

If we want more evidence-based practice, we need more practice-based evidence.

—L.W. Green (2006)



# RE-AIM for Program Planning: Overview and Applications

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## Introduction

The Center for Healthy Aging is pleased to sponsor this monograph that provides an introduction to the RE-AIM framework. RE-AIM is an evolving framework designed to inform program decision making. **RE-AIM** is an acronym that stands for **Reach, Effectiveness, Adoption, Implementation, and Maintenance**. These five elements are critically important for service providers and decision makers to consider when deciding to adopt an evidence-based health promotion program or when making choices among alternative programs.

This monograph also serves as a supplement to current and future issues of the Center for Health Aging popular and practical Issue Brief Series on Evidence-Based Health Promotion. In 2005, the Center published its inaugural Issue Brief in this series, introducing readers to the concept of Evidence-Based Health Promotion Programs. This issue brief and others are available on our Web site at [www.healthyagingprograms.org](http://www.healthyagingprograms.org).

The Center serves as the National Resource Center on Prevention Programs for the Administration on Aging's (AoA) initiatives to build the capacity of the aging services network to deliver evidence-based health promotion interventions. Under these initiatives, local aging agencies are partnering with other community-based organizations, health care providers, researchers, and to plan for, implement and sustain evidence-based programs. These are relatively complex demonstration projects in which evidence-based programs are adapted to the diversity of the population and existing services in each community. A variety of process and outcome measures are used to assess fidelity and impact in the demonstration projects.

As the Center worked with state and local organizations to address common translation issues and challenges, it became apparent that RE-AIM was an easy-to-use framework that allowed the project teams to better communicate with each other and the Center, and to more systematically address the variety of challenges inherent in this work. We have since adopted this framework and are applying its concepts as we work with demonstration programs to develop manuals, tools, and other products that can be used by local aging service providers. It is therefore, important for our readers to gain an understanding of this framework and its application. Once mastered, it can be a very useful tool for strategy and operations and can help you make better programming decisions. Future Issue Briefs will provide the reader with more illustrative examples of RE-AIM framework and how it is being utilized in support of the AoA initiatives and other programs.

The purposes of this issue brief are fourfold: 1) provide a background to the RE-AIM framework; 2) articulate the key elements of the RE-AIM framework with attention to the public health impact; 3) describe a scenario in which the

RE-AIM framework could be used for planning around physical activity programming; and 4) describe current initiatives and project future directions for RE-AIM.

The Center invited Russell Glasgow, PhD, Clinical Research, Kaiser Permanente Colorado, Deborah Toobert, PhD, Oregon Research Institute, and Basia Belza, PhD, RN, University of Washington, to collaborate on the development of this monograph. Dr. Glasgow has been instrumental in the initial development and ongoing revision and testing of RE-AIM. Dr. Toobert is the research partner in one of the AoA demonstration project teams. Dr. Belza participates in the Prevention Research Center-Healthy Aging Research Network and, in collaboration with community partners, is funded to disseminate an evidence-based physical activity program in the Pacific Northwest. The Center is delighted that they have written this monograph to introduce RE-AIM to our readers.

## Background

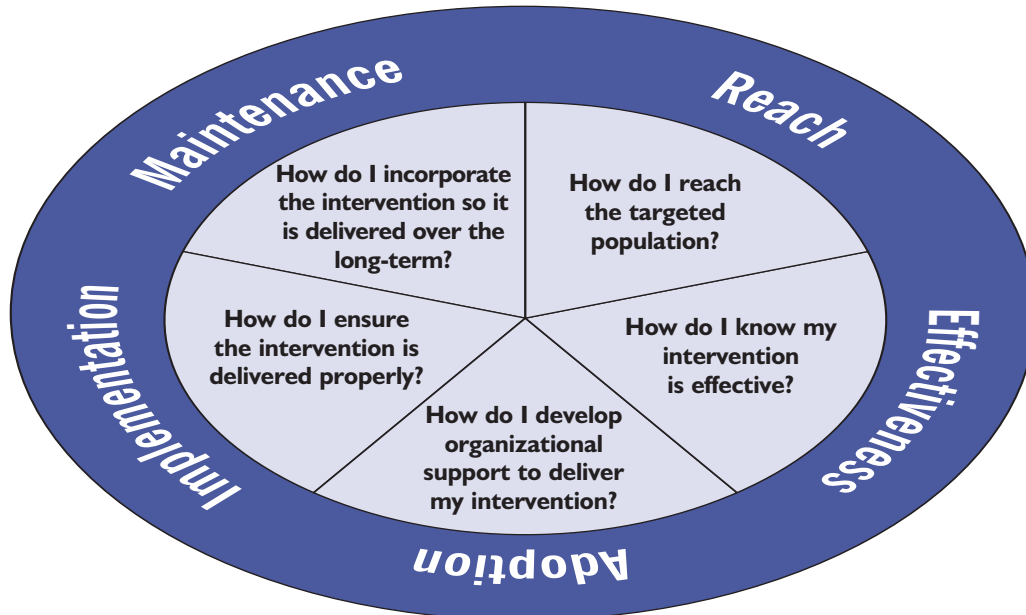
RE-AIM was developed initially as a framework for consistent reporting of the results of research studies (Glasgow, Whitlock, Eakin & Lichtenstein, 2000), and later used to organize reviews of the existing literature on health promotion and disease prevention in different settings (Glasgow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004). More recently, RE-AIM has been used to help plan realistic programs that have better chances of working in "real-world" settings (Klesges, Estabrooks, Glasgow, & Dzewaltowski, 2005). The framework has also been used to understand the relative strengths and weaknesses of different approaches to health promotion and chronic disease self-management—such as in-person counseling, group education classes, telephone counseling, and Internet resources (Glasgow, McKay, Piette, & Reynolds, 2001). The overall goal of the RE-AIM framework is to encourage program planners, evaluators, readers of journal articles, funders, and policy makers to pay more attention to essential program elements which can improve the sustainable adoption of effective, evidence-based health promotion programs.

### RE-AIM Model Elements

RE-AIM consists of the five elements or dimensions as illustrated in Figure 1. Taken together, these elements represent the overall public health impact of a program or policy. It is not enough for an intervention to do well on one or two elements. To maximize overall impact, programs need to do well on all five elements. Significant program weakness in any of the elements may adversely affect impact.

Although there is some overlap, each of the elements has been carefully designed to provide the user with guidance in the five key domains necessary to improve the chances of successfully planning the adoption of an evidence-based health promotion program. Additionally, the RE-AIM

FIGURE 1. Elements of the RE-AIM Model

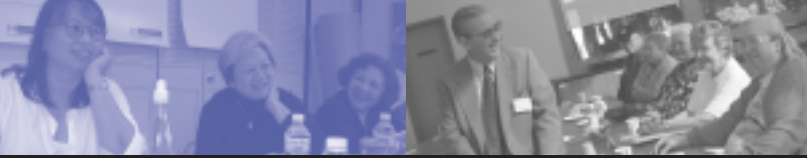


framework includes elements that draw attention to program design at the individual or participant level (Reach, Effectiveness and Maintenance) and the organizational or setting level (Adoption, Implementation, and Maintenance).

- “Reach” assesses the penetration of a program into its intended target audience. It is composed of the participation rate among eligible persons and the representativeness of these participants. For example, will men participate at the same rate as women? Will those having less education be as likely to participate? We are especially concerned about whether the program reaches those most in need and at highest risk. We are also concerned with reaching out to the growing diversity of our aging population.
- “Effectiveness” in the RE-AIM framework refers to the program outcomes. Minimally, it assesses improvement on intervention targets and impact on quality-of-life. Additionally, it includes any adverse consequences that may occur as a result of the program.
- “Adoption” is similar to Reach, but is assessed at the level of the settings (such as community-based organizations, clinics, or worksites). It consists of the participation rate among potential settings and the representativeness of these settings. We are concerned about whether a program can be adopted by most settings, especially those having few resources, rather than only those funded by research studies or with direct support

from an academic setting. The key to both Reach and Adoption is the identification of a “denominator” of eligible persons or settings for use in calculating participation rate. This can be challenging, but there are multiple approaches and tools ([www.re-aim.org](http://www.re-aim.org)) available to help decision makers to determine or estimate such denominators.

- “Implementation” is sometimes referred to as intervention fidelity and includes the extent to which different components of an intervention are delivered as intended by the developers. Local modifications that significantly alter essential components of the program can adversely affect its outcome. Fidelity is also concerned with the consistency of intervention delivery across different staff. In RE-AIM, we are also concerned about the extent to which programs are adapted or modified over time. RE-AIM uses both qualitative and quantitative approaches to understand and assess fidelity.
- Finally, “Maintenance” applies to both the individual participant and the setting or organization. At the individual level, maintenance is concerned with the long-term effects of the intervention on both targeted outcomes and quality of life indicators. At the setting level, it refers to the program’s institutionalization, or the extent to which a program is sustained (or modified or discontinued) over time.



## A RE-AIM Scenario

Consider the following illustrative scenario: Imagine that a randomized trial has been completed that documents a new, highly effective intervention for improving physical activity in sedentary, at risk seniors. The results indicate that after six months, 40% of the participants achieve the Surgeon General’s recommended 30 minutes or more of moderate intense physical activity on most days of the week (US DHHS, 1996).

Now, think about planning to replicate this new program. First assume that, of all the senior centers in your state, an unrealistically large 40% agree to adopt this excellent physical activity program. Next, assume that 40% of all the sedentary and at risk older adults who live around these senior centers agree to participate in this new physical activity program.

Now, reality sets in, and due to many competing demands, about 40% of the senior centers and their instructors consistently implement the program as designed. Finally, assume that an amazing 40% of the participants who achieved positive results at six months were able to maintain these improvements over the next six month. As shown in Table 1, the result is that about 1% of the at-risk population will actually achieve the intended results. These results are not intended to be discouraging but to encourage planners to think about all the RE-AIM elements when translating interventions into real world programs. Improvements in reach, adoption,

implementation and maintenance can improve impact. Also, providing other ways to increase activity (such as walking clubs and home-based programs) might attract organizations and seniors that do not want to do a group program, resulting in increased activity rates across the entire population.

There are several points to this exercise. First, it illustrates the need to attend to all RE-AIM dimensions when selecting interventions for translation—not just to the effectiveness of change reported from large clinical trials. To date, the vast majority of research has focused on effectiveness and has largely ignored other RE-AIM elements. Second, it illustrates that if even small improvements were made along two or more of these elements, the resultant public health benefits could be dramatically increased. For example, if 60% of the senior centers participate and they consistently implement the program for 80% of participants, the resulting impact is tripled. Third, even if only 40% of “adoption settings” participated, if you expanded the program beyond senior centers to YMCAs, recreation and community centers, and housing sites then perhaps 60% of at risk older adults might participate. You can improve the overall performance of your program by looking at all the dimensions and thinking about the “denominator,” e.g. the number of older adults at-risk, the number of settings that can adopt the program, the number of staff that can implement the program with fidelity every day.

**TABLE 1. The Reality of Translating an Evidence-Based Physical Activity Intervention**

<i>Issue</i>	<i>RE-AIM Element</i>	<i>Results-Multiplier</i>	<i>Population-wide Impact</i>
<b>Potential program results</b>	Effectiveness	0.4	40%
<b>Senior center participation rate</b>	Adoption	0.4	16%
<b>Participation rate among at risk sedentary seniors</b>	Reach	0.4	6.4%
<b>Consistent implementation with fidelity</b>	Implementation	0.4	2.6%
<b>Longer-term effects</b>	Maintenance (individual level)	0.4	1.02%

## Application of RE-AIM

How can RE-AIM be useful for planning your project? Start by asking yourself the questions listed in Table 2 (see page 10). If you cannot answer the questions based on data or experience with a program, just give your best estimate—taking into account what you know about the program, your settings, and your participants. If you are concerned about a given RE-AIM element, consider the strategies listed for strengthening that dimension in the right-hand side of the table. A publicly available Internet RE-AIM exercise may be found at [www.rei-aim.org](http://www.rei-aim.org). This exercise is more detailed and provides automated scoring and immediate feedback.

One way to use RE-AIM as part of a quality improvement exercise is to have different members of your project team log on to [www.re-aim.org](http://www.re-aim.org) and answer the questions and write down their summary scores, noting especially the elements on which they rated the program highest and lowest. Then, have a group discussion to see how similarly you each evaluated the program and brainstorm improvement ideas using suggestions in Table 2 as a starting point.

### Case Study: Disseminating a Community-Based, Group Exercise Program

The following case illustrates the application of RE-AIM in guiding dissemination of an evidence-based group physical activity program for sedentary older adults. A partnership between senior center meal sites and several aging service providers identified low rates of physical activity as an important risk factor for chronic conditions and disability within their community. Looking at data on meal site participants, they realized that these older adults report multiple chronic conditions and lead sedentary lifestyles. Attendees at these meal programs have been requesting additional physical activity programming. Members of the partnership reviewed a variety of approaches for increasing physical activity and decided that one important strategy was to offer structured, group, evidence-based physical activity programming throughout their catchment area at their congregate meal sites. They selected a program that was appropriate for diverse older adults, various settings, and had a substantial evidence-base. Essential program elements included: one hour classes each including stretching, balance, flexibility and aerobic exercises, convening three times a week in local community sites. Instructors needed to be certified and trained in this particular program and there was a fee for the training and a program license. Community outreach and marketing materials were available and easily adaptable.

The partnership identified resources to assist with planning and start-up costs. A large multi-purpose aging service's organization agreed to coordinate the planning and implementation process, in collaboration with the other

partners. The partnership agreed that the goal was to increase the ability of program participants to meet the Surgeon General's recommended levels of physical activity (US DHHS, 1996).

The planning process included using the RE-AIM framework to build the implementation plan and to monitor roll-out of the program. During the planning phase the partnership addressed all the RE-AIM elements, trying to ensure that decisions in one area, such as Reach, were consistent with and supportive of decisions about Effectiveness, Adoption, Implementation, and Maintenance. Tentative plans were revised as start-up and implementation were examined from the standpoint of the various RE-AIM elements.

**Reach.** To develop a plan for reach, the partnership reviewed existing data on participants and gathered some additional information. Data collected through annual surveys indicated that participants at the congregate meal programs were interested in attending exercise classes if they were held on site, were age-appropriate, safe, free, and taught by experienced instructors. Reasons that meal site participants were not exercising included having pain, fear of injury, and cost. Many of the participants suffered from osteoarthritis, a common chronic condition among older adults. When presented with the opportunity to exercise at the meal program site, potential participants readily agreed to register as well as recruit friends.

In considering reach, the partnership reviewed data on at-risk populations and examined what programming currently existed for various at-risk groups. There seemed to be very few programs with proven effectiveness for persons with arthritis. The partners decided that the initial target population would be sedentary persons age 60+ with arthritis, with special attention to persons who are ethnically diverse and living in neighborhoods without existing physical activity programs. They did not want to limit the physical activity classes only to people with arthritis, but they wanted to make a special effort to recruit these persons because they are over-represented among sedentary elders and are often hesitant to be active, despite proven benefits.

Evidence exists that arthritis-attributable activity limitation can be prevented or reduced. For example, both aerobic and strengthening exercises can improve physical function and self-reported disability among older adults with knee osteoarthritis. In addition, among persons with arthritis who are not limited in activity, physical activity reduces the risk for functional activity limitation by 32% (Dunlop et al 2005). Arthritis self-management classes reduce pain and disability (Lorig et al 2005). However, despite the known benefits of exercise for persons with arthritis, 44% of adults with arthritis are physically inactive (Shih et al, 2006).



The partnership wanted to find settings and organizations that had already reached some members of the target population and could likely reach more. They met with a variety of local aging and public health organizations to learn more about what neighborhoods they were serving and which older adults were participating in any programs. They also needed to identify settings that could meet the space and equipment requirements (chairs, storage rooms for weights, etc.). They decided to start their physical activity program in congregate meal sites in neighborhoods with large ethnic populations and few physical activity programs. Sponsoring organizations for the meal programs were senior centers, senior housing providers, churches, community service organizations, and recreation centers. Before finalizing the decision to work with meal sites, the partnership visited these meal sites to assess interest among staff, volunteers, and diners. They also wanted to learn how many of the diners with arthritis were not engaging in physical activity. The partnership also conducted site visits to determine characteristics of various locations to determine what settings might be most safe for a program offering.

**Effectiveness.** The effectiveness of the program was demonstrated in the original randomized trials and later large observational studies in senior centers. In those studies, older adult participants showed significant improvements in muscle strength and health status, and reduced falls. Members of the partnership reviewed the studies to learn how many classes an older adult needed to attend to receive these positive improvements as well as learn about other critical components of the program.

**Adoption.** Criteria were developed to select the first sites to target for Adoption. These criteria included: ethnic or racial groups served, previous experience with some type of physical activity programming, appropriate space and equipment, accessibility to older adults via public transportation or walking, and experience in recruiting and managing volunteers who could assist with recruitment and class logistics. Project leaders realized that these criteria might exclude some meal sites that serve sedentary elders with arthritis but they wanted to begin their efforts with sites that were likely to succeed. They agreed to focus on sites that met all the criteria but would welcome inquiries from other sites that wanted to conduct the program and assess them on a case-by-case basis.

They reviewed 20 sites and found that five were both appropriate and willing. Once the sites were selected, the project team began to estimate how many people were in the target population. They started by estimating how many sedentary older adults with arthritis already attended the meal site at least once per month. Then they looked at census and risk factor data to estimate how many sedentary older adults with arthritis lived in the neighborhood sur-

rounding the meal site. These numbers were estimates—they did not have these data for their local area—but they wanted to make an “informed guess” to guide their planning and to monitor Reach. They developed a way to understand the Reach of their program in terms of priorities for their recruitment efforts. From data on the diners who attended 5 meal sites (100 at each site), they knew that of the 500 who attended, 80% or 400 of the participants had arthritis and were not regularly physically active. They set a recruitment goal of 25% or 100 people.

Their next priority was to recruit people who were connected to the sponsoring organization but not participating in the meals program. These people were other residents of senior housing or other members of a senior or community center. They knew that there were about 100 older adults in this group and estimated that conservatively 50% had arthritis, were sedentary but could participate in a group-based exercise program. They set a recruitment goal of 10% for this group or 5 additional people

And lastly, they wanted to reach people in the surrounding neighborhood that were not already connected to the sponsoring organization. They knew that these would be the hardest people to attract but they also recognized that it was important to reach out to people who could benefit from the program but were not already connected to services. They estimated that 100 older adults lived in the neighborhood and due to ethnic and economic composition of the neighborhood, they estimated that 50% had arthritis and were sedentary. They hoped to reach 10% of this group—another 5 people. In total, they wanted to reach 110 out of a target population of 500.

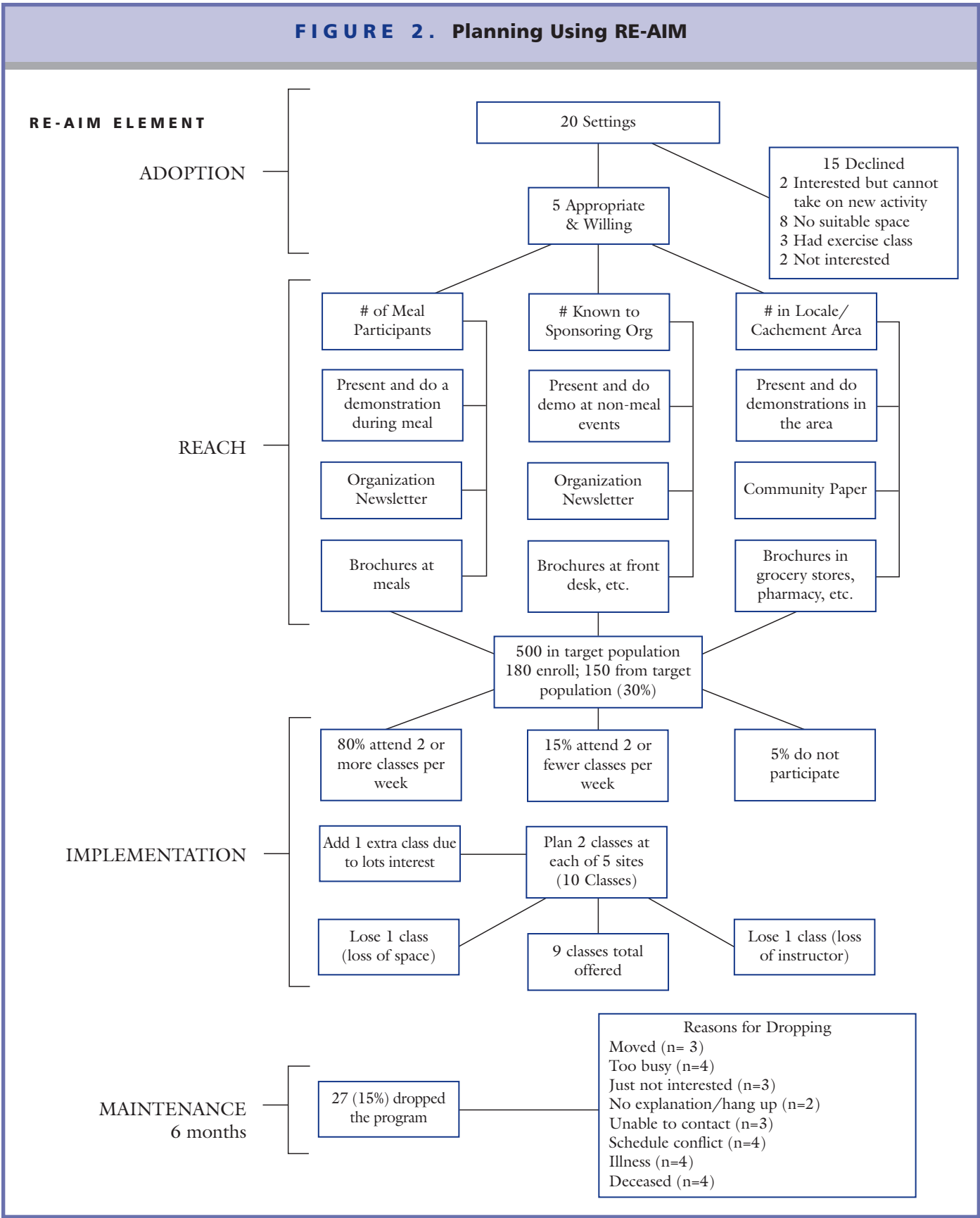
To recruit participants to the coordinating agency, partners and sponsoring organizations (that operated the meal sites) used a variety of marketing materials and channels including presentations to groups of older adults, newsletter and local newspaper announcements, flyers in local clinics, pharmacies, grocery stores, libraries, etc. They asked older adults with arthritis who were also physically active to participate in the presentations and to tell their story to local newspapers, describing the improvements in their lives.

After all their hard work, 180 people signed up for the program, 150 of whom had arthritis, representing 30% of those in the target population and more than the original projection of 120 people. Figure 2 illustrates the recruitment strategy and success rates for different populations.

**Implementation.** In this example Implementation includes program attendance and monitoring of the exercise class.

When classes started, attendance was taken at each site and at each class. In many sites a participant took attendance allowing for participants to encourage bonding, and ownership of the program. Classes were available three times each week at each site. Through the attendance logs, the team learned that approximately 80% of participants were rou-

**FIGURE 2. Planning Using RE-AIM**





tinely attending two or more classes/week. About 15% of participants were attending two or fewer classes/week. After the first week, about 5% of the participants did not attend any classes. There were a variety of reasons for missing classes: not interested; conflicts with the days and times; and/or had unexpected problems with their own health or the health of family or friends.

There were two classes offered at each of five sites for a total of 10 classes offered. At one of the meal sites, there was a change in staff and the sponsoring organization decided not to begin the program. So one class had enrolled 10 participants but they could not actually take the program. One class was dropped because the site could not find space, and another a class was added to a site because of increased interest in the program. Therefore a total of 9 classes were offered.

The manager at the coordinating agency visited each class to monitor the instructors. Visits occurred within the first month of the instructor starting to teach and then every 6 months. The manager was gratified to see that most of the instructors knew how to lead the classes safely and with maximum benefit for the participants. Nonetheless, one instructor with a class of 14 people required additional help. It is likely that her class did not receive the full benefit for at least six months, because of a delay in her developing adequate skills to teach the class. A master trainer worked with that instructor to improve her skills. Another instructor was terminated as even with extra training from a master trainer she was not able to maintain fidelity to the program.

**Maintenance.** The partnership knew that to be true to the RE-AIM model, they needed to address Maintenance from the outset. Due to limited funding they could not provide a choice in physical activity programs so they decided to make the one program they selected most appealing by modifying the aerobic component based on the choice of activity by ethnic group. Some ethnic groups elected to dance, others took a brisk walk outside. With this type of modification fidelity was still maintained to the original program. Through the use of performance measures, feedback about improvements in muscle strength and balance was provided to instructors and participants. Because this was an ongoing class, no booster sessions were needed. Participants completed annual written surveys. For those participants in which English was not a first language, volunteer translators read the surveys to participants and summarized their responses. Instructors received updated program information on an electronic list serve. Instructors attended an annual all-day instructor workshop. A manager for the program was available to instructors and provided ongoing support and assistance (e.g. served as a substitute). Partnerships with additional community agencies were established to secure additional instructors and financial assistance. After 6 months, 85% of initial enrollees were still exercising.

**Summary.** You may be wondering “is this level of detail really necessary?” The answer is that to establish a realistic plan, and anticipate the various challenges that will undermine the impact of your program, such an analysis is very helpful. Table 2 and the text also suggest ways that the overall program impact could be improved by substantially improving any one of the RE-AIM elements. The main difference between this approach and that typically used by many community program planners, is that RE-AIM focuses on participation and results at multiple levels, and studies both the numerator of number of participants and also the denominator of number of potential participants. The traditional approach focuses only on the numerator of how many people sign up for a program.

## Key Points

In summary, RE-AIM is an evolving framework to help translate research into practice. It is intended to help users to focus on issues important for public health, and on factors related to long-term impact on both targeted and non-targeted outcomes (such as unintended consequences and health disparities). Probably the greatest need at the present time is for more and better data on the RE-AIM dimensions of Adoption and Maintenance. Impact on the setting level RE-AIM factors of Adoption, Implementation, and Maintenance (sustainability) are just as important as the individual level results, which are more frequently reported.

There are ample opportunities for RE-AIM to impact and improve program planning. Currently, RE-AIM is being used as a framework for the planning of a national conference on the dissemination of evidence-based physical activity programs. Another use of RE-AIM is that it provides a structure for researchers and aging service providers to frame questions. There is growing interest among evaluators to collect data on each of the RE-AIM elements. And RE-AIM could be used as a framework for staffing inser-vices and training programs.

## Action Steps

One of the primary goals of the Center EB Issue Briefs is to provide guidance and action steps for researchers, community service providers, and policy makers on health promotion in older adults; more specifically, to help disseminate evidence-based health promotion programs across the aging services network. The Center hopes that its publications are useful and serve to educate, engage, and energize the aging services network. If this introduction has served to pique your interest in the RE-AIM model please visit the Web site at [www.re-aim.org](http://www.re-aim.org) and learn more about how this model can serve your quality improvement efforts. A good place to begin is to take the RE-AIM survey and discuss results among your team members.

In addition, visit the Center for Healthy Aging web site [www.healthyagingprograms.org](http://www.healthyagingprograms.org) to learn more about evidence-based health promotion programming and how it can help older adults in your community to enhance their health and well-being.

## Additional Resources

Behavioral Risk Factor Surveillance System (BRFSS):  
[www.cdc.gov/brfss/index.htm](http://www.cdc.gov/brfss/index.htm)

Cancer Control Planet:  
<http://cancercontrolplanet.cancer.gov/>

Community Toolbox: <http://ctb.ku.edu>

Healthy Aging Programs: [www.healthyagingprograms.org](http://www.healthyagingprograms.org)

RE-AIM: [www.re-aim.org/](http://www.re-aim.org/)

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**TABLE 2. Planning Questions Using a RE-AIM Framework**

<i>RE-AIM Element</i>	<i>Questions to Ask</i>	<i>Practical Ways to Address the Question</i>
<b>REACH:</b> Who is intended to benefit from the program?	What percent of your target population (those who are intended to benefit from your program) will participate in the program?	<p>Estimate the number and percentage of people in the local population that have the targeted risk factor (e.g., sedentary adults with chronic conditions).</p> <p>Estimate the approximate percent of this targeted population that will be appropriate for the planned program (e.g., cognitively and physically able to participate in a group-based program). Record the number of people in the target population who are appropriate participants.</p> <p>Consider if the population “appropriate” for this program is too limiting. Are people being excluded who are at high risk and could benefit from the program? If so, recalculate the size of the target population.</p>
	How do you reach the target population?	<p>Conduct focus groups or discussion sessions with potential participants. Conduct a needs assessment in the target group and/or with organizational settings.</p> <p>Offer programs in locations already serving high-need populations.</p> <p>Develop program recruitment and retention strategies that appeal to the diversity of your target population (diverse in income, cultures, age, gender, health status and other characteristics). Use multiple channels of recruitment (e.g. newsletters, local papers, other classes, case managers, programs of partner organizations). Think about which organizations, events, settings already have a connection with your target population.</p> <p>Ask community partners to help you identify potential barriers to participation and ways to overcome them. Ask members of the target population to help with recruitment; ask program participants to recruit others.</p> <p>Develop ways to track the effectiveness of different recruitment materials and strategies.</p>
	Does your program reach those most in need? Are participants representative of the targeted population?	<p>Monitor who actually participates in the program. Are these the people with greatest risk? If not, consider how outreach and recruitment activities can be modified. Talk with people who decline to participate and those who drop out.</p> <p>Examine the data on the characteristics of your participants. Do your programs have the same or larger proportions of people with risk factors as the community population? For example, compare data on your participants to data from the Behavioral Risk Factor Surveillance System (BRFSS).</p>

**TABLE 2. Planning Questions Using a RE-AIM Framework — CONTINUED**

<i>RE-AIM Element</i>	<i>Questions to Ask</i>	<i>Practical Ways to Address the Question</i>
<b>REACH:</b> Who is intended to benefit from the program? (Continued)	Does your program reach those most in need? Are participants representative of the targeted population? (Continued)	Calculate the participation rate of your target population. What percent of the target population is participating in your program? (For assistance with calculations and detailed explanations of reach see <a href="http://www.re-aim.org/2003/calc_reach.html">http://www.re-aim.org/2003/calc_reach.html</a> )
<b>EFFECTIVENESS:</b> How do you know if your program is effective?	Is your program achieving the outcomes that you had set?	<p>Use some of the most applicable measures and methods from the original intervention study. Compare your results to the published results.</p> <p>Use specific, reliable, and sensitive (responsive to change) measures of behavior change.</p> <p>Consider multiple outcome measures, especially at first, so that you can examine the impact of your program on a variety of outcomes (e.g. improved muscle strength, function, symptom management, mental health, and/or reduced falls, weight)</p> <p>Measure program retention. Document who drops out and when. Try to learn why.</p> <p>Track the costs of various aspects of the program including recruitment, retention, staffing, training, equipment, space, evaluation, etc.</p>
	How do you improve the effectiveness of your program?	<p>Incorporate more tailoring to individual participants (e.g., multiple languages, group and home-based programs).</p> <p>Support ways to improve activity levels through social connections and improvements in the environment (find a buddy to walk with, create safe and interesting walking routes).</p> <p>Use goal setting—ask participants to set very modest goals. Provide positive reinforcement of even modest improvements.</p> <p>Identify a few simple strategies to support behavior change that staff, volunteers and participants can use. Build to more complex behavior change methods. Offer incentives.</p>
	How do you track the short term impact of your program?	<p>Track participation in every class. Low participation rates and high drop-out rates indicate a problem. Talk to participants and to people who drop out.</p> <p>Supervisors and managers should observe the classes or other program activities. Use a checklist to record what you see and provide feedback to instructors and program leaders.</p>



**TABLE 2. Planning Questions Using a RE-AIM Framework — CONTINUED**

<i>RE-AIM Element</i>	<i>Questions to Ask</i>	<i>Practical Ways to Address the Question</i>
<b>EFFECTIVENESS:</b> How do you know if your program is effective? (Continued)	How confident are you that your planned program is being implemented without adverse consequences (e.g., injuries during physical activity)?	Establish a system for recording any adverse events. Track these events and understand their causes.
	How do you improve assessment of effectiveness?	Evaluate the effects of specific program components to identify which elements are essential.
<b>ADOPTION:</b> How can you ensure that your program will be adopted by those settings that have connections to people in the target population?	What percent of appropriate settings do you estimate will participate in your program?	<p>Define criteria for “appropriate” setting. Remember that, in general, the broader the criteria the more likely you are to reach a diverse population.</p> <p>Estimate the number and percentage of settings or organizations in your targeted group that meet your defined criteria.</p> <p>Record the number of settings that you exclude from participation and why. Record the percent of targeted settings that agree to participate. Record reasons that settings refuse to participate. Do you need to revise your criteria?</p> <p>Evaluate the representativeness of participating settings or organizations by comparing differences between those participating and those not participating on characteristics such as type and size of organization, previous experience with health promotion programs, number of members/clients, policies regarding health promotion programming, etc.</p>
	How do you develop organizational support to deliver your intervention?	<p>Recruit settings that have most contact with targeted participants.</p> <p>Convene meetings with leadership and staff from a variety of settings with the purpose of describing the program and working together to see how the program can fit within their organization.</p> <p>Help them to see the need for health promotion or risk reduction programming. Help them to see the critical role that their organization plays in reaching those people at greatest need. Demonstrate the advantage of this new program over existing or alternative programs. Develop recruitment materials outlining program benefits and required resources.</p> <p>Provide technical assistance and resources for planning and implementation. Provide different cost options and ways to customize the program.</p>

**TABLE 2. Planning Questions Using a RE-AIM Framework — CONTINUED**

<i>RE-AIM Element</i>	<i>Questions to Ask</i>	<i>Practical Ways to Address the Question</i>
<p><b>ADOPTION:</b> How can you ensure that your program will be adopted by those settings that have connections to people in the target population? (Continued)</p>	<p>How do you develop organizational support to deliver your intervention? (Continued)</p>	<p>Conduct formative evaluation with settings that choose to adopt the program and those that decline. Try to understand the differences in these organizations and how the adoption decision impacted them.</p> <p>In general, programs with the following characteristics will be easier to adopt:</p> <ul style="list-style-type: none"> <li>• Low complexity</li> <li>• Easy to understand program communications and materials</li> <li>• Compatibility with organizational values</li> <li>• Low disruption to organization</li> <li>• Minimal start-up time</li> <li>• Limited risk of poor or uncertain results</li> <li>• Observable results so everyone can see the benefits</li> <li>• Ease of making improvements or updates in the program</li> <li>• Ease of customizing the program to different populations or locations</li> </ul>
<p><b>IMPLEMENTATION:</b> How do you ensure that your program is delivered properly (e.g. with fidelity)?</p>	<p>Are different components delivered as intended?</p> <p>Can different levels of staff implement the program successfully?</p> <p>What parts of the program are flexible or adaptable, without decreasing program efficacy?</p>	<p>Start with a pilot project to assess how the program will work in various delivery settings and for various intervention staff.</p> <p>Provide staff with training and technical assistance.</p> <p>Provide clear protocols and implementation guidelines.</p> <p>Involve staff in the planning and implementation stages.</p> <p>Think about what parts of the program, if any, can be automated.</p> <p>Prepare a plan to acquire and use existing resources so as to maximize performance.</p> <p>Monitor and provide staff feedback and recognition for implementation.</p> <p>Routinely assess fidelity of the program as implemented. Compare actual implementation to parent study intervention and your original implementation plan.</p> <p>Track resource consumption—is it consistent with maximizing performance?</p>



**TABLE 2. Planning Questions Using a RE-AIM Framework — CONTINUED**

<i>RE-AIM Element</i>	<i>Questions to Ask</i>	<i>Practical Ways to Address the Question</i>
<p><b>MAINTENANCE:</b> How can you help participants to stay engaged and sustain positive behavior changes over time?</p>	<p>Does the program produce lasting effects (1-2 years or longer) at the individual level?</p>	<p>Design the program to address specific barriers to maintenance.</p> <p>Provide choice in programs—let people choose among effective program components so they can find what works best for them.</p> <p>Incorporate self-monitoring and feedback to participants.</p> <p>Help participants incorporate new changes into their daily lives.</p> <p>Increase social-environmental supports and policies supporting individual behavior change.</p> <p>Provide continuing contact with participants through face-to-face meetings, telephone, mail, and the Internet. Provide booster and follow-up sessions.</p> <p>Plan for relapse—understand that many events will interfere with program participation, and lifestyle improvements, and make plans to address these.</p> <p>Conduct long-term follow-up assessments. Learn why changes are maintained for some participants but not for others.</p>
<p>How do you incorporate the program so it is delivered over the long term?</p>	<p>Can organizations sustain the program over time—even after initial funding and enthusiasm?</p>	<p>Ensure that existing staff have the skills to continue the program; incorporate these skills into job descriptions.</p> <p>Ensure that supervisors and others know how to monitor quality and fidelity and can successfully guide the program.</p> <p>Ensure that organizational leadership, including Board members, know about the program, and see its value to the organization.</p> <p>Ensure that partners are engaged and see the importance of their various contributions.</p> <p>Reduce level of resources required.</p> <p>Provide incentives and policy supports.</p> <p>Continue contact and technical assistance to participating organizations or settings.</p> <p>Regularly meet with organizational staff, leaders and participants to learn what they like, what works etc. Make changes as feasible—attending to fidelity.</p> <p>Monitor which organizations continue the program and which do not. Explore what differentiates these two groups and see if you can do something that would help with sustainability.</p>



