

## ABSTRACT

*Project Name: Regional Prevention Partnerships (RPP)*

*Applicant: Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP)*

The goal of the Vermont RPP is to apply the Strategic Prevention Framework (SPF) model to reduce underage drinking, prescription drug misuse and abuse, and marijuana use among 12-25 year olds across the state of Vermont. The purpose of the grant is to strengthen the prevention infrastructure at the state, regional and community levels using VDH's existing health district structure as the primary mechanism to implement the RPP.

Building on the success of our current Partnerships for Success grant ending on 9/30/15, the RPP will continue to implement individual and environmental evidence-based strategies (EBS) to prevent and reduce the prevalence and negative impacts of underage drinking, prescription drug misuse and marijuana use. With half of VT's District Office regions currently implementing the SPF model for underage drinking and prescription drug misuse (e.g. underage drinking policy approaches, parenting programs, electronic screening and brief intervention, community mobilization, enhanced law enforcement, and targeted media campaigns), the RPP will extend that capacity to all areas of the state for the priority substance use targets and add the priority area of youth and young adult marijuana use that is in the spotlight due to VT's high rates of youth and young adult use, and the perceived influence of the legalization debate on perceptions of risk. We estimate the RPP will reach approximately 119,871 youth and young adults ages 12-25 in the first year, and a total of 149,703 throughout the lifetime of the project as it is expanded statewide. Because a number of interventions will be implemented at the population-level (e.g. policy education, enhanced law enforcement, and communications campaigns), and therefore will reach individuals outside of the 12-25 year old range, we estimate approximately 544,273 Vermonters will be exposed to RPP interventions by the end of the project.

The long term vision for the Regional Prevention Partnerships (RPP) is for a fully functioning statewide system for prevention services that is coordinated at the regional level and respectful of the regional and cultural diversity that exists across the state of Vermont. This system will build upon existing structures at the state, regional, and community level that can support this vision. In developing the vision, the state recognizes that a community-level structure in which individual communities are funded to plan and implement their own prevention efforts is inefficient and not sustainable. The ultimate goal is to have effective regional prevention structures that collectively cover the entire state, along with centralized support and services.

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## **SECTION A: STATEMENT OF NEED**

Vermont (VT) has one of the highest rates of past month underage alcohol consumption and binge drinking in the nation. According to the most recent data from the National Survey on Drug Use and Health (NSDUH), 30% of VT 12-20 year olds reported having a drink in the past month, and 20% of this age group reported binge drinking (5 or more drinks at one time) in the past month (SAMHSA, 2013). Underage drinking including binge drinking among persons aged 12-20 continues to be a priority for prevention efforts in Vermont, including for the Regional Prevention Partnerships (RPP) and is reflected in the state's Healthy Vermonters 2020 goals<sup>1</sup>.

Vermont has one of the highest rates of marijuana use in the nation, particularly among young adults. The NSDUH has found that 12% of VT's population ages 12 and older and nearly 30 percent of those ages 18-25 reported using marijuana in the past month (2012-2013 NSDUH)<sup>2</sup>. The 2013 Youth Risk Behavior Survey (YRBS) data indicate that among 9<sup>th</sup>-12<sup>th</sup> graders who reported smoking marijuana in the past 30 days, 49% reported using marijuana a minimum of 10 days out of the past 30. Heavy and persistent use among this age group has been associated with serious adverse consequences in adulthood (Meier et al., 2012; Silins et al., 2014). Because of these high rates of use among youth and young adults, the reduction of youth marijuana use is also a Healthy Vermonters 2020 goal.

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 decade. This has taken a great physical and economic toll on state resources and residents. In response, the state significantly increased its capacity for opiate treatment and its focus on prevention of prescription drug misuse among persons aged 12-25.

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

Vermont is the second most rural state in the US (2010 Census) with 61.1% of the population of just over 650,000 residents residing in rural areas. The target population for this proposal is VT residents aged 12-25, approximately 19% of VT's total population. This group is 51% male. Vermont is 94% white non-Hispanic and 12% of Vermonters live below the Federal Poverty Level (U.S. Census, 2010). Across VT's 14 counties, the most populated is Chittenden with approximately 159,515; the remaining counties have populations that range from less than 6,000 in Grand Isle and Essex to approximately 60,000 in Rutland<sup>3</sup>.

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

Vermont Department of Health (VDH) reviews data demonstrating state and county level prevalence rates, consequences, and risk and protective factors from several sources. These data sources reflect that alcohol and marijuana use are the most prevalent substances of misuse and abuse, and these prevalence rates are higher in some areas of the state compared to others. Areas of the state with high prevalence rates and risk factors, as well as low protective factors, have been identified as priority regions to be served through the RPP.

Vermont uses two main data sets to monitor trends in youth substance misuse, the Youth Risk

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<sup>1</sup> [http://healthvermont.gov/hv2020/documents/hv2020\\_behaviors\\_enviro.pdf](http://healthvermont.gov/hv2020/documents/hv2020_behaviors_enviro.pdf)

<sup>2</sup> [http://www.rand.org/content/dam/rand/pubs/research\\_reports/RR800/RR864/RAND\\_RR864.pdf](http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR864/RAND_RR864.pdf)

<sup>3</sup> <http://healthvermont.gov/research/pop/documents/TABLE113.pdf>

Behavior Survey (YRBS) and the NSDUH. The YRBS collects risk behavior and perception data on high school aged youth biannually from all school districts in the state and community level trends are available on line at <http://healthvermont.gov/research/yrbs.aspx#HV2020>. Vermont collected YRBS data on 22,525 students (76% of enrollment) in grades 9-12 in 2013. With such a high response rate, VDH is confident that the estimates are valid and reliable statewide indicators of use and misuse. Table 1 shows the counties with prevalence rates significantly different than the statewide values.

**Table 1. Past 30-Day Use of Substances by VT High School Students in Grades 9-12, Percent, (YRBS, 2013)**

County of residence	Marijuana use	Any alcohol use	Binge drinking	Prescription drug misuse
Addison	20*	29*	16*	5*
Bennington	24	30	17	7
Caledonia	18*	29*	17	7
Chittenden	24	31*	17*	6*
Essex	16*	22*	13	Too few students
Franklin	19*	32	18	5*
Grand Isle	20	37	20	5
Lamoille	27	39*	21	4*
Orange	22	31	17	6
Orleans	21	39*	24*	8
Rutland	20*	32	18	5
Washington	25	35	22	7
Windham	29*	37*	23*	10*
Windsor	27*	33	19	8
Vermont	24	33	19	7

\* indicates the county is significantly different than the state based on 95% confidence intervals

The NSDUH provides data at the state level and for four sub-state geographic areas using an instrument and methodology approved and monitored by the U.S. Substance Use and Mental Health Services Administration (SAMHSA). In Table 2, NSDUH data are presented for marijuana use among 12-17 year olds. This table shows that the rate of past year and past month marijuana use among youth is significantly higher and increasing in the more urban Champlain Valley region (Chittenden, Addison, Franklin and Grand Isle counties) and more stable elsewhere in the state.

**Table 2. VT Sub-State Data on Marijuana Use Among 12-17 Year Olds, Percent (NSDUH)**

	Champlain Valley <sup>2</sup>		Rural NE <sup>2</sup>		Rural SE <sup>2</sup>		Rural SW <sup>2</sup>	
	2010-12	2008-10	2010-12	2008-10	2010-12	2008-10	2010-12	2008-10
Marijuana Past Year	23.3	15.7	19.8	18.0	21.1	21.2	18.7	17.1
Marijuana Past Month	15.0	9.8	12.0	11.1	12.0	11.8	12.0	10.8

Understanding youth perceptions are critical to understanding the risk and protective factors that may be influencing their decision to use substances. Table 3 presents these measures from the

2013 YRBS by county. Risk factors include the proportion reporting alcohol and marijuana use before age 13. Protective factors include the percent who perceive risk of great harm for weekend bingeing and regular use of marijuana, the percent who report their parent/guardian think it is wrong or very wrong for students to be drinking alcohol or using marijuana, and the percent who report that they feel they matter to their community. Table 3 provides insights into the variation of risk behaviors and perceptions across counties. For example, 9% of students in Chittenden County report using alcohol before the age of 13, compared to 20% reporting early alcohol use in Orleans County.

**Table 3. Risk and Protective Factors among Vermont 9<sup>th</sup>-12<sup>th</sup> Graders by County, Percent (YRBS, 2013)**

	Risk Factors		Protective Factors				
	Alcohol Use Before Age 13	MJ Use Before Age 13	Risk of Great Harm of Alcohol Binging	Risk of Great Harm of Regular Use of M	Feel They Matter To the Community	Parents Think Wrong to Use Alcohol	Parents Thinks it's Wrong to Use Mj
<b>Addison</b>	14	6	40	33	55	76	94
<b>Bennington</b>	11	7	42	27	43	92	93
<b>Caledonia</b>	16	6	38	35	55	88	95
<b>Chittenden</b>	9	5	42	31	55	93	96
<b>Essex</b>	17	10	39	40	41	83	94
<b>Franklin</b>	16	6	36	32	47	87	95
<b>Grand Isle</b>	15	8	35	37	50	90	95
<b>Lamoille</b>	18	8	31	24	47	89	93
<b>Orange</b>	16	6	35	34	48	89	95
<b>Orleans</b>	20	7	35	34	42	85	94
<b>Rutland</b>	12	6	39	35	44	91	95
<b>Washington</b>	13	5	37	30	49	92	96
<b>Windham</b>	17	11	38	24	45	91	92
<b>Windsor</b>	15	8	38	31	47	91	95
<b>Vermont</b>	14	7	38	31	50	91	95

The VT YRBS data reveal that students reporting any of three mental health indicators – feeling sad, making a suicide attempt or engaging in self-harm – have a significantly higher prevalence of past 30-day alcohol use than their peers (Vermont YRBS, 2013). This is a concern because suicide is the third leading cause of death for Vermonters ages 10–14 and the second leading cause of death for Vermonters ages 15–34 (Web-based Injury Statistics Query & Reporting System, CDC 2009-2013).

Additionally, a review of the 2013 YRBS data reveal that there are significant behavioral health disparities between Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth and their heterosexual peers. Vermont’s 2013 YRBS reports that 1% of students describe themselves as gay or lesbian, 5% bisexual and 3% not sure. LGBTQ youth demonstrated fewer positive assets when compared to their heterosexual peers (2013 YRBS). They were less likely to agree that they matter to their community and less likely to talk to their parents at least once a week about school.

Almost half of LGBTQ students reported feeling sad for at least two weeks in a row in the past year, more than twice the rate of their heterosexual peers. LGBTQ students were also more than three times as likely as their heterosexual peers to report making a suicide plan in the past year and six times as likely to report attempting suicide (2013 YRBS). In addition to the mental health risk factors, LGBTQ students were significantly more likely than their peers to report drinking and binge drinking in the past 30 days, misusing a prescription drug in their lifetime and using marijuana in the past 30 days (2013 YRBS). The Young Adult Survey (YAS) is currently conducted by the Pacific Institute for Research and Evaluation (PIRE) to support the evaluation of VT’s current PFS project. The 2014 YAS was conducted with a convenience sample of 3,200 Vermont residents aged 18-25. The statewide estimates were similar to those provided by the 2011/2012 NSDUH and the sample sizes were adequate for estimating county-level rates for most measures. Although the primary purpose for the 2014 data is to provide baseline measures in order to track changes over time, the data reveal some relatively large differences in some of these rates across counties as represented in Table 4.

**Table 4. State-Level Data from the 2014 Young Adult Survey, Percent (YAS, 2014)**

County	Past 30-day binge	Past 30-day marijuana use	Of marijuana users, used 20+ days in past 30	Past year Non-medical use of prescription pain relievers
Addison	56.4	30.3	32.6	2.1
Bennington	41.5	33.1	38.3	3.0
Caledonia	50.1	32.8	64.8	5.4
Chittenden	64.8	43.6	45.8	6.9
Essex/Orleans*	34.9	33.6	48.5	9.0
Franklin/Grand Isle*	51.0	30.1	59.0	12.3
Lamoille	58.2	34.4	52.2	9.2
Orange	39.1	28.1	48.6	7.8
Rutland	49.1	31.0	63.2	9.0
Washington	51.4	36.8	49.7	7.4
Windham	49.3	40.8	60.7	9.2
Windsor	58.0	38.7	58.8	10.4
Vermont	55.3	37.3	49.9	7.4

\*Counties were combined due to small number of respondents

Source: PIRE

Vermont also relies on the NSDUH to understand the behavior and perceptions of young adults in the state between the ages of 18 and 25. As a whole, VT’s young adult population has some of the highest prevalence rates in the country for regular (past 30-day) binge drinking and marijuana use. According to the 2012-2013 NSDUH, VT’s rate of 18 to 25 year old past month binge drinking is 45.1% compared to the national average of 38.7%, and its rate of past month marijuana use is 28.7% (3<sup>rd</sup> highest in the country) compared to the national rate of 18.9%. NSDUH data reveal information on the regions of the state where young adult substance misuse is highest. As detailed in Table 5, sub-state data reveal that past month and past year use of marijuana is highest in the Champlain Valley region.

**Table 5. VT Sub-State Data on Marijuana Use Among 18-25 Year Olds, Percent (NSDUH)**

* = Suppressed	Champlain Valley <sup>2</sup>		Rural NE <sup>2</sup>		Rural SE <sup>2</sup>		Rural SW <sup>2</sup>	
	2010-12	2008-10	2010-12	2008-10	2010-12	2008-10	2010-12	2008-10
Marijuana Past Year	52.8	49.1	43.8	45.8	42.2	*	42.6	39.7
Marijuana Past Month	37.1	35.3	30.8	29.7	29.1	29.8	28.5	27.8

Finally, in January 2014 VT Governor Peter Shumlin devoted his State of the State address to opioid addiction and the consequences of this problem on VT communities and health and human service systems. For example, the percentage of children entering out-of-home care at year’s end with parental substance abuse identified as a reason for removal from the home increased nearly 20 percentage points from fiscal year 2011 through 2014. This increase was largely driven by opioid addiction, including prescription opioids (Casey Family Programs: Assessment of Family Services Division Safety Decision Making, Final Report to the VT Department of Children and Families, December, 2104).

Overall, data sources on prevalence for youth and young adults in VT highlight the increasing problem of marijuana use among 12 to 17 year olds and 18 to 25 year olds, regional differences for all categories of substance use, notable increases in marijuana use in different areas of the state, with a particularly dramatic increase in Champlain Valley, and possible contributing factors for higher marijuana use and low perceptions of its risks being the state’s medicalization of marijuana and its public debate of marijuana legalization. Data also reveal a possible relationship between substance misuse and suicidality and substance misuse and sexual and gender orientation.

**A.3 Infrastructure Needs**

As a small rural state, VT has been successful in building partnerships and leveraging resources to improve the health of its residents through the seasoned and experienced VDH central and district office (DO) staff. 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 community coalitions supported through a variety of funding streams.

Although significant outcomes have been achieved through the collective efforts of these organizations, this approach is unsustainable and has presented challenges to the development of long-term prevention capacity in VT. The Vermont 2011 system review team from SAMHSA noted, “Although Vermont is a relatively small state, the multiple layers of infrastructure and organization related to prevention may hinder efficient assessment, planning, coordination and implementation of prevention services” (SAMHSA, Federal Fiscal Year 2011). In addition, key state and community stakeholders who participated in VT’s Strategic Prevention Enhancement (SPE) Grant strategic planning process also recommended greater sustainability through a regional organization of prevention efforts (VDH, 2012). The VDH has made a commitment to strengthening the capacity of its twelve regional DOs in community assessment, capacity building and planning as part of VT’s health reform strategy; however, these capacities are not leveraged equitably in all regions of the state. Although enhancements in regional capacity are already evident among the currently funded PFS sub-recipients (Vermont Community Grants Reporting System (CGRS) data – see section D.1), they are inadequate in the remaining six regions. VDH identified two important limitations affecting capacity: 1) funding levels have been too diffused to support all of VT’s communities on a sustainable basis, and 2) limited capacity in the high-need communities has often resulted in lower likelihood of receiving prevention services funding. This

grant funding will support the expansion of infrastructure to the remaining districts allowing VT to address reductions of alcohol, marijuana and prescription drugs statewide.

#### **A.4 Developing a Monitoring System for Tracking Progress and Redirecting Resource**

The VT State Epidemiological Outcome Workgroup (SEOW) system for monitoring and tracking of progress includes bimonthly meetings to review current state and local data trends, respond to state or local needs for additional data or interpretation of existing data. The SEOW developed district/county data profiles for the current PFS grant so that these regions had a baseline against which to measure progress as evidence-based programs, policies, and practices were implemented. The SEOW has continued to monitor relevant state and local data to provide sub-recipients with accurate and current information. These data include, but not limited to, YRBS (state and local), NSDUH (state and sub-state), hospital and emergency department discharge data for targeted substances (state and local hospitals), and treatment census by substance (state and local).

The SEOW assists the DO regions in collecting and analyzing local quantitative and qualitative data and provides technical assistance (TA) on the local Results Based Accountability (RBA) processes required by the state. The SEOW also assists with developing meaningful performance measures and indicators that can be tracked over time, including measures of organizational capacity and program implementation fidelity.

This level of monitoring allows for “mid-course corrections” if programs are not being implemented with fidelity, if communities have low levels of readiness or infrastructure, or if contextual events create misalignments in community fit (e.g., emergence of new drugs such as synthetic marijuana, the introduction of novel drug delivery systems such as “vape pens, the legalization of marijuana in Vermont). Therefore, the SEOW’s work is the catalyst for quality assurance monitoring and program improvement by studying assessment and implementation data and allowing for flexibility that ensures maximum utilization of existing resources, including making recommendations for shifting resources to regions that demonstrate an altered need status.

## **SECTION B: PROPOSED APPROACH**

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

The purpose of VT’s Regional Prevention Partnerships (RPP) project is to reduce underage drinking, prescription drug misuse and abuse, and marijuana use among 12-25 year olds by applying the Strategic Prevention Framework (SPF) model to VT’s existing health district structure. This structure of twelve regionally organized District Offices (DOs) will serve as the primary mechanism to implement the SPF model, see Letter of Commitment (LOC) attached.

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 VT’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. Vermont’s current PFS grant supports interventions in six health districts identified as having high need (Chittenden, Lamoille, Rutland, Washington, Windham, and Windsor – LOC’s attached). We intend to expand to the remaining six districts over the course of the RPP grant. Vermont’s RPP initiative will support the continuation of existing efforts to permit the six currently funded regions to institutionalize their structures and

strategies, while expanding VT's PFS model statewide.

The proposed project has been structured to meet all of the requirements and expectations of the RFA, 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. Vermont's approach is guided by the evidence that multiple levels of intervention have the potential to influence a range of behavioral health issues in addition to the specifically targeted behaviors of underage and binge drinking, marijuana use, and prescription drug misuse.

Vermont's RPP aligns with the prevention principles underlying the Affordable Care Act (ACA) and supports SAMHSA's Strategic Initiative #1, Prevention of Substance Abuse and Mental Illness, as well as goal 1.2: prevent and reduce underage drinking and young adult problem drinking and goal 1.4: prevent and reduce prescription drug and illicit opioid misuse and abuse.

The following goals and objectives will serve to achieve the RPP's purpose.

*Goal 1: Increase state, regional and community capacity to prevent underage and binge drinking, prescription drug misuse, and marijuana use through a targeted regional approach.*

1.1 Support the continued development of VT's DOs to serve as a regional prevention delivery system grounded in the SPF theoretical framework that targets underage drinking and binge drinking, prescription drug misuse, and marijuana use. Vermont's Division of Alcohol & Drug Abuse Programs (ADAP) will achieve this through a) continuation funding for current PFS grantees and b) new funding of the SPF process for these prevention priorities in the remaining six DO's.

Six health district offices (DOs) serving the six high-need regions will continue to coordinate implementation of the current PFS grant ending on 9/30/15. In 2012 these six regions were established by our SEOW for the PFS application as having the highest need based on a review and analysis of statewide prevalence data and demographics (see section B.4.b). In order to allow adequate time and resources for them to achieve full and sustainable implementation and see measureable progress in achieving their outcomes, we will continue to fund them in Years 1 and 2 of the RPP grant award. In Years 3-5 of the grant, funding for these sub-recipients will be sustained but at a reduced funding level to enable us to fund the remainder of the state while maintaining current progress.

Each of the remaining six DOs will receive from the SEOW an assessment of their prevalence data, along with demographic data including socioeconomic status, race/ethnicity, gender, sexual orientation and other sub-populations that may be subject to behavioral health disparities. With guidance from VDH, the DOs will develop their strategic plans with regional and community partners representing resources and target populations within their regions.

1.2 Increase the capacity of the DOs to implement evidence-based approaches effective for the priorities articulated in this proposal through state and regional technical assistance and infrastructure support.

Based on community needs and district plans, some regions will receive additional capacity building and implementation grants, thus furthering the regional approach to community-based prevention to include evidence-based strategies (EBSs) designed to affect the specific risk factors

for underage and binge drinking, marijuana use and prescription drug misuse that have been identified within the region and the state. VT's Division of Alcohol and Drug Abuse Programs (ADAP) and its contractors will provide training, social marketing services and other direct supports to EBS implementation specific to targeting the priorities of the RPP with regional sub-recipients. Training, guidance materials and social marketing tools will be made available to partners statewide.

Where Goal 1 establishes an infrastructure, supports the SPF process within a regional structure, and guides the communities in EBS selection and implementation, the remaining three goals ensure that the identified substance priorities build upon existing capacity and approaches in VT.

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

2.1 Regions will plan and implement EBSs and associated activities designed to affect the specific risk factors for underage and binge drinking identified within the region and the state, with particular focus on sub-populations identified as having increased vulnerability through regional assessments that consider local data.

Tools and social marketing campaigns developed during the current PFS, such as *ParentUpVT.org* aimed at the prevention of underage and binge drinking, will be enhanced and booster campaigns implemented. Campaigns will be coordinated at the state level and supported by all 12 DOs and regional sub-recipients.

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

3.1 Regions will plan and implement EBSs 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 sub-populations identified as having increased vulnerability through the regional assessments process.

The twelve DOs will coordinate and collaborate with local and regional prescription drug misuse and abuse prevention efforts and will continue to integrate RPP sub-recipients into the work of the Governor's Regional Community Opiate Addiction Teams which were developed in response to the Opiate crisis in VT in the spring of 2014. Tools and social marketing campaigns developed during the current PFS (e.g. VT's Most Dangerous Leftovers) aimed at reducing prescription drug misuse will be enhanced and booster social media campaigns implemented. Campaigns will be coordinated at the state level and supported by all 12 DOs and all regional sub-recipients.

*Goal 4: Reduce marijuana use among persons aged 12 to 25.*

4.1 Regions will plan and implement EBSs and associated activities designed to affect the specific risk factors for marijuana use that have been identified within the region and the state.

The Evidence-Based Practices Work Group will update the menu of allowable EBPs to include those with marijuana outcomes. In addition, a statewide communications campaign aimed at the prevention of marijuana will be developed, coordinated centrally and supported by all 12 DOs and sub-recipients.

This proposed approach for the RPP 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 state-wide levels. In addition, the

prevention activities to be implemented through RPP funding will intentionally encompass a comprehensive mix of evidence-based strategies that collectively address multiple developmental stages of youth and young adults and will be complemented by state and regional communication campaigns to build public awareness.

## **B.2 Identification of Vermont's Priorities and Rationale for their Selection**

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

1. Underage and binge drinking among persons aged 12-20;
2. Prescription drug misuse and abuse among persons aged 12-25; and
3. Marijuana use among persons aged 12-25.

As described in Section A, VT's prevalence rates for underage drinking remain among the highest in the nation, despite some recent progress in addressing this behavior. This fact, along with the enormous public health and safety impact of underage drinking, has served to sustain VT's readiness and commitment to addressing this issue. The state's capacity to do so is demonstrated by the progress achieved through our current PFS grant which includes increased collaboration with local and state law enforcement to run proactive saturation and party patrols, implementation of parenting programs, electronic screening and brief intervention/education, and education on policy approaches.

Vermont also has a high level of readiness for addressing prescription drug misuse. The VT Prescription Monitoring System has been operational since 2009, and in 2011 the VT Prescription Drug Abuse Workgroup issued recommendations for specific actions for preventing and recognizing prescription drug abuse statewide that are aligned with Office of National Drug Control Policy's (ONDCP) Prescription Drug Abuse Prevention Plan. This high-level attention to the problems of prescription drug misuse are driven by the dramatic increase in and public concern about the health consequences of opioid addiction and its impact on human services systems.

Per our Governor's plan to combat opioid addiction, VDH was charged with implementing a statewide forum on community solutions, followed by the development of local task forces to develop action plans. Consistent with the vision outlined in this application, VDH's twelve DOs and ADAP Prevention Consultants were tasked with mobilizing communities on this issue, and are working closely with highly invested community members representing prevention, intervention, treatment and recovery interests. Current PFS sub-recipients are involved as members of the community teams and are providing expertise on prescription drug misuse prevention strategies and tools.

## **B.3 Vermont's Additional Priority: Marijuana Use Among Persons Aged 12-25**

**B.3.a Additional Data Prevention Priority:** Of great concern in VT currently is marijuana use among school-age adolescents (12-17 year olds) for past month use (11%) and past year use (20%). **Both of these rates are in the top three in the country.** Data from the 2013 YRBS indicate that among 9<sup>th</sup>-12<sup>th</sup> graders who report smoking marijuana in the past 30 days, 49% report use on at least ten days.

**B.3.b Additional Priority Rationale:** Vermont has selected marijuana over other prevention priorities due to the high rates of use as described in B.3.a above, and based on the RAND

Corporation report commissioned by the VT Agency of Administration and newly released in January 2015 titled, “*Considering Marijuana Legalization: Insights for Vermont and Other Jurisdictions*”. This report has raised public interest in marijuana use and abuse as a health issue, when previously there had been a low level of interest and readiness to implement evidence-based prevention interventions proven to reduce marijuana use. Because of the increased scrutiny of marijuana as a health and safety issue, we anticipate a dramatic increase in demand for evidence-based programming and community education on the health effects of marijuana use among youth and young adults. The RPP approach in this proposal will provide VT the opportunity to address these critical needs statewide.

#### **B.4 Project Structure and Implementation**

**B.4.a Proposed Approach:** The Public Health Accreditation Board (PHAB) Committee awarded five-year accreditation status to the Vermont Department of Health (VDH) on June 18, 2014. With accreditation, VDH is demonstrating its commitment to improving and protecting the health of Vermonters and advancing the quality of public health services nationally. The process has allowed our department to assess our strengths and identify areas for improvement in order to continue to improve the quality of our services and performance. The PHAB’s standards and measures provide a means for the department to continually assess its effectiveness in delivering the ten essential public health services. This grant will enable the department to continue to inform and educate the community about substance abuse (Domain 3) and to use evidence-based practices to identify areas of need (Domain 10).

The VDH, Office of Local Health (OLH), operates 12 District Offices (DO) located throughout the state. All VT residents have a local health office they can access for a range of public health services such as information, disease prevention and emergency response services. DO Directors (DDs) are increasingly involved in working with community teams, hospitals and health care providers on health care reform systems. The DDs will convene RPP regional stakeholders, including representatives of target populations, as well as community coalitions, schools, service clubs, human service agencies, medical providers, parent and youth groups, emergency responders, town officials and others. As with VT’s first PFS, each region that correspond with the DOs will identify an lead organization to serve as the sub-recipient of RPP funds for their distribution to community partners and service providers for effective and localized service delivery. Per VDH standards, each lead organization must show a strong history of effective partnership building for prevention, effective fiscal and program management of grant-funded initiatives, and long-standing ties to and repute within the community. These anchor organizations serve a critical role in VT’s prevention system, ensuring that funding is disbursed in alignment with state and funder priorities and specifications such as population targets and evidence-based strategies; facilitating the full participation of communities, stakeholders and consumers in planning, quality delivery and outcome monitoring; and ensuring fiscal stewardship and responsibility.

Working with each lead organization are DO Prevention Consultant (PC) staff at a part- or full-time basis with extensive training, and expertise in utilizing the SPF model to address local and regional substance prevention issues. The job duties of the PCs correspond to the skills necessary to facilitate implementation of the RPP, including planning and evaluation, education and skill development, community organizing, public policy and environmental change.

Vermont's PC system is funded by its federal Substance Abuse Prevention and Treatment Block Grant (SABG). We are leveraging SABG by enlisting the PCs as front line staff to coordinate the regional RPP and provide technical assistance.

The PCs will be leveraged to serve the RPP initiative in a technical assistance capacity to support successful implementation. Having received extensive training on the SPF during VT's SPF-SIG grant, PCs will facilitate and guide stakeholders through SPF Steps 1 through 5, and will work with providers to analyze regional data with assistance from the SEOW along with other community-specific data sources. Relevant planning data used to select and target EBS, in partnership with our Evidence-based Workgroup, will include data on underage and binge drinking, marijuana use, and prescription drug misuse and related consequences, contributing factors for these behaviors, and patterns of use related to poverty, race/ethnicity, and geographic location, as well as an inventory of other funding sources. A written plan will be developed that flows from a logic model driven by the data assessment and capacity analysis to identify the EBSs shown by research to impact the specific intervening variables. Identification of EBSs will follow the guidance document developed for the SPF-SIG (Interventions, 2009).

As part of both the planning and implementation process, DOs and sub-recipients are expected to identify community and regional stakeholders and partners that have particular skills and/or experience such as working with low socioeconomic status (SES), minority, ethnic, disabled, and LGBTQ sub-populations. These partners will include, but are not limited to, community substance abuse coalitions, Boys and Girls Clubs, local and state law enforcement, colleges and employers of young adults, recovery providers, Youth Service Bureaus, treatment providers, schools, town governance officials, health care entities, and the Governor's Regional Community Opiate teams.

Activities under this proposal will complement the substance abuse prevention work being done in schools, colleges and other youth-serving organizations including those that serve low SES and minority youth. This includes VT's School-Based Substance Abuse Services (SBSAS) grant program, currently available to only one-third of the school systems in VT. The VDH is currently awaiting findings from an evaluation of the SBSAS program due in fall 2015. Upon review of the evaluation findings, VDH and the SEOW will establish recommendations for alignment between SBSAS, and the RPP initiatives to ensure that as many youth as possible are reached by comprehensive interventions.

The VDH will continue to support our regional interventions with statewide training. Training events will be open to all VT prevention providers, such as schools and community coalitions regardless of their funding source. This will support an integrated public health approach and increase the state's overall capacity to implement the SPF framework. Such trainings and support will ensure consistent skill, capacity and readiness building in all regions in the state.

Lastly, communications campaigns developed by our current contractor, HMC, Inc. (LOC attached) will be enhanced based on available data and booster campaigns targeting underage drinking, binge drinking and prescription drug misuse will be implemented. A new public information campaign on the health effects of marijuana will be developed and linked to the state's existing *ParentUpVT.org* website. As there are fewer evidence-based models for social marketing

in the area of marijuana prevention, it is anticipated that the first phase of the marijuana project will involve focus group testing and other research. All RPP/DOs and all stakeholders will have access to campaign materials and will participate in message dissemination through as broad a network as possible.

The proposed plan to expand the RPP grant to additional regions in the state will allow VT to reach its goal of a regionally organized statewide prevention system that represents a significant step toward achieving a more regionalized organization of prevention work throughout the state including targeting underserved populations. This goal 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.

**B.4.b Selection of Sub-recipient Regional Approach and Methodology:** As explained in Section B.1, the geographic regions of the state to be funded initially under the RPP grant are the same six high-need regions that were funded through the current PFS project. Those areas were selected based on a formula that included the size of the age 10-24 population, YRBS-derived prevalence estimates for alcohol use, binge drinking, and prescription drug misuse, and the degree of disparity in prescription drug misuse between high and low SES students (as indicated by their mother’s education). The data used to inform the selection are shown in Table 6. Because the service areas of the state’s DOs correspond closely with county boundaries, the county (or counties) served by each DO are also shown in the table, and the values reported are based on county-level data. The overall rating was a composite indicator of high need derived from the standardized values of the component variables listed in the table. The DOs associated with the six areas having the highest need scores were selected to coordinate PFS-funded prevention activities in those areas. As indicated in the table, the Newport District would have qualified for PFS funding based on its need score, but subsequent conversations with the DO Director and the PC assigned to that region confirmed that the prevention infrastructure was insufficient to carry out the requirements of the PFS. For that reason, the region with the next highest need score, Rutland, was selected as the sixth and final target area for PFS funding.

**Table 6. VT Health Districts by Relative Need for Targeted PFS 2012-2015 Funding**

District Office	County served	Population	Prescription drug use	Alcohol use	Binge drinking	Disparity in prescription drug use	Overall need rating
Brattleboro*	Windham	-0.4	2.6	1.1	1.0	-1.4	2.8
Newport	Orleans/Essex	-0.6	-0.2	2.2	1.8	-1.2	2.0
Morrisville*	Lamoille	-0.5	0.6	1.1	1.0	-0.3	1.9
White River Jct.*	Orange	-0.2	0.6	0.2	0.1	0.9	1.6
Burlington*	Chittenden	3.1	-0.6	-0.9	-0.7	0.4	1.2
Barre*	Washington	0.2	-0.6	-0.1	0.5	0.1	0.2
Rutland*	Rutland	0.1	-0.2	-0.1	0.5	-0.4	0.0
Springfield	Windsor	-0.6	-0.2	-0.4	-1.1	2.0	-0.3
Bennington	Bennington	-0.4	0.6	-0.6	-0.3	0.3	-0.4
St. Albans	Franklin/Grand	0.0	-1.0	-0.4	-0.3	0.4	-1.3
Middlebury	Addison	-0.2	-1.0	-0.6	-1.5	0.6	-2.7
St. Johnsbury	Caledonia	-0.4	-0.6	-1.5	-1.1	-1.4	-5.0

\*DOs selected for coordinating PFS-funded prevention activities.

Our rationale for retaining the same regions for continued funding in the first two years of RPP is clear. With the current PFS grant being only three years, the DOs and the lead agencies and community partners they selected to implement the PFS need additional time and resources to consolidate their regional partnerships and implement their various prevention strategies as planned in order to measurably reduce the target outcomes. We believe a five-year timeframe is much more appropriate for achieving these objectives. In addition, an analysis of the most recent YRBS data available (2013) confirmed that five of the six funded areas would still have the highest composite need scores. For the reasons given mentioned previously, Rutland will continue to receive PFS funding (through the RPP grant) along with the five other high-need regions identified in our current PFS application.

Because there are only six additional (i.e., unfunded) regions in the state, the selection of the next wave of “high-need” areas was straightforward: all six of these regions will be funded in Years 3-5 of the RPP grant. We justify this approach of funding all six remaining areas based on our experience that the level of funding available will adequately support six new sub-recipients, especially as we expect to reduce funding to the current sub-recipients over the course of the project period.

This strategy is consistent with VT’s long-term goal for the RPP and beyond, which is to have functional and sustainable regional prevention systems operating across the entire state. Finally, the consideration for tribal entities as RPP sub-recipients does not apply to VT, as our state does not have any federally (or state) recognized tribes, tribal entities, or tribal jurisdictions.

### **B.5 Provision of Support and Guidance to Sub-Recipients to Implement the SPF Model**

Vermont will offer continued support and guidance to those implementing the SPF model through the RPP by providing training and technical assistance (TA), access to the SEOW and the Evidence-Based Practices Workgroup, as well as the expertise of our current evaluation, training, and communications contractors.

It is our intent to continue our current training contract with the Center for Health and Learning, Inc. (CHL) to provide statewide training to DO’s and sub-recipients (LOC attached). A learning community model will provide opportunity for more experienced grantees to train and mentor less experienced sub-recipients. Past training topics include, but are not limited to, logic model development; SPF implementation; ways to engage youth, young adults and parents/caregivers; cultural competency; ways to engage non-traditional partners; media advocacy; how to reach young adults who are not in college; leadership development; community mobilization; and how to use data for needs assessment, planning, and evaluation. The CHL is also the state’s Youth Suicide Prevention and Early Intervention grantee and they have committed to collaboration and coordination of their efforts with the RPP grant (See Section B10 and LOC attached).

In addition to the trainings provided by CHL and as mentioned throughout the proposal, additional regional training and TA is provided by regional PCs on each step of the SPF. PCs are required to complete the SAMHSA sponsored Substance Abuse Prevention Skills Training (SAPST) which is a workforce development training designed to teach foundational concepts and knowledge essential to delivering effective evidence-based substance abuse prevention.

The SEOW is another support that will be offered to DOs and sub-recipients throughout the course of the grant by providing data, guidance on interpreting data, and research results. The Evidence-based Practices Workgroup, which will continue to work with regions to identify evidence-based strategies (EBS) to meet their specific needs.

Support and guidance on data collection and analysis, for both process and outcome evaluation purposes, will be provided to our sub-recipient organizations by our current evaluator, the Pacific Institute for Research and Evaluation (PIRE). The VDH contracted with PIRE for evaluation services during the successful implementation and evaluation of two State Incentive Grants. It is our intent to continue to contract with PIRE (LOC attached) for the evaluation of the RPP grant, creating continued and sustained expertise in data collection activities, building data infrastructure, reporting, and development of performance measures. Additional information regarding performance monitoring and evaluation is provided in Section D.1.

When awarded our current PFS grant in 2012, ADAP central and district office staff developed a Guidance Document (GD) that provided a step-by-step set of instructions on how to assess needs, capacity and readiness, plan, implement and evaluate using the SPF. This GD and corresponding tools will be updated and provided to the new sub-recipients in Year 3. These resources will assist sub-recipients in determining which community entities are best suited to implement relevant EBS. VDH will also provide detailed implementation work plans to guide each selected EBS.

**B.6 Monitoring of the National Standards for Culturally and Linguistic Appropriate Services (CLAS)**

From 2005 to 2011, the Office of Local Health (OLH) regional and ADAP central office 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. OLH staff will work with each RPP grantee to assess their level of compliance with the CLAS standards and develop a work plan for improvements. That work plan and sub-recipients’ quarterly progress reports will be monitored to assess progress. Complementing this effort, ADAP’s Health Disparities Work Group provides guidance to the following SAMHSA grant programs in VT: PFS; Screening, Brief intervention and Referral to Treatment (SBIRT); and Youth Treatment Enhancement. We will utilize this group as a source of TA for our RPP sub-recipients and for ADAP staff on how to improve compliance with CLAS standards.

**B.7 Five-Year Timeline for Project Implementation**

Below is a five year timeline to support successful implementation of VT’s RPP.

<b>Time Frame</b>	<b>Key Activities</b>	<b>Milestones</b>	<b>Responsible Staff</b>
Year 1 10/1/15 – 9/30/16			
10/15	Inform advisors, stakeholders and grantees of award	Public Announcement and project abstract released	Cimaglio
10-12/15	Amendment of contracts to extend services over 5 years	Evaluation, communications and training contract amendments executed	Uerz/LaPlante
11-12/15	PH Specialist position recruitment	PH Specialist hired	Uerz
11/15	Orient OLH staff and RPP	Responsible staff and grantees	Uerz, Baroudi

<b>Time Frame</b>	<b>Key Activities</b>	<b>Milestones</b>	<b>Responsible Staff</b>
	grantees on additional priority and programmatic requirements	oriented on expanded model and timeline for increasing reach of RPP	
12/15	2015 VT YRBS Report released	SEOW updates state a regional epidemiological profiles	Div of Health Surveillance; Searles
1/16	Convene Evidence-based Practices Workgroup	Youth serving community practitioners added to membership; Updated menu of EB programs and practices to be funded	Searles/Uerz
1-2/16	VT's Most Dangerous Leftovers social media campaign	Social media campaign implemented and supported by RPP regional activities	Lamonda
2/16	Training to RPP grantees/staff	Sub-recipients and OLH staff complete training on evidence-based programs/practices re: marijuana use	Uerz; RPP Coordinator
3-4/16	RPP sub-recipients receive TA from OLH staff	Sub-recipient plans for state FY17 completed and submitted	Uerz; Reagan
5-6/16	Communications and Evaluation contractors plan marijuana communications objectives	Marijuana Social Marketing plan developed with staff and evaluation plan completed	Uerz; LaPlante
4-7/16	Sub-recipient plans reviewed	Sub-recipient grants fully executed	Uerz; RPP Coordinator
<b>Year 2 10/1/16 – 9/30/17</b>			
10/16	Training and TA plan developed including orientation to communications campaigns; Sub-recipients continue to implement plans with fidelity	Sub-recipient trainings implemented; sub-recipient plans implemented with fidelity	Uerz; RPP Coordinator
10-12/16	SEOW, OLH and ADAP plan for expanded number of RPP sub-recipients	Final selection of new RPP regional sub-recipients and outreach plan	Uerz; Searles; Reagan
1/17-2/17	Marijuana public information campaign launch during NIDA Drug Facts Week;	Launch implemented ; VT's Most Dangerous Leftovers continued	Lamonda; LaPlante
2-4/17	Current RPP sub-recipients plan for reduced funding; RPP sub-recipients plan for regional expansion start-up	Sub-recipient plans completed  OLH to provide guidance and TA	Uerz; RPP Coordinator; OLH staff
3/17	VT YRBS administered	2017 VT YRBS data collected I all sub-recipient regions	Health Surveillance; Searles
7/17	Old and new sub-recipient plans and plans reviewed	PFS sub-recipient grants executed; Regional PFS expansion completed	Uerz
9/17	ParentUp website/social media campaign updated with marijuana information	Enhanced ParentUp site launched	Lamonda; Uerz
<b>Year 3 10/1/17 – 9/30/18</b>			
10-12/17	Training and TA plan and topics established	RPP learning community established; mentoring commences	Uerz; RPP Coordinator
10/17	Sub-recipients continue to implement with fidelity	Progress reports submitted and approved	Uerz; RPP Coordinator
12/17	2017 VT YRBS Report completed	State and regional epidemiological profiles updated	Searles; Health Surveillance
1-6/18	Review SAPT Block Grant plan for supporting PFS regional	Plan for alignment of PFS and Block Grant funding in support of regional	LaPlante; Uerz

Time Frame	Key Activities	Milestones	Responsible Staff
	Structure	prevention infrastructure	
1/18	Continued implementation of Communications Campaigns	Campaign boosters implemented	Lamonda; Uerz
3/18	Mid-Course evaluation completed	RPP mid-term evaluation report to Advisory Council	Uerz
3-5/18	Regional work plans updated and submitted	Plans approved	Uerz; RPP Coordinator
8-9/18	Communications Campaign boosters	Campaign boosters implemented	Lamonda; Uerz
<b>Year 4 10/1/18 – 9/30/19</b>			
10/18-9/19	Sub-recipients continue to implement strategies with fidelity	Progress reports submitted/ reviewed	Uerz; RPP Coordinator
10/18-9/19	Trainings, learning community activities are based on needs assessed through review of quarterly reports	Trainings; learning community sessions completed	Uerz; RPP Coordinator
1/19	Continued implementation of Communications Campaigns	Campaign boosters implemented	Lamonda
3/19	VT YRBS administered	2017 VT YRBS data collected I all sub-recipient regions	Health Surveillance; Searles
8-9/19	Communications Campaign boosters	Campaign boosters implemented	Lamonda
<b>Year 5 10/1/19 – 9/30/20</b>			
10/19-6/20	Sub-recipients continue to implement strategies with fidelity	Progress reports submitted/ reviewed	Uerz; RPP Coordinator
10/19-6/20	Trainings, learning community activities are based on needs assessed through review of quarterly reports	Trainings; learning community sessions completed	Uerz; RPP Coordinator
12/19	2017 VT YRBS Report completed	State and regional epidemiological profiles updated	Searles; Health Surveillance
1/20	Continued implementation of Communications Campaigns	Campaign boosters implemented	Lamonda
3/20	Lessons learned forum with PFS sub-recipients and advisors	Final recommendations on priority programs and practices, and alignment of prevention funds	Uerz; LaPlante; Cimaglio
6-9/20	Final PFS data collection and analysis	PFS Evaluation Report	Uerz; Searles

### **B.8 Role of Evidence-Based Practice Workgroup with Sub-Recipients**

The Evidence-based Practice (EBP) Workgroup is made up of research and evaluation experts, VDH and OLH staff, and sub-recipients who have experience in implementing evidence-based practices in rural areas of the state as well as areas with high diversity (e.g. Burlington District Office/Chittenden County). Established in 2009, the EBP workgroup will participate in updating the menu of EBSs for the RPP grant and will expand its membership to include community practitioners with expertise in working with high-risk and low-SES youth. The EBP workgroup will continue to conduct its work based on SAMHSA's *Identifying and Selecting Evidence-Based Interventions* (2009). The EBP will be available to sub-recipients as requested to discuss and assess the need for additional or modified EBSs utilizing the standards identified by SAMHSA. The EBP workgroup is chaired by SEOW chair, Dr. John Searles, to ensure consistency and coordination between the two entities.

### **B.9 Role of Advisory Council, SEOW and Evidence-Based Practice (EBP) Workgroup on a Statewide Level**

The Vermont Alcohol and Drug Abuse Advisory Council (VADAAC) has served as the oversight body for Vermont's current PFS and will continue to serve in this role for the RPP grant. The VADAAC includes representatives from a broad array of state departments, consumers and interest groups from prevention through recovery, and is committed to the reduction of substance abuse. Per statute, the VADAAC serves in an advisory role to the Governor (18 VSA Ch 94 § 4803). The following state-level partners with resources targeted to the objectives of this project will serve as advisors in order to align those resources; they include the Agency of Education, Departments of Public Safety (includes Governor's Highway Safety Program), Liquor Control, Mental Health, and VDH's Division of Maternal and Child Health.

Mentioned earlier in the narrative, VT has an active SEOW which was established in 2005 as part of the SPF-SIG initiative, and it has continued this level of activity through our current PFS grant. The SEOW is charged with bringing systematic, analytical thinking to the causes and consequences of the use of alcohol, tobacco and other drugs to guide decision making about the allocation of prevention resources. The SEOW is made up of key state agency staff, epidemiologists, and representatives from higher education and the United Way. The SEOW generates VT's epidemiological profile. The SEOW will continue to provide data analysis to the state to review on a yearly basis and will provide regional data as needed to the DO staff and high-need communities identified to receive funding for this grant. SEOW Chair Dr. John Searles will assist DO staff in the drill-down analysis of DO data to specifically identify risk and protective factors and intervening variables unique to each district office catchment area.

The *Evidence-Based Practice Workgroup*, chaired by Dr. Searles, is composed of epidemiologists, evaluators, ADAP program staff and community-based providers. The Evidence-Based Practice Workgroup utilizes the standards identified by SAMHSA in published guidance (Interventions, 2009). Its role on a statewide level will be to define a specific list of EBPs recognizing the state's largely rural and homogeneous population for the RPP initiative.

### **B.10 Vermont's State-Sponsored Youth Suicide Prevention and Early Intervention**

The Center for Health & Learning (CHL) is the lead agency serving as VT's State-Sponsored Youth Suicide Prevention & Early Intervention Organization. In 2012, CHL with the support of the VT Department of Mental Health & the VDH received a Garrett Lee Smith Memorial Youth Suicide Prevention grant through SAMHSA to address priorities identified in the *Vermont Suicide Prevention Platform* including public awareness about mental health & suicide prevention and training in suicide prevention and post-vention for schools and communities.

The *Vermont Youth Suicide Prevention Coalition (VYSPC)* is the advisory group for these efforts represented by a broad array of constituents, including state and private agencies, suicide prevention advocacy and survivor groups, community prevention coalitions, youth leadership, education and mental health services. The VDH is an active member of the VYSPC and is poised to continue to collaborate and coordinate our substance abuse prevention efforts with the goals of the VYSPC. The VYSPC's *UMatter for Communities* campaign provides comprehensive community training and protocol development for suicide prevention and post-vention. This program will be enhanced to include training to support Lesbian, Gay, Bi-sexual, Transgendered & Questioning (LGBTQ) youth who are at a particularly high risk for mental health problems,

including substance use, depression and suicide (See Section A for details).

### **B.11 Vermont’s Collaborative Approach between Substance Abuse and Suicide Prevention Efforts through the SPF process**

As the state’s health department, we address all health issues including youth suicide and substance abuse as public health issues and seek to prevent, intervene, treat and support recovery through our grant funding and partnerships with state and community partners. Vermont can assure that our collaborative approach with CHL as the Youth Suicide state grantee, and as our current PFS training contractor, will result in closely aligned and coordinated efforts. In addition, of the eight current *UMatter* community partners, half are current PFS sub-recipients and the remaining groups are funded by other VDH funding, ensuring an existing partnership for service and program delivery. RPP sub-recipients will be required to disseminate educational information and to participate in training opportunities and public information campaigns.

### **B.12 Addressing Sub-Population Disparities and Needs**

*B.12.a Demographics:* With assistance from the SEOW, each DO will identify specific sub-populations based on the demographic data available for their geographic catchment area. District office staff provide both direct and indirect services to Vermonters and are skilled in interacting with Vermonters of low SES, non-English speaking population and migrant cultures as they relate to health. It is with this knowledge and expertise that each district plan will address SES, language and literacy, sexual identity, disability and issues specific to military families and veterans where identified in their region. Other demographic differences and subgroups will be identified and addressed as indicated based on community assessments, the comprehensive and inclusive planning process, and the selection of appropriate sub-grantees.

*B.12.b Language and Literacy:* As indicated above, each district will identify differences and subgroups including low-literate and non-English speaking populations. Each DO 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. As challenges are identified, we will utilize the VDH Translation Work Group and the ADAP Health Disparities Work Group for assistance.

*B.12.c Sexual Identity:* As detailed in Section A.2, mental health and substance risk factors are higher for LGBTQ youth compared to their heterosexual peers. Sub-recipients will access this population through its work with local schools and by sub-granting funds to existing youth serving agencies that focus on outreach and provide programs targeted to the LGBTQ community, including but not limited to Gay Straight Alliance chapters at local high schools and the statewide agency, Outright Vermont.

*B.12.d Disability:* Vermont’s full integration of youth and young adults into school and community will allow sub-recipients access to this subpopulation through its work with local schools and by sub-granting funds to existing youth serving agencies that focus on outreach and provide programs targeted to the disabled community.

*B.12.e Veterans and Military Families:* VDH currently provides a small grant to Vermont Vet to Vet, Inc. to provide peer recovery groups to veterans at each of the states eleven Recovery Centers and to collaborate with community partners to improve coordination with the substance abuse treatment network, advocacy groups and prevention coalitions. Executive Director David Morgan has committed to exploring how best to collaborate with the RPP to support family members

through the Vet to Vet program (LOC attached).

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

### **C.1 Capacity and Experience of Vermont Department of Health (VDH)**

The VDH ADAP has successfully implemented two State Incentive Grants aimed at increasing community prevention capacity and reducing alcohol and other drug use. These were the *VT State Incentive Grant, New Directions* and *VT's Strategic Prevention Framework Incentive Grant*. Population level changes in substance use prevalence among the funded communities were achieved in both cases (Flewelling et al., 2005). Vermont is currently in their third and final year of the PFS grant and has applied the lessons learned from each of the previous federal initiatives to our current grant and will continue to apply them throughout the RPP initiative. Also, VT's capacity to develop a more efficient and sustainable regional prevention system is evident in the success of its current PFS grant which has enabled the successful development of regional collaborations and coordinated implementations of individual and environmental evidence-based prevention strategies which have included the inclusion of sound prevention practices within regional and town plans, and the development of permanent disposal sites for unused prescription drugs.

ADAP will have statewide responsibility for the implementation of the RPP initiative utilizing staff that has been instrumental in managing the two previous federal initiatives, as well as the current PFS grant. They are **Lori Uerz**, Manager for Prevention Services; **Marcia LaPlante**, Director of Community Services and Planning; and **Barbara Cimaglio**, Deputy Commissioner of Alcohol and Drug Abuse Programs.

Ms. Uerz served as the evaluator on the original State Incentive Grant (SIG) and as the project coordinator for both the SPF-SIG and the current PFS grant, with a high level of skill and expertise in the SPF process, statewide planning, implementation and evaluation of community efforts, grant monitoring, workforce development, and cultural competency. Ms. LaPlante and Ms. Cimaglio have experience overseeing complex contracts, leading program design for statewide initiatives and leveraging collaboration across state and community agencies.

In addition, ADAP employs two Prevention Coordinators (PCs) at the state level. They both will have key roles in the RPP implementation. **Kelly Lamonda** is our school liaison and will ensure coordination of prevention efforts as she manages the School-based Substance Abuse Services (SBSAS) as detailed in Section B.4.a, which has similar goals and priorities of the RPP, namely underage and binge drinking and marijuana use among 12-17 year olds. Our second PC is **Patty Baroudi**, the department's representative on the state's Youth Suicide Advisory Board as detailed in Section B.10. Ms. Baroudi will be responsible for coordination and collaboration of activities between the RPP and the Center for Health & Learning (CHL) as detailed in section B.11.

The Office of Local Health (OLH), central management for the 12 District Offices (DOs), and each regional District Director (DD) will have a significant role in implementation of the SPF-PFS. As noted in Section B, the DOs are VT's key infrastructure for community organization and TA. Each DO has developed a cross-disciplinary prevention team with the knowledge of the five steps of the SPF model and employs a full- or part-time substance abuse PC. ADAP trains and sets the deliverables for the PCs, and OLH provides supervision. DO staff are the "face" of public

health for the health department and have a high level of skill and experience working with the specific populations within their geographic catchment area including low SES, minority and racially diverse Vermonters. Having the DD and DO staff serve as the lead for the SPF-PFS grant ensures culturally appropriate and competent services.

**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 OLH, 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.

<b>Staff</b>	<b>Role/Qualifications</b>	<b>Effort</b>
Barbara Cimaglio, Deputy Commissioner of Alcohol and Drug Abuse Programs	Project Director. Provides administrative leadership for the grant and VDH, ensuring ADAP complies with SAMHSA requirements and reporting needs. More than 30 years of experience in the ATOD field, and serves as the Single State Authority (SSA) for VT, as well as Project Director for Vermont’s SPF-SIG.	5%
Marcia LaPlante, Director of Planning & Community Service	Project Oversight. Supervision of Project Manager and oversight of interagency coordination and collaboration and policy development. 30 years of experience in the mental health and addictions field, 17 years as manager of VT substance abuse prevention system including 2 State Incentive Grants	10%
Lori Tatsapaugh Uerz, Manager Prevention Services NPN	Project Manager. Manage grant including, supervision of Project Coordinator, contract development and contractors. Served as project coordinator for SPF-SIG and PFSII grants. 30 plus years of experience in the substance abuse prevention field with expertise in grants management, evaluation, logic model development and strategic planning.	30%
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.	100%
Patty Baroudi, Prevention Coordinator	Coordination and collaboration with the state’s Youth Suicide Prevention and Early Intervention grantee and Suicide Advisory Board Member. 30 plus years in the prevention field as state level grant manager and liaison with OLH and PC’s work duties	10%
Kelly Lamonda, Prevention Coordinator	Liaison with middle and high schools. Ensure coordination and collaboration of school-based substance abuse prevention strategies with the RPP interventions. Over 20 years’ experience in the prevention field in evaluation, data analysis and strategic planning.	10%
10 Regional Substance Abuse Prevention Consultants (PC)	Consultation, training, and technical assistance. Will serve the RPP planning teams and sub-recipients on SPF model, District Directors in outreach to community partners on evidence-based strategy implementation and evaluation. Years of experience range from 15 to over 30 years in the substance abuse prevention field.	25% each
Lisabeth Sanderson , Administrative Assistant	Administrative support. Tasks include arranging meeting logistics; communications with District Office Directors, grantees and contractors; compilation of reports. Over 25 years as an administrative assistant and over 2 years as the current PFS admin.	50%
To be hired: Project Coordinator	Coordinator. Coordination of regional implementation, training and monitoring of grant working closely with PC’s. Will assure all reporting and data collection systems comply with federal requirements. Responsible for all	100%

	reports SAMHSA. To hire staff with experience in the substance abuse prevention field with expertise in grants management, evaluation, logic model development and strategic planning.	
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**C.3 Key Staff Experience with Cultural Competency**

From 2005 to 2011, ADAP staff and approximately 30 community coalitions received training and technical assistance (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 apply this learning across programs.

**SECTION D: DATA COLLECTION AND PERFORMANCE MEASUREMENT**

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

The collection, analysis, and reporting of performance (i.e., process) and outcome data at both the state and sub-recipient levels will serve several important purposes. Specifically, they will: meet Center for Substance Abuse Prevention (CSAP)/SAMHSA requirement for National Outcome Measures (NOMS) as needed to meet both Government Performance and Results Act requirements and their own internal program monitoring purposes including the PFS cross-site evaluation; provide process measures to VDH/ADAP regarding the implementation of the RPP at both the state and sub-recipient levels; provide a system for monitoring and enhancing implementation fidelity at the sub-recipient level; assess issues faced and progress achieved in enhancing regional prevention capacity; and assess levels and change over time in sub-recipient-level measures of risk and protective factors and targeted outcomes. Vermont has data collection systems already developed and operating to ensure all data requirements will be met. VDH in conjunction with the SEOW and PIRE will adapt these systems as needed in order to meet any new or revised requirements and to ensure that the data are collected and submitted in an efficient and timely manner.

Process data. The required process measures as identified in the RFA, and their data sources, are listed in Table 7. The primary source for process data is the Community Grants Reporting System (CGRS). This web-based system was developed by PIRE for collecting process data from community sub-recipients funded through VT’s current PFS grant. CGRS captures information on the number of community partners from each sector and their level of collaboration as well as an assessment of the TA provided by VDH staff and other training (T) and TA providers. At the intervention level, CGRS collects information on which interventions are being implemented and the status of their implementation, other funding sources supporting each intervention, fidelity to the implementation work plans, quantitative data on activities (e.g. number of saturation or party patrols conducted, number and types of outreach conducted on proper storage and safe disposal of prescription drugs, number and demographics of individuals reached by individual-based interventions), progress narrative, successes, challenges and T/TA needs. All sub-recipients are required to submit data to CGRS on a quarterly basis. A guidebook for using the CGRS was developed and provided to the current PFS sub-recipients and is updated whenever modifications to the system are made. New grantees will be provided T/TA on use of CGRS.

**Table 7. Required Process Measures and Data Sources**

<b>State-Level:</b>	<b>Data Source</b>
Number of training and technical assistance activities per	State Project Coordinator, augmented by records

<b>State-Level:</b>	<b>Data Source</b>
funded community provided by the grantee to support communities	from CHL, records from Vermont’s Prevention Consultant Data System, and data collected through PIRE’s Community Grantee Reporting System (CGRS)
Reach of training and technical assistance activities (numbers served) provided by the grantee	TTA attendance and contact logs prepared by CHL and the Prevention Consultants
Percentage of sub-recipient communities that have increased the number or percent of evidence-based programs, policies, and/or practices	Roll-up of sub-recipient-level data from CGRS (see below)
Percentage of sub-recipient communities that report an increase in prevention activities supported by leveraging of resources	Roll-up of sub-recipient-level data from CGRS
Percentage of sub-recipient communities that submit data to the grantee data system	State Project Coordinator based CGRS data from communities
<b>Community-Level:</b>	<b>Data Source</b>
Number of active collaborators/partners supporting the grantee’s comprehensive prevention approach	CGRS
Number of people served and/or reached by IOM category (universal, selective, indicated), six strategies, demographic group and targeted population	CGRS for individual-based interventions and U.S. Census for population-based interventions
Number and percent of evidence-based programs, policies, and/or practices implemented by sub-recipient communities	CGRS
Number of prevention activities at the sub-recipient level that are supported by collaboration and leveraging of funding streams	CGRS
Number, type and duration of evidence-based interventions by prevention strategy implemented at the community level	CGRS

In the event that some process data elements may be collected directly from sub-recipients by CSAP’s cross-site evaluator through the use of a system akin to the Community Level Instrument (CLI) used for the SPF-SIG, the CGRS will be revised accordingly to reduce duplication but ensure important process data that are not covered by the CLI, such as implementation fidelity, continue to be collected. PIRE will also provide sub-recipients with guidance and data collection tools needed to ensure they are prepared to provide all data elements requested in the CLI.

Outcome data. Vermont will rely on the YRBS and YAS instruments, administered biannually with large and representative sample sizes at both the county (YAS) and school district (YRBS) levels to measure outcome data. The NSUDH will serve as the core data source to measure state level change, and additional outcome measures will be captured by uniform crime reports, traffic data, and hospital and school data systems. SAMHSA required outcome measures and the respective data sources to be used for outcome data are listed in Table 8.

**Table 8. Required State- and Community-Level Outcome Measures and Data Sources**

<b>Outcome Measures</b>	<b>Grantee-level Data Source</b>	<b>Community-level Data Source</b>
30-day alcohol use, marijuana use, <u>and</u> prescription drug misuse and abuse	NSDUH State estimates	YRBS for HS students YAS for young adults
Binge drinking	NSDUH State estimates	YRBS for HS students YAS for young adults
Perception of parental or peer	NSDUH State estimates	YRBS for HS students

<b>Outcome Measures</b>	<b>Grantee-level Data Source</b>	<b>Community-level Data Source</b>
disapproval/attitude		
Perceived risk/harm use	NSDUH State estimates	YRBS for HS students YAS for young adults
Alcohol and/or drug-related car crashes, fatalities and injuries	Dept. of Transportation (NHTSA)	Vermont State Police: Crash Analysis Database
Alcohol- and drug-related crime	Uniform Crime Reports	Vermont Criminal Information Center: VCON Data System
Family communication around drug use	NSDUH State estimate	YRBS
Alcohol and prescription drug-related emergency room visits	Vermont Uniform Hospital Discharge Data Set	Vermont Uniform Hospital Discharge Data Set
(Optional) Alcohol and drug related suspensions and expulsions	Agency of Education (AOE)	Vermont Agency of Education

The substance use measures in the table above pertain to VT’s three priorities selected for the RPP and their associated risk and protective factors and will be collected via the YRBS for youth and via the YAS for young adults. As required for Section F, a link to VT’s version of the YRBS and the YAS instruments and administration protocols are included in Attachment 2. The consent forms are included in Attachment 3. Other measures listed in the table are available from archival data sources as indicated, and all sources geographic identifiers that will allow roll-up to the county level, the boundaries of which closely correspond to the service areas of the 12 Health DOs being used for the RPP.

Analysis and Reporting. In addition to submitting all required state and community data elements required by SAMHSA, these data will be analyzed and interpreted in order to augment the narrative summaries of VT’s PFS grant progress in its annual update reports to CSAP. Interim summaries and reports will be shared with the ADAP program and management staff, the Advisory Council, and our regional sub-recipients (see section D.2).

**D.2 Use of Data to Manage Project, Track Goals and Objectives, Inform Continuous Quality Improvement, and Communication with Staff, Governing Bodies, and Stakeholders**

The importance of monitoring implementation through the 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 providing essential contextual information needed to interpret the findings from the outcome evaluation.

Process evaluation will be conducted at both the state and the regional sub-recipient levels to document activities, monitor progress, and identify implementation issues that may need to be improved or rectified. Clear and candid communication, including opportunities for giving and receiving feedback among the project management team, project staff, regional sub-recipients, training, and evaluation contractor, will serve to monitor and fine tune project management and implementation. At the state level, the timetable developed for state implementation of the RPP (see Section B.7) will be expanded into an annotated work plan and include additional task and sub-tasks as they are identified, as well as columns for notation regarding: achievement (or non-achievement) of milestones, barriers encountered, and changes made to the plan. On a quarterly basis the RPP Project Coordinator 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. Urgent issues will be addressed more quickly, through either the project management-evaluation team monthly check-in meetings or other impromptu meetings or correspondence. The annotated work plan will serve as a resource for completing and submitting the state's quarterly progress reports and annual performance assessments to CSAP. This level of documentation will also be useful in addressing a number of questions central to understanding how the current PFS was implemented and adapted as necessary in VT, and provide contextual information for interpreting the outcomes.

As was done for the PFS, sub-recipients will be provided with implementation work plans for each evidence-based intervention they choose to implement. Key activities are built into CGRS and every six months sub-recipients are asked to rate their progress on each of these activities by indicating whether each step is "not started", "partially completed", "in progress" or "completed" to the degree expected. The RPP Project Coordinator and evaluator will review these data along with qualitative information provided on progress, successes and challenges in CGRS, and at annual site visits to identify whether any corrective action, adaptations or additional TA is needed. Summary accounts of the district-level implementation based on the information provided in CGRS and site visits will be prepared for inclusion in the state's quarterly progress reports and annual performance assessments submitted to CSAP.

PIRE will also conduct a qualitative evaluation of regional capacity-building which will focus on understanding how the targeted regional approach of the PFS has changed regional- and community-level capacity to prevent underage drinking and prescription drug misuse, including the barriers to making progress and how have they been overcome. PIRE will work with the RPP coordinator, DOs and sub-recipients to use the information learned for quality improvement. Findings from these assessments will be summarized in the final evaluation report.

Interim findings and final results from the evaluation will be disseminated in various formats, including: press releases from the VDH Communications Office; presentations to state policymakers and work groups; brief "one-pager" reports that may be widely disseminated to multiple audiences; detailed reports for selected audiences, sub-recipient organizations and their community partners; and manuscripts in prevention research journals.

### **D.3 Tracking, Assessing, and Reducing Disparities**

The data collection systems described in sections D.1 and D.2 will facilitate efforts to monitor and assess health disparities across population subgroups including by gender, race, ethnicity, and military/veteran (including family) status using ADAP's Program Participant Information forms. In accordance with CLAS standard #11, and in consultation with our CSAP State Project Officer, we will explore adding preferred language and disability status to the demographic data now collected. This information will be used to track participation levels in RPP-sponsored prevention services for designated population subgroups. In addition, our regional capacity assessment process (see section D.2) reflects CLAS standards #12 and #13 and will include a focus on disparities in both substance behaviors (i.e., prevalence) and access to prevention services. An important goal of this process will be to identify and engage community partners that can help to address whatever disparities are identified.

The two surveys that will be used to generate outcome data at the sub-recipient level (i.e., the YRBS and YAS) will be useful tools for tracking health disparities in substance use behaviors. Additional categories consistent with CLAS standards will be considered for both surveys. The subgroup data on substance use behaviors and risk factors collected with these surveys will serve to identify where there are important differences in risk levels and substance abuse prevalence rates, and to track these differences over time. When follow-up data are analyzed in the later years of the project, we will also use these data sources to identify differences in responsiveness to the prevention interventions across the subgroups of interest.

#### **D.4 Plans for Local Performance Assessment**

Vermont's plan for monitoring project activities (i.e., collecting process evaluation data) at both the state and regional sub-recipient levels, collecting sub-recipient-level outcome data, and submitting these data to both SAMHSA and stakeholders in VT, is explained in sections D.1 and D.2. As further explained in Section D.2, sub-recipient performance assessment and fine tuning at a relatively micro level will be conducted using the process data collected via CGRS on a quarterly basis. To maximize the usefulness of all these data, collectively, the evaluation will include joint analyses of data from multiple sources to address research questions regarding the overall implementation of the project and the outcomes achieved through it, and the connections between various aspects of program design and implementation (including the interventions implemented and their costs), and the outcomes achieved. Of particular interest in VT will be the degree of success achieved in operationalizing a regionally-structured prevention system, including the level of prevention services provided statewide, and the prevention-related outcomes connected to those services.

Vermont will 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. Specifically, comparisons will be made over time, comparing pre- and post-intervention periods for each sub-recipient. Additionally, the staggered timing on interventions will allow comparisons between those sub-recipients funded earlier (through the PFS grant) and those that will be funded later in the RPP project. Analyzing data from multiple communities, both intervention and comparison, provides a much stronger methodological basis from which to observe and confirm whether VT's RPP projects are achieving their outcome goals and allows 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.