

## **Abstract**

*Project Name: Vermont Strategic Prevention Framework - Partnerships for Success II (PFS)*  
*Applicant: Vermont Department of Health (VDH)*

The purpose of the Vermont PFS initiative is to: 1) reduce underage drinking among persons aged 12-20, including binge drinking; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. In collaboration with multiple state and local community partners, the Vermont Department of Health (VDH) will achieve these goals through focused application of the Strategic Prevention Framework model to strengthen the prevention infrastructure in six of twelve VDH health districts identified as having the most disparate needs. This initiative builds on the successes achieved in Vermont through previous Strategic Prevention Framework work including both the reduction of substance use among persons under 25 and in building statewide prevention capacity. However, much work remains to be done. Vermont leads the nation for underage alcohol consumption and binge drinking with 37% of those aged 12-20 years old reporting having an alcoholic drink in the past month, and 25% of this age group reporting binge drinking in the past month (National Survey on Drug Use and Health, 2009). While overall state-level prevalence rates of prescription drug misuse are below the national average, treatment demand for opiates other than heroin has increased more than ten-fold over the past decade. The State of Vermont has declared prescription drug misuse/abuse as an epidemic in light of the physical and economic toll it has taken on state resources and residents.

The project has been structured to meet all of the requirements and expectations of the Strategic Prevention Framework - Partnerships for Success II program, including the selection of priorities, strategy for allocating funds, implementation of evidence-based strategies, data collection and reporting, and leveraging of other prevention funds. District offices serving the six highest need health districts will coordinate implementation of the initiative by convening community partners to conduct district-wide needs assessment, prioritization, planning and capacity building. Each district will include in their assessment an examination of health disparities within their region and will include specific plans for addressing these disparities. Prevention activities to be implemented will intentionally encompass a variety of evidence-based strategies that collectively address multiple developmental stages of youth and young adults, through multiple levels of intervention, and that have the potential to influence a range of behavioral health issues. The project approach will substantially move the state towards a more equitable and efficient strategy for allocating prevention resources. It will also serve as a model for a revitalized state prevention system in which effective community-level prevention practices are brought to scale in a manner that can be sustained at the regional and statewide levels.

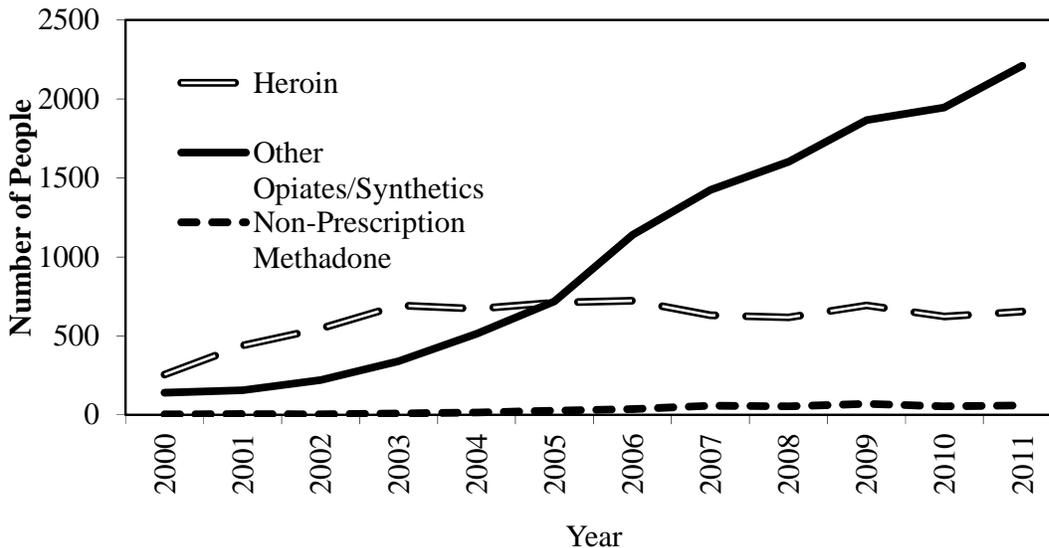
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## SECTION A: STATEMENT OF NEED

Although measurable progress has been made in recent years, Vermont still leads the nation for underage alcohol consumption and binge drinking in the past month. According to the most recent data from the National Survey on Drug Use and Health (NSDUH) 37% of those aged 12-20 years old reporting having a drink in the past month, and 25% of this age group reporting binge drinking (5 or more drinks at one time) in the past month (SAMHSA, 2010). In addition, Vermont has the highest rates in the country of past month and past year marijuana use rates among 18 to 25 year olds (31% and 45%, respectively). Vermonters in this age group also top the charts for cocaine use with 1 in ten young adults using cocaine in the past year. While overall state-level prevalence rates of prescription drug misuse are below the national average, treatment demand for these substances has increased dramatically over the past several years (Figure 1). The State of Vermont has declared prescription drug misuse/abuse as an epidemic in light of the physical and economic toll it has taken on state resources and residents.

**Figure 1. VT Residents Treated for Opiates (including Prescription Drugs) by Year**  
(Source: VT Treatment Data)



These figures are alarming, but Vermont has led successful initiatives, such as the Strategic Prevention Framework State Incentive Grant (SPF-SIG), that have helped to turn the tide for some of the youngest residents in the state. The Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) has seen a statistically significant drop between 2002/2003 and 2008/2009 nearly across the board for the **12 to 17 year age group** for 1) binge drinking in the past month, 2) past month and past year marijuana use, 3) past month illicit drug use, 4) past month prescription drug misuse, 5) past year use of cocaine, and 6) past month cigarette and tobacco product use (YRBS 2011).

Unfortunately, even with these strides forward, Vermont has a long way to go. With a population of 625,741 (2010 U.S. Census data), Vermont is the second most rural state in the nation: a higher percentage of its residents live in communities of 2,500 or less than any other state in the nation except Maine (2010 U.S. Census Bureau). The largest city, Burlington, has a population of 42,417. No other city (total = 9) has more than 16,500 residents. In 2007, the SAMHSA News reported that providing substance abuse prevention and treatment services in rural areas can be

extremely difficult (Clay, 2007). Barriers can include increasing influx of drugs into rural areas, isolation, self-medication, limited treatment options, and logistical difficulties (transportation, etc.). The infrastructure enhancements envisioned through the PFS will address these challenges through development of a regionally oriented prevention infrastructure that is fully integrated with the existing Public Health District Offices.

**A.1. Demographic Information on Population(s) to Receive Services**

The State of Vermont has 14 counties and 12 Health Districts. Racial and ethnic minority data are not readily available by the Health Districts; however, US Census data from 2010 indicate that across counties the white population ranges from a low of 92.5% (Chittenden County – Burlington District Office) to a high of 97.3% (Essex County – Newport District Office). The Burlington District which includes Chittenden County has the highest population density in the State and is the most diverse. The target population for this proposal is the cross-section of residents aged 10 to 24 and those residing in geographic regions with higher prevalence of underage drinking, prescription drug misuse, and socioeconomic disparities in substance use.

**Table 1. Health District Demographics (Source: U.S. Census 2010, YRBS 2011)**

<i>Health District</i>	<i>10-24 Pop</i>	<i>Gender (%Male)</i>	<i>MomEd HS or Less</i>
<b>Burlington</b>	39,132	50.0	21.8
<b>Barre</b>	12,495	55.2	32.0
<b>Rutland</b>	11,902	51.2	33.2
<b>St. Albans</b>	10,236	52.0	40.0
<b>Middlebury</b>	8,580	51.8	30.5
<b>White River Jct</b>	8,568	52.2	30.3
<b>Bennington</b>	6,958	49.0	31.6
<b>St. Johnsbury</b>	6,784	52.4	31.9
<b>Brattleboro</b>	6,624	52.9	33.2
<b>Morrisville</b>	5,956	51.6	36.9
<b>Springfield</b>	5,386	51.4	40.4
<b>Newport</b>	4,879	52.6	41.5
<b>Vermont</b>	127,500	51.5	31.2

Table 1 shows the relative distribution of the Vermont population of 10 to 24 year olds throughout the state by Health District, gender and socioeconomic status (SES) measure. The 10-24 year age group represents about 20% of Vermont’s total population. The six Health Districts which rank the highest in terms of alcohol and prescription drug use rates, population aged 10 to 24, and socioeconomic disparities will be the primary focus for subrecipient grant awards for the PFS. In this way, funds will be focused on the highest need regions to maximize their impact.

As a small, rural state, Vermont has been successful in building partnerships and leveraging resources to improve the health of Vermont residents. In addition to the seasoned and experienced VDH central and district office staff, the Stop Teen Alcohol Risk Team (START) Advisory Council that oversees VDH’s implementation of the Enforcing Underage Drinking Laws (EUDL) Block Grant is a key stakeholder and resource to this grant. Members of the Council include leadership from the Departments of Education, Liquor Control, Public Safety, Sheriff’s Association, Vermont Court Diversion Programs, the Vermont Criminal Justice Training Council and community coalitions. This organization will be key in advising VDH on

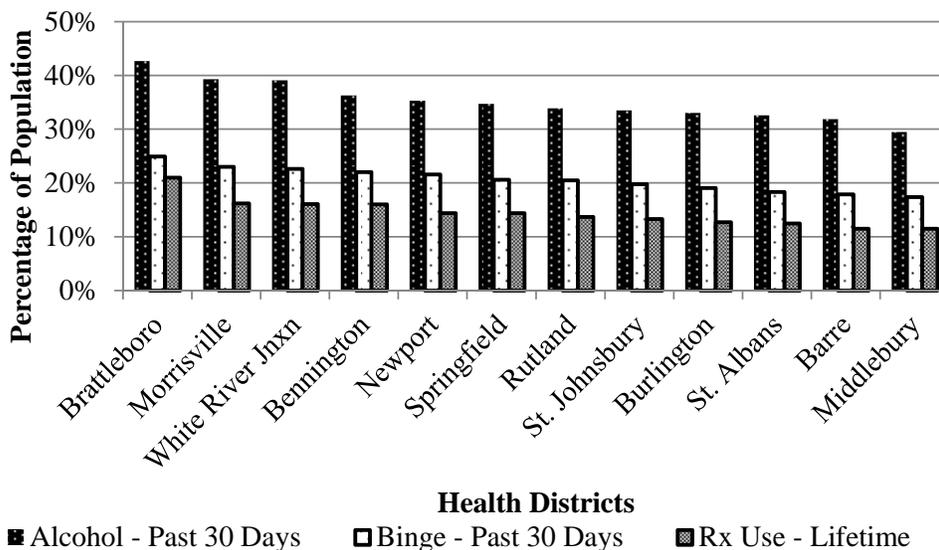
underage drinking and leveraging funds as Vermont implements the final year of its EUDL Block Grant. A second stakeholder is Prevention Works, a statewide coalition of prevention advocates already engaged in training for coalitions which will serve as a statewide resource for subrecipients.

**A.2 State and Community Prevalence Rates, Consequence, Risk and Protective Factor Data**

Data from the 2011 administration of the YRBS were used to assess prevalence rates, consequences, and risk and protective factors. Because of exceptional cooperation between the Department of Health, the Department of Education, and local school districts, Vermont collected YRBS data on 22,723 students in grade 9-12. This represents 88% of the total enrollment in those grades. With such a high response rate, VDH is confident that the estimates are valid and reliable statewide indicators of use and misuse.

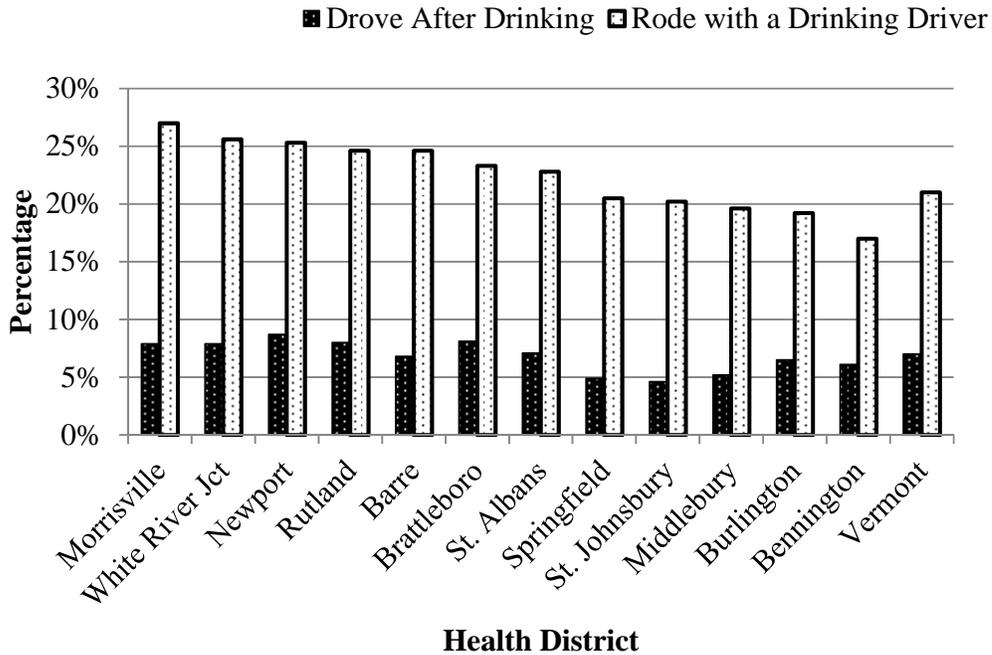
Prevalence data for the three indicators across Health Districts (presented highest to lowest rates) are presented in Figure 2. YRBS measures are also being used as proxies for 18 to 25 year olds in Vermont, due to the lack of community-level prevalence data for young adults (both in Vermont and across the country). The Vermont Behavioral Risk Factor Surveillance Survey (BRFSS) sample size is not large enough for reporting results for age groups smaller than 18 and without combining data over several years. State and sub state data are available for 18-25 year olds through the National Survey on Drug Use and Health (NSDUH); however, reporting by Health District is not currently possible. We do anticipate that district-level estimates for young adult binge drinking and prescription drug misuse will be provided by the planned revisions in Vermont’s Young Adult Survey (YAS), first implemented as an evaluation tool for the SPF-SIG.

**Figure 2. VT Alcohol and Prescription Drug Misuse by Health District (Source: VT YRBS 2011)**



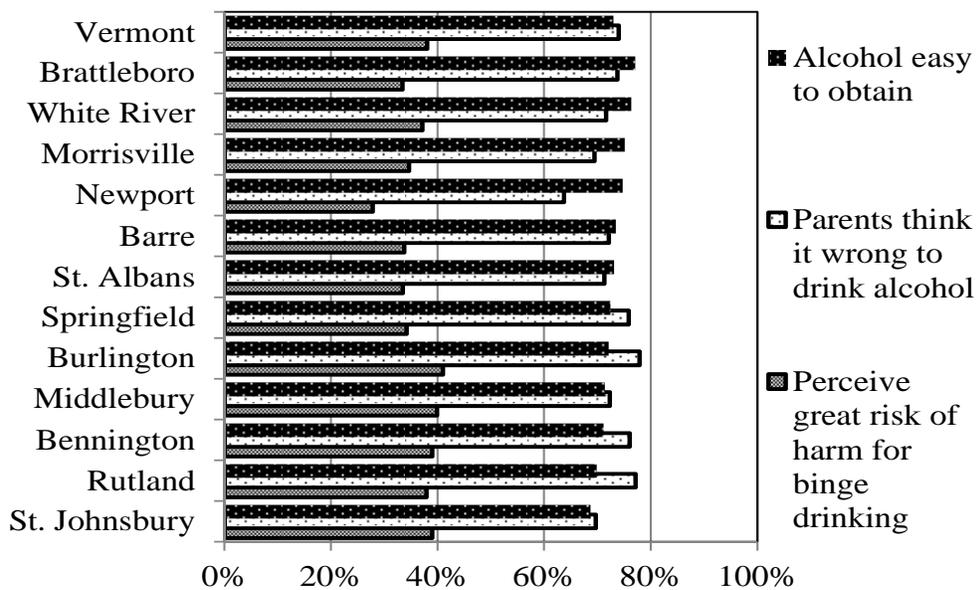
**Consequences:** Figure 3 presents Health District data for two consequence indicators from the YRBS: drove after drinking past 30 days, and rode with a drinking driver past 30 days. In Morrisville, White River Junction and Newport, one in four high school students have ridden with a drunken driver.

**Figure 3. Consequences by Health District (Vermont YRBS)**



**Risk and Protective Factors:** Figure 4 presents selected risk and protective factors by Health District including how easy to obtain alcohol, parents attitude about teen drinking, perceived risk of harm of binge drinking.

**Figure 4. Risk and Protective Factors by Health District (VT YRBS 2011)**



### **A.3 Infrastructure Needs**

Vermont's culture and value of strong local control has led to the development of numerous organizations which employ prevention planning processes. These include over 30 coalitions and partnerships, such as county-based START and community coalitions supported through a variety of funding streams. Significant outcomes have been achieved through the collective efforts of these organizations. However, this approach is unsustainable and has presented challenges to the development of long term prevention capacity in Vermont. The Vermont 2011 system review team noted, "Although Vermont is a relatively small State, the multiple layers of infrastructure and organization related to prevention may hinder efficient assessment, planning, coordinator and implementation of prevention services." (SAMHSA, Federal Fiscal Year 2011). In addition, key state and community stakeholders participated in Vermont's Strategic Prevention Enhancement (SPE) Grant strategic planning process also recommended greater sustainability through the organization of prevention efforts through regional approaches (VDH, 2012).

VDH has made a commitment to strengthening the capacity of its twelve regional District Offices (DOs) in community assessment, capacity building and planning, as part of Vermont's health reform strategy. Each DO has a director, a cross-disciplinary Prevention Team and experience with the SPF. Although DOs cannot serve as subrecipients, they have strong relationships with the prevention organizations in their region and the ability to facilitate regional decision-making about selection of regional subrecipients. The PFS provides an opportunity to employ a streamlined, sustainable infrastructure by supporting the DOs to facilitate collaboration, assessment, capacity building and planning, and subrecipients to implement integrated regional plans.

## **SECTION B: PROPOSED APPROACH**

### **B.1 Purpose, Goals, and Objectives**

The passage of the Affordable Care Act (ACA) has both highlighted and heightened our nation's commitment to prevention, emphasizing the need for data-driven planning, infrastructure development, and application of evidence-based practices. The principles underlying the ACA are further articulated through SAMHSA's Strategic Initiative #1, which stresses the importance of building emotional and behavioral health through all stages of development, along with building sustainable prevention infrastructure and reducing health-related disparities.

The ACA is further reinforced by Vermont's Health Reform Act 48 (2011), the fundamental goal of which is to provide universal access to health coverage to improve health care access and outcomes associated with disparities in health and socio-economic status. VDH is the lead agency for addressing population level health interventions. While some department priorities will change from year to year, VDH has identified *Youth and Young Adult Substance Use Prevention* as one of four permanent priorities of the State Health Improvement Plan (currently under development). Core functions of VDH include provision of technical assistance, training and data to local partnerships. The goal is to support development of the necessary capacity, skills and tools for community-based health assessments, implementation and refinement of effective public health programs and policies, and evaluation of the impact of such interventions. VDH's Office of Local Health and 12 District Health Offices are an essential part of the infrastructure for this work.

The specific purpose of Vermont's PFS proposal is to apply the SPF to reduce underage drinking and prescription drug misuse and abuse among 12-25 year olds in six of twelve VDH health districts identified as having the highest need, and to strengthen the prevention infrastructure at the state, regional and community levels using the existing health district structure as the primary mechanism to implement the SPF model. This proposal builds on the successes achieved in Vermont through the SPF-SIG including both the reduction of substance use among persons under 25 and in building statewide prevention capacity. This work will also advance several initiatives identified in the strategic plans for the VDH and ADAP, including strategic actions, statewide logic model, and priority interventions. This work is currently being developed through the Strategic Prevention Enhancement (SPE) Grant. The goals and objectives of the proposed project also relate directly to Vermont's Healthy People 2020 goals, which include development of community-based capacity to respond to public health needs and increased collaboration to assure health equity for all Vermonters.

The proposed project has been structured to meet all of the requirements and expectations of the PFS, including the selection of priorities, strategy for allocating funds, implementation of evidence-based strategies, data collection and reporting, and leveraging of other available prevention funds. Our plan to organize and fund prevention at the health district level specifically addresses two important limitations that have been identified in the state's traditional approach to prevention funding: 1) funding levels have been too diffused to support all of Vermont's communities on a sustainable basis, and 2) limited capacity in the most needy communities has often resulted in lower likelihood of receiving prevention services funding.

The proposed approach for the PFS will help move the state towards a more equitable and efficient strategy for allocating prevention resources. It will also serve as a model for a revitalized state prevention system in which effective community-level prevention practices are brought to scale in a manner that can be sustained at the regional and statewide levels. In addition, the prevention activities to be implemented through PFS funding will intentionally encompass a variety of evidence-based strategies that collectively address multiple developmental stages of youth and young adults, through multiple levels of intervention, and that have the potential to influence a range of behavioral health issues in addition to the specifically targeted behaviors of underage drinking and prescription drug misuse. The specific Goals and Objectives of this initiative are as follows:

*Goal 1: Increase state, regional and community capacity to prevent underage drinking and prescription drug misuse by implementing a targeted regional approach.*

Objectives:

1.1: Health district offices serving the six highest need districts will coordinate implementation of the SPF process by convening community partners and stakeholders to conduct district-wide needs assessment, planning and capacity building.

1.2: One high-functioning community-based organization will be chosen in each high need health district to coordinate implementation of evidence-based strategies as identified by the district plan and evaluate these strategies by collecting and reporting local process and outcome data.

1.3: Each high need health district will include in their assessment an examination of health disparities within their region based on socioeconomic status, race/ethnicity, gender, sexual orientation and other subpopulations that may have differences in prevalence rates, and will include specific plans for addressing these disparities where they exist.

*Goal 2: Reduce underage and binge drinking among persons aged 12 to 20.*

Objectives:

- 2.1: The six high need health district offices will identify which risk factors for underage and binge drinking they will address with their local implementation plan by selecting from the risk factors that have been prioritized for community-level intervention by the state through ADAP's Strategic Plan for Prevention (see Attachment 1).
- 2.2: Communities will plan and implement evidence-based strategies across the levels of Vermont's Prevention Model that are designed to affect the specific risk factors for underage and binge drinking that have been identified within the region and the state.
- 2.3: Local data will be collected to identify how well evidence-based strategies were implemented and the impact of these strategies on underage and binge drinking and the associated risk and protective factors.
- 2.4: Implement a statewide communications campaign aimed at the prevention of underage and binge drinking that will be coordinated by ADAP's central office and supported by all 12 health district offices and all community grantees.

*Goal 3: Reduce prescription drug misuse and abuse among persons aged 12 to 25.*

Objectives:

- 3.1: The six high need health district offices will work with the Drug Enforcement Agency (DEA) and community partners to coordinate prescription drug take-back days in their regions.
- 3.2: Information about best practices for prevention of prescription drug misuse and abuse will be shared through a statewide learning community event with opportunity for cross-regional sharing and planning.
- 3.3: The six high need health district offices will identify which risk factors for prescription drug misuse and abuse they will address with their local implementation plan
- 3.4: Communities will plan and implement evidence-based strategies and associated activities designed to affect the specific risk factors for prescription drug misuse identified within the region and the state, with particular focus on subpopulations identified as having increased vulnerability through the regional assessments.
- 3.5: Local data will be collected to identify how well evidence-based strategies were implemented and the impact of these strategies on prescription drug misuse and the associated risk and protective factors.

## **B.2 Identification of Priorities**

Based on the analysis of statewide substance abuse and prescription data as documented in Section A of this proposal, Vermont has identified the following two priorities for this grant:

- 1. Underage drinking among persons aged 12-20, including binge drinking, and**
- 2. Prescription drug misuse and abuse among persons aged 12 to 25.**

Prevalence data from the 2011 YRBS for key indicators across Health Districts were presented in Figure 2 in Section A.2 and indicated a range for past 30 day alcohol use from 42.7% to 29.5% and a range for lifetime prescription drug use from 21.0% to 11.5%. According to the most recent state level NSDUH report (2008-2009), Vermont ranks highest in the country for both underage drinking and underage binge drinking. As a result of these alarming data, and as a result of our prior SPF-SIG work (2005-2011), Vermont is in a high state of readiness to continue our prevention efforts specific to underage and binge drinking among persons ages 12-20.

Vermont also has a high level of readiness for addressing prescription drug misuse. The Vermont Prescription Monitoring System has been operational since 2009, and in 2011 the Vermont Prescription Drug Abuse Workgroup (VPD Workgroup, 2011) issued recommendations for specific actions for preventing and recognizing prescription drug abuse statewide that are aligned with ONDCP's Prescription Drug Abuse Prevention Plan. This high level attention to the problems of prescription drug misuse are again driven not only by prevalence rates in Vermont, but also by the dramatic increase in the number of people seeking treatment for prescription drug addiction as cited in Section A. Governor Peter Shumlin has identified prescription drug misuse as an urgent priority for Vermont.

With the exception of a specific focus on underage binge drinking within the priority area of underage drinking, VDH is not proposing to directly address any additional priorities explicitly through the PFS initiative. We believe it will be more useful to focus these funds on two specific, measurable substance abuse goals that are of high priority for the state in order to maximize the potential for determining the success of the regional approach. Funds available through the Block Grant and other sources will be used to address other substance abuse prevention issues, such as marijuana use.

### **B.3 Project Structure and Implementation**

**B.3.1 Proposed Approach:** The Department of Health operates 12 District Offices (DO) located throughout the state. All Vermont residents have a local health office they can count on for health information, and for disease prevention and emergency response services. DO staff work with a diverse cross section of community stakeholders including community coalitions, schools, service clubs, human service agencies, medical providers, parent and youth groups, emergency responders, town officials and others. The DOs work to build on the relationships and strengths that already exist in the community. Of highest priority are services that increase the local community's capacity to lead and carry out effective public health initiatives.

The VDH will use PFS resources to enhance the state's capacity to build, maintain and sustain the SPF process in communities of high need through the existing structure of the state's 12 health district offices as described above. ADAP will provide an orientation to the District Offices on PFS goals, objectives and timelines. District Health Directors will convene regional stakeholders including local coalition coordinators, START, schools, hospitals, and local treatment providers to review needs assessment data and commence planning. They will ensure coordination of the PFS with other local initiatives, such as school-based prevention systems supported through the Departments of Health and Mental Health, substance abuse treatment and recovery services, health reform, and chronic disease, tobacco and obesity prevention efforts.

Regional substance abuse Prevention Consultants (PCs) who are experienced at applying the SPF model at the community level will facilitate and guide stakeholders through SPF Steps 1-3. The PCs will work with the community providers to analyze the district level data provided by our existing State Epidemiological Outcomes Workgroup (SEOW) along with other community-specific data sources. Relevant planning data used to select and target evidence-based strategies will include data on underage drinking and prescription drug misuse and related consequences, contributing factors for these behaviors, and patterns of use related to poverty, race/ethnicity, and geographic location. In addition to step 1, needs assessment, capacity will be determined through the administration of the Coalition Capacity Checklist - a validated tool utilized during the 5-year SPF-SIG, as well as an inventory of other funding sources, and relationships with key

partners, to identify areas of strength and challenges. A written plan will be developed that flows from a logic model driven by the data assessment and capacity analysis to identify the evidence-based strategies shown by research to impact the specific intervening variables. Identification of evidence based strategies will follow the guidance document developed for the SPF-SIG (Interventions, 2009).

Orientation materials on the PFS will be provided by ADAP staff. Training to support the planning process and increase knowledge about recommended evidence-based practices will be provided on a statewide basis through webinars and face to face events. Training will be available to all 12 health districts to support Vermont's entire prevention infrastructure. District Health Directors will make recommendations on which local organization has the capacity to serve as a subrecipient for PFS grant funds to implement prevention strategies and local evaluation activities. Initial planning funds will be provided with the final community grant award contingent on approval of an implementation plan.

Lastly, a statewide communications campaign supporting the PFS goals will be developed. Where feasible, the campaign will build on and link to the ParentUpVT.org campaign which targets reduction of underage drinking.

The completion of assessment, capacity building and planning as a health district region and the selection of one high-functioning community-based organization per district for implementation will move Vermont toward a prevention system that is more sustainable and ensures more consistent and timely development of implementation plans across the state. This approach supports ADAP's draft Strategic Action #5: Regional Organization, as identified through our SPE planning process (Attachment 1, page 9) and is designed to attain greater sustainability of efforts through the organization of prevention efforts into regional approaches. Consequently, this approach:

- a) represents a significant step toward achieving a more regionalized organization of prevention work throughout the state including targeting underserved populations;
- b) relates directly to key strategic directions in the VDH Strategic Plan including enhanced capacity for collaborative community health assessment, prioritization, planning and implementation at the district and local level;
- c) addresses a recommended enhancement identified in Vermont's 2011 Substance Abuse Prevention and Synar System Review Report.

**B.3.2 Selection of Subrecipient Communities:** The SEOW analyzed a variety of data sources in order to identify an approach for targeting PFS funds to high need communities. The resulting methodology uses a set of variables to produce a composite need score that enables ranking of health districts by relative need. The variables included in this composite are:

1. Youth Risk Behavior Survey (YRBS) for 2011:
  - a. Lifetime use of prescription drugs (Rx) without a prescription
  - b. Past 30 day alcohol use
  - c. Past 30 day binge drinking
  - d. Disparity in Rx misuse by mother's education level
2. 2010 U.S. Census:
  - a. Population between the ages of 10 and 25 years old within each district area

Due to low numbers of non-white residents in the state, examining disparities across districts in

underage drinking and prescription drug misuse by race/ethnicity was not possible. Furthermore, there are no federally designated tribal governments in Vermont, with American Indians making up 0.5% of the state's total population. There is however a substantial heterogeneity in socioeconomic status (SES), both statewide and for each of the state's 12 districts. In order to examine SES disparities in binge drinking and prescription drug misuse by district, maternal education level was used as a proxy to examine disparities based on SES. This measure is validated and widely-used to determine SES among children (Davis-Kean, 2005; Nepomnyaschy, 2006). Alcohol use by maternal education did not vary by district, however prescription drug use disparity varied widely and was considered important to include.

In order to create the relative need score, each variable was standardized to have a mean of 0 and a standard deviation of 1 making them comparable and equally weighted. The standardized variables were summed to create a composite score that enabled a relative ranking of the 12 districts. The results are displayed in Table 2 which identifies the six districts selected for PFS funding (see Section A, Table 1 for demographic data on all 12 districts).

**Table 2. Vermont Health Districts by Relative Need for Targeted PFS II Funding**

District	Population <sup>1</sup>	Prescription drug use <sup>2</sup>	Alcohol use <sup>3</sup>	Binge drinking <sup>4</sup>	Disparity in prescription drug use <sup>5</sup>	Rank
Brattleboro	-0.4	2.6	1.1	1	-1.4	2.8
Newport	-0.6	-0.2	2.2	1.8	-1.2	2
Morrisville	-0.5	0.6	1.1	1	-0.3	1.9
White River	-0.2	0.6	0.2	0.1	0.9	1.6
Burlington	3.1	-0.6	-0.9	-0.7	0.4	1.2
Barre	0.2	-0.6	-0.1	0.5	0.1	0.2
Rutland	0.1	-0.2	-0.1	0.5	-0.4	0
Springfield	-0.6	-0.2	-0.4	-1.1	2	-0.3
Bennington	-0.4	0.6	-0.6	-0.3	0.3	-0.4
St. Albans	0	-1	-0.4	-0.3	0.4	-1.3
Middlebury	-0.2	-1	-0.6	-1.5	0.6	-2.7
St. Johnsbury	-0.4	-0.6	-1.5	-1.1	-1.4	-5

<sup>1</sup> between 10 and 25 (2010-Census)

<sup>2</sup> in life (2011-YRBS)

<sup>3</sup> in past 30 days (2011-YRBS)

<sup>4</sup> in past 30 days (2011-YRBS)

<sup>5</sup> disparity in prescription drug use by low maternal education (high school or less versus more than high school) (2011-YRBS)

The SEOW also examined the history of prevention resources in each district. The total number of multi-year substance abuse prevention grants (i.e. SPF-SIG, Drug Free Communities, VDH Community Grants) awarded to each district within the last 10 years was calculated to determine the historic level of resources in each. Of the six districts selected for this project, three districts (Newport, White River Junction and Morrisville) have a history of low levels of resources, two (Brattleboro and Barre) have had moderate levels of resources, and the Burlington area has had a high number of grants due to its status as the largest population center in the state. If after receiving funding any of the selected districts is considered to have insufficient readiness to implement the PFS (e.g. current status of key community coalitions, key staff vacancies), then an

alternate district may be considered.

**B.3.3 Documentation of Community-level Need and Baseline Prevalence:** As described in Section A, the YRBS is widely administered in Vermont enabling analysis of key prevalence indicators at a high level of precision at the district level. Measures of community level need were assembled and used to select the subrecipient communities, as detailed in the preceding section. Additional data to be collected in 2013 (e.g. YRBS, YAS) will also contribute to the district-level baselines (see Section D). Additional needs assessment to be conducted within the funded districts will be implemented as described in Sections B.3.1. The data in Table 2 provides currently available baseline data that will contribute to the outcome evaluation.

**B.3.4 Monitoring Community Progress and Outcomes:** Community-based subrecipient grantees will be monitored through the submission and review of quarterly work plan reports and National Outcome Measure (NOMs) reports (see Section D), along with subrecipient expense reports, by the VDH central office PFS Coordinator Lori Uerz. In cooperation with the District Office staff, Ms. Uerz will also monitor and support the progress at the district office level, including the activities of the PCs and district prevention teams. Based on funding levels, monitoring site visits will be scheduled yearly with monthly phone and email communications throughout the life of the project.

Sources and procedures for obtaining outcome data and plans for analyses of the outcome data are described in Section D.1. Community subrecipients will report any additional locally-collected outcome data relevant to the strategies they implement as part of their quarterly work plan updates.

#### **B.4 Provision of Support and Guidance to Subrecipients to Implement the SPF Model**

VDH has successfully implemented two State Incentive Grants aimed at increasing community prevention capacity and reducing alcohol, tobacco and other drug use. Population level changes in substance use prevalence were achieved in both cases. Vermont's State Incentive Grant (SIG), New Directions, was implemented from 1999 to 2001. New Directions communities collectively achieved significant reductions for past 30-day use of marijuana and cigarettes and lifetime use of marijuana and cigarettes, among 8<sup>th</sup> – 12<sup>th</sup> graders. Prevalence of alcohol use among 8<sup>th</sup> through 12<sup>th</sup> graders also decreased (Flewelling, 2004).

Vermont's SPF-SIG was implemented from 2006 to 2011. The evaluation revealed that reductions in binge drinking and marijuana use among 8<sup>th</sup> through 12<sup>th</sup> graders were significantly greater for the SPF-SIG communities as compared to non-funded communities (VDH, 2012). Prevalence on any alcohol use also declined more in the SPF-SIG communities although the difference did not reach statistical significance. Seventy-one percent of the state's population was covered by SPF-SIG intervention sites.

A critical factor in the successes achieved in the SIG and SPF-SIG projects was the commitment to and quality of the training provided to the grantee communities. Training included both guidance and technical assistance from experts in the field, as well as ample opportunities for peer learning and networking. The approach to training and technical assistance used, as well as other lessons learned from Vermont's SIG and SPF-SIG, will be applied in the implementation of the PFS work. An updated Training-of-Trainers on the SPF steps and cultural competency will be provided to regional substance abuse Prevention Consultants and District Directors. This will include updated information on recommended best practices in the area of underage drinking, binge drinking and prescription drug misuse, based on state logic models for both underage

drinking and prescription drug misuse currently under development through Vermont's Strategic Prevention Enhancement (SPE) Grant.

For the PFS, a training contractor will be selected through a competitive bid process to provide community-based grantees and district office staff an intermediate level of training on the SPF model (versus the basics that were received during the SPF-SIG) including knowledge and skill development in the areas of data analysis, logic model development, building capacity and readiness in the community, plan development, evidence-based strategy implementation, evaluation and cultural competency. Guidelines for implementing recommended evidence-based strategies with fidelity will also be provided to District Offices and subrecipients.

### **B.5 Subrecipient Implementation of the PFS and Adherence to CLAS**

Funded organizations will use the guidance provided in ADAP's strategic plan, logic models and recommended list of evidence-based strategies to implement the various components of the district's regional plan. Subrecipients will determine which community entities are best suited to implement each strategy and may choose to award sub-grants to other community organizations to implement some components of the plan. For example, if the district plan identifies the need to work with families with low SES to increase protective factors through a parenting program, they may identify an organization that has access to a population living in a low income housing development that would be best suited to take the lead on this strategy. Any sub-grants must be approved by VDH. Subrecipients will develop detailed implementation workplans for each proposed evidence-based strategy using guidance provided by ADAP. Prevention Consultants (PCs) and central office staff will provide technical assistance to communities to ensure effective implementation of all evidence based program, policies and practices.

In addition to strategies identified in the district plans, District Offices and subrecipients will conduct activities locally to support a statewide communications campaign targeting underage drinking. This campaign will be based on the existing ParentUpVT.org campaign, which is aimed at reducing alcohol use among school age youth through parent education and support. PFS communities will support the continuation of this campaign through paid and earned local media, distribution of campaign materials and referrals to the campaign website. Training and support on the implementation of this campaign at the district level will be coordinated by central office staff and supported by PCs and District Directors.

The SPF-SIG provided ADAP staff and community grantees the opportunity to further develop cultural competence and this will continue to be a focus with the PFS project. From 2005 to 2011, ADAP staff and approximately 30 community coalitions received training and TA on the Health Resources and Services Administration (HRSA) cultural competence assessment, *An Organizational Cultural Competence Assessment Profile*, (Linkins, 2002) which builds upon the work of the CLAS standards (Culturally Competent Care, Language Access Services and Organizational Supports). Grantees utilized this tool to improve coalition bylaws and practices based on the race, ethnicity, and socio-economic make-up of their communities. PFS sub-recipients will be expected to consider and be sensitive to cultural difference among the populations targeting and exposed to prevention strategies. As part of assessment, capacity building and planning communities will be required to look at health disparities within their regions to identify sub-populations that may need specific focus. Each subrecipient will receive a copy of the CLAS standards and these standards will be reflected in training provided to regional planners and subrecipient organizations. Pat Nelson-Johnson, VDH's Minority Health Coordinator will provide technical assistance to the staff in applying the CLAS standards. She

will also provide guidance on recommended regional needs assessment and planning, objectives for training, and culturally competent materials and communications strategies. PFS grantees will assess their progress on incorporating the CLAS standards as part of their final quarterly work plan report.

**B.6 Three-year PFS Work Plan**

<b>Time Frame</b>	<b>Key Activities</b>	<b>Milestones</b>	<b>Responsible Staff</b>
10/12	Inform stakeholders of PFS award & high need communities selected	Public Announcement & project abstract released	Cimaglio
10/06/12	VT College Symposium on High Risk Drinking	Training on EB practices targeted to institution staff & students completed	Baroudi
10/12-12/12	Competitive bid process for selection of training, evaluation & communications contractors	PFS statewide contractors selected	LaPlante/ Uerz
11/13/12	VDH Learning Community Day on Best Practices in the Prevention of Rx Drug Misuse	All regions oriented on Rx Drug Misuse Prev Plan; cross regional info sharing	Rx Drug Workgroup; PCs
11/12	Convene Advisory Council via teleconference	Council oriented on PFS & provide feedback on action plan for year 1	Cimaglio; LaPlante
11/12	SEOW creates regional profiles on alcohol & Rx consequences, consumption, community/disparities	Profiles completed	Searles
11/12	OLH & ADAP organize orientation activities for District Office Prevention Teams	DDs & PCs trained; ready to invite stakeholders & commence planning	OLH & ADAP
12/12	District Offices (District Directors – DDs) develop regional planning kick-off	Invitations issued & planning commenced with review of regional Epi profiles	Baroudi; DDs & PCs
12/12	Evidence-based practice workgroup identify recommended interventions, based on SAMHSA guidance, & present to advisory committee	Menu of evidence-based interventions approved	Searles & Eval Contr
1-3/13	Webinars on SPF Process, readiness assessment & EB practices implemented	Regional stakeholders & planners engaged in regional plan development	Eval Contr; PCs
3/13	VT Youth Risk Behavior Survey administered	Schools within intervention regions participate	VDH DHS
3-4/13	Face to face training for regional teams on EB practices, regional sharing; District Office Teams provide local TA	Regional grant subrecipients selected. Action plan submitted to ADAP for review.	Training Contr; Uerz; DDs; PCs
5/13	Regional plans reviewed & revisions requests	Regional plans approved & award implementation grants	Uerz; Lamonda

6-9/13	Subrecipients commence plan implementation	Implementation underway	Uerz
6-9/13	Webinar TA on selected interventions offered	Webinars implemented	Training Contr
<b>Year 2</b>			
10/13	Communications Campaign begins	All 12 regions & district offices promote communications campaign	Lamonda
10/13	Subrecipients continue to implement strategies with fidelity	Work plans' progress submitted & reviewed quarterly	Uerz; PCs
11/13-9/14	Trainings & regional sharing based on needs assessed through review of quarterly reports	Trainings implemented	Uerz; Training Contr; PCs
3/14	Regional work plans updated & submitted	Plans approved	Uerz & DDs
<b>Year 3</b>			
10/14	Communications campaign booster	Continue to promote communications campaign	Lamonda
10/14	Subrecipients continue to implement strategies with fidelity	Work plans progress submitted/ reviewed quarterly	Uerz & PCs
3/15	Regional work plans updated & submitted	Plans approved	Uerz
3/15	VT Youth Risk Behavior Survey administered	Intervention regions' schools participate	VDH DHS
11/14-9/15	Trainings & regional sharing based on needs assessed through review of quarterly reports	Trainings implemented	Uerz; PCs Training Contr
11/14-9/15	Each of 6 intervention regions mentors an additional region	All 12 regions developed prevention plans on state priorities	Uerz; Baroudi; DO
9/15	Final Report to CSAP and dissemination of findings	Report submitted; evaluation findings published	Uerz; Eval. Contractor

### **B.7 Role of Advisory Council, SEOW and Evidence-based Practice Workgroup**

The *Vermont Alcohol and Drug Abuse Advisory Council* has served as the oversight body for Vermont's SPE Grant. This Council includes representatives from a broad array of state departments, consumers and interest groups, from prevention through recovery, committed to the reduction of substance abuse. Per statute, the Council serves in an advisory role to the Governor (33 VSA Ch7 § 703). A sub-committee will be recruited from this group to advise VDH on the PFS. Those entities with resources targeted to the objectives of this project will serve as advisors in order to promote leveraging and aligning of resources. This will include the Departments of Education, Public Safety (includes Governor's Highway Safety Program), Liquor Control, Mental Health and the Division of Maternal and Child Health will be recruited. These members also serve on the statewide Stop Teen Alcohol Risk Team. Lastly, consumers will be recruited through the Vermont Association of Mental Health and Addiction Recovery, Prevention Works,

and Vermont's Young Adult Advisory Team.

Vermont has an active *State Epidemiological Outcomes Workgroup* (SEOW) which was established in 2005 as part of the SPF-SIG initiative. The SEOW has been charged with bringing systematic, analytical thinking to the causes and consequences of the use of alcohol, tobacco and other drugs in order to effectively and efficiently utilize prevention resources through data-driven decision making. The SEOW is made up of key state agency staff, epidemiologists of varying disciplines, and representatives from higher education and the United Way. The SEOW generated an initial report in 2007 and a revised epidemiological review in 2012 (EPI Profile 2012). The SEOW will continue to provide data analysis to the state to review on a yearly basis and will provide district level data to the district office staff and high need communities identified to receive funding for this grant. SEOW chair John Searles will assist district office staff in the drill down analysis of district office data to specifically identify risk and protective factors and intervening variables unique to each district office catchment area.

The *Evidence-Based Practice Workgroup* is chaired by John Searles and is composed of epidemiologists, evaluators, ADAP program staff and community-based providers. The workgroup was active at the beginning of the SPF-SIG project and during the statewide planning for FY 2012 to identify a discreet list of evidence based strategies communities could potentially implement. The Evidence-based Practice Workgroup utilizes the standards identified by SAMHSA in published guidance (Interventions, 2009). The workgroup continues to work on the development of a Vermont-specific list of EBPs recognizing the state's largely rural and homogeneous population. As part of the PFS initiative, the workgroup will be convened to review and make recommendations on a list of possible evidence-based strategies developed by PIRE as a result of their review of literature and development of state logic models for underage drinking and prescription drug misuse. These lists will be finalized, reviewed by the Advisory Council, and provided to District Office staff and subrecipients prior to the development of their regional plans.

### **B.8 Addressing Sub-population Disparities and Needs**

Each district office staff, with assistance from the SEOW chair, will identify specific sub-populations based on the demographic data specific for that catchment area. Each community plan will address socioeconomic status (SES) and how that impacts access to and or use of both alcohol and prescription drugs as each of the six regions identified have either many communities or specific areas of poverty. Other demographic differences and subgroups based on gender, age, race and ethnicity, sexual identity and orientation, language and literacy, and disability will be identified and addressed as indicated based on the community assessment, comprehensive and inclusive planning process, and the selection of appropriate sub-grantees. For example, the Burlington area health district has the highest percentage of immigrant populations in the state. This District Office will apply effective approaches for connecting with and including these populations by using educational and communication materials in multiple languages and through the inclusion of members of various immigrant communities to provide advice and input on effective outreach methods specific to different cultures.

## **SECTION C: STAFF, MANAGEMENT AND RELEVANT EXPERIENCE**

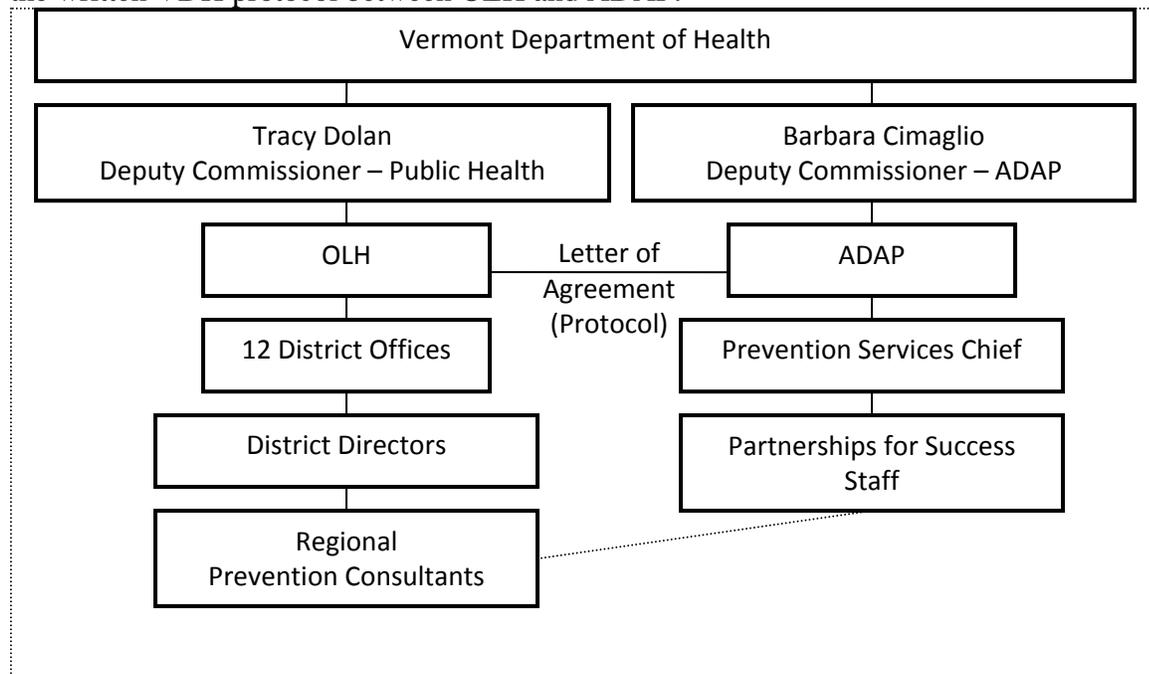
### **C.1 Capacity and Experience of VDH**

The Vermont Department of Health (VDH) has successfully implemented two State Incentive Grants aimed at increasing community prevention capacity and reducing alcohol, tobacco and

other drug use. These were the *Vermont State Incentive Grant, New Directions* and *Vermont's Strategic Prevention Framework Incentive Grant*. Population level changes in substance use prevalence were achieved in both cases (Flewelling, 2004). The details of these initiatives are discussed in more detail in Section B. These lessons learned from each will be applied in the implementation of the Partnership for Success (PFS).

ADAP will have responsibility for implementation of the PFS. Key staff on the PFS have previous experience in managing and implementing Vermont's SPF-SIG. In addition, ADAP has been responsible for management of Vermont's Enforcing Underage Drinking Laws (EUDL) Block Grant which has supported community education and enforcement, and was closely coordinated with the implementation plans of work of Vermont's community coalitions. The EUDL Coordinator will be directly involved in the PFS as noted below.

The Office of Local Health (OLH), central management for the 12 District Offices (DOs), will also have a significant role in implementation of the PFS. As noted in Section B, the DOs are Vermont's key infrastructure for community organization and technical assistance. Each DO has developed a cross-disciplinary prevention team with the knowledge of the five steps of the SPF model. Included on these teams, are the 8 Regional Substance Abuse Prevention Consultants (PCs) who have experience in employing the SPF model, including cultural competency training at the community level. (Note that 4 of the 8 PCs serve 2 DOs). ADAP trains and sets the deliverables for the PCs, and OLH supervises the PCs. These roles are defined and formalized in the written VDH protocol between OLH and ADAP.



VDH is making a substantial commitment to workforce development for the cross-disciplinary teams. An internal VDH multi-disciplinary work group is focused on workforce development. The workgroup consists of program staff from ADAP, Maternal Child Health, OLH, Health Surveillance, Health Promotion & Disease Prevention and the Commissioner's Office. The primary focus of the *Central Office Prevention Team Workforce Development Committee* is to promote core prevention competencies among District Office Prevention Team members. The

Committee developed and completed a staff assessment of core competencies in three areas; Public Health Prevention, Integration, and Strategic Prevention Framework. The results are being utilized to create a VDH Training Plan and will involve continued education on all aspects of the Strategic Prevention Framework. VDH's goal is to provide technical assistance and data to local partnerships and train them on the skills and tools they will need to assess the health of their communities; tailor effective public health programs and policies; and evaluate the impact of such interventions.

### **C.2 Personnel, Level of Effort and Qualifications**

Work on this grant will be performed by existing staff as part of their current positions. A part time administrative assistant will be hired to assist these staff with additional communications, meeting logistics and report compilation required (see staffing grid following this section).

In addition to the key staff identified on the staffing grid, additional VDH staff will be supporting the effort. Allison Reagan, Director of the Office of Local Health, will assure partnership between OLH and ADAP on this project. District Health Directors, under Alison Reagan, will invite stakeholders to engage in the PFS process, and lead the selection of a sub-recipient organization that has experience with the SPF process in each of the six high need districts. Pat Nelson-Johnson, Minority Health Coordinator, will provide technical assistance to the PFS staff in applying the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. She will provide guidance on recommended regional needs assessment, planning, and objectives for PFS training. Ms. Nelson-Johnson will review materials and messages for culturally competency.

### **C.3 Key Staff Experience with Cultural Competency**

From 2005 to 2011, ADAP staff and approximately 30 community coalitions received training and TA on the Health Resources and Services Administration (HRSA) cultural competence assessment, *An Organizational Cultural Competence Assessment Profile*, (Linkins, 2002) which builds upon the work of the CLAS standards (Culturally Competent Care, Language Access Services and Organizational Supports). Staff applied this learning across programs.

ADAP staff are also engaged in the VT Resiliency and Recovery Oriented Systems of Care (RROSC) initiative. RROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. RROSC networks improve access to services and supports in order to facilitate long-term recovery. The Regional Substance Abuse Prevention Consultants (PCs) are vital to the success of RROSC. PCs help the regional RROSC teams learn about and build linkages with the resources available in their communities. This has provided the PCs a rich experience in working with Vermonters suffering from a variety of health disparities, and co-occurring disorders.

<b>Staff</b>	<b>Role/Background</b>	<b>LOE</b>
Barbara Cimaglio, Deputy Commissioner of Alcohol and Drug Abuse Programs	Project Director. Provides administrative leadership for the process, supervision of project manager, and ensures that ADAP complies with SAMHSA requirements and reporting needs. More than 30 years of experience in the ATOD field. Single State Authority for VT. Project Director for Vermont's SPF SIG.	5%
Marcia LaPlante, Prevention Services Chief	Project Manager. Oversight of PFS workplan, contract development, and supervision of staff.. 30 years of experience in the mental health and addictions field, 17 years as manager of VT substance abuse prevention system and served as Vermont's National Prevention Network representative. Has managed 2 State Incentive Grants.	10%
Lori Tatsapaugh Uerz, Public Health Program Administrator	Project Coordinator. Oversight of community grants, training and monitoring of PFS program. Will assure all reporting and data collection systems comply with federal requirements. Responsible for all PFS reports to SAMHSA. 30 plus years of experience in the substance abuse prevention field with expertise in grants management, evaluation, logic model development and strategic planning.	50%
John S. Searles, Ph.D., Substance Abuse Research & Policy Analyst	State Epidemiological Outcomes Workgroup (SEOW) Chair. Develops and updates State Epidemiological Profile. Develops regional and community profiles to staff and PFS grantees specific to PFS priorities and special populations. Chair of Evidence-based Practice Workgroup. Over 30 years experience in research, epidemiology and data analysis.	25%
Kelly Lamonda, Prevention Coordinator	Assures coordination between Partnership for Success, Enforcing Underage Drinking Laws programs, school-based substance abuse prevention grant. 20 years of experience in the addictions field, with 10 in data collection, analysis, and reporting and 5 as VT Substance Abuse Prevention Coordinator.	10%
Patty Baroudi, Prevention Coordinator	Serves as liaison to the Office of Local Health and oversees regional prevention consultant services on the Partnership for Success Grant 26 years of experience in the addictions field with 18 as VT Substance Abuse Prevention Coordinator.	10%
Regional Substance Abuse Prevention Consultants	Provision of technical assistance and training to regional PFS planning teams and grantees; facilitate planning processes. Assist VDH District Directors in outreach to community partners on PFS. Years of experience range from 15 to over 30 years in the substance abuse prevention field.	25% of 8 FTEs
New Position: Administrative Assistant	The assistant will support the efforts of the project staff. Tasks include arranging meeting logistics; communications with District Office Directors, grantees and contractors; compilation of reports; and other duties.	50%

LOE = Level of Effort

**SECTION D: PERFORMANCE ASSESSMENT AND DATA**

**D.1 Plans for Collection, Analysis, and Reporting of Data**

The performance and outcome data to be collected at both the state and community subrecipient levels will serve a number of critically important purposes. Specifically, they will:

- meet CSAP/SAMHSA requirement for National Outcome Measures (NOMs) as needed to meet both GPRA requirements and their own internal program monitoring purposes;
- provide process measures to ADAP regarding the implementation of the PFS II at both the state and subrecipient levels;
- provide measures on intermediate outcomes (i.e. risk factors, or intervening variables) and ultimate programmatic outcomes (i.e. substance use behaviors and consequences) that can be used for both planning and evaluation purposes;

Vermont has data collection systems already developed and in place to ensure all data requirements are met. The following table lists the required state- and community-level process measures to be reported by the state to SAMHSA twice per year, and identifies the data source for each.

**Required Process Measure Data**

<b>State-Level:</b>	<b>Data Source</b>
Number of training and technical assistance activities per funded community provided by the grantee to support communities	State Project Coordinator, augmented by data from the Prevention Consultant Data System
Reach of training and technical assistance activities (numbers served) provided by the grantee	Training and technical assistance (TTA) attendance logs
Percentage of subrecipient communities that have increased the number or percent of evidence-based programs, policies, and/or practices	Roll-up of community-level data (see below)
Percentage of subrecipient communities that report an increase in prevention activities supported by leveraging of resources	Roll-up of community-level data (see below)
Percentage of subrecipient communities that submit data to the grantee data system	State Project Coordinator (based on receipt of data from communities)
<b>Community-Level:</b>	
Number of evidence-based programs, policies, and/or practices implemented	NOMs Program Report Forms
Number of active collaborators/partners supporting the grantee’s comprehensive prevention approach	NOMs Grant Report Form Cover Sheet (item to be added in 2013)
Number of prevention activities supported by leveraging of resources	NOMs Grant Report Form Cover Sheet (item to be added in 2013)
Number of people reached by IOM category (universal, selected, indicated) and demographic group	NOMs Program Report Forms

The sources for the state-level process data are self-explanatory and do not involve specific instruments other than the Prevention Consultant (PC) Data System (see Attachment 2). The

data collection form is designed to monitor the types of training and technical assistance provided by the PCs and will be modified to capture any regionally-coordinated trainings and technical assistance provided by other members of the health district prevention teams.

The National Outcome Measures (NOMs) reporting forms for process data to be submitted by the community subrecipients are already in use by ADAP community grantees funded through the FY12 and FY13 community grants programs. The forms and instructions are available online on the VDH website (see Attachment 2 for web link). The forms capture information, for both individual- and population-based programs, regarding the names and types of strategies implemented, the activities comprising each strategy, and the number of persons served according to age group, gender, race, and ethnicity. Planned additions to the forms include a list of community partners that helped to support each strategy, and a check box for whether the strategy was funded through leveraging of additional (i.e., non-PFS) resources. Vermont has had 100% submission rates of these forms by its FY12 community grantees. The state will require community subrecipients to submit their report forms on a quarterly basis, along with their quarterly work plan and fiscal report. The process data would, therefore, be available for quarterly submission if requested by SAMHSA (and will clearly meet the requirement for submitting process data to SAMHSA twice a year, as specified in the RFP).

The SAMHSA-required outcome measures, and data sources, are listed in the following table. Because SAMHSA will obtain the state-level outcome measures from existing national systems (e.g. NSDUH), only the community-level measures and sources are listed.

**Required Community-Level Outcome Data**

<b>National Outcome Measure</b>	<b>Community-Level Data Source</b>
30-day alcohol use	YRBS
30-day binge drinking	YRBS
30-day prescription drug misuse	YRBS (item is based on lifetime use), Young Adult Survey (YAS)
Perception of parental or peer disapproval/attitude	YRBS
Perceived risk/harm use	YRBS
School attendance and enrollment	Vermont Department of Education (Annual School Reports)
Alcohol and/or drug-related car crashes and injuries	Vermont State Police: Crash Analysis Division
Alcohol- and drug-related crime	Vermont Criminal Information Center: VCON Data System
Family communication around drug use	YRBS (item to be added in 2013)
Alcohol and prescription drug-related emergency room visits	Vermont Department of Health: Uniform Hospital Discharge Data Set

The substance use measures in the table above pertain to Vermont’s two priorities selected for the PFS, underage drinking (ages 12-20) and prescription drug misuse among persons aged 12 to 25. The YRBS items on prescription drug misuse pertain specifically to: a) prescription pain

relievers, and b) stimulants such as Ritalin or Adderall, and due to their low prevalence rates are defined on the basis of lifetime rather than 30-day use. The YRBS also includes items on several risk factors identified in Vermont's draft underage drinking prevention logic model being developed through Vermont's SPE grant. These include peer and parental disapproval, perceived risk of harm, and perceived availability. An item regarding family communication about substance use has been requested for inclusion in the 2013 and 2015 YRBS instruments. Although the YRBS is conducted only in Feb-March of odd-numbered years, the timing of these administrations is ideal for securing both baseline and follow-up measures relative to the planned implementation of PFS activities at the community level (see Attachment 2 for link to YRBS and the administration protocol, and Attachment 3 for the consent forms).

A second proposed source for measuring outcomes is the statewide Young Adult Survey (YAS). This survey was conducted in 2008 and 2010 as part of the state's SPF-SIG evaluation effort. The survey provided very useful data at the state level, but the sample sizes were sufficient to provide community-level data for only some of the communities. Participants were recruited both through Facebook and through local promotion efforts (e.g. posters and newspaper ads). Another round of the YAS is planned as part of the SEOW's efforts in FY13. With the focus now on districts rather than individual communities, and the use of enhanced participant incentives, we expect that sample sizes will be large enough in all or most districts to provide district-level estimates of prescription drug misuse and associated risk factors. The survey does not currently include items on prescription drug misuse, but items corresponding to those used in the NSDUH will be added for the FY13 version. The survey will continue to include items related to alcohol use as well. A copy of the current version is included in Attachment 2.

Other measures listed in the table above include consequences of underage drinking and/or prescription misuse and are important to track, both for the state's evaluation of the PFS and for submission to SAMHSA. All of these measures are publically available from archival data sources provided through existing data systems. Furthermore all data sources listed, including the YRBS, have geographic identifiers that will allow roll-up of the data to the level of the state's 12 health districts, which is the basis on which the community subrecipients will be defined. All data sources also provide either annual or (in the case of the YRBS and YAS) biannual estimates, and therefore meet SAMHSA's requirements for either annual or, at a minimum, first and third year submission of outcome data.

In addition to submitting all state and community data elements required by SAMHSA, these data will be analyzed and interpreted in order to provide meaningful narrative summaries of Vermont's progress in its quarterly and annual report submissions (described in Section D.2 below). Even more extensive analysis and reporting activities are also planned (see Section D.3 below), all of which will be shared with SAMHSA as products become available.

## **D.2 Use of Data to Manage Project, Quality Improvement and Communication with Staff**

The importance of monitoring implementation through collection of process data cannot be overstated. The process data to be collected serve to both enhance the quality of implementation through supporting continuous quality improvement efforts, and provide essential contextual information needed to interpret the findings from the planned outcome evaluation. Process data can, for example, be used to identify features of program implementation that enhance or hinder achievement of desired programmatic outcomes.

Process evaluation will be conducted at both the state and the community subrecipient levels in order to document activities, monitor progress, and identify implementation issues that may need to be improved or rectified. Clear and candid communication, including regular opportunities for giving and receiving feedback, among the project management team, project staff, community subrecipients, training coordinator, and evaluation contractor, collectively characterize Vermont's approach to using process data to help monitor and fine tune project management and implementation. At the state level, the work plan developed for state implementation of the PFS (see Section B.6 above) will be expanded to include columns for notation regarding: achievement (or non-achievement) of milestones, barriers encountered, and changes made to the work plan.

Over the life of the project, the PFS Project Coordinator will review the work plan and fill in the additional columns monthly. On a quarterly basis she will review the state-level work plan with the on-site project evaluator and add, revise or clarify as needed any elements of the plan, including the upcoming activities and milestones for the next quarter. The annotated work plans will serve as a resource for completion and submission to CSAP of the state's quarterly progress reports and annual performance assessments. This level of documentation will be useful in addressing a number of questions central to understanding how the PFS was implemented and adapted as necessary in Vermont, and provide useful contextual information for interpreting the outcomes. Similar benefits from the process data collection efforts at the community sub-recipient level are discussed below.

Two data collection instruments will provide process data regarding community subrecipient activities. The first of these, the NOMs reporting forms, were described in the preceding section. The second is the Strategy Implementation Work Plan (SIWP) template (see Attachment 2 for a copy). Both forms will be completed and submitted quarterly by the community subrecipient coordinator to the State Project Coordinator. The forms were designed to complement one another and avoid unnecessary duplication. The SWIP will be expanded to include work plans for the assessment, capacity building, and planning steps of the SPF, in addition to the existing work plan template for implementing and evaluating each strategy. Whereas the NOMs forms provide the community performance data necessary for submission to SAMHSA, the SIWPs provide more detailed information about community implementation, especially with regard to each of the strategies selected by individual community subrecipients. Similar forms were used for the SPF-SIG, and proved to be extremely helpful in laying out the core components of each strategy and then monitoring the progress in implementing those core activities and assessing their fidelity of implementation. In particular, they were instrumental in identifying deficits in the implementation plans before it was too late to make corrections, and also building in a level of accountability for implementation fidelity that otherwise would not have existed. The State Project Director and on-site evaluator worked closely with the community coordinators to develop the plans and review them on quarterly basis, including strategies to improve fidelity of implementation. More detailed discussions regarding work plan development and implementation occurred during annual site visits with the community subrecipients. The same strategies for working with, and providing feedback to, the community grantees will be applied in administering the PFS. Summary accounts of the community-level implementation, based on the information in the work plan updates and subsequent reviews, will be prepared for inclusion in the state's quarterly progress reports and annual performance assessments submitted to CSAP.

To assist subrecipient communities in developing their capacity building plans, as well as to assess progress in building community capacity, organizational capacity will be measured early in the grant period and again towards the end of the grant. For the SPF-SIG, a Coalition Capacity Checklist (see Attachment 2) was created and employed, and proved to be very useful in helping community grantees identify their organizational strengths and weaknesses, and develop their capacity building plans. Some modifications will be necessary to reflect the structure of the PFS, although many of the constructs assessed for the SPF-SIG remain extremely relevant to the PFS as well. Data from the checklist will also provide an opportunity to assess whether the PFS is achieving its goal of building regional and local prevention capacity, and to further explore the relationships between community capacity, fidelity of implementation, and success in achieving desired outcomes.

Findings from the evaluation will be disseminated in various formats, including:

- Press releases from the VDH Communications Office
- Presentations to state policy makers and work groups (e.g. the SEOW)
- Brief “one-pager” reports that may be widely disseminated to multiple audiences
- Somewhat more detailed reports for use by selected audiences within the state
- Manuscripts in prevention research journals

These venues have all been successfully used by VDH in previously funded large-scale prevention initiatives, and are viewed as being essential components of any evaluation effort. The state is equally committed to sharing data and results with the subrecipient communities, and providing the necessary training and technical assistance to help make data and evaluation findings interpretable and useful at the local level. Individual YRBS reports are already prepared for every school district in the state and made available online for community organizations to track changes in student substance use and other health-related behaviors and risk factors. County and/or community-level reports from the statewide parent and young adult surveys were made available to every SPF-SIG subrecipient community in which minimal sample sizes were obtained. In the spring of 2012, an intensive one-day workshop on local evaluation was held for VDH community grantees working on substance abuse, obesity, and/or tobacco prevention. For the PFS, similar efforts to both share data and findings with community subrecipients, and provide the training and tools necessary for communities to use data to support and enhance their work, will again be a fundamental feature of the project.

### **D.3 Plans for Performance Assessment**

Vermont’s plan for monitoring project activities (i.e. process evaluation) at both the state and community subrecipient levels, and reporting these activities to SAMHSA, is explained in the preceding section. Ultimately, policy makers need to know whether sponsored programs achieve their intended results, and for this purpose there can be no substitute for valid, diligently collected and rigorously analyzed outcome data. As the data accumulate, and in particular when follow-up outcome data become available later in the project, Vermont will also ensure that these data are carefully analyzed and the results disseminated in a manner that will inform decision makers at the federal, state, and community levels. Drawing on the Vermont’s strong tradition of supporting data systems that can provide population-level indicators at the local level, the state has the capacity in place to ensure that outcomes achieved through the PFS will be measureable. The availability of YRBS data at the community level for all school districts throughout the state, in particular, as well as survey and archival outcome data from other sources listed in the

preceding section, significantly enhances the opportunity for rigorously evaluating the impacts of the PFS.

The structure of the proposed PFS project provides a useful design for assessing impacts, both on the stated priority outcomes of underage drinking and prescription drug misuse, and on important risk factors connected to those outcomes. Specifically, with half of the state's health districts receiving PFS funding, comparisons will be made in changes in outcome measures and risk factors over time between the intervention (i.e. funded) districts and the comparison (i.e. non-funded) districts. Annual data (or biennial in the case of the YRBS) through 2013 will provide the baseline values, and subsequent years will provide the follow-up data necessary to assess change over time and assess the duration of programmatic effects. Although multiple factors in addition to prevention efforts may help drive changes in any particular community, analyzing data from multiple communities, both intervention and comparison, provides a much stronger methodological basis from which to observe and confirm whether the PFS is achieving its outcome goals. It will also allow for a more definitive analysis of population subgroups (e.g. by gender, race/ethnicity, SES, and sexual orientation) that may be differentially affected by the interventions. The extensive process data collected at both the state and subrecipient levels will provide essential contextual information necessary to interpret the outcome evaluation findings. For example, implementation data can often provide useful insights as to why, or why not, communities were successful in achieving desired outcomes. Specifically we will examine features such as which strategies were implemented, how well they were implemented, and community capacity, along with sociodemographic, cultural, and other contextual attributes.