What is ACCORDS?

Adult and Child Center for Outcomes Research and Delivery Science

ACCORDS is a ‘one-stop shop’ for pragmatic research:

- A multi-disciplinary, collaborative research environment to catalyze innovative and impactful research
- Strong methodological cores and programs, led by national experts
- Consultations & team-building for grant proposals
- Mentorship, training & support for junior faculty
- Extensive educational offerings, both locally and nationally

ACCORDS Upcoming Events – mark your calendars!

April 8-9, 2026	D&I Science for Researchers Workshop *Applications are open!*
April 24, 2026	ACCORDS & CCTSI Community Engagement Forum
May 20-21, 2026	Colorado Pragmatic Research in Health Conference *Pragmatic Research: Methods, Tools, and Technology for Rapidly Changing Contexts* Registration is live! Visit coprhcon.com for more info. ***New to COPRH Con*** Pre-conference workshops: • Pragmatic Research Planning • Planning for a Competitive Career Development Award: A Roadmap for Health Services Researchers • Mixed Methods Design & Integration Training for Health Services Research • Design for Innovation: Practical Use of User-Centered Design • AI Essentials for Health Services Researchers: Balancing Increased Productivity with Responsible Use • Elevating Research Project Management Practice • Dissemination in the Age of AI: Design Tools at Your Fingertip

ACCORDS Fellowship Opportunities

Scholars in Clinical Outcomes Research (SCORE)

- The Scholars in Clinical Outcomes Research (SCORE) Fellowship at ACCORDS is currently recruiting for the July 2026 cohort.
- Fellowship designed for junior and mid-career faculty at the University of Colorado Anschutz or affiliate institution with goal of translational or outcomes research
- Two-year program consists of weekly didactic training, weekly work-in-progress sessions, 1:1 mentoring, and intensive grant writing course
- Pilot awards available for competitive applicants
- Applicants must have support of home department/division; at least 50% protected time, and tuition support for program costs
- **Applications due March 15th, 2026!**

ACCORDS Primary Care Research Fellowship

- Goal: Train post-doctoral professionals to become primary care research leaders
- Nationally renowned training in Implementation Science
- Fellows receive funds for pilot project support, tuition, travel for conferences and a standard NIH-level T32 stipend (options to negotiate for additional salary support
- Expert support for fellows from ACCORDS cores, including: Biostatistics, Health Economics, Implementation Science, Qualitative/Mixed Methods, and Shared Decision Making
- Apply tuition toward an advanced degree tailored to your background (Master's Degree and/or Graduate Certificate in Implementation Science)
- **Applications open and reviewed on a rolling basis!**

ACCORDS Highlights: Fellowship Edition

Building Impactful Health Services Research Careers

Emily Dunston, PhD, MS
Postdoctoral Research Fellow,
University of Colorado, Division of
Internal Medicine

Megan Abbott, MD
Assistant Professor, Pediatric Epilepsy,
University of Colorado, Department of
Pediatrics, Division of Neurology

Beginning with the end in mind: An iterative prototyping of a cancer rehabilitation and exercise referral process in primary care

Emily R. Dunston, PhD, M.S.

Department of General Internal Medicine

University of Colorado Anschutz Medical Campus

University of Colorado
Anschutz Medical Campus

Disclosures

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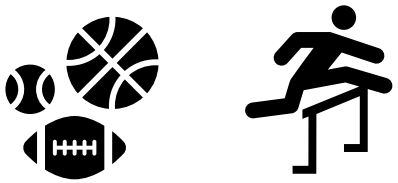
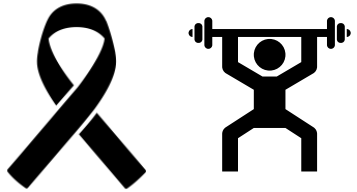
Primary Care Research Fellowship



Sports Science

Undergraduate & Masters Training

I want to help everyone benefit from physical activity



Exercise Oncology

Doctoral Training

These programs really help people, but reach is very limited

Primary Care Research Implementation Science

Postdoctoral Training

Cancer Survivorship Care

Table. Possible Late or Long-Term Side Effects of Cancer Treatment

Chemotherapy	Radiation	Surgery
Bone and joint problems	Bone growth issues (in children)	Chronic pain
Dental problems	Cavities and tooth decay	Lymphedema
Digestion issues	Cognitive challenges	Phantom pain
Early menopause	Digestion issues	Scarring
Fatigue	Dry mouth	**Hormone Therapy**
Hearing loss	Early menopause	Blood clots
Heart problems	Fatigue	Hot flashes
Infertility	Heart and vascular problems	Menopausal symptoms
Kidney and urinary problems	Hypothyroidism	Osteoporosis
Liver damage	Infertility	Risk of other cancers
Loss of taste	Intestinal problems	Sexual side effects
Lung disease	Lung disease	**Immunotherapy**
Nerve damage (neuropathy)	Lymphedema	Late effects unknown yet
Osteoporosis	Memory problems	**Targeted Therapy**
Reduced lung capacity	Osteoporosis	Late effects unknown yet
Risk of other cancers	Permanent hair loss	
Secondary cancers	Risk of stroke	
	Secondary cancers	
	Skin sensitivity	
	Thyroid/adrenal gland problems	

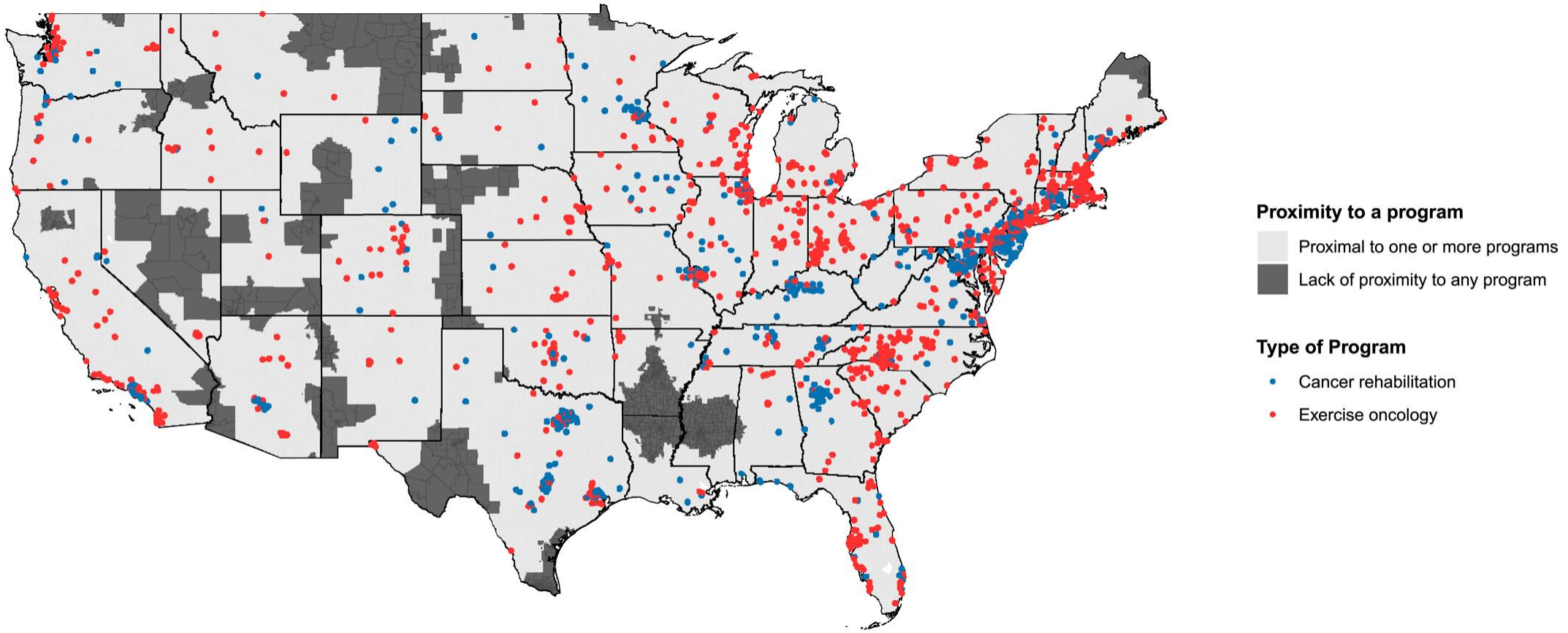
Meeting physical activity guidelines can attenuate cancer treatment related side-effects

66% of all cancer survivors are aged 65 years and older

Campbell et al., MSSE, 2019; Xierali et al., J Am Board Fam Med, 2022; Pollack et al., Cancer, 2009

Cancer Rehab and Exercise Services

Over 2,000 CaRES Across the United States



Benefits of CaRES

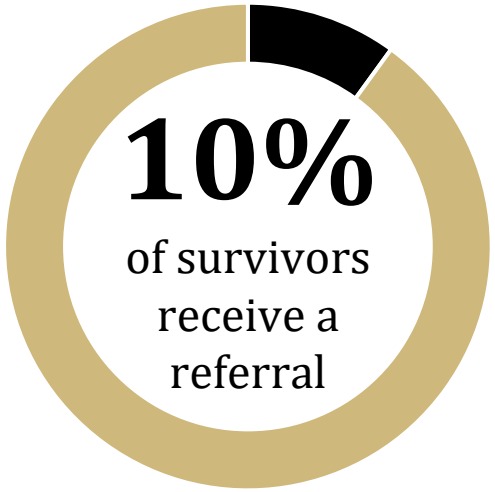
Outcome	Evidence Level	
	All Survivors	Survivors ≥ 65 years
↑ **Physical Function**	Systematic reviews across many cancer types	Two RCTs and two feasibility studies
↑ **Quality of Life**	Systematic reviews across many cancer types	One systematic review and several RCTs
↓ **Fatigue**	Systematic reviews primarily in breast and prostate cancers	Two systematic reviews and several RCTs
↓ **Anxiety**	Systematic reviews primarily in breast and prostate cancers	Insufficient evidence
↓ **Depression**	Systematic reviews across 4 cancer types	Insufficient evidence

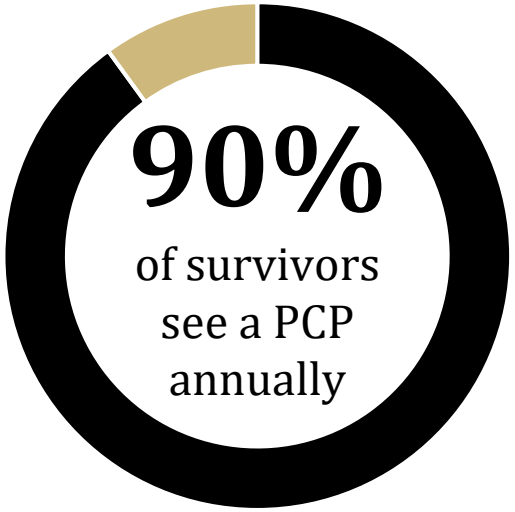
Adeline et al., J Geriatr Oncol, 2020; Bourke et al., Eur Urol, 2014; Campbell et al., MSSE, 2019; Dittus et al., Support Care Cancer, 2020; Forbes et al., J Cancer Surviv, 2020; Luctkar-Flude et al., Cancer Nurs, 2007; Winters-Stone et al., J Geriatr Oncol, 2022

CaRES Referrals

Limited awareness of and access to CaRES

Referral from a healthcare provider is a key facilitator to CaRES engagement





Efforts to improve CaRES referrals have been limited to the oncology settings

Aims

Aim 1: Explore perspectives and characteristics of three key groups that are involved in referral of older cancer survivors to CaRES from primary care:

1) Older cancer survivors

2) Primary Care Providers

3) CaRES program directors

Aim 2: Iteratively refine a prototype of a CaRES referral workflow tailored to older adults for use in primary care clinics

Conceptual Model

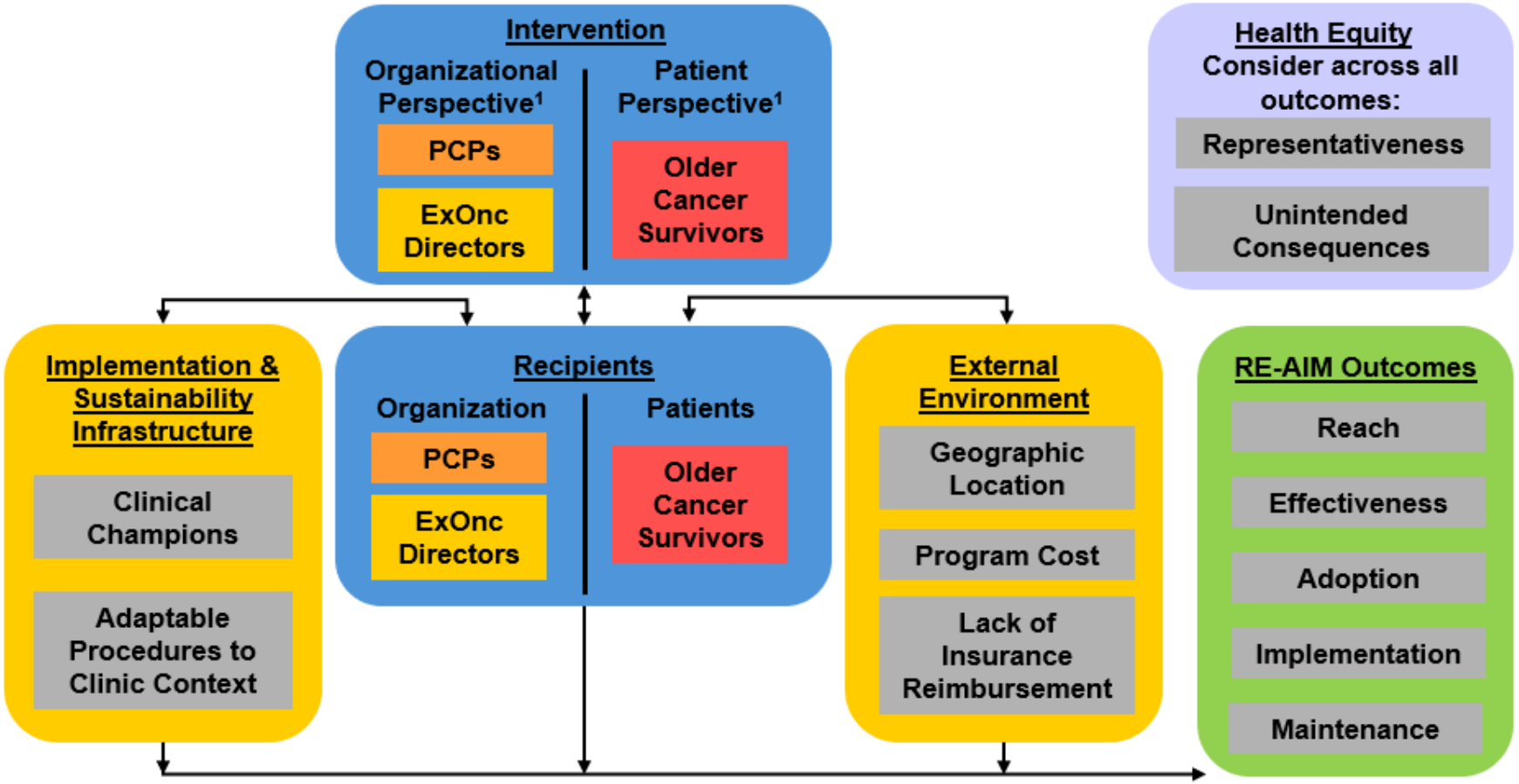


Figure 1. Conceptualization of the Practical, Robust Implementation Sustainability Framework
Note: PCPs = primary care providers; ExOnc Directors = Exercise Oncology Program Directors;

Target Populations and Recruitment

Purposive sampling was used to recruit interview participants

	Older Cancer Survivors	Primary Care Providers	CaRES Directors
Description	Adults ≥ 65 years who have received a cancer diagnosis	Physicians who care for older adults in their primary care practice	Individuals who director or manage cancer-specific exercise programs
Role	Agree to referral and attend program	Place referral to exercise program	Receive referral and enroll participant

In-depth Individual Interviews

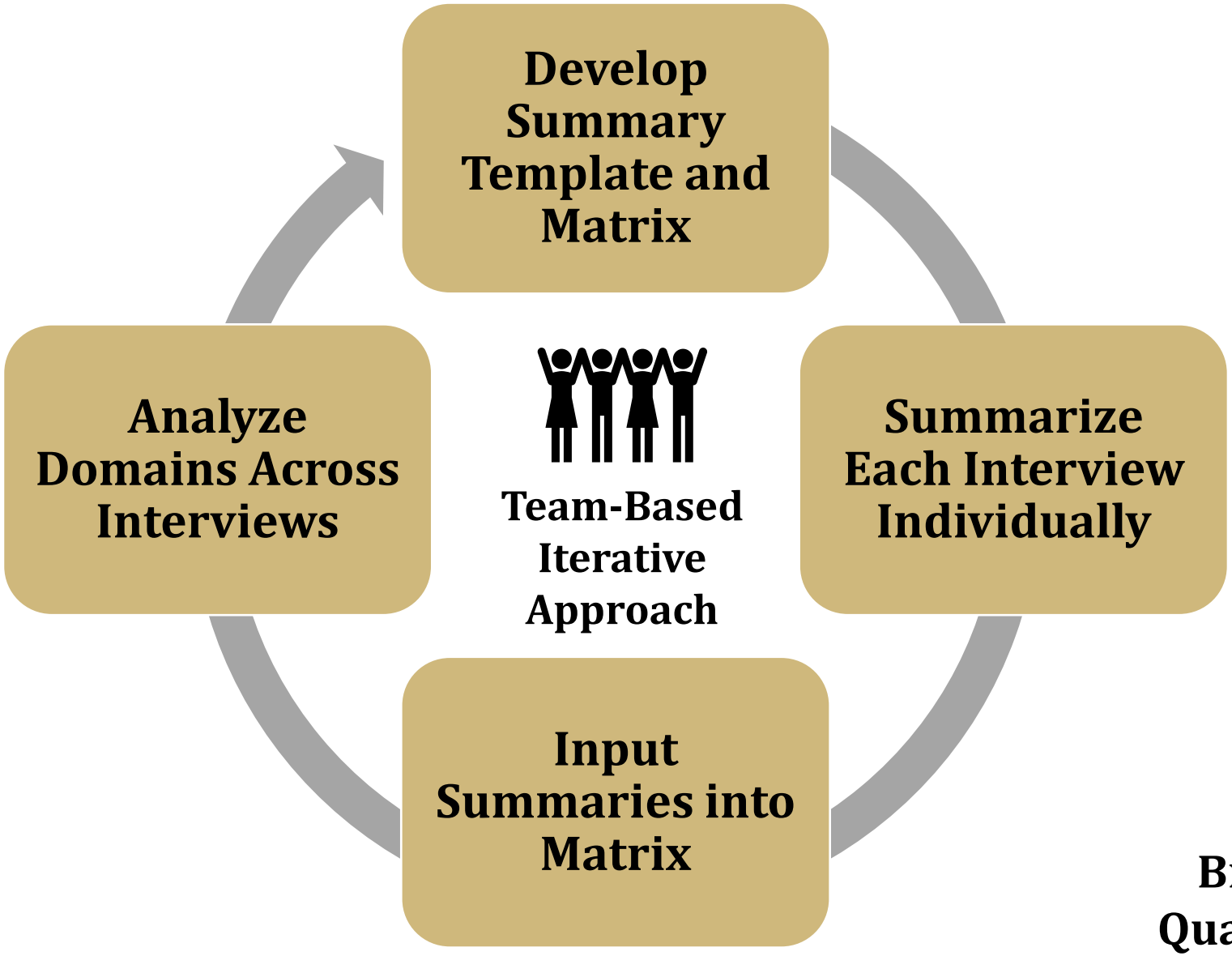
Semi-structured interview guides were used to elicit perspectives and feedback on a referral workflow

Interviews were ≤60 minutes

zoom

Recorded, transcribed verbatim, and de-identified prior to analysis

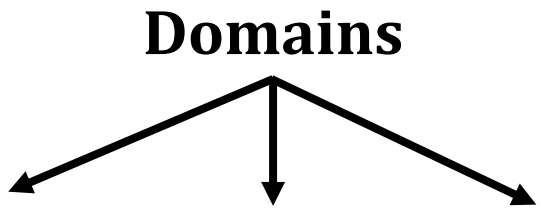
Analysis



Ashely Dafoe, MA
Qualitative Analyst

Brooke Holliman, PhD
Qualitative Methodologist

Example Matrix



Participant ID	Current Referral Processes	Potential PCP referrals	Determining Patient Eligibility
PCP0			
Director1			
Patient2			
PCP3			

Demographics

Cancer Survivors (n=5)

Age Range:
65 – 80 years

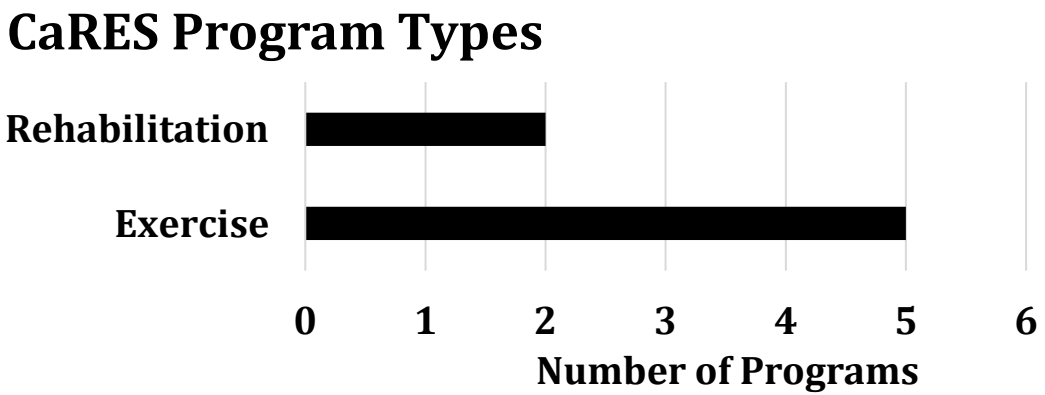
Cancer Types:
- Breast Cancer
- Colon Cancer
- Bladder
- Cardiac

Primary Care Providers (n=6)

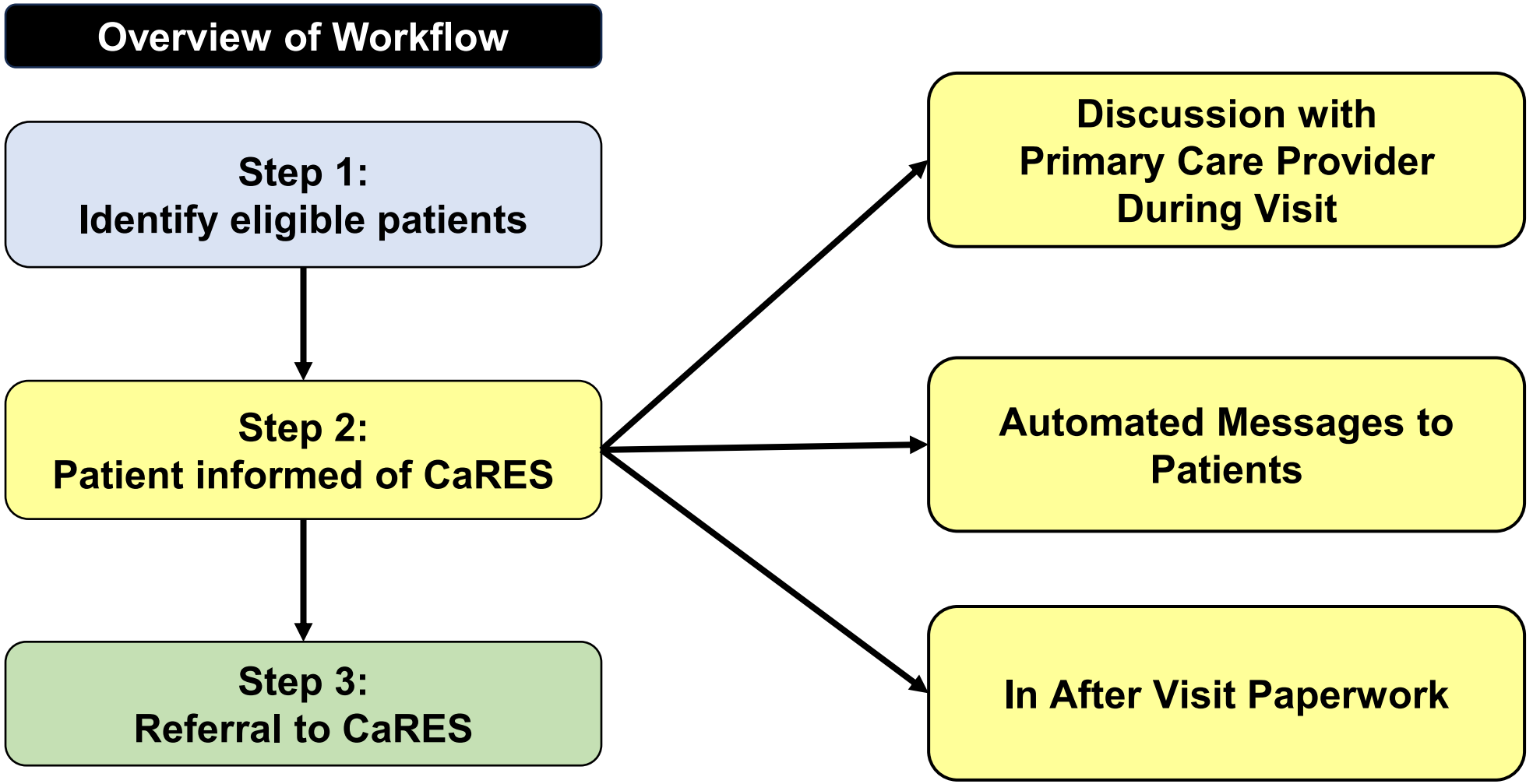
Clinic Types:
- General Internal Medicine
- Family Medicine
- Geriatrics

Time Practicing as a PCP:
Average: 14.2 Years
Range: 7 – 28 years

CaRES Directors (n=7)



Initial CaRES Referral Workflow



Educating PCPs about CaRES

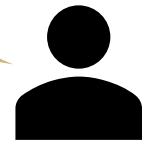
- PCPs and patients were not aware of CaRES programs
- Initial education about CaRES for PCPs is needed
  - What are CaRES?
  - What are the benefits of CaRES?
  - Who is a good fit for CaRES?
- Education should be delivered through existing clinical communication channels
  - Clinic-wide meetings
  - Emails from clinic directors

"First of all, you'd have to make sure that providers are aware of it... I wasn't aware of it. I was aware probably there was something, but it's not honestly on my radar to tell you the truth." (PCP 3)

Identifying Eligible Patients

- Information about cancer diagnoses are not always readily available in the EHR, especially for patient whose cancer care was in a different health system
- Eligibility process needs to be adapted to each clinics' workflow
- Patients wanted to be involved in considering their eligibility and readiness to participate

"I'd rather have a visit and talk to somebody than fill out a form…. Just because a question might pop into my head, and the questionnaire isn't gonna answer it." (Patient 7)



Informing Patients of CaRES

- Directors, PCPs, and patients all highlighted the importance of a conversation during a visit
  - Personal connection
  - Opportunity to ask questions
- Both Directors and PCPs expressed that a resource with CaRES information would be beneficial
- A follow-up message after the visit may be a helpful reminder for patients

> “my program, it's all about relationship building. With being able to add the primary care provider in person, being able to talk to them and understand like, "Hey, I saw you were diagnosed with this," it's a little bit more personal,” (Director 10)

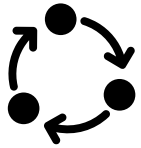
Referral

- Current referrals to CaRES rely heavily on word of mouth
- PCPs and Directors felt both provider and self-referral options should be offered
  - Patients were concerned that they might not follow through on self-referrals
- PCPs preferred to place referrals in the electronic health record
  - May be challenging for community-based exercise programs

"I know that some individuals in speaking with their provider might not be ready in that moment, so being able to self-refer down the road or down the line, I think is valuable." (Director 1)

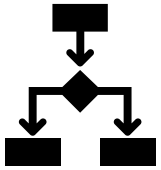
Round 1 Conclusions

Overall, CaRES referrals from primary care were acceptable across all three groups



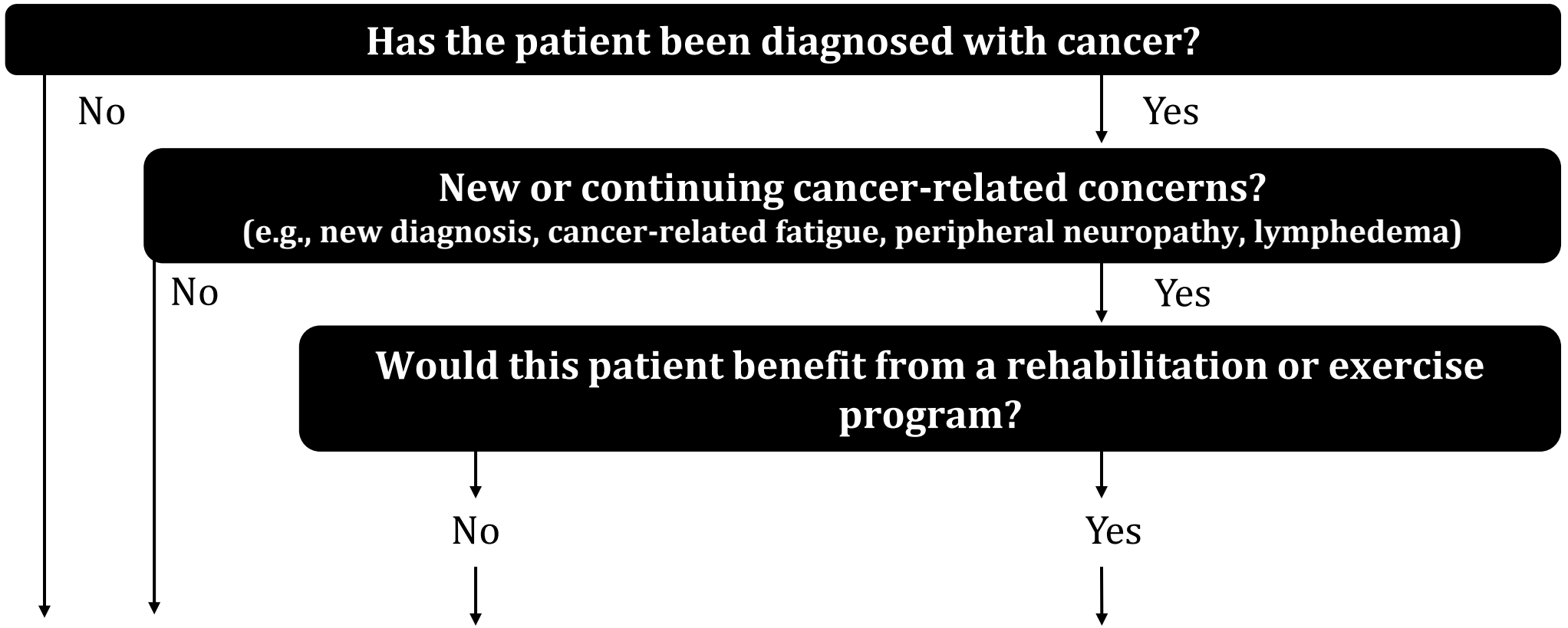
However, PCPs already do so much the process must be seamlessly integrated to be feasible

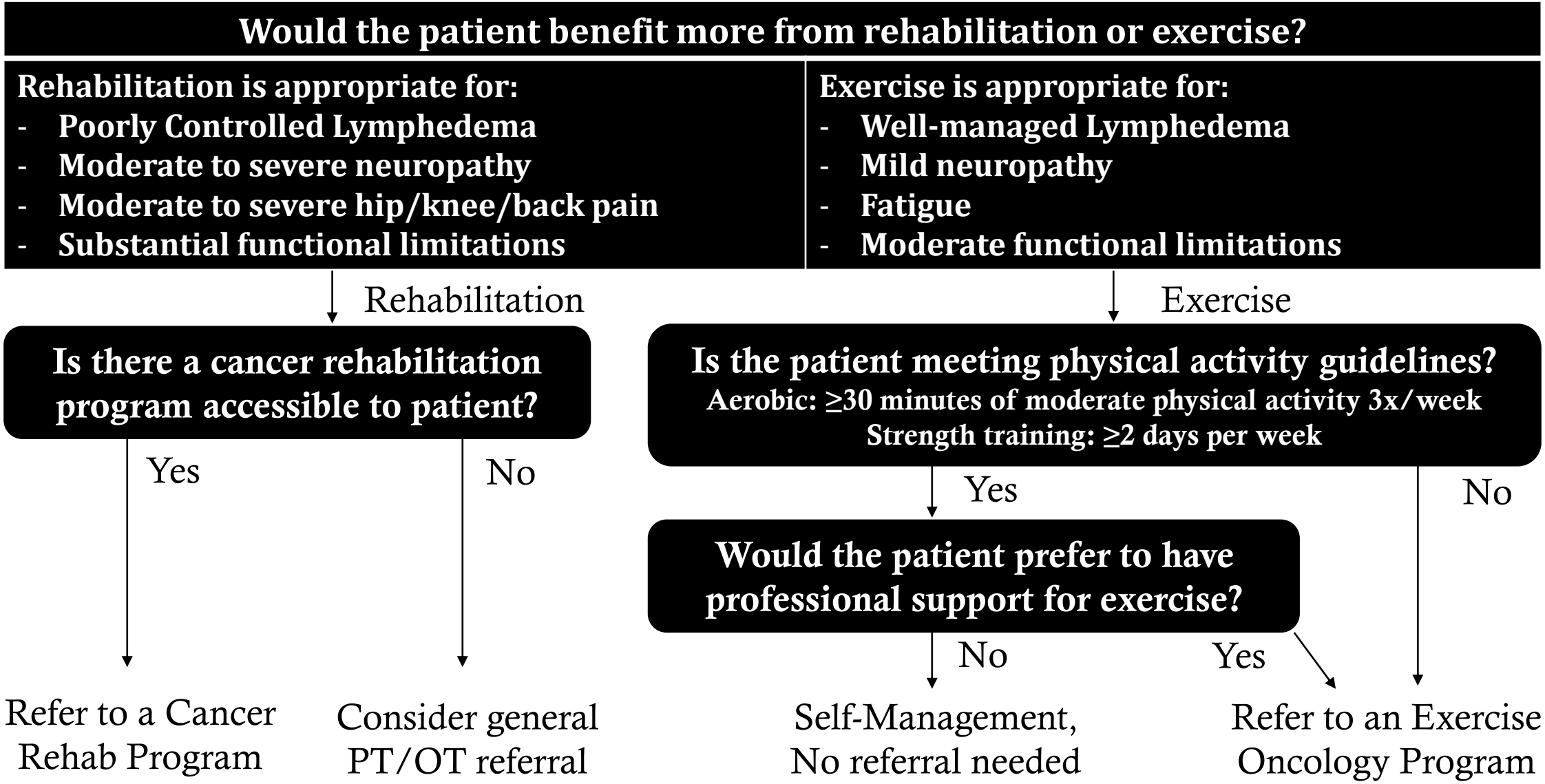
Promoting awareness about CaRES and leveraging existing referral processes will be critical to implementation success



A clinical decision support tool is needed to help PCPs and patients navigate CaRES referral together

Clinical Decision Support Tool




Would the patient benefit more from rehabilitation or exercise?
Rehabilitation is appropriate for:
- Poorly Controlled Lymphedema
- Moderate to severe neuropathy
- Moderate to severe hip/knee/back pain
- Substantial functional limitations
Exercise is appropriate for:
- Well-managed Lymphedema
- Mild neuropathy
- Fatigue
- Moderate functional limitations
Rehabilitation
Exercise
Is there a cancer rehabilitation program accessible to patient?
Yes
No
Refer to a Cancer Rehab Program
Consider general PT/OT referral
Is the patient meeting physical activity guidelines?
Aerobic: ≥30 minutes of moderate physical activity 3x/week
Strength training: ≥2 days per week
Yes
No
Would the patient prefer to have professional support for exercise?
No
Yes
Self-Management, No referral needed
Refer to an Exercise Oncology Program

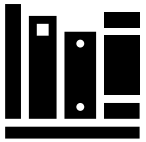
Feedback on the CDST

Feedback	PCPs	Patients	Directors
Clarify terms “moderate” and “substantial”	✓		✓
Clarify term “professional support”	✓		
Remove jargon like “exercise oncology”	✓		
Highlight psychosocial benefits of program		✓	✓
Unsure what counts as a “cancer-related concern”	✓		✓
Ask patients if they have already participated in a cancer exercise or rehabilitation program		✓	
Add a pathway to refer to an exercise program after completion of a rehabilitation program	✓	✓	
Educate on difference between exercise and rehab programs			✓
Integrate tool into the electronic health record	✓		

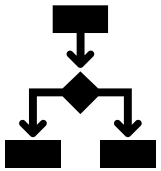
Round 2 Conclusions

Need to integrate the Clinical Decision Support Tool (CDST) into the EHR

Implementation of the CDST must be tailored to each clinics individual workflow while retaining key functions



Need a supporting library of information about the CaRES programs available to a clinic's patient population



Next Steps: Create a high-fidelity prototype clinical decision support tool and prepare for EHR integration

Acknowledgements

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Primary Mentor

Brooke Holliman, PhD
Qualitative Methodologist

Ashely Dafoe, MA
Qualitative Analyst

<u>Additional Mentors:</u>

Ryan Marker, DPT, PhD
Russ Glasgow, PhD
Elizabeth Bayliss, MD, MSPH

Romana Hasain-Wynia, PhD
Mandy Allison, MAEd, MD, MSPH

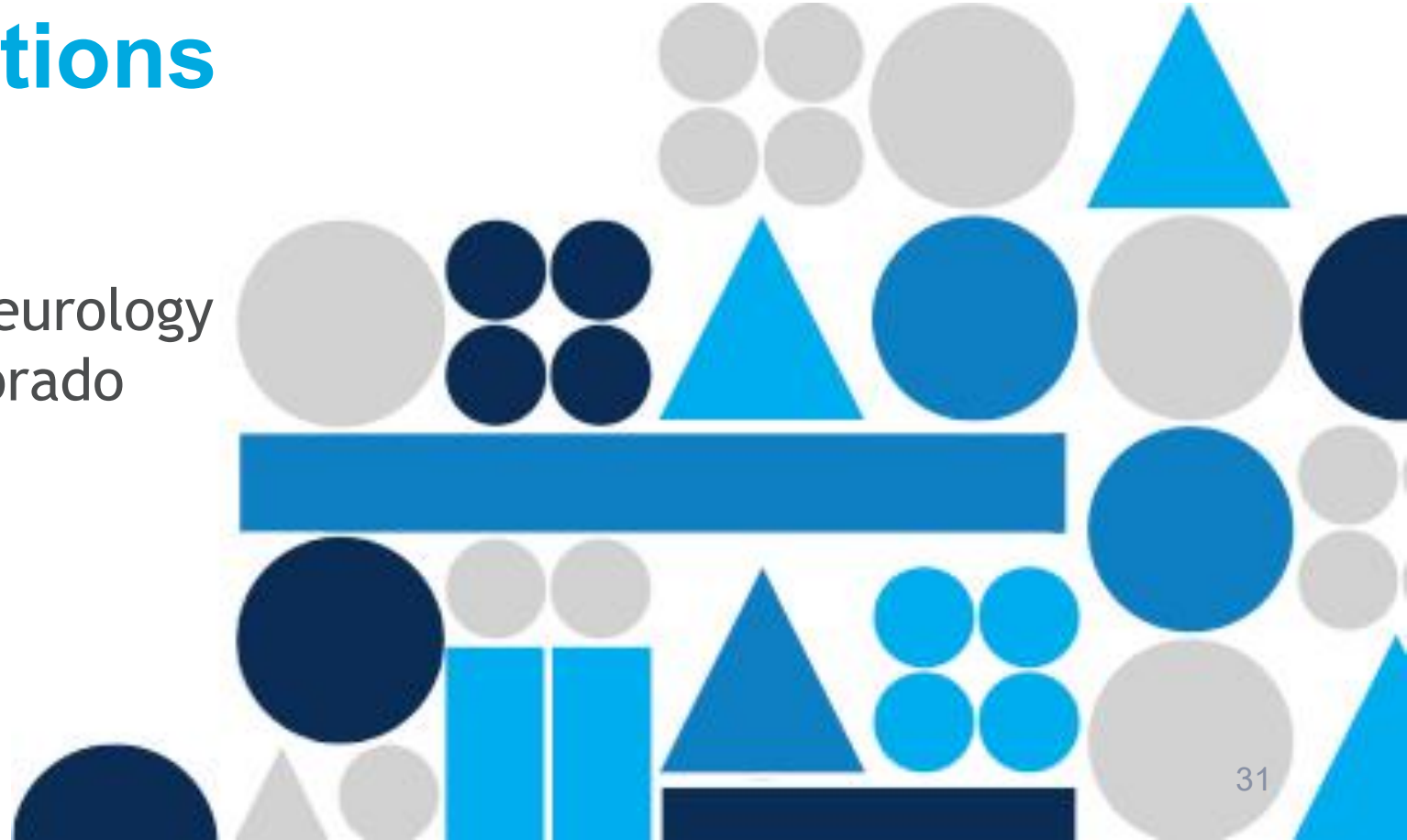
Cancer Rehabilitation and Exercise Services (CaRES)

	Cancer Rehabilitation	Cancer Exercise
Program Purpose	Address a specific injury of condition	Improve overall fitness and physical function
Participant Eligibility	Complications of cancer treatment or substantial functional limitations	Moderate function limitations or deconditioning
Program Staff	Physical and Occupational Therapists	Cancer Exercise Trainers
Program Delivery	In-person	In-person or virtual

Measuring Better: Outcome measures beyond epilepsy in Neurogenetic Conditions

Megan Abbott, MD

Assistant Professor, Pediatric Neurology and Epilepsy, University of Colorado



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Objectives

- Discuss challenges with epilepsy/seizures as the primary outcome measure in Neurogenetic Conditions
- Example of a novel clinical outcome assessment designed in CDKL5 Deficiency Disorder
- Walk through my current work modifying this scale for other DEEs
- Discuss the SCORE fellowship and impact on my work

A little about me…

- Pediatric Epileptologist at Children's Colorado
- Medical Director of several gene specific clinics at Children's Colorado including SYNGAP1 Multidisciplinary clinic and SCN2A/SCN8A Multidisciplinary Clinic
- Clinical Researcher focussed on outcome measure/endpoint development in rare disease
- SCORE (Scholars in Clinical Outcomes Research) Fellow in my second year

Challenges with current outcome measures for disease modifying clinical trials in rare disease:

- These are not epilepsy trials, therapies are aimed at improving disease overall, trial design is often longer (2-3 years)
- Need to specifically address top concerns noted by parents
- Need to be able to measure small but meaningful changes
    - In *SCN2A* the Vineland had limitations in showing growth or regression over time, with raw scores changing so slowly that standardized scores declined over time
- Lack of outcome measures specifically validated in Neurogenetic Conditions

Berg, AT, Palac, H, Wilkening, G, Zelko, F, Schust Meyer, L. *SCN2A*-Developmental and Epileptic Encephalopathies: Challenges to trial-readiness for non-seizure outcomes. *Epilepsia*. 2021; 62: 258–268. https://doi.org/10.1111/epi.16750

Seizure frequency as primary outcome measure: potential problems in neurogenetic conditions

- Developmental delay precedes epilepsy much of the time, with patients achieving seizure remission at various time points
- Often seizure types are difficult to track (myoclonic, spasms), seizure frequency is inconsistent, many genetic conditions have mild/well controlled seizures

Rong M, Benke T, Zulfiqar Ali Q, Aledo-Serrano Á, Bayat A, Rossi A, Devinsky O, Qaiser F, Ali AS, Fasano A, Bassett AS, Andrade DM. Adult Phenotype of *SYNGAP1*-DEE. Neurol Genet. 2023 Nov 17;9(6):e200105. doi: 10.1212/NXG.0000000000200105. PMID: 38045990; PMCID: PMC10692795.

Vlaskamp DRM, Shaw BJ, Burgess R, Mei D, Montomoli M, Xie H, Myers CT, Bennett MF, XiangWei W, Williams D, Maas SM, Brooks AS, Mancini GMS, van de Laar IMBH, van Hagen JM, Ware TL, Webster RI, Malone S, Berkovic SF, Kalnins RM, Sicca F, Korenke GC, van Ravenswaaij-Arts CMA, Hildebrand MS, Mefford HC, Jiang Y, Guerrini R, Scheffer IE. *SYNGAP1* encephalopathy: A distinctive generalized developmental and epileptic encephalopathy. Neurology. 2019 Jan 8;92(2):e96-e107. doi: 10.1212/WNL.0000000000006729. Epub 2018 Dec 12. Erratum in: Neurology. 2019 Nov 12;93(20):908. doi: 10.1212/WNL.0000000000008352. PMID: 30541864; PMCID: PMC6340340.

Patient Perspective: What should we measure?

- In *CDKL5* Deficiency Disorder, patients reported the following priorities in both a parent report and the natural history study:

CDD PFDD Top Concerns	NHS 3 Top Concerns (courtesy of Jeff Neul)
1. Global developmental delay	1. Epilepsy/Seizures
2. Epilepsy/seizures	2. Communication
3. Gastrointestinal and feeding problems	3. Sleep
4. Limited or absent speech	4. Lack of hand use
5. Behavioural disturbances	5. Abnormal walking/balance issues
6. Visual impairment	6. Constipation
7. Difficulty walking	7. Vision
8. Limited hand control	8. Teeth Grinding
9. Sleep	9. Repetitive hand movements
10. Scoliosis (curvature of the spine)	10. Poor weight gain

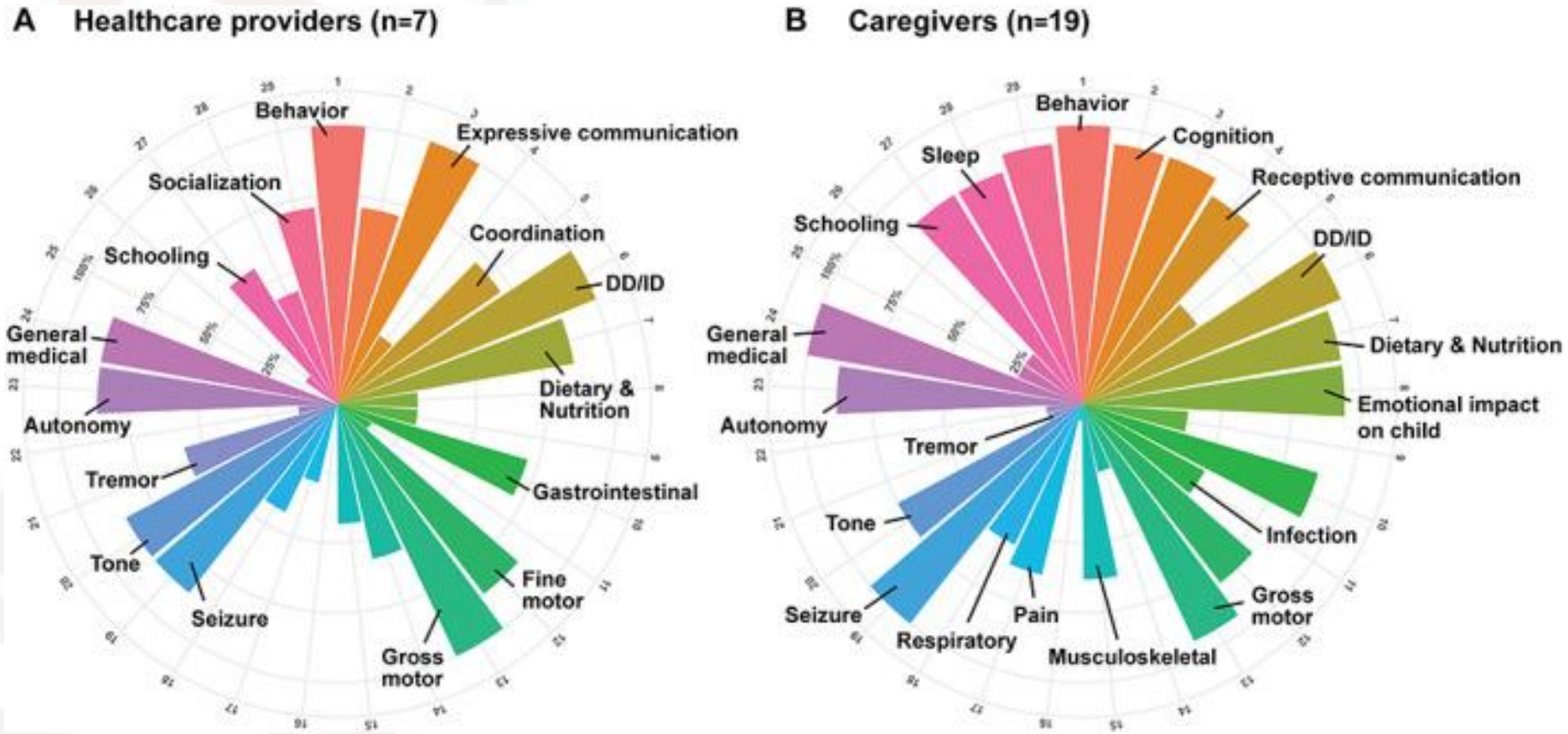
Patient Perspective: What should we measure?

In a study of parents of children with Angelman Syndrome, parents identified their top priorities for a clinical trial to focus on[5]:

1. Neurology/Seizures/Epilepsy
2. Communication skills
3. Motor Skills
4. IQ/Cognitive function
5. Expressive speech
6. Sleep
7. Behavior

Adams, D, Roche, L, Heussler, H. Parent perceptions, beliefs, and fears around genetic treatments and cures for children with Angelman syndrome. *Am J Med Genet Part A*. 2020; 182A: 1716–1724. https://doi.org/10.1002/ajmg.a.61631

STXBP1 Disease Concept Model



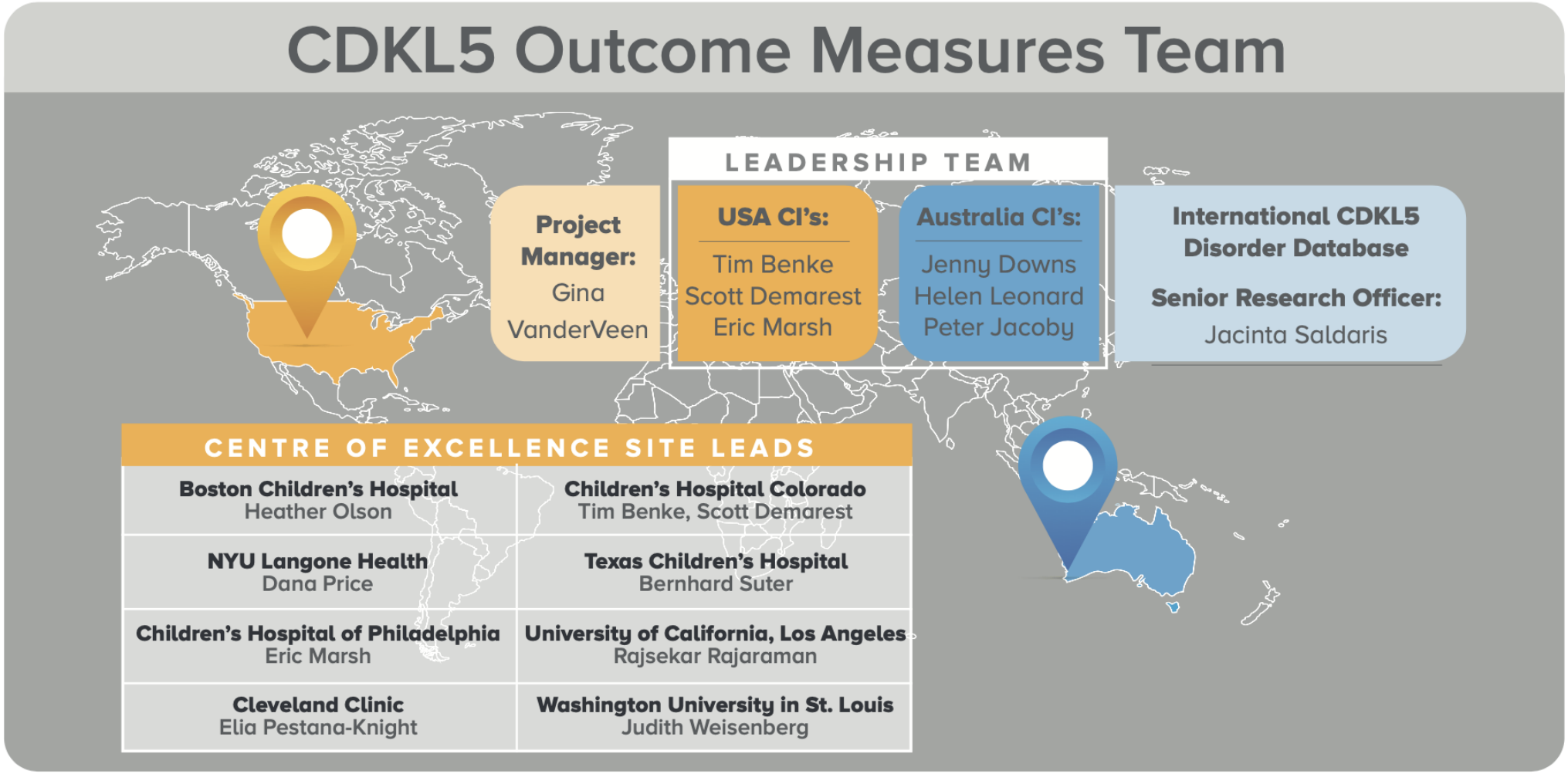
Sullivan, Katie R et al. “A disease concept model for STXBP1-related disorders.” *Epilepsia open* vol. 8,2 (2023): 320-333. doi:10.1002/epi4.12688

Take aways:

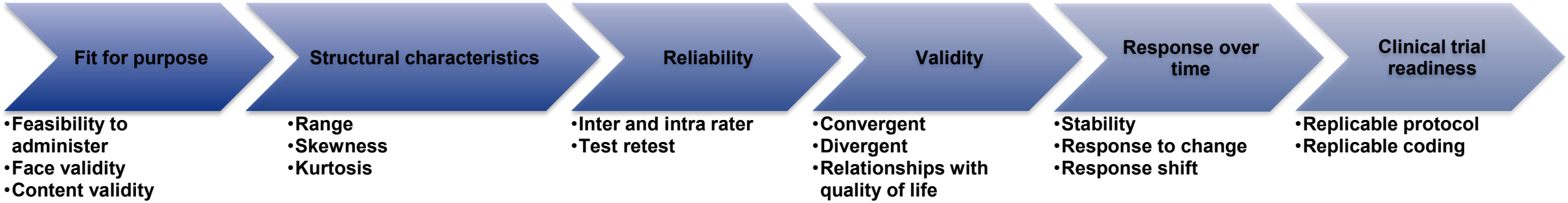
- While epilepsy is a major concern, it is not the only concern
- Disease modifying therapies should be aimed at improving the majority of these concerns
- Will need outcome measures which consistently can measure these concerns:
    - Cognition
    - Speech/Motor
    - Sleep
    - Behavior
    - Vision

Evaluating patients in the clinic: The Parent/Clinician CDKL5 Clinical Severity Assessment

Multi-Site Validation of Biomarkers and Core Clinical Outcome Measures for Clinical Trials Readiness in CDKL5 Deficiency Disorder (CDD): **NIH/NINDS U01NS114312** (Feb2021-Jan2026) (Benke, PD)



Process of developing an outcome measure:



Example of Motor CCSA Item:

Gross Motor Function

- *You can ask a parent to show you these skills*
- *Ensure the child is tested for the duration of the activity*
- *Score on the highest level of assistance needed during the task*

3) **(All ages)** Head control in sitting **-** *Support trunk in an upright position if required)*
0, Full, active range of motion to look left or right
33.333, Limited range of motion to look left or right, lack of chin control
66.666, Can get head into alignment whether momentary or longer
100, No head control

4**) (All ages)** Supine lying to sitting
0, Moves from laying to sitting independently - good head and trunk control
20, Moves into sitting with some limitations - lag in head control, or uses own arm to assist
40, Minimal assistance to guide getting into sitting - a light touch, one hand held
60, Pull child into sitting, child holds head in line with body through a portion or all of the movement
80, Pull child into sitting, may momentarily tighten muscles through the neck but does not align head with body
100, No, minimal effort; full assist

Example of Communication CCSA Item:

21) (< 15 months) Speech (verbal)

0, Purposeful vocalisation

50, Non purposeful vocalisation

100, No vocalization

22) (15-17 months) Speech (verbal)

0, Single words - vocal - eg yes or no

33.333, Purposeful vocalisation or word approximation

66.666, Non purposeful vocalisation

100, No vocalization

23) (18 months+) Speech (verbal)

0, Sentences or Phrases - 2 or more words - vocal, normal for age

20, Sentences or Phrases - 2 or more words - vocal, but not normal for age

40, Single words - vocal - eg yes or no

60, Purposeful vocalisation or word approximation

80, Non purposeful vocalisation

100, No vocalisation

Visual Components of CCSA score

1) Fixing and Following - *Follows in well-lit room, 10cm from examiner's face, without voice prompt.*
0- Fixes and follows examiner's face consistently
25- Fixes, occasionally/inconsistently follows examiner face
50- Fixes only, does not follow
75- Blinks to bright light (otoscope on maximum power)
100- Does not fix or follow

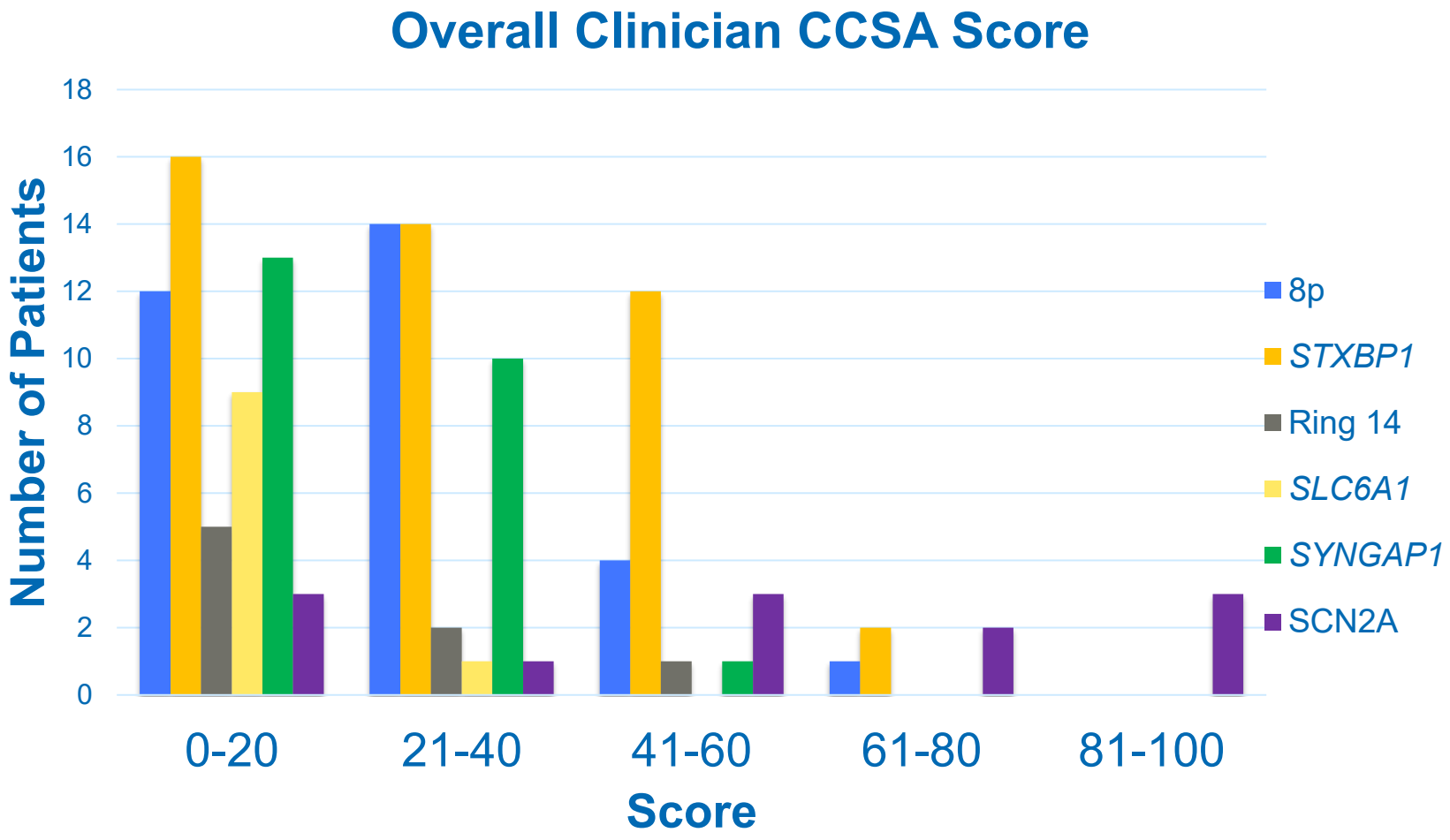
2) OKN - *OptOK app on ipad (minimum 10 inch) at full intensity in darkened room held 5-10 cm from the child's eyes for 30 seconds. Both directions tested.*
0- Normal OKN
33.33- Ignored OKN – notice then look away
66.66- Inconsistent OKN, Reduced OKN (movements present but reduced in amplitude, or loss of one visual field.
100- Very limited visual field. Absent OKN

3) Eye alignment
0 - Normal
50- Dysconjugate, intermittent
100- Dysconjugate, constant

Abnormal eye movements
4) Roving:
0- Not present
50- Intermittent
100- Persistent

5) Nystagmus
0- Not present
50- Intermittent
100- Persistent

Clinician Clinical Severity Assessment Scores:



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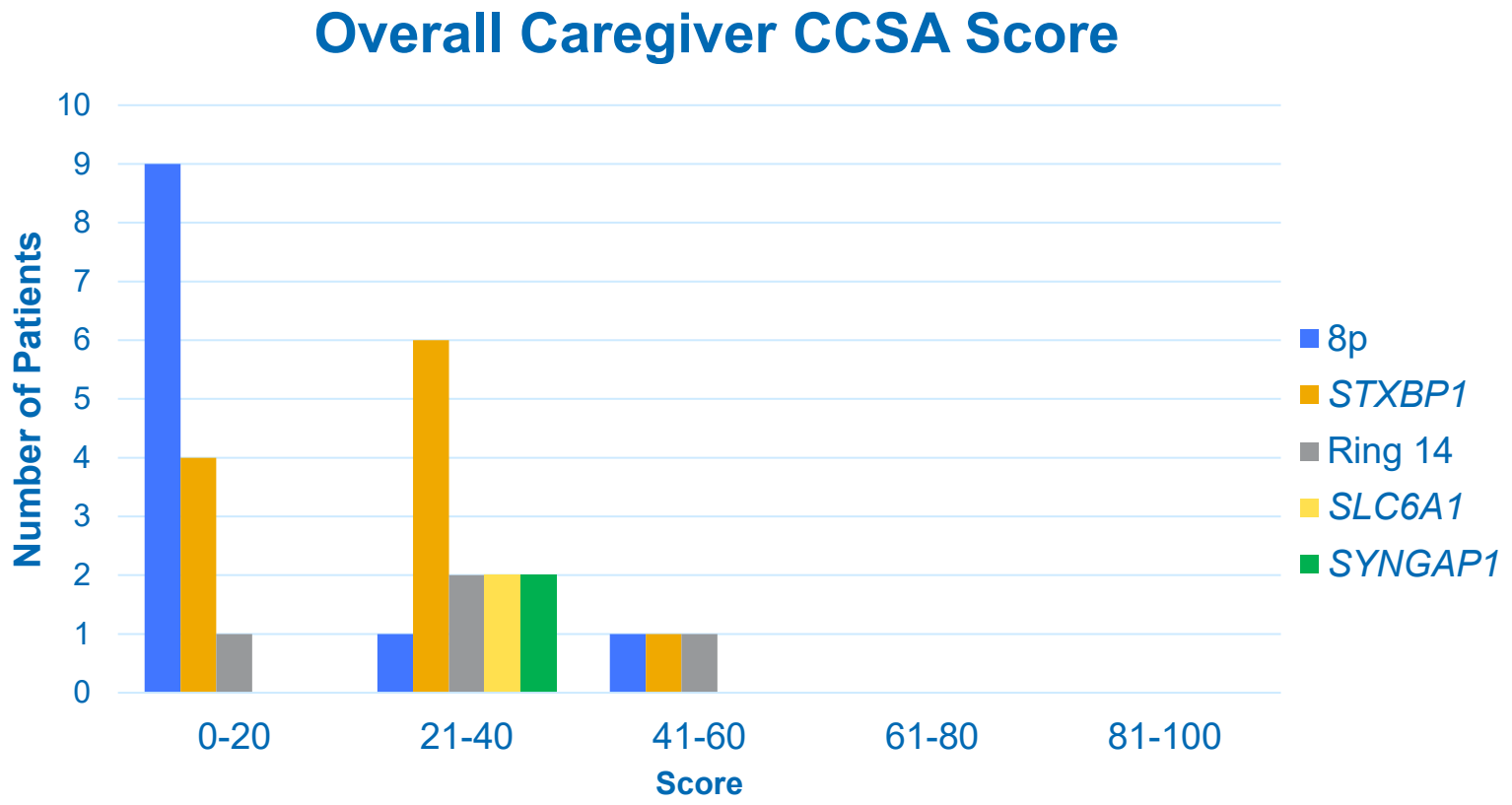
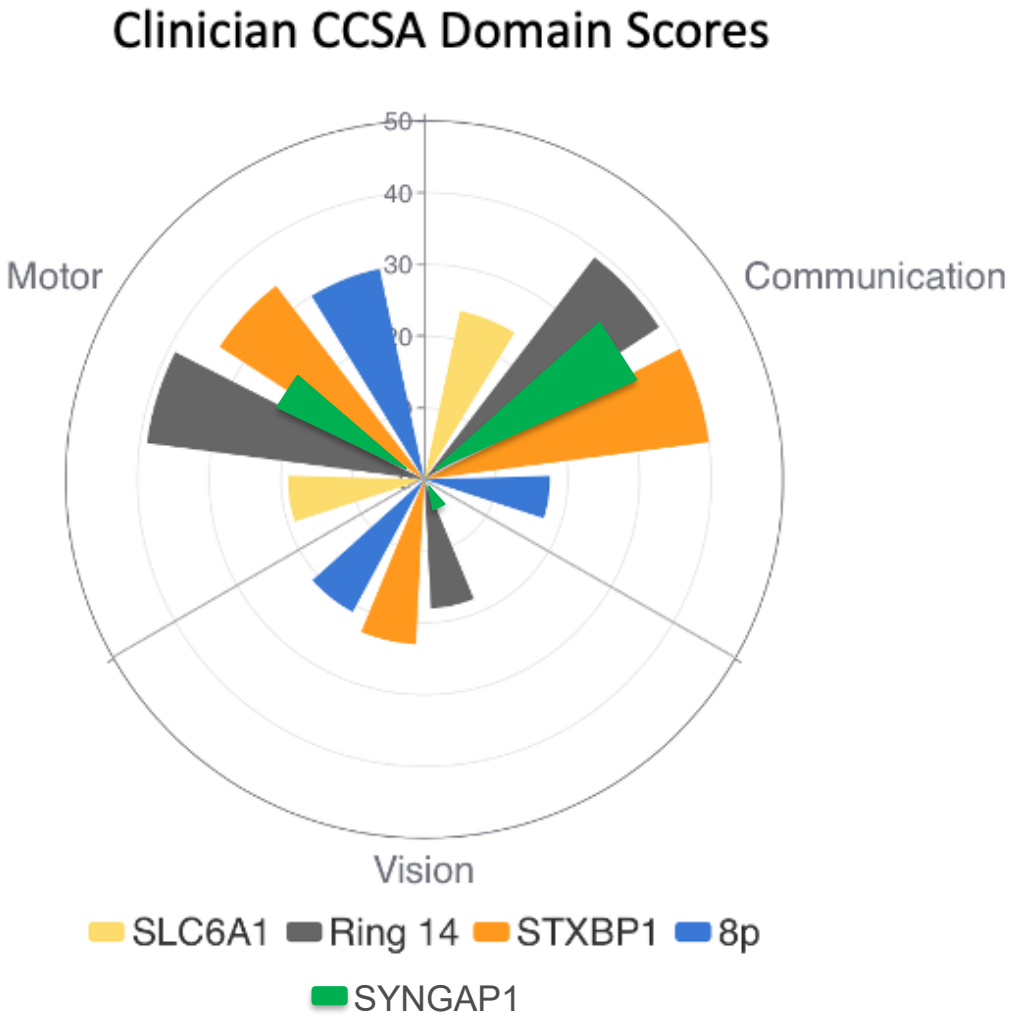
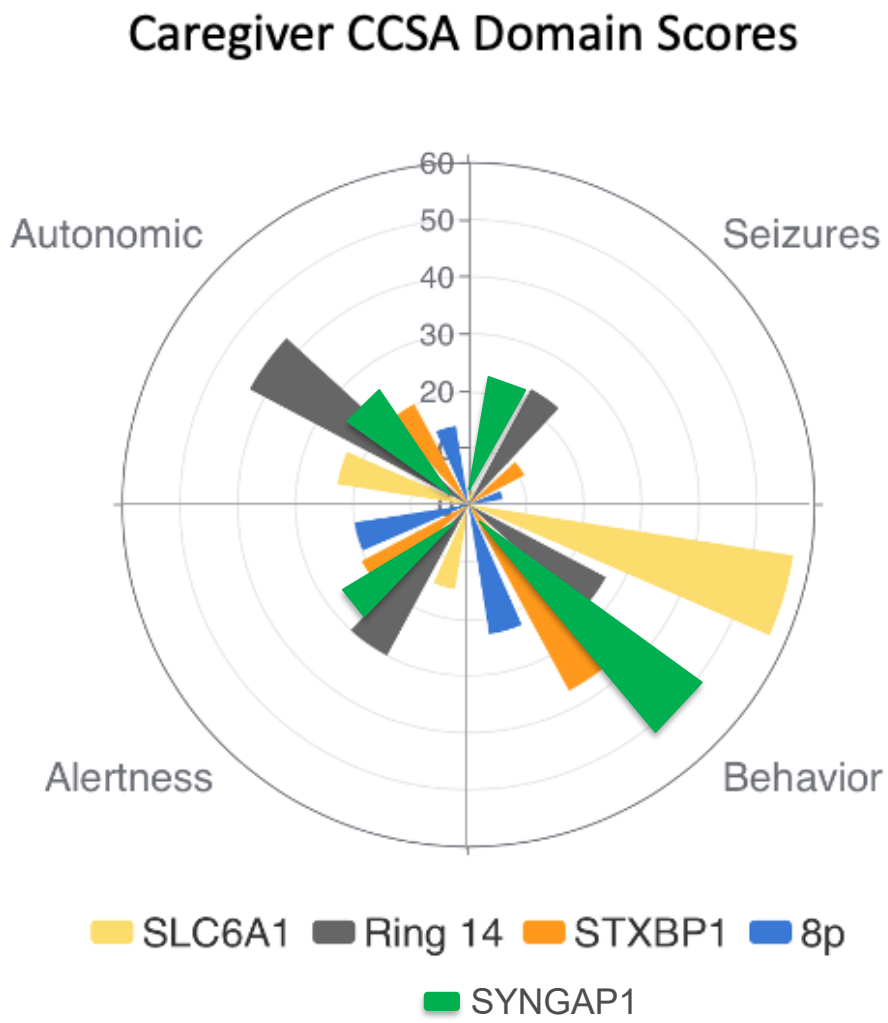
Caregiver Clinical Severity Assessment Scores:

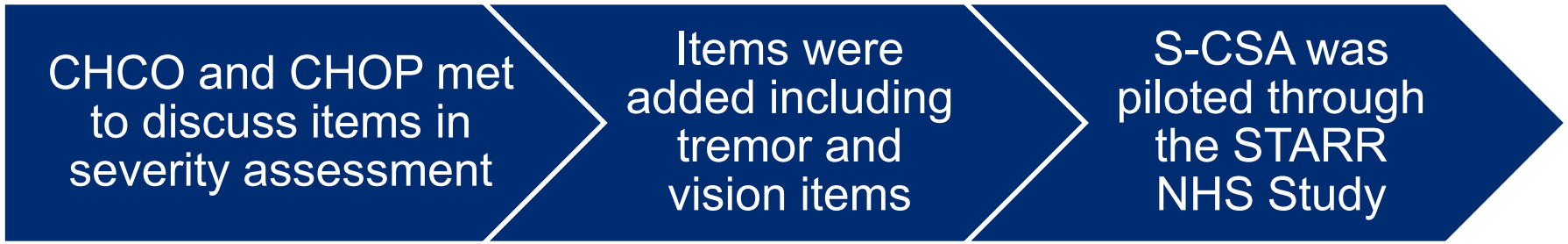


Comparison of Scores Across Domains and Disorders

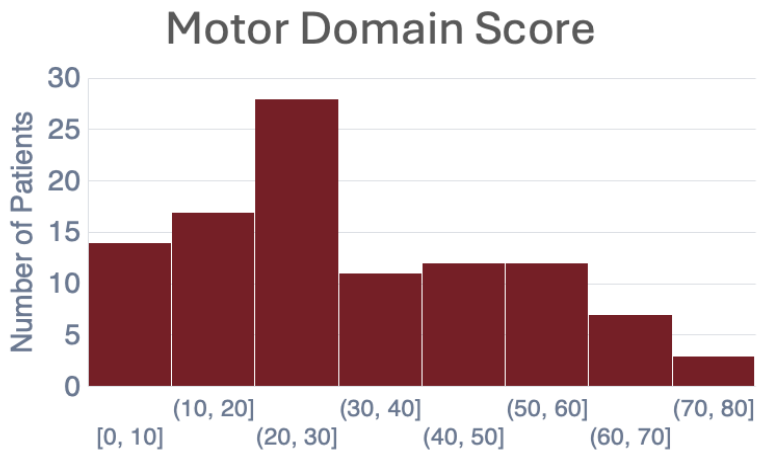


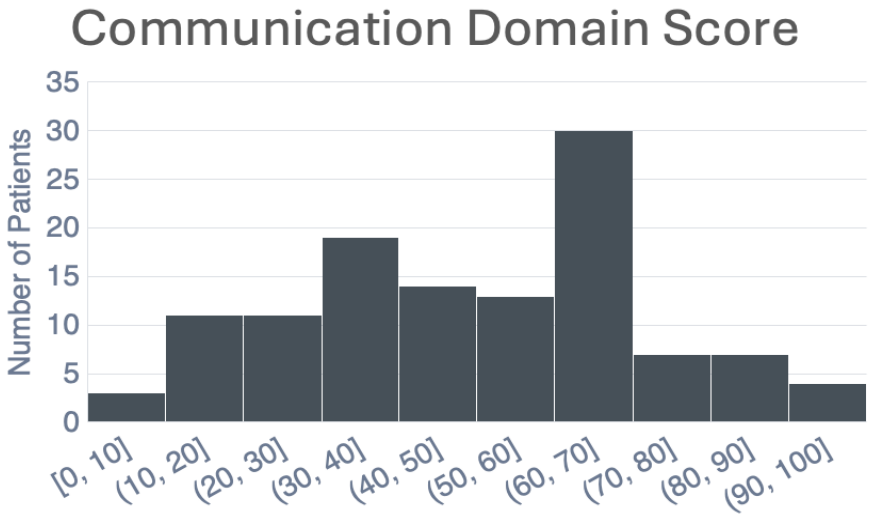


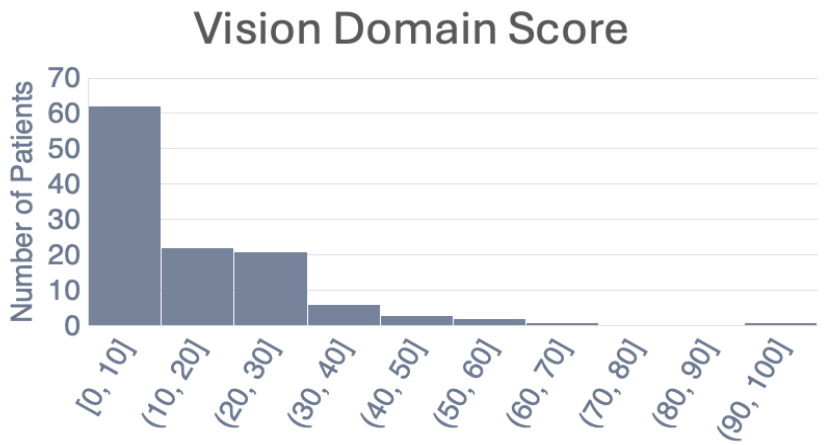
Adapting CCSA for STXBP1…

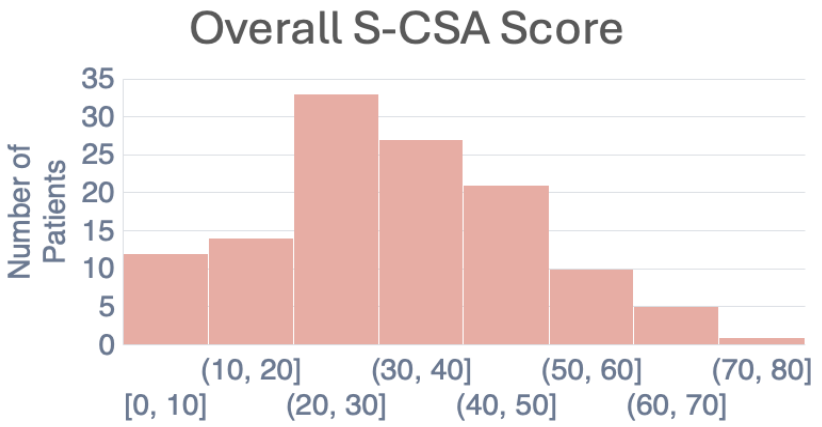


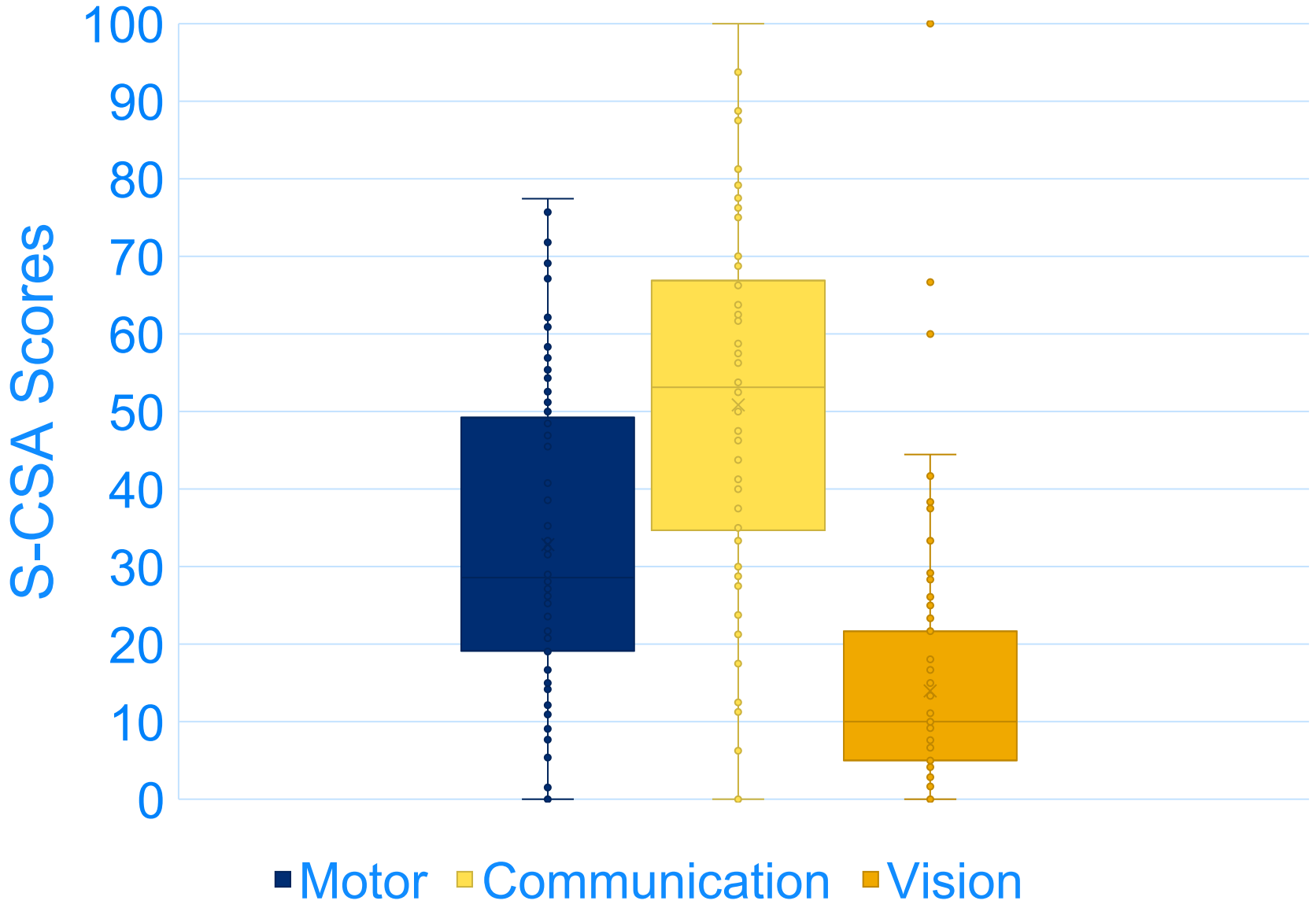
Scores in 123 Patients with STXBP1



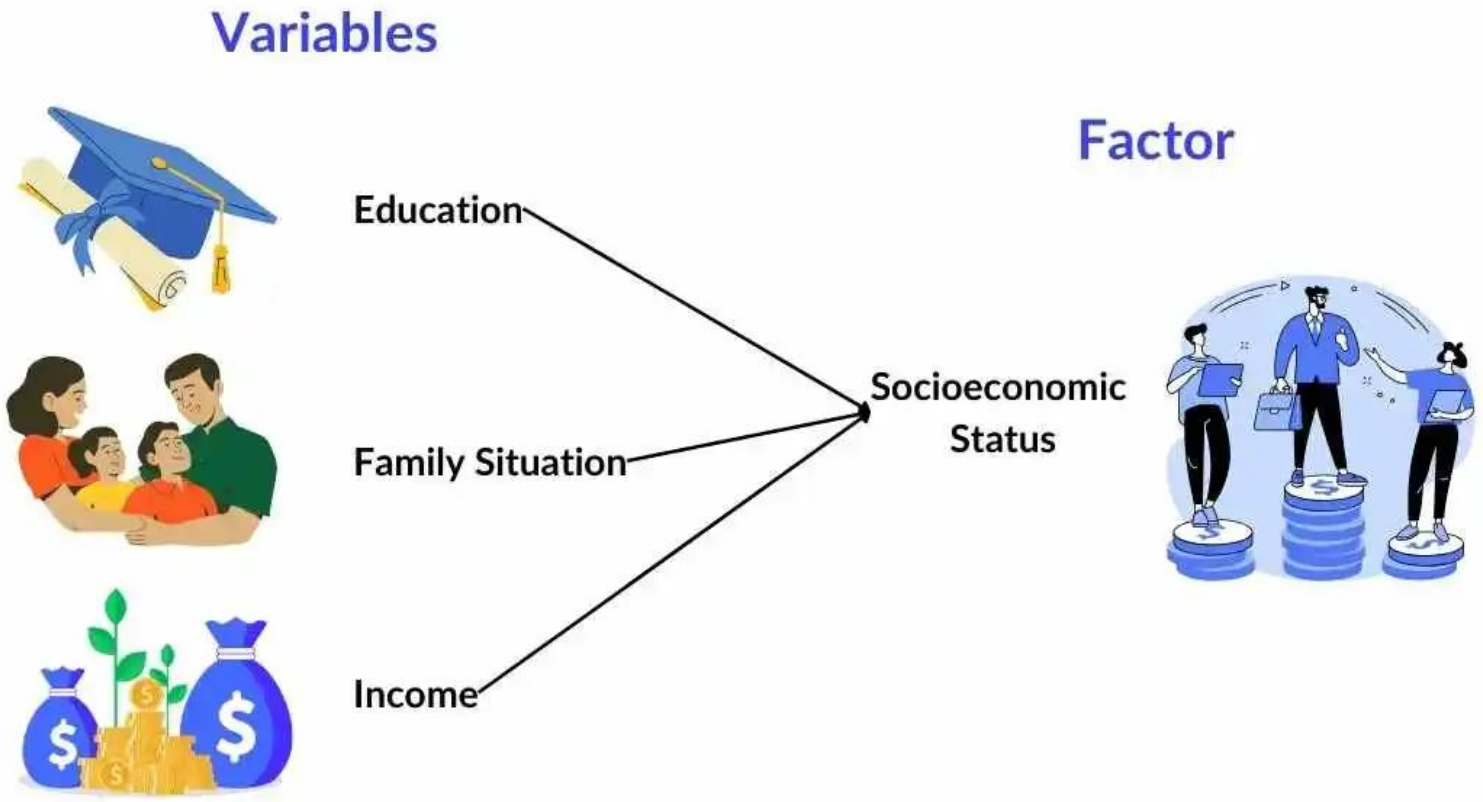







S-CSA Scores
100
90
80
70
60
50
40
30
20
10
0
Motor
Communication
Vision

Factor Analysis Explanation



Factor Analysis

Summary of Psychometric Analyses & Accepted Thresholds					
Analysis Type	Description	Statistical Measure and Threshold	S-CSA Validation Values		
			Motor	Communication	Vision
Factor Analysis	Statistical method that finds patterns in test responses by grouping together items that seem to be measuring the same idea into factors	Factor Loading (>0.45)	>0.78	>0.66	>0.55
		RMSEA (<0.1)	0.095		
		Tucker-Lewis Index (>0.810)	0.975		
Internal Consistency	Indicates how well the questions on a test or survey all measure the same thing	Cronbach's Alpha (>0.630)	0.852	0.894	0.797
		Composite Reliability (>0.630)	0.958	0.880	0.865
Avg. Variance Extracted	Shows how much of the information in a group of items reflects the concept being measured, compared to random error	Average Variance Extracted (AVE) (>0.450)	0.820	0.648	0.576
Divergent Validity	Evaluates that a concept being measured is clearly different from other concepts.	Max Correlation Squared (<AVE + 10%)	0.517	0.517	0.349

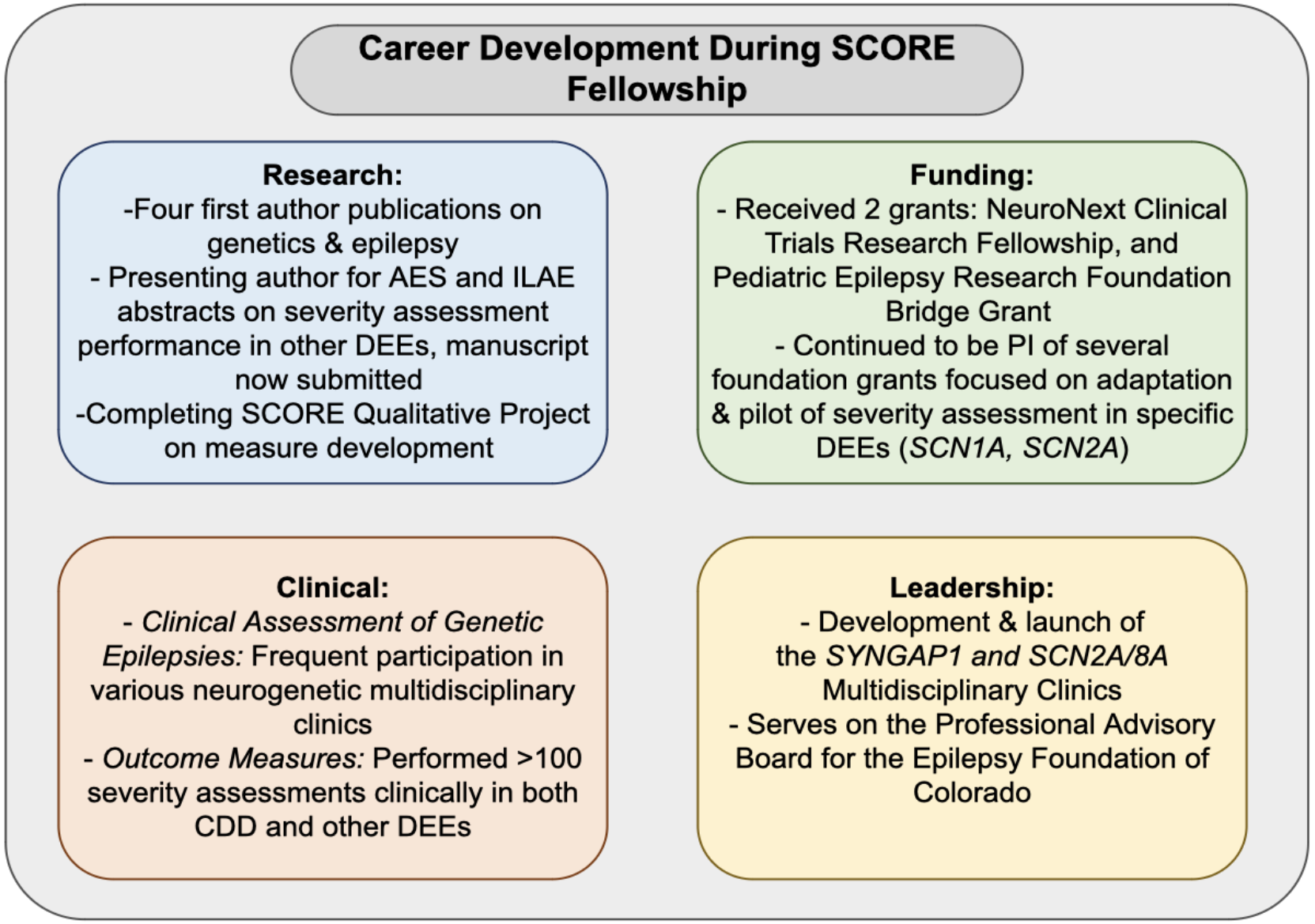
Results From Adaptation Process

- This clinician reported outcome measure demonstrates **a nice range of scores** in the three domains and overall score **without floor or ceiling effects**
- The initial way that items were grouped for CDKL5 **continues to work** well for STXBP1

Overall take aways…

- Outcome measures beyond seizure frequency are necessary for future disease modifying clinical trials
- Standardized/ “off the shelf” measures have significant limitations in neurogenetic conditions
- Disease specific outcome measures may have applicability for conditions outside of what they were originally designed for

My career development during SCORE fellowship…



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Next Steps following SCORE:

Will continue to work on measure development and natural history study design in rare disease, am the PI on 4 current foundation grants and am a site PI/collaborator on several FDA R01 applications for natural history study development

I am applying for a K23, aiming for June submission

I am working on my Masters of Science in Clinical Science

Thank you!

- To the wonderful patients and families I have the privilege of working with
- To my mentors and colleagues
- To the SCORE Fellowship and ACCORDS for excellent training and support

ACCORDS Fellowship Opportunities

Scholars in Clinical Outcomes Research (SCORE)

- The Scholars in Clinical Outcomes Research (SCORE) Fellowship at ACCORDS is currently recruiting for the July 2026 cohort.
- Fellowship designed for junior and mid-career faculty at the University of Colorado Anschutz or affiliate institution with goal of translational or outcomes research
- Two-year program consists of weekly didactic training, weekly work-in-progress sessions, 1:1 mentoring, and intensive grant writing course
- Pilot awards available for competitive applicants
- Applicants must have support of home department/division; at least 50% protected time, and tuition support for program costs
- **Applications due March 15th, 2026!**

ACCORDS Primary Care Research Fellowship

- Goal: Train post-doctoral professionals to become primary care research leaders
- Nationally renowned training in Implementation Science
- Fellows receive funds for pilot project support, tuition, travel for conferences and a standard NIH-level T32 stipend (options to negotiate for additional salary support
- Expert support for fellows from ACCORDS cores, including: Biostatistics, Health Economics, Implementation Science, Qualitative/Mixed Methods, and Shared Decision Making
- Apply tuition toward an advanced degree tailored to your background (Master's Degree and/or Graduate Certificate in Implementation Science)
- **Applications open and reviewed on a rolling basis!**