

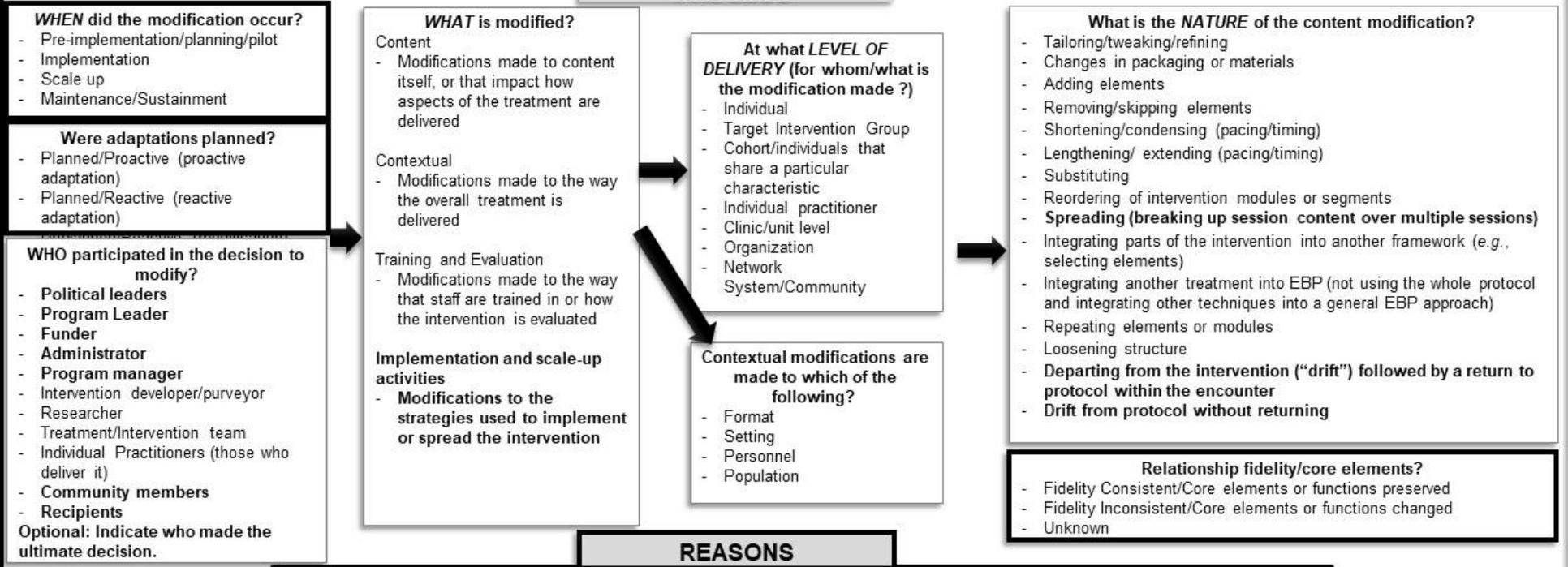
FRAME CODING MANUAL

This codebook supplements Wiltsey Stirman S, Baumann AA, Miller CJ. The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implement Sci.* 2019;14(1):5

For supporting materials, see <http://med.stanford.edu/fastlab/research/adaptation.html>

Framework for Reporting Adaptations and Modifications-Expanded

PROCESS



REASONS

	SOCIOPOLITICAL	ORGANIZATION/SETTING	PROVIDER	RECIPIENT
<p>What was the goal?</p> <ul style="list-style-type: none"> - Increase reach or engagement - Increase retention - Improve feasibility - Improve fit with recipients - To address cultural factors - Improve effectiveness/outcomes - Reduce cost - Increase satisfaction 	<ul style="list-style-type: none"> - Existing Laws - Existing Mandates - Existing Policies - Existing Regulations - Political Climate - Funding Policies - Historical Context - Societal/Cultural Norms - Funding or Resource Allocation/Availability 	<ul style="list-style-type: none"> - Available resources (funds, staffing, technology, space) - Competing demands or mandates - Time constraints - Service structure - Location/accessibility - Regulatory/compliance - Billing constraints - Social context (culture, climate, leadership support) - Mission - Cultural or religious norms 	<ul style="list-style-type: none"> - Race - Ethnicity - Sexual/gender identity - First/spoken languages - Previous Training and Skills - Preferences - Clinical Judgement - Cultural norms, competency - Perception of intervention 	<ul style="list-style-type: none"> - Race; Ethnicity - Gender identity - Sexual Orientation - Access to resources - Cognitive capacity - Physical capacity - Literacy and education level - First/spoken languages - Legal status - Cultural or religious norms - Comorbidity/Multimorbidity - Immigration Status - Crisis or emergent circumstances - Motivation and readiness

FRAME Adaptions and Modifications Check List

Describe the Adaptation/Modification_____

Process

When did the modification occur?

- Pre-implementation/planning/pilot
- Implementation
- Scale up
- Maintenance/Sustainment

Were adaptions planned?

- Planned/Proactive adaption
- Planned/Reactive adaption
- Unplanned/Reactive modification

WHO participated in the decision to modify

- Political leaders
- Funder
- Organizational unit/team
- Tx developer/purveyor
- Administrator(s)
- Tx team
- Provider
- Program staff
- Community members
- Coalition
- Recipient
- Other_____

Optional: Indicate who made the ultimate decision

WHAT is modified?

- Content
- Context
- Training and Evaluation
- Implementation and scale-up activities

Contextual modifications are made to which of the following?

- Format
- Setting
- Personnel
- Population

At what LEVEL OF DELIVERY (for whom/what is the modification made?)

- Individual
- Target Intervention Group
- Cohort
- Individual practitioner
- Clinic/unit level
- Organization
- Network System/Community

What is the NATURE of the content modification?

- Tailoring/tweaking/refining
- Changes in packaging or materials
- Adding/Removing/skipping elements
- Shortening/condensing/Lengthening/extending (pacing/timing)
- Substituting/Reordering/Spreading of intervention modules or segments
- Integrating parts of the intervention into another framework
- Integrating another treatment into EBD
- Repeating elements or modules
- Loosening structure
- Departing from the intervention ("drift") followed by a return to protocol within the encounter
- Drift from protocol without returning

Relationship to fidelity/core functions?

- Fidelity Consistent/Core elements or functions preserved
- Fidelity Inconsistent/Core elements or functions changed
- Unknown

Rationale

What was the goal?

- Increase reach or engagement
- Increase retention
- Improve feasibility
- Increase satisfaction
- Improve fit with recipients
 - To address cultural factors
- Improve effectiveness/outcomes
- Reduce cost

Reasons

Sociopolitical

- Existing Laws
- Existing Mandates
- Existing Policies
- Existing Regulations
- Political Climate
- Funding Policies
- Historical Content
- Societal/Cultural Norms
- Funding or Resource Allocation/Availability

Provider

- Race
- Ethnicity
- Sexual/gender identity
- First/spoken languages
- Previous Training and Skills
- Preference
- Clinical Judgement
- Cultural norms, competency
- Perception of intervention

Organization/Setting

- Available resources (funds, staffing, technology, space)
- Competing demands or mandates
- Time constraints
- Service structure
- Location/accessibility
- Time constraints
- Service structure
- Location/accessibility
- Regulatory/compliance
- Billing constraints
- Social context (culture, climate, leadership support)
- Mission
- Cultural or religious

Recipient

- Race; Ethnicity
- Gender identity
- Sexual Orientation
- Access to resources
- Cognitive capacity
- Physical capacity
- Literacy and education level
- First/spoken languages
- Legal status
- Cultural or religious norms
- Comorbidity/Multimorbidity
- Immigration Status
- Crisis or emergent circumstances
- Motivation and readiness

- Other_____

RECOMMENDED PROCEDURE FOR CODING MODIFICATIONS AND ADAPTATIONS

Interviews:

First, break the interview down into distinct segments that describe unique modifications. Sometimes more than one modification will be included in an interview response. If so, annotate the transcript.

For example, if a transcript says, “Sometimes instead of giving the worksheets for homework—I don’t actually call it homework, I usually call it something like practice—I just write down a couple of questions on a notecard”:

Modification 1a “gives a notecard instead of a worksheet”

Modification 1b “call it practice instead of homework”

We used a spreadsheet with columns for the source/subject as well as for each part of the framework (codes were numbered).

Observations:

During observation—if recorded, note the timestamp where you see evidence of the modification if possible (unless it’s something like lengthening or shortening)

Familiarity with the intervention is important for getting good rater agreement as well as in making appropriate distinctions. If interview data have not been collected, it is helpful for the interviewer to be familiar with the coding system so that they can make appropriate codes and determine if they have enough information to decide the most appropriate code.

For coding procedure

(note: Fillable coding sheet and coding form are in the back. One adaptation per form)

- 1) read the entire codebook before you start coding—each time you sit down to code.
- 2) be sure to read the question or prompt before each clinician segment as it sometimes includes context that will help with determining which code to assign.
- 3) read the description for each code each time you assign it to make sure it fits. Also read others that you think it could possibly be to help you make sure you’re made the right distinction.
- 3) make notes about anything that’s uncertain for you in the spreadsheet
- 4) contact the team if you see a segment that you believe is not actually a description of what the therapist does/would do (e.g., an abstract future hypothetical situation in an interview)

5) read the codebook again after you finish coding—if you realize that something may not fit after you've assigned it, go back and check

6) For consensus meetings—recommend that the coders get a spreadsheet with discrepancies highlighted before the meeting so they can look back over the items and codebook prior to the meeting. Additional decision rules or examples that are unique to the EBP may need to be added to the codebook.

WHEN did the modification occur?

1. **Pre-implementation/ planning/pilot** - prior to the formal beginning of the planned implementation
2. **Implementation**
3. **Scale up** - efforts to scale up/spread the intervention beyond the initial implementation site (e.g., to other regions, communities, or organizations)
4. **Maintenance/Sustainment** - beginning after initial supports or funding are withdrawn, or using the “2 years after implementation” rule of thumb

Were adaptations planned?

1. **Proactive** - a process of planned adaptation ideally as early as possible in the implementation process. Occurs through a planning process that identifies ways to maximize fit and implementation success while minimizing disruption of the intervention
2. **Reactive** - less systematic, occur during the course of program implementation, often due to unanticipated obstacles. often occur in an impromptu manner, in reaction to constraints or challenges that are encountered; may or may not be aligned with the elements of the intervention that make it effective. Note that iteration can accommodate unanticipated challenges, e.g., during the “Act” portion of a “Plan-do-study-act” cycle, an adaptation would not be considered reactive, because it was determined through a systematic process rather than through improvisation.

WHO made the decision to modify?

1. **Team** – healthcare team, organizational unit
2. **Individual practitioner/ facilitator** – the individual who delivers the intervention
3. **Non-program staff** – e.g., front desk staff schedule fewer sessions than indicated in protocol; contractors
4. **Administration** – Leadership within the organization
5. **Program developer/ purveyor** – intervention/treatment developer or expert
6. **Researcher** – researcher or team that leads a research effort
7. **Treatment/Intervention team** – treatment team (often smaller than team listed above, which may comprise all providers within an organizational unit). This focuses on the smaller team that delivers care
8. **Community members** - individual stakeholders in the community who may or may not ultimately receive the intervention
9. **Recipients** - individuals with the identified problem or risk factor who are the planned recipients of the intervention

10. **Coalition of stakeholders** – implementation team or advisory board that includes stakeholders from multiple stakeholders

11. **Unknown/unspecified**

Optional: Include a specifier to indicate who made the ultimate decision

WHAT is modified?

1. **Content** - Modifications made to content itself, or that impact how aspects of the treatment are delivered
2. **Contextual** - Modifications made to the way the overall treatment is delivered
3. **Training and Evaluation** - Modifications made to the way that staff are trained in or how the intervention is evaluated
4. **Implementation and scale-up activities** - Modifications to the strategies used to implement or spread the intervention

At what LEVEL OF DELIVERY (for whom/what is the modification made?)

Individual-individual patient or recipient: use this code if the clinician states that they modify the EBP for a particular patient (e.g. simplifying language if a patient has cognitive issues or if language barriers exist; cultural modifications for an individual consumer)

1. **Target Intervention Group** (e.g., all individuals with the problem that is being targeted)
2. **Cohort/individuals that share a particular characteristic** (e.g., individuals who do not speak the language in which the intervention was originally developed), all individuals with the target problem plus a specific comorbidity, individuals with lower levels of literacy, new mothers with the target problem)
3. **Individual practitioner** – an individual makes the adaptation/modification for all individuals with whom they work
4. **Clinic/unit level** – an entire unit or clinic makes a modification (e.g., limiting the number of meetings/sessions; changing the format of an intervention)
5. **Organization** – the full organization makes the modification/adaptation
6. **Network System/Community** (e.g., VA healthcare system, County or Community that is implementing)

Contextual modifications are made to which of the following?

1. **Format:** use this rating if changes are made to the format of treatment delivery (e.g. a treatment originally designed to be used one-on-one that is now delivered in a group format)
2. **Setting:** use this rating if the treatment is being delivered in a different setting (e.g. a treatment originally designed to be used in a mental health setting that is now delivered in primary care)

3. **Personnel:** use this rating if the treatment is being delivered by different personnel (e.g. a treatment originally designed to be administered by a psychologist that is now delivered by a psychiatric nurse or clergy)
4. **Population:** use this rating if the treatment that was SPECIFICALLY DEVELOPED to target a particular population is being delivered to a different population than originally intended (e.g., if an intervention developed for adults is now being delivered to older adults or teens; or if an intervention for borderline personality disorder is being delivered to individuals with PTSD).

Note the following examples for clarification:

- Delivering a treatment to a Hispanic/Latino individual that wasn't originally designed with a particular ethnic group in mind: Context, population
- Delivering a treatment to a Hispanic/Latino population that was originally specifically designed for African Americans: context, population.
- Delivering a treatment that wasn't originally designed with a particular ethnic group in mind, but modifying it to accommodate cultural or language differences: content, population, at the group level of delivery (content may also be addressed through tailoring, see below).
- Delivering a treatment to a Hispanic/Latino population that was originally designed for African Americans, and ALSO modifying the treatment itself to accommodate cultural or language differences: context, population, delivered at the group level of delivery, AND content, group (tailoring, see below).

[note—if a context-level modification is made, it is also possible that a content-level modification was also made, but that's not always the case. So sometimes 2 modifications would be made—such as:

Delivering a treatment in Spanish to some (but not all) Hispanic/Latino clients/patients that was originally specifically designed for African Americans: 1) context, population, cohort (individuals that share the same characteristics) 2) Content, tailoring (language)]; if other adaptations are made to address cultural differences, the goal of improving fit—to address culture would apply.

What is the NATURE of the content modification? (examples can be changed to fit the intervention being evaluated)

1. **Tailoring/tweaking/refining:** the clinician describes a change to the intervention that leaves all of the major intervention principles and techniques intact (e.g. modifying language, creating somewhat different versions of handouts or homework assignments, cultural adaptations)

If you would like to specify that the tailoring was a cultural adaptation, a separate “1C” code can be used to differentiate it from other forms of tailoring.

2. **Integrating intervention into another framework:** the clinician indicates, or it is apparent, that another treatment approach is the starting point, but elements of the intervention are brought into the treatment (e.g. selecting particular intervention elements or modules to use in the context of another treatment)

3. **Integrating another treatment into EBP:** the clinician indicates, or it is apparent, that the intervention is the starting point, but that they are also using aspects of different therapeutic approaches or EBP's in their treatment (e.g. integrating an empty chair exercise into a standard "CBT for Depression" treatment protocol). To use this code for interview data, the strategy or treatment should be specifically named, and should not be the use of general therapeutic skills (e.g., validation, listening would not be used, but if someone says, "I integrate a more client-centered approach into the EBP", this code could be assigned). Integration of Motivational Interviewing (MI) into a protocol that does not specify MI principles is another common example.

4. **Removing/skipping core modules or components:** the clinician indicates that their baseline or standard treatment is based on the EBP, but notes that they are dropping particular elements of the EBP. Note that this code may be used if interventions (e.g., agenda setting) or modules (e.g., the Cognitive Processing Therapy safety module) are intentionally left out

5. **Lengthening/extending (pacing/timing):** the clinician reports spending a longer amount of time than prescribed by the manual to complete the intervention or intervention sessions (whether due to changed spacing between sessions, or longer sessions, more sessions, or spending more time on one or more modules or concepts)

6. **Shortening/condensing (pacing/timing):** the clinician reports spending a shorter amount of time than normal to complete the intervention or intervention sessions (whether due to changed spacing between sessions, or shortening sessions, offering fewer sessions, or going through particular modules or concepts more quickly without skipping material)

a. If material is skipped in the context of shortened or abbreviated sessions, then this would qualify as two modifications (both "Removing/skipping" and "Shortening/condensing," e.g. shortening a protocol from 12 to 8 sessions by both condensing material and skipping some materials/interventions entirely).

7. **Adjusting the order of intervention modules or segments:** the clinician indicates that they have presented intervention modules or concepts in a different order than originally described in the manual, regardless of the reason (e.g. if the clinician deemed the patient not ready for a particular module, or if the clinician wanted to cover other material that seemed especially relevant to the patient at that time). If the intervention provides flexibility around the order of modules, then this code would not apply.

8. **Adding modules:** the clinician indicates that they inserted additional distinct materials or areas of focus consistent with the fundamentals of the intervention (e.g. a therapist doing CBT for depression who adds on a few sessions of CBT for insomnia would be coded here, but adding DBT or mindfulness modules to CBT would be "Integrating another treatment into EBP" above); or modules that are in some way complimentary (e.g., adding psycho-education about parenting to an anger management protocol). This differs from integration

in that this is adding a distinct/discrete element/focus rather than weaving in other interventions or techniques.

9. Loosening structure: If a clinician indicates that they don't always structure a session as prescribed in the manual but still believe that the intervention is the starting point from which they work, this code is appropriate (e.g., if they say they don't use the formal structure, but still endorse the use of Cognitive Therapy throughout the session; or if they say they allow a brief period of off-topic discussion or processing prior to the start of the CT session/agenda setting). If they also name specific elements that they do not use, a separate code would also be used, namely, "Removing/skipping". This code should not be used if they endorse something more along the lines of weaving CT into another framework (in which case, use Integrating intervention into another framework). Note that saying something like "it's not as formal" is not specific enough (as this could mean they just change the language)—they need to indicate in some way that they emphasize structure less in some way.

10. Repeating: If a module or intervention that is normally prescribed once during a protocol is done more than once, this code should be applied. For example, if one session of breathing re-training is prescribed, but a clinician later repeats this intervention, "repeating" would be coded. If no mention is made regarding implications for the length of the session or protocol, no assumptions should be made about length. However, if it is mentioned that repeating resulted in lengthening of the session/protocol, both codes should be applied as separate modifications.

11. Substituting: A module or activity is replaced with something that is different in substance (e.g., replacing a module on condom use with one on abstinence in an HIV prevention program).

12. Spreading-breaking up session content over multiple sessions; e.g., a 1-session intervention gets broken up into 2 sessions

13. Departing from the intervention ("drift") followed by a return to protocol within the encounter; e.g., moving from CBT to supportive therapy for 10 minutes or more, then getting back to the protocol

14. Drift from protocol without returning (e.g., start using another intervention); e.g., stop using CBT, do supportive therapy or another approach for the rest of the session; stop discussing lifestyle changes in a diabetes prevention intervention before module is complete and discussing contraception for the remainder of the meeting

0 - Not a modification: If activities are consistent with the intervention, even if the clinician does not think they are, it should not be coded as a modification (unless it meets the definition of tailoring/tweaking above). This code can also be used if clinicians endorse making referrals for adjunct services unless this is inconsistent with the intervention.

Not enough information to code---use sparingly!

The relationship to fidelity

Look to manual and fidelity tools for guidance about proscribed and essential elements. In their absence, determinations for coding should be in conjunction with someone who knows the protocol/literature/theory well, or after a review of theory and research

-**Fidelity-consistent modifications**- preserve core elements/functions of a treatment that are needed for the intervention to be effective

-**Fidelity-inconsistent modifications** - alter the intervention in a manner that fails to preserve its core elements/functions.

- **Unknown** -use when there is no theory or evidence to inform a decision about whether an element is core vs. peripheral.

What was the goal?

1. **Increase reach or engagement**—changes intended to increase the # of people that are willing to engage in the intervention
2. **Increase retention**- changes intended to increase the # of people that are willing to engage in a full dose of the intervention
3. **Improve feasibility**—e.g., accommodate time or space constraints, etc
4. **Improve fit with recipients**—this can include factors such as preferences, needs, abilities, etc. Note that cultural adaptation is a sub-category of fit
 - a. **To address cultural factors**—factors specifically identified to be unique to a particular group, that require a change from the original intervention. Consider language and meanings of words and terms, culture, and context in such a way that it is compatible with the client’s cultural patterns meanings and values
Note that culture is also listed under reasons (see below) and can be endorsed for cultural adaptations (creating some redundancy), but by stakeholder request, this specifier is a way to identify an adaptation specifically as a cultural adaptation. Note that some adaptations may be made in conjunction with cultural adaptations that are not in and of themselves cultural adaptation—these adaptations should be coded separately and not use the cultural specifier. For example, adaptations such as tailoring may be for the goal of improving fit with a specific culture, and culture may be checked off as a reason. Additionally, services may be delivered to this population in home rather than in a clinic with the same population, to improve engagement or fit, with the reason being the recipient’s access to resources such as transportation or the clinic’s location/accessibility, but NOT due to culture.
5. **Improve effectiveness/outcomes**—health outcomes, as opposed to satisfaction, engagement, etc.
6. **Reduce cost**
7. **Increase satisfaction**

Reasons—What factors influenced the Decisions

Multiple items across levels can be coded, but stick to the most salient, clear reasons for the actual adaptations. For example, if the recipients were of a different ethnicity than the original populations, but decisions to adapt were really made due to funding constraints, and no cultural adaptations or other elements to address the differences in populations were made, only code funding. Note that an “Other” code is included on the coding sheet but it should be used sparingly, and efforts should be made to identify a code (or combination of codes) that fits.

Sociopolitical/Outer Context

1. Existing Laws, Mandates, Policies, and Regulations that might place constraints or requirements on an implementation
2. Political climate—e.g., if some aspects of the intervention that are controversial are altered, or new elements are included due to significant political attention (e.g., integration of suicide or violence prevention or screening due to political attention)
3. Funding Policies—requirements for funding, constraints placed on funding or reimbursement (e.g., if telehealth isn’t reimbursable, etc)
4. Socio-historical context—e.g., if aspects of the intervention raise concerns or adaptations are requested due to the history or social context of a community
5. Societal/Cultural Norms—e.g., if there are norms regarding where mental health support is received (e.g., through clergy or spiritual advisors) or who provides it; norms that may necessitate alteration of intervention aspects or terminology used; stigma may also be considered here
6. Funding and Resource Allocation/Availability—adaptations made because more or fewer resources are available (e.g., shortening or expanding; changing what materials are distributed, etc)

Organizational level

1. Available resources (funds, staffing, technology, space)
2. Competing demands or mandates—Competing demands, de-prioritization of an intervention
3. Time constraints
4. Service structure (e.g., a clinic only provides group or time-limited interventions)
5. Location/accessibility
6. Regulatory/compliance – e.g., legal concerns may lead to certain aspects of an intervention not being delivered (e.g., limits to the types of physical activity or activities that may occur off-premises).
7. Billing constraints—e.g., only certain providers can bill for certain intervention, limits to frequency or amounts of services that can be billed
8. Social context (culture, climate, leadership support)—organizational climate and context
9. Mission –goal and purpose of the organization
10. Cultural or religious norms—E.g., norms that care providers need to be the same gender as the patient, or that a family member would remain present during care; religious norms that don’t fit with an intervention; cultural norms shared by members

of the organization that are at odds with aspects of the intervention (e.g., assertiveness training). These could also impact org culture or mission, but may not necessarily

Provider Level

1. For the four below: if the provider is of a different race, ethnicity, sexual orientation or gender identity than the recipient and components are added to facilitate cultural competence and shared understandings, or to acknowledge different experiences that the provider and recipient may have had
 - a. Race—
 - b. Ethnicity
 - c. Sexual/gender identity
 - d. Cultural competency
2. First/spoken languages—e.g., if training needs to include translation of concepts and terminologies; if intervention may need to include use of multiple languages to facilitate understanding
3. Previous Training and Skills—knowledge and familiarity with an intervention
4. Preferences—comfort and interest in providing aspects of the intervention
5. Clinical Judgement—decisions based on clinical presentation and judgement about the needs of the individual
6. Perception of intervention—beliefs about the intervention and it's fit, complexity, and effectiveness

Recipient level

1. For the four below: if the recipient (s) is/are of a different race, ethnicity, sexual orientation or gender identity than the recipient and components are added to facilitate cultural competence and shared understandings, or to acknowledge different experiences that the provider and recipient may have had. Decisions on whether to code these factors at the provider, recipient level, or both may depend on who identifies the need, or whether the adaptation applies to a single or few recipients or provider...
2. Race; Ethnicity
3. Sexual/gender identity
4. Sexual Orientation
5. Cognitive capacity; Physical capacity—ability to engage in the intervention due to physical or cognitive abilities
6. Access to resources—e.g., resources that make engagement in certain aspects of an intervention feasible
7. Literacy and education level—ability to engage with written materials or complex content
8. First/spoken languages
9. Legal status—e.g., individuals involved in the criminal justice system may not be able to engage in certain aspects of an intervention
10. Cultural or religious norms

11. Comorbidity/Multimorbidity—presence of other conditions that require intervention
12. Immigration Status—e.g., undocumented individuals may require changes to reduce risk of legal problems; some concepts may require additional attention or tailoring, such as concepts of autonomy and control may need to be addressed differently due to uncertainties related to immigration status
13. Crisis or emergent circumstances—emergencies (e.g., health risks, suicide risks); significant life events that require intervention or attention
14. Motivation and Readiness—willingness to engage in the intervention



FRAME coding
sheet.pdf