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Introduction

David Chambers[1], Lisa Simpson[2], Gila Neta[1]
[1]Division of Cancer Control and Population Sciences, National Cancer Institute, Rockville, MD, 20850, USA; [2]AcademyHealth, Washington, DC, 20009, USA
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At a time of significant upheaval in American health policy, maintaining a focus on a "North Star" is critical. For implementation science, this star is the knowledge base on how to optimally disseminate evidence related to health and health care, how to implement interventions to improve care within the many settings where people receive health care and make health-related decisions, and how to improve the health of the global population. To that end, the end of 2016 brought over 1100 engaged and activated "disciples of D & I" to Washington, DC for the 9th Annual Conference on the Science of Dissemination and Implementation in Health. Once again, the accompanying abstracts in this issue demonstrate the breadth, depth and vigor of this continually expanding and evolving subset of health research. During three dynamic plenaries with rows and rows of filled seats and packed concurrent sessions presenters and attendees shared findings, raised methodologic and other challenges, and discussed future priorities, trends, and next steps for this community of research.

For the third year in a row, we were buoyed by a strong partnership, co-led by AcademyHealth and the National Institutes of Health (NIH), with co-sponsorship from others committed to implementation science: the Agency for Healthcare Research and Quality (AHRQ), the Patient Centered Outcomes Research Institute (PCORI), the Robert Wood Johnson Foundation (RWJF), and the US Department of Veterans Affairs (VA). The multidisciplinary program planning committee informed the development of the key themes for the conference, identified the plenary sessions topics and speakers, established track leads to manage the review process for concurrent panels, papers, and posters, and convened a scientific advisory panel to advise on the overall conference, thus ensuring a robust, inclusive, and rigorous process.

Together, the opening keynote address and the three plenary panel sessions set a tone of innovation and dialogue, raised critical issues, surfaced different perspectives, and ensured that follow on lunchtime and hallway discussions delved deeper into thorny challenges facing the field. Roy Rosin, Chief Innovation Officer for the University of Pennsylvania's Perelman School of Medicine, introduced the audience to a range of methods for rapid testing, innovation in healthcare delivery, and lessons learned from other industries to maximize potential of new practices to be scaled-up. Each of the three plenary panels presented a general discussion on a high priority challenge for dissemination and implementation (D & I) research. A panel on the balance between intervention and implementation fidelity and local adaptation touched on the very real dynamic that is playing out in communities across this country as policy and payment changes are driving providers and others to seek new ways to solve the challenges in their particular contexts. A panel on the longer-term decisions around sustainment or de-implementation of interventions could not be more timely given the "improvement fatigue" of some systems and providers and the very real limits on providers' time and focus. Too often, the imperative is to "do more"; much more attention needs to be about stopping what is not working, particularly in light of estimates that 30 percent of care provided is either unnecessary, of low value or wasteful (Institute of Medicine, 2013). The third plenary panel brought different perspectives on the enduring and evolving challenges in the dissemination of evidence and evidence-based practices as well as the opportunities emerging from innovations in the digital health sector. The plenary sessions were complemented by facilitated lunchtime discussions on these topics, as well as additional research priorities, which enabled more in-depth discussions, additional question and answer time, and brainstorming of future directions. Synopses of the lunchtime discussions are included in this supplement.

The concurrent sessions were once again organized by tracks. Last year's tracks—Behavioral Health, Big Data and Technology for Dissemination and Implementation Research, Clinical Care Settings, Global Dissemination and Implementation, Promoting Health Equity and Eliminating Disparities, Health Policy Dissemination and Implementation, Prevention and Public Health, and Models, Measures and Methods—were maintained, and a new track on Precision Medicine was added, built upon the significant interest that emerged from last year's plenary and subsequent discussions at NIH, National Academy of Medicine, and beyond. The tracks again enabled conference participants to follow a consistent theme across the multiple sessions of the conference and to better group thematically the individual papers and posters submitted by the conference participants. This supplement also is organized by these track themes.

The call for abstracts, including individual paper presentations, individual posters and panel presentations, resulted in 601 submissions, spread across the nine thematic tracks. Over one hundred reviewers from multiple disciplines, sectors, settings and career stage devoted their time to ensuring a comprehensive and expert review, and reviews were conducted within each track and coordinated by the track leads. For the final program, 19 oral abstract sessions, 9 panels, and 334 posters were presented over the two-day meeting, in addition to a "poster slam". Slides for the oral presentations and panels (with the agreement of the authors) were posted on the conference website (https://academyhealth.confex.com/academyhealth/2016di/meetingapp.cgi/Home/0) and all abstracts were included on the conference webapp (https://academyhealth.confex.com/academyhealth/2016di/meetingapp.cgi). New this year was a presentation format that combined the

Implications for D&I Research
Data illustrate the benefits of implementing differential cultural adaptation designs. Furthermore, contrasting findings according to level of adaptation, indicates possibilities for relevant lines of research focused on integrating cultural adaptation and implementation science.
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Implementation and dissemination of the Sikh American families oral health promotion program

Mary Northridge[1], Rucha Kavathe[2], Jennifer Zanowiak[3], Laura Wyatt[3], Hardayal Singh[4], Nadia Islam[3]
[1]Epidemiology & Health Promotion, New York University College of Dentistry and College of Global Public Health, New York, NY, 10010, USA; [2]Community Health Projects, UNITED SIKHS, New York, NY, 10036, USA; [3]Population Health, NYU School of Medicine, New York, NY, 10016, USA; [4]Director, UNITED SIKHS, New York, NY, 10036, USA
Correspondence: Mary Northridge
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Background
The *Sikh American Families Oral Health Promotion Program* used a community-based participatory approach to develop, implement, evaluate, and disseminate a culturally-tailored oral health/healthy living curriculum for the Sikh—South Asian community. Here we examine the impact of community engagement throughout the process of program implementation in five Gurdwaras (places of worship) in New York and New Jersey, and dissemination of the findings through targeted venues and the curriculum via e-Health resources.
Methods
An interactive curriculum was developed (consisting of four core and three special topics) based upon a community-led needs assessment, adaptation of evidence-based oral health curricula, guidance from professional dental and medical associations, and input from Community Advisory Board (CAB) members. The Consolidated Framework for Implementation Research guided a mixed methods evaluation, consisting of both process and outcome measures.
Findings
Five trained community educators delivered a total of 42 educational sessions. Improved oral hygiene behaviors and self-efficacy were found among program participants. For participants with no dental insurance prior to program enrollment (n = 58), 81.0% credited the program with helping them obtain insurance for themselves or their children. Further, for participants with no dentist prior to program enrollment (n = 68), 92.6% credited the program with helping them or their children find a local dentist. Short videos in Punjabi were created in response to feedback received from community educators and CAB members to reach men, especially.
Implications for D&I Research
Community engagement was key to successful program implementation and dissemination, from the implementation leaders (community educators) to the opinion leaders and champions (CAB members). Demonstrations of brushing and flossing techniques delivered by trusted community educators in familiar settings may be effective in promoting oral health for individuals, families, and communities. The expansion of Medicaid under the Affordable Care Act provided a mechanism for Sikh—South Asian program participants to obtain dental insurance for themselves and their children, and program resources helped link families to local dentists who accepted their dental insurance. Integration of community-based participatory research and implementation science approaches may prove effective in translating evidence-based practices into culturally-tailored programs that are delivered by trusted community leaders in local settings.
Primary Funding Source
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Mapping the social context of food procurement: identifying leverage points for disseminating healthy eating messages among a low-income population

Madalena Monteban[1], Darcy Freedman[1,2], Kimberly Bess[3], Colleen Walsh[4], Kristen Matlack[2], Susan Flocke[1], Heather Baily[5]
[1]Epidemiology and Biostatistics, Case Western Reserve University, Cleveland, OH, 44106, USA; [2]Prevention Research Center for Healthy Neighborhoods, Case Western Reserve University, Cleveland, OH, 44106, USA; [3]Human and Organizational Development, Vanderbilt University, Nashville, TN, 37203, USA; [4]Health Sciences, Cleveland State University, Cleveland, OH, 44115, USA; [5]Anthropology, Case Western Reserve University, Cleveland, OH, 44116, USA
Correspondence: Madalena Monteban
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Background
Diet-related behaviors are structured by both the physical and social food environment. Within the social food environment, social capital - resources, support, and information attained through social connections or ties - has important implications for health behaviors and outcomes. Little is known about the nature of social connections at food procurement places among low-income populations. Our analysis focused on social connections supporting food procurement behaviors among parents/caregivers receiving Supplemental Nutrition Assistance Program (SNAP) benefits.
Methods
A mixed-methods approach was used including participatory social network mapping and semi-structured interviews conducted with 30 parents/caregivers receiving SNAP in Cleveland, Ohio in 2015-16. Data collection focused on food procurement places and staff with whom participants hold a social connection. Two-mode social network analysis was used to examine the ties between procurement places and participants and core-periphery analysis to identify the most common food procurement places among the sample.
Findings
In all, 27 types of food procurement places were identified by the 30 participants. Ten of these places were central indicating they are most frequented by participants. Most participants (70%) held a social connection with a staff person at one or more procurement place. Convenience stores and food pantries were the most socially connected food procurement places with 60% and 55% of participants, respectively, holding a relationship with staff in these venues while none of the participants held a connection with farmer's market staff. Qualitative analysis focused on three types of social connections: purely social, information exchange, and material benefit. Purely social connections included social interactions not related to food procurement. Information exchange included identifying deals at the store or indicating how to prepare a new food item. A few social connections offered material benefits in the form of setting aside sale items or price reductions for repeat customers.
Implications for D&I Research
Findings highlight that social connections with staff at food procurement places may be leveraged to disseminate healthy eating messages among SNAP recipients. Changes to the physical food environment may yield limited benefit without implementation of complementary interventions to either create new or catalyze existing social capital within these food procurement spaces.
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