



PREP

The Personal Responsibility Education Program Evaluation

Supporting Statewide Implementation of Evidence-Based Teen Pregnancy Prevention Programs: Findings from Four PREP Grantees

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**Supporting Statewide
Implementation of Evidence-
Based Teen Pregnancy
Prevention Programs:
Findings from Four PREP
Grantees**

November 2016

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OVERVIEW

The Personal Responsibility Education Program (PREP), authorized by Congress in 2010 as part of the Affordable Care Act, is one of the largest federally funded programs designed to address teen pregnancy. PREP provides \$75 million annually for evidence-based and promising teen pregnancy prevention programs, most of which states receive through formula grants. State PREP grantees must meet four funding requirements—they have to implement evidence-based or evidence-informed programs, provide information on abstinence and contraception, incorporate three of six adulthood preparation subjects, and focus on high-risk populations. States have discretion in how to meet these requirements, allowing them to tailor their PREP programs to fit their states' needs. An earlier report, describing all state PREP program plans, found that many state PREP grantees were going beyond meeting the four primary program expectations and were additionally establishing infrastructure to support the large-scale implementation of evidence-based programs with fidelity (Zief et al. 2013).

This report documents the implementation infrastructure developed in four states—California, Maine, Pennsylvania, and South Carolina. The four selected states differed along several dimensions, including the size of their PREP programs, the role the state PREP grantee took in supporting implementation and the resources they devoted to that support, and the settings in which the programs operated. Despite the variation, the four states developed similar approaches to support the implementation of their evidence-based programs with fidelity. All four states:

- Worked with providers before and in the early stages of implementation to fit their implementation plans to the local context.
- Formed a pool of qualified trainers on the evidence-based programs to train program facilitators and provide ongoing technical assistance.
- Went beyond federal performance measures requirements, collecting additional data for monitoring service delivery and informing continuous quality improvement.
- Established communication and feedback loops to facilitate data gathering, data sharing, and identification of lessons learned for continuous quality improvement.

Given the similarities in the implementation infrastructure established across these four distinct states, the infrastructure and its component parts may be applicable across other program and policy areas. The implementation infrastructure these states developed may also be indicative of a growing national awareness of the importance of implementing evidence-based programs with fidelity, and that doing so requires deliberate and careful attention across all phases of implementation.

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INTRODUCTION

In recent years, federal agencies have increased their investments in evidence-based social programs as a strategy for addressing teen pregnancy and other social problems (Haskins and Margolis 2014). The Personal Responsibility Education Program (PREP) is one of the largest of such programs. Authorized as part of the 2010 Patient Protection and Affordable Care Act (ACA) and administered by the Administration on Children, Youth, and Families (ACYF) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS), PREP provides \$75 million annually for evidence-based and promising teen pregnancy prevention programs through competitive and formula grants.

In fiscal year 2016, ACYF distributes most of the annual PREP funding (\$43 million) through formula grants to 48 states and territories (state PREP).¹ State PREP grantees are expected to implement their PREP programs in accordance with four primary expectations (Table 1).²

Table 1. State PREP programmatic expectations

Evidence-based	States must implement programs that have been proven through rigorous research to change teens' sexual behaviors, such as delaying sexual activity, increasing contraceptive use, and reducing pregnancy, or substantially incorporate elements of these programs. ^a
Cover abstinence and contraception	PREP programs must provide education on both abstinence and contraceptive use.
Incorporate adulthood preparation subjects	Programs must educate adolescents on at least three of six adulthood preparation topics: (1) healthy relationships, (2) adolescent development, (3) financial literacy, (4) parent-child communication, (5) education and employment skills, and (6) healthy life skills.
Focus on high-risk populations	States are encouraged to target youth living in areas with high teen birth rates, youth in foster care, adjudicated youth, and minority groups (including LGBTQ youth).

^a See Office of Adolescent Health. "TPP Resource Center: Evidence-Based Programs." Available at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/.

LGBTQ = lesbian, gay, bisexual, transgender, or queer/questioning.

An earlier report demonstrated that the state PREP program is replicating evidence-based, comprehensive teen pregnancy prevention programs at tremendous scale (Zief et al. 2013). State PREP grantees are working with more than 300 program providers at thousands of implementation sites, where more than 3,000 facilitators serve in excess of 100,000 youth annually with 32 unique programs.

¹In fiscal year 2016, American Samoa, Florida, Indiana, the Republic of the Marshall Islands, the Commonwealth of Northern Mariana Islands, North Dakota, the Republic of Palau, South Dakota, Texas, Virginia, and Kansas elected not to use their PREP formula allotments.

² See Government Publishing Office. "Public Law 111-148, 111th Congress." Available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm>.

The earlier report also described how state PREP grantees have discretion in how they meet the four funding expectations (Table 1), and all states use this flexibility to tailor their PREP programs to address local contexts and needs (Zief et al. 2013). Target populations across states vary as do the selected settings for reaching youth. For example, PREP programs serve youth in foster care group homes; adjudicated youth and youth with mental health needs in residential facilities; and males, runaway and homeless youth, pregnant and parenting youth, and youth identifying as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) through community-based settings.

States also addressed the needs of a broader population of youth through schools in areas with high teen birth rates (Zief et al. 2013).³ States also take different approaches to educate youth on both abstinence and contraception, and to incorporate adulthood preparation subjects; about half of the states allow their direct service providers to decide how to meet these expectations in a way that is appropriate for the local context and the selected evidence-based program model (Zief et al. 2013).

The PREP Multicomponent Evaluation

ACF contracted with Mathematica Policy Research and its subcontractors to conduct an evaluation of the PREP grant programs. This seven-year effort documents how PREP-funded programs are operationalized in the field and assesses their effectiveness in reducing teen pregnancies, sexually transmitted infections (STIs), and sexual risk behaviors. It includes analyses of program performance, implementation, and impacts. All components of the evaluation are designed to expand the evidence base on teen pregnancy prevention programs and help to identify the decisions, successes, and challenges involved in implementing, adapting, and scaling up evidence-based programs. For more on the PREP Multicomponent Evaluation, see <http://www.prepeval.com>.

At the time the state PREP grantees were beginning to enact their plans to serve youth, grantees also reported undertaking additional new activities: they planned to create an infrastructure to support successful large-scale implementation of the evidence-based programs through targeted partnerships (Zief et al. 2013). The purpose of this report is to document four states' efforts to create such a network for success. The implementation support infrastructure described in this report can serve as an example to states and other large social service organizations that seek to implement evidence-based programs on a larger scale. The report concludes with lessons these states learned along the way, offered as considerations for other organizations supporting large-scale implementation of evidence-based programs.

How do state PREP grantees support implementation of evidence-based programs?

To address what states are doing to support implementation of their PREP evidence-based teen pregnancy prevention programs, we identified four states implementing PREP in very different ways. We hypothesized that these differences would have implications for the organization and delivery of implementation support. By design, the four selected states varied in the:

- Extent to which they played a role in training, technical assistance, and monitoring efforts;

³ The named settings in which these youth are served is intended to be illustrative, and not inclusive of each setting in which these populations are served.

- Proportion of grant funds they devoted to these efforts;
- Number of unique evidence-based programs implemented;
- Extent to which programs were offered through schools, the most popular setting across all state PREP grantees.

Beyond this intended variation, the PREP programs in the four selected states—California, Maine, Pennsylvania, and South Carolina—also vary greatly in size, ranging from the largest in California, where the state contracted with 21 provider agencies and served more than 15,000 youth during the 2014–2015 grant year, to the smallest in Maine, where the state contracted with one provider agency and served about 400 youth during the same period (Table 2).

Table 2. Characteristics of the four participating states

	California	Maine	Pennsylvania	South Carolina
State agency involvement in training, technical assistance, and monitoring	Direct involvement	Involvement through a lead partner	Direct involvement	Involvement through a lead partner
Annual PREP funding ^a	\$6,500,000	\$250,000	\$2,000,000	\$760,000
Percentage of funding reserved for implementation support ^a	11	21	19	32
Number of programs implemented	5	1	2	3
Number of provider agencies	21	1	15	14
Percentage of implementation sites that were schools ^b	57	100	0	44
Number of youth served (2014–2015) ^c	15,035	423	1,523	3,147

^aAverage across first two years of program implementation (2011–2012 and 2012–2013), as per performance measures data.

^bReported by states during the first round of telephone interviews in 2012.

^cAverage across the last two years of program implementation (2013–2014 and 2014–2015), as per performance measures data.

We examined the four states’ implementation infrastructure by conducting semistructured telephone interviews with staff supporting program implementation at all levels, including state grantee administrative staff, training and technical assistance partners, evaluators, and program

Implementation Infrastructure

A growing body of research suggests that creating an infrastructure to support practitioners as they prepare for and deliver evidence-based programs is critical for promoting fidelity to program models (Metz et al. 2015; Supplee and Metz 2015; Metz and Albers 2014). The infrastructure should contain a process for assessing fit between the program and the community, implementing agency, target population, intended outcomes, and the resources to support implementation; a system for collecting data to inform decision making; communication and feedback loops among administrators, practitioners, and other stakeholders; and ongoing use of data for continuous quality improvement (Supplee and Metz 2015; Metz and Albers 2014).

providers. Respondents addressed questions about the organization of state infrastructure; key partners and their roles; the approach to staff hiring, training, and technical assistance; fidelity assessment and monitoring; data use; and lessons learned. Appendix A contains more detail on the data collection, and Appendix B provides more detail on each state and its infrastructure.

From the tremendous discretion states were given to decide how best to serve youth and the variation in funding they received to do so comes a surprisingly similar approach for ensuring the programs are implemented as intended. Across the four different states, they took similar

approaches to supporting the implementation of evidence-based programs with fidelity, suggesting that their infrastructure is applicable nationwide and possibly across different grant programs and social policy areas. In particular, all four states:

- Worked with providers before and in the early stages of implementation to fit their implementation plans to the local context.
- Formed a pool of qualified trainers on the evidence-based programs to train program facilitators and provide ongoing technical assistance.
- Went beyond federal performance measures requirements, collecting additional data for monitoring service delivery and informing continuous quality improvement.
- Established communication and feedback loops to facilitate data gathering, data sharing, and identification of lessons learned for continuous quality improvement.

COMPONENTS OF AN IMPLEMENTATION INFRASTRUCTURE SUPPORTING EVIDENCE-BASED TEEN PREGNANCY PREVENTION PROGRAMS

The four states examined in this report developed similar implementation infrastructure to support their delivery of evidence-based teen pregnancy prevention programs with fidelity, despite the variation in funding, program plans, contexts, and size. This section describes the similar components of the implementation infrastructure in more detail and with specific examples, including the selection of partners, implementation readiness plans, training and technical assistance, and using data for continuous quality improvement. While the implementation infrastructure components are similar across the four states, nuanced and small differences in approaches to implementing these components emerged, as well. Appendix B contains additional detail on the distinguishing features of each state's implementation infrastructure.

States strategically selected training, technical assistance, and evaluation partners

All four states contracted with at least one partner to expand their capacity to support program providers. They selected partners that had expertise in training and technical assistance, and also knowledge of teen pregnancy prevention and reproductive health programming.

- California partnered with the California STD/HIV Prevention Training Center and a national evidence-based program developer and distributor, ETR.



California organizes partners in technical assistance triads

California, which operated the largest state PREP grant, created technical assistance teams known as triads to support each of its 21 providers. Each triad included a representative from the grantee agency, an evaluation liaison from either the grantee agency or one of its partners, and an implementation specialist from the California STD/HIV Prevention Training Center. California reported that it used this approach so that it could maintain ongoing communication with each provider given the large size of its PREP program. The state required twice-monthly communication between the triads and providers, as well as bimonthly communication between the triads and the grantee.

- Maine collaborated with the organization that operates Title X Family Planning clinics throughout the state, the Maine Family Planning Center.
- Pennsylvania partnered with two organizations: AccessMatters, for program model training, and the PERSAD Center, whose training focused explicitly on working with LGBTQ youth.
- South Carolina continued its longstanding partnership with the nationally recognized South Carolina Campaign to Prevent Teen Pregnancy to deliver program model training and lead technical assistance efforts.

The four study states differed in the size of the role they gave to their training and technical assistance partners. Maine and South Carolina, the two smaller states, contracted with their training and technical assistance partners to also select and work closely with providers, monitor programming, and coordinate the statewide evaluation activities. State grantee staff in the two larger states, California and Pennsylvania played a more active role in selecting providers, monitoring and evaluating service delivery, and providing training and technical assistance.

All grantees expanded their capacity to collect and analyze fidelity data through partnerships with local evaluators. The evaluators developed and shared reports with the entire infrastructure—the providers, the training and technical assistance partners, and the state grantee staff. South Carolina worked with a single local evaluation team within a state university. Pennsylvania used one of their training and technical assistance partners for evaluation services, and Maine worked with a local consulting organization. California established a pool of evaluation experts from the state’s epidemiology division, a university, and a private research firm.

States worked with providers to plan for successful program delivery

California and South Carolina reviewed and assessed providers’ implementation plans before allowing programming to begin. They assessed whether providers had all necessary program materials and had considered potential disruptions that could affect fidelity. These states worked closely with providers and their training and technical assistance partners to improve plans that were incomplete or suggested that the evidence-based programs may not be implemented with fidelity.

Each of the four states and their providers collaborated to modify the selected programs to better align the content and delivery plans with targeted youth, service delivery settings, and expected implementation schedules, primarily to maximize participation and optimize the youth experience. Respondents reported incorporating the following four primary modifications.

- **All four states changed language in lessons and role-playing scripts to fit the target population.** In California, the state modified language in a program developed for Hispanic youth to be more inclusive of the non-Hispanic population it also expected to serve. Pennsylvania modified program language to reflect its target population of young urban males and females. Maine and South Carolina also modified language to be more appropriate for their higher-risk populations, such as youth in foster care (South Carolina) and youth at risk of dropping out of school (Maine).

- **Three states adapted program activities to comply with implementation site restrictions.** Pennsylvania providers implementing *Street Smart* in residential treatment facilities invited guest speakers from local health clinics in place of a lesson that included a trip to a health clinic. In Maine, the provider had to adjust the timing of the *All4You!* service learning requirement to better fit with the school schedule. Providers in California changed active lessons to demonstrations and discussions to address group management concerns, for example by reducing movement during interactive activities.
- **Three states allowed modifications to condom demonstration lessons to ease facilitators' discomfort.** The state grantee in South Carolina permitted providers to exclude condom demonstration lessons from the curriculum if they chose. In California, the state grantee permitted providers to eliminate anatomical models from the condom demonstrations. In Maine, the technical assistance provider would facilitate condom demonstration lessons to address facilitators' discomfort with the demonstrations.⁴
- **Two states offered multi-day programs in a single day to optimize attendance.** Providers in South Carolina and Pennsylvania consolidated multiple lessons into a single day to address the anticipated challenge of retaining high-risk youth in voluntary programs.

State grantees reported that they required providers to request approval from the state grantee for planned modifications to the program content and delivery. States, in turn, consulted with program publishers on adjustments that they felt were more substantive, such as modifying condom demonstrations. States reported that they oversaw the implementation of the planned modifications as part of their overall monitoring plans.⁵

States invested in developing, improving, and sustaining facilitators' capacity to deliver evidence-based programs

States recognized that supporting the delivery of evidence-based teen pregnancy prevention programs with fidelity required an early and sustained investment in the frontline facilitators working with youth. To ensure all facilitators had access to pre-service training on the evidence-based programs, states established pools of qualified trainers who could provide pre-service training at the start of the program year to all new facilitators, and then again midyear to any later hires. To continue to build the capacity to deliver evidence-based programs, states also offered ongoing trainings and technical assistance to providers and their facilitators. State grantees and their infrastructure partners met at least monthly to discuss providers' implementation challenges and technical assistance needs, and then used this information to target ongoing training and technical assistance.

⁴ Please see the state profiles in Appendix B for more information.

⁵ State PREP grantees are required to seek federal approval prior to adapting evidence-based teen pregnancy prevention programs. The data collected for this report could not be used to confirm whether this requirement was routinely met.

Hiring program facilitators. States reported that local providers made program facilitator hiring decisions, and most providers we interviewed said they used staff already working within their own organization to deliver the evidence-based teen pregnancy prevention programs, regardless of whether they had experience with the program.⁶ Among the providers interviewed, none required facilitators to have experience implementing the selected evidence-based programs and only one required facilitators to have experience delivering any teen pregnancy prevention programming. When hiring, providers sought staff who met education requirements and had experience working with the youth population they planned to serve.

Building a pool of qualified staff to train facilitators. States used a train-the-trainer approach, similar to the method used by about half of state PREP grantees (Zief et al. 2013). Staff from the publisher of the evidence-based programs or another outside organization trained state grantee or partner organization staff and these staff in turn trained program facilitators. This approach meant states had the internal capacity to train facilitators on an ongoing basis without having to rely on or pay for multiple trainings delivered by the publishers.

Providing pre-service facilitator training. States required facilitators to complete training before delivering the programs. To account for facilitator turnover and new hires, states developed the capacity to train new facilitators, as needed. Three states developed alternative training opportunities for new facilitators who could not attend scheduled group trainings. For example, new facilitators who missed the annual three-day *All4You!* training in Maine met individually with the state's technical assistance provider for an intensive one-day training and received additional support from the provider and peer mentors for their first year. In Pennsylvania, new *Rikers Health Advocacy Program* facilitators who could not attend a scheduled group training shadowed an experienced facilitator before they could implement the program independently. New facilitators in California received a telephone-based training before being approved to co-facilitate lessons, but needed to attend an in-person training before leading lessons.

Offering ongoing training and technical assistance. States described two approaches to providing ongoing training and technical assistance to providers: (1) annual group meetings and (2) individual technical assistance. Annual in-person meetings for providers focused on sharing findings from fidelity and performance data, as well as successful practices and lessons learned across providers. The meetings were also an opportunity for states to provide additional training and technical assistance to providers. For example, implementation support partners in South



Pennsylvania's approach to building a pool of qualified trainers for *Rikers Health Advocacy Program*

Agencies implementing *Rikers Health Advocacy Program* can purchase facilitator guides and subscriptions to online training modules from the model's developer, but the developer did not offer in-person training. To build a pool of certified trainers in the state, the Pennsylvania PREP training and technical assistance partner, AccessMatters, developed an in-person training in consultation with the program's developer. The training covered the four *Rikers Health Advocacy Program* modules, included discussions about how to implement the program in the states' various implementation settings, and required trainees to facilitate a mock lesson for their peers.

⁶ Across the 13 providers interviewed, 3 reported hiring at least one new staff person for their PREP programs.

Carolina and Pennsylvania conducted training on special topics at the meetings, including adulthood preparation subjects. States also offered individual technical assistance to providers and, as needed, facilitators to address their specific needs. This approach was provided in conjunction with facilitator observations. California and Pennsylvania offered technical assistance through frequent telephone calls with each provider.

States used data to monitor service delivery and inform continuous quality improvement

ACYF requires PREP grantees to collect annual performance measurement data from providers that states can use for continuous quality improvement. Measures include the proportion of facilitators trained and observed, implementation challenges, technical assistance requests, and the percentage of youth completing at least 75 percent of intended program hours.



Maine's use of observations to assess facilitators' strengths and needs

Maine's training and technical assistance partner, Maine Family Planning, along with managers from the state's sole program provider, Jobs for Maine's Graduates (JMG), conducted regular observations of facilitators, particularly those who were new or identified through prior observations as needing additional support. To structure the observations, they used an observation tool to collect information about the clarity and organization of the facilitator's presentation of a lesson, students' receptivity to the lesson, the facilitator's knowledge of the content delivered and rapport with students, and an overall rating of the lesson. Observers also noted strengths and weaknesses of the lesson. In turn, Maine Family Planning and JMG used the data to identify technical assistance needs for facilitators and coordinated with peer mentors to deliver the technical assistance.

States are also required to collect data from youth at program exit through surveys about their perceptions about and experiences in the PREP programs. Like many state PREP grantees (Zief et al. 2013), the four states included in this report went beyond these requirements and collected additional data on fidelity to the program model. They used the data to monitor service delivery and identify ongoing training and technical assistance needs. The states monitored fidelity using direct observations of program delivery by state and partner organization staff, as well as fidelity data on each implemented lesson, provided through facilitator self-report.

Visits to providers. Partner organizations in all four states, and state grantee staff in three states (Pennsylvania, South Carolina, and California), conducted on-site provider visits. During these visits, staff documented whether and how facilitators provided required lesson information, the facilitators' perceived comfort with lesson content, and youth engagement.

Collecting fidelity data. The four PREP grantees all required facilitators to record specific information after each lesson. Publishers of some evidence-based programs provided forms for this purpose; for other programs, states developed their own forms. Although the type of information collected varied across programs and states, all facilitators were asked to record three key components: (1) lesson date and duration, (2) an indication of whether the facilitator delivered the intended content, and (3) changes that the facilitator made to the lesson. For at least three of the selected evidence-based programs, facilitators were also asked to record their feedback on the lesson, including their perception of youth engagement, what went well, and any changes they would propose. At the end of each youth cohort, providers submitted the

information to evaluation partners that had responsibility for analyzing the data and creating reports for providers, the state grantee, and the training and technical assistance partners.

Using observation and fidelity data to inform continuous quality improvement.

States established processes and protocols to facilitate communication and feedback among state grantees, partner organizations, and providers so that they could use data effectively. State grantees and their technical assistance partners met at least monthly (primarily by telephone) to discuss implementation issues, providers' technical assistance needs, and program modifications and adaptations. State grantee staff and technical assistance providers shared feedback directly with providers after conducting observations about strengths and ways they could improve the delivery of services to adhere to fidelity standards. States also used this information to inform statewide planning for additional trainings and technical assistance. Evaluation partners produced provider-specific fidelity reports at least once per year, sharing them with the providers and their technical assistance partners. Evaluators also produced statewide reports for grantees and technical assistance partners to inform overall planning for training and technical assistance.



South Carolina's collection and use of fidelity data

The South Carolina grantee partnered with the University of South Carolina Arnold School of Public Health to expand its capacity to collect, analyze, and use fidelity data. Providers submitted to the evaluation team fidelity monitoring logs, attendance logs, and youth entry and exit surveys. Providers submitted the logs and surveys at the end of each program cycle; the evaluation team entered the data and produced monthly reports for South Carolina's lead training and technical assistance partner, the South Carolina Campaign to Prevent Teen Pregnancy. The training and technical assistance partner, in turn, used the data in its work with providers. In addition, the evaluation team presented reports on fidelity and attendance data across providers at an annual meeting of providers.

CONCLUSION

These four states, each of whom made different decisions about how to use their PREP funding to serve youth, established a very similar infrastructure to support implementation. These states differed in terms of their funding levels, size, and program plans, yet each developed an infrastructure with very similar components, designed to leverage the expertise of various partners, plan for implementation, train facilitators, identify technical assistance needs and address them in a timely manner, collect and analyze data on fidelity, and share information among all stakeholders. Given the similarities across these four distinct states, the infrastructure and its component parts may be applicable across other program and policy areas.

The infrastructure developed across these four states emerged organically, seemingly without clear expectations and guidance to do so. It may be that increased federal support for replicating evidence-based programs (General Accounting Office 2013; Orzag 2009), followed by nationwide adoption of evidence-based programs across a number of social policy areas, has created widespread appreciation of the importance of implementation with fidelity. With that awareness may come the realization that implementation fidelity requires deliberate and careful attention across all phases of implementation, and an implementation infrastructure can systematically support those efforts.

Lessons Learned

Just as implementation of an evidence-based program is anything but straightforward, replicating this implementation infrastructure requires careful attention to critical details. These four states shared key lessons learned along the way that should be considered as other states build or refine their own network of support:

1. **Identify expert partners to support training, technical assistance, and monitoring.** These critical partnerships increase the state grantees' capacity to support implementation with fidelity. Building collaborative relationships across these experts takes time, and states should continuously forge such partnerships so that they are ready to support implementation of evidence-based programs as funding opportunities arise.
2. **Gain providers' trust and buy-in on the usefulness of fidelity data.** To acquire high quality fidelity data, such as from facilitators' service logs, providers and their program facilitators must feel comfortable sharing their successes and challenges delivering evidence-based programs. They must understand that the data are for the greater good of continuous quality improvement. States found that providers and facilitators provided high quality data when they found the feedback based upon those data useful and informative for improving practice.
3. **Carefully assess the fit of evidence-based programs before adopting them.** The selected evidence-based program must fit the target population and the implementation setting, or be modified as appropriate and in accordance with adaptation standards. Program providers must also be assessed for their readiness to support the program with high quality staff, to collect and submit data on fidelity, and to identify any barriers within the organization or community for reaching the target population and implementing with fidelity.
4. **The quality of the program facilitator is a paramount consideration, and providers should be offered guidance on selecting them.** Delivering a high quality evidence-based teen pregnancy prevention program with fidelity is critically linked with the frontline staff. Prior experience with teens does not always translate into effective delivery of a teen pregnancy prevention program. States reported that effective facilitators generally have experience with evidence-based programs and understand the importance of fidelity, are comfortable delivering lessons on abstinence and contraception, and can successfully engage youth in the important interactive components of many of these programs.

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APPENDIX A

METHODS

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Through interviews with 44 state PREP grantees, we developed a broad, cross-state understanding of states' plans to implement evidence-based programming under PREP (Zief et al. 2013). For this data collection effort, we focused on developing and providing an in-depth description of how a subset of states ensured that program providers implemented evidence-based teen pregnancy prevention programs with fidelity. This appendix details how we selected states and providers to participate in the analysis, and how we collected and analyzed data.

State and Provider Selection

Selecting states. In consultation with ACF, we selected four states to participate in the second round of DIS interviews: California, Maine, Pennsylvania, and South Carolina. We selected states that varied in their approaches to implementing PREP along four key dimensions: (1) state involvement in training, technical assistance, and monitoring; (2) proportion of grant funds devoted to training, technical assistance, and monitoring; (3) number of selected programs; and (4) implementation settings.

Selecting program providers. We then purposively selected up to four program providers from each state to participate in the analysis, which helped us capture variation in program experiences within states, in addition to capturing variation among them.⁷ We selected providers that reported various implementation challenges and technical assistance needs (in performance data collected for program years 2011–2012 and 2012–2013), and that together delivered a variety of PREP program models.⁸

Table A.1. Number of interviews by type of respondent

	California	Maine	Pennsylvania	South Carolina
Total	15	6	15	10
State grantee staff	1	1	2	2
Training and TA providers	4	1	5	2
Evaluators	3	1	4 ^a	1
Program provider staff	7 (4 providers)	3 (1 provider)	8 (4 providers)	5 (4 providers)

^a The four evaluators in Pennsylvania were also interviewed as four of the five training and TA providers.

Data Collection

We conducted hour-long semi-structured telephone interviews with staff involved in PREP program implementation at multiple levels in each selected state including: state grantee lead staff, training and technical assistance staff, evaluator staff, and program provider staff. Speaking with respondents from across these groups ensured that the data collected represented the range of perspectives and positions involved in supporting implementation quality and fidelity, and that we understood not only how service delivery and administrative processes were *intended to* work, but also how they *actually* worked. In total, we conducted 28 interviews with 46 respondents from 25 agencies across the 4 selected states. We conducted interviews from February through April 2015.

⁷ Maine has only one program provider.

⁸ The selected providers represented eight of the 11 programs implemented across all four states.

We used a semi-structured protocol informed by the principles of implementation science to guide interviews. Implementation science is the study of how evidence-based or evidence-informed programs and practices are translated, implemented, and scaled up in diverse, “real-world” service delivery settings. We structured the protocol largely on the definitions and elements of implementation stages and implementation drivers as described in the National Implementation Research Network’s Active Implementation Framework. This framework is based on an extensive review of literature on implementation to identify the practices and supports that are common among successfully implemented programs or interventions (Fixsen et al. 2005). The protocol was organized into eight constructs (Table A.1). The specific questions that we asked during the semi-structured interviews varied by respondent type, but all questions remained within the scope of these constructs (Table A.1).

Table A.2. Implementation survey semi-structured interview constructs by respondent type

Construct	State grantee lead staff	Training and TA provider staff	Evaluator staff	Provider managers
Implementation Structure and Planning				
Implementation structure	✓			✓
Model fit for service providers	✓			✓
Lessons from PREP planning	✓			✓
Implementation Support: Training and TA				
Implementation support structure	✓	✓	✓	✓
Funding for training and TA	✓	✓		✓
Training to support PREP implementation	✓	✓		✓
Ongoing support and TA	✓	✓		✓
Implementation Drivers: Competency Drivers				
Staff selection	✓	✓		✓
Staff turnover and retention	✓	✓		✓
Staff expectations and receptiveness	✓	✓		✓
Staff supervision and performance assessment				✓
Implementation Drivers: Organizational Drivers				
Decision-support data systems	✓	✓		✓
Facilitative administration	✓	✓		✓
Communication and feedback loops	✓	✓		✓
Systems interventions	✓	✓	✓	✓
Fidelity Assessment and Monitoring				
Program modifications or adaptations	✓	✓		✓
Adherence to service model	✓	✓		✓
Monitoring service delivery	✓	✓	✓	✓
Evaluation Capacity				
Evaluation capacity	✓		✓	
Sustainability				
Sustainability	✓	✓		✓
Perceptions and Lessons Learned about PREP Implementation				
Perceptions and lessons learned	✓	✓	✓	✓

TA = technical assistance.

Data Analysis

We used qualitative methods to analyze collected data. First, we created a coding scheme that closely followed the eight protocol constructs and subtopics and organized each question response in an Excel table for each construct. This enabled us to access data on a specific topic quickly and to organize information in different ways to facilitate the identification of themes and compile the evidence supporting them. It also ensured that data about program implementation and support were documented in a standardized way that allowed for systematic analysis both within and across states. Next, we analyzed each construct and subtopic to identify themes and triangulate across respondents within each state and develop the state profiles included as Appendix B. And finally, we identified themes and patterns in the data across states to identify lessons learned.

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APPENDIX B

STATE PREP GRANTEE PROFILES

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California's PREP Implementation Infrastructure

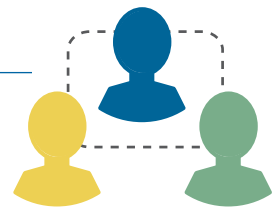
Overview

The California Department of Public Health, Maternal, Child and Adolescent Health Program (MCAH)—the California Personal Responsibility Education Program (PREP) grantee—operates the largest PREP program in the country. CA MCAH receives an average of \$6.5 million in PREP funds annually and serves an average of 15,000 youth each year. At the time of the interviews for this report, MCAH contracted with 21 providers to deliver five evidence-based program models—*Be Proud! Be Responsible!*; *¡Cuidate!*; *Making a Difference!*; *Making Proud Choices!*; and *SHARP*—in a mix of school-based and other settings, such as health clinics and foster care group homes. MCAH dedicates about 11 percent of its annual PREP funding to support implementation and takes an active role in the implementation infrastructure.



Implementation Support Infrastructure

MCAH deploys technical assistance (TA) triads to support implementation (Figure 1). Each triad includes MCAH staff and staff from each of the state's implementation support partners organized into one of three specialized roles. Frequent communication among triad partners, and monthly calls between triads and providers, enables the state to mobilize quickly to respond to TA needs. MCAH plans to expand the use of the triad structure to support more program providers beginning in 2015.

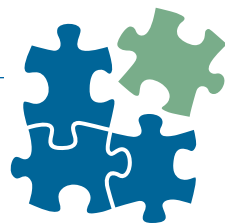


Each TA triad includes a program consultant, evaluation liaison, and implementation specialist:

- Program consultants from MCAH's program management branch manage grant administration, coordinate TA activities, and monitor implementation.
- Evaluation liaisons from MCAH's epidemiology branch, the University of California San Francisco (UCSF), and ETR collect, process, and analyze monitoring data. The evaluation specialists send monthly reports to providers with provider-specific data and semiannually with statewide data.
- Implementation specialists from the California STD/HIV Prevention Training Center (PTC) provide program model trainings, special topics trainings, TA, and program monitoring.

Planning for Implementation

Initially, and then throughout the years of programming, providers submit implementation plans to their TA triad. The plan describes any changes to the prescribed implementation. The TA triad must approve the plan before implementation, providing input as necessary to revise plans to ensure implementation fidelity.



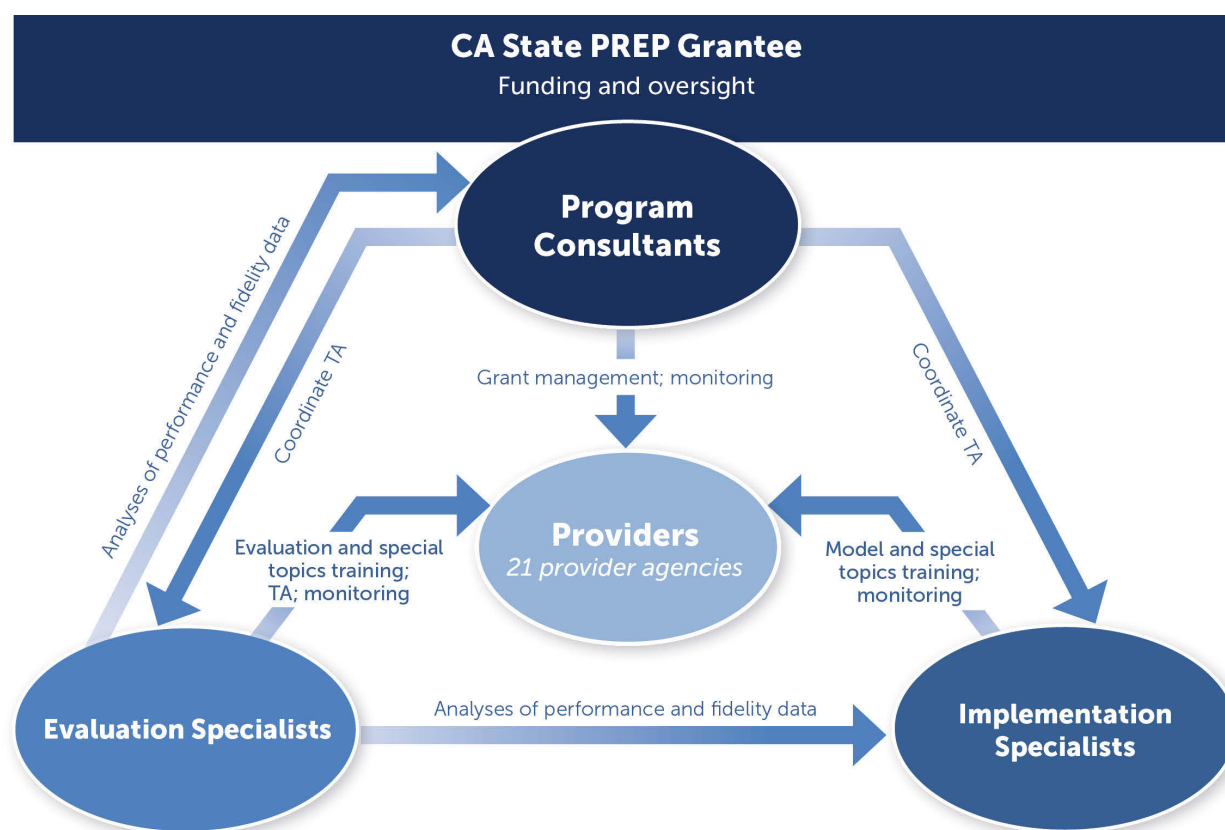
The selected programs made several modifications to align them with the state context, implementation settings, and target populations. TA triads support providers in implementing these changes

- MCAH requires that the programs incorporate family planning information from the California Family Planning, Access, Care and Treatment (PACT) Program.¹

(continued)

- Providers and the TA Triads anticipated challenges delivering programs in the prescribed time and with more challenging populations. As a result, providers can increase the time spent on certain lessons and change active lessons into seated demonstrations and discussions.
- MCAH allows language changes to make programs more relevant to a broader population, for example to include both Hispanic and non-Hispanic youth and both genders.
- Some providers modify condom demonstration lessons to address concerns expressed about the use of anatomical models.

Figure 1. TA Triads supported PREP implementation in California



Note: Providers submitted performance and fidelity data to program consultants, implementation specialists, and evaluation specialists; not pictured.

Training and Technical Assistance

California offers five evidence-based PREP programs; the training activities account for the differences among the programs.

California uses a train-the-trainer approach. Implementation specialists received training on all program models and then trained providers' program facilitators.

- Trainings for four similar programs (*¡Cuidate!*, *Making a Difference*, *Making Proud Choices!*, and *Be Proud! Be Responsible!*) are provided at the same time. Training for *SHARP* is provided separately.



- Trainings are held multiple times per year, in person, and last two days.

Implementation specialists offer in-person support on classroom management, group facilitation, and motivational interviewing (in particular, for *SHARP* program facilitators). Providers attend an annual PREP conference at which additional, group TA is available.

Use of youth survey data to inform TA. The state added items to the required federal performance measures program entry and exit surveys to measure knowledge gains and constructs of particular interest to MCAH, such as knowledge of contraception availability. The results of these data inform TA.

Special topic webinars

Implementation and evaluation specialists provide additional special topic training webinars that reflect needs identified through interaction with providers.

- ▶ Incorporating adulthood preparation subjects
- ▶ Improving implementation fidelity
- ▶ Meeting the needs of LGBTQ youth
- ▶ Complying with health and safety codes
- ▶ Sexual violence prevention
- ▶ Adolescent brain development

Sources

- Data reported in this profile were collected during separate telephone interviews with the PREP leadership from MCAH, UCSF, and PTC, and interviews with the PREP leadership at four California PREP providers that were implementing diverse program models in different settings. MCAH PREP leadership team respondents interviewed for this study were new to their roles as of July 2013 and September 2014 and had limited knowledge of program planning and early implementation.
- Interview data were supplemented with PREP Evaluation Performance Analysis study data (for program years 2011–2012, 2012–2013, and 2013–2014).

¹ Family PACT is California's initiative to provide comprehensive family planning service to low-income populations; see <http://www.familypact.org>.

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Maine's PREP Implementation Infrastructure

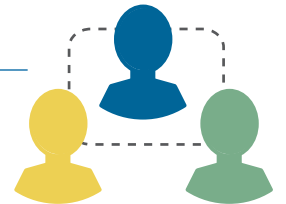
Overview

The Maine Centers for Disease Control and Prevention (ME CDC)—the Maine Personal Responsibility Education Program (PREP) grantee—receives an average of \$250,000 in PREP funds annually and serves an average of 423 youth each year. ME CDC contracts with one provider, Jobs for Maine's Graduates (JMG), to integrate a single evidence-based program, *All4You!*, into an existing school-based dropout prevention program across the state. ME CDC dedicates 21 percent of its annual PREP funding to support implementation, primarily through a partnership with Maine Family Planning (MFP). Over time, Maine's implementation infrastructure has supported the expansion of *All4You!* from an initial 7 schools to 20 schools.



Implementation Support Infrastructure

Maine's implementation infrastructure partners, and their roles and activities, reflect the need to support individual JMG teachers implementing *All4You!* in high schools across the state, without the support of other JMG teachers in their schools. (Figure 1)



- ME CDC contracts with MFP to support the implementation infrastructure by providing training and ongoing technical assistance to JMG. MFP also conducts site visits.
- JMG, whose teachers provide the PREP program in high schools across the state, developed its own infrastructure to further support implementation. Six regional JMG managers monitor program provision, provide technical assistance, and meet regularly to discuss implementation. JMG peer mentors—teachers who have delivered *All4You!* for at least two years—provide technical assistance to less experienced facilitators.
- Crescendo Consulting Group, Inc. (CCG) collects, analyzes, and reports program data to ME CDC, MFP, and JMG.

This infrastructure is maintained by monthly calls and quarterly meetings between ME CDC and MFP. A broader, annual meeting includes JMG managers and peer mentors.

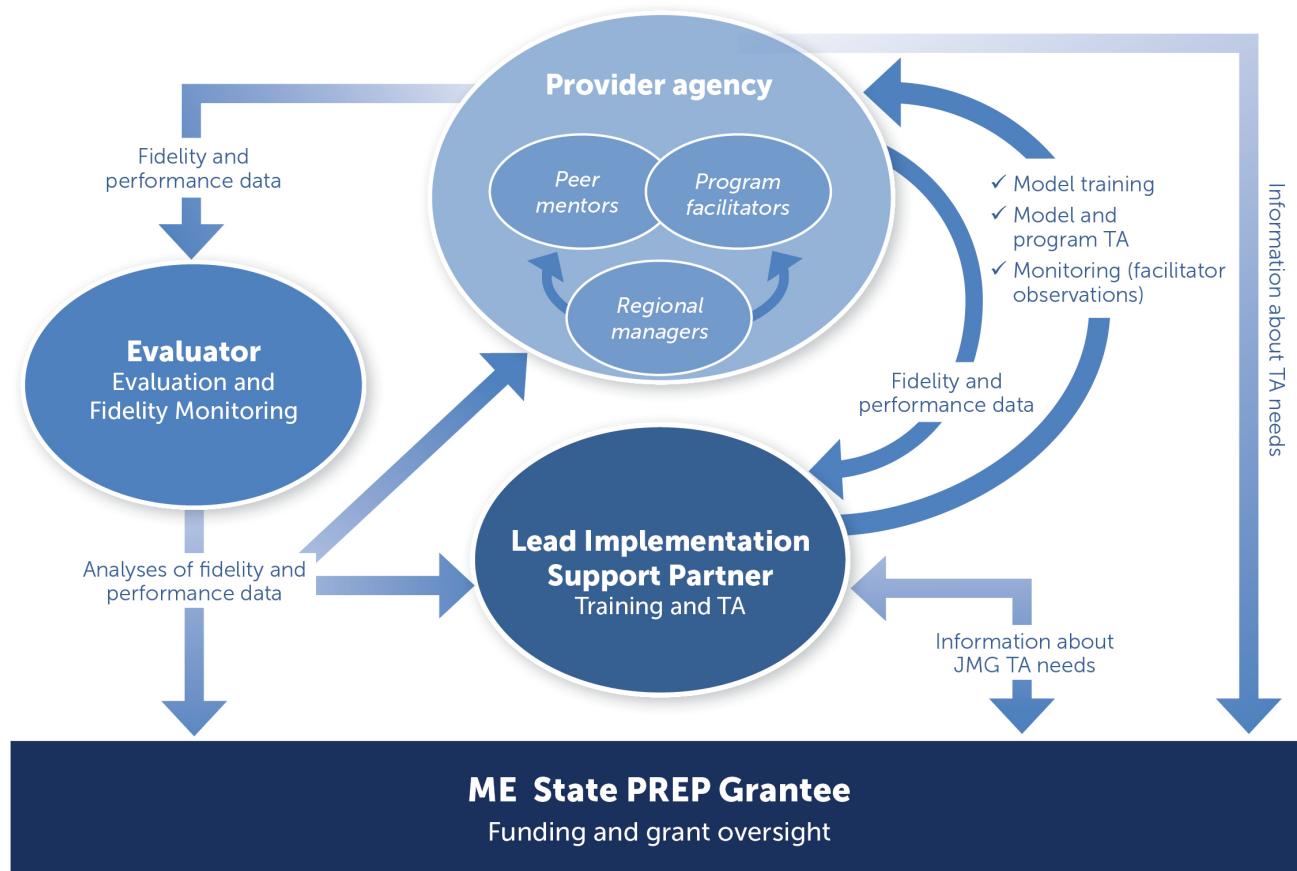
Planning for implementation

In preparation for the statewide integration of *All4You!* into the JMG program for high school youth at risk of dropping out, several modifications were made to the *All4You!* lessons.



- *All4You!* requires an intensive service learning component that is integrated throughout the multiweek program. To accommodate school schedules and the availability of local organizations that could provide students with opportunities for service learning, the developer approved a more flexible approach for implementing service learning.
- To address JMG facilitators' discomfort delivering lessons on contraception, including condom demonstrations, MFP staff co-facilitated lessons.
- MFP and JMG changed names in role-playing scripts to reflect the target population of youth at risk of dropping out.

Figure 1. Supporting PREP implementation in Maine



Training and Technical Assistance



Maine uses a train-the-trainer approach, building internal capacity to train facilitators on *All4You!* The *All4You!* developer led the first three-day, in-person training, which MFP staff and JMG staff and facilitators attended. MFP staff also attended subsequent trainings to prepare them to lead future trainings of new JMG facilitators. New facilitators were trained annually, in person and over three days in the summer. A one-day, in-person abridged training was developed for new facilitators hired during the school year.

MFP, JMG staff, and JMG peer mentors work collaboratively to provide ongoing technical assistance to the school-based JMG facilitators, as needed. The JMG peer mentors, who each work with four or five mentees, handle much of the technical assistance within the schools. MFP works closely with JMG staff to ensure they meet individual technical assistance needs. Additional group technical assistance is provided at an annual two-day summer retreat.

Facilitator observations, conducted by both MFP and JMG, focus on new facilitators and those with identified technical assistance or remediation needs. Facilitators receive immediate and direct feedback from their observers.

Sources

- Data reported in this profile were collected during separate telephone interviews with the PREP leadership from ME CDC, MFP, JMG, and CCG.
- Interview data were supplemented with PREP Evaluation Performance Analysis study data (for program years 2011–2012, 2012–2013, and 2013–2014).



Pennsylvania's PREP Implementation Support System

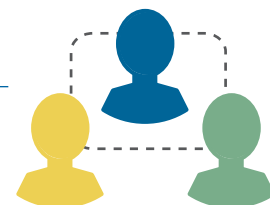
Overview

The Pennsylvania Department of Public Health, Division of Child and Adult Health Services (PA DCAHS)—the Pennsylvania Personal Responsibility Education Program (PREP) grantee—receives an average of \$2 million in PREP funding annually and serves an average of 1,523 youth each year. At the time of the interviews for this report, PA DCAHS delivered two programs—*Rikers Health Advocacy Program (RHAP)* and *Street Smart*—in 15 youth detention centers and other residential treatment facilities. Pennsylvania supplements each program with *SexEd 101*, a comprehensive sex education curriculum. PA DCAHS dedicates nearly 20 percent of its annual PREP funding to support implementation and leads implementation infrastructure activities.



Implementation Support Infrastructure

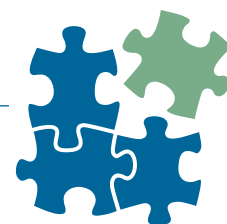
PA DCAHS takes an active role in overseeing PREP program provision, including weekly calls with the provider organizations. PA DCAHS staff also conduct in-person site visits to monitor implementation and provide technical assistance (TA). PA DCAHS partners with AccessMatters and the PERSAD Center in its implementation infrastructure. (Figure 1)



- AccessMatters develops and leads training on one of the PREP programs, *RHAP*. AccessMatters also offers special topics trainings, conducts site visits to monitor implementation, and collects and analyzes implementation data from all providers. It provides several reports a year on each provider, including a report following each site visit.
- The PERSAD Center provides training and TA related to serving LGBTQ youth, a target population for Pennsylvania.

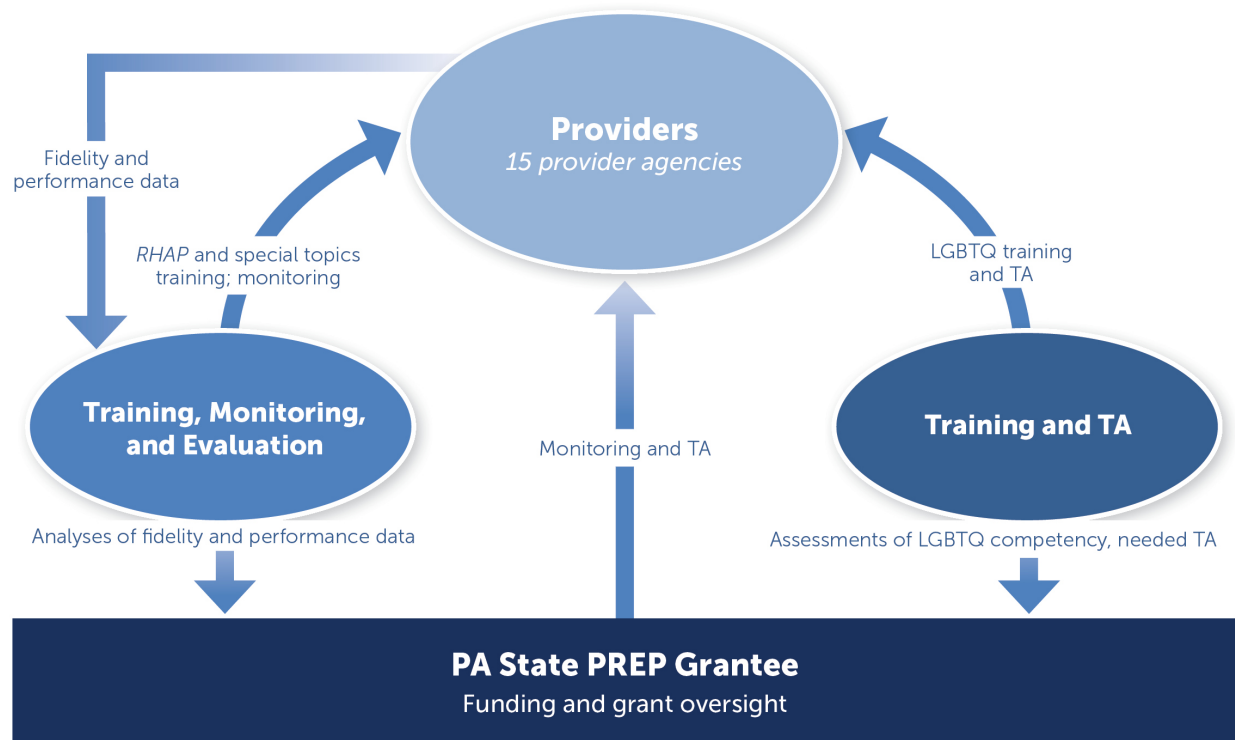
Planning for Implementation

Pennsylvania's support for implementation began with early modifications to *Street Smart* and *RHAP* to accommodate the target population of youth in detention centers and other residential treatment facilities. PA DCAHS approved modifications.



- *RHAP* was developed for incarcerated inner-city males ages 16 to 19 with histories of substance abuse. The populations in Pennsylvania residential facilities receiving PREP included females and youth younger than 16 who had not used drugs. Some *RHAP* providers revised the curriculum's language to be more appropriate for this population; they also added instruction on topics that were likely to be unfamiliar to younger youth.
- *Street Smart* providers substituted guest speakers from family planning clinics in place of the required tour of a local health clinic when providers did not have a local clinic or otherwise were unable to transport youth outside of the residential facility.
- Youth in residential treatment facilities confront mental health and behavioral problems that can interfere with regular program attendance. Providers could consolidate the multiday programs into a single day in order to optimize youths' attendance and retention.

Figure 1. Supporting PREP implementation in Pennsylvania



Training and Technical Assistance

Pennsylvania handled training for *Street Smart* differently from the training for *RHAP*, for which standard training materials were not available.

For *Street Smart*, Pennsylvania used a train-the-trainer approach. Managers at the provider organizations attended training by the developer and then trained their facilitators. Provider managers train new facilitators as needed.

The *RHAP* did not have a developer-designed training. AccessMatters developed and delivered the *RHAP* training annually, during a 2.5-day in-person training.

Special topics trainings. AccessMatters delivered webinars throughout the year, as needed, and group sessions at Pennsylvania’s annual regional provider meetings that addressed emerging TA needs. The topics included integrating adulthood preparation subjects, contraception, addiction, and providing sexual education to youth who have experienced sexual violence.

Implementation infrastructure

identifies a need to change program delivery plans

The data collected and reported through the implementation infrastructure in Pennsylvania resulted in a change in PREP plans for 2015. The 15 initial providers struggled to enroll and retain youth, in large part due to declining placements in residential facilities statewide. Pennsylvania planned to add new providers and end contracts with others. The new providers would deliver other evidence-based programs in new implementation settings in an effort to reach more youth annually. The state changed its implementation infrastructure as well, giving providers autonomy to subcontract for their own program training and eliminate the training role for AccessMatters.

Interviews with youth. AccessMatters conducted in-depth exit interviews with up to 25 percent of youth from each cohort. Interviews supplemented the required federal performance measures exit surveys by including free-response questions on youths' experiences in the PREP programs, knowledge gains, and perceived behavioral changes. Youths' responses became part of the data used to identify TA needs.

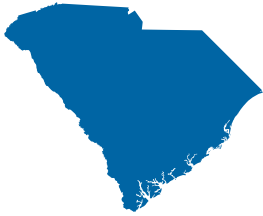
PERSAD Center training and TA

- ▶ PERSAD trained provider managers and facilitators twice per year on sexual orientation, gender and identity, LGBTQ resources, and other related topics.
- ▶ Additional trainings were given to provider managers to improve organizational capacity to support LGBTQ youth.
- ▶ PERSAD visited each provider annually to conduct a 72-point environmental scan to assess LGBTQ cultural competency, agency policies, procedures, and facilities. Results led to targeted TA to each provider, provided through monthly telephone calls.

Sources

- Data reported in this profile were collected during separate telephone interviews with the PREP leadership from DCAHS, AccessMatters, and PERSAD and interviews with the PREP leadership at four PA PREP providers that were implementing diverse program models in different settings.
- Interview data were supplemented with PREP Evaluation Performance Analysis study data (for program years 2011–2012, 2012–2013, and 2013–2014 [when available]).

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South Carolina's PREP Implementation Infrastructure

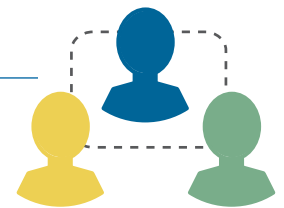


Overview

The South Carolina Department of Health and Environmental Control (SC DHEC)—the South Carolina Personal Responsibility Education Program (PREP) grantee—receives an average of \$760,000 in annual PREP funds and serves an average of 3,147 youth each year. At the time of the interviews for this report, SC DHEC contracted with 14 providers to deliver three evidence-based programs—*Making Proud Choices!*, *Safer Choices*, and *Seventeen Days*—in a mix of school-based and other settings, such as health clinics and juvenile detention centers. SC DHEC dedicates nearly one-third of its PREP funding to support implementation, primarily through a subcontract with the South Carolina Campaign to Prevent Teen Pregnancy (SCC).

Implementation Support Infrastructure

SC DHEC monitors implementation through visits to providers. Otherwise, SC DHEC contracts with the SCC to lead implementation support activities. The SCC selects program providers, prepares providers for implementation, provides all training and technical assistance, and coordinates with the evaluator. (Figure 1)

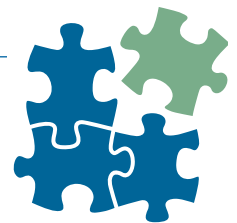


- A team of 14 SCC technical assistance (TA) specialists provides training and technical assistance to providers. SCC assigns TA specialists to providers by geographic area, with one exception—a single TA specialist supports implementation of *Seventeen Days* in health clinics statewide. SCC TA specialists support and monitor providers through monthly calls.
- The University of South Carolina Arnold School of Public Health (ASPH) collects, analyzes, and reports program data. ASPH sends a monthly report on each provider to SCC and hosts a website at which providers can access data collection tools and reporting requirements.

The infrastructure is maintained through monthly, in-person meetings among SC DHEC, SCC, and ASPH.

Planning for implementation

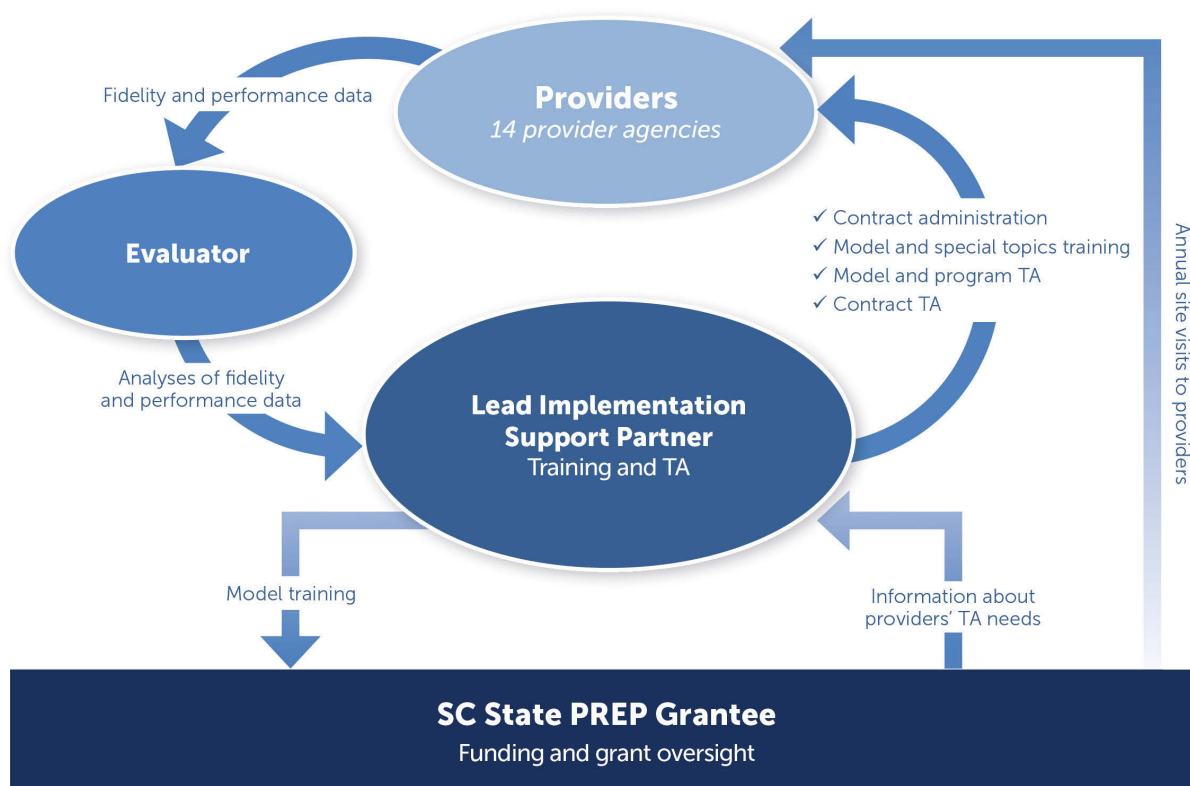
Initially, and as needed throughout programming, providers submit plans to SCC that outline their program implementation schedules and strategies for ensuring implementation fidelity. SCC uses the *Getting to Outcomes* framework to assess the plans for implementation readiness and to identify TA needs.¹



The SCC and the providers worked together to modify programs to address the state context and align programs with the planned implementation settings and target populations.

- South Carolina state law defines the type of health education instruction and reproductive health program content permitted in public schools. Providers delivering programs in schools removed unallowable demonstrations and emphasized the role of contraception in family planning.
- SCC and providers anticipated challenges recruiting and retaining some target populations in voluntary, out-of-school-time programs. SCC allowed providers to implement multi-lesson programs, such as *Making Proud Choices!*, in a single day.
- Providers modified or excluded condom demonstration lessons to address providers' and facilitators' concerns about these lessons.
- SCC and providers changed names in role-playing scripts to reflect the target populations, such as youth in foster care.

Figure 1. Supporting PREP implementation in South Carolina



Training and Technical Assistance

South Carolina's approach to training begins with training the SCC TA specialists on effectively communicating and building relationships with service providers. The Healthy Teen Network conducted this training.

South Carolina's training activities accounted for the differences among the three evidence-based programs. For *Making Proud Choices!* and *Safer Choices*, both group administered curricula, SCC uses a train-the-trainer approach. SCC TA specialists attended two-day trainings on these models provided by the program's distributor. The SCC TA specialists in turn train SC DHEC and provider staff through two-day, in-person trainings offered annually. *Seventeen Days* is a brief web-based program, and SCC, in partnership with the Healthy Teen Network, developed a 45-minute webinar to train facilitators to implement this brief program.

Each year, the SCC hosts a two-day conference in the summer and a brief meeting in the fall. Both provide opportunities for in-person TA to providers and their facilitators, and a review of results from the collected monitoring data. Outside of these meetings, the content, mode, and frequency of the TA between the SCC TA specialists and the providers varies depending on needs identified through ongoing reviews of implementation plans and monitoring data, providers' requests, or the results from the SC DHEC site visits.

Sources

- Data reported in this profile were collected during separate telephone interviews with the PREP leadership from DHEC, SCC, and ASPH, and interviews with four program providers that implemented different programs in different settings.
- Interview data were supplemented with PREP Performance Measures collected from the state PREP grantees for program years 2011–2012, 2012–2013, and 2013–2014.
- ¹ Recommended to grantees by the Administration for Children & Families as a useful resource for "identifying and creating relevant programs geared toward outcomes." RAND Corporation. "10 Steps to Promoting Science-Based Approaches (PSBA) to Teen Pregnancy Prevention Using Getting to Outcomes." Arlington, VA: RAND Corp., 2008. Comprehensive Health Education Act of 1988 Act No. 437, Section 1. Available at <http://www.scstatehouse.gov/code/t59c032.php>.
- ² See the Girlology website, available at <https://www.girlology.com/>.

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