

From “What Works?” to “What Works Here?”

RE-AIM, PRISM, and iPRISM for adaptive implementation
in diverse contexts

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Learning Objectives

1. Describe RE-AIM and PRISM, including their components and what each framework helps teams do.
2. Distinguish framework functions: outcomes, determinants, and implementation process.
3. Explain how PRISM has evolved to address context, iterative assessment and adaptation, contextual fit, and health equity through representativeness across RE-AIM dimensions.
4. Apply iPRISM from different stakeholder perspectives to identify disagreements, missing perspectives, priorities, and a feasible adaptation.

Agenda

1

Overview

RE-AIM / PRISM

How the frameworks work together

2

Health equity

Representation and context

Who participates, benefits, and has authority

3

Iterative use

Assessment and adaptation

How teams learn before, during, and after implementation

REAL WORLD IMPACTS



RE-AIM and PRISM guide users to plan, implement, evaluate, and sustain programs with contextual factors in mind, increasing equity and public health relevance.

re-aim.org
prismtool.org

RE-AIM and PRISM are an integrated framework family

They support the adoption and sustainable implementation of evidence-based interventions across health, public health, educational, community, and other settings.

RE-AIM

Population impact and
implementation outcomes

PRISM

Contextual fit, infrastructure,
and sustainability

NATIONAL RE-AIM / PRISM USER SURVEY

RE-AIM is established; PRISM needs clearer guidance

143 usable responses (12% of ~1,200 subscribers) | October 2025–January 2026

REPORTED ROLES

75%

researchers

15% clinicians

13% facilitators

RE-AIM

72%

rated useful

51% very + 21% somewhat

9% reported no prior use

0% rated it negatively

PRISM

42%

rated useful

20% very + 22% somewhat

38% reported no prior use

36% rated it neutral

Most endorsed domains

RE-AIM: Implementation 64% • Reach 64% • Adoption 58%

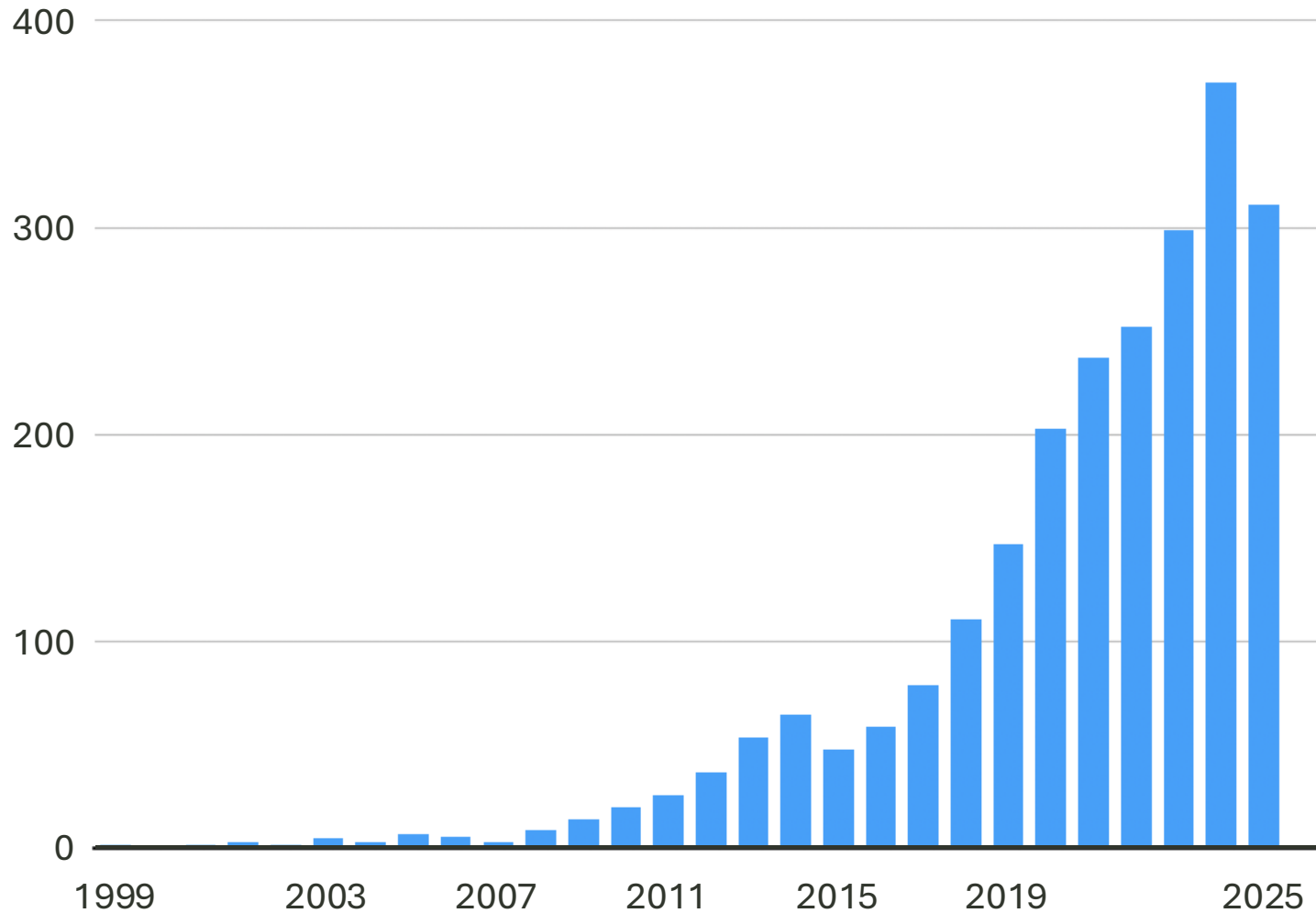
PRISM: Organizational perspective 36% • End-user perspective 33% •

Infrastructure 31%

What users need next

Challenges: complexity and measurement burden • conceptual overlap and limited clarity • limited practical guidance

Priority supports: examples and templates • measurement guidance • training • peer learning

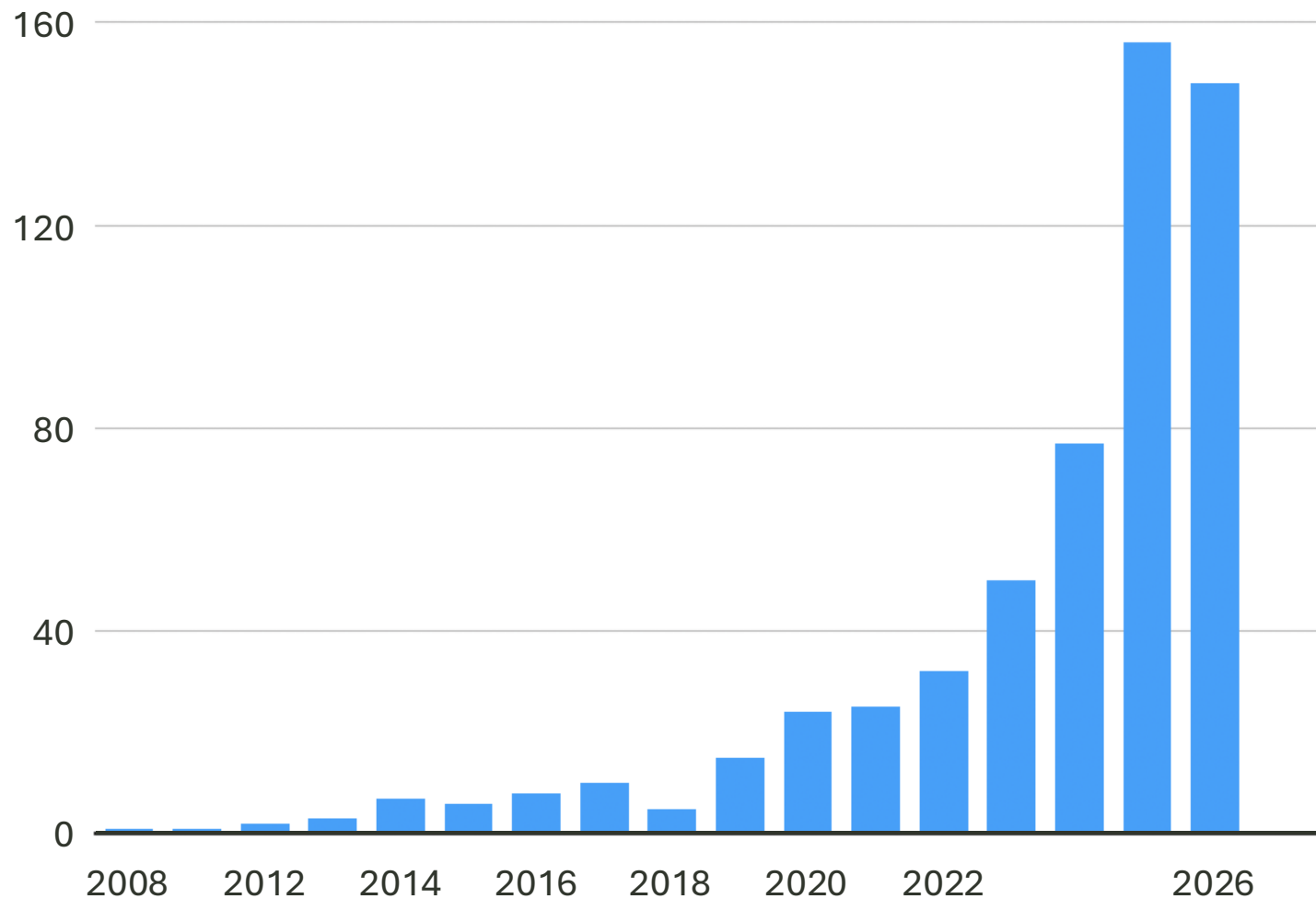


RE-AIM use over time

1999–2026

CONSORTIUM WORK

Clarify the model
Share examples
Train users
Build web tools
Connect peers



PRISM use over time

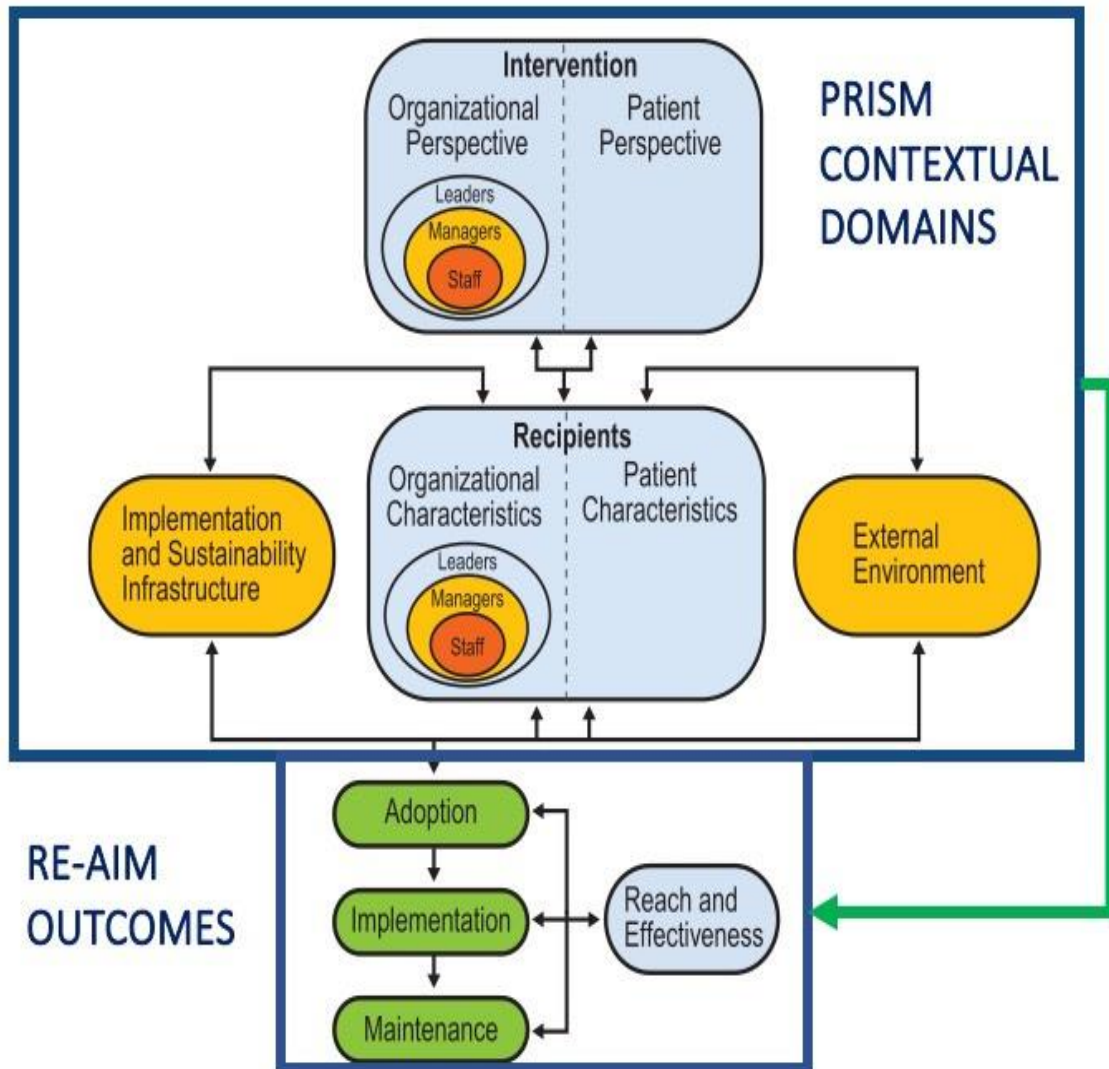
Through 2026

WHAT USERS ASK FOR

Examples + templates
Measurement
guidance
Training + peer learning
Clearer application

PRISM: Practical, Robust Implementation and Sustainability Model

Contextually expanded RE-AIM



Feldstein AC, Glasgow RE. A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice. *Jt Comm J Qual Patient Saf.* 2008 Apr;34(4):228-43.

Has been used as a:

- Determinant framework
- Process framework
- Implementation framework
- Evaluation framework

Includes constructs that can be applied to:

- Context
- Strategies
- Mechanisms of change
- Outcomes

Common Misconceptions

Table 2. RE-AIM misconceptions including misunderstanding of the original model, evolution of the model, and the current guidance

Misconception	Correct and current guidance	Potential source of confusion
Conceptual issues (what RE-AIM is and intended to be)		
RE-AIM is exclusively or primarily an evaluation framework	(1) RE-AIM has been used as a process framework to plan implementation and adaptations; (2) PRISM adds a determinants component; and (3) RE-AIM is widely used for evaluation	Misunderstanding of the original intent with some evolution to PRISM
RE-AIM only applies to two levels: individual and organizational	RE-AIM is multilevel although it may be tailored to each project but almost always includes individual, delivery staff, and setting (itself often multilevel)	The original model did not provide examples, but there was never an intent to restrict application to these two levels
RE-AIM (or Expanded RE-AIM/PRISM*) does not include contextual factors, or suggest ways to enhance outcomes	The Expanded RE-AIM/PRISM focuses on contextual factors and addresses ways to enhance RE-AIM outcomes	The model has evolved to PRISM that includes specific contextual factors
RE-AIM does not address (or clearly define/distinguish) longer term sustainment and is restricted to an arbitrary 6-month time frame	Addresses shorter and longer term sustainment (multilevel maintenance) and tailors length of assessment to program	Misunderstanding with the original model stating "at least 6 months following" program completion
RE-AIM does not include costs	Cost is specified as one of the key issues in the Implementation Outcome dimension	Costs are currently reported under Implementation; however, there are costs associated with all dimensions
RE-AIM considers fidelity as the only implementation outcome	Emphasizes both fidelity (consistency) and adaptations	Misunderstanding of original model although adaptation has evolved to be more important
RE-AIM does not account for different phases of implementation and focuses only on postintervention summative effects	Focuses on RE-AIM issues in planning, delivery, evaluation, and sustainment phases	Original model always included consideration of phases, but had not been explicitly stated; increased emphasis on use before, during, and after implementation
Methodological issues (how RE-AIM and RE-AIM dimensions are used)		
RE-AIM uses only quantitative data	Includes measures and guidance for both qualitative and quantitative assessment	Misinterpretation of the original model; qualitative has always been recommended, however, increased emphasis and guidance for use more recently
RE-AIM is static – meaning it does not address adaptations and is not used iteratively	Used for iterative assessment and guiding adaptations	Has been used informally to guide iterations, but more recently an explicit protocol for iterative use is available
RE-AIM insists on using all dimensions in every project and that all dimensions are equally important in every application	Pragmatic use emphasizes considering all dimensions but tailoring (a) which are assessed; (b) which are the intervention focus; and (c) how outcomes are weighted to be tailored to each project	Misinterpretation of the original model and evolving emphasis on pragmatic use
Use of the model issues (clarity of ways to use RE-AIM)		
RE-AIM constructs are difficult to distinguish	Specific definitions, clarifications, and examples are provided of differences among dimensions	Clarifications of model dimensions are increasingly available
RE-AIM only works for research or in large, well-funded studies	Scope and depth of use of RE-AIM for planning, iteration, and evaluation can be tailored pragmatically to fit each project	Always available for any type of project, however, more and better examples of diverse uses are now more available
Use of RE-AIM precludes use of other implementation science frameworks in the same project	RE-AIM can be combined with other TMFs** and examples of integration are provided	Use with other frameworks is increasingly encouraged

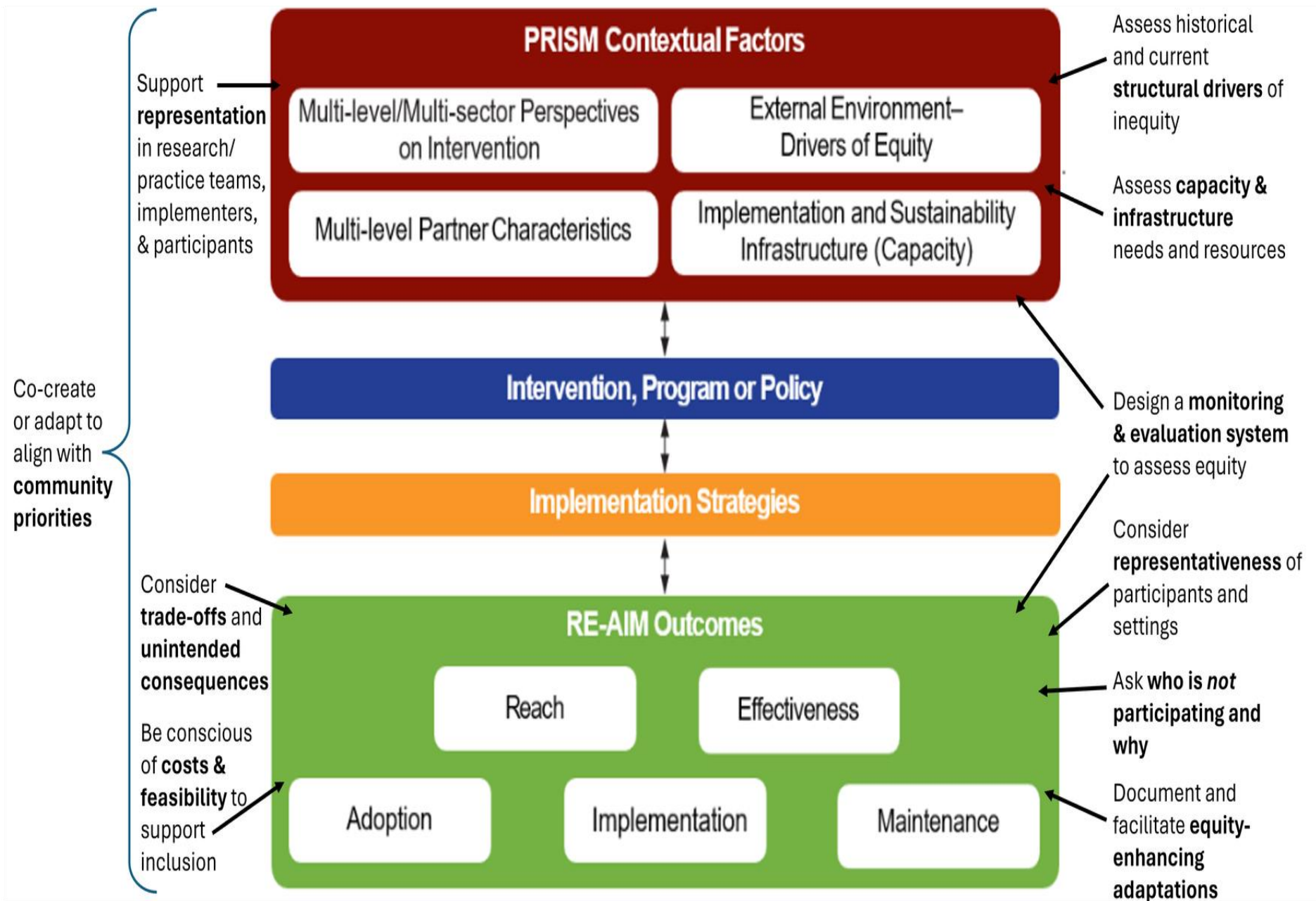
For evaluation only

For qualitative use only

Mandates all dimensions are used and equally important

Does not address context or determinants

How RE-AIM/PRISM addresses equity issues



Iterative Use: What do we mean?

Harden et al.

RE-AIM in Clinical, Community, and Corporate Settings

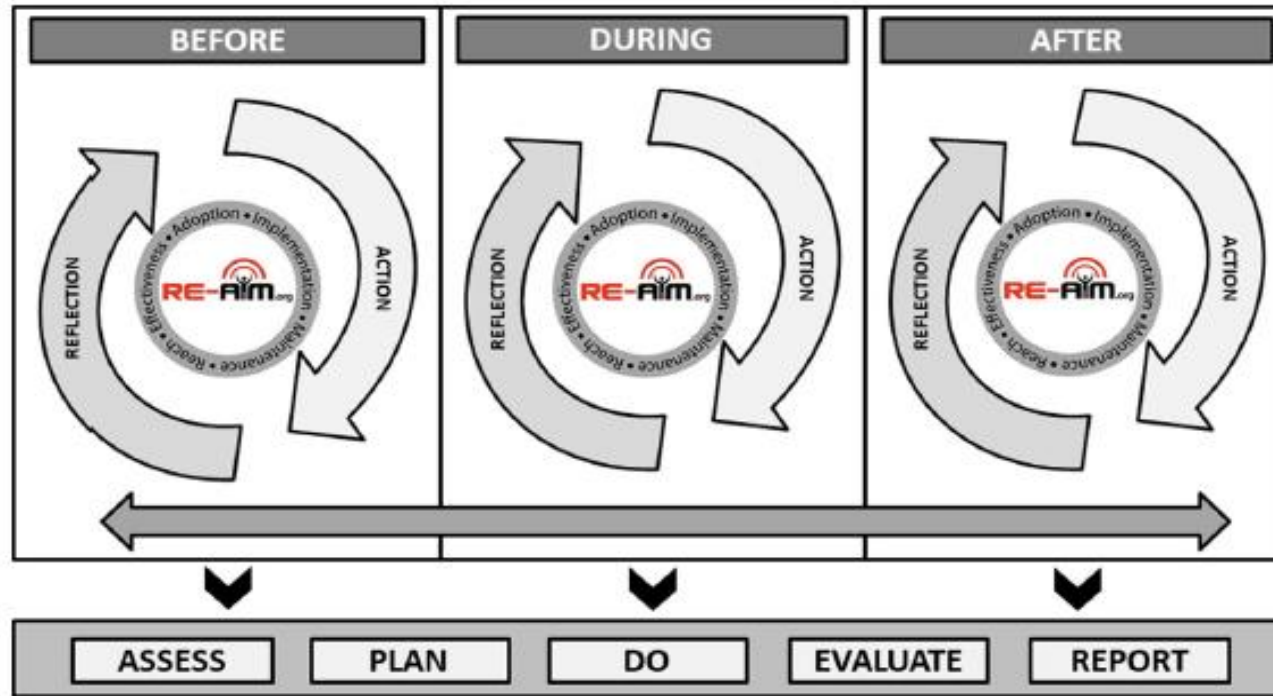


FIGURE 1 | Iterative and temporal application of the RE-AIM framework.

Harden et al. RE-AIM in Clinical, Community, and Corporate Settings: Perspectives, Strategies, and Recommendations to Enhance Public Health Impact. doi: 10.3389/fpubh.2018.00071

Systematically collecting adaptations

WHEN

Phase
Planned or
reactive

WHAT

Content, context,
training, or
strategy

WHO

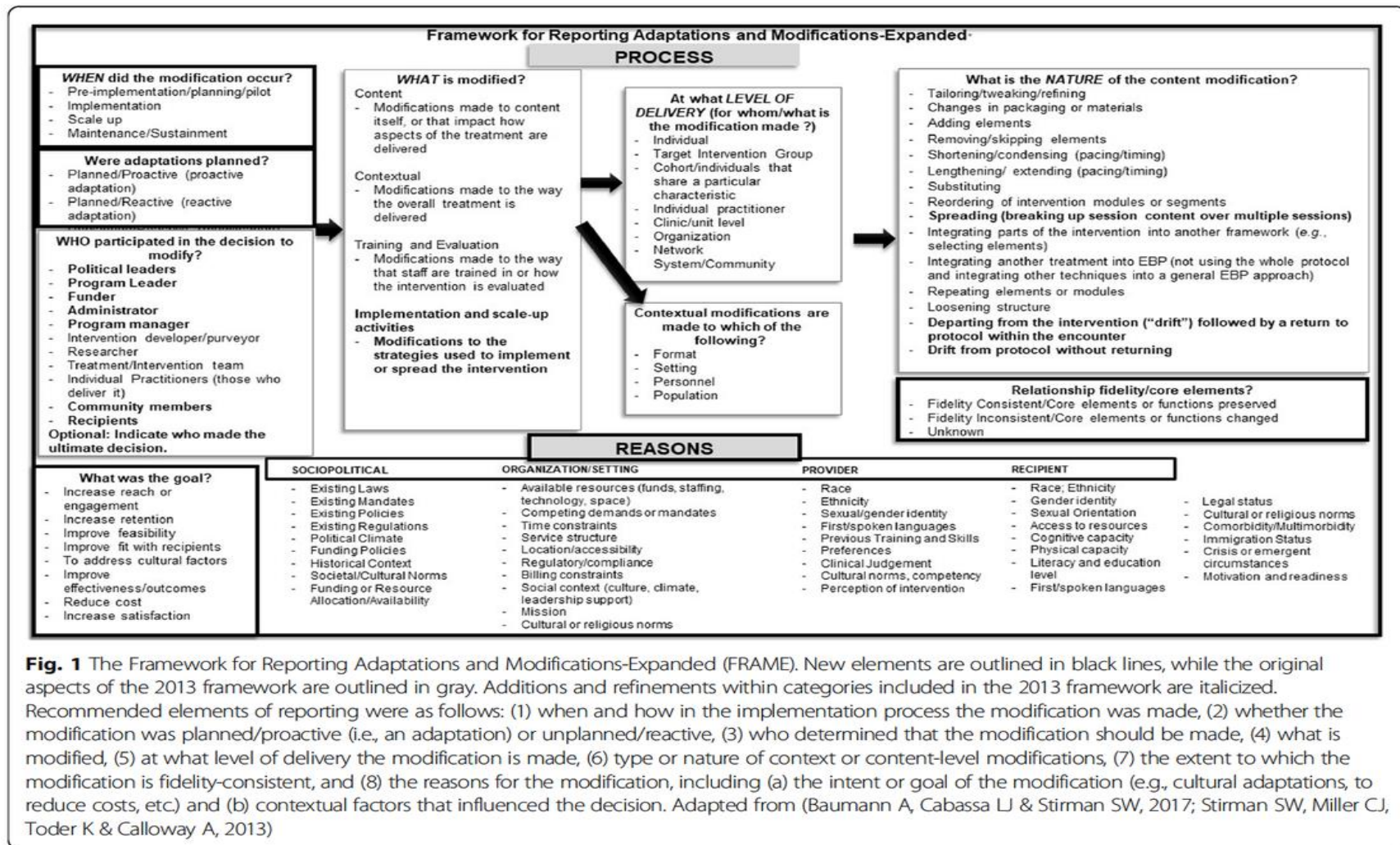
Who participated
and who decided

WHY

Goal, constraints,
and contextual
reasons

Track the adaptation, its purpose, and its relationship to fidelity and core functions.

Systematically collecting adaptations

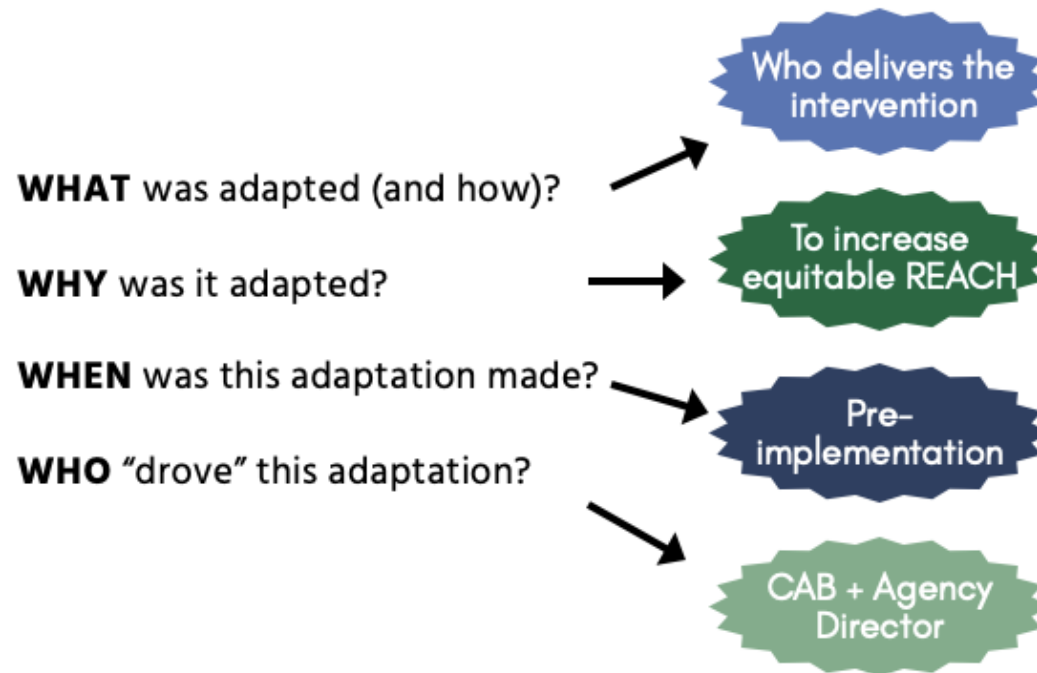


10.33097/1pub11.2010.000/1

Simplify your data collection

Types of Adaptations – Cultural; Resources; & Local: All with and driven by multi-level partners

RE-AIM and
PRISM can
**help guide
adaptations**



Rabin BA, et al. Systematic, multimethod assessment of adaptations across four diverse health systems interventions. Front Public Health. 2018;6(APR). [https:// doi.org/ 10. 3389/ FPUH. 2018. 00102](https://doi.org/10.3389/FPUH.2018.00102).

Simplify your data collection

Types of Adaptations – Cultural; Resources; & Local: All with and driven by multi-level partners

RE-AIM and
PRISM can
**help guide
adaptations**

Focus of Adaptation	Timing of Adaptation (point in the project)		
	Planning	During	Sustainment- Dissemination
Intervention			
Implementation Strategy			
Setting			

***Can include the “why”: What RE-AIM dimension was being improved?**

Rabin BA, et al. Systematic, multimethod assessment of adaptations across four diverse health systems interventions. Front Public Health. 2018;6(APR). [https:// doi.org/ 10. 3389/ FPUH. 2018. 00102](https://doi.org/10.3389/FPUH.2018.00102).



Questions?

Misconceptions

What have you heard about RE-AIM/PRISM that would prevent you from using it?

Health equity

How could you apply RE-AIM/PRISM through a health equity lens?

Iterative use

How could a framework help your team address a current change in your system?

Example : Using Iterative RE-AIM to enhance hospitalist adoption of lung ultrasound in the management of patients with COVID-19: an implementation pilot study

Maw et al PMID: 35962441

Study Objective: Rapidly implement lung ultrasound within a large hospitalist group during COVID

Initial Implementation strategies:

Lung ultrasound training

Iterative PRISM process

RE-AIM Dashboard

Methods

- **Study Design:** Mixed Methods Implementation Pilot Study
- **PRISM** was our guiding Framework
 - **Study outcomes:** *Reach, Adoption, Implementation*
 - **Contextual domains of PRISM** used to guide qualitative interviews of hospitalists aimed at characterizing dynamic implementation barriers

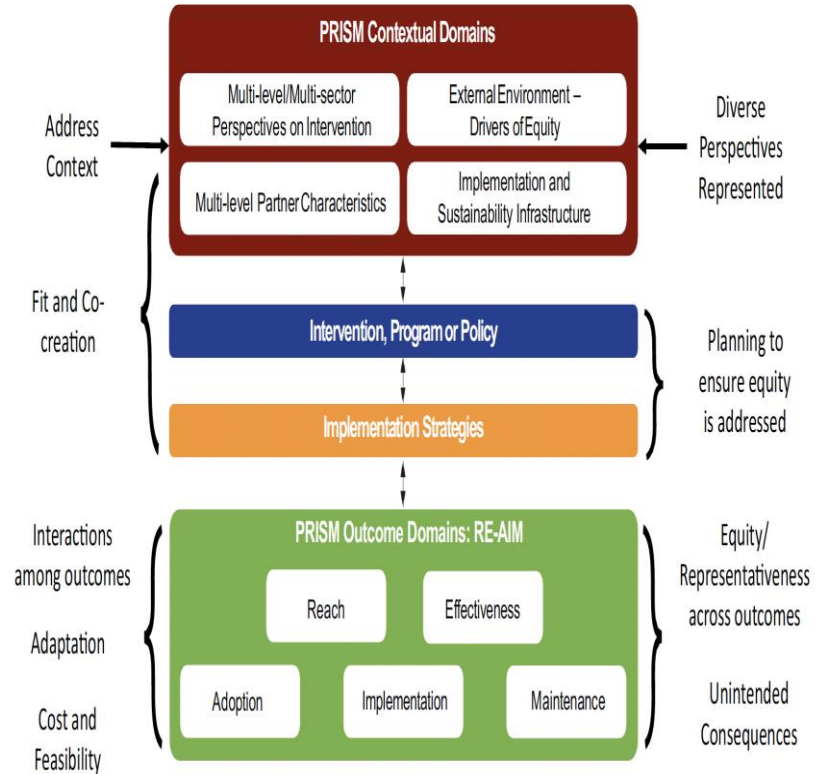
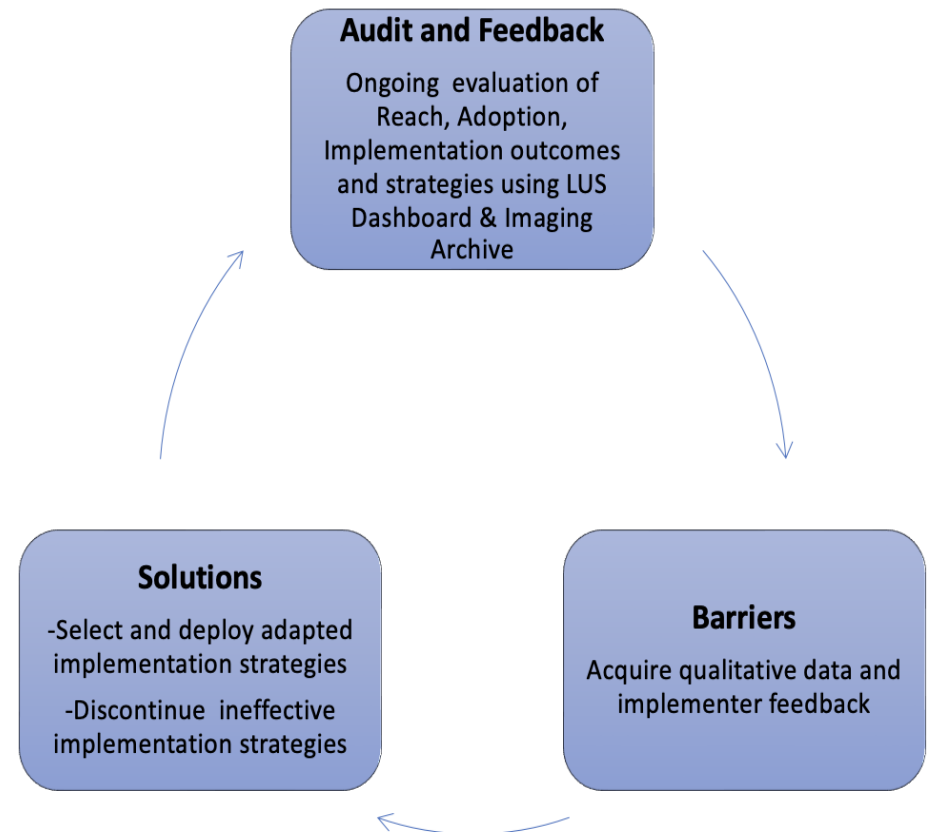


Figure 1 How the Practical Robust Implementation Sustainability Model (PRISM) facilitates equitable implementation of health interventions.

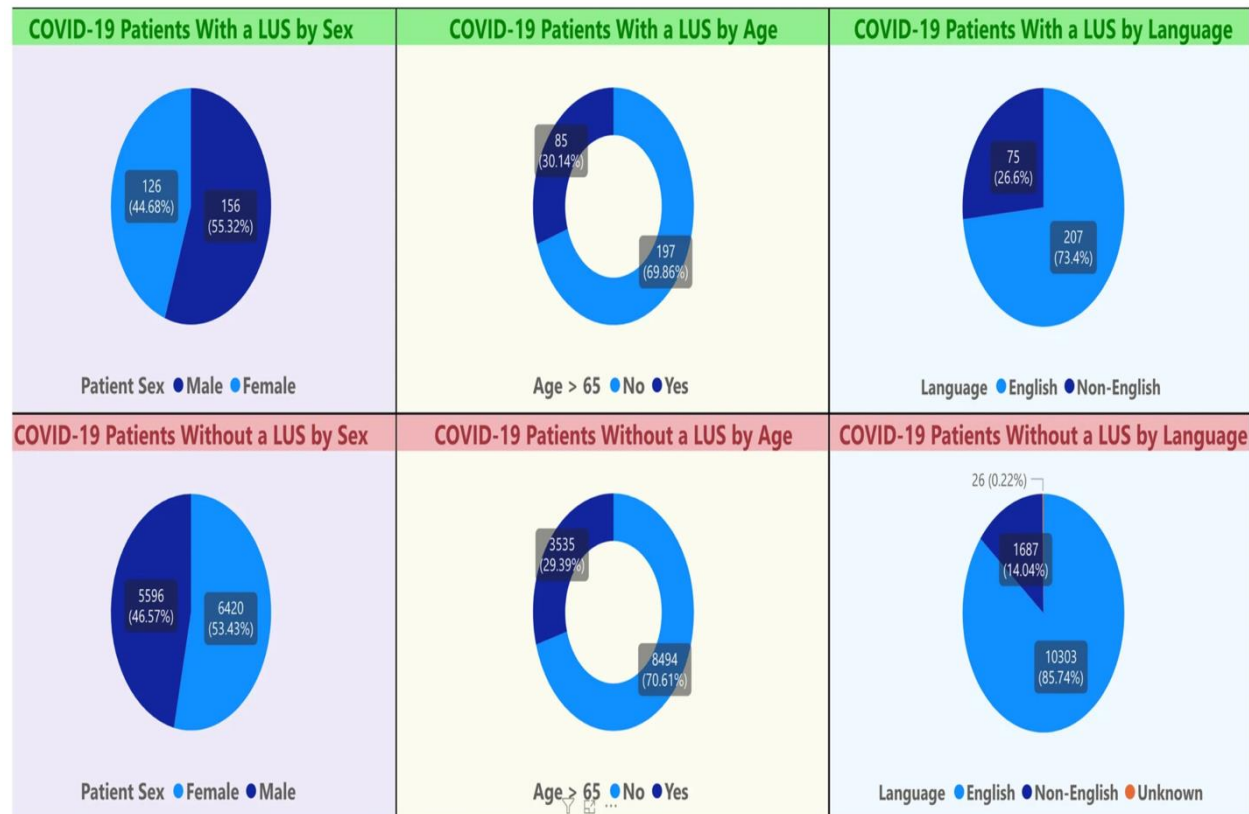
I-PRISM Process

- Implementation Team: four LUS hospitalist faculty
- Met every 2 weeks
- Reviewed RE-AIM Dashboard data to screen for barriers to Adoption and Reach (prioritized implementation outcomes)
- Reviewed interview data acquired to identify and characterize barriers
- Select adaptations in implementation strategies in response to this qualitative and quantitative data



RE-AIM Dashboard

- Quantitative data on **Reach** and **Adoption** extracted from the EHR via an external Power BI dashboard
- Displayed the number and demographics of Clinicians finalizing and ordering the LUS
- Representativeness of patients in which LUS were ordered
- Data automatically updated every 48 hours
- Low burden way to monitor progress of implementation and representativeness



Using Large Language Models to identify social determinants of health to enhance healthcare services and health equity

- PI: Foster Goss, DO, MMSc, FACEP, *University of Colorado*
- MPI: Li Zhou, MD, PhD, *Harvard Medical School*
- Study to be performed at University of Colorado Hospital

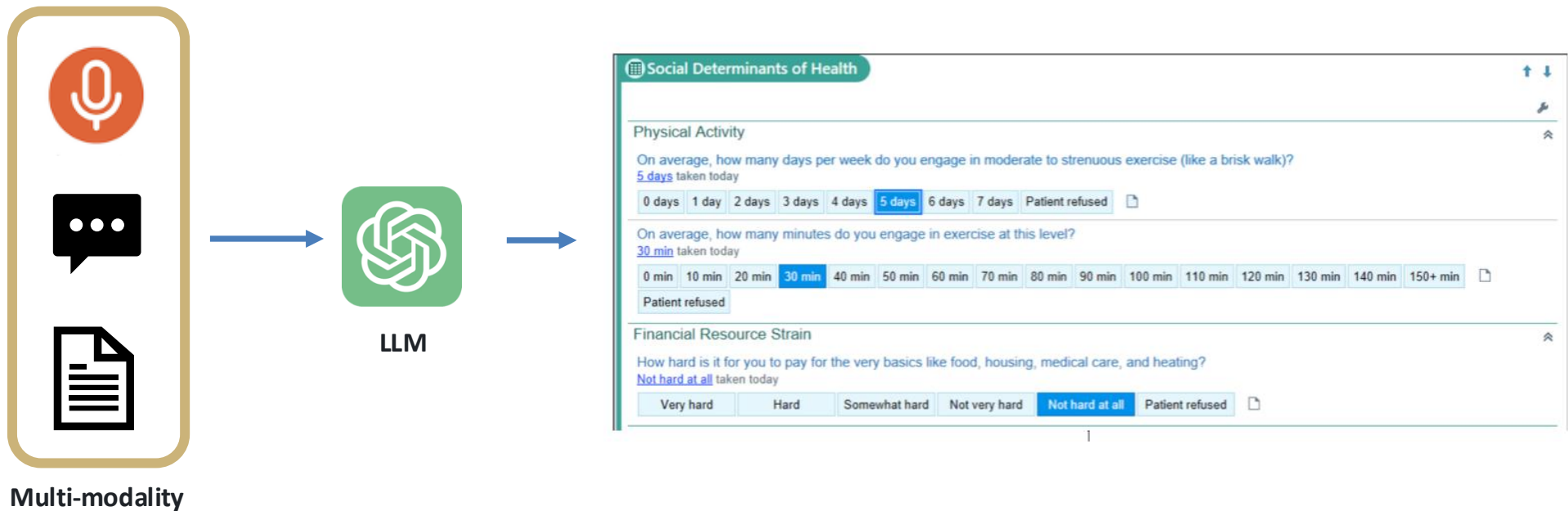
Importance of SDoH data

- SDoH responsible for 50% of health outcomes¹
- There are currently multi-level barriers to SDoH data collection and use: time constraints of clinicians and staff; SDoH data “trapped in text”.²
- **Important Gap:** Access to complete and high quality SDoH data for use at the point of care or for quality improvement at the system level ²
- Without these data we can't robustly evaluate for disparities in care

¹Tucker-Seeley et al 2024

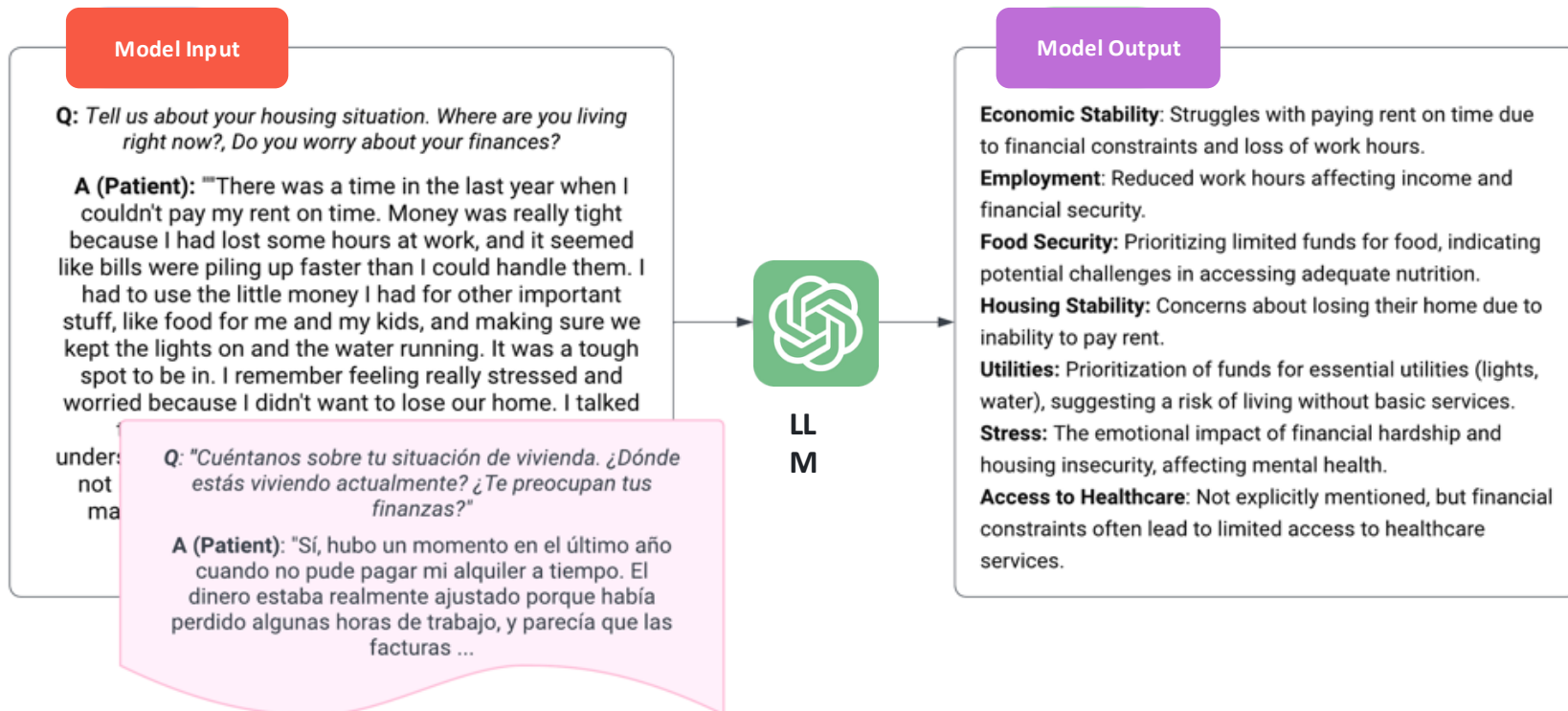
²Kepper et al. Health Serv Res. 2023

Capturing SDoH Data in the EHR using LLMs



Figures created by Foster Goss, DO, MSSc

Patients can offer their Social Needs Narrative in their native language

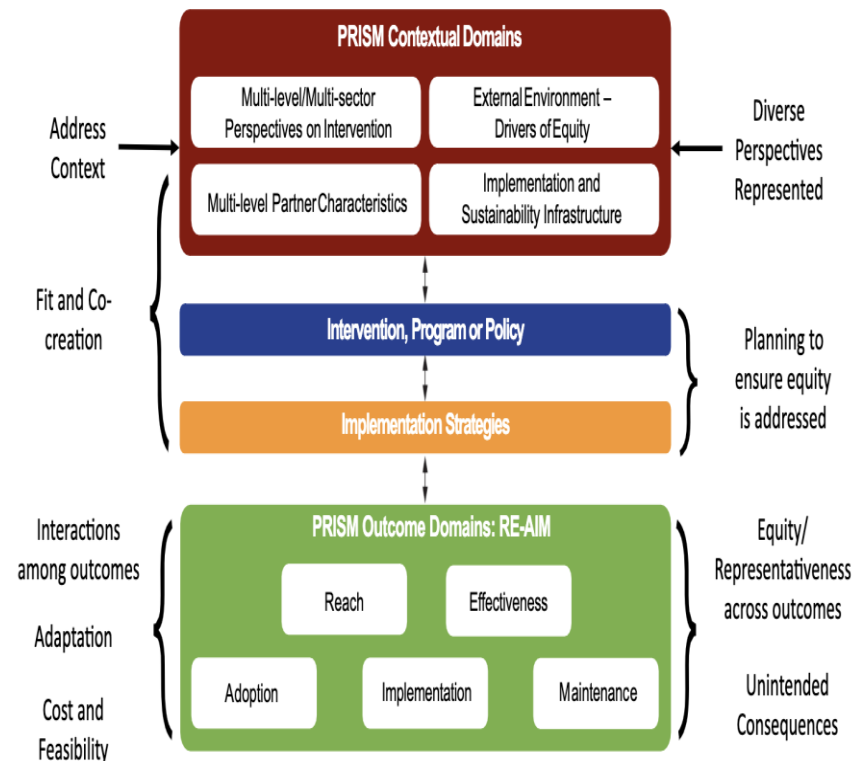


Figures created by Foster Goss, DO, MSSc

Iterative PRISM Evaluation will Focus on Health Equity

- Embedded Pragmatic RCT
- Iteratively measure context and
- RE-AIM outcomes
- Deploy Implementation Strategies adapted to *current* qualitative and quantitative data

Figure from: Maw AM, Trinkley KE, Glasgow RE. J Gen Intern Med. 2024



Iterative RE-AIM outcomes with a focus on representativeness

Iteratively measure representativeness of Reach, Effectiveness and Fidelity to screen to disparities in implementation delivery, effectiveness

RE-AIM Outcomes and Measures	
Domain	Measures
Reach	% Eligible patients who received the intervention; Qualitative interviews to access for barriers to Reach Representativeness: Age, sex, ethnicity, language spoken, housing status, insurance status
Effectiveness	1° outcome: # of return ED visits 2° outcomes: # of referrals, # of Z-codes documented; # evaluations by HTT team; qualitative interviews to screen for unintended consequences Representativeness: Age, sex, ethnicity, language spoken, housing status, insurance status
Adoption	% of social workers who acted on SDOH consult orders 100% of the time
Implementation	Fidelity: % of times all core intervention components were successfully implemented Representativeness: Age, sex, ethnicity, language spoken, housing status, insurance status *Was accuracy of SDOH data recorded as accurate for English speakers as for non-English speakers
Maintenance	Qualitative surveys from operations leaders, social workers, and clinicians.

Implementation and Evaluation of an Ambient AI Scribe to Reduce Clinician Burnout: A Pragmatic Mixed Methods Randomized Trial



uchealth



Led by Dr. Katy Trinkley

Objective & Design

OBJECTIVE

- Evaluate the implementation and effectiveness of ambient AI scribes in routine clinical practice

PRIMARY OUTCOMES

- Time in notes per appointment (Epic audit-log)
- Emotional exhaustion (Maslach subscale)
- Depersonalization (Maslach subscale)

DESIGN

- **Guided by PRISM**
- Pragmatic, embedded RCT
- Mixed methods
- Waitlist (crossover) design
- Clinician-level randomization
- Intention-to-treat analysis
- 43 ambulatory clinics: primary care, medical specialty, surgical

Representativeness of Reach

Reach	N = 57,814 / 85,268 (67.8%) ¹
Hispanic/Latino	6,116 / 9,128 (67.0%)
Asian	2,411 / 3,507 (68.7%)
Other/Multiple	1,767 / 2,651 (66.7%)
Missing	1,271 / 1,899 (66.9%)
Language Preference	
English	55,807 / 82,013 (68.0%)
Spanish	897 / 1,527 (58.7%)
Other	1,110 / 1,728 (64.2%)
Social Vulnerability Index³⁰	
Quartile 1	6,121 / 9,006 (68.0%)
Quartile 2	24,325 / 35,518 (68.5%)
Quartile 3	13,485 / 20,040 (67.3%)
Quartile 4	13,558 / 20,193 (67.1%)
Missing	325 / 511 (63.6%)
Visit Type	
In-person	49,815 / 72,002 (69.2%)
Virtual/Telehealth	7,999 / 13,266 (60.3%)

¹ n Abridge notes finalized for eligible encounters / n Abridge eligible Visits (%)

Mixed Methods: essential to for capturing context and achieving contextual fit across diverse clinical settings and intervention optimization

What: PCP adoption > Specialty adoption

Why: “For patients going to surgery...you have to include all those fine details...Abridge doesn’t get that.”

Why: “I believe the format of the note is made for PCP encounters. It does not follow the format of a note typically done by surgeons.”

Contextual domains of PRISM facilitate measuring unintended consequences of an intervention

Abridge didn't simply reduce cognitive work but it instead changes it:

- “My main issue was not being able to remember seeing the patient when I used Abridge versus writing my own notes. This was pretty bothersome to me mentally and emotionally. It also became more time consuming in trying to interpret lab results and answering questions the patient or staff may have had.”
- “I also have a substantially easier time remembering the encounter when I have written the note myself when it comes to reviewing labs and other studies. I could not recall the visit at all when it was a note I had used Abridge for documenting. This made me uncomfortable in carrying on with its use, as my practice is heavily weighted in adjusting therapy on labs.”

Questions?

For further exploration into PRISM/RE-AIM
please visit: <https://re-aim.org/resources-and-tools/>

What to expect in iPRISM

1

OPEN

Open the shared
program

2

ROLE

Use your assigned
perspective

3

RATE + EXPLAIN

Rate the items and
add comments

4

COMPARE

Submit; view live
group patterns

iPRISM lab: see the same program through different roles

YOUR ROLE

Patient / community member
Clinician / implementer
Health educator / support role
System leader / decision-maker

Multiple people may share a role.
Rate and explain from that
perspective.

GROUP OUTPUT

- 1 · Largest disagreement
- 2 · Contextual explanation
- 3 · One priority
- 4 · One feasible adaptation
- 5 · Owner + next signal + reassessment point

Team Code: PTJ50787

Debrief the disagreement—not the average

Variation across roles is information about context, fit, and power.

What changed when every role could see the problem?

DIAGNOSE — Where did roles disagree most?

INTERPRET — What context or power difference explains it?

CHECK — Whose perspective is still missing?

DECIDE — Which one or two priorities deserve action?

COMMIT — What changes, who owns it, and when do we reassess?

Closing question: what would your team do differently after seeing the problem through every role?