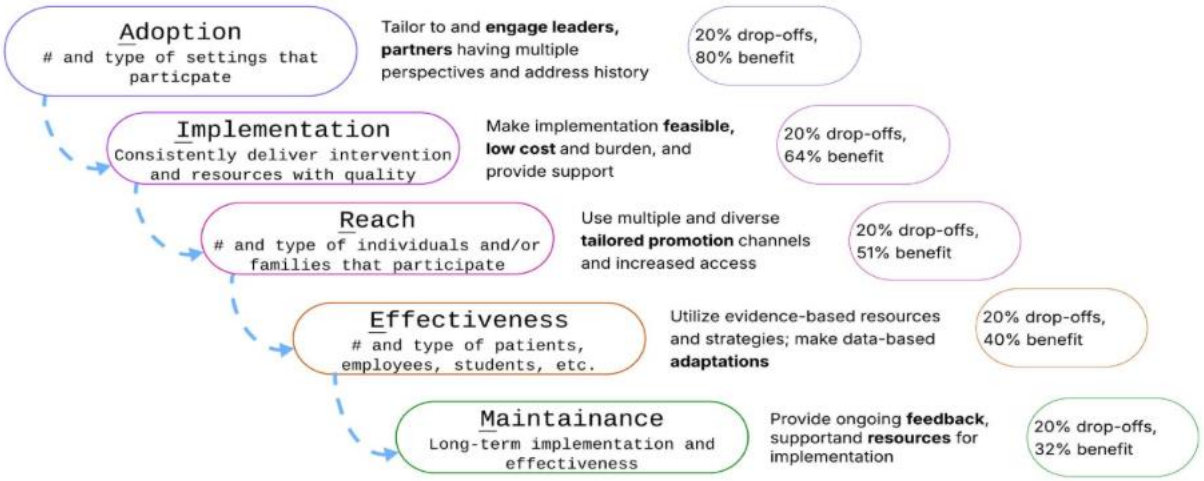
RE-AIM Cascade Tracking Worksheet

Using the RE-AIM Cascade Tracking Worksheet

The RE-AIM Cascade Tracking Worksheet is intended to guide researchers as they plan, conduct, and report their study to think about potential drop offs in impact of their study due to factors that may affect participation, representativeness, or effectiveness. The worksheet is designed to address drop off issues at each step in the RE-AIM Cascade shown below.



It is organized by RE-AIM implementation outcomes and specific challenges that may decrease impact pertinent to these outcomes. It is intended to help researchers with “critical reflection” around different decisions or actions that may help mitigate drop offs in impact. It is not intended to replace other planning or reporting tools for pragmatic research such as the Expanded CONSORT, PRECIS-2 or PRECIS-2 PS.

A blank fillable template is provided below with an example version of the worksheet provided at the end of this document. We recommend starting in the third column “actions taken during planning” **when you are planning your study** and returning to the worksheet to complete the “later actions taken” column **during or after the study.** As you go through, you can add additional notes as needed in the last column. It may be helpful to complete this worksheet with your team or advisory board representing a diverse set of perspectives on the study as opposed to completing on one’s own. You should also feel free to adapt the worksheet if one of the RE-AIM steps does not apply to your project or there are added steps between those shown.

The tracking tool is being continually updated. We appreciate any feedback you have on the tool. Please check the following website to see if there have been further updates or revisions of this tool: https://medschool.cuanschutz.edu/accords/CoresResources/dissemination-implementation-core/resources-services#Resources-Services-InteractiveTools

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Research / Project Stage	Challenge	Actions Taken During Planning	Later Actions Taken	Notes
Adoption (multi-level)	Diversity of sites participating			
Implementation	Consistent delivery of intervention (fidelity)			
	Level of adaptation to address emerging issues			
	Time, cost, and burden requirements			
Reach	Recruitment methods that appeal to key groups			
	Breadth of eligibility criteria			
	Opt-in informed consent			
Effectiveness	Level of participant engagement			
	Tailoring to different subgroups			
Maintenance	Setting resources to continue the program			
	Level of follow-up support			

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Example project (Real project but hypothetical scenarios): ***Comparing different forms of structured follow-up support in the treatment of multiple health risks for chronic disease: My Own Health Report (MOHR) Pragmatic Trial in Colorado***				
Research / Project Stage	**Challenge**	**Actions Taken During Planning**	**Later Actions Taken**	**Notes**
Adoption (multi-level)	Diversity of sites participating	Recruited a mix of urban and rural primary care sites with varying EHR systems and staffing models	Added a second rural health system partner after one original rural site withdrew due to staffing shortages	Intentional attempt to account for contrast between metropolitan and rural contexts to test adoption across differing resource levels
Implementation	Consistent delivery of intervention (fidelity)	Developed a fidelity checklist and trained staff at each site using a standardized protocol	Introduced a standardized call script and periodic call audits for CHWs after early variation was observed in navigation calls	Document continuously reflect how intervention were delivered for whom at what conditions and when, and to assess variation by different multilevel and temporal factors.
	Level of adaptation to address emerging issues	Built in a formal adaptation log and pre-specified which intervention components were core vs. adaptable	Adjusted text message timing after patients reported messages arriving during work hours were less actionable	Logging adaptations makes visible which sites or patient groups prompted a change, so adaptation decisions can be traced back to specific representation needs rather than applied uniformly
	Time, cost, and burden requirements	Estimated staff time per patient contact and built this into the budget	Found CHW caseloads needed adjustment partway through enrollment as navigation calls took longer than budgeted	if patient navigation is too costly to sustain at lower-resourced sites, those sites and their patients risk being excluded from future scale-up
Reach	Recruitment methods that	Designed multilingual recruitment materials and partnered with	Added flyers in Spanish and expanded recruitment through community partner	Multilingual materials and community partnerships aim to bring in patients who

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	appeal to key groups	community health workers for outreach	organizations after early enrollment skewed toward English-speaking patients	are typically underrepresented in primary care trials
	Breadth of eligibility criteria	Set criteria to include patients with any one of several chronic disease risk factors, not a single diagnosis including Spanish and English speakers	Clarified screening thresholds for physical activity after inconsistent interpretation across sites during early enrollment	narrow enough to keep the sample clinically coherent, wide enough that findings aren't limited to a narrow patient profile
	Opt-in informed consent	Used an opt-in consent process approved by the IRB	Simplified consent language after patient feedback indicated the original version was too technical	Too technical wording risks excluding patients with lower health literacy, which would undercut representation before enrollment even begins
Effectiveness	Level of participant (Patients) engagement	Built representative engagement with text message and patient navigation into the implementation outcomes to be measured, not just effectiveness outcomes	Added a mid-study check on engagement by age and language group after early data suggested lower engagement among older patients with text message	Representative engagement asks whether the intervention actually reaches and works for the full range of enrolled subgroups, not just the average patient
	Tailoring to different subgroups	Built MOHR around a menu of risk factor options rather than addressing all identified risks at once, letting each patient prioritize and work on the risk area most relevant to them	Included additional safety messages for participants with a history of falls or injuries when considering exercise activities	Effectiveness assessed in a subgroup, specifically to ask who benefits more from personal (CHW) support versus automated support
Maintenance	Setting resources to continue the program	Planned to co-develop an implementation, adaptation, and sustainment guide with partners, based on trial findings, targeting the most cost-effective strategy	Began early conversations with health system leadership about which strategy could be absorbed into standard clinic workflow post-trial	Sustainment decisions should account for which populations each strategy actually reached during the trial, not just overall cost-effectiveness, or representation gains

				could be lost after the trial ends
	Level of follow-up support	Through partnership with the clinics and communities, identify funding resource, including integrating w		This challenge is the core research question, but the underlying justification is representation and participation: determining which support level actually reaches and retains a broad range of patients over time

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