

Barriers and Facilitators to Adopting a Systematic, Proactive, Evidence-Informed Technical Assistance System

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Abstract

This article describes (a) key elements of a high-quality technical assistance (TA) system; (b) the operationalization of a high-quality TA system (Getting To Outcomes-Technical Assistance; GTO-TA) being implemented in a training and TA center (TTAC) interested in transforming its support services to include an evidence-informed approach to TA; and (c) key lessons learned in successfully transitioning from “TA-as-usual” to an evidence-informed TA system. GTO-TA is one operationalization of a systematic, proactive, evidence-informed approach to TA. GTO-TA includes best practices and core elements for a comprehensive TA system; it aims to increase the readiness (reduce barriers and increase facilitators) of an organization to deliver an innovation (program, policy, practice, and process new to an organization) with quality. We describe the collaboration between the Wandersman Center and the Geographic Health Equity Alliance team to co-design and implement the GTO-TA system. Data from surveys, interviews, and consensus conversations led to important lessons learned, which are applicable to other TTACs seeking to develop a more proactive and systematic approach to TA. Lessons include: changing internal operations to facilitate TA providers making necessary changes in providing TA and understanding the relative advantage perceptions about a new TA system that influence adoption and must be considered.

Keywords

technical assistance (TA), proactive technical assistance (TA), reactive technical assistance (TA), support system, Interactive Systems Framework for Dissemination and Implementation (ISF), readiness, Getting To Outcomes, Getting To Outcomes-Technical Assistance (GTO-TA), R=MC² framework

High-quality support of practitioners (e.g., health care professionals, teachers, prevention professionals or grassroots policy advocates, and coalition members) is an important ingredient in the implementation of evidence-based interventions (Berta et al., 2015; Harvey & Kitson, 2015; Katz & Wandersman, 2016). There are currently many funded training and TA centers (TTACs) designed to provide support to states, organizations, and coalitions nationally and worldwide. The type of support provided typically falls into four categories: tools, training, technical assistance (TA), and quality assurance/quality improvement (QA/QI; Wandersman et al., 2012), with TA playing a critical role in the transfer of knowledge and skills into practice (Joyce & Showers, 2002). Despite the importance of TA for quality implementation of evidence-based innovations, a scoping review of evaluation of TA shows that there is relatively little research documenting what type of TA is delivered and the effectiveness of TA at improving outcomes (Scott et al., 2022). Scott et al. suggest a gap between an evidence-informed approach to TA (referred to as a proactive and systematic TA system; defined below) and

what tends to be the common, current TA practice at a TTAC (herein referred to as “TA-as-usual”). Accruing evidence suggests the importance of TA on implementation and clinical outcomes (Aldridge, Roppolo, Chaplo, et al., 2023; Baumgartner et al., 2018; Domlyn et al., 2021). Systematizing effective and empirically informed TA is an important step for advancing the field of TA.

The purposes of this article are to (a) describe what a high-quality evidence-informed TA system looks like, based on the existing empirical literature; (b) present an operationalization of a TA system (known as Getting To Outcomes-Technical

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Assistance; GTO-TA); and (c) discuss key lessons learned for how to successfully transition from “TA-as-usual” within a TTAC to a more advanced evidence-informed TA system, using an applied case example. The overarching goals are to provide guidance on what high-quality TA looks like in practice as well as to offer insight into barriers that diminish opportunities and facilitators that enhance the likelihood of bringing high-quality TA systems into practice in a TTAC. A case example is included to share lessons learned for other TTACs that are motivated to transform TA practices to follow promising practices from the empirical literature. A glossary of key acronyms are available in Table 1.

There are several articles in the special issue on “Strengthening the Science and Practice of Implementation Support” (Wandersman & Scheier, 2024) that describe large TA transformations that are underway in TTACs (e.g., Gallagher et al., 2024; Holdeheide et al., 2024; Stanley et al., 2024). The current article goes one step further by providing greater detail (i.e., the “nitty gritty”) with regards to barriers and facilitators that TTACs may encounter in a TA transformation. Using a more commentary-based approach than the standard empirical article, we structured this article to contain two parts. Part I contains: basic foundational terms used in TA, a description of the core elements of what is currently known to be an evidence-informed TA system, operationalization of the core elements that comprise an evidence-informed TA system into a specific TA system (called GTO-TA), and an overview of a case example. In Part II, we describe lessons learned from the case example, in particular attending to the barriers and facilitators that can occur when transforming to an evidence-informed TA system in an existing TTAC.

PART I: Foundations of a TA System and the GTO-TA System

Basic Definitions of TA

Although there are multiple definitions of TA (Scott et al., 2022), we operationalize TA as: “An individualized, hands-on

approach to building an entity’s capacity for quality implementation of innovations, usually following training” (Wandersman et al., 2012; p. 449). We differentiate two basic types of TA: reactive and proactive.

- **reactive TA:** Reactive TA has the following features: (a) current problem focused; (b) recipient initiates a request to address questions, concerns, and/or problems that they face; and (c) the TA provider responds with information, etc. (Wandersman Center, 2023). The TA recipient is reaching out because they have an issue or problem, and TA provides a solution. This form of TA provides possible problem-solving ideas, subject matter expertise, or other resources to a specific issue.
- **proactive TA:** This type of TA is forward-looking, meaning the TA provider uses knowledge (e.g., personal experience, practice-based evidence, content knowledge, and/or evidence-based practices) to anticipate likely steps, facilitators and barriers, and addresses the cause of potential implementation failures (Katz & Wandersman, 2016; Olson et al., 2018; Ray et al., 2012; Scott et al., 2022). A proactive approach is helpful because often the recipient “doesn’t know what they don’t know,” and the TA provider can anticipate likely next steps and upcoming challenges. The TA provider may have clearly defined objectives and a support plan to achieve them over the course of time (Olson et al., 2020; Wandersman et al., 2012).

In both types of TA, the TA provider fulfills the role of individualized support to help facilitate implementation. All TA should be responsive to TA recipient needs in a rapid and timely manner, regardless of whether the TA session is initiated by the TA provider (e.g., if they notice a problem that needs addressing) or the recipient (for support). Distinctions between reactive and proactive TA include the nature of the interactions and relationship characteristics between TA provider and TA recipient. Reactive, responsive TA is

Table 1. A Glossary of Key Acronyms

Acronym	Explanation
EBSIS	Evidence-Based System for Innovation Support
GTO	Getting To Outcomes
GTO-TA	Getting To Outcomes-Technical Assistance
GHEA	Geographical Health Equity Alliance
ISF	Interactive Systems Framework For Dissemination and Implementation
QA/QI	Quality assurance/quality improvement
R = MC ²	Readiness framework
RTT	Readiness Thinking Tool
SAMHSA	Substance Abuse and Mental Health Services Administration
SWOT	Strengths, weaknesses, opportunities, and threats
TA	Technical assistance
TTAC	Training and technical assistance center

typically problem-solving focused and does not usually require an ongoing relationship or TA plan. Proactive, responsive TA adds a deliberate and intentional plan of action for TA recipient growth and generally involves a deeper relationship between the TA provider and recipient.

Both reactive and proactive TA can be systematic—which is a methodical approach to delivering TA that often has an organized step-by-step process and supporting tools. Systematic TA is important for the field of TA because it (a) allows for the evaluation and continuous quality improvement of TA, (b) includes a clear accountability structure and supporting evaluative data, and (c) is a standardized process that all TA providers within an organization can follow. Systematic TA—when paired with a proactive approach—is comprehensive, relational, and in-depth. It offers great promise for the advancement of TA; however, there are few models of proactive and systematic TA in the literature (Scott et al., 2022), and a change in operational infrastructure is often needed to facilitate success.

What TA Could Be/Should Be: Improving TA

TA often falls in the realm of practice and, less often, in the realm of research or evaluation. This results in a dearth of peer-reviewed literature on the professionals and organizations providing TA (Scott et al., 2022). Despite the well-recognized benefits of TA, there continues to be little focus on studying and further defining what effective TA looks like (Scott et al., 2022). Implementation science is emerging as a forerunner in developing the field of research on TA. Within this body of knowledge, there is an increasing emphasis on proactive TA as a potential key factor to achieve successful implementation outcomes (Aldridge, Roppolo, Chaplo, et al., 2023; Baumgartner et al., 2018; Kenworthy et al., 2022). Under the umbrella term “implementation facilitation,” there has been a call for TA providers to utilize a suite of skills that emphasize proactive planning, readiness assessment, and capacity building to support TA recipients (Albers et al., 2021; Kenworthy et al., 2022; Ritchie et al., 2020). Hypothesized benefits of a proactive approach to TA include increased internal knowledge, skills, and abilities; increased self-regulation of implementation activities and continuous process improvement; and sustained implementation and service outcomes (Aldridge, Roppolo, Brown, et al., 2023; Kilbourne et al., 2023). Initial evaluations of proactive TA indicate that it is feasible to undertake a proactive transformational shift even within an organization that typically engages in reactive TA; both TA providers and recipients reported perceived benefits from this approach (Kenworthy et al., 2022). Research documenting the benefits of TA has resulted in calls to grow the workforce of implementation practitioners and facilitators (Chambers & Emmons, 2024; Kirchner et al., 2022; Moore & Khan, 2023). We hypothesize that there is a continuum of quality of TA in terms of its effectiveness—with proactive being more effective than reactive alone and that, the more

systematic and evidence-informed the TA is, the more likely it is to be effective.

GTO-TA: A Proactive, Evidence-Informed, Systematic TA System

While the empirical literature provides some evidence that proactive and systematic TA have benefits for the TA recipient, discussions in the literature about TA lack sufficient detail for how a particular TTAC can transition from “TA-as-usual” to proactive and systematic TA. Dunst et al. (2019) conducted a scoping review of the frameworks and core elements of TA, seeking generally agreed upon TA practices considered essential for planning, implementing, and evaluating the effectiveness of TA (see left column of Table 2 for component and column 2 for the original description). Their scoping review moved the field forward by delineating the core elements of TA and how these core elements can be used in research and evaluation studies to determine the effectiveness of the element. The intent was the advancement of the science of TA; what is needed now is guidance on how to operationalize and actualize these core elements for the practice of TA. We hypothesize that the lack of concrete guidance and support for how to transform TA from “TA-as-usual” to an evidence-informed TA approach (defined as capturing the core elements derived from Dunst et al. [2019]) is one reason for why few TTACs are currently engaging in systematic and proactive TA. Put simply, TTACs often recognize that high-quality TA is important but need concrete guidance on what evidence-informed TA looks like in practice. In this section, we describe one approach to operationalizing systematic and proactive TA, referred to as GTO-TA. The GTO-TA system crosswalks with all of the Dunst et al. (2019) core components, which are described in the section below (see right column of Table 2, which describes how we operationalize the Dunst et al. components for GTO-TA). GTO-TA is designed as a synthesis and translation of core elements for the planning, implementation, and evaluation of TA. The Dunst et al.’s (2019) core elements are the closest delineation of what it takes to deliver effective, evidence-informed TA. GTO-TA provides a framework and guidance to a TA provider on how to bring promising TA practices to applied contexts.

GTO-TA Definition and Application. The GTO-TA system is one operationalization of a systematic, proactive, evidence-informed approach to TA. It adapts the widely cited and applied Getting To Outcomes® (GTO) framework (Wandersman et al., 2000) to fit the context of a TTAC providing TA support to a delivery system organization (e.g., health care system, school, or community coalition). GTO is a 10-step, proactive approach to accountability that includes a full systematic process of planning, implementing, monitoring, evaluating, improving, and sustaining innovations. Typically, GTO has been used by delivery system organizations to plan, implement, evaluate, and sustain a program or

Table 2. GTO-TA System and the Core Elements of a TA System

Core element	GTO-TA system
Preparation for technical assistance	
Needs assessment	GTO-TA step 1 (needs and resources)
Decision-making	Collaborative decision-making of TA provider and recipient
Visioning	10 steps of GTO-TA present a full vision of TA
Readiness for change	Readiness is built into GTO-TA through needs assessment phase
Organizational capacity	Trained GTO-TA providers
Technical assistance plan	
Goals and objectives	GTO-TA step 2 (goals)
Intervention practices	GTO-TA step 3 (best practices)
Fit assessment	GTO-TA step 4 (fit)
Logic model or theory of change	GTO-TA 10 steps are a theory of change
Technical assistance provided resources	GTO-TA tools
Staff roles and responsibilities	Proactive checklist and timeline GTO step 5 is capacity GTO step 6 is the plan (e.g., who does what, when, and how)
Technical assistance implementation	
Technical assistance provider credibility	Trained
Professional development	Continuous learning
Coaching and mentoring	Style of use
Technical assistance provider consultation	Tailored responses to individual staff or groups of staff members
Technical assistance provider support/feedback	TA provider acknowledgment, encouragement, and feedback on staff efforts to build capacity and accomplish activities
Technical assistance evaluation	
Process evaluation	GTO-TA step 7 (process)
Outcome evaluation	GTO-TA step 8 (outcomes)
Intervention practice fidelity	GTO-TA step 7 (process)
Technical assistance practice fidelity	GTO-TA step 7 (process)
Lessons learned	GTO-TA step 9 (continuous quality improvement)
Sustainability	
Capacity-sustaining activities	GTO-TA step 10 (sustainability)
Continuous quality improvement	GTO-TA step 9 (continuous quality improvement)
Ongoing technical assistance provider supports	Periodic supervision that includes step 9
Follow-up technical assistance activities	GTO-TA step 10 (sustainability)

policy. Chinman, Acosta, Hunter, and colleagues have engaged in a series of studies on a GTO system (that included manuals, training on GTO, and using GTO tools for TA). Over multiple quasi-experimental and randomized controlled trials in the areas of positive youth development and the prevention of alcohol use, drug use, and teen pregnancy, they demonstrated that a GTO system improved capacity among community-based prevention practitioners to engage in various prevention program activities with better quality (Chinman et al., 2008; Hunter, Chinman, et al., 2009; Hunter, Paddock, et al., 2009), led to programs being implemented by these practitioners with greater fidelity (Chinman et al., 2014; Chinman et al., 2016), and led to participants of these programs to experience better outcomes (Chinman et al., 2018)—compared to those who did not receive the GTO system.

GTO-TA is an extension of the standard GTO model; it uses the ten steps to guide the work of the TA provider. In GTO-TA, the TTAC uses GTO steps to shape thinking about how to support the TA recipient; it guides the TA providers to use the 10 steps of GTO in their TA process. The 10 steps of GTO are often described as answering 10 accountability questions. Each accountability question is accompanied by a set of tools that support the TA provider in completing each GTO-TA step. The 10 steps are designed to facilitate systematic thinking on the part of the TA provider and help the organization engage in improvement cycles that support implementation and programmatic success.

One notable feature of GTO-TA is that it serves a purpose at both organizational and individual TA provider levels. Specifically, GTO-TA meets the needs for a TTAC (organization) that is interested in implementing an

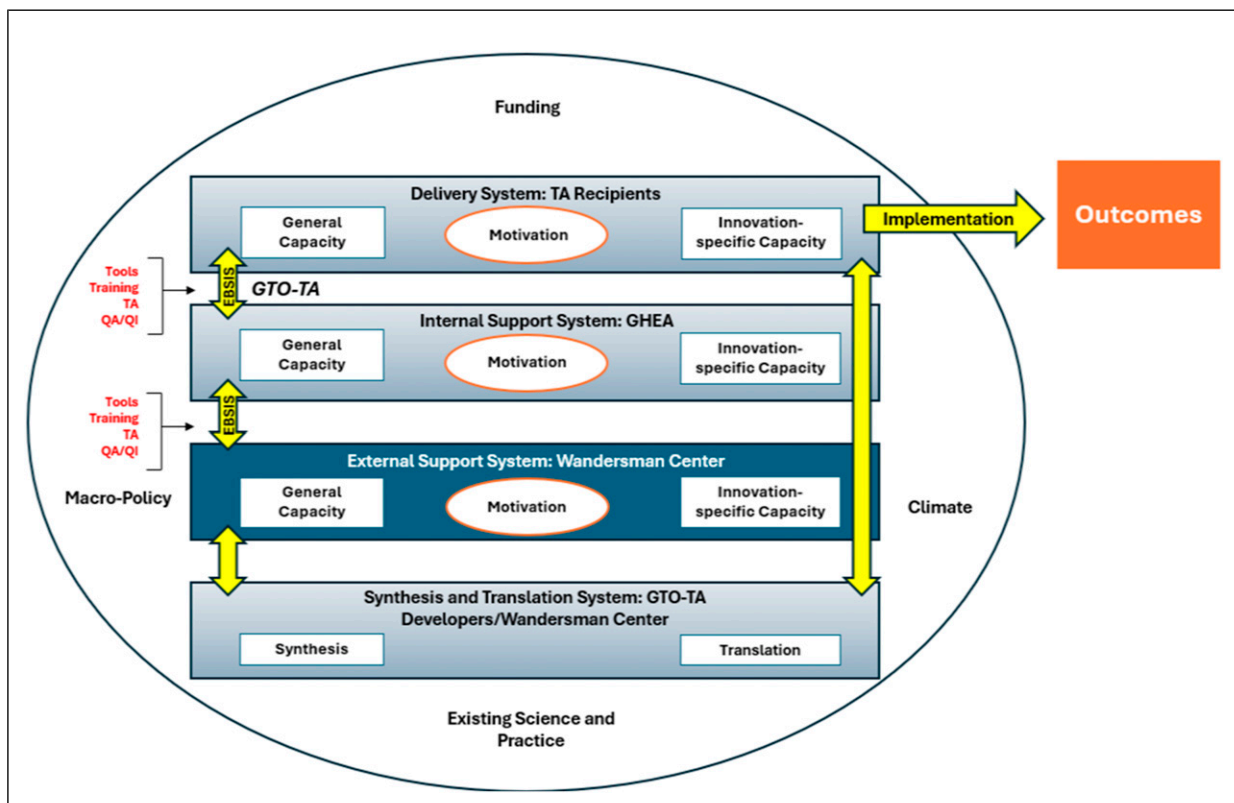
evidence-informed TA system with the ability to evaluate and demonstrate the effectiveness of TA. GTO-TA simultaneously offers specific tools and step-by-step guidance for a TA provider seeking a systematic and proactive approach to TA. Notably, the system is designed to fit within a broader system of organizational change, which includes activities conducted prior to the start of TA (e.g., engagement work, visioning, establishing a team, and selecting a focus of change; Scott et al., 2024).

Theory of Change in GTO-TA. The overarching purpose of GTO-TA is to help increase the readiness of a delivery system organization (e.g., coalition, school, or health care practice) to implement an innovation with quality, thereby increasing the likelihood of achieving favorable outcomes. In addition to working directly with the organization on problems that may arise, the GTO-TA provider focuses on the underlying facilitators and barriers that can affect implementation (also known as the “readiness” of the organization) as part of the effort to establish conditions favorable for implementation success. This is demonstrated in the Interactive Systems Framework for Dissemination and Implementation (ISF; Figure 1) by the arrows connecting the support system to the delivery system, which represent readiness building of the delivery system. Conceptualizing the role of the TA provider as

building the *readiness* of the TA recipient (rather than solely a problem-solver or troubleshooter) represents a transformational way of thinking about the role of the TA provider. It moves from a reactive role into a more proactive, systematic approach that is focused on enhancing implementation facilitators and reducing barriers—for example, it builds capacity for the TA recipient or organization to solve its own problems and challenges. Of course, if a TA recipient requires reactive support, the GTO-TA provider plays that role as well. Proactive TA and reactive TA activities are not mutually exclusive; we are simply noting the primary role of the GTO-TA provider’s approach.

The theory of change underlying GTO-TA is based on the concept of *readiness*, conceptualized using the $R=MC^2$ framework (Scaccia et al., 2015). $R=MC^2$ defines readiness (R) as the organization’s motivation (M), general capacity (C), and innovation-specific capacity (C) (abbreviated as $R=MC^2$) to implement the innovation. Readiness refers to the overall abilities and willingness of an organization to engage in a change effort; it has been accepted as a necessary precursor to successful implementation of innovations across the implementation science literature. The $R=MC^2$ framework synthesizes what is known about readiness, explicitly calling attention to motivational and capacity aspects of readiness for change. Motivation refers

Figure 1. A Customized Adaptation of the Interactive Systems Framework for Dissemination and Implementation (ISF)



to the ways in which the organization supports the *willingness* of the organization to engage in implementation of a change effort and the momentum of implementation; general capacities refer to the structure and functioning of an organization overall; and innovation-specific capacities refer to the capacities needed to implement a specific innovation. Within these three main components, multiple subcomponents make up an organization's overall readiness (see Table 3).

$R=MC^2$ states the hypothesis that the relationship among motivation, general capacity, and innovation-specific capacity is multiplicative—if any of the components are approximately zero, then the organization is not ready to implement the innovation. The expectation is that readiness can be built through high-quality TA, thereby optimizing implementation of innovations, regardless of baseline readiness. Critically, readiness is important in both the delivery system and the support system (Kenworthy et al., 2022)—the latter is the focus of this article.

According to the readiness framework, if the successful implementation of an innovation takes more than innovation-specific knowledge, skills, and abilities (which is often the sole focus of reactive TA), then the role of the TA provider should also extend beyond helping to build

knowledge, skills, and abilities to include the other dimensions of readiness. GTO-TA broadens the scope of TA to more comprehensively include the readiness of the recipient. The role of the GTO-TA provider is to assess and build readiness as a mechanism for successful implementation.

PART II: A Case Example of Transforming TA

Case Study Background

Despite a general trend toward interest in more proactive and systematic TA, there has been minimal guidance on what a proactive and systematic approach to TA looks like in practice. Instead, existing literature focuses on proposed mechanisms (Kilbourne et al., 2023) and knowledge and skills (Albers et al., 2021; Ritchie et al., 2020) for TA. Furthermore, there are few examples of how to build the TA infrastructure to ensure a systematic, proactive approach to TA. This creates a gap between an approach theorized to optimize implementation success and guidance for how to do it in applied contexts. In Part II of this article, we provide a case example of a TTAC that decided to transform existing TA into a full proactive and

Table 3. $R=MC^2$ Readiness Components and Subcomponents

Readiness construct	Definitions
Motivation	Degree to which the organization wants the new innovation to happen
Relative advantage	The innovation seems more useful than what we've done in the past
Compatibility	The innovation fits with how we do things
Simplicity	The innovation seems simple to use
Ability to pilot	Degree to which the innovation can be tested and tried out
Observability	Ability to see that the innovation is producing outcomes
Priority	Importance of the innovation in relation to other things we do
Innovation-specific capacity	What we need to implement the innovation
Innovation-specific knowledge and skills	Sufficient abilities to implement the innovation
Champion	A well-connected person who supports and models the use of the innovation
Supportive climate	Necessary supports, processes, and resources to enable the use of the innovation
Intra-organizational relationships	Relationships within our site that support the use of the innovation
Interorganizational relationships	Relationships between our site and other organizations that support the use of the innovation
General capacity	The overall functioning of the organization
Culture	Norms and values of how we do things at our site
Climate	The feeling of being part of this site
Innovativeness	Openness to change in general
Resource utilization	Ability to acquire and allocate resources including time, money, effort, and technology
Leadership	Effectiveness of our leaders at multiple levels
Internal operations	Effectiveness at communication and teamwork
Staff capacities	Having enough of the right people to get things done
Process capacities	Effectiveness to plan, implement, and evaluation

Note: Scaccia et al. (2015).

systematic TA system, opting to use GTO-TA as the model to implement. We first describe the setting and context of the case example; then we describe the methods used to derive generalizable lessons learned from the case example; and finally, we conclude with a discussion of key takeaways for other TTACs interested in transforming TA in the future.

Wandersman Center (co-authors of this article) collaborated with the Geographic Health Equity Alliance (GHEA) team of CADCA¹ (co-authors of this article) to co-design and implement the GTO-TA system in this case example. CADCA is a TTAC that works to reduce substance use and misuse through the establishment of multi-sector community prevention coalitions. CADCA is an umbrella organization that supports local communities worldwide with the necessary tools to create safe, healthy, and drug-free communities. They provide training and TA focused on an evidence-based strategic planning process that fosters coalition development. CADCA receives funding from the Office of National Drug Control Policy, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Substance Abuse Prevention; and GHEA is funded by the Centers for Disease Control and Prevention.

The Wandersman Center and CADCA relationship has been influenced by CADCA's interest in becoming a TTAC Center of Excellence. CADCA leadership convened a design and implementation team composed of CADCA leadership and representatives across all CADCA teams (National Coalition Institute and its Coalition Development Support, GHEA, International, Youth, and Evaluation and Research teams) to help improve and demonstrate effectiveness of TA offered at CADCA. This design and implementation team engaged in a mini-evaluability assessment that included conducting stakeholder interviews, a review of key documents related to their existing TA structure, and the completion of a strengths, weaknesses, opportunities, and threats (SWOT) analysis to identify shared and unique needs around TA across and within CADCA teams. Across all CADCA teams, there was a reported lack of a systematic TA process and a desire to have consistent shared language and processes for TA, as well as increased data on the effectiveness of TA. The GTO-TA system was introduced as an evidence-informed, systematic TA process that could address this need. Teams across CADCA decided to improve TA; the GHEA team committed to a full and comprehensive transformation of their TTAC to manifest a comprehensive systematic and proactive approach to TA. Their concerted effort is the focus of the case example below.

GHEA and Co-Development of a TA System. GHEA focuses on reducing place-based health disparities through enhancing coalitions' capacity to implement policy, systems, and environmental change strategies. GHEA was developing a policy training academy and was motivated to integrate a systematic TA process to follow up on training. The GHEA team includes an organizational director in a leadership role, two project

managers, and an internal evaluator. The GHEA team worked closely with the Wandersman Center team (who are both developers of GTO-TA and serve on the implementation team supporting GTO-TA adoption). The inclusion of an implementation team—which can be either internal, external, or a combination of both—is essential for quality implementation (Meyers et al., 2012). The GHEA team engaged in co-design of GTO-TA tools and training materials. Co-design is a collaborative approach where stakeholders—in this case, Wandersman Center, GHEA leadership, and TA providers—work together to develop, implement, and evaluate innovations. The participatory process of co-design can ensure that the needs, preferences, voice, and experiences of all parties are considered, leading to more effective solutions (Butler et al., 2022; Erwin, 2013; Sanders & Stappers, 2008; Vargas et al., 2022). The Wandersman Center/GHEA team met weekly to learn the process and work together to consider how to make it best fit for GHEA and GHEA's externally contracted TA providers.

The roles and interactions between the Wandersman Center and GHEA team can be more clearly illustrated using an adaptation of the ISF (see Wandersman et al., 2008; refer to Figure 1), where there are two layers of the support system. The Wandersman Center acted as an external support system and the GHEA team as an internal support system. The Wandersman Center provided support to both the GHEA team and directly to the TA providers, while the GHEA team received support from the Wandersman Center, co-designed tools and processes, and provided additional direct support to the TA providers.

GHEA's programming has been reflective of CADCA's overall organizational culture, which emphasizes training as a major component to community coalition building and empowerment. A training organization typically focuses on a set curriculum that can vary in length, sometimes delivered as one-off offerings, or at other times, a curriculum spanning a longer time frame that can last up to a year. GHEA provides a wide range of different types of training to its TA recipients, including training that addresses policy, systems, and environmental change; 10 steps to policy adoption; building equity-centered coalitions; selection of evidence-based practices; and other similar topics. Under its cooperative agreement with the Centers for Disease Control and Prevention, GHEA has experimented with programming going beyond training, including developing learning collaboratives that mixed training and reactive TA. For GHEA, developing an evidence-informed TA system that would be applicable to achieving its various goals and objectives required a significant shift in the programming offered to TA recipients. The process took many months of co-design—and significantly changed the programs and services offered to the coalitions. (The changes are summarized below in lessons learned.)

While GTO-TA was a pre-existing innovation that had been used in multiple settings, the process of bringing GTO-TA into

the GHEA context needed to be customized, and new tools needed to be developed. GHEA was historically a training center, and the changes needed to support a high-quality TA system were extensive. GHEA and Wandersman Center staff engaged in a process of co-design to ensure the compatibility and alignment of the innovation with the context. The process of GHEA adopting GTO-TA began with the Wandersman Center providing introductory training on the purpose of the 10 steps of GTO-TA. This entailed informing GHEA how systematic and proactive TA differed from “TA-as-usual” and providing initial examples of several of the GTO-TA tools as a starting point for co-designing tools that would fit for GHEA. Introductory meetings were intended to provide GHEA with a preliminary understanding of the relative advantage of adopting a new system and inform a conceptual understanding of the TA system.

The GHEA team and Wandersman Center then spent several months adapting the Readiness Diagnostic Scale (a psychometrically-valid readiness assessment that has previously been adapted for other contexts; Scott et al., 2017; results of comprehensive measurement testing in progress²) for GTO-TA Step 1. The scale was administered to GHEA’s contracted TA providers and to TA recipients. As data were being collected, the collaborative team worked to co-design tools for the other GTO-TA steps. The purpose was to ensure tools were meaningful and usable for the TA providers. Tool development was a lengthy process because each tool needed to provide sufficient instruction, include quality and depth of accountability questions, appropriately include content-specific adaptations, and be formatted and integrated in a way that TA providers could and would use and which GHEA could monitor for accountability (e.g., are tools being used as intended?). Due to the implementation timeline, training of GHEA’s TA providers occurred in tandem with the co-development of the tools and accountability process.

An extremely important feature of this case example is the strong commitment to excellence held by GHEA leadership. The relationship between the GTO-TA developers (Wandersman Center) and GHEA was one of collaboration and co-creation to optimize learning about what it takes to transform TA. This provided a rich experience for studying the process of adoption, specifically the pre-implementation work needed for successful adoption in a well-functioning organization. Below, we (1) describe the evaluative process we used to derive meaningful lessons learned for how to adopt a new TA system within an existing TTAC and (2) share reflections on what it takes to transform TA in the context of a well-run TTAC.

Deriving Lessons Learned. GHEA leadership adopted a playful approach to transforming the GHEA TTAC to a full GTO-TA system. Recognizing the importance of this work for the field in general, the Wandersman Center engaged in an evaluative effort to capture key lessons learned and suggestions for other TTACs engaging in a TA transformation. Our process is described below.

Readiness Thinking Tool and Other Forms of Data Collection. Several methods of measurement were employed to identify themes and lessons learned for the adoption of GTO-TA within GHEA—most notably, we utilized the Readiness Thinking Tool (RTT; Wandersman Center, 2019), conducted key stakeholder interviews, and held guided discussions with key stakeholders and GHEA leadership. The RTT is a brief 19-item assessment based on the R=MC² readiness framework. As noted earlier, R=MC² identifies organizational motivation, innovation-specific capacity, and general capacity as components of readiness. Each component can be specified further into subcomponents. The RTT includes one item per readiness subcomponent to facilitate thinking and conversation about the ways an organization has supported motivation and organizational capacities for a particular innovation. The RTT is a practical tool with strong face validity that provides a framework for collecting and organizing data that was based on implementation science literature. No software is required for tool completion. It promotes conversation and is used to stimulate deep dialogue from multiple perspectives.

For this evaluation, we adapted the RTT to include columns for representing the perspectives of different stakeholder groups, including the implementation team (i.e., Wandersman Center, TA providers, project managers, program leadership, and organizational leadership). Each column included space for qualitative notes about barriers, facilitators, and lessons learned for each stakeholder for adopting a systematic and proactive TA process, specifically GTO-TA. The RTT was used to capture a retrospective account of needs, reflecting on lessons learned and what worked/didn’t work. The RTT was introduced to all participants, who included the GHEA team and TA providers. Each stakeholder group (Wandersman Center, $n = 5$; GHEA team, $n = 2$; GHEA leadership, $n = 1$; and TA providers $n = 2$) completed the RTT from their own perspective, adding qualitative data for each subcomponent. GHEA project managers, who worked closely with the TA providers and were learning the process alongside them while applying it at a project level, responded in the TA provider column in the modified RTT. Additional feedback collected directly from the TA providers ($n = 2$) was captured through interviews or a brief survey and was included in the analysis.

The RTT was completed primarily during group discussions within teams using a shared document. In some cases, individual stakeholders would respond to sections of the RTT and collectively discuss and develop a consensus regarding their responses. Inter-team (e.g., GHEA and Wandersman Center) discussion of the RTT was conducted several times throughout the process to ensure clarity and shared meaning of the data collection. The RTT was supplemented with key stakeholder interviews and discussions (e.g., GHEA leadership and project managers), with additional feedback collected directly from the TA providers captured through interviews or a brief survey (described below). The whole process of data collection was aimed at understanding barriers and facilitators

to adopting the GTO-TA system in the TTAC and requisite changes needed at the organizational level to adopt GTO-TA. Notably, discussions and interviews were not held with leadership alone. Questions about changes in TA practices and support to adopt a systematic and proactive TA process were elicited directly from the TA providers. The Wandersman Center and GHEA teams collaborated on (a) identifying the most important questions to ask TA providers, (b) ensuring the questions were not overly burdensome (e.g., not interfering with daily tasks and adding extra workload), and (c) determining a procedure for TA providers to answer the questions honestly without fear of recrimination. This evaluation and lessons learned encompasses the combined input from all engaged parties.

Once all stakeholder columns were filled in, the content was analyzed deductively using an a priori coding and data summarization scheme (i.e., successes, challenges, key lessons learned, and recommendations for improvement). Following initial review and coding, the authors determined which facilitators/barriers occurred across multiple groups and which themes were surfacing in one stakeholder group and not others. The authors also conducted independent ratings of the level of importance of each key theme. These ratings and initial themes were discussed and further synthesized and then written up in greater descriptive detail. These detailed themes were then discussed further with key stakeholders (e.g., GHEA leadership and Wandersman Center) to ensure that all themes were captured, that none were missing, and there were no superfluous or redundant additions. Any disagreement or different perspectives were discussed until there was consensus.

After themes were identified, we elicited direct feedback from the TA providers via a brief online survey. Technical assistance providers were able to view the questions and determine if they were more comfortable responding virtually or if they were comfortable responding to either GHEA or Wandersman Center team members verbally. Technical assistance providers responded to the questions, which included how their TA changed through the adoption of GTO-TA, what supports were helpful or not, what they felt would be most useful for TA providers and leadership at other TTACs to know, and additional questions about the specific themes. Technical assistance provider responses were integrated into the themes and recommendations discussed below.

Lessons Learned: What it Takes to Transform TA in an Existing TTAC. The responses to the RTT and key stakeholder interviews provided a framework to guide discussions related to the facilitators and barriers of adopting a new, evidence-based TA system (GTO-TA). This multifaceted assessment converged on several primary themes. In this article, we focus on two major themes that we agreed were very important and would be generalizable to other contexts and organizations: (a) aligning general capacities with the innovation in order to

support success and (b) communicating the relative advantages of transforming TA to a proactive and systematic system and ensuring buy-in. The content below represents the collective input obtained through the detailed discussions, interviews, RTT, and self-report surveys, as well reflections from the authors based on decades of experience working in this field.

Theme #1: Aligning General Capacities to the Innovation in Order to Support Success. The construct of readiness encompasses three primary subcomponents: general capacities, innovation-specific capacities, and motivation. A primary lesson learned in this case example—with strong implications across the field—is that high *general capacities overall* differ from the *general capacities needed to adopt an innovation*, and both are important for success. In this section, we first delineate three related readiness subcomponents, then describe how the specific alignment between general capacities and GTO-TA played a critical role in the adoption of GTO-TA at GHEA.

Most attention in the empirical literature and field of implementation typically focuses on two types of capacities: (a) general capacities, which are overall characteristics of an organization that affect the daily functioning of an organization like leadership, culture, and number and experience of staff and (b) innovation-specific capacities, which are the conditions necessary to implement a particular innovation. General capacities are seen as foundational conditions that support innovation success, regardless of the innovation. Prior to adopting a new TA system, GHEA was characterized as having moderately high general capacities, evidenced through formal baseline assessments (completed during the SWOT analysis described above; results outside the scope of this case example). Generally speaking, GHEA was evaluated as having effective leadership, a strong culture and favorable professional climate among staff, and efficient internal operations and was accustomed to innovating. In the implementation science literature and general field of practice, this would be considered a strength and used to justify implementation of an innovation (Flaspohler et al., 2012).

What this case example illustrates, however, is that these general capacities overall are not enough to support program adoption. In addition, the *general capacities* have to be more closely *aligned to the innovation* in order to facilitate program adoption. General capacities need to be suitably matched or compatible with the innovation to ensure the innovation can be implemented effectively. An organization may be high functioning and well structured overall (high general capacities), and yet implementation of a new innovation may suffer because of a lack of *alignment* between the way the organization is structured and the needs of a particular innovation. Just because a TTAC is well structured for providing training, for instance, does not mean the structure and culture of the organization support the implementation of TA. The

organizational needs required to support a TA system are different from a training system—e.g., resources must be allocated appropriately, the culture among staff must align with TA, the TTAC should have connections with other TA-serving organizations, and so forth. This alignment of general capacities to the innovation is different from the innovation-specific capacities of an organization. Innovation-specific capacities refer to how well the organization can *do* the innovation. General capacities aligned to the innovation refer to how well the organization is structured and how it functions to support the innovation.

For example, GHEA had measurable high general capacities at baseline; however, these capacities were in alignment with the organization being a training center. Leadership and internal operations focused on what it takes to run a successful training center. Staff support and budgeting/contracts (resource allocation) were designed around what it takes to train effectively, and the culture and climate among trainers were focused on the identification of being a trainer and understanding the vision of the training center. While the general capacities were aligned for *training* per se, they did not necessarily align with *TA*. General capacities are not “one size fits all” for all innovations, so GHEA leadership had to *align* their general capacities to the needs of the new TA system. In the next section, we describe specific changes to general capacities that were required for alignment to GTO-TA.

Changes to Internal Operations. A major theme that emerged during the collaboration was the necessity for fundamental changes to GHEA’s internal operations in order to support adoption of a proactive and systematic TA system. We define internal operations as the overall structure, communication, and teamwork that takes place within the organization. While GHEA had well established and effective internal operations early in the adoption of GTO-TA, leaders in the organization noticed that these internal operations needed to be altered in order to support a proactive and systematic TA system. The move from being training-centric to adopting and implementing a proactive and systematic TA system required a deep examination of the alignment between the way things were previously done to what is required to implement the GTO-TA system. The building of an evidence-informed TA system brought about a transformation among program staff with regards to the role that TA plays in capacity building, and GHEA staff updated their programming to correspond to the new TA-centric approach (versus a training-centric approach). In the words of a GHEA leader, “We fundamentally changed everything to make this work.”

Table 4 summarizes specific changes in internal operations that were needed to support adoption, organized by dimensions of internal operations determined to be necessary for high functioning of organizations: policies and practices, workforce development, supervision, workflow, TA recruitment and engagement, and client relationships.

These dimensions were identified as important to consider when implementing organizational-level change (SAMHSA, 2019). Initially, they were developed by SAMHSA for substance abuse treatment centers; we revised the wording and made definition adaptations to align them with the current context. Several of the dimensions are highlighted in detail below.

The transformation to becoming a proactive and systematic TA center at GHEA necessitated changes in their standard approach to *workforce development*. Previously, staff training and onboarding primarily focused on a training curriculum and a TA plan that merely accompanied the training program as somewhat of an add-on support service. The TA offered was reactive in nature and neither proactive or systematic. The transformation to the GTO-TA system meant that the backbone of major capacity-building initiatives became the *relationship* between TA provider and TA recipient and proactive, ongoing work to systematically address TA needs of the recipients. Technical assistance became focused around both the training plan and also addressing coalition readiness. The focus on readiness helped the TA providers identify and address fundamental challenges (root causes) that may have limited TA recipient’s progress in implementation of activities. This was a very new approach that required a new set of requisite abilities to implement. GHEA altered internal operations to better support staff in this process. Specific changes included increased support services for TA providers, including all four components of an evidence-based system of innovation support: tools, training, TA, and QA/QI (Wandersman et al., 2012). This level of support required time capacities from TA providers and leadership, fiscal capacities to support time and Wandersman Center involvement, and human capacities to build tools and provide TA. To support and streamline this work, leadership showed a high degree of innovativeness and a willingness to change in order to maximize output. For instance, leadership and program managers altered the way internal meetings were conducted to better meet the needs of the GTO-TA providers within the changing organization. Meetings that were originally intended for teaching trainers the training curriculum became more focused on the GTO-TA process. Additionally, time allocation as a resource was intentionally shifted to allow for more one-on-one time with the project management team and engage in more ongoing supervision of the GTO-TA providers.

In addition to workforce development, leadership at GHEA also made substantial changes to the way GHEA assigned, interfaced, and worked with TA recipients. Across all programs, GHEA changed the structure of TA assignment (e.g., how TA recipients and TA providers are paired) and the expectations of the TA recipients. Technical assistance providers had new expectations of TA recipients, which included a longer expected duration of work (12- to 18-month time commitment), a commitment to engage in monthly TA meetings and the regularly scheduled monthly trainings. The longer time frame and commitment were designed such

Table 4. Specific Changes Made to Align Internal Operations to GTO-TA Adoption

Operation	Change
Policy and practices	Policies about TA moving from a reactive system to a proactive system and setting expectations for all TA providers. New formal policies and prioritized practices associated with documentation requirements (e.g., completing tools and/or using a formal tracking system).
Workforce development	Unified and consistent methods of documentation and fidelity checking. Prioritized attendance by contractors at trainings. Invested and prioritized attendance by contractors at TA sessions (conducted by Wandersman Center) and supervisory sessions (conducted by project management staff). Increased focus and investment in developing high-quality tools and engaging in a QA/QI process to continuously improve the tools.
Supervision	Prioritization of QA/QI for how well the TA providers felt supported in completing the GTO-TA steps. Implementation of a new supervisory structure that includes regular contact with TA providers, oversight of a tracking system, and ongoing support for adopting GTO-TA. Increased hours for the project management staff to focus on the supervision and support of TA providers. Engaged in regular formal and informal dialogue with TA providers to establish trust and reduce social desirability of reporting. Honest and candid feedback was necessary for successful adoption.
Workflow	Changes in the ways in which TA providers interacted with clients (e.g., how they schedule time with TA recipients, frequency and duration of TA sessions, increased planning time, and work between sessions). Recognition that TA goals sometimes focus on TA recipient capacities that need building, even if the recipient does not recognize the problem. This means that the TA provider may set goals independent of the recipient request for the work.
TA recruitment and engagement	New contracts and budgets created to reflect the increased pay and increased hours associated with the work. Aligning roles, expectations, and budgets to support the work of the TA is encouraged before training TA providers to ensure ease of adoption. Recruitment of the right TA providers. The most successful trainers (in the old system) may or may not be the best people to recruit for the new TA system. Find the champions of the system first. Changes in expectations for onset: "GTO-TA is the way we do TA at this organization," as opposed to TA providers implementing and documenting TA in their own way. Considerations about who receives what training. Not all TA providers need to understand the full conceptual background; some simply want to know what to do and how. Prioritized an intentional shift to have GHEA program managers onboard new TA providers internally, rather than relying on Wandersman Center for onboarding. This supports sustainability of the system in the long-term.
TA provider/TA recipient relationship	Emphasis on longer-term relationships when selecting and engaging TA recipients. More focus on alignment and fit over quantity and ensuring that TA recipients have interest in receiving proactive TA services by stating expectations clearly up front.

that a proactive and systematic TA process (GTO-TA) could achieve outcomes (versus sporadic TA sessions, as in reactive TA).

Reallocation of resources was necessary to make the required changes in internal operations. Notably, GHEA did not receive *more* funds for doing this work; their ability to transform TA came from the reallocation of funds already available and the flexibility in how to spend the dollars. With the implementation of GTO-TA, and a system in place for TA delivery, program managers had more detail regarding the expectations and time commitments for TA than previously. For example, for one project, project managers were able to anticipate that each TA provider would need contract hours for 1.5 hours of monthly TA per TA recipient (totaling 4.5 hours a month), 2 hours a month of TA coaching with co-developers, 3 hours a month of TA updates and support from GHEA internal staff, 2 hours a month for training, and 3

hours a month for project-related administrative tasks. This type of detailed TA contract was markedly different than in previous projects, where contract hours generally fell into larger buckets of training, TA, content development, and necessary administrative work. In other words, contracts were written with the required TA-related hours in mind first, and then other necessary parts of support were incorporated on top of that.

Similarly, in another project, the program manager began by calculating the hours required for adequate implementation of the GTO-TA process, calculating the number of TA hours per coalition involved (6), coaching hours, and administrative tasks related to TA. Then, with any remaining funds, the project manager included other activities such as training, program support, etc. In this example, with the inclusion of more robust TA activities, the contract amount for TA providers was increased by 25% from previous years where TA was not delivered in a

systematic and proactive manner. Without additional external funding and with an increased focus on and budget allotment for TA, program managers needed to be creative to support the development of other important program components, such as training. Project managers leveraged relationships with external partners, which had ready-made, “plug-and-play” training content for cost-effective training delivery or, in some cases, built the training curriculum themselves, leveraging internal resources.

Commitment by Leadership. This case example illustrates how important it is for leadership to be prepared to fundamentally change the way work is done within a TTAC to adequately implement a proactive and systematic TA system. The transition from “TA-as-usual” to proactive and systematic TA requires time and effort on the behalf of leadership and involves both demonstrating and communicating buy-in to organizational staff and TA providers. Leadership expectations need to be clear and accountability systems put in place. As described above, GHEA’s leadership championed bringing evidence-based TA into how the organization provided support and allotted time and resources to support adoption through many of the infrastructure changes described above and outlined in [Table 4](#).

A noteworthy lesson learned from the GHEA experience was that work by leaders should begin before onboarding TA providers and that leadership should be engaged in the co-design process. Leadership could not simply hand off the TA system to TA providers or project managers, and the TA system could not simply be pulled from the shelf without adaptation. Leadership must consider what they want to track and how, what tools they want used, what those tools should look like, and the processes to have in place to ensure accountability and fidelity. This was a lengthy process that would ideally be done prior to engaging TA providers to help streamline communication and simplify the adoption process for TA providers. In this case example, we onboarded TA providers during the development and co-design of GTO-TA for GHEA, which caused unnecessary confusion and stress. One example of this occurred during the training of TA providers on conceptual information about GTO-TA. These foundational trainings were done before tools and logistical decisions were finalized, making the operationalization of “how to do GTO-TA” very obtuse and challenging, leading to some frustration. Having a clear “story” and expectation would have facilitated an easier onboarding and adoption process.

Leadership in GHEA quickly adapted to the identified frustrations related to complexity by increasing support through bi-weekly TA trainings, reworking contracts to

Table 5. Examples of Diverse Opinions About the Relative Advantage of GTO-TA Within GHEA

Key stakeholder	Examples of statements of relative advantage
GHEA leadership	<p>“We should be doing evidence-based support, and systematic TA that is tailored will be more effective than the training-focused models of the past.”</p> <p>“Demonstrating outcomes has implications for funding.”</p> <p>“Desire to become a center of excellence.”</p> <p>“To be leaders in the field.”</p>
Project managers	<p>“Identifying root causes of challenges is extremely helpful. We can identify the problem and come up with strategies to address the specific problem.”</p> <p>“What GTO-TA is or would be—an evidence-based, systematic approach to TA. The idea that we would have a system of TA, rooted in evidence, that could be replicated by TA providers (CADCA trainers, GHEA staff, external partners/SMEs) across projects, always seemed better than what we are currently.”</p> <p>“We had to dedicate time and resources from other projects or that could have gone to other project opportunities to build this system of TA, and even still, we dedicate significant resources and time to learn to the system, test, and pilot tools, understand different levels of intensity, learn to coach TA providers through the process, etc... I Understand how this work would build our capacity, impact all our current and future projects, and open new opportunities for work, funding—you name it.”</p> <p>“I saw the relative advantage of the theory of GTO-TA and understood how it could bring GHEA’s offerings to the next level. Seeing it in practice strengthened this perspective.”</p>
TA providers	<p>“Transforming to GTO-TA allows us to show that our TA is making an impact—going beyond satisfaction to actual TA outcomes.”</p> <p>“Having a shared TA system means any other TA provider can pick up what I’ve done and could follow up. It provides helpful structure for the internal TA team to be on the same page.”</p> <p>“Been training and doing TA for a long time, and relative advantage of a new systems is low for me. What was done before seemed to work fine.”</p> <p>“Helps to identify the barriers or challenges more clearly.”</p> <p>“Focused on wanting to maintain relationships and valuing relationships with GHEA, so compliance for those reasons (this is in contrast to seeing the value of the system itself).”</p>

allocate sufficient time required for GTO-TA, and leaning on positive and trusting relationships between TA providers and project managers to support the transformation process. GHEA leadership made changes in the staff roles to provide more supervision and oversight, which included developing and maintaining a TA team, ensuring adoption of GTO-TA tools and processes, managing schedules (e.g., trainers were more familiar with shorter contracts, and ongoing TA contracts meant more meetings and more coordinating), and ensuring quality of GTO-TA.

A major role for leadership in the transformation of TA is to provide an environment that is supportive for adoption of a proactive and systematic TA system and to set clear expectations for organizational staff and TA providers. In addition, leadership is also critical for communicating the vision and purpose of the transformation. GHEA leadership was highly motivated to adopt GTO-TA and saw it as a true paradigm shift in the way support should be provided—from training-focused to TA-focused. GHEA leadership acted as a program champion, which supported the building of GHEA staff and TA providers' unique motivations and capacities to adopt GTO-TA.

Theme #2: All Levels Involved Should See the Relative Advantage. From the outset, the leadership in GHEA saw the relative advantage of transforming from a training center to a proactive and systematic TTAC. These advantages included better ability to demonstrate TA outcomes, better coalition outcomes, and ability to use data to track and monitor TA. While it is common for leaders to see the relative advantage of an innovation that they are promoting, not all staff and contractors necessarily see the relative advantage of some new idea. This is what initially occurred in our case example, too. Understanding the status of various key stakeholders and their relative understanding of the transformation was an important lesson learned as the GTO-TA system became adopted. Table 5 illustrates variability in the reported relative advantage of engaging in GTO-TA. As indicated, different key stakeholders reported different reasons for engaging in GTO-TA. For example, TA providers tended to focus on simply wanting to help coalitions succeed; whereas leadership focused on what the TA system could mean for becoming a Center of Excellence.

Understanding the relative advantage of an innovation to different key stakeholders (Armenakis et al., 1993; Damschroder et al., 2009; Hall & Hord, 2010; Rafferty et al., 2013; Rogers, 2003; SAMHSA, 2010; Schoenwald & Hoagwood, 2001; Weiner, 2009) is important for shaping messaging—in this case, how the TA system is communicated to staff. For instance, when developing training for the new TA approach, it is important to speak to the values that matter to that key stakeholder. This may mean having separate trainings for different levels of the organization or to address different aspects of motivation, which can be

budgeted into contracts early on. The critical lesson exemplified here is that people participate in new initiatives for many reasons, so taking time to understand these reasons early on will benefit adoption in the long-run by meeting staff where they are and speaking their language. The values of the leaders do not always equate to the values of the TA provider.

Conclusions

As Wandersman and Scheier (2024) note in the introduction to the first issue of the special issue on “Strengthening the Science and Practice of Implementation Support: Evaluating the Effectiveness of Training and Technical Assistance Centers,” a major feature of implementation science is its concern with the barriers and facilitators of implementation. What will it take to change how support systems operate? In this article, we focus on barriers and facilitators in implementing change in the support system. We (a) describe what a proactive, and systematic TA system looks like, as outlined in the implementation science literature; (b) illustrate how GTO-TA operationalized a high-quality TA system; and (c) describe lessons learned and reflections on developing and implementing a more advanced TA system in practice. Our experience adopting GTO-TA within a TTAC yields many suggestions related to barriers and facilitators for TTACs to consider, including:

- The process of transforming TA should start prior to onboarding TA providers. Leadership should consider changes in internal operations and ways to champion the effort prior to training staff in order to simplify the process of adoption.
- Consider TA providers' perspectives when adopting a new TA system. The relative advantages of adopting GTO-TA may differ across key stakeholders. Different messaging should be used to engage different stakeholders, based on their perceived relative advantages.
- To successfully adopt a comprehensive, proactive and systematic approach to TA, leadership must remain actively involved and be willing to change the way things are done at the organization to support TA provider needs.

As the science of TA grows, we will learn more about what it takes to provide effective TA in TTACs. The ability of an organization to prepare and support the transition to providing evidence-based TA will be a critical component to bridging the gap between research and practice. The purpose of this article is to demonstrate an operationalization of high-quality TA (i.e., a proactive and systematic TA system based on what is currently known in the literature) and provide lessons learned about how to transform an existing TTAC that primarily performs responsive and reactive TA into a TTAC that provides proactive and systematic TA. As a case example, our

results should be interpreted as a rich stimulus from a single case illustration. However, the experiences that we describe resonated with other TTAC experiences we have had and appear generalizable enough to warrant more empirical attention and promising practices for other TTACs to consider—if they want to transform their TA. Future research and evaluation studies are encouraged to continue to study the organizational changes necessary for successful adoption of proactive and systematic TA. The collection of practice-based evidence is needed to strengthen the science and practice of TA.

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Supplemental Material

Supplemental material for this article is available online.

Notes

1. CADCA is the official name of the organization without use of an acronym.
2. Five year R01#1RO1CA228527 demonstrates adequate factor structure, validity, and reliability; publication in preparation.

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