Sustaining Collaborative Problem Solving: Assessing Fidelity and Identifying Barriers to Implementation in Outpatient Mental Health

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NURS 703B: DNP Project Planning

Submitted to: Dr. Tara O'Connor

March 13th, 2026

Sustaining Collaborative Problem Solving: Assessing Fidelity and Identifying Barriers to Implementation in Outpatient Mental Health

Background: Despite proven effectiveness of evidence-based practices (EBPs), the consistent implementation in clinical settings remains limited, particularly in outpatient mental health clinics. Fidelity monitoring is an important mechanism for maintaining high adherence to EBP and supports the effectiveness and sustainability of the intervention in clinical practice. This quality improvement project focused on measuring staff fidelity to the Collaborative Problem Solving (CPS) model and identifying barriers to sustained implementation. **Methods**: Conducted at two outpatient child and adolescent psychiatric clinics, the project utilized two Plan-Do-Study-Act (PDSA) cycles, and a mixed-methods approach to assess fidelity to the CPS philosophy and staff perceptions, including burnout and perceived competence. **Interventions**: The CPS-Assessment and Intervention Measure (AIM) is a validated and reliable tool was used to measure adherence to CPS philosophy and provider burnout, while open-ended questions gathered qualitative data on implementation barriers. **Results**: At the end of PDSA Cycle 2, staff reported higher adherence to CPS philosophy and burnout, alongside lower perceived competence with the CPS model. Qualitative results identified limited time and insufficient ongoing training as common barriers to sustained implementation. **Conclusions**: Consistent adherence to CPS philosophy across PDSA cycles indicates sustained fidelity to EBP and the delivery of a high-quality intervention known to achieve positive outcomes for patients.

Keywords: sustainability of evidenced-based practices, intervention fidelity, Collaborative Problem Solving, CPS-AIM

Sustaining Collaborative Problem Solving: Assessing Fidelity and Identifying Barriers to Implementation in Outpatient Mental Health

Implementation of evidence-based practices (EBP) is widely recognized as the most important mechanism to provide high-quality care with optimal outcomes for patients across all areas of health care (Flynn et al., 2023; Dusin et al., 2023). EBP incorporates available knowledge on the safety and effectiveness of both current practices and new treatments, guided by expert clinical judgment and practical feasibility. When providers use practices or treatments that lack empirical support, or only partially adhere to EBP, the interventions may prove ineffective or lead to harmful outcomes (Speers et al., 2022). Despite the established efficacy and benefit of EBPs, implementation research reveals that EBP are not routinely sustained in clinical practice, with estimates ranging between only 23-50% of EBP are sustained two years after initial implementation (Finch et al., 2020; Lau et al., 2020; Speers et al., 2022).

Sustainability refers to the continued use of EBP over time in real-world settings. When EBPs are not sustained after the initial implementation period, financial resources, clinician time and organizational efforts are wasted (Flynn et al., 2023; Lau et al., 2020). In addition, when EBPs are discontinued from routine practice, patients lose access to treatments and interventions known to be safe and effective in achieving optimal health outcomes (Flynn et al., 2023). Because of this gap between implementation of EBP and long-term use, sustainability has been identified as one of the most significant problems in translational and implementation science (Flynn et al., 2023). Understanding how to sustain the delivery of high-fidelity evidenced-based care is critical for ensuring safe, effective interventions and positive outcomes for patients.

Available Knowledge

Fidelity refers to the degree to which an EBP adheres to the core components of the model when applied in clinical practice (Pollastri et al., 2022). Current translational research demonstrates that when interventions are delivered with higher fidelity, they are more likely to produce positive health outcomes compared to the same intervention with lower fidelity (Akiba et al., 2022; Esposito et al., 2024; Power et al., 2022). Multiple systematic reviews and meta-analyses of psychotherapy interventions consistently show positive associations between high fidelity to an EBP model and intended patient outcomes (Esposito et al., 2024; Power et al., 2022). Additionally, higher fidelity to an EBP has been identified to be a key factor in sustaining the intervention beyond the implementation period (Acosta et al., 2020; Bond et al., 2020). This evidence demonstrates that maintaining high fidelity to EBP and adhering to the core components of the model is essential for achieving positive health outcomes.

To achieve high-fidelity of an EBP in a real-world setting, measuring fidelity to an EBP plays a key role in supporting both improvement and long-term sustainability of EBPs. Implementation research consistently identifies fidelity monitoring as one of the most effective strategies for improving EBP fidelity as it allows for the standardized assessment of whether they are being delivered with adherence to the core components of the model (Flynn et al., 2023; Pollastri et al., 2019; Toomey et al., 2020). Ongoing monitoring of fidelity facilitates the early identification of deviation from the EBP core components and provides an opportunity for intervening with feedback, supervision and support before further departure away from the EBP model (Akiba et al., 2022; Esposito et al., 2024; Ruud et al., 2021; Toomey et al., 2020). Together, the current literature highlights fidelity monitoring as an important mechanism for

maintaining high adherence to EBP which supports the effectiveness and sustainability of the intervention in clinical practice.

Rationale

The outpatient mental health clinics where this quality improvement project takes place provides training on Collaborative Problem Solving (CPS) to all new hires within three months of employment. CPS is an evidenced-based approach developed by Think:Kids to address challenging behaviors in children and reduce conflicts between children and their parents (Pollastri et al., 2022). CPS has been shown to be effective in reducing problem behaviors, improving emotional regulation, and enhancing parent-child interactions (Pollastri et al., 2023). Prior to the start of this quality improvement project, there was no standardized process for monitoring fidelity to the CPS model or identify barriers that might limit sustainability at the outpatient mental health clinics.

To ensure the model is being implemented effectively, the CPS-AIM (Assessment and Intervention Measure), was developed by Think:Kids to measure fidelity to the CPS philosophy in clinical practice (Pollastri et al., 2019). This tool evaluates adherence to the CPS philosophy of "skill, not will," perception of competence in implementing CPS in practice, and assesses for burnout. By assessing fidelity, CPS-AIM helps ensure that the approach remains collaborative, proactive, and true to its intended design. The intervention for this quality improvement project consisted of administering a reliable and validated measurement of fidelity to the CPS model.

After synthesizing research from implementation research, the National Implementation Research Network (NIRN) developed five frameworks to inform organizational adoption and successful utilization of EBP called the Active Implementation Frameworks (AIF) (NIRN, 2015).

The fifth AIF focuses on the continuous assessment of newly implemented processes for identification of strengths and ineffective practices with the use of improvement cycles (NIRN, 2015). The primary goals of improvement cycles are to reduce burden, enhance efficiency and improve patient care (Pollastri et al., 2019). Plan-Do-Study-Act (PDSA) cycles are a common improvement cycle process developed by the Institute for Healthcare Improvement which provides a simple, systematic approach to continuous improvement of patient care delivery and outcomes (Institute for Healthcare Improvement, n.d.). Carrying out multiple PDSA cycles provides opportunities for clinical systems to evaluate strengths of processes and areas for improvement, intentionally making changes to address weaknesses and reevaluating the impact.

Specific Aims

This quality improvement project aimed to measure clinician adherence to the CPS philosophy across two PDSA cycles using the CPS-AIMS-S questionnaire. Additionally, a second goal was to identify and document up to three key barriers reported by clinicians and staff that hindered their sustained implementation of the CPS philosophy through additional questions.

Methods

Context

This quality improvement project was implemented at two separate outpatient child and adolescent psychiatric clinics within the same hospital system. The clinics were located on the east and west sides of a large urban city in the Pacific Northwest. Staff located at each clinic location included administrative, licensed professional counselors, psychiatric mental health nurse practitioners and medical doctors. Standard onboarding for new staff at the clinics involved introductory training on the CPS model within three months of employment. Despite ensuring

that all staff receive introductory formal training on the CPS model, there was no formal process in place to assess fidelity to the CPS model or barriers to sustained implementation over time.

Intervention

The intervention consisted of two PDSA cycles where an electronic survey was administered to clinic staff through Microsoft Forms, an online platform used to create surveys and collect responses (Microsoft, n.d.). The survey questions included the CPS-AIM with 18 Likert-style items and five additional questions specific both outpatient clinics. Results were shared with the manager of the clinics through presentation and discussion. A second PDSA cycle was implemented two months after the first PDSA cycle, and after a CPS training November 2025.

Study of the Intervention

This quality improvement project utilized a mixed-methods approach, process and outcome measures were obtained with the CPS-AIM-S, a standardized and validated measure, and qualitative methods assessed barriers to implementation. CPS-AIM-S subscale scores were calculated and interpreted according to the CPS-AIM User Manual. Responses from the additional questions were translated to numerical outputs to support analysis, and free-text responses were recorded and organized into categories. Completion rates were assessed using the Microsoft Forms platform statistics.

Measures

Study measures included the CPS-AIM developed by Think:Kids at Massachusetts General Hospital measure fidelity to the CPS approach and identify barriers to ongoing implementation. The CPS-AIM questionnaire assesses adherence to the model and provides information with four different subscales (Wang & Pollastri, 2019). Scale scores range between 1 and 7, where 4 represents the midpoint. The CPS-AIM-S was designed specifically for staff in

clinical systems and determined to be a reliable and valid measure for each subscale. The first scale, **CPS Philosophy**, includes seven items measuring staff adherence to the "skill-not-will" mindset, where higher scores reflect greater adherence to the model (Wang & Pollastri, 2019). The second scale, Perceived Positive Impact was not chosen to be an area of focus for this quality improvement project. The third scale, **Perceived Burnout**, contains five items assessing the level of perceived stress and burnout in clinicians and staff, where higher scores indicate greater feelings of burnout. Lastly, the **Perceived CPS Competence** scale comprised of five items measures confidence and perceived effectiveness in applying CPS, with higher scores indicating stronger self-efficacy in using the model. Internal consistency ratings range between 0.73, 0.75, and 0.72, for CPS Philosophy, Perceived burnout, and Perceived CPS competence scales, respectively (Pollastri et al., 2019).

Additional questions were included in the survey to collect information about staff role at the clinic, what level of CPS training they had received and if it had occurred within the last two years. At the request of the clinic manager, one question evaluated if the responder was hired within the last three months was also included to assess if staff received training within a reasonable time after date of hire. Lastly, one open response question asked responders to identify and describe barriers to implementing CPS at the clinic. Together with the CPS-AIM-S questions, this constituted The CPS Survey administered in each PDSA cycle (Appendix A).

Analysis

Process and outcome measures were analyzed using descriptive statistics to compare changes between PDSA cycles. Qualitative data was organized into categories of responses, and direct quotations were chosen to represent each identified theme. This mixed-methods approach

supported the evaluation of differences between PDSA cycles, assessment of CPS fidelity by clinic staff and gathering information on reported barriers to implementation.

Ethical Considerations

This project involved the collection of anonymous survey responses from clinic staff and did not include clinic patients or any identifiable information of the responders. Participation was completely voluntary and no incentives were provided. Respondents were informed that their responses would remain confidential and that they could skip any questions or withdraw at any time without retribution. The project was submitted to two local Institutional Review Boards and was deemed “not research”. No formal ethics review was required as no patient information or any identifiable information was utilized in this quality improvement project.

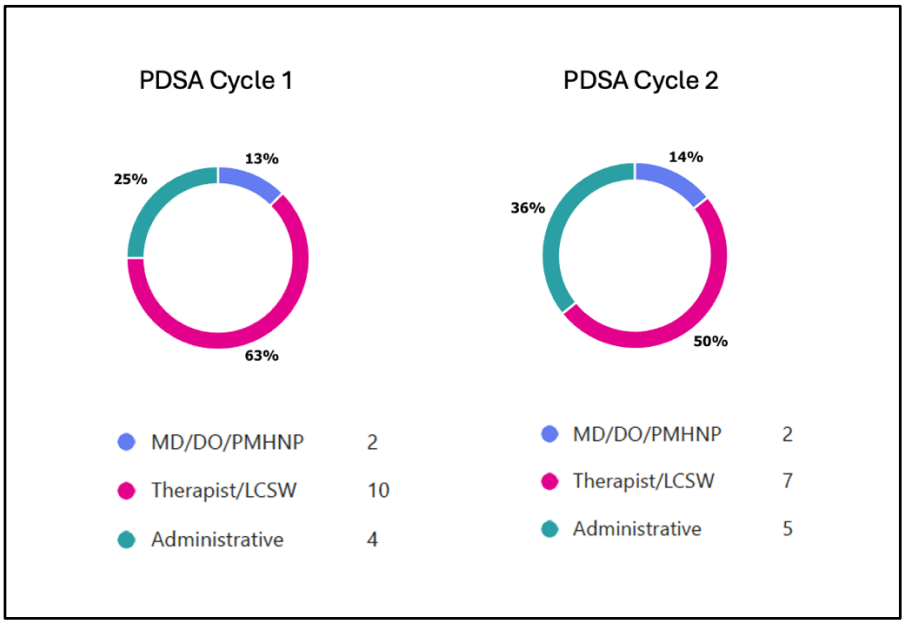
Results

Two PDSA cycles were conducted by sending electronic invitations to complete the CPS Survey via Microsoft Forms to staff at both clinics, with an explanatory message and identified closing date. PSDA Cycle 1 was open from October 27th and at the survey closure on October 31st, 2025, 16 out of 33 (48%) clinic staff members had completed the survey. PSDA Cycle 2 was open from Tuesday, January 6th, 2026, and at the survey closure on Friday, January 16th, 2026, 14 out of 33 (42%) clinic staff members had completed the survey. The PDSA cycles were intentionally timed before and after two separate eight-hour Level One CPS trainings that occurred on November 3rd and 11th of 2025. No modifications were made to the project’s materials or methods between PDSA cycles. In PDSA Cycle 1, two (n=2) respondents had never received CPS training, three (n=3) individuals had completed introductory training, nine (n=9) had achieved Tier One training and two (n=2) had completed Tier Two level CPS training. However, one participant with no prior CPS training did not complete the AIM-S questionnaire

within the CPS Survey. In PDSA Cycle 2, no (n=0) respondents had never received CPS training, two (n=2) individuals had completed introductory training, nine (n=9) had achieved Tier One training and three (n=3) had completed Tier Two level CPS training. The breakdown of roles of survey responders in each PDSA cycles are displayed in Figure 1 below.

Figure 1

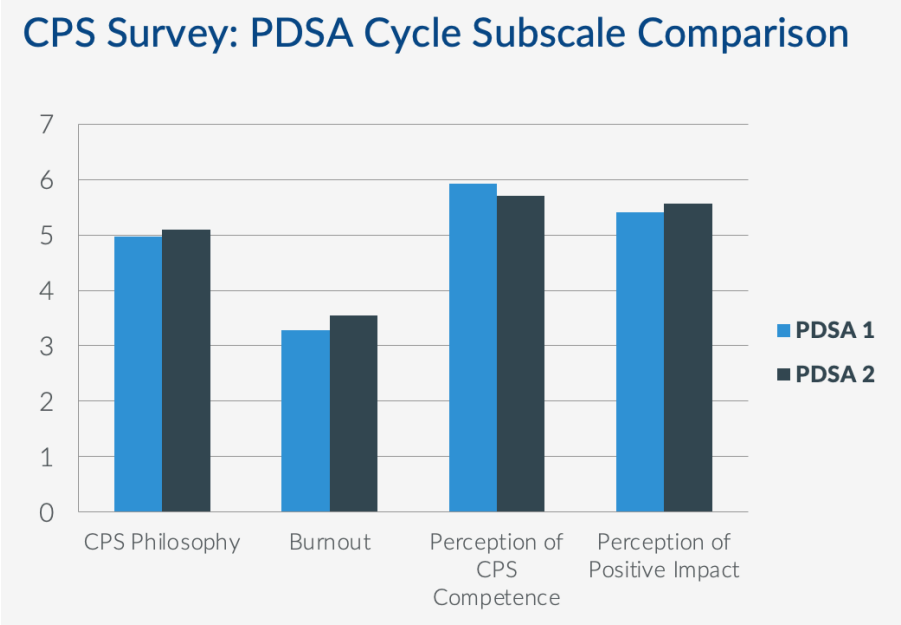
Role of Survey Responders by PDSA Cycle



Outcome measures from the CPS-AIM-S subscale scores are summarized and compared in Figure 2 below. Scores were obtained using Microsoft Excel, with reverse scoring applied to items according to the CPS User Manual and analyzed to obtain subscale scores. Final scores for CPS Philosophy were 4.97 (sd=1.66) in PDSA Cycle 1, and 5.09 (sd=1.59) in PDSA Cycle 2. Assessment of burnout was captured in the Burnout subscale, with a final score of 3.28 (sd=1.73) in PDSA Cycle 1, and 3.54 (sd=1.86) in PDSA Cycle 2. Perceived Competence subscale scores in PDSA Cycle 1 were 5.92 (sd=1.34), compared to 5.71 (sd=1.25) in PDSA Cycle 2.

Figure 2

CPS Survey Outcome Data Comparison Between PDSA Cycles



Qualitative findings highlighted several barriers to consistent application of the CPS model in the outpatient clinics. Respondents noted that CPS tools and strategies were not always applicable to administrative roles, limiting their practical use. Participants also emphasized the need for ongoing CPS training, consultation, and role-specific support to improve clinician skills and address complex situations that were not fully covered in initial trainings. Time constraints were frequently cited, specifically that there was limited time for case conceptualization, planning, consultation and preparation for sessions, and that the outpatient clinics were more of a short-term therapeutic intervention.

In PDSA Cycle 1, one respondent without prior CPS training did not complete the CPS-AIM-S questionnaire, suggesting that clearer instructions emphasizing the importance of survey completion regardless of training status may be beneficial in future cycles. This did not affect outcome scores as non-responses were excluded from analysis.

Summary

This quality improvement project measured fidelity to the CPS model when implemented by staff at two outpatient mental health clinics and identified two of the most reported barriers to sustained implementation. PDSA Cycles 1 and 2 resulted in similar completion rates just under 50%. At the end of PDSA Cycle 2, findings indicated higher adherence to CPS philosophy and higher levels of burnout, alongside lower perceived CPS competence during PDSA Cycle 2. Qualitative results provided information on barriers, specifically identifying that limited time and insufficient ongoing training were the most common barriers to consistent implementation of the CPS model by clinic staff.

Interpretation

CPS philosophy scores remained above the midpoint across both PDSA cycles, indicating general alignment with the CPS mindset of "skill, not will" at both clinics. A slight increase following the November trainings suggests that regular trainings may reinforce understanding of the model and support practice fidelity over time. An independent samples Welch's t-test indicated no statistically significant difference ($p = 0.68$) between the PDSA cycles.

Perceived burnout scores remained below the midpoint and increased modestly in PDSA Cycle 2, although the difference did not reach statistical significance ($p = 0.45$). Perceived CPS competence scores were just above the midpoint in both PDSA cycles, although they decreased slightly in Cycle 2. Although burnout scores in both PDSA cycles were below the midpoint, even relatively low burnout may have functioned as a subtle but meaningful barrier to achieving higher scores on CPS philosophy and perceived CPS competence as implementation science literature consistently highlights clinician stress and burnout as barriers to sustained EBP fidelity (Motamedi et al., 2021). Qualitative results from both PDSA cycles support this interpretation,

with time constraints and limited opportunity for case consultation identified as key barriers. The relationship between burnout and CPS philosophy scores warrants further exploration, particularly whether interventions aimed at reducing burnout might improve model fidelity.

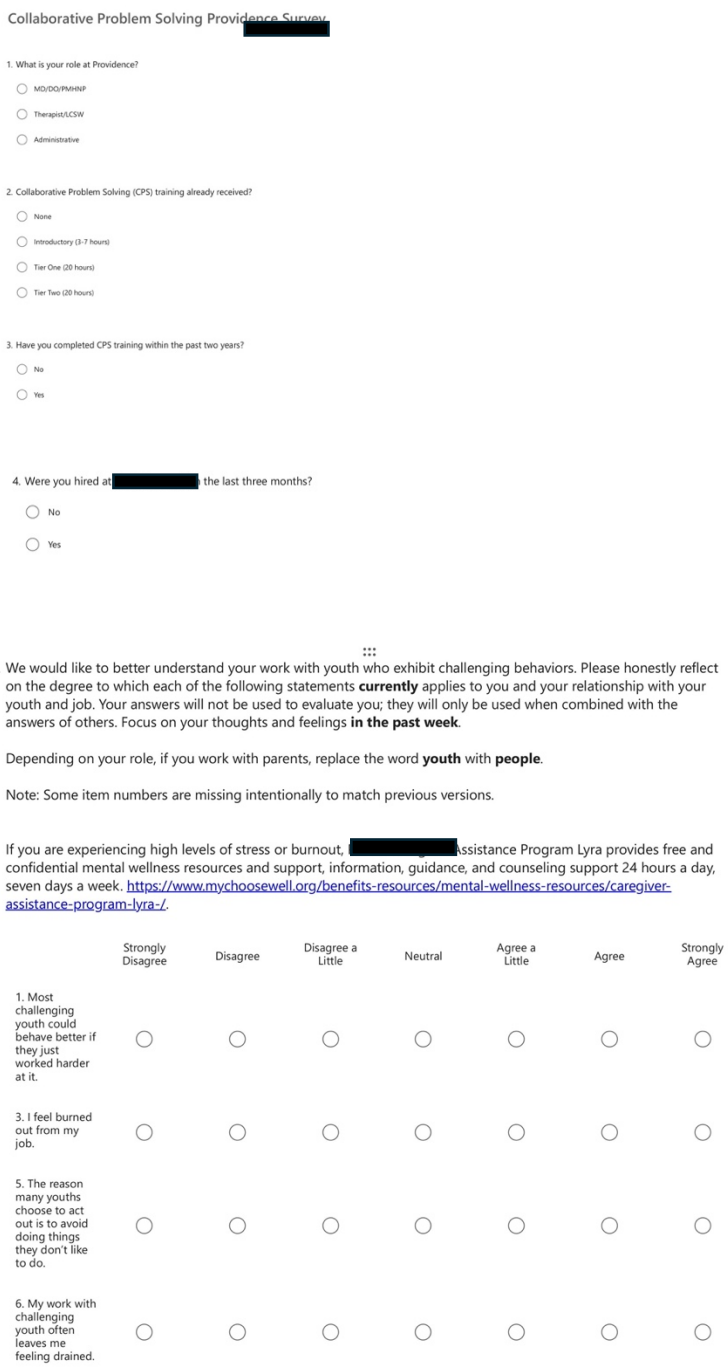
Limitations

This quality improvement project has several limitations. Only two PDSA cycles were conducted, limiting the ability to evaluate ongoing fidelity beyond three months. Additionally, the short interval between PDSA cycles and following a CPS training may not have allowed sufficient time for clinicians to fully integrate new knowledge into practice. Measurement was based on self-reported data, which introduces the possibility of challenges with recall and response biases, despite anonymous participation. Finally, small sample sizes and response rates under 50% in both cycles limits the generalizability of the findings and may not fully represent the perspectives of all clinic staff.

Conclusions

This quality improvement project examined fidelity to the CPS model across two PDSA cycles and identified barriers to sustained implementation in two outpatient child and adolescent psychiatric clinics. Overall, findings demonstrated a relatively stable adherence to CPS philosophy across cycles, no significant changes in perceived competence and burnout, and consistent identification of organizational barriers including time to apply the intervention and consult with peers. Consistent adherence to CPS philosophy indicates that the clinic's established practice of providing ongoing introductory training facilitated the sustained implementation. These results contribute to the growing implementation literature emphasizing that initial training alone is insufficient to ensure sustained, high-fidelity implementation of EBP.

Appendix A: The CPS Survey



Collaborative Problem Solving Providence Survey [redacted]

1. What is your role at Providence?
   - ○ MD/DO/PMHNP
   - ○ Therapist/LCSW
   - ○ Administrative

2. Collaborative Problem Solving (CPS) training already received?
   - ○ None
   - ○ Introductory (3-7 hours)
   - ○ Tier One (20 hours)
   - ○ Tier Two (20 hours)

3. Have you completed CPS training within the past two years?
   - ○ No
   - ○ Yes

4. Were you hired at [redacted] the last three months?
   - ○ No
   - ○ Yes

5. We would like to better understand your work with youth who exhibit challenging behaviors. Please honestly reflect on the degree to which each of the following statements **currently** applies to you and your relationship with your youth and job. Your answers will not be used to evaluate you; they will only be used when combined with the answers of others. Focus on your thoughts and feelings **in the past week**.

   Depending on your role, if you work with parents, replace the word **youth** with **people**.

   Note: Some item numbers are missing intentionally to match previous versions.

   If you are experiencing high levels of stress or burnout, [redacted] Assistance Program Lyra provides free and confidential mental wellness resources and support, information, guidance, and counseling support 24 hours a day, seven days a week. https://www.mychoosewell.org/benefits-resources/mental-wellness-resources/caregiver-assistance-program-lyra-/.

	Strongly Disagree	Disagree	Disagree a Little	Neutral	Agree a Little	Agree	Strongly Agree
1. Most challenging youth could behave better if they just worked harder at it.	○	○	○	○	○	○	○
3. I feel burned out from my job.	○	○	○	○	○	○	○
5. The reason many youths choose to act out is to avoid doing things they don't like to do.	○	○	○	○	○	○	○
6. My work with challenging youth often leaves me feeling drained.	○	○	○	○	○	○	○

	Strongly Disagree	Disagree	Disagree a Little	Neutral	Agree a Little	Agree	Strongly Agree
7. I can usually identify which lagging skills contribute to a youth's challenging behaviors.	○	○	○	○	○	○	○
8. I am able to separate myself from my work when I am not at work.	○	○	○	○	○	○	○
10. My work with challenging youth often feels rewarding.	○	○	○	○	○	○	○
12. I am confident in my ability to work with behaviorally challenging youth.	○	○	○	○	○	○	○
13. I believe I am having a positive influence on the lives of the most challenging youth.	○	○	○	○	○	○	○
14. I doubt whether I am able to make a difference in the lives of my most challenging youth.	○	○	○	○	○	○	○

	Strongly Disagree	Disagree	Disagree a Little	Neutral	Agree a Little	Agree	Strongly Agree
15. Many youths choose to misbehave because negative attention is better than no attention at all.	○	○	○	○	○	○	○
17. When youth are refusing to do something, I typically try to get them to doit by reminding them of the consequences of their actions.	○	○	○	○	○	○	○
22. I do not feel I am having much impact on changing youths' behaviors.	○	○	○	○	○	○	○
27. Many youths engage in negative behaviors because they have learned that those behaviors get them what they want.	○	○	○	○	○	○	○
28. I usually follow up on a problem-solving conversation with youth to see if a solution is working for them.	○	○	○	○	○	○	○

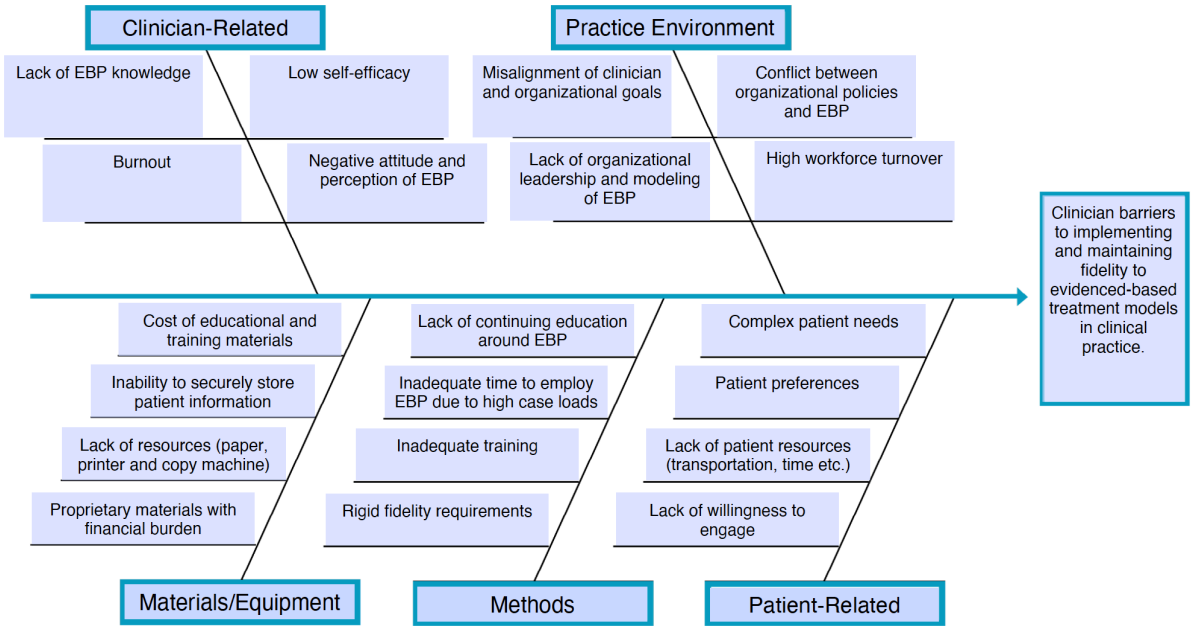
	Strongly Disagree	Disagree	Disagree a Little	Neutral	Agree a Little	Agree	Strongly Agree
32. I am at my maximum stress level when I am at work.	◯	◯	◯	◯	◯	◯	◯
33. It can be useful and productive to listen to youths' perspectives regarding their own challenges.	◯	◯	◯	◯	◯	◯	◯
35. Youth and I are usually able to work things out in a way that feels okay to both of us.	◯	◯	◯	◯	◯	◯	◯

6. What areas of additional support would help you feel more confident and prepared to successfully implement the CPS model with your clients?

- ◯ Added time
- ◯ Additional CPS training
- ◯ Organizational support
- ◯ Other

7. Feel free to explain your answer (if needed).

Appendix B: Root Cause Analysis



Appendix C: IRB Determination of Not Research

[redacted]

IRB MEMO

Research Integrity Office

[redacted]

NOT HUMAN RESEARCH

August 14, 2025

Dear Investigator:

On 8/14/2025, the IRB reviewed the following submission:

Title of Study:	Assessing Fidelity to Evidence-Based Practices and Identifying Barriers to Sustained Implementation at an Outpatient Mental Health Clinic
Investigator:	Tara O'Connor
IRB ID:	STUDY00029023
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The [redacted] IRB Office

Version Date: 10.25.2021 Page 1 of 1

Appendix D: Letter of Support from Clinical Agency

Letter of Support from Clinical Agency

Date: *August 5th, 2025*

Dear Anna Erway,

This letter confirms that I, Ken Ensroth, MD allow *Anna Erway* (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 *August 2025* to *December 2025*. This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor.

- **Project Site(s)**:
  - [redacted]
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
  - Identified Clinical Problem: Despite the established efficacy and benefit to consistently applying evidenced-based practices (EBP) to clinical care, implementation research reveals that EBP are not routinely utilized or sustained over time. Multiple intersecting factors are known to impede sustained EBP delivery within mental health systems, including both organizational-level and clinician-specific variables. Evaluating EBP fidelity over time and identifying barriers to sustained delivery is important for developing strategies to facilitate consistent application of EBP and improving patient outcomes.
  - Rationale: Adopting the Model of Improvement developed by the Institute for Healthcare Improvement provides a simple, systematic approach to continuous improvement of patient care delivery and outcomes. Carrying out three Plan-Do-Study-Act (PDSA) cycles provides opportunities for clinical systems to evaluate strengths of processes and areas for improvement, intentionally making changes to addresses weaknesses and reevaluating the impact of those changes.
  - Specific Aims:
    - Measure clinician adherence to Collaborative Problem Solving (CPS) philosophy over two PDSA cycles.
    - Identify up to three barriers reported by clinicians preventing sustained implementation of CPS.
    - If relevant, address identified barriers from first PDSA cycle and reassess in second PDSA cycle.
  - Methods/Interventions/Measures:
    - Study measures will include the CPS Adherence and Impact Measures for Clinical Systems (CPS-AIMS-S) developed by ThinkKids, a self-report measure with 18 Likert-style items. Two additional questions from Providence's CPS Caregiver Perception survey and one open response question for describing barriers will be included in the survey.
    - Intervention will consist of administering an electronic survey to clinicians at the clinical site and evaluating responses. CPS-AIM-S scores will be calculated and interpreted according to the CPS-AIM User Manual. Results will be shared with clinical site and if applicable, any interventions carried out to address identified barriers will be reassessed at subsequent PDSA cycle one month after initial survey.

    Data Management: Data collected will include specific role, time since initial CPS training, additional CPS training received, and responses to survey questions. No identifying data will be collected. All data will be stored in a password-protected secure database.
  - Site Support: Authorize identification of clinicians at the clinical site, participate in discussion with results from first PDSA cycle with consideration of addressing any identified barriers to reevaluate at next PDSA cycle.

During the project implementation and evaluation, *Anna Erway* 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 *Anna Erway* and *Dr. Tara O'Connor* (student's DNP Project Chairperson).

Regards,

DNP Project Preceptor (Name, Job Title, Email, Phone): Ken Ensroth, M.D

Signature: _____ Date Signed: 8/07/25

Appendix E: Approval from Think:Kids to utilize CPS-AIM-S Questionnaire

Outlook

[EXTERNAL] Re: Student research project, permission request for CPS-AIM-S

From MGH Think Kids Research Team <thinkkidsresearch@partners.org>
Date Tue 7/15/2025 12:25 PM
To Anna Erway <erway@ohsu.edu>

Hi Anna,

Thank you so much for reaching out. You may absolutely use the CPS-AIM-S for your DNP thesis. All we ask is that you cite our group in your final paper.

Please let me know if you have any questions or if we can provide you with any support throughout this process! Feel free to email me at mgalbright@mgh.harvard.edu at any time.

Best,

Grace Albright, PhD
she/her/hers
Postdoctoral Research Associate

Think:Kids at Massachusetts General Hospital

HARVARD
MEDICAL SCHOOL

From: Anna Erway <erway@ohsu.edu>
Sent: Monday, July 14, 2025 7:23 PM
To: MGH Think Kids Research Team <thinkkidsresearch@partners.org>
Subject: Student research project, permission request for CPS-AIM-S

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