## Optimization of Triple P Implementation & Scale-Up Outcomes

The ICTP projects promote the idea that implementation and program outcomes can be optimized in the local context [73]. Hence, we refer to this section of the ICTP integrated theory of change as “Optimization of Triple P Implementation and Scale-Up Outcomes.” Implementation capacity and performance are primary influencers of implementation outcomes [1]. Perhaps the most well-recognized implementation outcome is *fidelity—*delivery of a program as intended. However, several other implementation outcomes are also important, particularly as related to achieving favorable service and client outcomes at scale.

Proctor and colleagues [6] detail eight implementation outcomes: acceptability, adoption, appropriateness, cost, feasibility, fidelity, penetration, and sustainability. The ICTP integrated theory of change adapts and incorporates essential features of these and includes other implementation outcomes that may be of particular interest given Triple P’s model, history, and ongoing aims in the Carolinas:

* **Accessibility.** Progressing beyond Proctor and colleagues’ *adoption* outcome, we define *accessibility* as the degree to which families can obtain Triple P services in accordance with the level of support they need or prefer.
* **System Alignment.** Not represented in Proctor and colleagues’ original list but important for any system of interventions like Triple P, *system alignment* is defined by the ICTP projects as the degree to which community Triple P service providers and/or individual Triple P interventions work in concert toward collective well-being goals rather than in silos or fragmentation.
* **Feasibility.** Adapting Proctor and colleagues’ definition for the ICTP projects, *feasibility* is the extent to which Triple P can be successfully used or carried out within a given setting (e.g., region, community, or organization). Feasibility hinges largely on whether or not the local setting of care has the necessary financial, human, and implementation resources to support delivery of Triple P as intended.
* **Appropriateness.** Adapting Proctor and colleagues’ definition for the ICTP projects, *appropriateness* is the perceived fit, relevance, or compatibility of Triple P for a given community, practice setting, practitioner, or caregiver/family; and/or the perceived fit of Triple P to address a particular issue or problem in the community or organization, or for a given practitioner or caregiver/family. When considered at the community level, *appropriateness* should also include racialized histories of place that acknowledge the history and impacts of similar parenting and family support interventions.
* **Fidelity.** Adapting Proctor and colleagues’ definition for the ICTP projects, fidelity is the degree to which Triple P is delivered as prescribed in current program protocols or as it was intended by Triple P program developers. Within ICTP, we consider Triple P fidelity related to the presence of core Triple P program components rather than just to session protocols. To learn more about core Triple P program components, view [Module 9 in the ICTP Simulation Lab](https://modules.fpg.unc.edu/ncic/ICTPMod9/index.html).
* Dane and Schneider [89] detailed four dimensions of program fidelity relevant to community Triple P implementation, which were later reinforced by Mihalic [90]. We adapt those definitions for the ICTP projects as follows:
1. *Adherence* refers to whether Triple P is being delivered as it was designed or written (i.e., with all core components being delivered to the appropriate population; practitioners trained appropriately; using the right protocols, techniques, and materials; and in the locations or contexts prescribed).
2. *Quality* of program delivery is the manner in which a practitioner delivers Triple P (e.g., skill in using the techniques, methods, and core components prescribed by Triple P; enthusiasm; preparedness; and attitude).

EQUITY IN IMPLEMENTATION

Disaggregated data could be helpful in illuminating the potential presence of systemic issues that may be contributing to these discrepancies. Download

Brief #5: Foundations of the ICTP Implementation Support Practice Model, Section [Equity in Implementation Practice](https://ictp.fpg.unc.edu/wp-content/uploads/equity.docx) (docx) for more information on equity in implementation practice

Brief #7: Digging Deeper Into the Implementation Support Practice Model at the Regional Level, Section [Co-designed Support Planning and Processes](https://ictp.fpg.unc.edu/wp-content/uploads/co-designed-support-planning-and-processes.docx) (docx) for more information on Disaggregation of Data.

1. *Caregiver engagement* is the extent to which participants are engaged by and involved in the activities and content of Triple P (e.g., role plays, homework).
2. *Dosage* may include any of the following: the number of Triple P sessions delivered, the length of each session, or the frequency with which Triple P program techniques were implemented.
* **Acceptability.** Adapting Proctor and colleagues’ definition for the ICTP projects, *acceptability* is the perception among implementation partners, including families, that Triple P is agreeable, palatable, or satisfactory as delivered.
* **Reach.** Proctor and colleagues use a synonymous term, *penetration*, which we define as the integration of Triple P within a service setting and its subsystems. *Reach* might be measured by (a) the number of people who receive Triple P in a community or population, or (b) the number of practitioners actively delivering Triple P compared to the number trained in or expected to deliver Triple P. Triple P Implementation Evaluation (TPIE) results and experience from Triple P stakeholders in North Carolina suggest that a significant discrepancy has existed between the number of practitioners trained in Triple P and those who remain actively delivering Triple P interventions to community families.
* **Cost.** Adapting Proctor and colleagues’ definition for the ICTP projects, *cost* isrelated to the financial impact of a Triple P implementation effort. Proctor and colleagues note three cost components that may be of interest:
* *costs of delivering Triple P*,
* *costs of the implementation strategies* that will be used to support Triple P, and
* *cost variability* associated with the local service delivery setting.
* An additional variable related to cost, *benefit-cost*, has received increasing interest and attention relative to the implementation and scale-up of evidence-based practices [91]. In the context of implementation, this variable typically represents the ratio of realized *participant or societal financial benefits* (e.g., increased earnings and productivity) and/or *cross-system financial savings* (e.g., decreased taxpayer expenditures in health, criminal justice, child welfare, or other systems) in comparison to the costs associated with program implementation at some scale [92]; for more information, visit <https://www.wsipp.wa.gov/BenefitCost>.
* **Sustainability.** Adapting Proctor and colleagues’ definition for the ICTP projects, *sustainability* is the extent to which Triple P is maintained or institutionalized within a region’s, community’s, or service setting’s ongoing, stable operations.

System partners involved in different levels of Triple P scale-up (e.g., state, county, agency, and practitioner) may have varied interests across these nine implementation outcomes. While partners may want to review these alternatives and determine which mix may be useful at their system level, the ICTP projects team strongly recommends that program *fidelity* be monitored by every system level. Fidelity has demonstrated particular importance in replicating evidence-based program outcomes in real-world settings [90, 93]. In addition, by choosing from and attending to other implementation outcomes, we believe that system partners at any level can monitor implementation in accordance with Triple P’s stated philosophy of “fidelity and flexibility.” For example, monitoring variables like acceptability and appropriateness can ensure that core intervention components are reaching local families in a way that is responsive to their needs and preferences.