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NATIONAL ALLIANCE OF STATE
& TERRITORIAL AIDS DIRECTORS

Evidence-Based
Interventions

Issue Brief

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EVIDENCE-BASED INTERVENTIONS: ISSUES AND PRIORITIES FOR HEALTH DEPARTMENTS

INTRODUCTION

Behavioral and social interventions are key elements of the HIV prevention portfolios of health departments, particularly since the advent of community planning. These interventions are strategies designed to facilitate prevention by influencing knowledge, skills, and attitudes, as well as individual and community social norms.

Health departments have a demonstrated and long-term commitment to and capacity to provide (or support) evidence-based behavioral and social interventions. Recent federal policy initiatives, in conjunction with Cooperative Agreement funding from the CDC, such as the Diffusion of Effective Behavioral Interventions (DEBI) project, have impacted (both positively as well as negatively) health department efforts to continue support of evidence-based behavioral and social interventions.

This paper provides an overview of health department efforts to implement and support evidence-based behavioral and social interventions (EBIs). It is intended to highlight health department capacity and commitment to provide effective prevention programming. Simultaneously, it highlights areas of need for health departments relative to implementing and supporting, for the longer term, evidence-based interventions, and suggests strategies to strengthen the portfolio of HIV prevention interventions.

The diverse experience of health departments serves as the foundation for this paper, and it reflects a general

consensus among health departments about their key issues and priorities related to EBIs. Input for this paper was obtained through multiple means, including the NASTAD Prevention Work Group (PWG) and a survey conducted among PWG members in the fall of 2005. The Evidence-Based Interventions Work Group, a sub-group of the PWG, provided specific direction about the content and format of this paper, and provided feedback on earlier drafts. This paper also incorporates input from health departments through the Evidence-Based Intervention Breakout Sessions convened at the Health Department HIV Prevention Meeting, in January of 2006.

IMPLEMENTATION ISSUES

Well before the advent of the DEBI project, health departments engaged in providing or supporting EBIs. DEBI interventions are viewed as additional

tools to enhance health department prevention portfolios. Health departments have taken a variety of approaches to implement EBIs. Some health departments have developed and evaluated interventions for specific target populations. Often these interventions are developed in collaboration with universities or consultants, but in some cases, health departments use internal resources for this purpose. Other health departments have replicated interventions researched by others. These include interventions in CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, the National Institute of Allergy and Infectious Diseases' HIV/AIDS Prevention Program Archive (HAPPA), or interventions based on logic models. Some health departments have used a combination of these approaches.

Decisions about the types and models of EBIs to be implemented within a jurisdiction are based upon

Definition of Evidence-Based Interventions

What is meant by "evidence-based?" In general, evidence-based social and behavioral interventions:

- are highly targeted
- address population needs and priorities, as identified through systematic process of needs assessment
- are consistent with community norms
- are based on sound theory, including logic modeling
- have demonstrable impact on meeting needs and influencing determinants of risk (e.g. knowledge, attitudes, and norms, as well as behaviors).

many factors, including community needs and priorities, capacity within the health department and/or its grantees to implement and support EBIs (or particular models), feasibility of specific intervention models, existence of appropriate intervention models and resources, as well as policy and statutory factors. More importantly, health departments place a high priority on supporting interventions which are feasibly implemented by community-based organizations and other providers, to ensure that programming is sustainable. Many health departments use a request for proposal (RFP) process to identify and select support for EBIs. RFPs issued by health departments commonly require respondents to demonstrate that proposed interventions are responsive to identified needs and priorities, and are culturally, linguistically, and developmentally competent. Many RFPs require respondents to demonstrate the theoretical base of proposed interventions and any evidence of effectiveness (e.g., findings from outcome monitoring efforts).

Health departments also work collaboratively with providers, outside of an RFP or bid process, to identify or develop interventions. This is particularly important with respect to addressing issues of agency capacity, resource constraints, and emerging issues and needs, as well as filling gaps in the service array.

The CDC has emphasized interventions included within its DEBI portfolio in recent funding decisions and capacity building activities. All directly funded community-based organizations funded under Program Announcement 04064 are required to replicate DEBI interventions. Health departments have received strong encouragement from the CDC to replicate DEBI interventions; and in some cases, individual jurisdictions have been directed by Project Officers to utilize DEBI interventions. The DEBI portfolio has numerous critical limitations, however. Limitations identified by health departments include:

- lack of interventions targeted to and appropriate for key populations (e.g. Latino MSM)
- lack of interventions that are responsive to the prevention needs of certain populations
- interventions are difficult to implement in the “real world” with limited resources and provider capacity, having been developed in a research environment
- interventions that are often far more complex than many providers have the ability to implement and monitor appropriately.

TRAINING AND CAPACITY BUILDING

Training and capacity building are essential to implementing and sustaining evidence-based interventions, both at the level of health departments, as well as local providers of prevention services. Health departments utilize a variety of strategies to ensure local capacity to deliver EBIs. Some have relied exclusively or primarily on federal training and capacity building resources, particularly as related to replicating DEBI interventions. Others have well-developed training and capacity building resources that are able to address a wide variety of training and capacity building needs. Some health departments utilize consultants to provide needed expertise. Still others utilize a mix of tools to provide needed support to grantees, including CDC trainings, consultants or other resources.

Beyond formalized trainings and workshops, technical assistance provided to individual agencies (or groups of agencies providing a particular intervention model) is an important component of the work of many health departments relative to implementing and supporting EBIs. Individualized technical assistance is a critical strategy used by health departments as it relates to adapting and tailoring intervention curricula, including DEBIs. Health departments engage in close collaboration with grantees,

sometimes with the help of other experts and consultants, to systematically evaluate the need, appropriateness, and strategies for adaptation and tailoring. This approach facilitates thoughtful and systematic adaptation, ensures interventions that are responsive to the needs of target populations, and simultaneously serves to build capacity within individual agencies to implement and monitor EBIs. It is important to note that the capacity of health departments to provide individualized technical assistance and capacity building is variable.

Health departments utilize and rely upon CDC’s training and capacity building resources to support and facilitate implementation of EBIs. At the same time, health departments note critical weaknesses in CDC’s training and capacity building approach.

First and foremost, CDC’s current and recent training and capacity building efforts have emphasized supporting implementation of interventions included within the DEBI portfolio. Few efforts have been directed toward supporting health departments or others to develop or identify interventions which are not included in the DEBI portfolio. Expansion of training and capacity building efforts to support replication of other interventions, including those within the CDC’s *Compendium* would be a very useful investment. Similarly, supporting health departments to prepare replication “packages” for EBIs proven effective would be useful. Expanding training and capacity building efforts beyond the DEBIs would help to expand the “menu” of EBIs available to health departments and grantees. This is essential to ensuring the availability of interventions appropriate to a variety of target populations and which providers can feasibly implement with variable capacity.

Training opportunities associated with the DEBI deployment have been directed primarily to staff that will facilitate the interventions (i.e., “line staff”). With the exception of SISTA, little attention has been focused on “training of

trainers” (TOT). CDC’s capacity building resources that exist in relation to the DEBI interventions have been preferentially targeted to directly funded CBOs, rather than health departments. This has created challenges for health departments to build the capacity needed to support their grantees. Effective monitoring and quality assurance efforts require health department staff that conduct these activities to understand EBIs (e.g., core elements, formats, expected outcomes) in a way that will enable them to recognize a lack of fidelity, identify its causes, and identify strategies for getting the intervention “back on track.” This underscores the importance of ensuring that health department staff has access to and support for participation in appropriate training opportunities.

The DEBI deployment project has relied upon national and regional-level training activities, an approach which is resource intensive for the CDC as well as training participants. Access to and availability of DEBI trainings has been extremely problematic for health departments and their grantees. The need for access to trainings is ongoing, owing to staff turnover within health departments and grantee agencies. Lack of trainings or inability to access trainings has resulted in delayed and/or disrupted implementation of programming at the state and local levels. Expanded TOT opportunities, which prioritize health departments, are essential to facilitating wider replication of EBIs, including DEBIs. Perhaps most important, such opportunities are critical to ensure sustainable programming.

Curricula and tools associated with DEBI interventions have been made available only to those who participate in CDC-sponsored trainings. Many health departments possess the expertise and capacity to translate intervention curricula into trainings if they could gain access to needed materials. This lack of access to intervention curricula and associated tools has hampered the ability of both the health department and local provider to adopt DEBI interventions and further

delayed replication efforts. Enabling health departments to obtain these materials, regardless of participation in CDC-funded trainings, would enable health departments to develop local training and capacity building resources and would contribute to both diffusion and sustainability of these interventions. Further, this would allow health departments to tailor trainings to be responsive to local issues, policies, and requirements. It would also enable health departments to maintain quality control over training and capacity building efforts, and to guide the adaptation and tailoring efforts of their grantees.

CDC has placed relatively less attention on building capacity to select DEBI interventions appropriate to local populations. Similarly, there has been little capacity building activity on how to adapt and tailor interventions within the DEBI portfolio to local populations, even while CDC encourages adaptation and tailoring. Health departments, however, have attempted to address these issues.

Many health departments have, through formal trainings on EBIs or through individualized technical assistance, addressed selection of interventions. Specifically, health departments have sought to assist grantees in “matching” interventions to the needs of target populations. Systematic assessment of population needs is critical to selection of interventions and health departments work with individual grantees as well as community planning groups (CPGs) to obtain this information and apply it to intervention selection.

Health departments also address adaptation and tailoring, through both formal trainings and individual technical assistance. Working collaboratively with grantees, health departments bring technical and “scientific” expertise about EBIs to the table, while grantees bring knowledge about the needs of a target population and the experience of intervention implementation. This approach ensures that adaptation/tailoring is a

thoughtful and systematic process, which results in an intervention that is responsive to target population needs, but well grounded in sound theory and practice.

CDC’s current approach to training and capacity building on EBIs has given little emphasis to assessment of agency “readiness” to implement such interventions, a factor which is critical to ensuring intervention fidelity as well as program sustainability. Indeed, the lack of systematic readiness assessment among grantees awarded funding under Program Announcement 04064 has resulted in a the failure of many agencies to implement particular interventions, to implement them with fidelity as well as a lack of community participation owing to a “mismatch” between the intervention and the needs of the target population.

“Readiness” encompasses a range of factors and characteristics, including access to target population(s), knowledge of target population prevention needs, credibility with the target population(s), staff skills and competence to deliver EBIs, experience in delivering EBIs or related services, organizational stability, and financial resources. Health departments, through RFPs and contract monitoring processes, have a wealth of experience in and mechanisms for assessing agency capacity to deliver prevention services. Many health departments work closely with grantees to bring this experience and expertise to bear on assessing agency capacity in advance of awarding funding or on an ongoing basis to ensure responsiveness to the evolving needs of target populations or changes in organizational capacity.

MONITORING AND QUALITY ASSURANCE

Monitoring of interventions to guarantee fidelity to curricula is essential to ensure high quality and effective prevention services. Many health departments have well-developed processes for conducting contract monitoring and quality assurance of grantees, especially as related

to the “core” prevention services of counseling and testing and partner services. Many have established data systems that allow monitoring activities to be data-driven. There is wider variation, however, in the capacity and experience across jurisdictions as related to monitoring and quality assurance of EBIs, indicating a need to expand the resources and opportunities available to health departments to develop their capacity to monitor appropriately and effectively and assure quality of EBIs.

Health departments have identified a lack of tools for conducting monitoring and quality assurance of EBIs, particularly related to assessing fidelity as an important challenge. Identification and diffusion of existing tools, including those developed by other health departments as well as development and diffusion of new tools and associated guidance would improve health department capacity to monitor and assure quality of EBIs, including those in the DEBI portfolio.

RECOMMENDATIONS

A long-term, national plan is needed to support replication and sustain implementation of evidence-based interventions. This plan should address identification and/or development of interventions for replication, capacity building and training, as well as monitoring and quality assurance.

- **CDC should increase investment in activities to identify or develop new EBIs to address current gaps in the national portfolio.**

An expanded portfolio must include interventions which address a diversity of audiences. Of particular importance are interventions which target racial/ethnic minorities and HIV-infected persons. CDC is in the process of revising its *Compendium*, which may aid in filling current gaps with certain populations. Nevertheless, population needs change rapidly, resources vary widely, and it

often takes several years for science to be “translated” into practice. For these reasons, emphasis should be placed on identifying interventions designed, implemented, and evaluated by local service providers, health departments, and others. They must be shared, as expediently and as widely as possible. At the same time, it is essential that CDC invest in new interventions, with a high priority placed on interventions developed through participatory research with community partners.

- **CDC should revisit and revise the criteria by which interventions are evaluated as “effective.”**

Many health departments do not possess the resources necessary to conduct evaluations of interventions with the level of rigor required by the CDC for inclusion in its *Compendium*. Nevertheless, many do possess or have access to the expertise needed to design and implement sound prevention interventions. Therefore, CDC should make it a priority to increase its support of health departments in evaluating promising prevention interventions.

CDC must reexamine the current “standards” regarding the criteria it uses to determine whether an intervention is considered “evidence-based.” In particular, “scaling back” the level of evaluation rigor, especially as related to demonstrated long-term temporal stability of outcomes is essential. This would accomplish expansion of the portfolio of available EBIs by inclusion of locally developed EBIs grounded in sound theory and practice, but which have not been subjected to formal outcome evaluation using an experimental or quasi-experimental design. In this way, the diversity of target populations served by available EBIs would be expanded and the speed of intervention diffusion would be increased. An additional benefit is the diffusion of EBIs that are “field tested” and, because of this, are feasible and affordable to implementing agencies.

- **Training and capacity building opportunities targeted to and accessible by health departments should be expanded.**

Training and capacity building efforts supported by federal agencies have underemphasized health departments in terms of targeting and accessing such opportunities. Health departments have the responsibility for supporting their grantees to provide high quality services and are in a unique and important position to be able to address training, capacity building and technical assistance needs. It is therefore important to ensure that health departments have access to as many training and capacity building opportunities as possible. Training and capacity building activities targeted to health departments should emphasize TOT formats. Finally, the resources necessary to support their participation in such opportunities must be made available to health departments.

- **Health department expertise and experience related to EBIs should be acknowledged and fully supported.**

Federal efforts to implement EBIs have not fully acknowledged the resources available to and within health departments. In order to optimize capacity building and training resources in support of EBIs, developing and strengthening partnerships between the CDC and health departments is essential. Priority should be placed on developing TOT programs targeted to health department staff to allow them to develop their knowledge and skills of intervention models. This approach would facilitate wider replication of interventions and greater access to training opportunities and would, most importantly, ensure that interventions can be sustained, over time.

By the same token, strengthening communication and developing strategies for sharing resources among health departments, as well as between health departments and the CDC should be a

priority. Many state health departments and local HIV/AIDS prevention service organizations have the knowledge, expertise, and credentials needed to develop and/or replicate EBIs. Sharing intervention models, curricula related to “homegrown” interventions, capacity building tools and peer-based training (or exchange of trainings) are all strategies that are worthy of consideration. Such strategies would be both cost-efficient and ensure that the unique needs of health departments relative to implementation and support of EBIs are addressed and acknowledged. Priority

should be given to facilitating opportunities designed specifically for health departments to come together to address issues concerning implementation and replication of EBIs, including adaptation and tailoring of EBIs, quality assurance of EBIs, and training and technical assistance strategies.

- **Development and implementation of a long-term national-level training and capacity building plan should be a priority.**

A long-term plan for providing training, technical assistance, and

capacity building support is essential to successfully sustaining EBIs. The ability of state health departments to provide appropriate support to local agencies is predicated, in part, upon CDC resources. Therefore it is critical that the CDC plan for and ensure that adequate resources are made available to health departments, both through cooperative agreement funding and through training and capacity building opportunities delivered by the CDC and other national partners. This plan should be developed in partnership with health departments.

EVIDENCE-BASED INTERVENTIONS: STATE PROFILES

FLORIDA

Implementation of Evidence Based Interventions

The Florida Department of Health (DOH), Bureau of HIV/AIDS wrote the 2005-2008 Prevention Invitation to Negotiate (ITN) based on the CDC’s *Advancing HIV Prevention* (AHP) initiative. The ITN required applicants to use DEBI/REP interventions. Applicants were also allowed to propose one non-DEBI/REP intervention, Shanti’s The LIFE program. This intervention was included based on requests from community providers familiar with the methods of the intervention. After much discussion and training, it was decided that it would work well with HIV-positive persons in South Florida. Most of the contracts resulting from the ITN therefore were based upon the DEBI/REP interventions and LIFE. It is anticipated that future ITNs will include even more non-DEBI/REP EBIs that have been evaluated and proven effective. Particular emphasis will be placed on interventions targeted to MSMs and Latino populations.

Adaptation and Tailoring

The Florida DOH, Bureau of HIV/AIDS has hosted approximately three regional workshops on adapting and tailoring interventions for community providers, county health departments, as well as Bureau staff. County health department contract managers work with individual agencies to provide technical assistance in adaptation and tailoring on an as needed basis. They often consult with Bureau staff who have, in turn, consulted with CDC staff scientists with responsibility for the respective interventions in order to address specific questions or issues raised by community providers regarding specific EBIs. The Bureau also consults with grantee staff who have completed CDC TOT courses on the various DEBI/REP interventions, who themselves are implementing these interventions and are thus able to provide practical suggestions for other providers.

Training and Capacity Building

The Bureau has made the implementation of the AHP initiative and DEBI/REP training a priority. Funded providers and county health department (CHD) staff have responded to this effort

with numerous requests for DEBI/REP training. The Bureau convened three separate DEBI/REP overview training sessions in 2005. Two were done by the Dallas Prevention Training Center (PTC) and one by Bureau staff. Additionally, the Bureau coordinates intervention training through CDC-funded capacity building agencies to deliver trainings for VOICES/VOCES, Comprehensive Risk Counseling Services (formerly prevention case management), SISTA, Healthy Relationships and the complete Community PROMISE trainings. On occasion, the Bureau has paid the intervention researcher/developer to conduct training for community providers and county health department staff. Bureau staff also attends training to facilitate the provision of technical assistance and monitoring.

Monitoring and Quality Assurance

Local county health department contract managers monitor contracts, via site visits, at least twice per year in addition to making more frequent visits to provide technical assistance when providers are having difficulty implementing interventions. Bureau staff provides technical assistance on an as

needed basis to county health department staff that implement interventions. This is in addition to formal quality improvement visits that often take the form of a review of HIV prevention processes and technical assistance. Additionally, the Bureau obtains technical assistance, as needed, from experts such as the Behavioral Social Science Volunteers and CDC staff scientists.

In 2005, the first year of the current funding cycle, contracted providers had the opportunity to fine tune the implementation of their HIV prevention programs to know what works and what does not in order to reach more people through their specific interventions in the subsequent years of the funding cycle. Providers submit quantitative data and narrative documentation monthly. Descriptive analyses are done from the monthly reports submitted and programmatic monitoring reports were also analyzed. In some instances, the need for extensive technical assistance became apparent, while other providers exceeded program objectives and demonstrated a good understanding of the intervention.

At least fifty percent of intervention sessions are evaluated to assess the quality of the information being presented as well as the quality of the method of instruction. Client feedback about the intervention is solicited as part of this evaluation.

MASSACHUSETTS

Implementation of Evidence Based Interventions

Prior to releasing a Request for Responses (RFR) for prevention services, the Massachusetts Department of Public Health (MDPH) HIV/AIDS Bureau (HAB) set a new policy that required all programs to implement an evidence-based intervention as part of their overall prevention program. MDPH HAB conducted a year long planning series to affirm targeting prevention programming

based on epidemiological, behavioral, population, and geographic needs. To achieve greater effectiveness and efficiencies of HIV prevention programming, this planning series resulted in prioritizing four initiatives: 1) continued investment in developing, piloting, and implementing evidenced-based interventions; 2) capacity building strategies to improve health department and grantee staff expertise for client-level data collection; 3) sustain behavioral health capacities by training health department and grantee prevention staff to apply behavioral theories to prevention programming through logic models and assistance in translating research to evidenced-based practices; and 4) anticipating a national-level data collection system, new monitoring tools and technical assistance plan for grantees focusing on real life research to practice settings.

The MDPH HAB supports EBIs drawn from CDC's DEBI portfolio, the CDC's *Compendium*, as well as some "homegrown" EBIs. *The Mujeres Unidas Por La Salud* is an example of a "homegrown" EBI. *The Mujeres Unidas Por La Salud: Preventing HIV with Immigrant Latinas*, is a 12-session, curriculum-driven intervention that was developed in response to an identified need for deeper discussions of the social problems that directly contribute to HIV/STD risks affecting Latinas. It is designed to help women build the skills and knowledge they need to protect themselves, their families and communities. The Boston University School of Public Health conducted a formal evaluation of the intervention and the findings were published. In addition, the MDPH HAB supports EBIs drawn from a compendium of EBIs compiled by the Massachusetts HIV Prevention Community Planning Group (MPPG, 2005).

Adaptation and Tailoring

The cornerstone of selection, adaptation, and tailoring of interventions is best accomplished with a thorough and

practical understanding of the interventions. Selection requires an understanding of contextual factors influencing risk of the identified priority populations along with an understanding of organizational and staff capacities.

As early adopters of EBIs, including DEBI's, the MDPH HAB recognized the need to tailor and/or adapt interventions to fit local population and contextual needs. To this end, a training was developed and delivered to community planning group members, contracted trainers, grantees, health department staff as well as staff representing CDC-directly funded programs. A local technical assistance and training partner collaborated with health department staff in delivering this training, which provided participants with a foundation for adaptation and tailoring. Small group exercises were incorporated into this training in order to build participant skills to undertake program adaptation. More training offerings are needed to build common understandings and application of these methods of ensuring interventions are fit to local needs.

Training and Capacity Building

In Massachusetts, a combination of health department, local, regional, and national training and capacity building assistance contributed to providing expertise in social and behavioral interventions. After analyzing local and national data sources, MDPH HAB in collaboration with the City of Boston Public Health Commission, conducted a two-year technical assistance and capacity development project piloted with Boston-serving MSM programs to respond to rising sexually transmitted diseases (STDs) and substance use and to develop locally informed evidence-based program planning strategies; a six month formative evaluation of the needs of HIV-positive persons to inform positive prevention service goals and a series of logic model trainings for grantees. These examples offered both capacity

building and opportunities to pilot locally developed interventions as well as those included in the DEBI portfolio including SafetyNET, VOICES/VOCES, Healthy Relationships, and the Learning Immune Function Enhancement (L.I.F.E.) programs.

Regional and national CDC-funded capacity building providers offered supplemental training that complimented local provider and academic partnerships. NASTAD facilitated needed peer-to-peer technical assistance for a variety of needs, including identifying and linking the MDPH HAB with other health departments that had developed and implemented EBIs for African American MSM and HIV-infected persons. NASTAD also assisted the MDPH in identifying a health department to assist them with enhancing program monitoring activities.

Monitoring and Quality Assurance

In conjunction with its 2003 RFP, the HAB established higher service standards and expectations. These standards are reinforced in training, program development, and technical assistance activities. Multi-year contracts provide the opportunity to monitor progress toward locally developed standards with new approaches. These approaches are: 1) a revised professional training series, 2) regional program development meetings and 3) intervention-specific technical assistance sessions.

Core training curricula were revised and other trainings were implemented to provide a foundation in the fundamentals of HIV, STD, and viral hepatitis education, practice of risk assessment and harm reduction, prevention for positives, and basic skills in selecting and implementing social and behavioral interventions. There are six health service regions in Massachusetts. Twice a year, prevention providers are brought together for “Regional Program Development Meetings.” Program development meetings serve as opportunities to discuss and address quality improvements and

provide education to providers regarding promising and/or best practices.

Monitoring intervention fidelity begins with the completion of health department developed annual workplans, complete with monthly schedules, and service templates that define core elements, and intervention and health department defined service outputs. Progress toward achieving goals is monitored through tri-annual qualitative and monthly data collection forms and through site visits provided no less than twice annually.

Programs are surveyed for technical assistance needs. Health department designed technical assistance sessions that are intervention-specific (e.g. Community PROMISE) are offered, as little guidance and/or tools are available for grantees post training. These locally developed sessions provide a forum to reinforce core elements, problem-solve with grantees, and reinforce successes. Planning these sessions requires considerable effort and participants must demonstrate quality improvements to their programs. This method of offering guidance for grantees will be further developed for each intervention. Trained service delivery testers offer objective assessment of verification of location, quality of engagement and delivery of prevention services to inform development plans.

MICHIGAN

Implementation of Evidence Based Interventions

The Michigan Department of Community Health (MDCH) requires agencies applying for prevention funding to propose evidence-based interventions. Applicants to a 2003 RFP were encouraged to consider interventions included within CDC’s DEBI portfolio as well as interventions included in the HIV/AIDS Prevention Program Archive (HAPPA) portfolio and the CDC *Compendium*.

Workshops were held prior to the RFP to introduce prospective applicants to these interventions. Applicants to this RFP could also propose other interventions so long as evidence of effectiveness, such as findings from outcome evaluations or outcome monitoring was provided. Eighteen community-based organizations (CBOs) are currently funded to deliver EBIs. Fourteen agencies are contracted to conduct one or more EBIs which have been formally evaluated. Many of these EBIs are drawn from either the DEBI or HAPPA portfolio (SISTA, Many Men/Many Voices, VOICES/VOCES, POL, and Mpowerment), although two (LIGHT and Prevention Options for Positives) have been formally evaluated by researchers within Michigan. The remaining four CBOs are funded to provide “homegrown” logic model driven interventions.

Adaptation and Tailoring

Adaptation of interventions is considered on a case-by-case basis and grantees must obtain the approval of the MDCH in order to undertake adaptation of any intervention. Approval of changes is given only after careful consideration of the potential impact that the proposed changes to the curriculum will have on the intended outcomes of the intervention. Health department staff and consultants with expertise in behavioral science, evaluation, and program implementation consider adjustments to intervention curricula. When adapting an intervention for use with a population other than that for which the intervention was initially researched, the clear evidence that the intervention meets the prevention needs and priorities of that population must be provided before the MDCH will consider authorizing adaptation.

In some circumstances where clear evidence of the potential impact of a proposed change to a curriculum is not available, the MDCH has given provisional approval to adapt or tailor

intervention curricula. Implementation of a modified curriculum must be accompanied by outcome monitoring for at least one intervention “cycle.” If outcome data indicate that curriculum modifications have not negatively impacted the effectiveness of the intervention, MDCH will approve the modification.

Training and Capacity Building

Michigan utilizes national, state, and local resources to support implementation of EBIs. For example, the MDCH provided a one-day workshop to give local providers an overview of a number of potential “prepackaged” interventions, including some included within the DEBI and HAPPA portfolios. Michigan was selected as a regional training site for two DEBI interventions, VOICES/VOCES and SISTA. Travel support was provided to grantees to participate in national-level trainings for Mpowerment and prevention case management. A local community-based organization is funded to provide capacity building and training for the Popular Opinion Leader model (POL) and for an intervention for HIV-infected MSM developed and evaluated in Michigan. The MDCH has collaborated with intervention researchers to develop and deliver trainings for one EBI. Health department staff also participated in training to ensure their knowledge and skills associated with many of the DEBIs and HAPPA models. Finally, MDCH has staff with advanced academic training in behavioral and social interventions and access to local consultants with expertise needed to assist local agencies in replicating EBIs.

Monitoring and Quality Assurance

Monitoring and quality assurance of EBIs emphasizes intervention fidelity. Monitoring and quality assurance processes occur at the level of the grantee as well as the level of the health department and are data-driven. MDCH has developed a corresponding process monitoring tool for each EBI to assess

the extent that the curriculum was executed as intended. These self-administered tools are completed by implementing agency staff following intervention sessions. Supervisors are strongly encouraged to review these tools periodically with staff and problem solve in the event of reoccurring deviation from the curriculum.

Michigan’s web-based data system is an important tool for monitoring and quality assurance of EBIs. Grantee and MDCH staffs are able to identify a number of “fidelity flags” including: the extent to which intervention elements are consistent with curricula; timing and scheduling of sessions; retention of clients in multi-session interventions; and whether intervention participants are from the intended target population. Reports generated through this system aid staff in identifying problems. The workshop, “Utilizing HIV Event System (HES) Data for Program Monitoring and Quality Assurance,” is conducted annually and includes step-by-step education and practice on how to identify “intervention drift” utilizing these on-line reports. Recently, MDCH has formalized a protocol and corresponding contract monitoring tool to assess intervention fidelity and data integrity in the HES data management system. The protocol standardizes what data is reviewed and how often. This tool serves as a guide for health department staff to diagnose problems with EBI implementation and for providing technical assistance to grantees.

NEW JERSEY

Implementation of Evidence Based Interventions

In its 2004 request for proposal (RFP) process, the New Jersey Department of Health and Senior Services (NJDHSS) required potential grantees to propose interventions from either the DEBI portfolio or CDC’s *Compendium*. Twenty-seven population-targeted programs using EBIs from the DEBI portfolio or

the *Compendium* are currently supported by the NJDHSS. In addition, the NJDHSS funds a school-based prevention program, the New Jersey Teen Prevention Education Program (Teen PEP). Teen PEP is a “homegrown” EBI. It has been formally evaluated and has been demonstrated effective in increasing student participants’ reported behavior changes associated with STI prevention. The NJDHSS has submitted the curriculum to the CDC and requested that it be reviewed in an effort to obtain CDC’s endorsement of effectiveness.

Adaptation and Tailoring

New Jersey provides direct technical assistance (TA) to grantees in tailoring and adapting DEBI curricula in order to better meet the specific prevention needs of clients. NJDHSS or Rutgers University staff provides one-on-one consultations with grantees seeking to tailor and/or adapt a DEBI curriculum. Staff providing technical assistance break down each curriculum into its core elements, and help grantees to assure fidelity to the core elements as they transform the existing curriculum to better meet their own target population needs.

Training and Capacity Building

The NJDHSS uses a mix of capacity building resources to support implementation of EBIs. Over the summer and autumn of 2004, the NJDHSS worked collaboratively with CDC, bringing national trainers into New Jersey to hold full-scale trainings for our CBO grantees on six of the DEBI interventions.

The NJDHSS is actively trying to build DEBI training capacity within the state, but has only been successful, to date, with one of the DEBIs (Safety Counts). The health department’s goal is to build in-state capacity for at least the six DEBIs most widely deployed in the state. Factors such as staff turnover within grantee agencies and the need to change curricula over time, as experience dictates, create an enormous and ongoing training demand.

CBO budgets are not adequate to support travel to multiple national-level trainings. It is more cost effective to conduct needed trainings in New Jersey. Importantly, many staff of grantee agencies possess the knowledge and skills needed to become successful trainers through participation in a TOT. However, the requirements that CDC and its capacity building partners have established regarding becoming trained as a trainer are onerous. Currently, to be successful as a TOT, individuals must participate fully in two trainings of an intervention and then be observed

delivering a third training. This is both time and resource intensive, as it requires national-level travel over multiple days.

Monitoring and Quality Assurance

NJDHSS' monitoring and quality assurance activities are closely linked to individualized technical assistance for grantees and is data driven. As an example of this link between quality assurance and technical assistance, three grantees using the Popular Opinion Leader (POL) model expressed difficulty in understanding how to evaluate their success. The NJDHSS

staff met with each of the agencies and reviewed their program implementation plans. On the basis of this review, they collaborated in the development of revised implementation plans that included expanded core intervention elements that had not been part of the original program design. The result: data collection forms designed to capture information about the revised program plan were developed and implemented and the result was that each of these agencies developed an enhanced capacity to evaluate their success with POL.

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