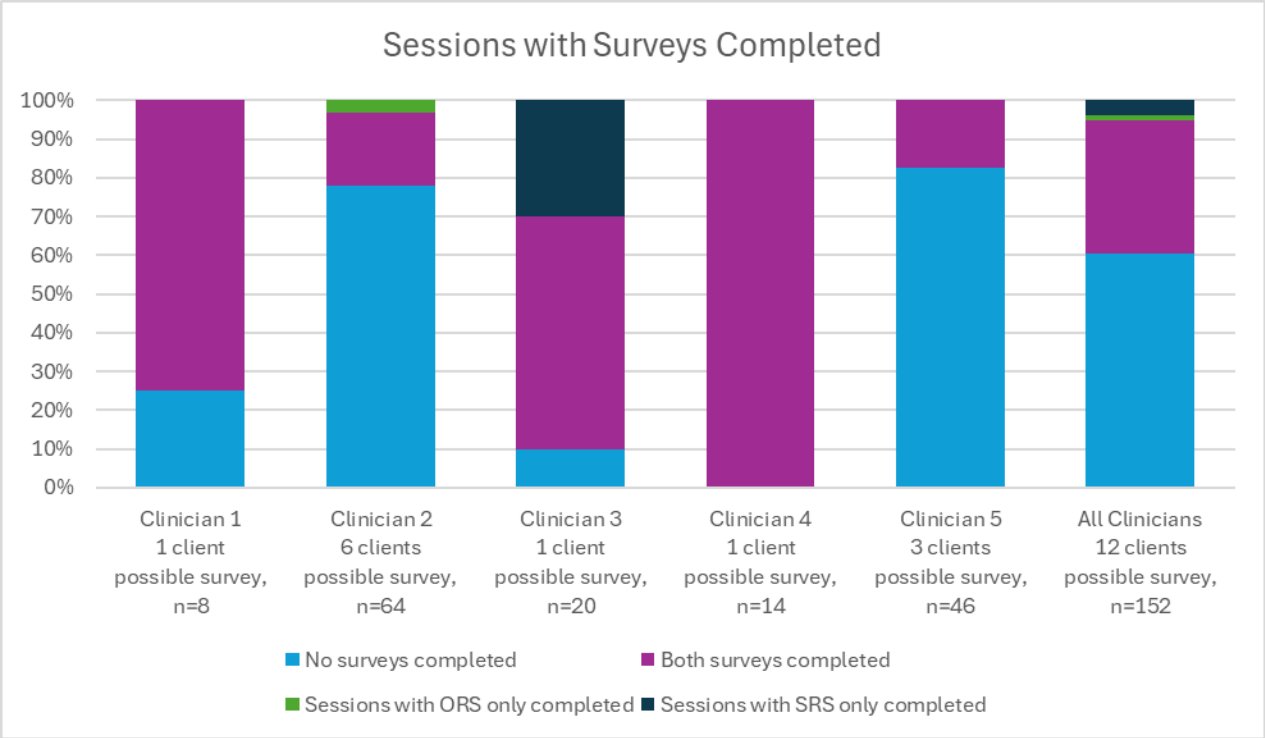
Date		Pilot Program	DNP QI Project
June '24			· Discuss schedule of QI project with organizational leadership
July '24			· Develop understanding of contextual factors of QI project and FIT implementation
Aug '24			· Finalize project proposal/ letter of support Obtain IRB determination
Sept '24			· Project proposal completion · Schedule first structured group interview
Oct '24		**10/14, Pilot initiation email** **10/20, 1st use of OpenFIT**	· Provide clinicians with resources and identify target clients
10/20-10/26	Week 1	Start - Clinician 1 **10/20, 1st use of OpenFIT**	
Nov '24			· 11/14, DNP student and Clinician 1 attend FIT training from ICCE · Continue collection of quantitative survey
10/27-11/2	Week 2	Start - Clinician 2	
11/3-11/9	Week 3		
11/10-11/16	Week 4		
11/17-11/23	Week 5	Start - Clinicians 3, 4, 5	
11/24-11/30	Week 6		
Dec '24			· Continue collection of quantitative survey completion data
12/1-12/7	Week 7	**Structured Interview**	
12/8-12/14	Week 8		
12/15-12/21	Week 9	Last survey - Clinicians 1, 5	
12/22-12/28	Week 10		
Jan '25			· Continue collection of quantitative survey completion data · Preliminary analysis of qualitative findings
12/29-1/4	Week 11		
1/5-1/11	Week 12	Last survey - Clinician 2	
1/12-1/18	Week 13		
1/19-1/25	Week 14		
1/26-2/1	Week 15		
Feb '25			· Continue collection of quantitative survey completion data · Analyze project measures
2/2-2/8	Week 16	Last survey - Clinician 3	
2/9-2/15	Week 17	Last survey - Clinician 4 **2/20, Structured Interview 2**	
March '25			· Present summary of qualitative findings, propose recommendations

Appendix G: Structured Interview Guide for Key Informant Interviews

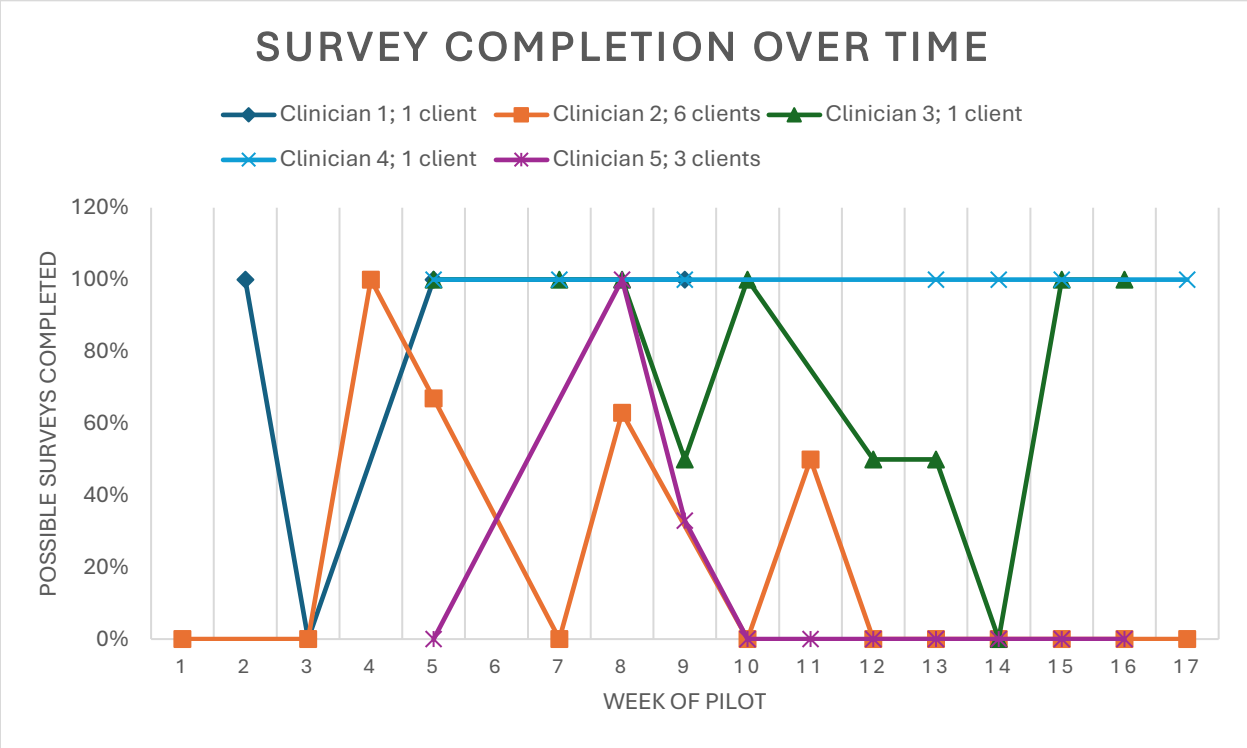
	Focus of Interview Questions	CFIF Fidelity Components (Carroll et al., 2007)
1st Interview, Pilot week 7, 12/22/25	Can you share with the group where you are, with using FIT so far?	Adherence: Coverage and Frequency
	Can you describe how you integrate FIT surveys into a session?	Potential moderators: Quality of delivery, Participant responsiveness Adherence: Details of content
	What impact on your practice or client treatment have you noticed from using FIT so far? Any specific experiences to share?	Outcomes: Client progress toward treatment goals
	What barriers or challenges have you encountered to using FIT so far?	Potential moderators: Strategies to facilitate implementation, Quality of delivery
2nd Interview, Pilot week 18, 2/20/25	What updates do you have around FIT?	Adherence: Coverage and Frequency; Adherence: Details of content
	Are there any specific client stories you'd like to share?	Outcomes: Client progress toward treatment goals
	What have the challenges been? • Updates to challenges identified in the last discussion: clunky logistics, awkward interpersonal roll-out, our personal reaction to "negative" scores?	Adherence: Coverage and Frequency; Potential moderators: Strategies to facilitate implementation, Quality of delivery
	What have the challenges been? • New challenges?	Adherence: Coverage and Frequency; Potential moderators: Strategies to facilitate implementation
	Pie in the sky—what would you like or need to support this FIT Pilot going forward?	Potential moderators: Strategies to facilitate implementation, Quality of delivery

Appendix H: Completion Rates by Clinician





Appendix I: Percent of Possible Surveys Completed Over Time



Appendix J: Survey Completion by Client

		Number of sessions	Sessions with survey(s) completed	Percent sessions with survey(s) completed	Date 1st survey	Date last survey	Number of weeks between 1st and last surveys
Clinician 1	Client 1a	4	3	75%	10/31/2024	12/17/2024	7
Clinician 2	Client 2a	6	1	17%	12/31/2024		N/A
	Client 2b	9	2	22%	11/14/2024	11/21/2024	1
	Client 2c	6	1	17%	12/10/2024		N/A
	Client 2d	2	1	50%	11/20/2024		N/A
	Client 2e	3	1	33%	12/11/2024		N/A
	Client 2f	6	1	17%	12/10/2024		N/A
Clinician 3	Client 3a	10	9	90%	11/21/2024	2/6/2025	11
Clinician 4	Client 4a	6	6	100%	11/20/2024	2/12/2025	12
Clinician 5	Client 5a	6	2	33%	12/10/2024	12/17/2024	1
	Client 5b	7	1	14%	12/10/2024	2/4/2024	N/A
	Client 5c	9	1	11%	12/12/2024		N/A

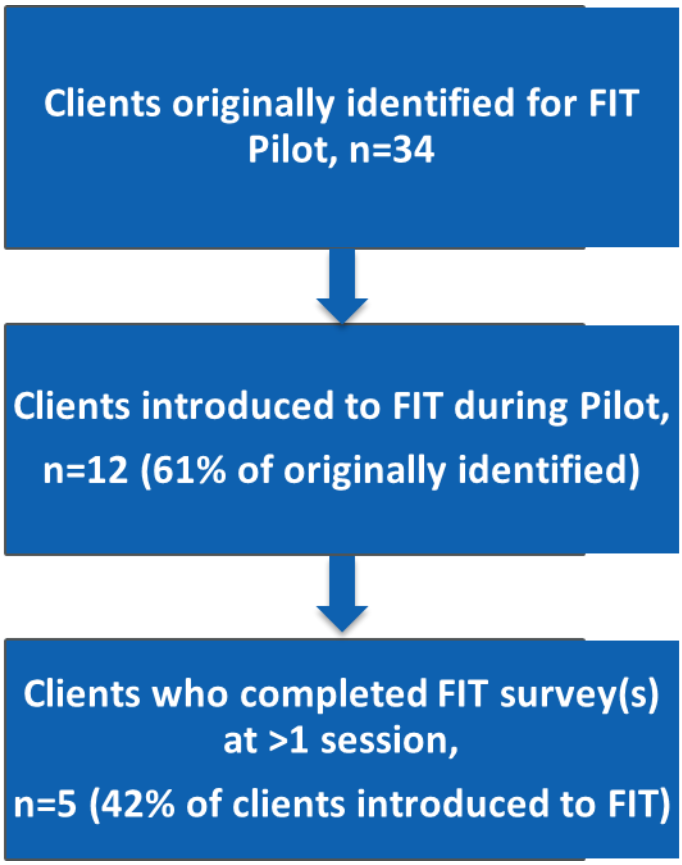
Appendix K: Qualitative Data Table

	Interview Question	Themes
1st Interview, Pilot week 7, 12/22/25	Can you share with the group where you are, with using FIT so far? *Adherence: Coverage and Frequency*	Heterogeneity of clinician approaches Clinician One: one client, started week two of pilot - in person sessions, administering survey via clinician laptop, planning to try tablet Clinician Two: six clients, started week one of pilot -telehealth sessions, emailing link to survey Clinician Three: one client, started week five of pilot - telehealth sessions, texting link to survey Clinician Four: one client, started week five of pilot -telehealth sessions, tried emailing and texting link to survey Clinician Five: three clients, started week five of pilot - in person and telehealth sessions, administering survey via clinician laptop, planning to try tablet, emailing link, and copy/pasting link into zoom chat
	Can you describe how you integrate FIT surveys into a session? *Potential moderators: Quality of delivery, Participant responsiveness* *Adherence: Details of content*	Two general implementation philosophies emerged. Clinician One, Clinician Three, Clinician Four: -Selected one client based on specific treatment challenges -Most recently exposure to FIT training or content (Clinician One originally selected six clients, then scaled down after attending ICCE training in November) Clinician Two, Clinician Five: -Focusing on the pilot as an implementation process -More heterogeneity of survey administration techniques, willingness to jump in -Originally selected 19 clients, five clients respectively
	What impact on your practice or client treatment have you noticed from using FIT so far? Any specific experiences to share? *Outcomes: Client progress toward treatment goals*	Impact on practice and client treatment aligned by implementation philosophy. Clinician One, Clinician Three, Clinician Four: -Described specific treatment challenges they hoped to investigate with FIT -Included addressing avoidance behavior, addressing persistent low mood despite client endorsement of treatment changes, exploring differential diagnosis Clinician Two, Clinician Five: -Described ORS responses guiding session in a general way -Described positive initial conversations with clients who felt unconscious giving feedback

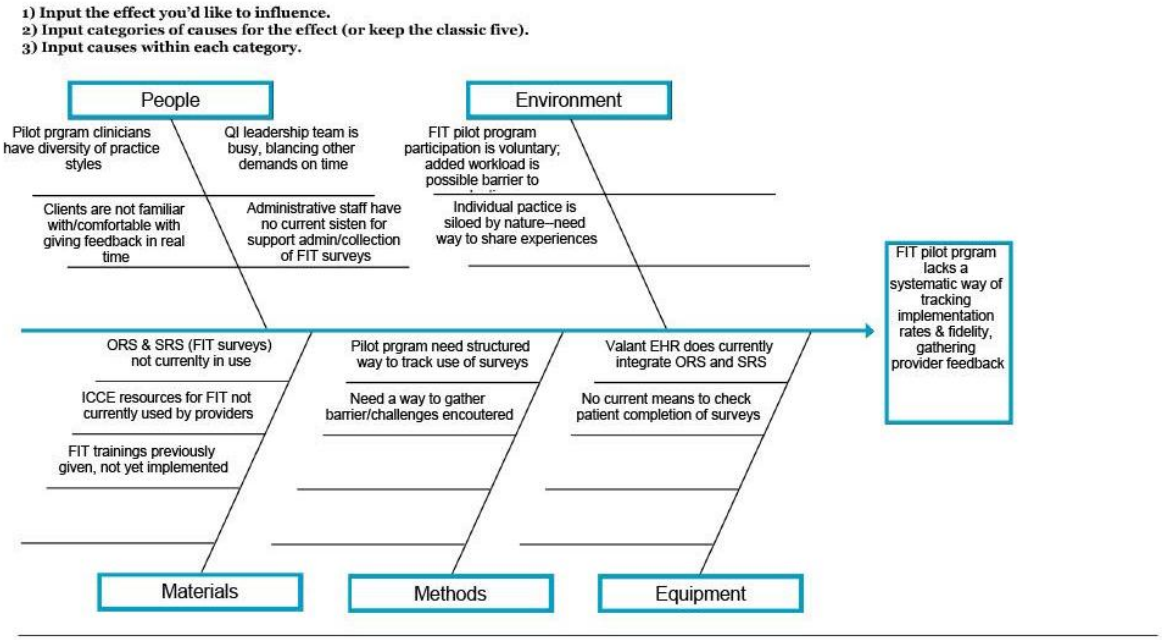
		"I started with this client because she's kind of an avoider, she often talks about practical things instead of doing trauma work" "I see the SRS a valuable part of the work for time at the end, if we need more than four min, I've at least captured that that I can pull forward . . . There's a kind of natural wind in, a bookend of the session" "The thing I'm hearing from y'all that's making me shift—because I'm been focusing on 'bear with me, this is a pilot program—is making sure than I'm tying it in with something related to our work specifically, which might make it more like it's not a waste of time."
	What barriers or challenges have you encountered to using FIT so far? *Potential moderators: Strategies to facilitate implementation, Quality of delivery*	Clinicians identified significant logistical/administrative challenge. Much of the structured interview time was spent collaboratively problem-solving these difficulties. -Survey administration -Limited time in sessions -Interpersonal awkwardness of introducing feedback surveys to the client
		"When I remember, a bit of a mad rush, then either the first or the last [survey]" "it's been kind of clunky . . . she's really kind of using the full time in session so timing is challenging" "Right now, I'm just trying to get familiar with the system itself" "There have been points of clunkiness, points of usefulness" "It's not ideal, the amount of extra administrative steps sometimes, as I try to remember to do it" "it's ideologically and abstractly useful but in practice it's a little more stressful"
2nd Interview, Pilot week 18, 2/20/25	What updates do you have around FIT? *Adherence: Coverage and Frequency; Adherence: Details of content*	Heterogeneity of clinician approaches Clinician One: one client, care discontinued after 7 weeks of FIT -decided the client needed another modality and transferred care Clinician Two: six clients, survey administration dropped off after week 11 Clinician Three: one client, continuing FIT with some missed ORS surveys Clinician Four: one client, continuing FIT Clinician Five: three clients, survey administration dropped off after week 10
		"Four people right out of the gate was like, that was dumb. . . So knowing this meeting's here, I'm like, 'I'm going to wait' " "We'll do the ORS, all the neurovegetative questions—we get all that out of the way, then we've got like 50min. I feel like [the client] really likes that"

	Are there any specific client stories you'd like to share? *Outcomes: Client progress toward treatment goals*	Clinicians Three and Four continued to use FIT with their client and described its application to specific treatment goals. Clinician One decided to transfer their client's care, partly based on reflections from FIT results. Clinicians Two and Five did not have any specific client stories or connections between FIT and client treatment goals.
		"My patient really likes it, and she's a cranky lady. And she's getting better . . . she's a big avoider and it's keeping us accountable. It allows a more clear way to name that"
		"I think it was the FIT review process, I was like 'oh yeah somethings not working there', I ended up terminating almost
	Updates to challenges identified in the last discussion: clunky logistics, awkward interpersonal roll-out, our personal reaction to "negative" scores? *Potential moderators: Strategies to facilitate implementation, Quality of delivery*	The administrative burden was ongoing, Clinicians Three and Four described adjusting to a routine with their client after some trial and error. Clinicians Two and Five described administrative overwhelm as a primary contributing factor to survey administration dropping off.
		"I lost all of my admin time in February, basically, which was a miscalculation on my part, because it has impacted not just FIT but everything"
		"If I don't get it set up before hand its not happening"
	New challenges? *Adherence: Coverage and Frequency;* *Potential moderators: Strategies to facilitate implementation*	Clinicians described their own attitudes toward FIT as informing client engagement and FIT adherence.
		"I still have this barrier of a digitization of therapy . . . I know it's my own reaction, and I feel like when I present it, I have a double signal and that gets picked up".
	Pie in the sky—what would you like or need to support this FIT Pilot going forward? *Potential moderators: Strategies to facilitate implementation, Quality of delivery*	All clinicians described the structured interviews as a resource for collaborative learning and requested more frequent group consultation.
		"I think the consult would keep me more consistent, keep it at the forefront and about what the data means".
		"over the past month as I have lost admin time . . . I have been telling myself, I'm not dealing with this until the FIT meeting, so I came into this with the expectation of problem solving".

Appendix L: Target Client Population over 12-17 week PDSA cycle



Appendix I: Root Cause Analysis



Appendix J: Letter of Support from Clinical Agency

Letter of Support from Clinical Agency

Date: *July 3, 2024*

Dear Elizabeth Frost,

This letter confirms that I, Nicole Bennett, allow Elizabeth Frost (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately *September 2024 to January 2025.*

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

Project Site(s):

Willamette Health and Wellness
700 NE Multnomah St. Suite 275
Portland, OR 97232

Project Plan:
Identified Clinical Problem: Willamette Health and Wellness (WHW) is planning to initiate a pilot program of Feedback Informed Treatment (FIT), as a part of the installation phase of the FIT Quality Improvement process (FRIFM). WHW is prioritizing a full-fidelity adoption of FIT. This DNP project seeks to measure fidelity to the FIT model as performed by pilot program clinicians.

This DNP project's focus is fidelity of implementation of an existing, evidence-based QI model, i.e. FIT. The project will use the Institute for Healthcare Improvement Quality Improvement (IHI-QI) framework and will consist of one Plan-Do-Study-Act (PDSA) cycle. The specific aims will be to evaluate the rate of completion of the FIT surveys and the fidelity of implementation of FIT among pilot program clinicians. Specific goals include the percent FIT surveys completed, and fidelity of FIT as defined in collaboration with WHW. The intervention is to improve care delivered at WHW with the evidence-based model of FIT; specifically, with the FIT pilot program as an important component of the installation phase. This DNP project will use a mixed methods model for data collection. Data collection will occur by reviewing Valant EHR for completion of FIT surveys, brief surveys of participating clinicians at end of first PDSA cycle, and brief interview of participating clinicians by the student for qualitative data collection. Anticipated measures include: process measures of the percent of sessions with FIT surveys completed, outcome measures that are process-based and qualitative focusing on the clinician perceptions of FIT utility in practice, as well as fidelity to the spirit of FIT in administering surveys to clients. Balancing measures will track clinician experiences of barriers to FIT implementation. Data management will include de-identified data stored on encrypted OHSU drop-box and no collection of patient information.

Site supports provided by WHW include: initiating the FIT pilot program, providing access to Valant EHR records for relevant patient sessions, and support soliciting clinician feedback. The student will provide WHW with all findings and recommendations for next steps for fidelity to FIT during FRIFM installation stage.

During the project implementation and evaluation, *Elizabeth Frost* will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact *Elizabeth Frost* and *Kasey McCracken* (student's DNP Project Chairperson).

Regards,

Nicole Bennett Director nbennett@WHWPDX.com

DNP Project Preceptor (Name, Job Title, Email, Phone):

7.3.24

Signature Date Signed

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