GETTING TO OUTCOMES®

OPERATIONS GUIDE FOR

AIR NATIONAL GUARD COMMUNITY ACTION TEAMS

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Preface

Getting To Outcomes® (GTO®) is a user-oriented ten-step process for comprehensive planning, implementation, and evaluation of programs and community initiatives. It is designed to help organizations run programs well and get desired outcomes. It was developed to bridge the gap between the research evidence of effectiveness, established by program developers, and the often less-effective implementation of the same programs outside a research setting.

The *GTO Operations Guide for U.S. Air Force Community Action Teams* and four companion content area modules (CAMs) are designed for use by U.S. Air Force Community Action Teams (CATs) to aid each wing in developing its 2019–2020 Community Action Plan (CAP) for Integrated Resilience and Violence Prevention, as directed in Air Force Instruction (AFI) 90-5001 (and to aid the development of CAPs in future years). The guide and the CAMs contain tools that will help each wing's Community Support Coordinators, Air Force Reserve Command Community Action Team Chairs, Violence Prevention Integrators, CATs, and the Community Support Program Managers at the major command (MAJCOM) level complete each GTO step. GTO is part of an Air Force initiative to increase the quality and effectiveness of CAPs while enabling each wing to address its unique needs.

This guide, the Operations Guide for Air National Guard Community Action Teams, is a streamlined version adapted from the Air Force guide to meet the unique needs of the Air National Guard (ANG). It provides guidance on how to plan, implement, and evaluate various types of programs, policies, practices, and processes—what we call P^4. The guidance includes examples of evidence-based brief P^4 and measures for how to evaluate them in the ANG. Each chapter has tools that provide guidance on how to make the many decisions needed to plan and evaluate P^4. These tools then serve as a written record of those decisions that can be reviewed later. This guide is not specific to any content area because the CATs are expected to identify P^4 across many different content areas. However, we have included process and outcome evaluation measures specific to three Air Force ANG priority areas: work-life balance, responsible alcohol use, and healthy relationships and communication.

There are other GTO guides on many other topic areas (see http://www.rand.org/gto), but this guide is streamlined and tailored specifically for the ANG's efforts to enhance resilience and well-being. Although this GTO guide has been designed for use in the ANG, the GTO steps and instructions for completing them that are included in this guide could be used by all Air Force installations and MAJCOMs and other types of community coalitions and organizations to plan, evaluate, and improve P^4.

The research reported here was commissioned by the U.S. Air Force Integrated Resilience Office under the Deputy Chief of Staff for Manpower, Personnel and Services, Headquarters U.S. Air Force, and conducted within the Manpower, Personnel, and Training Program of RAND Project AIR FORCE as part of a fiscal year 2018 project, "Getting To Outcomes for Integrated Violence Prevention and Resilience in the Military: Phase 3 Follow-on Support."

RAND Project AIR FORCE

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Additional information about PAF is available on our website:
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Contents

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Abbreviations

ADAPT	Alcohol and Drug Abuse Prevention and Treatment
A&FRC	Airman and Family Readiness Center
AFCCARS	Air Force Chaplain Corps Activity Reporting System
ANG	Air National Guard
CAB	Community Action Board
CAT	Community Action Team
CAP	Community Action Plan
CFT	Community Feedback Tool
CQI	continuous quality improvement
DEOCS	Defense Equal Opportunity Management Institute Organizational Climate Survey
DUI	driving under the influence
EBP^4	evidence-based P^4
FTE	full-time equivalent
GTO	Getting To Outcomes®
HRA	Human Resources Advisor
JA	Judge Advocate
MAJCOM	major command
N/A	not applicable
NIAAA	National Institute on Alcohol Abuse and Alcoholism
P^4	programs, policies, practices, and processes
PTSD	posttraumatic stress disorder
SMART	specific, measurable, achievable, realistic, and time-based

Introduction

Every two years, Air Force installations and Air National Guard (ANG) wings are required to develop Community Action Plans (CAPs) to address the resilience and well-being needs of their communities of Airmen and Guard members. Since 2018, the Air Force has been offering installations and wings an evidence-based approach called Getting To Outcomes (GTO). GTO can help identify, select, plan, and evaluate the strongest P^4 (programs, policies, practices, and processes) to enhance resilience and well-being.

To assist ANG wings with completing their CAPs, ANG asked the RAND Corporation to develop a more streamlined version of the GTO process that recognizes the unique needs and time and staffing constraints in the ANG compared with installations. For example, many effective P^4 require multiple sessions over several weeks with significant interaction time among participating Airmen. However, members of ANG wings are geographically dispersed and usually meet only once per month and two weeks a year for active-duty training. They spend most of their time in their communities and on civilian jobs. This guide, therefore, includes a list of brief but effective P^4 that better accommodate the schedule of Guard members. It also streamlines some of the CAP planning process by offering lists of generic process and outcome evaluation measures to reduce measurement selection time involved with evaluation planning. Its content and example tools focus on three AF ANG priority areas: work-life balance, responsible alcohol use, and healthy relationships and communication.

The responsibility for the ANG CAP in each wing is overseen by the Community Action Team (CAT) Chair and Co-Chair. They head overall CAP development, leading discussion of the Community Feedback Tool and selection of resilience priorities, compiling other wing data, and completing the CAP GTO tools and CAP Face Sheet. Other personnel focus on different parts of the CAP development process. CAT members participate in meetings, collaborate and share needs data, and bring prevention and resilience activities forward to ensure alignment with the CAP. Completed CAPs must be approved by wing commanders.

WHAT IS GETTING TO OUTCOMES?

GTO lays out ten steps (see Figure I-1) needed to plan and implement any P^4 at any stage (i.e., with new and existing P^4). In 2020, ANG contracted with the developers of GTO to support wings with concrete help—written templates, training, ongoing coaching (called technical assistance), and quality assurance to complete each step and develop a CAP that addresses wings' needs. GTO is not an additional step; it is a process to complete your work. GTO helps leaders at any level and supporting staff make better decisions on what P^4 to use and how to ensure that future investments in new or existing P^4 lead to the desired results. For this guide, several GTO steps and tools are combined to streamline CAP development and evaluation.

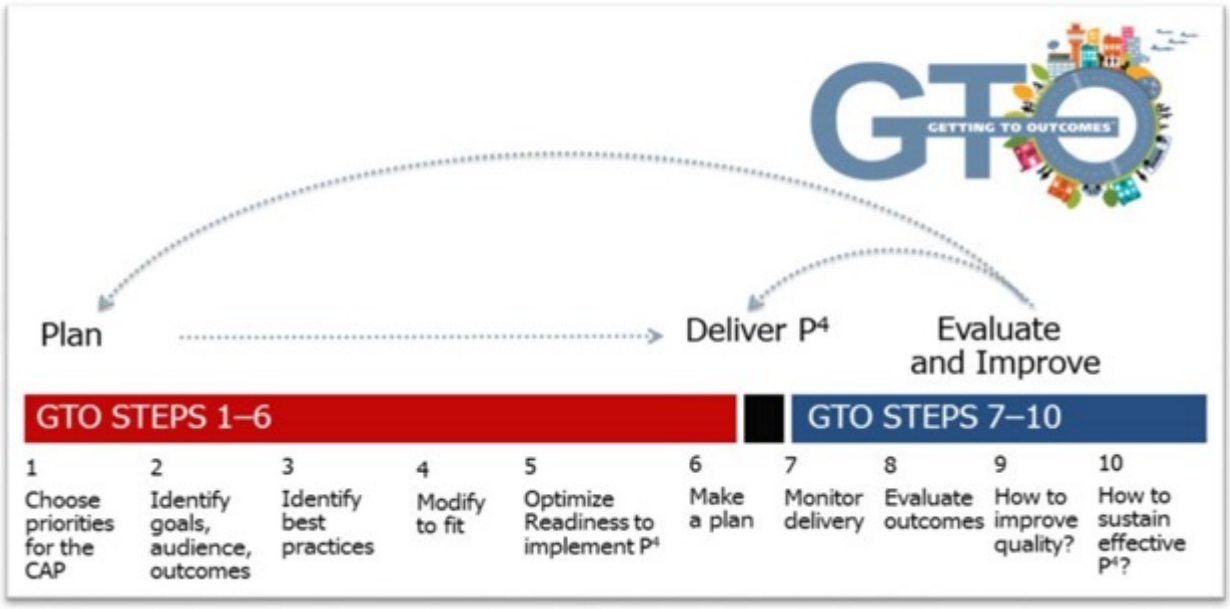


Figure I-1. The Ten GTO Steps

How Does Using GTO Benefit My Wing?

- GTO moves wings to adopt the strongest P^4 possible.
- GTO can be applied to any type of P^4 intended to create positive change in a community or wing.
- GTO can be used to show you, your wing, your community, and your chain of command the progress you are making without having to wait several months or years.
- GTO builds and sustains the capacity and the resources needed to implement P^4.
- GTO helps wings continuously evaluate and improve P^4.
- GTO helps wings get positive outcomes from effective P^4.
- GTO can help sustain your P^4.

How to Use This Guide to Complete Your CAP

Although GTO has ten steps, it is the first six steps that will be used by each CAT to create its CAP. Learning the GTO steps and completing the tools in this guide will help each wing develop its CAP.

1. First, the CAT will use the guide to help **identify the priority problems or challenges** to address with the CAP (GTO Step 1).
2. Next, the CAT will **set goals and specific desired outcomes** to reach through its CAP for each priority (GTO Step 2).

3. The guide then helps the CAT **select P[4] with evidence of effectiveness**; that fit their organization's target population, community, and wing; and for which they have staff capacity and resources needed for implementation (GTO Steps 3–5).
4. The CAT then uses the work plan and process and outcome evaluation planner tools in the guide to **lay out the details for the implementation and evaluation** of each P[4] to be included in its CAP (GTO Step 6).
5. Finally, the whole **CAP is presented in the form of a logic model** by completing the CAP Overview Tool (GTO Step 6). Work on this tool actually begins with Step 1. By the end of Step 6, you have all the pieces of the logic model and can copy them into the overview tool.

Although you will need to complete the GTO steps 1–6 tools to develop your CAP, **each wing's finalized CAP will only include the following documents** (see Figure B-1 in Appendix B):

- ✓ a CAP Face Sheet
- ✓ a brief CAP narrative overview
- ✓ a CAP overview tool
- ✓ a set of the GTO Step 6 tools for **each** P[4] you include in your CAP (work plan tool, process evaluation planner, and outcome evaluation planner).

All of the GTO tools are available in electronic form. They are included in a Word document, in fillable format, that is located with the guide at www.rand.org/t/tl311. We recommend that you use the fillable form tools to create your drafts and final documents, which can then be used to easily assemble your CAP.

GTO steps 7–10 will be useful to you after you have your P[4] and its evaluation underway.

Note About GTO Tools and P[4]: All the tools in this guide were originally designed for programs (because they often require the most detail), but this GTO guide can also accommodate policies, practices, and processes.

Organization of the GTO Guide

Each chapter contains

- ✓ a brief overview of the step(s) and their importance, including key definitions
- ✓ helpful tips  and resources for completing the steps
- ✓ detailed instructions for completing each tool 
- ✓ a hypothetical scenario in which a wing CAT team works on their CAP. This hypothetical team is addressing responsible alcohol use, and examples of each of the completed tools for a P[4] addressing alcohol misuse are included in each chapter.

The GTO guide also includes a series of appendixes with important information about evidence-informed P[4] and outcome evaluation measures for **three content areas** that were selected by ANG leadership:

1. healthy relationships and communication

2. responsible alcohol use
3. work-life balance.

These P^4 and measures have been specially selected for ANG's unique context, which often includes a geographically dispersed workforce with limited availability for face-to-face training. Therefore, **P^4 included in this guide are either brief or can be implemented remotely** (i.e., online or through a smartphone application). The P^4 and measures were selected after an extensive expert review process in which researchers, P^4 staff, and ANG staff provided input on their feasibility and relevance.

The ANG CAP Process: Tips for Using the GTO Guide

- **Who leads the GTO process at my wing?** The GTO tools and final CAP will be the responsibility of the wing CAT, headed by the CAT Chair and Co-Chair. It will be important for the CAT to use their regular meetings to work together to go through the GTO process. Each member of the team will likely have different knowledge and experience that, when brought together, will enrich the final CAP. AFI 90-5001, January 2019, provides additional guidance on the role of the CAT.
- **How much time will GTO take?** Completing these tools takes time, thought, and consideration. The CAT should meet monthly while working on the GTO tools for its CAP because coordination and collaboration are critical for optimal results. In addition, the CAT Chair and Co-Chair should plan to allocate a few hours to work on the GTO process. More time might be required for the initial steps than for the subsequent steps, depending on the experience of the staff involved.
- **How should the CAB be engaged?** Leadership buy-in is critical to the success of the CAP. Therefore, we recommend that the GTO work be completed in collaboration with the local Community Action Board (CAB) and wing leadership who will ultimately sign off on the wing's CAP. The guide highlights points in the course of CAP development at which to contact the CAB.
- **What goes in the GTO tools?** Each tool has instructions and a hypothetical scenario displayed in a shaded space to show how the tools could be completed within this scenario. In this scenario, the wing is an ANG wing commanded by Col Jane Smith that is trying to promote responsible alcohol use. Col Smith has tasked Wing Vice Commander Lt Col Robert Jones with leading a team to use GTO to plan, implement, and evaluate an alcohol prevention program, which was identified as a concern given the recent increase in driving under the influence (DUI) incidents. To complete the CAP, Lt Col Jones forms a GTO team composed of several CAT members, including Chaplain Margot Johnson; Human Resources Advisor (HRA) Sylvia Hernandez; and Captain Gilbert Lily from the Medical Group, who is a nurse. Col Smith has given the GTO team 18 months to find a program, implement and evaluate it, and present findings about its effectiveness and recommendations for improvement.

Chapter One

GTO Step 1—Identifying Priority Problems to Address

What is GTO Step 1, and why is it important?

IN BRIEF

Step 1 helps you identify and document the priority problems at your wing and existing resources to address them.

Step 1 is the process of gathering information about problems or challenges related to Guard members' resilience and what is already being done (e.g., existing P^4) to address these problems. Knowing the current level or rate of problems and their associated risk and protective factors will help with prioritizing among them and setting realistic CAP goals and desired outcomes. Tip 1-1 suggests data sources with information about levels of local and Air Force–wide problems.

Based on the Community Feedback Tool and other data, ANG has identified three priority areas: work-life balance, responsible alcohol use, and healthy relationships and communication. Each wing has to consider how common problems in these areas are for their wing compared with others, whether these problems involve violence among Guard members or impact resilience, whether these problems appear to be increasing or are a greater problem than in other wings, and why.

Learning about what is already being done, including how effective it has been, can avoid duplication and help identify whether there is an opportunity to partner with existing resources.

Step 1 lays the foundation for your CAP and shows that you understand the problem(s) your CAP will address.

By having data about the current level of your priority problem(s) (a baseline), you will be able to gauge the change in the problem(s) after your CAP has been implemented.

Definition

In GTO, a **priority problem** refers to a challenge or problem that leads to violence or fails to promote Guard members' resilience and that the wing CAT Chair and Co-Chair have determined to be the most important to address in the CAP. This could be in one of the three ANG priority areas or could be a problem of local priority.

Tip 1-1. Links to existing local data sources to help identify priority problems to address with your CAP

Wing-level data sources:

1. The **Defense Equal Opportunity Management Institute Organizational Climate Survey (DEOCS)** provides periodic installation surveys and reports on organizational effectiveness, equal opportunity and fair treatment, and sexual assault prevention and response. You can view sample surveys and reports, request new assessments, and get help interpreting reports and creating and executing an action plan at www.deocs.net.
2. The **Airman and Family Readiness Center (A&FRC)** provides quarterly trends data on support services offered to Airmen and their family members (i.e., financial, transition, relocation, etc.). Information about concerns identified through leadership consultations, unit networking, and community partnerships is provided on an as-needed basis.
3. The **Chaplain Corps** provides quarterly data on the top five counseling trends from the Air Force Chaplain Corps Activity Reporting System (AFCCARS); aggregated quarterly data on suicide ideation, sexual harassment and assault, bullying (all types), and domestic violence (all types and financial problems); and additional data upon request.
4. The **Drug Demand Reduction Program (DDRP)** provides raw numbers on active-duty and civilian drug test results by fiscal year and information on illicit drug use trends and concerns on an as-needed basis.
5. **Legal (Judge Advocate [JA])** provides aggregate quarterly data on the number and types of legal assistance visits (such as child custody and domestic relations) and aggregated military justice data, such as the number of Article 15s, court martials, and other relevant installation data and trends.
6. The **Director of Psychological Health or Suicide Prevention Program Manager (SPPM)** can provide quarterly aggregated data on suicides and suicide-related data trends, risk factors, and known warning signs; the number of psychiatric inpatient hospitalizations; and the number of high-interest patients being treated within the Mental Health Flight.
7. The **Sexual Assault Response Coordinator (SARC)** provides quarterly aggregated data on sexual assault trends, demographics, risk factors, and unrestricted and restricted report referrals. Reports on the top five trends are provided semiannually.
8. **CAT and CAB meeting minutes** are another source of information on the issues and experiences of your installation community.
9. **The Chief's Council, First Sergeant's Council and Junior Enlisted Council,** as well as any other bodies or advisory councils that meet with enlisted or members on a regular basis, often hear from members about ongoing and pressing issues and might be able to provide verbal feedback about the challenges and priority problems that members are facing.
10. **Human Resources Advisors (HRAs)** who deal with diversity and inclusion issues often collect information to self-assess the current state and monitor progress toward aligning their diversity and inclusion plans with unit goals, messaging, and priorities.

Step 1 instructions: Identifying Your Priority Problem Tool

Purpose: To identify and prioritize problem(s) to address with your CAP.

1. **Review problem data (column 1).**
    - Review data from the various local data sources (Tip 1-1) and any other information you can pull together.
    - If you have limited data available to you, data that do not represent your population well, or data that include only a few individuals or incidences:
        - Talk to your CAT members. They might have additional data sources to share or could be aware of specific problems faced by Guard members.
        - Solicit feedback and suggestions from Guard members through a suggestion box, online poll, conference call, or other method.
        - Conduct a focus group with Guard members (and, potentially, their family members). A focus group can bring to light issues that other surveys and data sources might not ask about. You could even ask the group to rank the top five or top ten problems to understand their priorities. Consider these results in conjunction with other data you may have.
        - Consider whether the limited data you DO have appear to be pointing toward a specific issue or issues (triangulation).
    - Some problems you might be interested in addressing, such as suicide or workplace harassment, could be low-base-rate problems (meaning that there were only a few incidences of the problem in a given time period). This makes it difficult to interpret trends in the data. (For example, is the problem of suicide decreasing if a wing experiences two suicide deaths in one year and one in the next? It is not possible to say.) Instead, review data on the risk and protective factors for those problems, which can be measured in greater numbers. We recommend reviewing Chapter 1 of the GTO guide content area modules on workplace harassment prevention and suicide prevention in the Air Force, available at www.rand.org/t/tl311, to learn more about those risk and protective factors.
    - Use each row of the tool to address different types of problem areas (e.g., sleep problems, alcohol misuse).
2. **Summarize data, list available resources, and identify any trends (columns 2–4).**
    - Summarize the data for each problem listed and specify the data source.
    - Next, list any resource that is already attempting to address the problem.
    - Then comment about the data trends (i.e., is the problem getting better, worse, or staying the same?).
3. **Decide on Community Action Plan Priorities (column 5).** Complete this task *after* you have completed tasks 1 and 2 for all problems you have identified.
    - **Decide on one or two *high* priorities** to address with your CAP. Review the information in this tool with your CAT to determine whether it is a low, medium, or high priority (the last column).
    - **Be sure you have consensus** from your CAT about the one or two high priorities that your wing should address in its CAP before moving on to GTO Step 2.

Below is an example of the type of information that should be entered into each column. This is only an example, and you should tailor your responses to the problems affecting your wing.

The GTO team finds that alcohol misuse has become more of a problem lately, and local data and CAT discussions persuade the team that this should be the priority problem for their CAP.

EXAMPLE GTO Step 1: Identifying Your Priority Problem Tool

Completed by: __Lt Col Jones_____ **Date**: _January 2020___

Risk factors or problem areas to decrease or protective factors to promote	**What do various data sources say about these risk and protective factors?** List the data and the source.	**List any resources that currently address this risk or protective factor.** Include - resource name - target population - any data that show whether it is or is not impacting the risk or protective factor.	**Is there any data to suggest the issue is getting better, worse, or staying the same?** If available, look at previous years of data (from column 2).	**Is addressing this risk factor a low, medium, or high priority?** Consider leadership priorities, duplication with other initiatives, and available resources.
Alcohol misuse	- Chaplain Corps Activity Reporting System data show that chaplains have seen 38 cases of alcohol misuse this year. - According to JA quarterly reports, there have been five incidents of Guard members being arrested for DUI during drill weekend over the past 6 months.	The Chaplain Corps serves the whole wing. Chaplains feel overwhelmed and unprepared for the alcohol misuse issues. The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program serves all Airmen. Staff report that it is typically only utilized after an offense has occurred, and Airmen rarely engage voluntarily or for prevention purposes.	Data show that it has gotten worse—compared with last year, there were 4 more DUIs and 15 more reports of alcohol misuse cases from chaplains.	High

Before moving on to Step 2

You will use the priorities you've identified in Step 1 to develop specific goals and desired outcomes. These priorities, goals, and desired outcomes will form the basis for selecting the P^4 you could implement at your wing and the outcomes you eventually plan to measure. Before you move on, double-check that you will be addressing wing and ANG priority problems.

Chapter Two

GTO Step 2—Setting Goals and Desired Outcomes

What is GTO Step 2, and why is it important?

Step 2 is important because setting broad goals and specific changes, called desired outcomes, ensures that

- everyone involved "is on the same page" with what you are trying to accomplish
- you have benchmarks so that you know when your P^4 is working as planned
- you are collecting the right evaluation data to assess progress.

IN BRIEF
Step 2 prompts you to develop a goal and specific desired outcomes to reach the goal.

Step 2 is also important because it forces you to **state in detail** what you want to accomplish with your CAP for each priority problem you have decided to tackle. A desired outcome might need to be adjusted later based on what the best P^4 you can find has achieved in the past.

Definitions

A **goal** for a CAP is a broad statement that represents the overall impact you would like to achieve to reduce your CAP priority problem(s)—for example, reduce alcohol misuse.

A **desired outcome** is a way to make goals more specific—for example, a reduction of a specified percentage of alcohol misuse (e.g., binge drinking) within a defined time frame for a target population.

Specific, measurable, achievable, realistic, and time-based (SMART) is an acronym that includes all the characteristics of a well-stated desired outcome. See the SMART checklist in the SMART Desired Outcomes Tool below for definitions.

Step 2 instructions: SMART Desired Outcomes Tool

Purpose: To help you create SMART desired outcomes for each of your broader goals.

1. **Copy and paste your identified priority problem(s)** from column 1 of the Step 1 tool into the first column of the SMART Desired Outcomes Tool.

2. **Write at least one goal and one desired outcome for each priority problem.**
   a. Make sure that your desired outcome statements are SMART and specify (1) the change you want to achieve (i.e., a change in knowledge, attitudes, or behaviors), (2) how much change you expect to achieve (often a percentage) and how you will measure it, and (3) when you expect to see or measure that change (a time-based component—for example, immediately after implementation or 30 days after the policy goes into effect).
   b. You might have multiple goals and desired outcomes for each priority problem—repeat or merge the cells in the SMART Desired Outcomes Tool as needed to fit your plan. For example, if you have more than one goal, you could simply repeat the priority problem in another row and add your additional goal.

Given the increasing number of DUIs, the GTO team decides to target the quantity and the frequency of binge drinking, which are related to DUIs. They use this tool to document their broad goals and specific desired outcomes to address binge drinking.

EXAMPLE GTO Step 2: SMART Desired Outcomes Tool

Completed by: Lt Col Jones **Date:** January 2020

Priority Problem (from Step 1)	**Goal**	**SMART Desired Outcome**
Alcohol misuse	Reduce the *quantity* of drinking among all Guard members	By six months after participating in the P[4], participants will show a one-third average decrease in the number of drinks consumed, as measured by the Daily Drinking Questionnaire.
SMART Checklist		
What **SPECIFIC** *knowledge, skills, attitude,* or *behavior* are we expecting to change?	Number of drinks consumed	
How much change is expected, and how will change be **MEASURED**?	Decrease in number of drinks by one-third, as measured by the Daily Drinking Questionnaire[1]	
How do you know this change is **ACHIEVABLE** (i.e., possible) in terms of what we are attempting to change?	Brief interventions have shown that drinking quantity can be reduced by one-third.	
How do you know this change is **REALISTIC**? I.e., is the specific change logically related to the problem(s) identified (from a content perspective)?	It is reasonable to expect that a brief intervention targeting alcohol use can reduce quantity.	
By when, or in what **TIME FRAME**, is this change expected to occur?	Six months after participating in the P[4]	

Priority Problem	**Goal**	**SMART Desired Outcome**
Alcohol misuse	Reduce the *frequency* of binge drinking among Guard members	By six months after participating in the P[4], at least 50% of participants who participated in binge drinking in the past month before the P[4] will have decreased the frequency of their binge drinking.* * Measured by a decrease in response to the following National Institute on Alcohol Abuse and Alcoholism (NIAAA) question: How often have you had 5 or more (for males) or 4 or more (for females) drinks containing any kind of alcohol within a two-hour period? Choose only one: Every day, 5 to 6 days a week, 3 to 4 days a week, 2 days a week, 1 day a week, 2 to 3 days a month, 1 day a month, 3 to 11 days in the past year, 1 or 2 days in the past year.
SMART Checklist		
What **SPECIFIC** *knowledge, skills, attitude,* or *behavior* are we expecting to change?	Episodes of binge drinking	
How much change is expected, and how will change be **MEASURED**?	At least 50% of participants who have participated in binge drinking in the past month will decrease their binge drinking by one level on the binge drinking question.[1]*	
How do you know this change is **ACHIEVABLE** (i.e., possible) in terms of what we are attempting to change?	Brief programs have resulted in reductions in the maximum amount of drinks in a single setting.	
How do you know this change is **REALISTIC**? I.e., is the specific change logically related to the problem(s) identified (from a content perspective)?	It is reasonable to expect that a brief intervention targeting alcohol use can reduce binge drinking.	
By when, or in what **TIME FRAME**, is this change expected to occur?	Six months after participating in the P[4]	

[1] At Step 2, you might not know yet exactly how you will measure the change; the measure name(s) can be added later as you work your way through the remaining steps.

Before moving on to Step 3

Now you are ready to take the information from Steps 1 and 2 and use it to start assessing and choosing P^4 to implement. The next three GTO steps (3 through 5) lead you through selecting the most evidence-based and feasible P^4 possible to achieve your goals and desired outcomes.

Connecting with your CAB

At this point, it is important to communicate with your CAB to ensure its support for the priority problem, goals, and desired outcome you have set. Reviewing Step 1 and 2 tools with the CAB will allow you to demonstrate how you are being systematic and accountable in your planning. Once the CAB has weighed in, update any tools, as needed.

Chapter Three

GTO Steps 3, 4, and 5—Assessing and Selecting Effective P4

What are GTO Steps 3, 4, and 5, and why are they important?

IN BRIEF

Steps 3, 4, and 5 guide you through the assessment of P4 and CAT capacity to narrow down your selection of P4 for each goal and desired outcome that you identified in Step 2.

In Step 3, you find one or more candidate P4 designed to address your priority problem and determine how much evidence there is that the P4 are effective. There are no "magic bullet" P4 to select, but your CAP should include evidence-based P4 (EBP4), if possible (see Appendixes C–E for a listing of P4), or P4 that follow best-practice principles for achieving results. Using an EBP4

- increases the likelihood of achieving goals and desired outcomes
- promotes confidence among Air Force leadership and others that you are using the best approach possible
- usually comes with features that newly created, untested approaches do not have, such as tools to track outcomes.

In Step 4, the list of candidate P4 are narrowed through assessment of fit with your wing. Regardless of how effective a P4 is in one setting, it must be a good fit for your wing. P4 are most effective when they are used in settings similar to those in which they were found to be effective or where there is a good fit with the target population, the community, and the organization. Assessing fit *before* doing a P4 is important because it

- increases the chances that it will be accepted by, and good for, the target population
- helps avoid duplication of efforts (P4 that target the same problem might not be needed)
- reduces the possibility of the P4 failing because it was a mismatch (a poor fit) with your target population, your community, and/or your wing
- rules out P4 when there are fit problems that cannot be resolved
- helps to select among several candidate P4 (choose the one with the best fit).

In Step 5, you consider and decide whether you have several kinds of needed capacity, or resources (e.g., bandwidth), to implement the candidate P4 in your wing. Knowing about your capacity strengths and limitations ahead of time gives you the opportunity to fill the gaps and do a better job of implementation.

Definitions

Best practices are those that are generally accepted among practitioners and other experts in the field to be the most effective, but, unlike evidence-based P^4, they have not been rigorously evaluated using research methods.

An **EBP^4** is a program, policy, practice, or process that has rigorous research evidence that it achieves a desired outcome (e.g., it reduces binge drinking frequency).

Fit means that you have a good and close match between the P^4 as designed and (1) your own target population (e.g., military personnel) and its problems; (2) your wing's culture, mission, and schedule; and (3) values shared in your broader community.

Capacities are the resources (staff, skills, facilities, finances, and others) that your wing has to implement and to sustain a P^4.

Step 3 Instructions: P^4 Evidence Scorecard Tool

Purpose: To help you compare the evidence for each P^4 under consideration, so you make the most informed decision about what to implement.

1. **Save a copy of the tool for each P^4 under consideration** and enter the name of the P^4 in the space provided at the top.
2. **Search the intervention tables in Appendixes C, D, and E** to find new EBP^4 or to find evidence about a P^4 you are currently implementing.
3. **In row 1, summarize the evidence** behind the P^4: What outcomes has it been known to achieve? What kinds of results could be expected, and for whom? What are the strengths and limitations of the P^4? List the source of the information.
   Note: If there is no formal evidence available, see whether the P^4 at least has experiential evidence (colleagues have successfully used the P^4) or adheres to best practices (participants receive sufficient "dose" or exposure, targets known risk factors, builds skills, based on good theory).
4. **In row 2, copy the goal and desired outcome** from the SMART Desired Outcomes Tool (GTO Step 2) that this P^4 addresses. The P^4 should clearly address and align with the goal and desired outcome(s).
5. **In row 3, work through each consideration**, summarizing or taking notes as needed and deciding whether the P^4 has the necessary materials and activities clearly defined, whether it has interactive components to engage the participants, and whether it is intensive enough to have the desired outcomes. This information will be useful in the next GTO step, Fit.
6. When you have completed an Evidence Scorecard Tool for each P^4 under consideration, compare the tools. **Eliminate from consideration P^4 that**
   a. lack evidence of sufficient effectiveness
   b. don't relate to your desired outcomes or don't address your priority problem
   c. would need impractical or unfeasible changes to meet your wing's needs.

In looking for a best practice P[4] that reduces binge drinking, the GTO team reviewed a program called eCHECKUP TO GO (http://echeckuptogo.com) and found that it had a great deal of evidence of effectiveness among participants who completed the program. It would need to be tailored for ANG, however.

EXAMPLE GTO Step 3: P[4] Evidence Scorecard Tool			
Completed by: Lt Col Jones **Date:** January 2020 **P[4] Being Considered:** eCHECKUP TO GO			
1. Evidence rating from online registry and registry name: *(if available, or N/A)*			Rated three out of three stars by CollegeAIM (NIAAA's rating of the effectiveness of college drinking prevention programs)
2. Summary of main findings: *(outcomes that changed, major strengths or limitations)*			
Source 1: *(name or citation)*	GTO guide	**Source 1 main findings:**	Seven studies demonstrate the program's efficacy with the general college freshman population and at the population level (Hustad et al., 2010; Doumas et al., 2011; Doumas and Andersen, 2009; Lane and Schmidt, 2007; Wilson, Henry, and Lange, 2005; Steiner et al., 2005; Henry, Lange, and Wilson, 2004). Outcomes improved include heavy drinking, general alcohol use, alcohol-related problems, and alcohol-related consequences. Outcomes were generally stronger for those who were heavy drinkers.
Source 2: *(name or citation)*	GTO guide	**Source 2 main findings:**	Two studies show the efficacy of eCHECKUP TO GO with heavy drinkers (Walters et al., 2009; Walters, Vader, and Harris, 2007). One study shows eCHECKUP TO GO's efficacy at reducing heavy drinking in first-year intercollegiate athletes (Doumas, Haustveit, and Coll, 2010).
Duplicate the rows above as needed to accommodate additional sources			

EXAMPLE GTO Step 3: P4 Evidence Scorecard Tool (continued)		
3. Goals and/or desired outcomes addressed *(copy and paste all that apply from Step 2, or write "None"):*	By six months after participating in the P4, participants will show a one-third average decrease in the number of drinks consumed, as measured by the Daily Drinking Questionnaire. By six months after participating in the P4, at least 50% of participants who have participated in binge drinking in the past month will have decreased the frequency of their binge drinking.	
4. Does the P4 . . . *(mark Yes or No and explain)*	**YES**	**NO**
. . . provide necessary activities and materials?	Yes. Purchasing the program gives access to the online materials.	
. . . employ varied teaching methods to actively involve participants? *(e.g., not just lectures or not just informational materials)*		No. But the program is designed to be brief. Can add a one-on-one component if desired.
. . . provide a sufficient dosage? *(e.g., intervention is not a one-off, participants receive repeated and/or reinforced messaging over time)*	Yes. The program is designed so that participants "check up" on their drinking behaviors.	

Step 4 Instructions: P4 Fit Assessment Tool

Purpose: To help you compare the fit of P4 under consideration and identify adaptations that can be made to increase their fit.

1. **Save a copy of the tool for each P4 under consideration** and write the name of the P4 in the space provided at the top.
2. **Work through the questions in the tool** to consider the fit of the P4. You might need to talk to several different people to get the answers (e.g., members of target group, helping agency colleagues, CAT and CAB members).
3. **Decide whether adaptations are needed to improve poor fit.**
    a. If the fit is good, then no adaptations are needed, and you can do the P4 as is.
    b. If the fit is poor, then adaptations will be needed. Enter your adaptation ideas in the column labeled, "What adaptations, if any, need to be made to increase the fit?"

c. Determine how large an adaptation is needed to improve fit. Definitions and examples of each type of adaptation are provided in Tip 4-1. Determine whether the adaptions are acceptable (i.e., smaller in scope, called green-light or yellow-light adaptations) or unacceptable (much larger in scope, called red-light adaptations).
d. Rule out any P^4 that would require red-light adaptations.

Tip 4-1. Types and examples of adaptations to improve P^4 fit

Red-light adaptations could greatly weaken the P^4 and generally would not be advised.

Examples of Red-Light Adaptations
Shortening a program (for example, deleting an activity or whole session)
Reducing or eliminating activities that allow participants to personalize material
Reducing or eliminating opportunities for skill practice or certain topics
Replacing interactive activities with lectures or individual work

Yellow-light adaptations are complex, so you should proceed with caution. They often require expert assistance from the developer or someone experienced with using the P^4.

Examples of Yellow-Light Adaptations
Changing the order of sessions or sequence of activities
Adding or replacing activities to address additional topics or reinforce learning
Replacing or supplementing videos (with other videos or activities)
Using other models or tools that teach the same skill
Implementing the program with a new population (e.g., an ethnic or cultural group)
Adapting a program to the Air Force that has no prior use in the military

Green-light adaptations are considered safe, minor changes that can make a P^4 better connect with the audience (i.e., to fit a program to the culture and context) without reducing its effectiveness.

Examples of Green-Light Adaptations
Updating or customizing statistics and other information included in the curriculum or handouts
Adjusting the location of the program to one familiar and convenient for participants
Adding debriefing or processing questions
Making activities more interactive and appealing to different learning styles

The GTO team reviews the eCHECKUP TO GO materials and decides that although eCHECKUP TO GO fits in some respects (targets alcohol problems, fits with the schedule of ANG), it was designed for college students and would need to be tailored to ANG members.

EXAMPLE GTO Step 4: P4 Fit Assessment Tool		
Completed by: Lt Col Jones **Date**: January 2020 **P4 Being Considered:** eCHECKUP TO GO		
Does the P4 fit with the	**Yes/No**	**What adaptations, if any, need to be made to increase the fit?**
Target population's • Needs • Demographics (e.g., gender, pay grade, race/ethnicity) • Other important characteristics (e.g., education level, work schedules)	No	It fits overall; however, the program was designed for college students and would likely need some adaptation for ANG
Community's • Cultural norms and values • Other important characteristics (e.g., rural or urban, U.S. or international)	Yes	None
Wing's • Leadership priorities • Current programming (e.g., Wingman Day, training schedule, other activities) • Other important characteristics (e.g., duty schedule)	Yes	None

Step 5 Instructions: Capacity Assessment Tool

Purpose: To assess your wing's capacity to implement P4 you are considering for your CAP.

1. **Save a copy of the tool for each P4 still under consideration** and write the name of the P4 in the space provided at the top.
2. **Go through each section in the tool and answer the questions** to determine whether your wing's capacity is adequate and then, as needed, explain your plan to increase capacity.
   - Be sure to include any capacities that are required for each P4 you are considering. For example, if two staff are required to facilitate, you would list this as a needed capacity.
3. **If you discover that your wing lacks the necessary capacities to deliver a P4**, it might be better to delay implementation of the P4 while you take time to build the capacities that are lacking, or you might want to select another P4.

The GTO team concludes that eCHECKUP TO GO does not require a great deal of capacity to implement. The wing would have to purchase it and encourage its use.

EXAMPLE GTO Step 5: Capacity Assessment Tool

Completed by: Lt Col Jones **Date:** January 2020 **P^4 Being Considered:** eCHECKUP TO GO

1. Staff capacities	What is needed?	Is there sufficient capacity?
Availability: Do you have the number of staff recommended for the P^4? Do they have the needed time available? Consider any additional staff that might be needed—for example, to serve as backup in case of a facilitator's absence or transfer.	Need Guard members to complete the program online. Need someone to monitor the completion rate and encourage completion.	☒ Yes ☐ No → What is the plan to increase capacity?
Qualifications: Are all staff (primary and backup) adequately qualified to deliver the P^4? Consider • education and training • experience or skills • comfort with the topic	Expertise is not needed to deliver the program because it is online. Need some training on how to monitor the program and encourage participation.	☒ Yes ☐ No → What is the plan to increase capacity?
2. Leadership capacities	**What is needed?**	**Is there sufficient capacity?**
Commitment: How committed is your organization leadership (at all levels) to the P^4 you are considering? Does leadership support prevention staff? Is there a prevention champion who will help introduce and sustain new P^4?	Somewhat committed. Leadership knows about the program but has not officially announced their support.	☐ Yes ☒ No → What is the plan to increase capacity? Need to have leadership announce their expectation that all will complete the program.
Communication: Are there clear channels of communication in place between levels of leadership (e.g., in case orders are needed to ensure participation)?	Leaders need to announce expectation to complete program.	☐ Yes ☒ No → What is the plan to increase capacity? Communication is usually clear once leaders decide on a course of action.

EXAMPLE GTO Step 5: Capacity Assessment Tool (continued)		
3. Technical capacities	**What is needed?**	**Is there sufficient capacity?**
Are any specific materials, equipment or technology needed (e.g., smartphones or computers with internet access)?	Minimal needs. Just need to access program from an internet-ready device and inform participants that they should use eCHECKUP on their personal device for privacy and because network computers will not allow access to the site. Will also ask Air Force information security personnel to review the data privacy and use policy of eCHECKUP TO GO.	☒ Yes ☐ No → What is the plan to increase capacity?
4. Financial and resource capacities (include in Step 6 budget tool)	**What is needed?**	**Is there sufficient capacity?**
Is there a cost or fee to use the P^4? Are printed materials needed (including curriculum and recruiting flyers)? Are there any other needs (e.g., transportation, space, evaluation materials and efforts)?	The program does cost money, and leadership needs to approve that purchase.	☐ Yes ☒ No → What is the plan to increase capacity? Need to reach out to the developers to get a final quote on the cost for our wing.
5. Collaboration or partnership capacities	**What is needed?**	**Is there sufficient capacity?**
What relationships with other organizations are needed to do this P^4? Are memoranda of understanding or memoranda of agreement or MOAs for collaboration with nonmilitary entities needed?	It could be beneficial to have substance abuse treatment options available in case the program identified a serious drinking problem that requires more intense services.	☒ Yes ☐ No → What is the plan to increase capacity?

Before moving on to Step 6

You have now reviewed one or more P^4 to see whether they meet your goals and desired outcomes, to assess their evidence of effectiveness and fit with your wing, and to determine your capacity to implement them well. If you have decided that one or more of these P^4 is right for your wing, you are ready to develop a P^4 implementation and evaluation plan (Step 6) and to complete the CAP Overview Tool.

It is possible that none of the new or existing P^4 you considered were feasible, given their poor fit or capacity gaps that you cannot fill. If this is the case, circle back to Step 3 to find more suitable P^4.

Chapter Four

GTO Step 6—Planning for P[4] Implementation and Evaluation

What is GTO Step 6, and why is it important?

In this step, you will use the P[4] Work Plan Tool, Process Evaluation Planner Tool, and Outcome Evaluation Planner Tool to create a detailed plan for running each P[4], which includes

- a written list of all P[4] activities, from preparations through evaluation
- a timeline showing who is responsible and what, where, when, and how activities should be implemented.

In GTO Step 6, you also create a logic model outlining the key components of your overall CAP. A logic model

- is a visual map that allows you to clarify assumptions about how each step builds on the preceding step until the desired outcome is reached (e.g., problems to goals to desired outcomes to P[4])
- allows you to easily see whether there are any gaps in the logic of your CAP. For example, say that the results of your needs assessment show that many at your wing are stressed by their personal finances and the CAP includes P[4] aimed at reducing stress. While the P[4] might help, there could be a gap if the CAP does not have a P[4] that builds skills in managing personal finances.

IN BRIEF

Step 6 helps you make a detailed work plan for delivering and evaluating each P[4] you selected at the end of Step 5 and a logic model overview of your whole CAP.

GTO Step 6 is important because having a detailed plan for implementation and evaluation

- ensures that no key implementation tasks are left out
- improves teamwork and partner communication
- identifies the need for changes as things begin to run counter to the plan
- reduces lost time, wasted energy, and turmoil from turnover (e.g., generates documentation useful to transitioning responsibility for implementation to new individuals).

The tools you complete for Step 6 become the documents you include in your CAP (see Appendix B). As a reminder, GTO tools were originally created with programs in mind, and not all tool content will be relevant to other types of P[4] (i.e., policies, practices, or processes). Enter "Not applicable" as needed. In addition, questions in the Work Plan Tool are intended to be customized by the GTO team as needed to increase relevance to your P[4].

Definitions

The **work plan** is the organized, formal documentation of tasks (for example, recruitment) necessary to implement a P^4, broken down by resources, personnel, delivery dates, and accomplishments. The work plan specifies who will do what, when, where, and how.

Process evaluation assesses the degree to which a P^4 is implemented well and as planned. It includes monitoring the activities, who participated, and how often, as well as the strengths and weaknesses (the quality of the implementation).

Outcome evaluation tests whether a P^4 achieved an improvement among its participants on specific areas of interest (for example, whether there was a reduction in incidents of workplace harassment) and by how much.

Step 6 Instructions: P^4 Work Plan Tool

Purpose: To document all the tasks that will need to be completed to implement each P^4.

BEFORE YOU BEGIN:

- **Save a copy of the tool for each P^4 you plan on implementing** and write the name of the P^4 in the space provided at the top.
- **Assemble the tools you developed in the five previous steps** so that you can refer to them as you complete a P^4 Work Plan Tool for each P^4.

TO COMPLETE THIS TOOL:

1. **Starting on the left, under Tasks, list each task that needs to be accomplished** to implement and evaluate the P^4. Include as much detail as possible. The tool is divided into several categories of tasks. The tool has some suggested tasks. Include these if relevant to your P^4, as well as other tasks that you know will need to be completed. Add additional rows to the tool for additional tasks as needed.
    - **Administrative**
        - Prepare budget (see P^4 Budget Tool).
        - Complete job descriptions.
        - Complete memoranda of understanding with partnering agencies, if any.
    - **Policies and Procedures**
        - Obtain any required permissions or approvals needed (e.g., to purchase a curriculum, hire a certified trainer, conduct a survey)
        - For a formal installation policy change, have legal and the wing commander review and approve.
    - **P^4 Preparation**
        - Designate the CAT Chair or Co-Chair or helping agencies, or recruit volunteers to be the facilitator(s), as needed.
        - Train facilitators, if applicable.
        - Develop installation community support through outreach (if needed).
        - Confirm the location for the P^4 (at the installation or at a community-based organization).
        - Get needed materials (e.g., copy worksheets needed for P^4 modules, acquire and test audio/video equipment).
        - Organize transportation for facilitators and participants.
        - If the P^4 is a policy change, ensure that all relevant Guard members are informed about the change and its consequences.

- **P^4 Recruitment and Retention**
  - Develop and test participant recruitment and retention plans and materials.
  - Notify the eligible population.
  - Confirm dates, time, and space, and send reminders.
- **Implementation**
  - Create a detailed schedule for implementing the P^4 (where and when each part of the P^4 will be conducted—e.g., dates of program sessions; when and how each component of a media campaign will be rolled out).
- **Evaluation**
  Note: Appendixes C, D, and E have outcome measures useful for evaluation planning.
  - Collect, enter, and analyze data.

2. For each task, **list the date by which the task will need to be completed and the person responsible** for the task. Seek feedback from your CAT and the persons responsible for each task before finalizing the document to ensure that everyone agrees to the timelines.
3. These tools are meant to be living documents. **Regularly review your plans** while you prepare and implement each P^4 to ensure that tasks have not been neglected.
4. **Fill in the Date Done column** when activities are complete, and update the tool as new tasks arise.

The GTO team divided up tasks to plan eCHECKUP TO GO. As the P^4 progresses, the team will fill in the "Date Done" column. The version below is the first draft of the work plan that they will share with the CAT for further input and revisions.

EXAMPLE GTO Step 6: P⁴ Work Plan Tool

Completed by: Lt Col Jones **Date:** January 2020 **P⁴:** eCHECKUP TO GO

Tasks: Administrative	When Will It Be Done? (Time Frame)	Who Is Responsible?	Date Done
Prepare budget (see P⁴ Budget Tool)	Within 1 month	HRA Hernandez	
Meet with program developers to deliver program at the wing	Program becomes available within 6 months	Lt Col/Vice Commander Jones	
Tasks: Policies and Procedures	**When Will It Be Done? (Time Frame)**	**Who Is Responsible?**	**Date Done**
Obtain any required permissions or approvals needed—for example, approval to purchase a curriculum, hire a certified trainer, buy ad space, or conduct a survey	Within 2 months	Lt Col/Vice Commander Jones	
Tasks: P⁴ Preparation	**When Will It Be Done? (Time Frame)**	**Who Is Responsible?**	**Date Done**
Secure wing leadership support for the program	Within 1 month	Lt Col/Vice Commander Jones	
Secure funding for the program	Within 2 months	HRA Hernandez	
GTO team reviews the program materials and works with developers to make changes for ANG	Within 3 months	GTO team	
Have wing leadership announce the availability of the program and the expectation that all wing members are to complete it	Within 5 months	Lt Col/Vice Commander Jones	
Tasks: P⁴ Recruitment and Retention	**When Will It Be Done? (Time Frame)**	**Who Is Responsible?**	**Date Done**
Develop participant recruitment (and retention) plan and materials	Within 3 months	Chaplain Johnson	
Notify the wing about the program and how to access it and deadline for its completion	Within 5 months	Chaplain Johnson	
Send reminders to wing about how to access and complete the program	Within 6 months	Chaplain Johnson	
Tasks: Implementation	**When Will It Be Done? (Time Frame)**	**Who Is Responsible?**	**Date Done**
Create a detailed schedule for implementing the P⁴ (where and when each part of the P⁴ will be conducted—e.g., when and how each component of a media campaign will be rolled out)	First draft by month 2, with updates occurring on an ongoing basis as more detail is obtained and decisions are made	HRA Hernandez	

EXAMPLE GTO Step 6: P⁴ Work Plan Tool (continued)			
Tasks: Evaluation	**When Will It Be Done? (Time Frame)**	**Who Is Responsible?**	**Date(s) Done**
Design the evaluation and complete the GTO Process Evaluation Planner Tool and Outcome Evaluation Planner Tool	Within 4 months	Captain Lily	
Collect process data	During months 6–12	Captain Lily	
Administer baseline outcome measures	At month 5 (pre-survey)	Captain Lily	
Administer follow-up outcome measures	At month 12 (i.e., 6 months after implementation begins)	Captain Lily	
Enter the collected data into a spreadsheet or other analysis program, review data quality and make adjustments as needed (e.g., spot-checking for data entry errors, eliminating duplicate entries, etc.), and analyze data	Within 14 months	Captain Lily	
Review process evaluation data from the relevant data collection tools and complete the GTO Step 7 summary tool	Some data will be reviewed monthly (such as adherence to work plan); others (e.g., user completion) will be reviewed quarterly (at months 9 and 12); satisfaction will be measured at month 12 (post-survey)	Captain Lily	
Review outcome evaluation data (including pre- and post-survey data) and complete the GTO Step 8 summary tool	Within 14 months	Captain Lily	
If the evaluation results are adequate enough to continue the P^4, decide which changes to make to improve the performance and outcomes, using the GTO Step 9 continuous quality improvement (CQI) process and tools. Adjust goals and outcomes and reassess fit and capacity in light of implementation; update the Work Plan Tool with lessons learned from implementation	Within 16 months	GTO team, individual task assignments to be determined depending on changes needed	
Finalize documentation, inventory any supplies, and begin planning the next round or next steps	Within 18 months	Captain Lily, supported by GTO team as needed	

Step 6 Instructions: Optional P^4 Budget Tool

Purpose: This is an optional tool that can be used to set budgets for tasks that will need to be completed to implement and evaluate each P^4.

BEFORE YOU BEGIN:

- **Save a copy of the tool for each P^4 you plan on implementing** and write the name of the P^4 in the space provided at the top.
- **Assemble the Work Plan tools for each of your P^4** so that you can refer to them as you complete a Budget Tool for each of your P^4.

TO COMPLETE THIS TOOL:

1. **Enter the resources required** to implement each of your P^4 in each of the categories shown in the tool:
   - **Personnel:** For some P^4, such as programs, personnel costs will mostly involve delivering the program. For other P^4, such as changes in policies, part of the personnel costs will involve securing support at the installation for the change and getting approval for it by legal and leadership. Unlike other areas of cost, it might be most useful to think about personnel costs in terms of percentage of effort or hours of effort rather than a dollar amount. Other personnel costs could include consultants, such as the program developer's trainer, a supervising social worker or counselor, a marketing expert, or someone who has successfully implemented your desired policy change at another installation. Carefully consider the amount of time required for evaluation as well, such as liaising with outside evaluators, training staff to collect or analyze data, collecting surveys, leading focus groups or in-person interviews, transcribing interviews, or creating presentations or briefs of results for leadership or others. Strong evaluations can often take as much time to execute as the P^4 itself. Any other personnel costs unique to your installation should also be included in this section.
   - **Program materials, equipment, and supplies:** If the P^4 is a program, expenses should include the program's curriculum and any other purchases needed to run the program (laptop or DVD player, projector, easels, flip chart paper for facilitating activities, markers, pencils, etc.). In addition, costs could include those related to evaluation—for example, printing surveys; paying for transcription services for interviews; or providing participant incentives, such as gift cards or snacks and refreshments.
   - **Other** (e.g., travel, transportation): If the P^4 requires travel for the participants, expenses should include the cost of traveling to and from the site where the P^4 is being conducted. Travel costs could also include those associated with sending the selected P^4 facilitators to any training required to deliver it.

   Add extra lines or categories, if necessary. You might want to create a rough draft of the P^4 Budget Tool as you gather the information necessary to determine the costs. Consult the Step 5 section that you completed on fiscal capacities and resources to make sure all costs are included.
2. **Subtotal the costs** by category.
3. **Enter a total** of the nonpersonnel costs on the line provided at the end of the tool.
4. Be sure to **update your budget periodically** to account for changing costs. You might also need to complete different budgets for subsequent years. For example, the equipment costs might not repeat from year to year.

The GTO team decides to use this optional tool. They need some time devoted to eCHECKUP TO GO to manage its rollout, evaluation, and quality improvement. eCHECKUP TO GO charges $1,075 per year per college campus (the GTO team needs to reach out to the developers to assess the cost for a wing). Captain Lily will need more time budgeted than the other team members to lead the evaluation efforts.

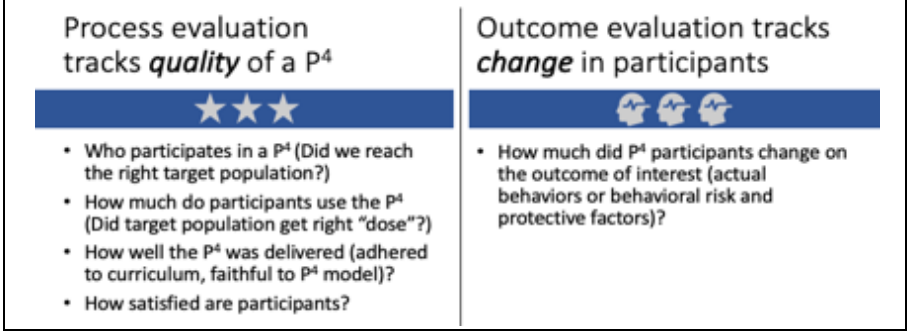
EXAMPLE GTO Step 6: Optional P^4 Budget Tool

Completed by: HRA Hernandez **Date:** January 10, 2020 **P^4:** eCHECKUP TO GO

Item by Category	Calculation	Cost Estimate
Personnel	% of effort or hours	
Lt Col Jones	0.10 full-time equivalent (FTE)	
HRA Hernandez	0.10 FTE	
Captain Lily	0.30 FTE	
Chaplain Johnson	0.10 FTE	
Personnel subtotal:	**0.6 FTE**	No cost, covered by Wing
Materials, Equipment, and Supplies		
eCHECKUP TO GO annual subscription		**$1,075**
Materials, Equipment, and Supplies subtotal:		**$1,075**
Other (e.g., travel, transportation)		
None		
Other subtotal		**$0**
Total of nonpersonnel category subtotals:		**$1,075**

Process and outcome evaluation planning: The remainder of this chapter will help you plan for the evaluation, including a process evaluation (how well the P^4 ran relative to your plan) and an outcome evaluation (how the results compare with your desired outcomes) before you launch your P^4. See Tip 6-1 to better understand the difference between process and outcome evaluation.

Tip 6-1. The difference between process and outcome evaluation in GTO



Step 6 instructions: Process Evaluation Planner Tool

Purpose: To plan how you will evaluate how well your P^4 was implemented. This tool is part of your completed CAP.

BEFORE YOU BEGIN:

- **Save a copy of the tool for each P^4 you plan on implementing** and enter the name of the P^4 in the space provided at the top.

TO COMPLETE THIS TOOL:

1. **Consider each process question** listed (and any you add), and note your measures and other considerations for data needed in the column labeled "What will you measure?" For example, for Question 1, you might enter age and gender if you are interested in these characteristics. See Tip 6-2 for suggested process measures.
2. **Enter the *evaluation methods and data collection tools*** that you will use to address the following process evaluation questions:
   - ***Program participant characteristics***, such as age and gender, can be gathered in the pre-survey or via sign-in sheets.
   - ***Attendance.*** For multi-session P^4, rosters should be designed to capture the percentage of time that participants attend each session or module. You can also sum how many of the sessions each registered participant attended. Online P^4 often can track the completion level of each participant.
   - ***Level of delivery quality achieved*** can be determined by outside observers or those completing monitoring logs, checklists of required activities and core elements, or simple notes about the actual delivery compared with the agenda or curriculum.
   - ***Participant satisfaction*** can be determined through participant focus group discussions, general observations, or a post-P^4 evaluation survey that asks open-ended questions. Some evidence-based P^4 have their own satisfaction surveys that you can adapt.
   - ***Implementer perception*** can be determined by asking program staff or facilitators questions about what they believed to be the successes, challenges, and opportunities related to the implementation.
   - ***Work plan adherence*** can be determined by reviewing the initial Step 6 Work Plan to see how closely it was followed. This could include tracking the timeliness of carrying out various tasks or the extent to which you served the number or type of expected participants.
3. Enter the ***anticipated schedule for data collection and analysis*** (i.e., when the data will be collected and the frequency of collection) and when the results will be available. Transfer key dates into the evaluation section of the Step 6 Work Plan for each P^4.

   Note about different P^4: Although this tool has questions that are useful for programs, some of these questions can also be used to track other P^4, such as changes in policies. For example, to conduct a process evaluation on a policy change, collect data about the extent to which Guard members know about the policy, the extent to which the policy is consistently implemented, the extent to which the policy is monitored for compliance, and the extent to which consequences for policy violation are consistently applied. The rows in this tool can be applied to these questions.

In this scenario, the GTO team decides that they will collect basic demographic data and log in to the eCHECKUP TO GO system to monitor how much of the P^4 the Guard members completed. They will also give all members of the wing a short survey about their satisfaction with eCHECKUP TO GO.

Tip 6-2. Examples of process evaluation measures

Types of Measures	Description	Source
Characteristics of participants compared with the target population (e.g., compare demographics of actual participants with those of the intended target population).		
Gender	Do you describe yourself as male or female? *Response options: Male, Female*	ANG leadership
Age	What is your age? *Response options: Number*	National Health Promotion Associates, 2018
Ethnicity	What is your ethnicity? *Response options: Hispanic or Latino, not Hispanic or Latino*	Office of Management and Budget, 1997
Race	What is your race? Select all that apply. *Response options: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White*	
Pay grade	What was [is] your highest pay grade? *Response options: E1–E4, E5–E8, O1–O3, O4 and above*	ANG leadership
Brief interventions: Level of delivery the P[4] achieved and whether all planned components were delivered		
Program attendance and dosage	How many sessions a participant attended within a given time period How many minutes a participant received of the program within a given time period	Gamarra et al., 2015 Christensen et al., 2006
Training fidelity and quality	Staff observations of whether the trainer covered all the training elements or whether some were skipped or not given adequate time Staff perceptions of how prepared the trainer was—for example, whether they were able to present material without reading verbatim from script or slides; whether they brought all necessary materials with them, such as handouts or props	Farris et al., 2019
Attention and participation	Staff observations of whether trainees appeared attentive (for example, nodding, active posture, looking at trainer or slides) Self-report of whether trainees were able to pay attention—for example, asking how much participants agree with the statement "I was able to pay attention during the training" Staff observations of the number of trainees who actively participated—for example, by asking or responding to questions or making productive contributions to discussions	Farris et al., 2019
Participant-program staff interactions	Number and quality of documented accounts of collaboration between participants and program facilitator or provider	Gamarra et al., 2015

Tip 6-2. Examples of process evaluation measures

Types of Measures	Description	Source
Attrition rate of participants involved in program	The number of participants who were still participating at the end of the program divided by the number who enrolled at the start of the program to determine the percentage of attrition	Shear et al., 2016
Remote interventions: Level of delivery the P[4] achieved and whether all planned components were delivered		
Reach of the intervention	Number of website sessions: A session is a group of interactions that take place on a website within a given time frame (also described as the number of visits made to a website).	Acosta et al., 2020
Engagement with the intervention	Bounce rate: The percentage of total website sessions that are single-page visits Average session duration: The total duration of all sessions divided by the number of sessions	Acosta et al., 2020
Remote and brief interventions: Participant perceptions		
Likelihood to recommend	How likely participants would be to recommend the program to others—for example, how much participants agree with the statement "I would recommend this program to others"	Tompkins and Witt, 2009 Lee, Lee, and Choi, 2011; Lee et al., 2011
Perceived usefulness of the material	Participant ratings of the usefulness of the material covered in the program	Thomas and Taylor, 2015

Tip 6-2. Examples of process evaluation measures

Types of Measures	Description	Source
Understanding of factors that contribute to participants' use (or lack of use) of the intervention	Open-ended questions on post-program evaluation survey asking: • What factors contributed to your use of the intervention (e.g., the intervention is easy to access throughout the day)? • What factors made it difficult to use the intervention (e.g., the material was hard to navigate, the technology did not work well)? • Did the material help you to think of ways the recommendations could be incorporated into your daily life? Why or why not? • What obstacles did you experience in trying to incorporate the recommendations into your daily life (e.g., it was difficult to fit the recommendations into the demands of my military job; I don't think it is an important issue or concern for me)? • In what ways could the intervention be modified to increase the chances that you will use the recommendations in your daily life?	
Participant satisfaction	The proportion of participants indicating that they were satisfied or very satisfied with • the program content • the exercises or interactive pieces of the program • the user friendliness of the program material The extent to which participants indicated they incorporated strategies from the program into their daily life Participant ratings of how knowledgeable the trainer was (for example, was the trainer able to easily answer trainee questions?)	Farris et al., 2019
Satisfaction with an online course	Participant responses to the Telecourse Evaluation Questionnaire to understand important factors for satisfaction in the online environment	Bolliger, 2004

Tip 6-2. Examples of process evaluation measures

Types of Measures	Description	Source
System Usability Scale A ten-item scale to assess the usability of a website or web-based system	For more information: This scale is available for free to use at https://www.usability.gov/how-to-and-tools/methods/system-usability-scale.html This scale uses a 5-point Likert scale to assess agreement from "strongly disagree" to "strongly agree." Items ask about the complexity and consistency of the system, whether users would use the system frequently, and their confidence using the system.	Brooke, 1996
Mentoring Event Evaluation A 7-point Likert scale with 6 questions to evaluate satisfaction with the event	For more information: This scale was developed specifically for use with this specific type of mentoring event and is available in the reference listed. Mentors and mentees were asked their level of agreement with items that asked about the extent to which their time was well spent, whether the discussions were stimulating, whether they would recommend the event to a colleague, and whether one-on-one mentoring was better than paired mentoring. Mentees were also asked whether their key questions were answered and whether they would be pursuing a relationship with one of the mentors.	Cook, Bahn, and Menaker, 2010

EXAMPLE GTO Step 6: Process Evaluation Planner Tool

Completed by: Captain Lily **Date:** January 2020 **P⁴:** eCHECKUP TO GO

Process evaluation topics	What will you measure?	How will you measure it? (Evaluation methods and data collection tools)	Anticipated schedule for data collection and analysis
1. Characteristics of participants compared with the target population (e.g., compare demographics of attendance, utilization, exposure, etc., with those of the target population).	eCHECKUP TO GO collects basic demographic questions (age, race, gender)—could explore asking about rank and tenure in ANG	eCHECKUP TO GO has a portal that allows leaders to view the data collected	eCHECKUP TO GO has each user complete the demographic questions first
2. Level of delivery the P⁴ achieved, and whether all planned components were delivered (e.g., adherence to the curriculum)	eCHECKUP TO GO allows leaders to monitor completion of its components by targeted users	Logging into the eCHECKUP TO GO system after the completion deadline	After 3 months from when eCHECKUP TO GO was announced
3. Participant perceptions (e.g., satisfaction, perceived relevance, likelihood to recommend, etc.)	Satisfaction with eCHECKUP TO GO; perceived relevance of the program to participants	Satisfaction and relevance survey	After 6 months, will ask all of those who participated to take survey (this question will be added to the outcome evaluation post-survey)
4. Staff and volunteer perceptions (e.g., whether trainees appeared engaged, suggestions for improvement, etc.)	Not applicable		
5. Adherence to the GTO Step 6 Work Plan	Will track timeline adherence and percentage of completion in the wing	GTO team meets each month to check on timeline. Percentage of completion will come from eCHECKUP TO GO.	GTO meetings each month. At the meetings, GTO team will log into eCHECKUP TO GO to assess completion rate
6. Other	Frequency of reminders provided by wing leadership	Check-in meeting with leadership will ask how many times they reminded Guard members about eCHECKUP TO GO	Quarterly

Step 6 instructions: P^4 Outcome Evaluation Planner Tool

Purpose: To help you plan how to carry out your outcome evaluation for each P^4 you have selected. This tool should be included in the CAP.

BEFORE YOU BEGIN:

- **Save a copy of the tool for each P^4 you are planning to implement** and enter the name of the P^4 in the space provided at the top.

TO COMPLETE THIS TOOL:

1. **Copy each desired outcome** you identified in GTO Step 2 into the first column (one desired outcome per row).
2. Check the appropriate box in the Evaluation Design column to **indicate your choice of evaluation design** for each outcome. Design has to do with what data you will collect and when. There are three types that are the most appropriate for wings:
   - Post- only: Data are collected only after Guard members participate in the P^4. This only indicates that the group reached some benchmark; it does not indicate change over time.
   - Pre-/post-: Data are collected before Guard members participate in the P^4 and after. This design allows you to gauge change over time.
   - Pre-/post- with comparison group: Data are collected before Guard members participate in the P^4 and after. In addition, the same data are collected at the same timepoints from a similar group of Guard members not participating in the P^4. This design lets you assess change over time and whether the P^4 may have been responsible for that change.
3. Next, **identify the measure name or metric** that you will use to measure each of your desired outcomes statements. Include the source (link or citation). Although it is possible to create your own outcome evaluation survey items, we recommend that, whenever possible, you choose measures that already exist and have been used to evaluate programs like yours. **To find measures**, see the resources specified in Appendixes C, D, and E of this guide. Some evidence-based P^4 might have their own established outcomes surveys. You might be able to request measures by contacting the developer.
4. In the last column, list the questions or survey items that you plan to use from the measure that directly assess your stated desired outcome.
5. You can use this tool to construct your outcome survey questionnaire or identify which data to collect from existing databases. These outcome measures can be combined with any process measure questions from your process evaluation planner, such as demographics or level of participation or satisfaction, that you also decide to measure.

In this scenario, the GTO team will give all members of the wing a short survey on drinking amount and binge drinking. The wing will then take the same survey about six months later after implementation of the P^4. The team will look for change over time.

EXAMPLE GTO Step 6: P4 Outcome Evaluation Planner Tool

Completed by: Captain Lily **Date**: _January 2020_ **P4:** eCHECKUP TO GO

Desired Outcome (copy and paste from Step 2)	**Evaluation Design**	**Measure Name and Source**	**Questions or Items to Include**
By six months after participating in the P4, participants will show a one-third average decrease in the number of drinks consumed, as measured by the Daily Drinking Questionnaire.	☐ Pre-/post- with comparison group ☒ Pre-/post- ☐ Post- only	Daily Drinking Questionnaire R. Lorraine Collins, Ph.D. Department of Community Health and Health Behavior University at Buffalo, the State University of New York lcollins@buffalo.edu	Respondents answer for each day of the week for both questions: Typical drinking amounts in a given week in the past month Heaviest drinking amounts in a given week in the past month
By six months after participating in the P4, at least 50% of participants who participated in binge drinking in the past month before the P4 will have decreased their binge drinking by one level on the NIAAA binge drinking question.	☐ Pre-/post- with comparison group ☒ Pre-/post- ☐ Post- only	NIAAA binge drinking question https://www.niaaa.nih.gov/research/guidelines-and-resources/recommended-alcohol-questions	Question about frequency of binge drinking in past 6 months: During the last 6 months, how often did you have 5 or more (for males) or 4 or more (for females) drinks containing any kind of alcohol within a two-hour period? (That would be the equivalent of at least 5 [for males] or 4 [for females] 12-ounce cans or bottles of beer, 5 [or 4] five-ounce glasses of wine, or 5 [or 4] drinks each containing one shot of liquor or spirits.) Choose only one response: every day, 5 to 6 days a week, 3 to 4 days a week, 2 days a week, 1 day a week, 2 to 3 days a month, 1 day a month, 3 to 11 days in the past year, 1 or 2 days in the past year

Step 6 instructions: Community Action Plan Overview Tool

Purpose: This is the most important tool because it presents an overview of your whole CAP. It is a summary of your work from each GTO step and an overview of your CAP (your plan at a glance). The column headings specify which GTO steps are linked to each column on this tool. It can be completed by copying key information from the other tools that you have already completed.

TO COMPLETE THIS TOOL:

Column 1: Copy and paste your identified priority problem(s) from GTO Step 1 into the first column of the Community Action Plan Overview Tool (one problem per row).

Column 2: Copy and paste your goal(s) for each priority problem from GTO Step 2 into column 2. The combined efforts of the P^4 you decide to implement should help to contribute to your goal, but, by themselves, they might not be sufficient to achieve it.
Note: You may have multiple goals and desired outcomes for each priority problem—repeat or merge the cells in the Community Action Plan Overview Tool as needed to fit your plan.

Column 3: Copy and paste your desired outcome(s) for each goal from GTO Step 2 into column 3.

Column 4: Write in the P^4 you identified to address your priority problem(s) and produce your goals and desired outcomes. You will have finalized this choice by going through GTO Steps 3–5. Ensure that there is a strong link between the chosen P^4 and the goals and desired outcomes (e.g., does the P^4 target your priority problem? will the P^4 have a chance to achieve the goal and desired outcomes?).

Column 5: Summarize the process evaluation measures and instruments you identified on the Process Evaluation Planner Tool in GTO Step 6.

Column 6: Summarize the outcome evaluation measures and instruments you identified on the Outcome Evaluation Planner Tool in GTO Step 6.

Column 7: Specify how you will monitor any population-level changes in the problem over time. This type of tracking looks at longer-term or overall impacts and can cut across multiple P^4. Data for this tracking usually come from sources that wings can easily access on a regular basis (e.g., DEOCS). You can compare these data to the data collected in GTO Step 1 to observe any changes that might have occurred.

In one page, the GTO team summarizes their whole approach, pulled from the other GTO tools. They were able to use this document, the Community Action Plan Overview Tool, to communicate with leadership and other stakeholders about their plans.

EXAMPLE GTO Steps 1–6: Community Action Plan Overview Tool

Completed by: Lt Col Jones **Date:** January 2020

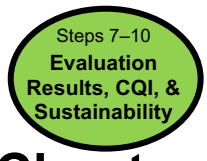
What challenges is your Community Action Plan addressing? (summarize GTO Step 1)	What are the goals for your Community Action Plan? (from GTO Step 2)	What are your desired outcomes? *Specifically include:* ***What will change*** *(knowledge, attitude or behavior),* ***by how much****,* ***for whom****, and* ***when*** *change is expected*	What P^4 are you using to achieve these desired outcomes? (finalized by GTO Step 6)	How will you assess the quality of your P^4? ***PROCESS EVAL*** (from GTO Step 6)	How will you assess the outcomes of your P^4? ***OUTCOME EVAL*** (from GTO Step 6)	How will you monitor population changes in the initial problem over time? (see GTO Steps 1 and 6)
Alcohol misuse. Chaplain Corps Activity Reporting System data show that Chaplains have been seeing more cases of alcohol misuse. There have also been several incidents of Guard members being arrested for DUI during drill weekend.	Reduce the quantity of drinking among Guard members	By six months after participating in the P^4, participants will show a one-third average decrease in the number of drinks consumed, as measured by the Daily Drinking Questionnaire.	eCHECKUP TO GO	Using the eCHECKUP TO GO system, we will measure - the demographics of participants - the completion rate of the wing. We will assess satisfaction with participation with a satisfaction question on the post- survey.	Daily Drinking Questionnaire (pre- and post- survey), measured before and six months after the start of eCHECKUP TO GO	Monitor DUI arrests and reports of alcohol misuse in the Chaplain Corps Activity Reporting System over time.
	Reduce the frequency of binge drinking among Guard members	By six months after participating in the P^4, at least 50% of participants who have participated in binge drinking in the past month will have decreased their binge drinking by one level on the NIAAA binge drinking question.	eCHECKUP TO GO		NIAAA binge drinking question (pre- and post- survey), measured before and six months after the start of eCHECKUP TO GO	

Connecting with your CAB

At this step, showing the CAB a completed draft of all tools (including your Community Action Plan Overview Tool and the P^4 Work Plan Tool, Process Evaluation Planner Tool, and Outcome Evaluation Planner Tool for each P^4) would be an excellent way to obtain feedback and buy-in from this group. Showing the CAB how you will fit the specific P^4 into your wing (from GTO Step 4) and how you will ensure P^4 capacity (from GTO Step 5) could allow for leadership input that secures their support. Reviewing all the tools with the CAB will allow you to demonstrate how you are being systematic and accountable in your planning. Once the CAB has weighed in, make sure to update any tools you changed, as needed.

Before moving on to Step 7

With the guidance provided in Appendix B, you are ready to assemble your CAP document, using the completed Step 6 tools for each P^4 included in your CAP.



Chapter Five

GTO Steps 7, 8, 9, and 10—Using Evaluation to Improve P4

What are GTO Steps 7, 8, 9, and 10, and why are they important?

IN BRIEF

Steps 7–10 help you analyze and document your process and outcome evaluation results and make changes suggested by the results to improve and sustain the P4 you evaluated.

These steps can be completed when you have collected process and outcome data and are ready to consider P4 changes intended to improve the P4 and sustain it over time. Evaluation *planning* is part of step 6, where process and outcome evaluation are both covered in detail.

Steps 7 and 8 guide you through organizing and analyzing your data and *recording the results* on the Process Evaluation Summary Tool and the Outcome Evaluation Summary Tool.

Process evaluation (which is an evaluation of the implementation quality) and outcome evaluation (which is an evaluation of effectiveness) go together because:

1. Poor implementation results could explain poor outcomes.
2. Good implementation results with poor outcomes might indicate the need to change the P4.

The results summarized in the Steps 7 and 8 tools do not stand alone. Their entire purpose is to inform decisionmaking about how to improve a P4 or maintain its effectiveness going forward.

To make such decisions, GTO Step 9 guides the user through a systematic CQI process that is driven by your evaluation results and is intended to identify strategies for improving the P4 performance and progress toward desired outcomes and long-term goals. As part of CQI, you also reevaluate the need for the P4, the fit, and your capacity to implement the P4. These considerations are covered in the earlier GTO steps.

The Step 9 CQI Review Tool will help you create a snapshot of your P4's successes and shortcomings and prompt you to identify and plan to start necessary improvements or discontinue using the P4. Using CQI represents an emphasis by the organization on the quality of its services.

Step 9 is important because:

- CQI takes advantage of what you have learned over time from your process and outcome evaluations to improve the P^4 for the future without starting over.
- It puts the investment made in evaluation to work by using the results to make changes and understand their effects as you continue to implement your P^4.
- It helps all staff to keep the P^4 fresh and ensures that it is still a good fit for your participants, your organization, and your community.

Step 10 assumes that you have decided to continue using, or sustain, a P^4 that you have evaluated. (If you are changing P^4, this step does not apply.)

Step 10 helps you review staffing, training, and other factors (such as promoting the P^4 and sustaining champions, or advocates) so that the P^4 retains its value and is ready for future or ongoing implementation. These issues require planning and updating of GTO tools over time. The Sustainability Review Tool asks you to consider and record your plans for needed next steps.

Definitions

Process evaluation assesses the degree to which a P^4 is implemented well and as planned. It includes monitoring the activities, who participated, and how often, as well as the strengths and weaknesses (the quality of the implementation).

Outcome evaluation tests whether a P^4 achieved an improvement among **its participants** on specific areas of interest (for example, did their knowledge, attitudes, skills, or behavior change?). Longer-term goals, such as reducing workplace harassment by monitoring trends in ongoing indicators, are part of outcome evaluation.

CQI is a process for deciding what changes should be made to improve implementation and outcomes and determining what difference they make.

Sustainability refers to the integration of an effective P^4 into the routine operations of an organization over the long term.

Step 7 instructions: P^4 Process Evaluation Results Summary Tool

By the time you have come to this step, you should have already completed the GTO **Process Evaluation Planner Tool** for each P^4 you included in your CAP (in GTO Step 6).

Once you have collected the data called for in that tool, use it to complete the **Process Evaluation Results Summary Tool** for each P^4, following these instructions:

1. Complete a Process Evaluation Results Summary Tool for *each* P^4 you have process data for.
2. Ask the person(s) you identified to collect and analyze the data in **the Process Evaluation Planner Tool** to provide the results for which they were responsible.

3. Enter the results that answer the evaluation questions in the **Process Evaluation Summary Tool**. Be sure that the questions in the Process Evaluation Summary Tool are the ones you included in your Process Evaluation Planner Tool. **Definitions and data collection methods are included in the Step 6 instructions for the Process Evaluation Planner Tool**.
4. Complete the fields describing P^4 dates and target population (this part of the tool is mostly designed for programs, but it can still be adapted for other P^4, such as policies). The lettered fields are asking for (A) total target population, (B) total number of participants who attended at least one session of the program, (C) total number of participants who attended every session of the program, and (D) total number of participants included in the P^4 process evaluation. You can then calculate the percentage of your target population that attended at all (B divided by A) and the percentage of participants who will be included in the evaluation (D divided by B). For assessing other P^4, such as policies, you could change the prompt about Adherence/Delivery (Total P^4 participants who attended at least one session) to one that assesses knowledge of the policy (knowledge of the policy assesses the degree to which those implementing the new policy adequately promoted it, a key aspect of delivery for this type of P^4).

In this scenario, the GTO team evaluated implementation by collecting data from the eCHECKUP TO GO portal on who used the system and how much.

EXAMPLE GTO STEP 7: P4 Process Evaluation Results Summary Tool

Completed by: Captain Lily **Date:** November 2020 **P4:** eCHECKUP TO GO

Target Population

Who did you want your P4 to reach?

A. How many people did you target for this P4: 902

What characteristics defined your target population (e.g., gender, age, rank, unit, etc.)?

17–20 years old	48	E1–E4	292
21–24 years old	80	E5–E6	356
25–30 years old	212	E7–E9	188
31–40 years old	337	O1–O3	41
41+ years old	225	O4–O6	55
		O7+	0

Participants' Utilization

What was the participants' P4 utilization compared with the P4 plan?

P4 dates: Ongoing from April to November 2020

B. Total P4 participants who attended at least one session: 608*

C. Total who attended every session: 443

D. Total participants in the P4 evaluation: 404	% of target population that got at least some of the P4: 608 ÷ 902 x 100 = 67% (B ÷ A × 100)	% of participants included in the evaluation (i.e., representativeness of results): 404 ÷ 608 x 100 = 66% (D ÷ B × 100)

Evaluation participants (check all that apply): ☐ Facilitators or staff
☐ Participants (all) ☒ Participants (some) ☐ Others _____

How well does the evaluation represent the population of P4 participants? (check one):
☐ Not at all well ☒ Somewhat well ☐ Very well

Participant characteristics (e.g., gender, age, rank, unit, etc.) compared with the target population characteristics: Good representation across age and rank at the wing

P^4 Process Evaluation Results Summary Tool (continued)
P^4 Adherence/Delivery What level of delivery did the P^4 achieve, and did all planned components get delivered?
How closely did the P^4 implementation follow the GTO Step 6 Work Plan? Most elements were followed, except leadership did not announce the availability of eCHECKUP TO GO as many times as expected (only twice instead of monthly). Greater specificity on the frequency of leadership communications would be helpful next time. Was the P^4 delivered as planned? About two-thirds of the wing did some of the program. About half of the wing did all of it. If not, why not? The wing did not hear about it enough from leadership.
What level of P^4 adherence did you achieve (offered activities according to P^4 requirements or curriculum), and what evidence do you have to document this level of adherence? In this case, adherence means completing the eCHECKUP TO GO program. About two-thirds of the wing did some of the program. About half of the wing did all of it.
Participant and Staff Perceptions
What did participants think about the P^4 (satisfaction, utility, would recommend to others)? Overall, the wing participants were satisfied with eCHECKUP TO GO. They thought that the program was helpful and not too much work. Having the program being available on their smartphones got high marks. Those who did all of the program had higher satisfaction than those who did not complete it.
What was the staff's (including volunteers) perception of the P^4? Leaders liked that the program was easy to do and mobile.

* For assessing a new policy, this question could ask how many Guard members know about the new policy.

Step 8 instructions: P^4 Outcome Evaluation Results Summary Tool

Analyzing outcome evaluation data. Now that you have gathered your data, the next step involves analyzing them. It could be worthwhile to consult an expert in data analysis procedures to ensure that you are using appropriate techniques. When using quantitative data collection methods, such as surveys, it is common to use quantitative data analysis methods, such as comparing averages and frequencies, or distributions. Sometimes, your analysis might simply involve comparing your results on some indicator with the amount of change you stated in your desired outcomes in GTO Step 2. If you are using evaluation measures from the P^4 developers, the measures might have scoring criteria or might tell you what values are expected from P^4 participants so that you can assess whether the P^4 is having the intended effect. The P^4 Outcome Evaluation Results Summary Tool can help you analyze and summarize quantitative data.

This tool helps document and interpret your quantitative outcome data to see how much impact each of your P^4 has had on the desired outcomes. With this tool, you can summarize your data (including post- only or both pre- and post- scores if you have both) for your P^4 participants and a comparison group (if you have one). Although much of this guidance is appropriate for surveys, it can also be used to summarize other kinds of quantitative data (e.g., number of referrals to mental health services, number of incidents of harassment reported).

1. Copy over your measures (scales of questions, other indicators) from the P^4 Outcome Evaluation Planner Tool. Refer to Appendixes C, D, and E for information about scoring any measures or scales you selected from them.
2. Enter the results from your measures in the remaining columns.
3. If you have pre-P^4 data, calculate the pre-P^4 averages for the participants:
    - Calculate averages across all participants for each scale, item, or other type of data. Add the scores for each participant together, then divide by the number of participants. Place this final number into the Pre-P^4 Score column of the tool in the space labeled "P^4." Do the same for each different data source.
4. Repeat the same procedure to generate post-P^4 averages, if you have post-P^4 data.
5. If you have data for a comparison group, you will need to calculate pre- and post- averages for each scale, item, or other type of data and enter them into the tool in the space labeled "Comparison" (below the participants' scores) or write in "Not applicable" (N/A).
6. For each scale, item, of other type of data, calculate the percentage change from the pre- to post- averages:
    - Subtract the pre-P^4 average from the post-P^4 average.
    - Divide the result by the pre-P^4 average.
    - Convert to a percentage (you can do this by multiplying by 100).
7. If you used a comparison group, calculate the percentage change for that group as well (for each scale, item, or other type of data), and enter it in the appropriate column.
8. Indicate whether your outcome missed, reached, or exceeded your desired outcome statement.
9. Briefly summarize the meaning of each result in the Interpretation column.

- Consider how big the change was overall. In general, small movement in either direction should not be taken to mean that a genuine change has occurred. In general, the bigger the change, the more confident one can be that it is genuine (although there are several caveats to this rule of thumb, including if you have a very small sample size, or if an external event impacts participants between the pre- and post- timepoints). Although it might be challenging, measuring against a comparison group can be helpful. For example, a 20-percent increase in the number of Guard members getting adequate sleep might or might not be a genuine change. But considered against a 10-percent decrease over the same time period in a comparison group, this result could suggest that there was a genuine positive change because of the P^4. However, if individuals were not randomly assigned to participate in the intervention or be in the control group, we cannot say with certainty that the intervention *caused* the change; in fact, it could be that individuals who choose to participate in the intervention already differed from those who did not (for example, in their willingness to participate in the first place).

Interpreting evaluation results. Whatever the outcomes, you will need information from both GTO Step 7 (Process Evaluation) and 8 (Outcomes Evaluation) to tell you what is happening with your P^4 and how it might be improved. That is because, in order to reach desired outcomes, the P^4 needs to be both implemented well (assessed by GTO Step 7) and based on good evidence (assessed by GTO Step 3). In other words, good evidence + good implementation = results. A poorly designed P^4, even if implemented perfectly, will not produce desired outcomes. Conversely, a strong P^4 that is implemented poorly will not produce desired outcomes. Therefore, if you do not achieve the outcomes that you hoped for, a process evaluation can give you clues about why: If the process evaluation shows that the implementation was good, maybe the P^4 was not ideal. If the process evaluation shows that the implementation was poor, maybe it was the poor implementation that led to poor outcomes. You can only conclude this with information from both types of evaluations. Interpreting your results in a thoughtful way helps you see what's working and what you need to change. The CQI Review Tool is intended to help guide you through this process.

The GTO team next organized their outcome evaluation survey results to see whether they met their desired outcomes.

EXAMPLE GTO Step 8: P4 Outcome Evaluation Results Summary Tool

Completed by: Captain Lily **Date:** December 2020 **P4:** eCHECKUP TO GO

Metric/Item/ Scale/Other Data Name (copied from Outcome Evaluation Planner Tool)	**Pre-P4 Score**	**Post-P4 Score**	**Percentage Change** [(post- minus pre-) divided by pre-]	**Progress on Desired Outcome**	**Interpretation, Including Whether Any Action Is Needed**
Daily Drinking Questionnaire	P4: Number of drinks in the past month during a typical week: 10 Number of drinks in the past month during the heaviest drinking week: 20	P4: Number of drinks in the past month during a typical week: 7 Number of drinks in the past month during the heaviest drinking week: 12	P4: Number of drinks in the past month during a typical week: –30% Number of drinks in the past month during the heaviest drinking week: –40%	☐ Exceeded ☒ Reached ☐ Missed	Among those who completed the program, there was a percentage change drop by the amount specified in the desired outcome for both the typical and the heaviest drinking weeks.
	Comparison group: None	Comparison group: None			
NIAAA Binge drinking question	P4: % who participated in binge drinking	P4: % who participated in binge drinking	% who dropped by at least one level of binging frequency: 50%	☐ Exceeded ☒ Reached ☐ Missed	Among those who completed the program, 50% dropped by at least one level of frequency of binge drinking.
	5 to 6 days/week: 10 3 to 4 days/week: 10 2 days/week: 15 1 day/week: 20 2 to 3 days/month: 20 1 day/month: 10 3–11 days/year: 15 1 or 2 days/year: 0	5 to 6 days/week: 5 3 to 4 days/week: 5 2 days/week: 10 1 day/week: 10 2 to 3 days/month: 10 1 day/month: 5 3-11 days/year: 5 1 or 2 days/year: 50			
	Comparison group: None	Comparison group: None			

Assessing Goals Specified in the Community Action Plan Overview Tool

By the time you get to GTO Step 8, you might have had the opportunity to collect some follow-up data on the overall trends in your priority problem (i.e., additional timepoints of the data you used to identify your priority problem in Step 1). You will need to be careful when interpreting these types of data. Desired outcomes tied directly to P^4 are generally easier to improve than the type of data you used in your needs assessment. Thus, your P^4 might be working well, but you still might not see change in your overall goals. This result could mean that not enough Guard members went through the P^4 to improve the whole wing's goals. It could also mean that you need more time for the P^4 to have an impact or that an outside event (such as mobilization) interfered with the P^4's effects. Another explanation could be that different P^4 are needed. A good example is awareness-building events. A wing could be very successful at running awareness-building events about the consequences of alcohol abuse (i.e., the wing could meet the desired outcomes of building awareness), but if that is all the wing is doing, then it is unlikely that the wing will address the overall goal of having fewer DUI incidents. In Step 9, you will look at all of your data to brainstorm ways to improve your P^4.

Long-term outcomes. Another consideration in interpreting outcome data is reconciling the conclusions from tracking both short-term and long-term outcomes. The evaluation of short-term outcomes might show that the P^4 was successful—for example, Guard members improved their knowledge of the dangers of DUI. However, it is possible that tracking long-term outcomes—actual incidents of DUI on and near the wing—shows that the long-term outcome is unchanged. How can you reconcile those two results? One possibility is that not enough Guard members were exposed to the P^4 to improve the long-term outcome. Another possibility could be that simply improving knowledge does not translate into actual behavioral changes. As you can see from this example, long-term outcomes are more difficult to improve than short-term outcomes. The conclusions that you come to using the data that you collect will help you develop a plan for CQI. For example, in the above example, if the P^4 seems to be working for those exposed to it, the improvement might simply be to increase the P^4 delivery to more Guard members. Alternatively, maybe the P^4 needs to be strengthened beyond improving knowledge to have a chance at improving long-term outcomes.

Step 9 instructions: P^4 CQI Review Tool

BEFORE YOU BEGIN:
This tool prompts you to review your evaluation results and prior GTO steps and consider whether changes are needed for next time. If your answers suggest that changes are needed, you can rework the relevant planning tools to inform your next round of implementation, including the possible selection of a different P^4.

If you decide that you need to make changes in any GTO step, go back and update the relevant GTO tools. For example, if you need to change your goal or desired outcomes, you might need to make changes to the measures in your Outcome Evaluation Planner Tool and your Community Action Plan Overview Tool, in addition to changes in GTO Step 2.

Discuss and answer each of the questions honestly, and, where needed, **create strategies for improvement for your next implementation**.

- Include as many stakeholders (e.g., CAT members) as possible in this review.
- Use your completed GTO tools, including the process and outcome results summary tools and notes containing additional process and outcome evaluation data gathered during the course of the P^4.

1. Answer items 1–4 using your evaluation results.
2. Document your conclusion from the evaluation results in item 5.
3. Next, use the probes in items 6–11 to think about any changes in priority problems to address, whether changing goals or desired outcomes is appropriate, alternative P^4 with a stronger evidence base, how fit and capacities might be different now, and why and how changes in your Step 6 planning tools could make an improvement in outcomes.
4. Finally, in item 12, document your decision about whether or not to continue with the P^4 and what to change to attempt to achieve needed improvements.

The GTO team reviewed their data so that they could draw overall conclusions about what occurred and next steps. They completed this tool to document what happened and will share it with the CAT to facilitate discussion of their conclusions and recommendations.

EXAMPLE GTO Step 9: CQI Review Tool

Completed by: Lt Col Jones **Date:** January 2021 **P⁴:** eCHECKUP TO GO

Step-by-step review	Response, including any changes for next time
How effectively did the P⁴ help us reach our desired outcomes? (GTO Step 8)	
1. Which, if any, desired outcomes were not met or not completely met? Were any of unmet outcomes critically important (i.e., must be met to justify continuing the P⁴)?	Both desired outcomes were met.
2. Which desired outcomes were reached or exceeded? Was there progress toward your long-term goals?	The change in number of drinks and amount of binge drinking desired outcomes were met.
How well did we implement the P⁴? (GTO Step 7)	
3. What does the data tell you about what you need to do next time to improve implementation of the P⁴ in terms of the following aspects? a. reaching the right target population b. ensuring engagement or utilization of the P⁴ c. ensuring that all components are implemented as planned d. increasing participant satisfaction e. making staff suggestions for improvement	The biggest problem was the reach of eCHECKUP TO GO. Only about half of the wing completed the program because there was insufficient awareness of the program. Next year, plan to have leaders increase their communication about the program and the need to complete it.
4. Which, if any, of 3a through 3e above were likely to have impacted your desired outcomes? How and why? These will be critical components to improve (or sustain) the next time you implement the P⁴.	Leader communication was not intense and consistent enough. This is what needs to be improved next year.
Determination based on evaluation results	
5. **Are your process and outcome evaluation results overall good enough to continue implementing the P⁴?** **If YES**, what adjustments, if any, will be critical to its improvement? **If NO**, how and why was this decision made? Which missed outcomes were most important to this decision?	Definitely! Those who completed eCHECKUP TO GO were very satisfied and exhibited important drops in drinking frequency overall and drops in binge drinking.
Determination based on other considerations	
6. **Were the problems identified the right needs to be addressing with our P⁴? (GTO Step 1)** Was there any improvement in the overall trend of the priority problem? Review the original problem data from Step 1 and compare with any newer updates to the data, if available. Have the needs changed or remained? Are there new priorities now that should be addressed?	It looks like the right needs were identified. The numbers of cases of alcohol misuse (Chaplain Corps Activity Reporting System) and DUI arrests (JA quarterly reports) are lower than the same time last year, but they are still too high. Working on the alcohol issue is still a priority.

P⁴ CQI Review Tool (continued)	
Step-by-step review	**Response, including any changes for next time**
7. **Do we need to change goals and desired outcomes or potential participants? (GTO Step 2)** Target different conditions or behaviors? Reset benchmarks up or down?	No. Meeting the desired outcomes appears to be pushing the amount of alcohol incidents and DUIs down.
8. **Should we consider another P⁴? (GTO Step 3)** Or are there other improvements we need to make?	No. eCHECKUP TO GO appears to be working for those who complete it.
9. **Does the P⁴ still philosophically and logistically fit our installation, community, and participants? (GTO Step 4)** If not, why not? What adaptations could be made? Were any adaptions made? How did that go?	Yes! The wing members like the brevity and mobility of the program.
10. **Do we have the readiness (willingness and capacities) to do the P⁴ well? (GTO Step 5)** Has there been a shift in resources? Are new staff capacities needed? How can we better utilize our champion to support the P⁴?	Some. Leaders did not consistently encourage participation in the program. Other than that, the readiness is there.
11. **How well did we plan? (GTO Step 6)** Any suggestions for improvement? Anything missing? Are additional funds needed to run the P⁴ well? Do we need to make any changes to staff assigned to implementation or evaluation tasks? How can we keep staff trained in the P⁴? The more staff are trained, the more likely you will be able to continue the P⁴.	Moderately well. To help leaders consistently encourage participation in the program next time, we could help prepare more messages in advance for dissemination and look for events where we could request that leaders announce it. Also, we could seek additional channels for encouraging participation.
12. Review and discuss your responses above with your CAT and leadership and reach a conclusion about continuing implementation of the P⁴: ☒ **We plan to continue with this P⁴ (with improvements as needed).** *Complete the GTO Step 10 P⁴ Sustainability Review Tool.* ☐ **We do not plan to implement this P⁴ again.** *GTO Step 10 is not applicable (N/A) if you do not plan to continue using this P⁴.*	

If you do not plan to implement the P[4] again:
After you have gone through the evaluation and quality improvement steps, you might determine that your P[4] is not performing well enough to continue with it. For example, if the implementation of the P[4] was done well but the outcomes were still not achieved, and no other exacerbating factors can be identified, that would suggest that the program might not be effective in your setting. Thus, you might have concluded to discontinue the P[4]. Although this can be disappointing and disruptive, discontinuing a P[4] based on sound data analysis can be the best decision. A key point is that it will be important to inform your key stakeholders about how you came to this decision. If leaders understand that it was a data-driven decision, they will likely be supportive. After discontinuing a P[4], it will be important to restart the GTO process to select another P[4] that can address the problems and achieve the goals and desired outcomes you set.

Step 10 instructions: P[4] Sustainability Review Tool

Step 10 applies only when you have decided to continue implementing the P[4] that you have been using and have evaluated.

1. The members of your team who have had the most involvement with implementing the P[4] are key to this review. The tool can be completed by an individual or as a group with one person as the recorder.
2. Collect your completed GTO tools. You will also want any written guidance (for example, a program manual or policy guidance) that came with your chosen P[4] to help you complete this tool.
3. Follow the questions and the guidance provided in each row. By answering each question, you will address how you want to do things that are critical to sustainability in the future.

With the endorsement of the CAT, the GTO team makes a sustainability plan by completing the P[4] Sustainability Review Tool. This document will be a useful record over time as members of the CAT change.

EXAMPLE GTO Step 10: P4 Sustainability Review Tool

Completed by: Lt Col Jones **Date:** February 2021 **P4:** eCHECKUP TO GO

Questions	Response, including any next steps
Updating GTO Step 6 (work plan, budget, and evaluation tools) is a critical sustainability task, including identifying who will be in charge of implementation and evaluation going forward. Who will update the GTO tools based on the improvements identified on the CQI tool? Do they need support or training on GTO, and, if so, who can provide this? (GTO overview, planning and evaluation training videos are available at www.RAND.org/t/TL311.)	The full GTO team will review the plan to make improvements (Jones, Hernandez, Johnson, and Lily). All members expect to continue in the ANG and thus do not need more GTO training.
How can we keep staff trained in the P4? The more staff are trained, the more likely you will be able to continue the P4. Look back at the P4 materials and what is required of facilitators. Consider who could be trained and who would be responsible for doing the training.	eCHECKUP TO GO does not require any training. It is self-administered. Some training is needed to get usage data from the system, but eCHECKUP TO GO developers provide extensive guidance on how to do that.
What particular result can we use to justify the P4? Any goal or desired outcome that you achieved could be a good result to share with stakeholders to justify the P4. Look at the Outcome Evaluation and CQI tools to see what desired outcomes were reached or exceeded. Highlight any dramatic improvement from your data. Make a plan to share these results.	There were large drops in the overall frequency of drinking and binge drinking, and both desired outcomes were met for those who completed the program.
Who knows the P4 and supports keeping it going here? Consider which individuals at the installation are champions of this P4—i.e., influential people who really like the P4—and are enthusiastic about it, including leadership. Should someone else be brought on? Who is going to take the lead?	The current GTO team will manage the program going forward. Need to consider bringing someone from the leadership team to be part of the GTO team so that they will communicate more about it to everyone.
Where will the GTO tools, the P4 evaluation, and the P4 manual and materials be kept? Decide who will have access to them and consider how this is the same or different from other P4 materials at your installation.	HRA Hernandez maintains all the completed GTO tools. Lt Col Jones has access to the eCHECKUP TO GO data. This will be the same going forward.

Checklist Completion of Steps 7–10

When you finish working on this step, you should have:

- ☐ Carried out the process and outcome evaluation data collection and analysis specified in your P^4 Process Evaluation Planner Tool and Outcome Evaluation Planner Tool (from GTO Step 6)
- ☐ Completed the Step 7 Process Evaluation Results Summary Tool for each P^4 for which you have data
- ☐ Completed the Step 8 Outcome Evaluation Results Summary Tool for each P^4 for which you have data
- ☐ Completed the Step 9 Continuous Quality Improvement Tool for each P^4 you evaluated and decided whether or not to continue using the P^4
- ☐ Completed the Step 10 Sustainability Review Tool for any P^4 you have decided to continue using

APPENDIX A

GTO Glossary of Terms

(When relevant, the GTO step associated with that term is provided in parentheses.)

Activities are the important parts of an EBP[4] that need to be implemented to reach the desired outcomes (GTO Step 6—Planning for P[4] Implementation and Evaluation).

Adaptation is the process of changing an EBP[4] to make it more suitable to a particular population or an organization's capacity without compromising or deleting the activities of the P[4] that make it effective (often called core components) (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P[4]).

Best practices are those that are generally accepted among practitioners and other experts in the field to be the most effective, but, unlike EBP[4], they have not been rigorously evaluated using research methods.

Capacities are the resources (staff, skills, facilities, finances, and others) that an organization has to implement and sustain a P[4] (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P[4]).

Continuous quality improvement (CQI) is a systematic assessment using feedback from evaluation information about planning, implementation, and outcomes to improve P[4] (GTO Step 9—Continuous Quality Improvement).

Culture can be thought of as a person's or an organization's values, practices, beliefs, religion, customs, rituals, or language, for example, and there can be subcultures or countercultures within an overarching culture (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P[4]).

Desired outcomes are specific changes in behaviors and risk and protective factors that you expect to result from a specific P[4]. They make a broad goal—such as reducing suicide rates—more concrete. Well-written desired outcomes are specific, measurable, appropriate, realistic, and time-based (SMART) (GTO Step 2—Setting Goals and Desired Outcomes).

Dosage is a way to show how much of a P[4] a participant receives. Depending on the P[4], the dosage can be the amount of time, the number of sessions or modules completed, or the number of activities in which a participant actually takes part (GTO Step 6—Planning for P[4] Implementation and Evaluation, GTO Step 7—Process Evaluation).

An **evidence-based program** or **evidence-based P[4] (EBP[4])** has been demonstrated through rigorous research methods to achieve positive outcomes.

Fiscal, resource, and technical capacities include adequate funding and other basics needed to implement a P[4] as planned (e.g., transportation, food, printed materials, and evaluation resources). Technical capacities are the expertise factors needed to address all aspects of P[4] planning, implementation, and evaluation; access to special materials needed for implementation; and the technology appropriate to the implementation, such as computers (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P[4]).

Fit expresses the overall compatibility between a P[4] and the target population, organization, and stakeholders (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P[4]).

The **goal** is the overarching big picture of the impact that a CAP seeks to achieve through its included P[4]. Goals reflect the anticipated impact in the future. Each CAP should include goals for addressing the problems it is targeting (GTO Step 2—Setting Goals and Desired Outcomes).

Logic models illustrate how a goal to address a specific need will be reached. Like a flow chart, a logic model shows needs; goals; and, for each goal, desired outcome(s), P^4 to achieve the desired outcome, and how the quality of the P^4 and its actual outcomes will be assessed (GTO Step 2—Setting Goals and Desired Outcomes).

Measures are individual questions or scales on a survey designed to obtain information about the behavior and/or risk, protective, and resilience factors being examined (see Appendix C for examples and repositories of measures) (GTO Step 6—Planning for P^4 Implementation and Evaluation, GTO Step 7—Process Evaluation, GTO Step 8—Outcome Evaluation).

A **needs and resources assessment** is a systematic way to identify current problems that suggest the potential need for improvement and to identify related community resources (GTO Step 1—Identifying Priority Problems to Address).

A **P^4** is a policy, program, practice, or process in your CAP.

P^4 capacity refers to the degree to which a team or wing is ready and able to develop and implement a P^4. It is a combination of motivation (commitment) and capacity (ability) and other resources. (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P^4).

Partnership and collaboration capacities involve connections with other service providers who can help implement and support a P^4 (GTO Steps 3, 4, and 5—Assessing and Selecting Effective P^4).

The **priority population** is the group(s) determined to be most in need of an EBP^4 (GTO Step 1— Identifying Priority Problems to Address, GTO Step 2—Setting Goals and Desired Outcomes, GTO Steps 3, 4, and 5—Assessing and Selecting Effective P^4).

A **program** is a purposeful organized set of activities designed to improve knowledge, awareness, or skills; change attitudes; or change behavior.

A **scale** is a grouping of individual survey questions that work together to assess a single attribute or concept. Individual questions are designed to be averaged together and interpreted as a group (GTO Step 8—Outcome Evaluation).

Staff and volunteer capacities refer to staff with appropriate credentials, training, experience, and commitment to a P^4—trained and committed volunteers (GTO Step 5—Capacities to Implement P^4).

Stakeholders are the individuals invested in the delivery and results of a P^4. Stakeholders include participants, their families, wings, community members and organizations, leadership, volunteers, funders, and CAB and CAT members (GTO Step 4—Fit).

Sustainability refers to the continuation of a P^4 after initial startup has been completed (GTO Step 10—Sustainability).

Tasks encompass all the broader actions needed to prepare for and carry out a P^4. They include such aspects as preparation, training, and debriefings of implementers, among others (GTO Step 6—Planning for P^4 Implementation and Evaluation).

Tools are the worksheets and templates associated with each GTO step that prompt GTO users to make and record decisions (GTO Steps 1–10).

APPENDIX B

Assembling Your CAP Document

Checklist for Assembling Your CAP Document:

- ☐ One CAP Face Sheet (see next page)
- ☐ One CAP Overview Tool (see GTO Step 6)

and

a set of the following tools for **each P^4 you include in your CAP**:

P^4 name: _____

- ☐ P^4 Work Plan Tool (see GTO Step 6)
- ☐ Optional P^4 Budget Tool (see GTO Step 6)
- ☐ P^4 Process Evaluation Planner Tool (see GTO Step 6)
- ☐ P^4 Outcome Evaluation Planner Tool (see GTO Step 6).

P^4 name: _____

- ☐ P^4 Work Plan Tool (see GTO Step 6)
- ☐ Optional P^4 Budget Tool (see GTO Step 6)
- ☐ P^4 Process Evaluation Planner Tool (see GTO Step 6)
- ☐ P^4 Outcome Evaluation Planner Tool (see GTO Step 6).

Community Action Plan Face Sheet

Name of wing: _____

Demographics of wing: Complete as much of this table as possible.

Total Air National Guard members assigned: [TOTAL HERE]		Number
	17–20 years old	
	21–24 years old	
	25–30 years old	
	31–40 years old	
	41+ years old	
Air National Guard members assigned by rank		
	E1–E4	
	E5–E6	
	E7–E9	
	O1–O3	
	O4–O6	
	O7+	
Marital status		
	Single (includes divorced, separated, and widowed)	
	Married: not dual military	
	Married: dual military	
	Declined to answer	
Nonspouse dependent status		
	Has nonspouse dependent(s)	
	No nonspouse dependent(s)	
	Declined to answer	
Total DoD Title 5 civilians (non–dual status)		
Unemployment rate in local civilian community (%)		
Unemployment rate of wing personnel (%)		

Community Action Plan Overview. Below, briefly write a narrative summarizing your CAP. You can include a brief description of your problems and goals, which P^4 you chose and why, and how you plan to evaluate your P^4.

APPENDIX C
Healthy Relationships and Communication Interventions and Measures

Interventions[2] (7 total)

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Meditation: A recent study (Kohlenberg et al., 2015) experimented with the effect of meditation and meditation with social awareness on mindfulness and social connectedness. There were 3 groups: a control group that watched a nature video; an intrapersonal group that participated in Phase 1, an intrapersonal meditation; and an interpersonal group that experienced Phase 1 and Phase 2, expanding from intrapersonal meditation to begin to consider others in the group. The intervention ran approximately 1 hour total, with 2 additional assessments at 48 hours and 2 weeks post-intervention. The meditation used was particular to this study. This study's mediation was built on 1) contextual behavioral theory of mindfulness (Sisti, Stewart, and Kohlenberg, 2014; Tsai et al., 2009) 2) therapeutic model of social connectedness derived from functional analytic psychotherapy (Kohlenberg and Tsai, 1991). For more information: Contact the developer, Robert Kohlenberg (fap@u.washington.edu).	Brief, in person	Adults, not tested with military personnel	Results found that mindfulness increased for all three groups. Only the intra- and interpersonal meditation saw an increase in social connectedness measures. The Inclusion of the Other in the Self Scale found that social connectedness was greater for both inter- and intrapersonal meditation. Prior studies found similar results.	Kohlenberg et al., 2015; Bowen et al., 2012
The Marriage Checkup: Seeks to assist in outreach for couples who would usually be excluded from marital therapy for an assortment of reasons by reframing the treatment to fall in line with the concept of a medical or dental checkup. Participants received 4 sessions over 2 years, each lasting around 2 hours. Each year, 1 assessment session and 1 feedback session would occur, with 2 weeks between the assessment and feedback sessions. Both the control group and the treatment group received 2-week, 6-month, and 1-year follow-up questionnaires. The Marriage Checkup includes assessment and feedback sessions of about 2 hours, each including social support interactions, problem-solving interactions, and therapeutic interviews. The feedback session was approximately 2 weeks after the assessment session. This intervention requires a clinician to implement. For more information: Information on the program itself can be found in two sources: Córdova, 2009; and Córdova, 2014.	Brief, in person	Married couples, not tested with military personnel	There were significant effects in the levels of intimacy and acceptance with the couples. Intimacy significantly increased. Acceptance similarly significantly increased, but they had a significant bump following intervention points and a decreasing effect throughout follow-up. For women, the effect was largely sustained over the 2 years, whereas for men the effect began to disappear between 6–12 months. Early increases in acceptance led to long-term satisfaction increases.	Hawrilenko, Gray, and Córdova, 2016; Córdova et al., 2014

[2] Some of these interventions could be triggering for individuals who are experiencing moderate or severe anxiety and depression, as they can cause an individual to reflect on troubling circumstances (possibly for the first time). Participants should always be provided contact information and additional resources for traditional mental health care in conjunction with any of these interventions.

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Family of Heroes: An internet-based intervention focused on psychoeducation and simulated conversations about postdeployment stress and mental health treatment. A visual meter allows the user to see how their side of the interactive conversation is going, with a focus on de-escalation of the conversation. The intervention takes about 1 hour, with surveys at baseline and one 2-month follow-up survey. For more information: https://www.familyofheroes.com/. Organizations can contact Kognito to purchase a license to make the training available to families in their area. Kognito can be reached at 212-675-9234 or info@kognito.com.	Remote	Military veterans	The study looked at 103 veteran significant-other pairs. It found that the veterans' reactivity to criticism significantly decreased. Veterans also reported a decrease in their perceived family member's reactivity.	Interian et al., 2016
ePREP: This intervention focuses on improving relationship functioning by building communication and problem-solving skills, based on cognitive behavioral therapy (CBT) delivered via computer. The intervention consisted of 1-hour computer sessions are followed by weekly standardized emails over 8 weeks. An individual license is $34.95, and the purchase is good for six months. The program can be completed in one to three hours depending on the time you want to spend on each concept. You will be able to stop, start, and review the program as often as you need in that six-month period. For more information: https://www.lovetakeslearning.com/ Email: contact@lovetakeslearning.com Phone: (800) 366-0166	Remote	Adults, not tested with military personnel	Initial trials found that ePREP showed promise in improving key outcomes, such as problematic communication, intimate partner violence, depression, and anxiety, and maintained these at the 2-month follow-up. At a 10-month follow-up, participants in the ePREP condition experienced improved mental health (less anxiety) and relationship outcomes (greater reduction in physical assaults, fewer incidences and greater reductions of psychological aggression). These positive impacts were also found to remain even if the relationship ended.	Davies, Morriss, and Glazebrook, 2014; Braithwaite and Fincham, 2009; Braithwaite and Fincham, 2007
Emotional Reappraisal: Couples in both groups were asked to report fact-based summaries of their most significant disagreement with their spouse on 7 different occasions over 24 months. In waves 4–6, the study group participated in a 7-minute writing task in which they reappraised the conflict by writing as a third-person observer to the conflict. For more information, contact the developer, Eli Finkel: https://www.psychology.northwestern.edu/people/faculty/core/profiles/eli-finkel.html	Remote	Couples, not tested with military personnel	The control group saw a decrease in overall marital quality over time, whereas the intervention group did not. The intervention group also saw a significant decrease in conflict-related marital distress.	Finkel et al., 2013
Acceptance and Commitment Therapy: A web-based intervention based on *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* (Follette and Pistorello, 2007). The initial assessment was done in person, but the intervention was 6 hour-long multimedia interventions from acceptance and commitment (ACT) therapy. For more information: https://contextualscience.org/list_of_resources_for_learning_act The site contains free practical audio exercises and videos about learning and applying ACT, as well as additional references.	Remote	Women who have experienced sexual or physical violence, not tested with military personnel	Significant positive correlations were found across all outcome and process measurements. Participants had decreased posttraumatic stress disorder (PTSD), depression, and anxiety scores. Process measures found a significant decrease in psychological inflexibility.	Fiorillo et al., 2017; Ahtinen et al., 2013; Ly et al., 2012

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
OurRelationship is a web-based counseling program for individuals or couples. Programs take 7–8 hours to complete over the course of 2 months. They include brief videoconference calls with a staff coach to help couples apply what they've learned to their relationship. OurRelationship is an online adaptation of Integrative Behavioral Couple Therapy, a well-validated in-person couple therapy (Christensen et al., 2004; Christensen et al., 2010). For more information: https://www.ourrelationship.com/	Remote	Adults in relationships (enrolled as individuals or couples)	Several well-designed studies have shown positive outcomes: 300 heterosexual couples (600 individuals) participated in a waitlisted randomized control trial (Doss et al., 2016). Compared with the control group, couples participating in the intervention had significant improvements in relationship satisfaction and relationship confidence and a decrease in negative relationship quality. Couples also improved in individual domains, including symptoms of anxiety and depression, perceived health, work functioning, and quality of life. In one study, OurRelationship was even more effective than in-person couple therapy (Salivar et al., 2018).	Doss et al., 2016; Nowlan, Roddy, and Doss, 2017 Doss et al., 2019; Salivar et al., 2018

Measures (6 total)

Sample measure	Brief description	Reference(s)
C1. Postdeployment Social Support Scale	A subscale of the Deployment Risk and Resilience Inventory, this 15-item subscale uses a 5-point Likert scale to assess perceived availability of social support since returning home from the war zone. This scale has demonstrated good internal consistency (0.87) in prior research with veterans.	King et al., 2006 For more information: This scale is available for free at https://www.ptsd.va.gov/professional/assessment/deployment/postdeployment-support.asp
C2. Perceived Relationship Quality Components Inventory (PRQCI)	Consists of 6 3-item subscales that measure the components of relationship quality: satisfaction, commitment, intimacy, trust, sexual passion, and love. Items such as "How satisfied are you with your relationship?" (satisfaction; α = 0.96), "How committed are you to your relationship?" (commitment; α = 0.90), "How intimate is your relationship?" (intimacy; α = 0.89), "How much do you trust your partner?" (trust; α = 0.93), "How passionate is your relationship?" (sexual passion; α = 0.90), and "How much do you love your partner?" (love; α = 0.87) are scored on a 7-point scale ranging from 1 (not at all) to 7 (extremely). Consider using just one or two relevant subscales (3 questions each) to reduce respondent burden.	Ratelle et al., 2013 For more information: Scale available for free here: http://socialinteractionlab.psych.umn.edu/sites/socialinteractionlab.dl.umn.edu/files/behavioral_scales/Behavioral%20Scales/Perceived%20Relationship%20Quality%20Components%20Inventory%20%28PRQC%29.doc
C3. Perceived Criticism Scale	Participants are asked, "How critical is your spouse of you?" Responses on a 10-point Likert-type scale range from 1 (not at all critical) to 10 (very critical indeed). In addition, participants are asked to rate "How critical are you of your spouse?" on the same scale. Prior studies found test-retest reliability for perceived criticism to be 0.75 over intervals of 2 weeks and approximately 20 weeks, respectively. Perceived criticism is negatively correlated with marital satisfaction.	Chambless and Blake, 2009 For more information: The 2-question scale was developed by Hooley and Teasdale, 1989.
C4. Quality of Marriage Index (QMI)	A 6-item Likert-scale to assess a partner's evaluation of the quality of her or his marriage. The first five items in the measure are each ranked on a 7-point scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Examples of these items include "we have a good relationship" and "my relationship with my partner makes me happy." The final question asks participants to rate their overall level of happiness from 1 (not at all happy) to 10 (extremely happy). The sum of the items was used, with a possible range from 6 to 45. The measure has been extensively validated and was found to be reliable in evaluation studies of relationship interventions (Cronbach's 0.97).	Norton, 1983; Cigrang et al., 2016 For more information: QMI developed by Norton, 1983. The brevity of the instrument in comparison with other tools can be a considerable advantage because large populations can be assessed in a short period of time. The six items are available in their entirety here: https://bmcresnotes.biomedcentral.com/articles/10.1186/s13104-019-4438-2/tables/1
C5. Inclusion of the Other in the Self Scale (IOS)	A single-item pictorial measure with Venn diagrams measuring the perceived closeness of the self and another person (X). The item has 7 response options and shows the circles as separate to almost entirely overlapping and asks participants to select the pair of circles that best describes their relationship with X. Prior studies have shown this to be a reliable measure of relationship closeness.	Aron, Aron, and Smollan, 1992; Gächter, Starmer, and Tufano, 2015 For more information: The Venn diagram images are available for free online at http://sparqtools.org/mobility-measure/inclusion-of-other-in-the-self-ios-scale/
C6. Couples Satisfaction Index (CSI-4)	Very brief (4-item) measure of couples' satisfaction with their relationship. Participants rate their happiness in the relationship, warmth, and satisfaction with the relationship. Scores are summed and can range from 0 to 21, with greater scores indicating higher satisfaction. This brief measure was originally 32 items and has been psychometrically optimized.	Funk and Rogge, 2007 Copy of the measure available here: http://couples-research.com/wp-content/uploads/2017/06/CSI-4.docx

APPENDIX D
Responsible Alcohol Use Interventions and Measures

Interventions[3] (6 total)

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components: 1. Screening—A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting. 2. Brief Intervention—A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice. 3. Referral to Treatment—A health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services. SBIRT is not a proprietary model; it is a general approach using the three components described above. There are many free resources on how to implement SBIRT: "A Pocket Guide for Alcohol Screening and Brief Intervention" is a detailed flowchart also created by NIAAA for alcohol screening and brief interventions: https://www.integration.samhsa.gov/clinical-practice/sbirt/NIAAA_SBIRT_Pocket_Guide_-2-.pdf There is free online training through Medscape (registration is free): https://www.medscape.org/viewarticle/830331 Providers can download a free app (search for "OHN SBIRT" in the Apple app store) that provides screening tools and specific advice that providers can give. The University of Colorado has extensive training resources: https://bigsbirteducation.webs.com/ The Substance Abuse and Mental Health Services Administration (SAMHSA) also has a long list of resources: https://www.integration.samhsa.gov/clinical-practice/sbirt	Brief 1-on-1 in person		SBIRT has been positively evaluated in several studies. A recent study (Babor, Del Boca, and Bray, 2017) of more than 1 million people who were screened for drug and alcohol use disorders over a 5-year period evaluated the effectiveness of SBIRT in a variety of medical and community settings. The study, funded by SAMHSA, found SBIRT to be an innovative and effective way to integrate the management of substance use disorders into primary care and general medicine. Substantial numbers of patients received recommendations for intervention or treatment, with greater intervention intensity associated with larger decreases in substance use. Patients receiving SBIRT demonstrated significant reductions in substance use, with some caveats that raise questions about the best ways to implement SBIRT as a public health program. It was also associated with improvements in treatment system equity (the provision of care to patients varying in economic status, race/ethnicity, and setting) and efficiency and was found to be cost-effective.	Babor, Del Boca, and Bray, 2017

[3] Some of these interventions could be triggering for individuals who are experiencing moderate or severe anxiety and depression, as they can cause an individual to reflect on troubling circumstances (possibly for the first time). Participants should always be provided contact information and additional resources for traditional mental health care in conjunction with any of these interventions.

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Brief Alcohol Screening and Intervention for College Students (BASICS), a Harm Reduction Approach, is a preventive intervention for college students 18 to 24 years old. It targets students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems, such as poor class attendance, missed assignments, accidents, sexual assault, and violence. BASICS is designed to help students make better alcohol-use decisions based on a clear understanding of the genuine risks associated with problem drinking, enhanced motivation to change, and the development of skills to moderate drinking. The program is conducted over the course of two brief interviews that prompt students to change their drinking patterns. The program's style is empathetic, nonconfrontational, and nonjudgmental, and it aims to (1) reduce alcohol consumption and its adverse consequences, (2) promote healthier choices among young adults, and (3) provide important information and coping skills for risk reduction. Staffing expertise needed: Health professional and coordinator who knows motivational interviewing. Information about this program (costs, etc.) can be found here: https://www.blueprintsprograms.org/programs/brief-alcohol-screening-and-intervention-for-college-students-basics/ There are two separate groups that provide training, and costs could differ between them: George A. Parks, Ph.D., Caring Communication (206) 930-1949; geoaparks@earthlink.net Or: Jason Kilmer, jkilmer@uw.edu http://depts.washington.edu/abrc/basics.htm	Brief 1 on 1 in person. Assessment can be online.	Individuals or specific groups. Has not been done with military personnel.	The initial study done at the University of Washington (Marlatt et al., 1998; Baer et al., 2001) screened high school students intending to attend the university and selected 348 students-to-be who were predicted to be at high risk for drinking problems in college. After random assignment, the treatment group but not the control group underwent the brief intervention during the freshman year. Assessments at baseline, 6 months, 2 years, and 4 years measured both drinking rates and harmful consequences. A separate group of normal students not at high risk was followed for comparison. Participants who received BASICS demonstrated a significantly greater deceleration of drinking rates and problems over time in comparison with control participants. These results were sustained at the 2- and 4-year follow-ups. Multiple other studies have found similar outcomes (e.g., Borsari and Carey, 2000), although the program appeared to work somewhat better in combination with a parent-based intervention (Turrisi et al., 2009).	Baer et al., 2001; Borsari and Carey, 2000; Marlatt et al., 1998

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Check Your Drinking is a brief web-based program that provides personalized feedback designed to reduce high-risk drinking and normative data regarding drinking and the associated risks. The program is free to the public. For more information: http://www.checkyourdrinking.net/CYD/CYDScreenerP1_0.aspx	Online assessment and feedback	Young adults (ages 18–24) who are problem drinkers. Has not been used in military settings.	This study evaluated the efficacy of an alcohol-related web-based personalized feedback program delivered in the workplace to young adults. Participants (N = 124) were randomly assigned to one of three conditions: web-based feedback (WI), web-based feedback plus a 15-minute motivational interviewing session (MI), or a control group. Results indicated that participants in the intervention group (WI and MI conditions combined) reported significantly lower levels of drinking than those in the control group at a 30-day follow-up. This was particularly true for participants classified as high-risk drinkers at the baseline assessment. Similar results were found when comparing the WI condition with the control group. No differences were found between the WI and MI conditions, indicating that the addition of a 15-minute motivational interviewing session did not increase the efficacy of the web-based feedback program.	Doumas and Hannah, 2008
CheckUp & Choices (formerly Drinker's Checkup and College Drinker's Checkup) is a confidential, evidence-based digital program created to assist those who want to assess their drinking or substance use through a series of questionnaires and personalized solutions. CheckUp & Choices uses the elements of motivational interviewing to determine the user's stage of change and then create a customized plan that provides detailed feedback and is anonymous. Once a user has engaged in the full assessment phase, the choices modules in CheckUp & Choices ask subscribers to set up customized e-mail and text messages reminding them of the change plan. These can be empowering messages, encouraging change, and positive feedback supporting wise decisions. Subscriptions are offered at three-month increments or one year, with a 100% money-back guarantee. CheckUp & Choices has a significant Facebook presence with daily articles, posts, and shares. For more information: https://checkupandchoices.com/	Online	College students or adults who are problem drinkers; has not been used in military settings	In Experiment 1, 144 students were randomized to either the computer-delivered intervention (CDI) or an assessment-only control group with follow-ups at 1 and 12 months. Participants in both groups significantly reduced their drinking at both follow-ups. Compared with the control group, the CDI group reduced their drinking significantly more at 1 and 12 months on three drinking measures. Using a more conservative criterion yielded one significant difference in a measure of heavier drinking at the 1-month follow-up. The mean between-groups effect sizes were d = 0.34 and 0.36 at 1 and 12 months, respectively. In Experiment 2, 82 students were randomized to either the CDI or a delayed-assessment control group with follow-up at 1 month. Compared with the delayed assessment control group, the CDI group significantly reduced their drinking on all consumption measures. These results support the effectiveness of the CDI with heavy drinking college students when used in a clinical setting. An earlier study had 61 adult problem drinkers who were randomly assigned to either immediate treatment or a 4-week wait-list control group. Overall, participants reduced the quantity and frequency of drinking by 50% and had similar reductions in alcohol-related problems that were sustained through 12-month follow-up.	Hester, Delaney, and Campbell, 2012; Hester, Squires, and Delaney, 2005

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
The eCHECKUP TO GO programs (alcohol, marijuana, sexual violence, and tobacco) are personalized, online behavior interventions that assess the problem and provide concrete feedback and solutions. The alcohol version was developed first and has the most evidence. eCHECKUP TO GO was designed to decrease alcohol use by reducing risk factors associated with drinking (e.g., positive alcohol beliefs and expectancies, high normative perceptions about peer drinking) and to increase protective behavioral strategies (e.g., strategies to limit drinking and risky drinking behavior) to reduce alcohol-related consequences. eCHECKUP TO GO provides personalized normative feedback on peer drinking, positive alcohol beliefs, and positive alcohol expectancies, as perceptions of peer drinking. The alcohol program costs $1,075 per campus per year (includes all students). There is a practitioner package for those who want to work in person and 1-on-1 that includes all the programs ($3,500 per year). The assessment takes about 6–7 minutes to complete, is self-guided, and requires no face-to-face contact time with a counselor or administrator. For more information: http://www.echeckuptogo.com/	Online	See Evaluation Findings; was not used in the military	eCHECKUP TO GO has been evaluated in several studies, in several populations. **College freshmen:** Seven studies demonstrate the program's efficacy with the general college freshman population and at the population level (Hustad et al., 2010; Doumas et al., 2011; Doumas and Andersen, 2009; Lane and Schmidt, 2007; Wilson, Henry, and Lange, 2005; Steiner et al., 2005; Henry, Lange, and Wilson, 2004). Outcomes improved include heavy drinking, general alcohol use, alcohol-related problems, and alcohol-related consequences. Outcomes were generally stronger for those who were heavy drinkers. **Integrated into alcohol education***:* Two studies demonstrate reductions in alcohol use and related harms and improvement in retention rates and grade point average when eCHECKUP TO GO is integrated with 3rd Millennium Classroom's knowledge-based curriculum (Lane and Schmidt, 2007; Salafsky, Moll, and Glider, 2007). **Added to alcohol education:** Three studies demonstrate significant improvements in outcomes when eCHECKUP TO GO is added to existing alcohol education programs (Lane and Schmidt, 2007; Wilson, Henry, and Lange, 2005; Henry, Lange, and Wilson, 2004). **As a stand-alone intervention:** Two studies show the efficacy of eCHECKUP TO GO as a stand-alone intervention (Walters, Vader, and Harris, 2007; Steiner et al., 2005). **Heavy drinkers:** Two studies show the efficacy of eCHECKUP TO GO with heavy drinkers (Walters et al., 2009; Walters, Vader, and Harris, 2007). **Athletes:** One study shows eCHECKUP TO GO's efficacy reducing heavy drinking in first-year intercollegiate athletes (Doumas, Haustveit, and Coll, 2010).	Doumas et al., 2011; Doumas and Andersen, 2009; Henry, Lange, and Wilson, 2004; Hustad et al., 2010; Lane and Schmidt, 2007; Salafsky, Moll, and Glider, 2007; Steiner et al., 2005; Walters, Vader, and Harris, 2007; Walters et al., 2009; Wilson, Henry, and Lange, 2005

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
VetChange is a free app for veterans and service members who are concerned about their drinking and how it relates to posttraumatic stress after deployment, as well as for all people who are interested in developing healthier drinking behaviors. This app provides tools for cutting down or quitting drinking, tools for managing stress symptoms, education about alcohol use and how it relates to PTSD symptoms, and guidance to find professional treatment. For information, search for "VetChange" in the app store.	Online	Used with veterans	A randomized clinical trial evaluated VetChange's impact on drinks per drinking day, average weekly drinks, percentage of heavy drinking days, and PTSD symptoms. Six hundred participants were randomized to either an initial intervention group (n = 404) or a delayed intervention group (n = 196) that waited 8 weeks for access to VetChange. Initial intervention group participants had greater reductions on each drinking measure and PTSD symptoms between baseline and the end of the intervention than did delayed intervention group participants between baseline and the end of the waiting period. Delayed intervention group participants showed similar improvements to those in the initial intervention group following participation in VetChange. Alcohol problems were also reduced within each group between baseline and 3-month follow-up. Results indicate that VetChange is effective in reducing drinking and PTSD symptoms in Operation Enduring Freedom and Operation Iraqi Freedom veterans.	Brief et al., 2013

Measures (6 total)

Sample measure	Brief description	Reference(s)
D1. Protective Behavioral Strategies Scale-20 For a listing of the 20 items, see Table 2 in Richards et al., 2018: https://www.sciencedirect.com/science/article/pii/S2352853218300075?via%3Dihub	Protective behavioral strategies are most commonly defined as behaviors that are used while drinking to reduce alcohol use (e.g., stop drinking at set time) or limit alcohol-related problems (e.g., use a designated driver). The Protective Behavioral Strategies Scale-20 lists 20 such behaviors and asks the degree to which respondents engage in protective behavioral strategies when using alcohol or "partying" on a 6-point response scale ranging from 1 (never) to 6 (always). The Protective Behavioral Strategies Scale has demonstrated internal consistency, convergent validity, and construct validity.	Treloar, Martens, and McCarthy, 2015
D2. NIAAA measure of binge drinking For more information: https://www.niaaa.nih.gov/research/guidelines-and-resources/recommended-alcohol-questions	NIAAA has developed a 3-, 4-, 5-, or 6-item set of questions that assess drinking, including heavy drinking. The 3-item set asks about the frequency of past-12-month drinking, the number of drinks consumed on a typical drinking day in the past 12 months, and the frequency of binge drinking in the past 12 months to capture information about both level of consumption and drinking patterns, as recommended. The 4-item set adds a question about the maximum number of drinks consumed in a 24-hour period in the past 12 months. This question is important because it provides additional information about drinking patterns and because it is highly correlated with alcohol use disorders. It is inserted before the binge drinking question, which then becomes question 4 in the 4-item set. The 5-item set adds a question about maximum drinks in a 24-hour period in the respondent's lifetime as the last question in the set. Finally, the 6-item set adds, as the fourth question immediately following the item about maximum drinks in a 24-hour period in the past 12 months, an item that asks about the frequency of consuming this maximum number of drinks in the past 12 months. The 12-month time frame can be changed depending on the needs of the evaluation.	Caetano et al., 1997; Cherpitel et al., 1995; Greenfield and Rogers, 1999; Midanik et al., 1996; Rehm and Bondy, 1996; Rehm, Greenfield, and Rogers, 2001; Room, Bondy, and Ferris, 1995
D3. Alcohol Use Disorders Identification Test (AUDIT) For more information: https://auditscreen.org/	The AUDIT is a 10-item measure that enquires about the three key domains of alcohol intake, potential dependence on alcohol, and experience of alcohol-related harm. Its reliability and validity have been established in research conducted in a variety of settings and in many different nations. It is considered to be a highly suitable screening instrument for the whole range of unhealthy alcohol use in primary care and other health care settings. AUDIT has been used in primary care research and in epidemiological studies for the estimation of prevalence in the general population as well as specific institutional groups (e.g., hospital patients, primary care patients).	Hundreds of studies have been conducted assessing the AUDIT or using the AUDIT with various populations. The link provides access to multiple references organized into the following categories: primary publications, systematic and other reviews, AUDIT derivatives, validation in different populations and comparison with other instruments. https://auditscreen.org/about-validation/

Sample measure	Brief description	Reference(s)
D4. Brief Young Adult Alcohol Consequences Questionnaire (B-YAACQ) For a copy of the actual measure and scoring guidelines: https://arlbuffalo.com/the-young-adult-alcohol-consequences-questionnaire/the-brief-yaacq/ For more information, contact: Christopher Kahler, Ph.D. Center for Alcohol and Addiction Studies, Brown University Box G-BH Providence, RI 02912 christopher_kahler@brown.edu	This scale can help assess alcohol problems among college students, track changes in alcohol problems throughout college, and measure the response to alcohol interventions. It consists of 24 items and was derived from the 48-item Young Adult Alcohol Consequences Questionnaire. The B-YAACQ has items that cover the full range of the alcohol problems continuum from signs of excessive drinking to symptoms consistent with alcohol abuse and alcohol dependence. The tool can be used for a number of purposes: by college students as a self-assessment, by community and educators to monitor alcohol problems on their local college campus, and to identify treatment needs. Its brevity and good resolution across a range of drinking problems support its clinical utility. Raw scores on the brief scale can range from 0 to 24. Validity/reliability: In Kahler et al., 2008, the B-YAACQ showed excellent distributional properties, had items adequately matched to the severity of alcohol problems in the sample, covered a full range of problem severity, and appeared highly efficient in retaining all of the meaningful variance captured by the original 48 items in the Young Adult Alcohol Consequences Questionnaire.	Kahler, Strong, and Read, 2005; Read et al., 2006; Kahler et al., 2008; Devos-Comby and Lange, 2008; Verster et al., 2009
D5. Daily Drinking Questionnaire For more information, contact: R. Lorraine Collins, Ph.D., Department of Community Health and Health Behavior, University at Buffalo, the State University of New York lcollins@buffalo.edu	The Daily Drinking Questionnaire assesses weekly alcohol consumption. It is a condensed version of Calahan's Drinking Habits Questionnaire, which assesses the volume, quantity, and frequency of alcohol consumption. On the Daily Drinking Questionnaire, respondents fill in a series of seven boxes indicating their typical pattern of alcohol use on each day of the week in the past month. A modified version of the Daily Drinking Questionnaire that includes a second set of boxes for the typical number of hours spent drinking for each day in a typical week has also been developed.	Collins, Parks, and Marlatt, 1983; Dimeff et al., 1999
D6. Drinking Norms Rating Form (DNRF) The DNRF is simply an extension of the Daily Drinking Questionnaire. Thus, when using this measure, a reference group would be chosen (e.g., other members of your unit) and the Daily Drinking Questionnaire would be used (e.g., how many drinks do you think other members of your unit drink on a given day?). Actual amounts of drinking can be compared with perceived drinking and used in prevention—e.g., people often overestimate how much others actually drink. For information, contact: John Baer, Ph.D., Alcohol & Drug Abuse Institute, University of Washington (206) 616-3397; jsbaer@u.washington.edu	The DNRF is an extension of the Daily Drinking Questionnaire, which obtains subjects' estimates of typical alcoholic drinks on each day of the week. The DNRF asks people to rate themselves and also to consider different groups of people and rate "typical" or "average" drinking for persons in that group (e.g., people in your unit or wing). People are asked to think about the days of the week those individuals usually drink and then estimate the number of standard drinks typical individuals in each group drink on those days. They are instructed to try to average across members in each reference group and to think back over the past 3 months when making their estimates. Studies of the DNRF have found it to be valid, predictive of drinking behavior, and reliable (Broadwater et al., 2006).	Baer, Stacy, and Larimer, 1991; Broadwater et al., 2006; Kypri and Langley, 2003; Larimer et al., 1997; Dimeff et al., 1999

APPENDIX E
Work-Life Balance Interventions and Measures

Interventions[4] (12 total)

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Headspace is a mindfulness intervention delivered through a smartphone application, offering 10-minute guided meditations (audio only), occasional animated videos (audio and video), and longer and focused meditations. Meditations use techniques such as body scanning, guided breathing, and focus. The intervention has been used in the following ways: • Daily mindfulness exercises from the Take 10 feature for 10 minutes a day over 10 days; control condition listened to 10 excerpts from the audiobook *The Headspace Guide to Meditation and Mindfulness* (Economides et al., 2018) • Participants used app as desired over four weeks (no minimum use required) (Wen et al., 2017) • 30-day program of daily guided meditations that increase in duration, beginning with 10 minutes a day for the first 10 days, 15 minutes a day for the next 10 days, and 20 minutes a day for the next 10 (Bennike, Wieghorst, and Kirk, 2017) • One session of self-guided mindfulness meditation per week for 4 weeks (Wylde et al., 2017) • Daily mindfulness exercises from the Take 10 feature for 10 minutes a day over 10 days (Howells, Ivtzan, and Eiroa-Orosa, 2016) For more information: https://www.headspace.com/	Smartphone app	Adults (see evaluation findings); no reported military use	Numerous studies have shown promising outcomes in increasing mindfulness skills and reducing stress. For example: **Self-selected adults who had not meditated in the last 6 months** (Economides et al., 2018) were randomly assigned to the Take 10 mindfulness Headspace feature or to a Headspace audiobook featuring an introduction to the concepts of mindfulness and meditation. Although both interventions were effective at reducing stress associated with personal vulnerability, only the mindfulness intervention had a significant positive impact on irritability, affect, and stress resulting from external pressure. **Medical residents** (Wen et al., 2017): 30 primarily female (90%) medical residents completed this study, showing significant increase in mindfulness at week four but no significant changes in positive or negative affect (mood). However, both positive affect and mindfulness scores increased with increasing use of the smartphone app (negative affect did not change). **Novice pediatric nurses** (Wylde et al., 2017): Nurses using the Headspace smartphone app showed improvements in certain mindfulness skills (acting with awareness and nonreactivity to inner experience) and marginal improvements in compassion satisfaction and burnout compared with those participating in a traditional mindfulness intervention. The traditional mindfulness group had significantly less of the "acting with awareness skills" than the smartphone group. Other differences between the smartphone and traditional mindfulness intervention groups were not significant. **Self-selected adults** (Howells, Ivtzan, and Eiroa-Orosa, 2016): 121 predominantly female (87%) participants showed significant increases in positive affect with a medium effect size and reduced depressive symptoms with a small effect size, although no statistically significant differences in satisfaction with life, flourishing, or negative affect were found. No statistically significant gains were observed in the control condition.	Economides et al., 2018; Wen et al., 2017 Bennike, Wieghorst, and Kirk, 2017; Wylde et al., 2017; Howells, Ivtzan, and Eiroa-Orosa, 2016

[4] Some of these interventions could be triggering for individuals who are experiencing moderate or severe anxiety and depression, as they can cause an individual to reflect on troubling circumstances (possibly for the first time). Participants should always be provided contact information and additional resources for traditional mental health care in conjunction with any of these interventions.

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Mental Health Guru is a brief online training targeted to workplaces. Employees complete two modules that include information, interactive exercises, videos, quizzes, and personalized feedback intended to increase knowledge about depression and anxiety, destigmatize mental health, and encourage help-seeking. For more information: https://mhguru.com.au/info/about	Modular website	Adults; not tested with military personnel	Only one published study is available (randomized controlled trial) with promising results. **Employees of a large multidepartmental government agency** (Griffiths et al., 2016): Mental Health Guru participants showed significantly greater improvements in knowledge about depression and anxiety compared with a control group. Participants also had significantly greater reductions in depression, anxiety, and personal stigma. There was no effect on help-seeking intentions or help-seeking attitudes. However, self-reported help-seeking behavior was significantly greater in the Mental Health Guru group at posttest. Participants also had greater intentions to seek help for depression from the internet at 6-month follow-up.	Griffiths et al., 2016
Learning2Breathe is a mindfulness program originally developed for use in schools with adolescents, but it has been adapted for use with college students and educators. The purpose of the program is to build emotion regulation skills by practicing principles of mindfulness. The program comes with sample outcome measures, teacher narratives, audio files, posters, wallet cards, and customizable workbooks. It can be delivered in 6, 12, or 18 sessions. For more information: https://learning2breathe.org/	Brief, in person	Adoles-cents, college students, educators	Several studies have shown promising outcomes. Learning2Breathe has been recognized in the 2015 Collaborative for Academic, Social, and Emotional Learning Guide as meeting research criteria for effective social-emotional learning programs. For example: **Female high school seniors** (Broderick and Metz, 2009): Compared with the control group, participants had a significant reduction in negative affect (mood) and a significant increase in feeling calm/relaxed/self-accepting.	Broderick and Metz, 2009; Mahfouz et al., 2018 Many more references available here: https://learning2breathe.org/list-of-l2b-publications/
Stress Free Now is an 8-week mindfulness-based stress management intervention. The intervention is delivered through weekly web page views and 5- to 10-minute video clips of key concepts, audio guided meditations (20–25 minutes) that participants are encouraged to practice five times a week, daily articles about the research and benefits of the week's mindfulness theme, and daily tips on managing stress and incorporating mindfulness. For more information: http://www.clevelandclinicwellness.com/Pages/StressFreeNow.htm Smartphone app: https://my.clevelandclinic.org/mobile-apps/stress-free-now-app	Website and smartphone app	Adults; not tested with military personnel	Preliminary evidence suggests positive outcomes. **Adults age 18 and over recruited at clinics (patients with psychosis excluded)** (Morledge et al., 2013): This 12-week randomized controlled trial found significant positive effects for stress, mindfulness attention, psychological well-being, and other outcomes for participants who remained active in the intervention for 6 to 8 weeks. Change scores were larger for the more active participants compared with all participants.	Morledge et al., 2013; Allexandre et al., 2016

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Moodgym is an online self-help intervention for anxiety and depression management. The intervention consists of 5 online cognitive behavioral training modules (30 minutes weekly) and quizzes and exercises with visual aids and detailed feedback focusing on thoughts, moods, problem-solving, and coping methods. For more information: https://moodgym.com.au/	Modular website	Adults, including employees and under-graduate and graduate students	At least 4 studies using randomized control trial designs have shown improvements in anxiety and depressive symptoms. Examples include: **Employees in transportation, health, and communications sectors** (Phillips et al., 2014): Randomized control trial showed reduction in depressive symptoms, as measured by the Patient Health Questionnaire-9 (PHQ-9). **Undergraduate university students** (Ellis et al., 2011; Sethi, Campbell, and Ellis, 2010): This randomized control trial found improvements in anxiety and depression compared with the control group and compared with the control intervention. Anxiety and depression were measured using the Depression, Anxiety, and Stress Scale-21.	Phillips et al., 2014; Ellis et al., 2011; Sethi, Campbell, and Ellis, 2010; Guille et al., 2015; Christensen, Griffiths, and Jorm, 2004; O'Kearney et al., 2006; Lintvedt et al., 2013
MoodPRISM is a smartphone app that helps participants understand their emotional health through daily tracking and colorful, detailed feedback reports on their wellness, anxiety, and depression symptoms. It provides health information based on daily mood and links to mental health resources. For more information: http://www.moodprismapp.com/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): This study compared users of three different apps with a waitlisted control group. Compared with the control group, there was a positive improvement within the group as well as against the control group for a range of mental health indicators. MoodPrism had a significant positive impact on psychological well-being and emotional self-awareness. Compared with the control group, MoodPrism did not show a significant improvement in generalized anxiety scores.	Bakker et al., 2018
MoodMission is a smartphone app designed to help individuals cope with feelings of anxiety and depression. Users input information about their current mood and are provided with a tailored list of five simple, quick, and effective "missions" (activities) that can help improve mood. Users can track what does and does not work for their specific feelings, obtaining more accurate feedback the more they use the app. For more information: http://moodmission.com/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): This study compared users of three different apps with a waitlisted control group. Compared with the control group, MoodMission had a significant positive impact on depression symptoms (measured using the PHQ-9), on mental well-being, and on coping self-efficacy, but users did not show a significant improvement in generalized anxiety scores.	Bakker and Rickard, 2018; Bakker et al., 2018
MoodKit encourages users to engage in mood-enhancing activities, identify and change unhealthy thinking, rate and chart their mood over time, and create journal entries to promote well-being. MoodKit was developed by clinical psychologists and uses principles of CBT. For more information: http://www.thriveport.com/products/moodkit/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): The randomized control trial shows that there is a positive improvement within group as well as against the control group for a range of mental health indicators. Relative to the control, MoodKit had a significant positive impact on depression symptoms (measured using the PHQ-9), on mental well-being, and on coping self-efficacy, but users did not show a significant improvement in generalized anxiety scores.	Bakker et al., 2018

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
myStrength is a smartphone app based on principles of CBT designed to help users with feelings of anxiety and depression as well as insomnia and chronic pain through mood tracking, targeted activities, and a library of wellness resources. For more information: https://mystrength.com/	Web- and mobile-based platform	Adults; not tested with military personnel	Several white papers and case studies on the https://mystrength.com/outcomes website suggest evidence of effectiveness. Peer-reviewed papers show a return on investment and reductions in anxiety and depression. **Patients of a rural community health center** (Abhulimen and Hirsch, 2018): Medical claims from a large sample of app users were matched to a control group. The return-on-investment (ROI) study demonstrated an incremental cost reduction of $382 per user (an ROI between 142% and 695%).	Abhulimen and Hirsch, 2018; Hirsch et al., 2017
SuperBetter is a free website and smartphone app in which users play games and accomplish challenging goals to increase social support, build resilience, and improve mental health. SuperBetter is based on principles of CBT. Recommended game time is five minutes twice a day. For more information: https://www.superbetter.com/	Website and smartphone app	Adults, college students, adoles-cents; not tested with military personnel	Some studies have shown promising outcomes, including: **Adult iPhone users with significant depression symptoms** (Roepke et al., 2015): SuperBetter users had greater reductions in depression scores than the waitlisted control at posttest and at longer-term follow-up. The sample was self-selected, and there was high attrition.	Roepke et al., 2015; Chou, Bry, and Comer, 2017 Other references available here: https://www.superbetter.com/science
Team Resilience (web-based) is an online adaptation of an evidence-based intervention. The e-learning module aims to increase the participant's ability to be resilient in the workplace, knowledge about resilience, awareness of helping resources, and willingness to use those resources. The online program consists of video, audio, interactive exercises, and quizzes. The program consists of 55 slides that participants can view on a computer or mobile device at their own pace (viewed over 4 to 6 weeks) For more information, contact: Joel B. Bennett, Ph.D. Organizational Wellness & Learning Systems (817) 921-4260; owls@organizationalwellness.com https://organizationalwellness.com/pages/evidence-based-curriculum	Modular website	Adults (not tested with military personnel); previous studies with restaurant workers (Bennett et al., 2010) and employees of an engineering firm (Bennett et al., 2018)	The original in-person Team Resilience training was rated by the National Registry for Evidence-Based Programs and Practices as a *promising practice*. The web-based version was developed later and evaluated by the developers: **Employees of a national engineering firm** (Bennett et al., 2018): In this nonrandomized quasi-experimental study with a convenience sample, participants increased their workplace resilience compared with the control group. There was no difference in stress between participants and control. Participants significantly improved in several areas from pre- to post-: perception of ability to be resilient, knowledge of how to be more resilient, knowledge of where to get help, and willingness to use the resources.	Bennett et al., 2018

Policy/program name and description	Mode	Target audience	Summary of evaluation findings	References
Mindfulness-Based Stress Reduction (MBSR) is a mindfulness training program designed to reduce stress and help participants improve coping skills. In-person training is provided by a trained facilitator who completes an 8-week or 9-day fundamentals course (approx. $4,850 to $5,390) conducted by the University of Massachusetts Center for Mindfulness. The implementation approach has varied slightly in published studies and has included • a 30-minute session once a week for 4 weeks (Mackenzie, Poulin, and Seidman-Carlson, 2006) • a daily exercise for 15 consecutive days, with 15 minutes each day to practice each exercise (Halamová, Kanovský, and Pacúchová, 2018) For more information contact: The Center for Mindfulness (508) 856-2656 mindfulness@umassmed.edu www.umassmed.edu/cfm/	Typically brief in-person sessions, but has included remote (emailed instructions; Halamová, Kanovský, and Pacúchová, 2018)	Numerous civilian adult populations, including veterans with PTSD	MBSR is designated as a *promising practice* by the Penn State Military Families Clearinghouse. Several studies have shown improvements in physical and psychological symptoms, life satisfaction, and mental health-related quality of life (https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_680). Evaluation findings include: **Nurses and nurse aides in geriatric teaching hospital in Canada** (Mackenzie, Poulin, and Seidman-Carlson, 2006): Significant improvements in burnout symptoms, relaxation, and life satisfaction for the intervention group. Size effects were small for emotional exhaustion and life satisfaction and insignificant for depersonalization and relaxation. **Convenience sample of adults** (Halamová, Kanovský, and Pacúchová, 2018): MBSR participants reported significantly decreased self-criticism and self-uncompassionate responses with effects present at two-month follow-up. There was a short-term increase in self-compassion, but this was not present at the two-month follow-up. Participants had decreased feelings of inadequacy and self-uncompassionate responses at the post-test survey, but these did not persist to the longer-term follow-up. Participants had decreased self-criticism for both the posttest survey and the follow-up survey.	McIndoo et al., 2016; de Vibe et al., 2013; de Vibe et al., 2015; Mackenzie, Poulin, and Seidman-Carlson, 2006; Call, Miron, and Orcutt, 2014; Halamová, Kanovský, and Pacúchová, 2018

Measures (9 total)

Measure	Brief description	Reference(s)
Mindfulness*		
* Mindfulness interventions teach participants skills to ultimately improve mood, stress, and other outcomes. The measures in this category just determine whether participants have learned the mindfulness skills. In your outcome evaluation, be sure to use measures in the other sections of the table as well to assess your ultimate desired outcomes (e.g., improved mood, decreased stress, decreased burnout).		
E1. Five Facet Mindfulness Questionnaire (FFMQ)	Measures the five facets of mindfulness (subscales): observing, describing, acting with awareness, nonjudging of inner experience, and nonreactivity to inner experience. The scale is constructed of 39 statements rated on a 5-point scale (1 = never or very rarely true to 5 = very often or always true), with higher scores indicating greater mindfulness. Each of the five subscales has good internal consistency (Cronbach's α ranging from 0.75 to 0.91). To reduce participant burden (i.e., the length of the survey), consider using only one or two subscales at a time. Subscales are listed at the end of the PDF link on the right under "Scoring Information."	Baer et al., 2006 Copy of the measure available here: https://goamra.org/wp-content/uploads/2014/06/FFMQ_full.pdf
E2. Mindful Attention to Awareness Scale–State (MAAS)	5-item unidimensional scale of "state" (or current) mindfulness. This measure assumes that respondents are receiving a page or text to rate their immediate experiences. Respondents rate statements such as "I was finding it difficult to stay focused on what was happening" on a 7-point Likert scale from 0 (not at all) to 6 (very much). Scores are calculated as an average across the scale, with higher scores indicating greater dispositional mindfulness. MAAS has demonstrated good internal consistency (α = 0.92).	Brown and Ryan, 2003; Carlson and Brown, 2005 Copy of the measure available here: https://ggsc.berkeley.edu/images/uploads/The_Mindful_Attention_Awareness_Scale_-_State.pdf
E3. Cognitive and Affective Mindfulness Scale–Revised (CAMS-R)	12 items measuring mindfulness. Participants rate statements such as "I can accept things I cannot change" on a 4-point Likert scale from 1 (rarely/not at all) to 4 (almost always). This measure is valid and reliable, and experts recommend it because it is easier to score and easier for participants to understand than some other measures of mindfulness.	Feldman et al., 2007 Copy of the measure available here: https://ggsc.berkeley.edu/images/uploads/The_Cognitive_and_Affective_Mindfulness_Scale_%E2%80%93_Revised.pdf
Mental health and mood		
E4. Kessler-10 (K-10)	The K-10 is a very well-established 10-item measure of psychological distress. Respondents rate on a 5-point Likert scale how often they experienced symptoms of depression and psychological distress in the last 30 days. Scores are summed on a range from 10 to 50, with higher scores indicating greater distress. Cut points have been established that indicate levels of severity.	Kessler et al., 2002 Examples of studies using this measure: Ellis et al., 2011; Anderson et al., 2013 Copy of the measure available here: https://www.tac.vic.gov.au/files-to-move/media/upload/k10_english.pdf

Measure	Brief description	Reference(s)
Stress and coping		
E5. Coping Self-Efficacy Scale (CSES)	This 26-item measure is widely used to measure ability to cope with stress. Respondents rate how confident they are that when things are not going well they can engage in 26 different coping actions (e.g., "Take your mind off unpleasant thoughts") from 0 (cannot do at all) to 10 (certain can do). Items are summed to create a CSES score (α = 0.95; scale mean = 137.4, standard deviation = 45.6).	Chesney et al., 2006 Examples of studies using this measure: Bakker and Rickard, 2018 Copies of the measure available here: https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/CopingSelf-EfficacyScale.pdf https://prevention.ucsf.edu/research-project/coping-self-efficacy-scale-scoring
E6. Perceived Stress Scale (PSS-10 and PSS-4)	This 4- or 10-item measure is perhaps the most widely used measure of perceived stress. Respondents rate how often in the last month they experienced stress-related feelings or circumstances, such as "In the last month, how often have you found that you could not cope with all the things that you had to do?" on a five-point scale from 0 (never) to 4 (very often). The PSS is scored by reversing responses to the four positively phrased items and then summing across all scale items. An even briefer 4-item scale can be made from items 2, 4, 5, and 10 of the PSS-10.	Cohen, Kamarck, and Mermelstein, 1983; Cohen and Williamson, 1988 Examples of studies using this measure: Hinkle, 2015; Radhu et al., 2012; Arpin-Cribbie, Irvine, and Ritvo, 2012; Rose et al., 2013; Chiauzzi et al., 2008 Copy of the measure available here: http://www.mindgarden.com/documents/PerceivedStressScale.pdf
Life satisfaction*		
* Brief and remote interventions are not likely to change participants' satisfaction with life, but you might consider measuring this to understand overall life satisfaction within your wing (i.e., for context, with the expectation that it is not likely to change through the intervention listed here).		
E7. Satisfaction with Life Scale; also called Life Satisfaction Scale	A widely used five item self-report scale assessing respondents' satisfaction with life (e.g., "I am satisfied with my life"). Respondents rate statements on a seven-point Likert scale (1 = strongly disagree, 7 = strongly agree). Scores are summed, with higher scores indicating greater life satisfaction. It has shown high test–retest reliability (r = 0.82) and high internal consistency (α = 0.87).	Diener et al., 1985 Examples of studies using this measure: Howells, Ivtzan, and Eiroa-Orosa, 2016; Mackenzie, Poulin, and Seidman-Carlson, 2006; Foster et al., 2018; Roepke et al., 2015 Copy of the measure available here: http://www.hkcss.org.hk/uploadfileMgnt/0_201443011362.pdf
Job satisfaction and burnout		
E8. Job Satisfaction Scale	Consists of 9 subscales each with 4 items (34 items total): Pay, Promotion, Supervision, Fringe Benefits, Contingent Rewards (performance-based rewards), Operating Procedures (required rules and procedures), Coworkers, Nature of Work, and Communication. Respondents rate their agreement with statements such as "My supervisor is quite competent in doing his/her job" on a six-point Likert scale. Internal consistency ranges from 0.6 to 0.82 for subscales and was 0.91 overall in a community sample of 2,870 respondents.	Spector, 1985 Examples of studies using this measure: Mackenzie, Poulin, and Seidman-Carlson, 2006 Copy of the measure available here: http://shell.cas.usf.edu/~pspector/scales/jsspag.html
E9. Maslach Burnout Inventory	One of the most well-established measures of burnout, the Maslach Burnout Inventory consists of 22 items assessing work-related burnout, such as "I doubt the significance of my work." Different survey versions are available depending on the population being assessed (e.g., human services professionals, physicians, etc.). Manuals and survey licenses are available to purchase from the developers.	Maslach and Jackson, 1981 Examples of studies using this measure: Mackenzie, Poulin, and Seidman-Carlson, 2006 Purchase different forms of the survey from the developers here: https://www.mindgarden.com/117-maslach-burnout-inventory

APPENDIX F

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