

Date Last Updated: April 14, 2025

The UW ALACRITY Center (UWAC) has several measures to be collected by grantees. Some are required across all projects, while others are suggested and optional. Several of them may need to be edited to fit the needs of each specific project; please consult with the Center on the feasibility of any potential edits you would need to make. The table below outlines the measures and describes requirements for each stage of the Discover, Design, Build, Test (DDBT) process. If your project is not doing a phase, the measure listed in that phase will not be collected. Items highlighted in **blue** are collected from the research and/or research-redesign team.

Note: UWAC R01s and R34s have different requirements than the R03s. Measures that are optional for R03 are noted under “measure/activity.”

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
DDBT mechanisms							
Usability	Usability issues grounded in participant data and reported using UWAC’s standard structure	Usability issues will be collected by the research team and reported to the UWAC in a measure administered by UWAC. This could be informed by the identification of user needs as well as usability evaluation methods, such as <ul style="list-style-type: none"> • heuristic evaluation, • cognitive walkthroughs, • usability testing (preferred), etc. 	Yes	Yes, <i>if</i> the design phase identifies further usability issues with either the existing CI/IS or the redesigned one.	Yes, <i>if</i> the design phase identifies further usability issues with the redesigned CI/IS.	n/a	Reporting should take ~5-15 minutes per issue, once issues have been identified.
	System/ Intervention/ Implementation Strategy Usability Scale (SUS/IUS/ISUS)	Collect the most appropriate one of these measures from participants, based on what the project is redesigning. See narrative for guidance on which to use and when, including alternate measures that may fatigue in the design/build phase.	Yes – of existing CI/IS if possible (if it exists and if possible)	Yes – at least once at end of test, of redesigned CI/IS	Yes – of redesigned CI/IS (+ comparison to unadapted, if possible)	n/a	5 minutes; 10 items
Engagement	User Responsiveness Scale	Measures the level of engagement by participants. Likely needs to be adapted	Yes – of existing CI/IS (if it exists	Required, of the redesigned	Yes – of redesigned CI/IS (+	n/a	5 minutes; 4 items (10 additional

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
		to the specific study—UWAC staff can help with this.	and if possible)	CI/IS, if not collected in discover or test. Optional if collected in discover and/or test.	comparison to unadapted, if possible)		items are optional to add)
	Coding of interactions	Quantitative scores and qualitative codes of engagement, which as appropriate for the CI/IS could be based on: <ul style="list-style-type: none"> • observations of user interactions, • Self-report, • Telemetry from applications, e.g., information about time spent in app, screens viewed, participating in responding to prompts, etc 	Yes – of existing CI/IS	Maybe – of redesigned CI/IS	Yes – of redesigned CI/IS (+ comparison to unadapted, if possible)	n/a	Varies based on approach taken
Appropriateness	Intervention Appropriateness Measure (IAM)	Four item measure of the appropriateness of a CI/IS.	Yes – of existing CI/IS <i>Note: This can be based on existing literature.</i>	Maybe – of redesigned CI/IS	Yes – of redesigned CI/IS (+ comparison to unadapted, if possible)	n/a	2 min, 4 questions
	Revised Goodness of fit interview <i>Optional for R03s</i>	Probes areas of CI/IS alignment and misalignment on goals and expectations, roles, etc.	Yes – of existing CI/IS	Maybe – of redesigned CI/IS	Yes – of redesigned CI/IS (+ comparison to unadapted, if possible)	n/a	Varies

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
Proximal implementation outcomes							
Adoption and reach	User report	Study-specific measure of the adoption or use of the intervention or implementation strategy	Yes – of existing CI/IS, if feasible <i>Note: This can be based on existing literature.</i>	No	Yes (+ comparison to unadapted, if possible)	n/a	5-10 min, if just reporting a numerator and a denominator
Intervention and implementation strategy fidelity	Fidelity of practice	Should be specific to whatever intervention or strategy is being studied	Yes – of existing CI/IS, if feasible <i>Note: This can be based on existing literature.</i>	No	Yes (+ comparison to unadapted, if possible)	n/a	Varies
Planned adaptations (i.e., redesign solutions)	Framework for Reporting Adaptations and Modifications to Evidence-based Implementation Strategies (FRAME/-IS)	Checklist of possible redesign solutions and adaptations. This measure will be administered by the UWAC and completed by PIs	No	Yes	Yes	n/a	30 minutes
Unplanned/ reactive MODIFICATIONS	Framework for Reporting Adaptations and Modifications to Evidence-based practices (FRAME)	Provider-completed checklist of adaptations and modifications	No	No	Yes	n/a	~10 minutes; 17 questions
Distal service recipient outcomes							

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
Client outcomes	PROMIS Social Functioning	PROMIS Satisfaction with Social Roles & Activities (v2.0 Short Form 8a) PROMIS Pediatric Peer Relationship (v3.0 Short Form 8a)	No	No	Yes	n/a	8 items; 5 minutes
	Top Problems Assessment	Measure of the client/patient-reported major problems and severity	No	No	Yes – pre and post	n/a	3-6 items (3 problems and their ratings at baseline then 3 items for their updated ratings); 5 minutes
	DSM-5 Level 1 Cross-Cutting Symptom Measure <i>Optional for R03s</i>	DSM-5 Level 1 Cross-Cutting Symptom Measure (Youth Ages 11-17) DSM-5 Level 1 Cross-Cutting Symptom Measure (Parent/Caregiver Report Form for Youth Ages 6-17) DSM-5 Level 1 Cross-Cutting Symptom Measure (Adults)	No	No	Yes	n/a	15 min; 25 items for youth and caregiver; 23 items for adults
	Revised Children's Anxiety and Depression Scale-25 (RCADS-25) <i>Optional for R03s</i>	Revised Children's Anxiety and Depression Scale-25 (Youth) Revised Children's Anxiety and Depression Scale-25 (Parent/Caregiver Report Form for Youth)	No	No	Yes	n/a	15 min, 25 items for youth and caregivers
	Patient Health Questionnaire - 9 (PHQ-9) <i>Optional for R03s</i>	Patient Health Questionnaire – 9 (ADULTS ONLY)	No	No	Yes	n/a	5 min, 9 items

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
	General Anxiety Disorder-7 (GAD-7) <i>Optional for R03s</i>	General Anxiety Disorder-7 (ADULTS ONLY)	No	No	Yes	n/a	5 min, 7 items
	WHO Disability Assessment Schedule (WHODAS 2.0) <i>Optional for R03s</i>	WHO Disability Assessment Schedule (ADULTS ONLY)	No	No	Yes	n/a	7 min, 12 items
Demographic and process measures							
Demographics	Demographics Pedigree (NDA term) <i>Optional for R03s</i>	Participant demographics. Required and reported to National Institute of Mental Health (NIMH).	Yes	Yes	Yes	n/a	5 minutes; ~ 8 questions
User Needs & Experience	User interviews	User interviews are applied across UWAC to identify key challenges end users might face when applying clinical interventions/implementation strategies (CI/IS). Interviews consist of questions derived from HCD principles such as organizational and stakeholder culture, values, and challenges in applying CIs or ISs.	At least one of these activities, as appropriate for project	At least one of these activities, as appropriate for project	At least one of these activities, as appropriate for project	n/a	Varies based on approach chosen
	User-centered design activities <i>& other methods for understanding and probing user needs.</i>	Various activities as appropriate for the project, such as contextual observation, reactions to design sketches, co-design activities, design activities in Asynchronous Remote Communities ,. This could include observations, focus groups, etc.					

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
Participant research burden, incentive appropriateness, and research satisfaction	Three study-specific items borrowed from CREATIV's ADAPT study pilot trial	Measures the burden of participation in the study which can be useful as a pilot tool to guide research modifications	No	No	Yes	n/a	3 items; 2 minutes
Adherence to DDBT process (DDBT fidelity and cost measure)	Survey <i>Optional for R03s</i>	Survey data collected from each project's redesign team about their application of HCD techniques during each DDBT phase will be collected at the conclusion of the phase and summarized.	Yes	Yes	Yes	n/a	Variable: 9 questions (per activity), >2 hours
Team collaboration, trust, and respect	Transdisciplinary Tobacco Use Research Center (TTURC) satisfaction measure of team collaboration and transdisciplinary integration (productivity and satisfaction sections only/process quality and outcomes) <i>Optional for R03s</i>	Administered to redesign team members along with participation measure (below). Assesses satisfaction with the collaboration, impact of collaboration, trust, and respect. This ongoing review of outcomes will allow for critical assessment and course correction as needed and recommended by these bodies.	R01, R34s	R01, R34s	R01, R34s	n/a	5-10 minutes; 18 questions
Community participation in research	Modified Ladder of Participation Measure <i>Optional for R03s</i>	Administered to design team members along with collaboration measure (above). This measure has been modified to target design of CI/IS across 6 dimensions: identification of design issues, design activities, use of resources, design methods, indicators of success, and sustainability.	Yes—teams complete near or immediately after Discover	Yes – Redesign teams will complete near or immediately after Design/Build	Yes— Teams complete immediately after project ends	n/a	20 minutes; 6 items and interview
Investigator satisfaction with	UWAC satisfaction measure	UWAC-developed measure of the satisfaction of grantee investigators	n/a	n/a	n/a	Yes	5-10 minutes; ~ 10 questions

Construct	Measure / Activity	Notes	Required to collect in Phase?				Estimated time burden
			Discover	Design/Build	Test	End	
the support they receive from the center		about support received. UWAC will administer this measure to grantee teams					
			Yes	Yes	Yes	n/a	

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DDBT Mechanisms

Usability

Usability is a fundamental HCD outcome and is commonly assessed using interviews coupled with other methods for usability studies to gather insight on both ability to perform tasks and experience. International Organization for Standardization (ISO) 9241-11 definition of usability is the “extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use.” A *formative* usability study aims to identify opportunities for design improvements and aligns with the “discover” phase of DDBT. A *summative* usability study aims to evaluate how well a product or service meets its objectives and aligns with the “test” phase of DDBT.

Usability issues are: *Aspects of the intervention or implementation strategy and/or a demand on the user which make it unpleasant, inefficient, onerous, or impossible for the user to achieve their goals in typical usage situations (adapted from [Lavery, Cockton, & Atkinson, 1997](#)).*

Teams will be asked to report usability issues using the [ALACRITY Center usability issue format](#), which includes:

- A descriptive name
- A description of the issue
- Issue severity
- Issue scope
- Issue complexity
- Categorizing the issue (if possible)

Usability issues should be reported at the end of the Discover phase, and then additionally identified issues should be reported at the end of discover/build and test phases. UWAC Methods Core members will provide feedback to teams after submission of usability issues to potentially revise wording and discuss how the usability issues will be addressed in subsequent DDBT stages.

Intervention/Implementation Strategy/System Usability Scale

The Intervention Usability Scale (IUS), Implementation Strategy Usability Scale (ISUS), and System Usability Scale (SUS) are a set of related scales that support assessment of the usability—the extent to which a system or service can be used by specific people to achieve specified goals with effectiveness, efficiency, and satisfaction within a specified context of use (ISO 9241-11:2018)—of interventions, implementation strategies, and systems, where a system may be software program or paper form. This can support decisions like whether a prototype is ready to advance to more widespread testing or comparisons, such as whether a redesigned intervention is more usable than the original intervention. While they can help answer how usable something is, the scales on their own do not directly guide how to redesign something to be more usable.

Highlights

Here are some ways you can use these measure in the design process...

- SUS/IUS/ISUS can be administered in early usability tests to provide quick, quantifiable feedback. This allows designers to assess whether users find the intervention interface intuitive and easy to navigate.
- Although the SUS/IUS/ISUS provides a general usability score, when paired when paired with qualitative follow-ups, it can help identify specific issues (i.e., confusing navigation or awkward flow).
 - Repeated use of SUS, or a shorter form measure (see below), throughout the redesign process can track improvements (i.e., benchmarking). If the score increases over time, it signals that changes are positively affecting usability.

Which to use: Implementation Usability Scale, Intervention Usability Scale, or System Usability Scale?

Overall, our guidance parallels the name of each scale. If your goal is to assess the usability of the intervention (including any associated supporting tools), then use the Intervention Usability Scale (IUS). If your goal is to assess the usability of a system or artifact, use the System Usability Scale (SUS). SUS was developed primarily for digital systems but may work for other kinds of artifacts such as worksheets.

There may be times when you need to assess two or all three. However, in these instances, we recommend against using SUS and IUS in the same session with the same participants, as the similarities may lead to fatigue or confusion. Further, because UWAC projects are often investigating the usability of an intervention and usability of a system, it is important for the object or target of the survey to be clear.

Role of scales in each DDBT phase: When and how to use them

Even if you use the same scale in each phase, it may have different roles.

Discover and Test Phases

From the center perspective, we hope to collect or set up **comparisons** between the usability of the **un-adapted intervention or implementation strategy** and the **redesigned intervention or implementation strategy**, among the intended users and in the intended population. Example comparisons include:

- Comparing an un-adapted intervention in discover phase to the redesigned intervention in the test phase using the IUS
- In a project with a test phase that has a control condition of the un-adapted intervention/implementation strategy, comparing usability of the un-adapted intervention/implementation strategy (control group) with the adapted intervention/implementation strategy (redesign group) by comparing the IUS/ISUS scores between the control and redesign groups after a period of use in the test phase.
- In a project that focuses on redesigning an artifact-based intervention strategy (e.g., software, paper form) to improve usability, comparing the artifact's usability between the discover phase and test phase using SUS.

Projects where the un-adapted intervention or implementation strategy cannot be used at all in the destination context without adaptation can prevent collecting meaningful IUS/ISUS/SUS data at this stage. In this situation, please reach out to the Methods Core to discuss what might be useful for both your project and center goals.

Design Build / Phase

Teams also may use IUS/ISUS/SUS to assess **usability during the design/build phase**. Early in this process, a scale might be used with scenarios or storyboards to assess perceived or anticipated usability of a design direction. Interviewers might probe about responses to items that indicate potential usability issues to guide redesign. Later, as prototypes mature, participants can complete the IUS/ISUS/SUS after doing a set of tasks (e.g., using the system or role-playing steps in an intervention or implementation strategy). Usability experts tend to look for a SUS score to reach 70 (a benchmark for satisfactory usability) before moving to a test phase, as doing so earlier will likely mean that significant usability issues remain that would interfere with overall goals for a test phase. It is not known if a similar benchmark carries over to the newer IUS/ISUS. [This guide](#) provides further detail on interpreting SUS scores.

The shorter **Usability Metric for User Experience (UMUX) (4-item) or (UMUX-Lite) 2-item** might also be used in this iterative process, to avoid measurement fatigue. UMUX-Lite [correlates well with SUS](#), at least for evaluation of technologies – but to convert between UMUX-Lite and SUS, you must use 7-point Likert scales. Currently, there are not published examples of using UMUX or UMUX-Lite for non-digital interventions and implementation strategies.

As teams wrap up the **design/build phase**, participants **must** complete the IUS/ISUS/SUS about their redesigned intervention or implementation strategy. Please report this (and not all iterations) to the center, as we would like to know what usability level is reached by the end of design.

Adapting the wording of scale items

Before administering the survey, review—and possibly pilot—your selected scale to assess if the wording of items is appropriate for your participants and what you are evaluating. Sometimes, it can make sense to adapt items – you are welcome to meet with the Methods Core to discuss possible adaptations or adding clarifications. Please meet with the Methods Core before dropping items or changing the response scale, as this can inhibit later comparisons with other projects.

If you need to translate the scale into a different language, the translated scale should be piloted and discussed with community partners. A protocol you can consider using for translating IUS/ISUS/SUS is Toma G, Guetterman TC, Yaqub T, Talaat N, Fetters MD. A systematic approach for accurate translation of instruments: Experience with translating the Connor–Davidson Resilience Scale into Arabic. *Methodological Innovations*. 2017 Nov;10(3):2059799117741406, which has also been used to translate AIM/IAM/FIM.

Example of scale adapted for children: [Putnam C, Puthenmadom M, Cuerdo MA, Wang W, Paul N. Adaptation of the system usability scale for user testing with children. In Extended abstracts of the 2020 CHI conference on human factors in computing systems 2020 Apr 25 \(pp. 1-7\).](#)

Some examples of adaptations: <https://www.questionpro.com/blog/system-usability-scale/>

An example set of uses: PST Aid

Consider the following example: a team is developing a technological tool, PST Aid, to support the delivery of Problem Solving Treatment (PST). The team has already completed the IUS regarding PST in the Discover phase.

The team chooses to use the IUS and SUS in the design phase to inform their design direction (IUS) and assess readiness of the prototype (SUS), and the IUS in the test phase to compare usability of PST without PST Aid to PST with PST Aid.

Design phase

In early design workshops, the team uses the IUS to assess participant perceptions about whether PST Aid will make PST, the intervention, more usable. They describe PST (without the Aid) and ask participants to complete the IUS based on it, using “PST” as the object they are evaluating. They then describe PST Aid and how it can be used to support PST delivery, and ask participants to repeat the IUS, this time using “PST, as supported by PST-Aid” as what they are evaluating.

As the team begins to work on their prototype, they periodically present it to participants and ask them to complete tasks using the prototype. They integrate collection of SUS with their usability testing and interviews. After completing a set of tasks, they ask participants to complete the SUS regarding PST Aid’s usability. In early uses, when they know the prototype has many areas for improvement, they ask participants about items where there is the most opportunity for improvement (e.g., “What problems kept this from being a 10?” for positively worded items). This, along with their observations of teams using the tool, informs their design refinements. As the design matures, they begin paying attention to the total score, as they want to ensure they are above the benchmark of 70 (satisfactory usability) before moving to the test phase.

Because the team knows that training will be part of how PST Aid is introduced to clinicians, they guide clinicians to anticipate usability post-training for SUS questions, such as “After you have been trained to use [system]...”. Because clients will not receive training, they do not adapt those items in similar ways.

Test phase

In the test phase, the team uses the IUS to compare usability of PST with PST Aid to PST without PST Aid. Their test phase has a control group (PST without the aid) and a test group PST with PST aid), so they decide it is best to collect IUS during the *test* phase and compare groups. This is also the

comparison in which the center is most interested, as it helps answer the question of whether the introduction of PST Aid makes PST (the intervention) more usable.

System Usability Scale

You should include qualitative probing about scores in an interview format – consult with Methods Core in best practice in doing this, how long your interview may be, and the order (usability scale then interview; interview then scale, etc.). See also: “Usability Interviews & Task-based Usability Testing” below.

Goal: To get a baseline usability score and inform if redesign is ready

Response scale: 1 = Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree

1. I think that I would like to use [system] frequently
2. I found [system] unnecessarily complex
3. I thought [system] is easy to use
4. I think that I would need the support of an expert consultant to be able to use [system]
5. I find the various functions in [system] are well integrated
6. I thought there was too much inconsistency in [system]
7. I would imagine that most people would learn to use [system] very quickly
8. I found [system] very cumbersome to use
9. I felt very confident using [system]
10. I needed to learn a lot of things before I could get going on [system]

Intervention Usability Scale (IUS)/Implementation Strategy Usability Scale (ISUS)

1. I like to use [intervention/implementation strategy] frequently
2. I find [intervention/implementation strategy] unnecessarily complex
3. I think [intervention/implementation strategy] is easy to use
4. I need the support of an expert consultant to be able to use [intervention/implementation strategy]
5. I find the various components of [intervention/implementation strategy] are well integrated
6. I think there is too much inconsistency in [intervention/implementation strategy]
7. I would imagine that most people would learn to use [intervention/implementation strategy] very quickly
8. I find [intervention/implementation strategy] very cumbersome to use
9. I felt very confident using [intervention/implementation strategy]
10. I needed to learn a lot of things before I could get going on [intervention/implementation strategy]

Scoring guidelines included [here](#). All three measures are scored the same way.

Child/Youth IUS Version

Intervention Usability Scale (IUS)



Response scale: 1 = Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree

1. I think I would like to use [intervention] a lot
2. I thought the different parts of [intervention] were confusing
3. I thought [intervention] was easy to use
4. I think I would need extra help to be able to use [intervention]
5. I always felt like I knew what to do next when I was using [intervention]
6. I thought that parts of [intervention] were too different from each other
7. I think most kids like me would learn how to use [intervention] very quickly
8. Using [intervention] was a lot of work
9. I was confident when I was using [intervention]
10. There was a lot to learn before I could use [intervention]

Scoring guidelines included [here](#).

Usability Interviews & Task-based Usability Testing

Critical Incident Technique Interviews

Sometimes, teams may be most interested in learning about usability issues that emerge only in complex, real-world situations, and that are hard to reproduce in usability evaluations, in the lab, or other contexts. For this, interviews that elicit details of past events can be most effective, despite being limited by people's ability to recall information.

Example questions ask respondents to recall a time when they did a certain behavior. For example, "tell me about a time you used an app in your job." This question prompt is slightly different than "tell me about the last time you used an app in your job." A critical incident question variation could be "tell me about a particular time you used an app in your job where it did not help you accomplish your work."¹

Sessions that combine interviews with other methods

Using interviews alone to gather data may be limiting because of issues with recall and/or challenges with describing behavior. Interviews can be particularly insightful if they incorporate observation or demonstrations, as people's ability to recall and articulate details of their use of a product or system is limited. Observation can involve you asking a respondent to complete or demonstrate tasks, and you ask the respondent questions based on what you see (see Figure 1). Observation during interviews focuses on monitoring and recording people, behavior, artifacts, and environments. When environments or behaviors are defined, structured observation (such as using checklists to record behavior observed) is a good option (Hanington & Martin, 2019, 158).² Unstructured observations can be more exploratory and leave the researcher open to seeing what you may not anticipate.

1. Introduce purpose of study, what you're hoping to observe and learn, and obtain consent
2. Pre-observation interview to ask questions about first impressions or respondent's typical day
3. Observe respondent and take note of respondent's behavior
4. Post-observation interview to ask questions about what you observed

Figure 1. Sample sequence of interview and observation

Observation can be similar to a cognitive walkthrough, which is a **usability** assessment method to systematically walk through sequential steps of a system or process from a user's perspective to identify potential usability issues. Cognitive walkthroughs are usually conducted by domain experts, who may be part of the design team, and can be conducted one-on-one or in groups.

Task-based usability testing

Usability evaluations often involve asking participants to complete one or more tasks using a product or according to a service. This could be using the baseline intervention/implementation strategy/app, using partial or complete prototypes of the redesign, or using the newly redesigned intervention, implementation strategy, or supporting artifacts. After each task, researchers might present them with a scale or ask follow-up questions,

¹ "The Critical Incident Technique in UX - Nielsen Norman Group." 26 Jan. 2020, <https://www.nngroup.com/articles/critical-incident-technique/>. Accessed 26 Aug. 2023.

² Hanington, B., & Martin, B. (2019). *Universal Methods of Design Expanded and Revised: 125 Ways to Research Complex Problems, Develop Innovative Ideas, and Design Effective Solutions*. Rockport Publishers.

though if this interrupts the flow, you may save this until after all tasks are completed. You may refer to this [example of task-based usability testing protocol from a UWAC project](#).

For tasks that involve collaboration (e.g., a session between a clinician and a patient), it may be necessary to have a researcher take on one of the roles. This increases internal reliability but decreases external validity.

Task design. Designing appropriate tasks requires practice and iteration. If a task is too unclear, you may instead uncover usability issues with your task design, not what you are studying! However, if the task design mirrors the language of what a participant must do too closely (e.g., if you tell them to click the button labeled “search”), the task is leading, and you may not uncover key usability issues.

Think aloud protocol. As we cannot read people’s minds, participants are often asked to think aloud while working toward tasks to help researchers learn as much as possible. This can help researchers learn what a participant is considering doing next and why, better understand their in-the-moment goals, and identify misconceptions. To incorporate think aloud in your interview guide, include instructions for the facilitator to give to the participant about the think aloud process. The facilitator should then demonstrate the technique with an unrelated task so that respondents understand it as best as possible. The participant may still forget (especially when concentrating hard on a task!), and it is often necessary for the facilitator to encouragingly remind participants to think aloud. Even with reminders, some respondents may find it distracting or it might not be contextually appropriate to speak before fully processing behavior. In these cases, it is not worth pushing to use the technique, and instead probe respondents on their task experience after they’ve completed their tasks. For example, you can ask a respondent to walk you through how they accomplished their task.³

Additionally, think aloud protocol is not well suited to tasks that require speaking (e.g., talk therapy, interacting with a voice assistant, etc). In these situations, an alternative is to record the task (e.g., video, screen recording, audio) and then play it back to participants, asking them to describe what they were thinking at the time. This retrospective think aloud is less reliable than in-the-moment think aloud, but sometimes it is the best compromise we can make.

Facilitation. Participants asked to complete tasks may feel like they are being evaluated, and this is especially the case if those tasks parallel anything they might have to do for certification in a therapy or related to their professional expertise. As a result, it is even more important for facilitators to remind participants that the intervention/implementation strategy/artifact is being evaluated, not them.

When testing new designs (or existing designs with significant usability issues), it is also not uncommon for participants to have interactions that frustrate them. To an extent, it is valuable to allow this frustration to continue so you learn how the participant would navigate the barriers. If participants ask for help, the facilitator might at first turn it back around to them and ask, “what would you do if I were not here?” However, the facilitator should use their discretion in offering assists that keep the session moving or that help prevent frustration levels from becoming so great that the rest of the session is lost.

Although much task-based usability testing has historically been applied to digital technologies, the approach is quite relevant to complex psychosocial interventions such as client-facing interventions and implementation strategies. As one example, the [Usability Evaluation for Evidence-Based](#)

³ Rubin, J., & Chisnell, D. (2008). *Handbook of usability testing: How to plan, design, and conduct effective tests*. John Wiley & Sons.

[Psychosocial Interventions \(USE-EBPI\)](#) method specifies how “lab-based” user testing (one of the array of sub-methods specified within USE-EBPI) can be completed for interventions such as psychotherapies.

1. Introduce purpose of study, what you’re hoping to observe and learn, and obtain consent
2. Pre-test interview to ask questions about first impressions, demographics, experience with similar products
3. Describe task 1
4. Respondent performs task 1
5. Describe subtask 1a
6. Respondent performs subtask 1a
7. Describe subtask 1b
8. Respondent performs subtask 1b
9. Post-task interview to debrief on what was observed during task and subtasks (and reduce cognitive load of recall)
10. Describe task 2
11. Respondent performs task 2
12. Describe subtask 2a
13. Respondent performs subtask 2a
14. Describe subtask 2b
15. Respondent performs subtask 2b

Figure 3. Sample sequence for usability test

Sample Usability Questions

- *Following a task:* How would you describe your experience completing this task?
- What is one thing you would change about this intervention or product? Why?
- How did your experience compare to (a different intervention or product)?
- What are features that would encourage you to use this intervention or product?

Engagement

A concept complementary to usability is **engagement**.⁴ Specifically with mobile mental health applications, measuring engagement has been challenging with inconsistency in methodology due to lack of consensus of what is engagement. Similarly, there are inconsistent definitions of engagement within HCI, however, engagement generally represents user connection to an intervention and/or product and the ability to engage and sustain engagement.⁵ O'Brien describes engagement as “the depth of the actor’s investment in the interaction” and has affective, behavioral, and cognitive aspects.⁶ There are two different approaches to measuring engagement: subjectivity-oriented and objectivity-oriented.⁷ Subjectivity-oriented measures are self-reported and include (in order of most documentation of use): questionnaires, behavior logging, observation, task outcomes, and interviews.⁸ Objectivity-oriented measures are devoid of researcher involvement such as behavior logging, psychophysiological measurements, or telemetry. In industry, objectivity-oriented telemetry measures like user data—logs, time, number of interactions, and frequency of logins—are commonly used. Other examples of telemetry data could be behavior data captured in an app or data generated from devices that track health metrics.

To measure engagement, UWAC’s proposed approach includes both quantitative and qualitative measures. UWAC requires that all projects use the User Responsiveness Scale to quantitatively measure engagement. The User Responsiveness Scale is an adapted version of a patient responsiveness scale, developed by Moullin et al.⁹ We developed the User Responsiveness Scale based on considering responsiveness as a proxy for service effectiveness. The scale includes 10 items, which will likely need to be adapted based on study. UWAC requires all R01 and R34s to include qualitative measures of engagement (see included scale below). Qualitative measurements of engagement may vary by project, but could include subjectivity-oriented (observation, self-report) and objectivity-oriented (telemetry) approaches. UWAC proposed approach of contextual observations stems from using observation to assess teacher delivery of an anti-bullying program and corresponding student responsiveness.¹⁰ This study defined student responsiveness as student engagement and following rules, which researchers measured by rating two items during observations. Observers rated the following two items on a scale of 1 = not at all, 2 = somewhat, and 3 = extensively; UWAC staff can advise on adapting the items for your project:

- “Students were actively engaged in meeting [i.e., on tasks; participating actively by responding and asking questions; and looking at teacher]”
 - Suggested adaptation for UWAC projects: “Users were actively engaged in [intervention/strategy]”
- “Students followed classroom meeting rules”
 - Suggested adaptation for UWAC projects: “Users adhere to expected activities and modifications to [intervention/strategy]”

It is especially challenging to assess engagement during intermittent activities that are conducted between researcher contact points. For example, during the first phase of UWAC, critical components of interventions were to happen between sessions (e.g., follow a plan & track how it went, practice skills, track behaviors and moods). It is not practical to rely on observation to assess these behaviors, and even if a researcher watched for this behavior,

⁴ Ng, M. M., Firth, J., Minen, M., & Torous, J. (2019). User engagement in mental health apps: a review of measurement, reporting, and validity. *Psychiatric Services*, 70(7), 538-544.

⁵ Doherty, K., & Doherty, G. (2018). Engagement in HCI: conception, theory and measurement. *ACM Computing Surveys (CSUR)*, 51(5), 1-39.

⁶ O'Brien, H. (2016). Theoretical perspectives on user engagement. *Why engagement matters: Cross-disciplinary perspectives of user engagement in digital media*, 1-26.

⁷ Doherty, K., & Doherty, G. (2018). Engagement in HCI: conception, theory and measurement. *ACM Computing Surveys (CSUR)*, 51(5), 1-39.

⁸ *ibid*

⁹ Moullin JC, Sabater-Hernández D, García-Corpas JP, Kenny P, Benrimoj SI. Development and testing of two implementation tools to measure components of professional pharmacy service fidelity. *Journal of evaluation in clinical practice*. 2016 Jun;22(3):369-77.

¹⁰ Goncy, E. A., Sutherland, K. S., Farrell, A. D., Sullivan, T. N., & Doyle, S. T. (2015). Measuring teacher implementation in delivery of a bullying prevention program: The impact of instructional and procedural adherence and competence on student responsiveness. *Prevention science*, 16, 440-450.

the behavior may be subject to social desirability bias. To assess fidelity of paper-based interventions, you could use subjectivity-oriented measures (paper logs, surveys) at different time intervals with follow-up interviews, although this approach is not perfect:

1. You could collect paper logs that respondents must fill out. However, these may be unreliable since respondents may fill out a week's worth of logs right before turning them in.
2. You could administer a daily survey or integrate a diary-study approach by submitting a picture, voice recording, or some other type of documentation. However, the process of collecting these measures is its own intervention, which could bias your results.

To assess fidelity of digital-based interventions, objectivity-oriented measures may be possible such as app logs to see user activities. This can simulate observation and can be done without adding extra reminders. Comparing engagement between a paper-based and digital-based intervention is difficult given measuring engagement for a paper-based intervention is imperfect. Likely the best option would be to interview both respondents that receive the paper-based intervention and digital-based intervention to compare responses, but interpret the results with caution given respondents receiving the digital-based intervention may be more truthful with themselves compared to the respondents receiving the paper-based intervention.

Engagement (User Responsiveness Scale, URS) updated 2/5/25

Adapted from the Patient Responsiveness Scale (Moullin, J. C., Sabater-Hernández, D., García-Corpas, J. P., Kenny, P., & Benrimoj, S. I. (2016). Development and testing of two implementation tools to measure components of professional pharmacy service fidelity. Journal of evaluation in clinical practice, 22(3), 369–377. <https://doi.org/10.1111/jep.12496>

Adult URS Version

Response scale: 1 = Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree

Note: Item #1 is item 1 of the IUS/SUS/ISUS. You only need this item once per data collection.

Based on your experiences during this session...

1. I think I would like to use [CI/IS name] [frequently/a lot]. (Item 1 from SUS)
2. I [would] actively participate[d] in this [CI/IS]. (pro/retrospective based on DDBT phase)
3. I found the [CI/IS] engaging.
4. I would recommend this [CI/IS] to others.

NOTE: For youth participants: 4. “I would suggest [CI] to kids like me”

Scoring: take the average

Note: Please add to the above 4 items any of the 10 below that are relevant to your study.

Note to researcher: your project may need to modify the wording of this measure to be appropriate for your study. Please reach out to the methods core for consultation.						
1	Users will request the [intervention/strategy].					
2	Users will be proactive in asking questions about the [intervention/strategy].					
3	Users will readily provide information relevant to the [intervention/strategy].					
4	Users will actively participate during meetings about the [intervention/strategy].					
5	Users will collaborate in decisions about the [intervention/strategy].					
6	Users will do the expected activities of the [intervention/strategy].					
7	When the plans for the [intervention/strategy] are modified, users will adhere to them.					
8	When education is provided, users will adhere to the [intervention/strategy].					
9	When the [intervention/strategy] is active, users will come to scheduled meetings.					

10	Through other people (e.g., colleagues, friends), users will speak positively about the [intervention/strategy].					
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Child/Youth URS Version

Response scale: 1 = Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree.



Based on what we just talked about

1. I think I would like to use [the thing].
2. I would participate in [the thing].
3. I found [the thing] engaging.
4. I would suggest [the thing] to other kids.
5. Bonus: I would do the expected activities of [the thing]

Scoring: take the average

Appropriateness

Intervention Appropriateness Measure (IAM)

IAM Adult Version

1 = Completely disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Completely agree

- 1) [Intervention or implementation strategy] seems fitting.
- 2) [Intervention or implementation strategy] seems suitable.
- 3) [Intervention or implementation strategy] seems applicable.
- 4) [Intervention or implementation strategy] seems like a good match.

Scoring: take the average

Citation: [Weiner BJ, Lewis CC, Stanick C, Powell BJ, Dorsey CN, Clary AS, Boynton MH, Halko H. Psychometric assessment of three newly developed implementation outcome measures. Implementation science. 2017 Dec;12:1-2.](#) As with the other measures, we recommend each team should discuss internally and with Methods Core if the statements make sense in the context of their intervention and/or implementation strategy and

if there are any contextual or language issues that would affect understanding. There are challenges with translating the IAM to different languages and sometimes can be challenging to understand in English.

Protocol for translation: [Toma G, Guetterman TC, Yaqub T, Talaat N, Fetters MD. A systematic approach for accurate translation of instruments: Experience with translating the Connor–Davidson Resilience Scale into Arabic. Methodological Innovations. 2017 Nov;10\(3\):2059799117741406.](#)

Reach out to Methods Core for inquiries around existing translations.

Participants may seek clarification when filling out the survey on specific words or overlap with scale statements. Reach out to Methods Core to have clarification examples or phrasing that anchors statements. With these scales, Dr. Weiner suggests adding a **referent** so that respondents have an easier time responding. Below are his suggestions on adding referents:

- Person: e.g., suitable for nurses (given scope of practice), suitable for my patients, kids like me
- Place: e.g., suitable for my organization (this clinic, schools)

Here are some ways you can use this measure in the design process...

- IAM can be used to test relevance during development to ensure that both educators and adolescents see the intervention as appropriate for their context (e.g., school setting) and needs (e.g., addressing anxiety or depression). This is critical for driving acceptance and uptake.
- If IAM scores are low, it indicates a mismatch between the intervention and user needs (i.e., a poor contextual adaptation), suggesting that content or strategies need to be adapted to better align with the context.
- IAM results can guide decisions that can be used to refine the content, for instance on whether to adapt specific modules (e.g., behavioral support) or modify the intervention's focus (e.g., more emphasis on emotional regulation).

IAM Child Version



Response scale: 1 = Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree.

- 1) [The thing] seems fitting.
- 2) [The thing] seems like a good match.

Scoring: take the average

Revised Goodness of Fit Interview

1. What aspects of [CI/IS] are a good fit for your setting?
2. What aspects of [CI/IS] are a poor fit for your setting?
3. What could feasibly be changed to improve the fit of [CI/IS] for your setting? (if needed, probe about organizational, personnel, and student/client factors)
4. Magic Wand Questions
 - a. If you had a magic wand, what would help you learn the [IS]?
 - b. If you had a magic wand, what would you change about this {IS}?
 - c. (potential probe, if you had all the time and money, what would you do to improve fit for your setting?)
5. What would help motivate you to integrate the [CI/IS] into your [WORK/TREATMENT DELIVERY/ETC] philosophy and practice?

Proximal implementation outcomes

Adoption and Reach

Intervention Reach

Definition: The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative, intervention, or program, and reasons why or why not.

(From the RE-AIM Model Dimension Items Checklist)

Reach
Exclusion Criteria (% excluded or characteristics)
Percent individuals (clients, patients) who participate, based on valid denominator (not of volunteers who indicate interest)
Characteristics of participants compared to non-participants or to target population
Use of qualitative methods to understand reach and/or recruitment

Intervention Adoption

Definition: (Setting levels) The absolute number, proportion, and representativeness of settings and intervention agents (people who deliver the program) who are willing to initiate a program, and why. Note that adoption can have many (nested) levels- for example, staff under a supervisor under a clinic or school, under a system, within a community.

(From the RE-AIM Model Dimension Items Checklist)

Adoption – Setting Level
Setting Exclusions (% or reasons)
Percent of settings approached that participate (valid denominator)

Characteristics of settings participating (both comparison and intervention) compared to either: non participants or some relevant resource data	
Adoption – Staff Level	
Staff Exclusions (% or reasons)	
Percent of staff invited that participate	
Characteristics of staff participants vs. non participating staff or typical staff	
Use of qualitative methods to understand staff participation	

For projects focused on Implementation Strategies (IS)

Definition: The absolute number, proportion, and representativeness of settings and recipients who received the implementation strategy.

IS Receipt

Setting – same as intervention adoption
Staff Exclusions (% or reasons)
Percent of staff invited that participate
Characteristics of staff participants vs. Non-participating staff or typical staff
Use of qualitative methods to understand staff participation

[Intervention and implementation strategy fidelity](#)

This is specific to your project. Please consult with Methods Core.

[Planned adaptations \(ie, redesign solutions\)](#)

[Framework for Reporting Adaptations and Modifications to Evidence-based Implementation Strategies \(FRAME/IS\)](#)

Project teams will receive a survey with adaptations described in FRAME/IS and asked which changes they made, as well as whether these adaptations were made proactively (e.g., as part of the design process) or reactively (e.g., after deployment or during the test, including top-down changes as well as changes made bottom-up, e.g., by clinicians).

Unplanned/Reactive Modifications for Interventions

In this section, we are interested in any changes that you have made to [THE INTERVENTION] while you were delivering it. Please mark all the boxes that best reflect the changes you made.							
Type of Change	Never (0%)	Rarely (<10%)	Occasionally (10-40%)	Half the time (>40-60%)	Frequently (>60-90%)	Almost all (>90%)	Unable to Assess (Don't Know)
I made minor changes to tailor, and/or refine the pieces of [THE INTERVENTION] (e.g., changed wording, simplified a worksheet).	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I substituted pieces of a different treatment approach for one of [THE INTERVENTION] pieces or activities. (e.g., provided different psychoeducation, taught a different skill).	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I integrated another treatment approach into [THE INTERVENTION].	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I skipped core components of [THE INTERVENTION] during a single session.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I did not deliver one or more of [THE INTERVENTION] components over the course of treatment.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I spread a single session's content over multiple sessions.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I extended the session time.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I shortened the session time.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁

I did more sessions of [THE INTERVENTION] than in the protocol.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I did fewer sessions of [THE INTERVENTION] than in the protocol.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I adjusted the order of [INTERVENTION] components.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I adjusted the order of the content within a session (loosened the structure).	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I stopped using [THE INTERVENTION] before completing all components to start using another treatment strategy.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
Stopped using [THE INTERVENTION] and used another strategy for part of the session (e.g., 10 minutes or more) other than [THE INTERVENTION].	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I did not complete [THE INTERVENTION] protocol during a session (i.e., did not complete [THE INTERVENTION] content due to reasons other than a crisis or uncommon interruption).	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I repeated pieces (e.g., concept or activity) from a [THE INTERVENTION] session that were not intended to be done twice.	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
I delivered the [THE INTERVENTION] protocol in a	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁

different format (e.g., group or telephone format).							
Another change (please describe): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
Another change (please describe): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁
Another change (please describe): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₋₁

What was the goal of the modifications you made? Check all that apply.

- a. Increase reach
- b. Increase engagement
- b. Increase client retention
- c. Improve feasibility for this setting
- d. Improve fit of intervention to client's needs
- e. To address cultural factors
- f. Improve effectiveness/outcomes
- g. Reduce cost
- h. Increase client satisfaction
- i. Other (describe) _____

Potential qualitative question: Based on the modifications you made, if you had to recommend making a change to this intervention protocol, what would you recommend?

Distal service recipient outcomes

Client outcomes

PROMIS Satisfaction with Social Roles and Activities (Adult Short Form)

Satisfaction with Social Roles and Activities – Short Form 8a

Please respond to each item by marking one box per row.

		Not at all	A little bit	Somewhat	Quite a bit	Very much
SRPSAT06r1	I am satisfied with my ability to do things for my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT33_CaPS	I am satisfied with my ability to do things for fun with others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT34r1	I feel good about my ability to do things for my friends.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT49r1	I am satisfied with my ability to perform my daily routines	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT33r1	I am satisfied with my ability to do things for fun outside my home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT45_CaPS	I am satisfied with my ability to meet the needs of my friends.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT09r1	I am satisfied with my ability to do the work that is really important to me (include work at home)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SRPSAT45_CaPS	I am satisfied with my ability to meet the needs of my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Scoring: Sum the values of the response to each question. All items need responses to use table below.

With total raw summed score, use score conversion table to translate into a T-score. T-scores are standardized scores with a mean of 50 and SD of 10.

v2.0 Satisfaction with Social Roles and Activities 8a		
Short Form Conversion Table		
Raw Summed Score	T-Score	SE*
8	26.2	4.0
9	30.0	2.6
10	31.7	2.3
11	33.1	2.0
12	34.2	1.9
13	35.2	1.8
14	36.1	1.7
15	36.9	1.7
16	37.7	1.7
17	38.5	1.7
18	39.4	1.7
19	40.2	1.7
20	41.0	1.7
21	41.8	1.7
22	42.7	1.7
23	43.5	1.8
24	44.4	1.8
25	45.3	1.7
26	46.2	1.7
27	47.1	1.7
28	47.9	1.7
29	48.8	1.7
30	49.7	1.7
31	50.6	1.7
32	51.6	1.7
33	52.5	1.7
34	53.4	1.7
35	54.4	1.8
36	55.5	1.8
37	56.8	2.0
38	58.3	2.2
39	60.4	2.8
40	65.6	4.9

*SE = Standard Error on T-score metric

https://www.healthmeasures.net/images/PROMIS/manuals/Scoring_Manual_Only/PROMIS_Satisfaction_with_Social_Roles_and_Activities_Scoring_Manual_05Dec2023.pdf

PROMIS Pediatric Peer Relationships Short Form – 8a

PROMIS® Pediatric Item Bank GenPop v3.0 – Peer Relationships – Short Form 8a

Pediatric Peer Relationships – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days...

		Never	Almost Never	Sometimes	Often	Almost Always
5018R1r	I felt accepted by other kids my age.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5058R1r	I was able to count on my friends.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5055R1r	My friends and I helped each other out.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
233R2r	Other kids wanted to be my friend.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
1147R1r	I was good at making friends.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
210R1r	Other kids wanted to be with me.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5056R1r	I was able to talk about everything with my friends.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9020R1r	Other kids wanted to talk to me.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Scoring: Sum the values of the response to each question. All items need responses to use table below.

With total raw summed score, use score conversion table to translate into a T-score. T-scores are standardized scores with a mean of 50 and SD of 10.

https://www.healthmeasures.net/images/PROMIS/manuals/Scoring_Manual_Only/PROMIS_Satisfaction_with_Social_Roles_and_Activities_Scoring_Manual_05Dec2023.pdf

PROMIS Pediatric GenPop v3.0 – Peer Relationship 8a		
Short Form Conversion Table		
Raw Summed Score	T-score	SE*
8	18.6	3.4
9	21.4	3.0
10	23.2	2.7
11	24.7	2.5
12	26.0	2.4
13	27.1	2.3
14	28.2	2.3
15	29.2	2.3
16	30.2	2.3
17	31.3	2.3
18	32.3	2.3
19	33.4	2.4
20	34.5	2.4
21	35.6	2.5
22	36.8	2.5
23	38.0	2.5
24	39.3	2.5
25	40.6	2.5
26	41.9	2.5
27	43.2	2.4
28	44.5	2.4
29	45.8	2.4
30	47.1	2.4
31	48.3	2.4
32	49.6	2.4
33	50.9	2.4
34	52.2	2.4
35	53.5	2.5
36	55.0	2.5
37	56.6	2.7
38	58.6	3.0
39	61.1	3.5
40	66.1	5.2

*SE = Standard Error on T-score metric

Top Problems Assessment

Administered to client and/or caregiver, pre (and post rating with the same problems, as appropriate)

For client: What are the most important problems you think you need help with in treatment (*or “counseling” or whatever name is appropriate for the service*)? What are the behaviors or emotions you’re having difficulty with? You can name up to three top problems.

For caregiver: What are the most important problems you think your child needs help with in treatment (*or “counseling” or whatever name is appropriate for the service*)? What are the behaviors or emotions they’re having difficulty with? You can name up to three top problems.

Top Problem #1: _____

Top Problem #2: _____

Top Problem #3: _____

Now, please rate each of these problems on a scale from 0 to 4, where 0 means not a problem at all and 4 means a very big problem.

[TOP PROBLEM 1]	0	1	2	3	4
[TOP PROBLEM 2]	0	1	2	3	4
[TOP PROBLEM 3]	0	1	2	3	4

1= Not a problem; 2= A small problem; 3= A medium problem; 4= A very big problem

REDCap Administrative Item: Respondent: Mother; Father; Parent; Caregiver; Guardian; Teacher; Child; Self; Partner; Other; NA

Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) Level 1 Cross-Cutting Symptom Measures

DSM-5 Cross-Cutting Symptom Measure for Adults

0 = Not at all; 1 = Rare, less than a day or two; 2 = Several days; 3 = More than half the days; 4 = Nearly every day; -9 = Missing

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?

None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
0	1	2	3	4

- I. 1. Little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?
- II. 3. Feeling more irritated, grouchy, or angry than usual?
- III. 4. Sleeping less than usual, but still have a lot of energy?
5. Starting lots more projects than usual or doing more risky things than usual?
- IV. 6. Feeling nervous, anxious, frightened, worried, or on edge?
7. Feeling panic or being frightened?
8. Avoiding situations that make you anxious?
- V. 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?
10. Feeling that your illnesses are not being taken seriously enough?
- VI. 11. Thoughts of actually hurting yourself?

- VII. 12. Hearing things other people couldn't hear, such as voices even when no one was around?
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?
- VIII. 14. Problems with sleep that affected your sleep quality over all?
- IX. 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?
- X. 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?
17. Feeling driven to perform certain behaviors or mental acts over and over again?
- XI. 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?
- XII. 19. Not knowing who you really are or what you want out of life?
20. Not feeling close to other people or enjoying your relationships with them?
- XIII. 21. Drinking at least 4 drinks of any kind of alcohol in a single day?
22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?
23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?

<https://www.psychiatry.org/getmedia/e0b4b299-95b3-407b-b8c2-caa871ca218d/APA-DSM5TR-Level1MeasureAdult.pdf>

DSM-5 Cross-Cutting Symptom Measure – Self-Report Child Age 11-17

Items 1 – 19: 0 = Not at all; 1 = Rare, less than a day or two; 2 = Several days; 3 = More than half the days; 4 = Nearly every day; -9 = Missing

Items 20 – 25: 1 = Yes; 2 = No; -9 = Missing

None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
0	1	2	3	4

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

During the past TWO (2) WEEKS, how much (or how often) have you...

- I. 1. Been bothered by stomachaches, headaches, or other aches and pains?
2. Worried about your health or about getting sick?
- II. 3. Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?
- III. 4. Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?
- IV. 5. Had less fun doing things than you used to?
6. Felt sad or depressed for several hours?
- V. & VI. 7. Felt more irritated or easily annoyed than usual?
8. Felt angry or lost your temper?
- VII. 9. Started lots more projects than usual or done more risky things than usual?
10. Slept less than usual but still had a lot of energy?
- VIII. 11. Felt nervous, anxious, or scared?
12. Not been able to stop worrying?
13. Not been able to do things you wanted to or should have done, because they made you feel nervous?
- IX. 14. Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?
15. Had visions when you were completely awake—that is, seen something or someone that no one else could see?

X. 16. Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?

17. Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?

18. Worried a lot about things you touched being dirty or having germs or being poisoned?

19. Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?

In the past TWO (2) WEEKS, have you... (NOTE: Yes = 1, No = 2, Missing = -9)

XI. 20. Had an alcoholic beverage (beer, wine, liquor, etc.)? Yes No

21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? Yes No

22. Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? Yes No

23. Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? Yes No

XII. 24. In the last 2 weeks, have you thought about killing yourself or committing suicide? Yes No

25. Have you EVER tried to kill yourself? Yes No

<https://www.psychiatry.org/getmedia/9352851c-d69f-411a-8933-3212e8c29063/APA-DSM5TR-Level1MeasureChildAge11To17.pdf>

DSM-5-TR Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Items 1 – 19: 0 = Not at all; 1 = Rare, less than a day or two; 2 = Several days; 3 = More than half the days; 4 = Nearly every day; -9 = Missing

Items 20 – 25: 1 = Yes; 2 = No; -9 = Missing

None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
0	1	2	3	4

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

During the past TWO (2) WEEKS, how much (or how often) has your child...

- I. 1. Complained of stomachaches, headaches, or other aches and pains?
2. Said he/she was worried about his/her health or about getting sick?
- II. 3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?
- III. 4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?
- IV. 5. Had less fun doing things than he/she used to?
6. Seemed sad or depressed for several hours?
- V. & VI. 7. Seemed more irritated or easily annoyed than usual?
8. Seemed angry or lost his/her temper?
- VII. 9. Started lots more projects than usual or did more risky things than usual?
10. Slept less than usual for him/her, but still had lots of energy?

VIII. 11. Said he/she felt nervous, anxious, or scared?

12. Not been able to stop worrying?

13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?

IX. 14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?

15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?

X. 16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?

17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?

18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?

19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?

In the past TWO (2) WEEKS, has your child ...

XI. 20. Had an alcoholic beverage (beer, wine, liquor, etc.)? Yes No Don't Know

21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? Yes No Don't Know

22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? Yes No Don't Know

23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? Yes No Don't Know

XII. 24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? Yes No Don't Know

25. Has he/she EVER tried to kill himself/herself? Yes No Don't Know

<https://www.psychiatry.org/getmedia/1e799501-f718-4d06-817e-ce98e35c6bdd/APA-DSM5TR-Level1MeasureParentOrGuardianOfChildAge6To17.pdf>

Revised Children's Anxiety and Depression Scale- (RCADS) 25

1 = Never; 2 = Sometimes; 3 = Often; 4 = Always; -9 = Missing

For the following questions, please select the response that shows how often each of the following things happen to you. There are no right or wrong answers.

1. I feel sad or empty
2. I worry when I think I have done poorly at something
3. I would be afraid of being on my own at home
4. Nothing is much fun for me anymore
5. I worry that something awful will happen to someone in the family
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)
7. I worry what other people think of me
8. I have trouble sleeping
9. I feel scared if I have to sleep on my own
10. I have problems with my appetite
11. I suddenly become dizzy or faint when there is no reason for this
12. I have to do somethings over and over again (like washing hands, cleaning, or putting things in a certain order)
13. I have no energy for things
14. I suddenly start to tremble or shake when there is no reason for this
15. I cannot think clearly
16. I feel worthless
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening
18. I think about death
19. I feel like I don't want to move
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of
21. I am tired a lot
22. I feel afraid that I will make a fool of myself in front of people
23. I have to do some things in just the right way to stop bad things from happening
24. I feel restless
25. I worry that something bad will happen to me

RCADS-25 Parent/Caregiver Assessment

1 = Never; 2 = Sometimes; 3 = Often; 4 = Always; -9 = Missing

Please the response that shows how often each of these things happens for your child.

1. My child feels sad or empty
2. My child worries when he/she thinks he/she has done poorly at something
3. My child feels afraid of being alone at home
4. Nothing is much fun for my child anymore
5. My child worries that something awful will happen to someone in the family
6. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)
7. My child worries what other people think of him/her
8. My child has trouble sleeping
9. My child feels scared to sleep on his/her own
10. My child has problems with his/her appetite
11. My child suddenly becomes dizzy or faint when there is no reason for this
12. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)
13. My child has no energy for things
14. My child suddenly starts to tremble or shake when there is no reason for this
15. My child cannot think clearly
16. My child feels worthless
17. My child has to think of special thoughts (like numbers or words) to stop bad things from happening
18. My child thinks about death
19. My child feels like he/she doesn't want to move
20. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of
21. My child is tired a lot
22. My child feels afraid that he/she will make a fool of him/herself in front of people
23. My child has to do some things in just the right way to stop bad things from happening
24. My child feels restless
25. My child worries that something bad will happen to him/her

RCADS-25 Scoring

The total score of the RCADS-25 is calculated by assigning 0-3 to the response categories of “never”, “sometimes”, “often”, “always”, respectively. The sum of all 25 items is tallied and represents the severity of general anxiety and depressive symptoms.

- The Total Anxiety subscale is the sum of items 2, 3, 6, 7, 9, 11, 12, 14, 17, 18, 20, 22, 23, and 25.
- The Total Depression subscale is the sum of items 1, 4, 8, 10, 13, 15, 16, 19, 21, and 24.

Total scores are converted to T-scores using specific equations that have been developed through research; and account for the gender and grade of each child. In all instances, a higher score reflects a greater degree of symptom severity. Converted scores on the total scale and both sub-scales are divided into scoring ranges, where: (a) scores below 65 represent low severity, (b) scores between 65-70 represent medium severity and are on the borderline clinical threshold, and (c) scores above 70 represent high severity and are above the clinical threshold.

Scoring for the RCADS-25-P is identical to the RCADS-25.

Range	Symptom Severity
0-64	Low severity
65-70	Medium severity – borderline clinical threshold
> 70	High severity – above clinical threshold

For grade and age T-scores (if relevant to your project): <https://www.childfirst.ucla.edu/resources/>

[RCADS-25 Child Version Scoring Program 3.1 \(.xls\)](#) 

[RCADS-25 Parent Version Scoring Program 3.1 \(.xls\)](#) 

Patient Health Questionnaire (PHQ) - 9

0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day; -9 = Missing

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Scoring: add up scores (sum score) Interpretation of Total Score

1-4 Minimal depression

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

General Anxiety Disorder (GAD)-7

0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day; -9 = Missing

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

Scoring GAD-7 Anxiety Severity

Scoring: add up scores (sum score)

Interpretation

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

WHO Disability Assessment Schedule (WHODAS) 2.0

0=None; 1=Mild; 2=Moderate; 3=Severe; 4=Extreme or cannot do; -9 = Missing

Instructions: In the past 30 days, how much difficulty did you have in.....

whodas_1	Standing for long periods such as 30 minutes?
whodas_2	Taking care of your household responsibilities?
whodas_3	Learning a new task, for example, learning how to get to a new place?
whodas_4	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?
whodas_5	How have you been emotionally affected by your health problems?
whodas_6	Concentrating on doing something for ten minutes?
whodas_7	Walking a long distance such as a kilometer or half a mile?
whodas_8	Washing your whole body?
whodas_9	Getting dressed?
whodas_10	Dealing with people you do not know?
whodas_11	Maintaining a friendship?
whodas_12	Your day-to-day work?

Simple scoring

Scores assigned to each of the items – “none” (1), “mild” (2) “moderate” (3), “severe” (4) and “extreme” (5) – are summed. This method is referred to as simple scoring because the scores from each of the items are simply added up without recoding or collapsing of response categories; thus, there is no weighting of individual items. This approach is practical to use as a hand-scoring approach, and may be the method of choice in busy clinical settings or in paper–pencil interview situations. Simple scoring of WHODAS is specific to the sample at hand and should not be assumed to be comparable across populations. For IRT scoring: <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule>

Demographic and process measures

For NIMH NDA (R34s, R01s)

Need permission in the consent form to give data to NDA. Ask Methods Core for an example if you don't have one.

All of the following information is required:

- First Name
- Middle Name
- Last Name
- Sex - M = Male; F = Female; O=Other; NR = Not reported
- Date of Birth dd/mm/year
- City/Municipality of Birth

Demographics

What is your age? (in years)

What is your race? (check all that apply)

American Indian/Alaska Native

Asian

Black or African American

Hawaiian or Pacific Islander

White

Another Race (please specify)

Unknown

Prefer Not to Answer

What is your ethnicity?

Hispanic/Latina/o/e

Not Hispanic/Latina/o/e

Prefer not to say

What is your gender?

Female

Male

Non-binary

Transgender

Prefer not to say

Prefer to self-describe {gender_self_describe}

What is your highest level of education?

No schooling completed

8th grade

Some high school, no diploma

High school graduate or equivalent

Some college, no degree

Trade/technical/vocational training

Associate degree

Bachelor's degree

Master's degree

Professional or doctorate

Prefer not to say

What is your professional role? (e.g. social worker, high school student, etc.)

(open-text)

User needs and experience

User Interviews: Understanding User Needs

Interviews are one of the most common methods to collect data in HCD (including among ALACRITY teams). Interviewing is used in HCD to understand perspectives and experiences of respondents. Well-designed interviews in HCD aim to gather data that drives the design process and helps make better design decisions (Beyer & Holtzblatt, 1998, 417).¹¹ We provide guidance on conducting interviews and specific tips on interviewing as part of assessing usability, accessibility, and appropriateness. An example from UWAC 1.0 is available at <https://docs.google.com/document/d/1AJwfyBXG78kHF1AYffwr3VMr7Gubqy0s/edit?usp=sharing&oid=117884759419095647223&rtpof=true&sd=true>.

Interviews may be used at all phases of the DDBT process, with different goals:

- Discover (formative): Understand who users are and their current ways of doing things, including things that work well and things that could be improved.
- Design/build: Show participants prototypes and elicit reactions. It is also not uncommon to need to do some additional “discover” work when the team realizes it needs to know more to make an informed design decision.
- Test (summative): Assess whether the (re)designed intervention and/or implementation strategies are achieving its design goals and understand people’s lived experiences with them.

Planning

Aligning Interviews and Other Methods with Research Questions

Any research method selected should align with your research questions, data needed, timeline, and available resources. One challenge researchers familiar with interviews may encounter when first using interviews to support design processes is ensuring that information generated from interviews will inform resulting design decisions. There are a great many things researchers are curious about, but when used in a design process you must prioritize the questions that will help make decisions. This includes:

- Who are your users? (This may include primary users, e.g., people directly interacting with your product, artifact, or service, as well as secondary users who interact with the product, artifact, or service through the actions of another party. For example, when designing a worksheet for an interventionist to use in a session, you may still need to engage with patients as well.)
- What do your users know?
- What do they want to do?
- How do they do things? (and where? In what conditions?)
 - What successes do they experience?
 - What barriers do they face?

¹¹ Beyer, H., & Holtzblatt, K. (1998). *Contextual design: defining customer-centered systems*. Elsevier Science.

Note that interviews may be used fluidly with other methods. You might, for example, present a scale and then decide where to focus an interview based on responses to individual items on the scale or overall scores. Many interviews also intermix other activities, such as asking participants to demo a part of their work, give a tour of their workspace, or some other context relevant to the design challenge. They might also ask participants to engage with a prototype to complete tasks, before and/or after interview parts of a session. We will discuss this in more detail below.

A caution about focus groups. Many research teams are tempted to use focus groups in place of interviews to reduce time and expenses. This may not be a good idea, as expenses such as participant compensation remain fixed, yet you are getting much less depth from any one participant. Focus groups can also further confound results due to effects such as a group think and social desirability bias. We also know that people from marginalized backgrounds are more likely to be further marginalized in focus groups. If you find yourself considering focus groups only for efficiency, we strongly urge you to reconsider and potentially instead invest in interviews.

Where focus groups *can* shine is when you want participants to build on each other or to elicit, e.g., workflow details that live between different roles. Careful attention to power dynamics among potential participants when forming groups and to facilitation techniques that elicit attitudes and experiences from all participants while avoiding group think (e.g., by having participants write down notes about a prompt individually before sharing) is important.

Identifying and Prioritizing Participants

To recruit the right participants for your study, your team must come to a consensus on users and interested parties. This is necessary to determine appropriate recruitment criteria. With your team, brainstorm users and interested parties. Use existing data such as literature and other surveys to gather preliminary research. Often it is helpful begin with a broad and overly-inclusive preliminary user list and then narrow your focus (see [Table 1 in Lyon et al., 2020 for an overview of this process](#)). Once you have identified a set of potential users and interested parties, you can prioritize participants by considering which groups:

- has the most diverse set of tasks?
- is the largest?
- is most important to help achieve intervention and/or product goals?
- has the most needs?/seems to be having the most trouble with the product?
- has the most to lose of the intervention and/or product does not work for them?

Another recommendation is to recruit participants based on behavioral criteria followed by demographic attributes important to your design (Goodman et al., 2012, 97).¹² Behavioral criteria includes people that currently do (or would be interested in doing) what your product or service can provide. For example, with a mobile application for adolescent use, while adolescents may be the intended user, a caretaker that gives permission or phone time for an adolescent to download an application may be important to capture. When planning recruitment, you may also want to consider segmenting respondents by traits that could influence their response to a design solution. This could include traits like level of experience with competing/similar products or services. Finally, consider characteristics that you may want to avoid during recruitment (Goodman et al., 2012, 102).¹³ This could include

¹² Goodman, E., Kuniavsky, M., & Moed, A. (2012). *Observing the User Experience: A Practitioner's Guide to User Research*. Elsevier Science.

¹³ *ibid*

people who you know well and who thus may bias the results. Participant eligibility and segmentation can be facilitated using a short screening survey that exclusively includes questions that will determine participant eligibility, ask for specific quantities related to behaviors, and are neutral in tone. Including some open-ended questions in screeners may help give a sense of whether an individual will give more detailed feedback during an interview or usability test (Goodman et al., 2012, 108).¹⁴

Interview Types

Individual vs. contextual: Individual interviews are “traditional” interviews where an interviewer asks questions and probes a single respondent.¹⁵ These types of interviews can be relatively straightforward to administer and conducted in-person or remotely. Contextual interviews are conducted in a respondent’s own environment and are a combination of observation and interviewing.¹⁶ A key advantage of contextual interviews is that it places a user in their own environment, which may create a more authentic depiction of a user’s everyday experiences. You may want to conduct interviews within an environment where you foresee a product or service to be used can both help improve participant recall and accuracy of relevant details during an interview since individuals aren’t always cognizant of their behavior (Beyer & Holtzblatt, 1998, 43).¹⁷ The interviewer asks questions based on a respondent’s behavior completing their own tasks. During usability studies, contextual interviews can be combined with assigned task scenarios.

Structured vs. unstructured: Interviews can be structured, unstructured, or semi-structured. Structured interviews have a set script that is followed and may be easier for comparability and analysis. Unstructured interviews may be more conversational and increase comfort for participants but must be moderated well so that priority information is collected within the interview time (Hanington & Martin, 2019, 138).¹⁸ Interviews with both structured and unstructured sections give you the opportunity to ask some questions exactly the same for everyone, but space to follow up on topics of interest.

Interview Guide

For structured and unstructured interviews, an interview guide helps ensure that you ask questions that will answer your research questions. Your interview guide should primarily be open-ended questions, which will give you more of an opportunity to probe and generate richer data. While you should focus on creating open-ended questions, don’t develop questions that are too general or framed around what respondents “usually do” (an alternative to this would be asking about behavior during a specific reference period). As a starting point, brainstorm interview questions and map them to each research question they address. One resource to help write questions is Nikki Anderson’s Taxonomy of Cognitive Domain chart, which lists question verbs aligned with what you’d like to learn.¹⁹

Iterate your initial list with an eye for questions that generate duplicate and/or unrelated information and reword questions that are leading or could be made more open-ended. Your interview guide should start with easier warmup questions, such as “tell me about yourself,” as you build rapport with the participant. More sensitive questions typically work better later in an interview. Sequence questions in a logical order and share your interview guide with colleagues for feedback.

¹⁴ *ibid*

¹⁵ "Individual Interviews | Usability.gov." <https://www.usability.gov/how-to-and-tools/methods/individual-interviews.html>. Accessed 24 Aug. 2023.

¹⁶ "Contextual Interview - Usability.gov." <https://www.usability.gov/how-to-and-tools/methods/contextual-interview.html>. Accessed 24 Aug. 2023.

¹⁷ Beyer, H., & Holtzblatt, K. (1998). *Contextual design: defining customer-centered systems*. Elsevier Science.

¹⁸ Hanington, B., & Martin, B. (2019). *Universal Methods of Design Expanded and Revised: 125 Ways to Research Complex Problems, Develop Innovative Ideas, and Design Effective Solutions*. Rockport Publishers.

¹⁹ "70+ Great User Testing Questions To Ask Before, During, & After" 4 May. 2023, <https://www.userinterviews.com/blog/user-testing-questions>. Accessed 26 Aug. 2023.

Conducting interviews

We recommend the following considerations when conducting interviews:

- Be prepared
- Express gratitude for respondent participation
- Remind the participant that the intervention or implementation strategy is being evaluated, not them. There are no right or wrong answers.
- Practice active listening, don't interrupt respondent and use body language or subtle prompts (nodding, taking notes, to say more)
- At the end of each interview, ask yourself if you understand what the respondent shared. Are there things you need clarification on?
- Following interviews, interviewers and/or research team should reflect on each interview, how things went, and additional questions to consider:
Is the data collected meeting research goals?
- Review recordings and/or transcripts as data is collected. Leave enough time to analyze data.

Cognitive Walkthroughs for Implementation Strategies:

A hybrid of usability evaluation and interviews

Lyon et al. developed the Cognitive Walkthrough for Implementation Strategies (CWIS) to assess implementation strategy usability.²⁰ CWIS has six steps; interviews can be conducted during step five as part of task testing (see Figure 2). As part of task testing, a facilitator presents a scenario and subtasks, respondents are invited to ask clarifying questions, and rate for each task the extent to which they personally expect successful at: 1) discovering the correction action as an option; 2) performing the correction action or response; and 3) receiving sufficient feedback receiving sufficient feedback to understand that you have performed the right action or that the task was successfully completed (see Figure 3). The facilitator subsequently asks respondents to explain their ratings, what might promote success, and what impedes accomplishing the task. This information can then be used to specify usability issues.



Figure 2. [The Cognitive Walkthrough for Implementation Strategies \(CWIS\): a pragmatic method for assessing implementation strategy usability](#)

Following all steps outlined in CWIS can be challenging for some projects, including interventions and implementation strategies that are complex and involve significant training to learn. Participant familiarity with an intervention or implementation strategy can also vary, which can make conducting a CWIS or task-based testing challenging. CWIS combines elements of cognitive walkthroughs and task-based testing.

Like traditional cognitive walkthroughs, the focus of CWIS is on evaluating the usability of a system by proceeding through the interface in a logical, task-oriented sequence. Unlike traditional cognitive walkthroughs, which engage a team of expert reviewers, CWIS engages real, current or potential users.

As with task-based testing, the focus on CWIS is about understanding how participants do our would interact with a system, service, or product. In task-based testing, researchers can observe if users successfully complete a task and what successes or barriers they encounter. In CWIS, participants may be unable to actually do the task, or all of the tasks, and so instead respond by critiquing a design.

In practice, UWAC projects have combined elements of CWIS and task-based testing during the discover and design/build phases. For example, PST-Aid and TF-CBT have each used different aspects of CWIS and task-based testing to explore usability.

PST Aid: To assess usability of PST-Aid at the end of the Design/Build phase, we first created an implementation strategy map that visually depicted ideal use of PST-Aid for PST the intervention. We created separate maps for clinicians and patients that highlighted those users'

²⁰ Lyon, A. R., Coifman, J., Cook, H., McRee, E., Liu, F. F., Ludwig, K., ... & McCauley, E. (2021). The Cognitive Walkthrough for Implementation Strategies (CWIS): a pragmatic method for assessing implementation strategy usability. *Implementation Science Communications*, 2, 1-16.

expected use of PST-Aid by therapy sessions. We prioritized tasks and subtasks based on usability challenges that had come up in the previous phases and functions critical to using PST-Aid. For each task and sub-task, we specified goals, a starting state, estimated time, and what would be considered “success.” We additionally drafted interview questions and probes that accompanied each task and sub-task. When we reviewed findings from the usability study, we classified issues based on the 12 categories of usability issues from UWAC 1.0 projects and prioritized usability issues for reporting and addressing in PST-Aid. We ran test sessions with individuals that had participated in other PST-Aid design activities. As a result, they may have seen the interface before, but in a limited capacity.

TF-CBT: As part of the Discover phase, we are exploring usability issues with TF-CBT when used in school settings. A TF-CBT consultant identified core tasks to the intervention when implemented as-intended. The team conducted a hierarchical task analysis and rated tasks for prioritization. We developed initial tasks and test scenarios based on this prioritization. We also developed an intervention map illustrating implementation of TF-CBT to fidelity (similar to what was done with PST-Aid). A version of this map will be used for one activity during the test session to get general reactions to TF-CBT from clinicians. Additionally, this map supported sequencing of tasks for the protocol. After piloting the two protocols (one testing TF-CBT with clinicians, one testing TF-CBT with students), we realized that an understanding of fundamental skills taught early when implementing TF-CBT is essential to be able to accomplish subsequent tasks we had prioritized. Thus, even though we did not quantitatively prioritize these fundamental skills for the test session, we created tasks based on these skills for the protocols. We will run clinician test sessions with clinicians that have varying experience with TF-CBT (some fully trained, others having viewed the introduction TF-CBT training module).

Participant Research Burden, Incentive Appropriateness, and Research Satisfaction

1. How satisfied were you with your experience in this study overall?	Very unsatisfied	Satisfied	Neutral	Unsatisfied	Very unsatisfied
2. How burdensome did you find completing the surveys?	Not at all burdensome	A little burdensome	Somewhat burdensome	Burdensome	Very burdensome
3. Do you have any suggestions for reducing the burden of completing surveys? Are there any types of questions that you feel should be removed?	OPEN ENDED				
4. It is typical in the US to pay research participants for completing surveys. Did you feel the amount you were compensated for participation to be...	Too low	Low but fair	The right amount	Too much but fair	Too much
5. Before the study began, did you feel prepared for what to expect during the study based on the informed consent form or other materials?	No	Yes			
6. What could we do to improve future participants' satisfaction with this study?	OPEN ENDED				

Adherence to DDBT Process and Cost Measure

DDBT Fidelity and Cost Measure

The purpose of this survey is to gather details related to how your team has used the DDBT framework to guide redesign of clinical interventions and/or implementation strategies. There are core goals that can be completed in each DDBT phase. We will ask you to report which goals your team completed, and then to detail design activities that contributed to those goals.

You are reporting on the Discover phase. We estimate that it will take teams about one to two hours to complete the survey, depending on how many activities you conducted. We suggest you complete this form as a team or, at minimum, with all Principal Investigators. We have provided a PDF of a complete example so you can see the depth of responses we are looking for and preview the questions before filling out this REDCap measure. REDCap will guide you through the steps, and you can pause and resume at any time using your unique survey link. You can also return to earlier survey pages as needed for clarification or modification.

For naming the design activities that you used, some resources that may be helpful include:

- Dopp, A.R., Parisi, K.E., Munson, S.A. and Lyon, A.R., 2019. [A glossary of user-centered design strategies for implementation experts](#). *Translational behavioral medicine*, 9(6), pp.1057-1064.
- Hanington, B. and Martin, B., 2019. *Universal methods of design expanded and revised: 125 Ways to research complex problems, develop innovative ideas, and design effective solutions*. Rockport publishers. [Preview here through Google Books](#).
- Kumar, V., 2012. *101 design methods: A structured approach for driving innovation in your organization*. John Wiley & Sons. [Preview here through Google Books](#).
- Creative Reaction Lab., 2018. *Equity-centered community design field guide*. [Available here](#).

When ready, click here to begin. **Brief project name/description:**

People who completed this form:

DISCOVER PHASE
Goals Completed To begin, please check off all goals completed for your project during the Discover phase. The purpose of the Discover phase is to gather information about (a) the context of implementation and (b) the clinical intervention and/or implementation strategy, to identify needs and priorities for redesign in later phases. By “direct users” (also known as “primary users”), we are referring to people who <i>directly interact</i> with the intervention or strategy. By “indirect users” (also known as “secondary users”), we are referring to people <i>affected</i> by the intervention or strategy. For example, if a clinician

uses a system in their interactions with a patient, the clinician would be the direct user and the patient would be the indirect user.

- Understand needs and perspectives of direct users
- Understand needs and perspectives of indirect users
- Understand the context of the clinical intervention and/or implementation strategy
- Understand the appropriateness of the original clinical intervention and/or implementation strategy
- Understand the usability of the original clinical intervention and/or implementation strategy
- Understand user engagement with the original clinical intervention and/or implementation strategy
- Understand the original clinical intervention and/or implementation strategy from an equity lens (including how/why/for whom it works and potential sources of disparities)
- Other goals [describe]:

When finished, click [here](#) to continue.

Design Activities that Contributed to Goals

Think about the full range of design activities that your team used to complete the Discover Phase. For each discrete design activity, please specify all details requested below. These details will help us understand the activities involved in completing the Discover phase.

By “design activity,” we mean activities focused on understanding and maximizing the usability of the clinical intervention and/or implementation strategy of interest. (Hover your cursor [HERE](#) for resources that may be helpful in identifying activities.)

By “discrete,” we mean you can clearly describe how many times the activity occurred, who was involved, and what resources and costs were involved. Discrete design activities may have multiple steps or components involved, if you can still provide the requested details for the entire activity; you can present activities in whatever way makes the most sense for your project.

Once you have specified one activity, you can choose to specify another activity; after all design activities are specified, you can continue to the next page.

Name of activity		
Please briefly describe how the activity was completed and its purpose or rationale		
Which goal(s) in the Discover phase did this activity contribute to? Check all that apply.		
<input type="checkbox"/> Understand needs and perspectives of direct users <input type="checkbox"/> Understand needs and perspectives of indirect users <input type="checkbox"/> Understand the context of the clinical intervention and/or implementation strategy <input type="checkbox"/> Understand the appropriateness of the original clinical intervention and/or implementation strategy <input type="checkbox"/> Understand the usability of the original clinical intervention and/or implementation strategy <input type="checkbox"/> Understand engagement with the original clinical intervention and/or implementation strategy <input type="checkbox"/> Understand the original clinical intervention and/or implementation strategy from an equity lens (including how/why/for whom it works and potential sources of disparities) <input type="checkbox"/> Other goals		
Did you make any major modifications to the design activity in response to challenges or barriers that emerged when you tried to conduct the design activity as originally planned?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what were the modifications and why did they occur?		
How many times <u>total</u> did this activity happen during the Discover phase? (In the total, count every instance the activity was done, including repeat activities with the same participants/users [such as a series of interviews or sessions])		
In a typical single instance of this activity for the Discover phase, who organized and executed the activity? (If this varied, please list the average, median, or otherwise most typical value)		
Role or personnel type involved in activity <i>(provide details for all roles/personnel, adding extra rows as needed)</i>	# of individuals involved per instance	Estimated # hours spent per person, per instance (include prep and follow-up)

<p>In addition to specific instances of the activity, who spent time during the Discover phase creating and completing the activity? This refers to time spent preparing the activity before it was used, analyzing data collected, etc.</p>		
<p><i>Role or personnel type involved in activity</i> <i>(provide details for all roles/personnel, adding extra rows as needed)</i></p>	<p><i># of individuals</i></p>	<p><i>Estimated total hours spent per person for the activity</i></p>
<p>In a typical single instance of this activity for the Discover phase, who spent time and effort completing the activity as a participant? <i>(If this varied, please list the average, median, or otherwise most typical value)</i></p>		
<p><i>Participant or user type</i> <i>(provide details for all participant and user types, adding extra rows as needed)</i></p>	<p><i># of participants/users who completed activity</i></p>	<p><i>Estimated total \$ payment received, across all instances of the activity per participant</i> <i>OR</i> <i>Estimated total hours spent per participant/user, across all instances of the activity</i> <i>(If per-person total varied, please list the average, median, or otherwise most typical value)</i></p>
<p>What other resources or costs were involved in completing the activity during the Discover phase? (This could include materials, software, travel, or any other resources or expenses needed to complete the design activity. Only include direct, measurable project expenses)</p>		
<p><i>Resource or expense</i> <i>(please provide a description)</i></p>	<p><i>Unit of resource/expense</i></p>	<p><i>Estimated \$ amount for unit of resource/expense</i> <i>OR</i> <i>information about cost, if \$ amount not known</i> <i>(If per-instance cost varied, please list the average, median, or otherwise most typical value)</i></p>

	<input type="checkbox"/> Per-instance: Resource incurred once for each instance of the activity <input type="checkbox"/> Overall: resource incurred once for the entire activity (not specific to # of instances)	
	<input type="checkbox"/> Per-instance <input type="checkbox"/> Overall	
Please share any other information you think is helpful for understanding this design activity and/or interpreting the information you reported in this form. This can include details of how certain or uncertain you were about the time and cost estimates provided.		

Were there any other design activities you completed during this phase?

- Yes
- No

Thank you for completing the DDBT Fidelity and Cost Measure!

NOTE: This is the final page to complete before submitting your responses. The survey will remain active / in progress until you click “Click Here to Submit the Survey” below.

We appreciate your taking the time to provide this information. It will be very useful for understanding how the DDBT framework is being used in your project.

As a reminder, a member of the Methods Core team will arrange a follow-up meeting with you to review and clarify your responses. These are typically scheduled 1-2 weeks in advance. If you wish, you can provide details below to assist in scheduling that meeting; however, you can feel free to leave these questions blank and we will follow up with you directly.

Who from your team should participate in the follow-up meeting? Please limit to 3 people max, and please provide both names and email addresses.	
Name	Email Address

Are there any times that work well for these team members to meet in the next 1-2 weeks? If yes, please note dates and times, being as specific as you can.	
Is there anyone else we should work with for scheduling the meeting? If yes, please provide name(s) and email address(es).	

If you prefer to follow up directly about this survey for any reason, please contact Alex Dopp (adopp@rand.org), and he will be happy to assist.

CLICK HERE TO SUBMIT THE SURVEY

Team collaboration, trust, and respect

Community participation in research

Note: the community participation in research questions are the modified ladder of participation measure. Naylor, Wharf-Higgins, Blair, Green, & O'Connor (2002)

Thank you for your participation in the UW ALACRITY Center's end-of-phase survey.

This survey features two measures of the levels of collaboration participation among your team. Your participation is confidential. Please recognize that your team will receive a simple report of the number of participants and average scores for each item. We will not provide any quotes to your team from your open-ended item responses, but we will summarize comments from all team members. We encourage your team to have a conversation about these results in order to improve your project. Please keep this in mind when responding and use the "choose not to respond" option or leave open ended items blank if you are concerned about this sharing of summary information.

Which project are you reporting on?

- RUBIES-IS
- BRISC
- TF-CBT
- PST-AID
- Other (describe):

Which DDBT phase are you reporting on? This will be the phase your project team recently completed.

- Discover
- Design/Build
- Test

Please evaluate the collaboration within your project by indicating if the collaboration is (1) inadequate, (2) poor, (3) satisfactory, (4) good, or (5) excellent (or -999 choose not to respond).

1. Acceptance of new ideas
2. Communication among collaborators
3. Ability to capitalize on the strengths of different researchers
4. Organization or structure of collaborative teams
5. Resolution of conflicts among collaborators
6. Ability to accommodate different working styles of collaborators

- 7. Involvement of collaborators from outside the center
- 8. Involvement of collaborators from diverse disciplines
- 9. Productivity of collaboration meetings
- 10. Productivity in developing new products (e.g., papers, proposals, courses)
- 11. Overall productivity of collaboration

Please rate your views about collaboration with respect to your project by indicating if you (1) strongly disagree, (2) somewhat agree, (3) not sure, (4) somewhat agree, or (5) strongly agree with the statement, or (-999) choose not to respond.

- 12. In general, collaboration has improved your productivity.
- 13. In general, collaboration has improved the quality of your work.
- 14. Collaboration has posed a significant time burden in your work.
- 15. You are comfortable showing limits or gaps in your knowledge to those with whom you collaborate.
- 16. In general, you feel that you can trust the colleagues with whom you collaborate.
- 17. In general, you find that your collaborators are open to criticism.
- 18. In general, you respect your collaborators.

In the question below, “academic researchers” refers to the academic study team while “community partners” refers to service providers and clients who were study participants and/or design team members (including therapists, supervisors, teachers, patients, clients, students, caregivers/parents).

What is your role on the project?

- Academic researcher
- Community partner

Please rate the extent to which community partners and academic researchers were involved in design team decision making in this phase of the project. *[INCLUDE -999 “Choose not to answer” in all options below]*. Remember that your individual responses will be kept confidential. Reports back to your team will only include mean scores for the overall team.

	0	1	2	3	4	999
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<p>How were decisions made about identification of design and usability issues?</p>	<p>Community partners were not involved in decisions about design and usability issues</p>	<p>Academic researchers presented pre-identified design and usability issues, community partner input sought only once or twice</p>	<p>Community partners offered advice and ongoing advisory input on identifying design and usability issues, but decision-making rests with academic researchers</p>	<p>There was equal decision making on identification of design and usability issues between academic researchers and community partners</p>	<p>Community partners controlled decision making about design and usability issues while academic researchers provided advice</p>	<p>Choose not to answer</p>
<p>Please provide a specific example that influenced your rating</p>						
<p>How were decisions made about design goals and activities?</p>	<p>Community partners were not involved in decisions about design goals and activities</p>	<p>Academic researchers determined design goals and activities; community input on design activities was sought briefly</p>	<p>Community partners offered advice and ongoing advisory input when determining design goals and activities, but decision-making rested with academic researchers</p>	<p>There was equal decision making on determining design goals and activities by academic researchers and community partners</p>	<p>Community partners controlled decision making on determining design goals and activities, while academic researchers provided advice</p>	<p>Choose not to answer</p>
<p>Please provide a specific example that influenced your rating</p>						
<p>Who developed the design methods?</p>	<p>Design methods were conducted by academic researchers without any community partner involvement, even as research participants</p>	<p>Design methods were conducted by academic researchers, with community partners as research participants</p>	<p>Design methods were conducted by academic researchers with advice and input provided by community partners</p>	<p>Design methods were co-conducted by academic researchers and community partners</p>	<p>Design methods were developed and conducted by community partners, while academic researchers provided advice and input</p>	<p>Choose not to answer</p>
<p>Please provide a specific example that influenced your rating</p>						

What indicators were used to determine the success of the design efforts during this phase?	No indicators were used, success of the design efforts was not evaluated	Primary indicators were improved health or educational outcomes	Primary indicator was community relevant redesign	Primary indicator was enhanced capabilities for redesign team members	Primary indicator was participant empowerment	Choose not to answer
Please provide a specific example that influenced your rating						
How sustainable do you believe these program design efforts will be after ALACRITY funding ends?	Not applicable, design efforts were not completed	The program design will die at completion of ALACRITY funding	A few residual impacts of the program design will continue after ALACRITY funding	The program redesign will be sustained when ALACRITY research funding ceases	The program redesign will lead to the initiation of new programs	Choose not to answer
Please provide a specific example that influenced your rating						

Investigator satisfaction with the support received from the center

Adapted from a survey used by the [IMPACT Center](#)

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with the support I received through the UW ALACRITY center					
I would recommend the experience I had via UW ALACRITY to a colleague					
ALACRITY team provided me with helpful guidance and feedback					
ALACRITY team was available to meet with me in a timely manner					
ALACRITY team responded to my emails and communications in a timely manner					

Please provide any specific feedback: