

Preventing Mental, Emotional and Behavioral Disorders: Financing and Implementation Strategies

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Introduction

One of the most appealing aspects of primary prevention and promotion in mental, emotional and behavioral (MEB) health is the broad scale impact that preventive activities have on overall health and wellbeing. The problem behaviors and other health conditions that they prevent span the full range of human experience from academic problems through juvenile justice, violence reduction, somatic illnesses as well as mental and addictive illnesses. Similarly, the risk and protective factors that impact healthy development also cover a wide range from nutrition through child abuse and neglect, other adverse and traumatic experiences, availability of addictive substances as well as biological and genetic vulnerability. Given this panoramic range of influences and effects, financing for MEB prevention and promotion is spread across many sectors of interest and government departments, different levels of organization (national, state and local) and differing sources of funding (public, private and philanthropic). This fragmentation in funding creates challenges in understanding and strategically directing our overall efforts in this area as well as maintaining sustainable funding for these activities. This paper will address these challenges by providing an overview of financing mechanisms for primary MEB prevention efforts and discussing implementation strategies being used across the country at the federal, state, and community levels. The aim of the paper is to help assure coordination among the widely varying interests in the prevention arena and the overall effectiveness of these investments.

The first half of the paper will catalogue major existing funding mechanisms that can be utilized by states, localities, and community based organizations as well as feature some innovative financing strategies that are emerging in the field. The second half will document implementation strategies to advance prevention efforts and coordinate financing, programming, and monitoring. Case examples will be utilized throughout the paper to illustrate the use of financing mechanisms and implementation strategies.

This guide is meant to be used by multiple stakeholders – federal, state, and local policy makers, community leaders, community based organizations and coalitions, advocates, researchers, and purveyors of specific evidence-based preventive interventions. These stakeholders include the full range of individuals who are interested in healthy human development and community wellbeing.

Operating Definitions

For the purposes of this guide, we are considering funding sources that promote the health and wellbeing of individuals, families, and communities, including those that enhance known protective factors, resilience, and nurturing environments, and those that reduce risk factors, including those that address poverty, violence, and family functioning. We also have taken a broad view of primary prevention programs or activities that can benefit from prevention funding and implementation strategies. Primary prevention interventions can involve individual/clinical encounters, programs, public campaigns, public policies, or community level investments that affect social issues like poverty, incarceration, safety, and community cohesiveness, which subsequently impact behavioral health outcomes. Interventions can be implemented at the individual, family, group (e.g., school, child care setting), neighborhood, community, state, or national (e.g., public health campaigns) levels.

Current Landscape

Since the 2009 IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*,¹ primary prevention has gained traction in public discourse. In 2011, SAMHSA made the prevention of substance abuse and mental illness its first priority.² The Affordable Care Act (ACA) prioritized prevention as a reform strategy as well as universal insurance coverage.³ The ACA sought to better align financing incentives to promote population based preventive efforts. Research continues to demonstrate the impact of primary prevention on behavioral, general and social health outcomes while additional cost analyses are needed to fully understand the economic impact of interventions both on specific human service sectors and overall societal costs and benefits. The private sector, public policy makers at all levels, and communities are gaining a greater recognition of the need for and benefits of prevention, providing more opportunities for funding and collaboration.

Although many positive advances have occurred during the last several years—primary prevention still suffers from a lack of funding and sustainability of successful interventions. The fragmented systems addressing aspects of MEB health (i.e., healthy development and community wellbeing) promote differences in language/terminology, financing sources, policy/administrative structures, delivery systems and settings, data systems, and desired outcomes. For example, while behavioral health systems are looking for improvements in mental health and reductions in substance abuse, education systems are concerned with outcomes related to academic achievement. These two outcomes are related and can both be achieved with primary prevention focused on strengthening families, schools, and communities, but the two systems do not often consider their converging goals and work together to achieve them. Additionally, categorical funding structures make it difficult to track outcomes and appropriately allocate cost savings to sectors. Prevention efforts in behavioral health will often result in reductions in special education, Medicaid, juvenile justice, and child welfare expenditures, but documenting those savings and reinvesting them into primary prevention rarely occurs. This is further complicated by the ‘wrong pocket problem’ in which expenditures from one sector provide savings in another – putting the financial benefits of investment in prevention into the coffers of an agency that did not provide the funding for the program. For example, a prevention program financed by the behavioral health budget might reduce juvenile justice expenditures – depositing the savings incurred by the behavioral health investment in juvenile justice pockets.

There is a need for collaboration to align incentives, develop sustainable interventions, and reinvest system savings to support prevention, promote human capital development (i.e., the knowledge, skills, and intangible benefits an individual offers his family, workplace, community, and society as a whole), and enhance wellbeing at all levels. The first section of this guide will review the financing sources available to multiple sectors for these efforts. The second section will consider the implementation issues that must be considered to optimize the use of those funds and sustain preventive interventions.

Section One - Financing Review

The following section will review the existing funding mechanisms available for primary MEB prevention with a focus on sustainability and population-based approaches. Since this guide takes a broad view of MEB health, the financing mechanisms reviewed will include the many different sectors concerned with healthy development of children and youth as well as the wellbeing of individuals, families, and communities (e.g., education, child welfare, health, juvenile justice/corrections). Funding for primary prevention interventions is available from several different sources – federal block grants and discretionary grants; state and local funding; ACA supported insurance models; ACA grant funding; Center for Medicare and Medicaid Services (CMS) prevention incentives; foundation funding; special purpose taxing authority; wellness trusts; tax incentives for nonprofit hospitals and health plans; performance based contracts (e.g., Social impact bonds); and reinvestment contracts.

I. Federal Block Grants and Discretionary Grants

The federal government provides block grants to states in many different human services sectors that can be used for primary prevention activities. Stakeholders should identify the state's receipt of these funds, ensure the funds are used for evidence-based practices, ideally ones that are cost effective, and focus on upstream programs to begin to promote health and prevent social problems. The following section will document the major block grant funds used for primary prevention/healthy development.

SAMHSA's discretionary grants will be briefly reviewed, but demonstration grants from other federal agencies will not be included since the focus of this paper is sustainable financing. Demonstration grants are useful for testing and establishing programs, and should be implemented with early consideration of sustainability. These planning and sustainability issues will be covered thoroughly in the implementation section.

SAMHSA funded mechanisms. In 2011, SAMHSA made the prevention of substance abuse and mental illness its number one priority. SAMHSA has promoted MEB prevention in its policy development, technical assistance, and funding to states, communities, and organizations. SAMHSA facilitates the implementation and sustainability of prevention interventions through in-kind technical assistance to states and communities, as well as block grants and discretionary grants.

Block Grant funds. The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the mechanism through which SAMHSA provides the most funding for substance abuse prevention. Twenty percent⁴ of the approximately \$1.3 billion (FY2014) that SAMSHA provides to the states is required to be used for primary prevention, equating to approximately \$260 million in prevention funding. States must target prevention efforts at both the general population and high-risk subgroups, and utilize specific primary prevention strategies designated by SAMHSA. The prevention efforts by states are not limited to the required strategies, but must include information dissemination (e.g., public awareness campaigns), educational activities (e.g., teaching peer resistance, positive coping strategies), alternative healthy activities, problem identification and referral (i.e., identify early use and stop behaviors through education), community-based TA and planning, and environmental change (i.e., influence at the population level through community standards and attitudes). States must also prioritize all three levels of primary prevention - universal, selective, and indicated. The SAPT Block Grant also requires states to implement and enforce laws and practices to prevent underage tobacco use, including random inspection of tobacco retail outlets.⁵

Discretionary grants. SAMHSA also provides funds to states and communities for specific prevention activities. For instance, the Strategic Prevention Framework (SPF) Partnerships for Success^{6 7} grant

program provides funds to states to utilize the [SPF](#) to identify needs, develop prevention capacity, and plan, implement, and evaluate prevention interventions.⁸ Other discretionary grant programs involve early intervention activities for young children, school safety, and specific interventions like the Good Behavior Game, among others. Each of these is intended to demonstrate the effectiveness of particular strategies often aimed at specific populations. Partnerships for Success (PFS) grants are given to states to utilize the SPF to reduce the incidence of and prevent substance abuse. The grants are aimed at statewide population level efforts, aiming to improve infrastructure and streamline and realign prevention funding.⁹ Additionally, SAMHSA provides technical assistance to grantees in several of these programs to support successful implementation. Sustainability of the programs following the end of the demonstration grant funding is always an important concern.

Other federal grant programs. Table 1 provides an overview of federal funding available for prevention interventions. Taking a broad approach, these grant mechanisms increase resilience and protective factors, promote healthy child development and performance in school, and help to ameliorate risk factors, including issues related to poverty and child maltreatment.¹⁰

Table 1. Federal Grant Mechanisms

Grant Mechanism	Description
Drug Free Communities Support Program (ONDCP/SAMHSA)	Provides funding to local community coalitions to prevent and reduce youth substance use.
Title V - Maternal and Child Health Block Grants (HRSA)	Encompasses infrastructure, population-based, and direct services for the entire maternal and child health population.
Child Care and Development Fund (ACF)	Provides support for children of working parents to find and pay for appropriate and nurturing child care programs.
Maternal, Infant, and Early Childhood Home Visiting (HRSA)	Provides financing for home visiting programs with the aim of improving health, development, and related social outcomes.
Child Abuse Prevention and Treatment Act (ACF)	Supports prevention, assessment, investigation, prosecution, and treatment activities related to child maltreatment.
Title IV-B - Promoting Safe and Stable Families (ACF)	Strengthens families to prevent child abuse and neglect and provides services for children in foster care.
Temporary Assistance to Needy Families (ACF)	Provides cash assistance and employment support to low income families. Can be used to expand childcare subsidies.
Social Services Block Grants (ACF)	Funds locally relevant social services, including prevention/intervention programs.
Community-based Family Resource and Support Grants (ACF)	Supports coordination of resources and activities to reduce the likelihood of child abuse and neglect.
Community Services Block Grant (ACF)	Provides funds to alleviate the causes and condition of poverty.
Injury Prevention and Control (CDC)	Core Violence and Injury Prevention Program - funds to collect and use data regarding injury National Violent Death Reporting System - assists states in tailoring violence prevention and intervention efforts Rape Prevention and Education Program - sexual violence prevention Domestic Violence Prevention Enhancement and Leadership

	through Alliances - addresses interpersonal violence
Preventive Health and Health Services Block Grant (CDC)	Supports activities related to Healthy People 2020 objectives, including those related to violence prevention, including sexual violence, employer-sponsored health promotion, MH/SU education and community-based prevention programs, LGBT health, social determinants of health, and older adult health promotion (e.g., caregiver stress).
Title III-D - Disease Prevention and Health Promotion Services (Administration on Aging - AoA)	Provides support for education and implementation activities that support healthy lifestyles and promote healthy behaviors among older adults. Includes MH and SU prevention.
Evidence-based Disease and Disability Prevention Program (AoA)	Funds programs to implement evidence-based programs to prevent disease and disability, including depression and substance use prevention and management.
Event Start (ED)	Family literacy projects for low income families, including early childhood education and parenting education
Title I Part A Improving the Academic Achievement of the Disadvantaged (ED)	Funds to improve academic achievement in high need, high poverty areas. Includes parent involvement activities.
Juvenile Justice Accountability Block Grants Program (OJJDP)	Provides programs for youth in the justice system, as well as school safety, needs assessments, and screening activities.
Community Development Block Grant (HUD)	Ensures affordable housing, provides services and economic opportunities for vulnerable communities

II. ACA Supported Primary Prevention

The passage and implementation of the Affordable Care Act has provided expanded access to health insurance and several program components intended to strengthen preventive activities and focus on population health. Insurance models have historically focused on individual beneficiaries – a service is only covered if it is administered to and benefits the covered individual. This made it difficult to provide a service to an entire family, classroom, or community. Additionally, in the case of prevention and early intervention for children and youth, insurance requirements made it difficult to provide a service to a parent when the beneficiary is the covered child. Medical necessity criteria required a condition to be present to authorize a treatment, but with prevention, interventions are administered before the presence of symptoms. Therefore, under traditional insurance requirements, prevention services are not reimbursable since they are not deemed medically necessary to treat a present condition. However, with a move toward universal coverage and elimination of pre-existing condition exclusions from insurance policies, insurance companies' should have incentives to promote population health and with the requirement in the ACA that prevention services in commercial plans be covered at no cost to the beneficiary, new possibilities are emerging for utilizing insurance to fund primary prevention.

Essential health benefits. The ACA required prevention services to be covered by insurance plans at no cost to the beneficiary. The specific prevention services included can vary by state, but at a minimum, the interventions given an [A or B rating](#) by the U.S. Preventive Services Task Force (USPSTF) must be included. For behavioral health, these include alcohol screening, depression screening, and tobacco use prevention for children and adolescents.¹¹ The USPSTF primarily reviews clinical preventive interventions offered in primary care settings rather than population-based primary prevention. Given the increasing research demonstrating positive outcomes of many universal,

selective and indicated primary prevention programs, the number of interventions covered by insurance could greatly increase with a USPSTF review and an A or B rating. Increased review of primary prevention interventions and greater representation of behavioral health specialists on the USPSTF likely would enhance the preventive activities.

Risk based financing. The ACA allows states to expand Medicaid coverage to individuals living at or below 133% of the Federal Poverty Level (FPL). Those individuals will not receive traditional Medicaid coverage but be covered with an Alternative Benefit Plan, which must include the 10 essential health benefits. Many expansion states are utilizing a capitated financing mechanism, where insurers are provided a set amount per person per month enrolled in the program. Reimbursement for individual services (i.e., fee for service) provides the incentive for plans to maximize the number of services rendered - the sicker the beneficiaries, the more interventions needed, the more revenue generated. With a capitated plan, the insurance company may have an incentive to keep its beneficiaries healthy, minimizing medical costs and therefore increasing excess reimbursement in the capitated rate. This is particularly true to the degree to which capitated plans are responsible for population health indicators of their beneficiary population. Therefore, identifying methods of providing group preventive interventions to large numbers of plan beneficiaries or investing in a community to improve overall health (e.g., playgrounds for kids to safely play/exercise, street lights to improve safety) increasingly may make business sense for plans. This is especially true for communities with large concentrations of Medicaid enrollees. Since persons with pre-existing conditions can no longer be denied coverage, insurers have fewer mechanisms to segment their service population and de-select individuals who are known to be ill, increasing their interest in promoting overall health.

Risk based financing case example. Oregon has obtained a waiver from CMS to undergo a Medicaid transformation to develop community based Coordinated Care Organizations (CCOs) with the aim of reducing Medicaid costs by 2 percent. CCOs are geographically-based insurers that cover the entire Medicaid population in a given area, receiving a capitated payment per covered beneficiary. The intention of the CCO structure is to reduce costs, improve quality of care, and improve health thereby avoiding the need for costly services, especially those related to chronic disease and hospitalizations.

In Lane County, Oregon, the CCO provider is Trillium Community Health Plan. Through an agreement with the Lane County Public Health Department, and in large part due to preexisting relationships between public health and Medicaid, Trillium provides \$1.33 per beneficiary per month for primary prevention activities. As a result of this partnership, Lane County Public Health Department is utilizing some of the prevention funding to implement the Good Behavior Game (GBG)¹² in schools with high percentages of students receiving Medicaid. Eighty-five elementary school teachers have been trained in the GBG with the goal of reducing tobacco use in the years to come. Trillium has determined that investment in the prevention of smoking and the other benefits of the GBG for youth in schools with a high concentration of Medicaid beneficiaries makes fiscal sense for the benefits that will be garnered in their covered population in the years to come.^{13 14 15}

Accountable Care Organizations. Accountable Care Organizations (ACOs) are groups of providers who come together to give coordinated, quality medical care with the goal of improving health and reducing costs. When those costs are realized, ACOs are then compensated part of the savings for the improved performance. Currently, ACOs generally realize savings through care coordination, chronic care management, and avoiding service duplication and errors.¹⁶ However, like risk based financing in the Medicaid expansion population, the ACO model could provide a structure for providing primary prevention interventions that realize savings in medical costs (e.g., a parenting intervention to prevent substance use in adolescents administered to a group of beneficiaries).

Universal coverage incentives. The move to universal insurance coverage, a main goal of the ACA, provides incentives for payers and insurers to improve population level health. If everyone in a geographical area (e.g., state, county) has insurance and insurers are unable to deny coverage based on preexisting conditions, all of the insurers authorized to operate in that area know they could potentially have any one of the residents of the area as a beneficiary. This provides an incentive to improve the health of everyone in the area in order to decrease treatment costs by providing prevention and early intervention services.

Universal coverage incentive case example. Vermont is a small state that is quickly moving toward universal insurance coverage. To improve quality and access to care and reduce costs, the insurers operating in the state are mandated by legislation to each pay a per-member-per-month fee that is pooled to enhance primary care for the population. The fee provides enhanced reimbursement for primary care to fund case management as well as the financing for community health teams that work independently of any provider to link state residents with primary care, regardless of their insurance status. The health teams have flexibility to identify individuals in various setting (e.g. homeless shelters, emergency rooms) and address their needs regardless of traditional medical necessity criteria.¹⁷

Although the health teams have not yet focused on primary prevention, this model demonstrates proof of concept regarding pooled insurance coverage for pooled benefit and could serve as a reliable funding source in geographic areas nearing universal coverage for the provision of primary care. It therefore demonstrates the logic of pooled financing where there is pooled risk and benefit – an incentive structure that could promote primary prevention.

Community benefit requirements. To maintain their tax-exempt status, non-profit health plans and hospitals are required to enhance the health of the community, which has generally been achieved through the provision of charity care. With a move toward universal coverage and coverage of low-income individuals through the Medicaid expansion ([in states where it has been adopted](#)), there will increasingly be less need for charity care. Along with a reduction in uninsured patients, the ACA required that non-profit hospitals conduct regular community health needs assessments taking into account the voices of community members and public health experts, adopt a plan to meet the identified needs, and demonstrate how the needs are being addressed. Working with public health authorities, business partners, Federally Qualified Health Centers (FQHCs), and other community organizations to identify and address community needs while meeting tax and ACA requirements, many non-profit hospitals have identified social determinants of health (e.g., poverty, adequate housing) as community needs and drivers of health care costs.¹⁸ Community benefit requirements are therefore a potential funding source for improving surveillance activities related to community needs and assets, alleviating risk factors with targeted programs and policies (e.g., increased monitoring of alcohol and tobacco retail to reduce access by underage residents, neighborhood improvements like street lights, park maintenance) and promoting health through primary prevention interventions in the community (e.g., programs implemented at schools, community-based organizations like the YMCA, senior citizen centers).

ACA grant funds. In addition to transforming the insurance-based model of coverage and health care delivery, the ACA provided funds for primary prevention in the form of grants. These are generally pilot or demonstration grants not designed to provide sustainable funding for prevention interventions, but provide states and communities initial funding to plan, implement, scale up, and/or identify sustainable funding sources.

The ACA authorized \$18.75 billion for the Prevention and Public Health Fund (PPHF) from FY 2010-FY 2022, with \$2 billion per year available after 2022 to expand federal prevention efforts. Although 2012 legislation cut the PPHF by \$6.25 billion from FY 2013-2021, funding will be available for ongoing support for the public health system and prevention interventions. The PPHF is providing resources for demonstration projects and infrastructure investments, including workforce training and systems integration. Funds are administered by several HHS agencies, including CDC, HRSA, and SAMHSA.¹⁹ A major vehicle of the PPHF are the CDC Community Transformation Grants, providing states, tribes, and communities with funds to promote population level health and prevent chronic disease.²⁰ Grants administered by the CDC to promote workplace wellness, including mental health and substance use related programs, have also been funded by the PPHF. SAMHSA administers cooperative agreements to states utilizing Prevention and Public Health Funds to implement the National Suicide Prevention Strategy, provide other grants related to suicide prevention (e.g., campus suicide, youth suicide prevention), improve surveillance using the CDC's Behavioral Risk Factors Surveillance System, and implement and maintain prescription drug monitoring systems. HRSA also utilizes PPHF dollars to increase public health workforce training.

III. CMS Incentives

CMS has an expanding role in providing health insurance to a broad population of individuals, including the traditional categorically eligible population, mothers and children, and the new Medicaid expansion population. Although Medicaid has traditionally provided health insurance covering only medically necessary treatments, clinical screenings and early intervention, there may be methods of using waivers to provide primary prevention to groups of Medicaid beneficiaries. Additionally, in communities with large populations of Medicaid enrolled individuals, plans can increase the scope and flexibility of coverage in order to provide primary prevention at the community or population level. One initial method of utilizing Medicaid for primary prevention in clinical settings is by gaining authorization from CMS to bill for those specific services.

Primary prevention in clinical settings. Washington State has received permission from CMS to provide the Positive Parenting Program (Triple P) in pediatric settings. Providers were trained on Brief Primary Care Triple P (Level 2) and Primary Care Triple P (Level 3), which provide parents with brief consultations regarding parenting, child development, and behavior problems.²¹ After the up-front cost of training the providers, which can be funded with block grant, state funds, foundation grants, or other sources, Washington received approval to create specific CPT (Current Procedural Terminology) codes to authorize reimbursement of the service for providers and add the service to the Washington Medicaid benefits package. Only trained providers can utilize the codes, providing quality control. This represents an important departure from insurance mechanisms that have traditionally restricted services to primary beneficiaries. Here the primary beneficiary is the child who indicates a developmental need. The prescription, however, is for the parent to receive parenting interventions that are reimbursed by Medicaid. While the intervention does not cover Level 1 Triple P programming, which is the universal component, this expanded use of Medicaid reimbursement is an example of more flexible insurance regulation helping to promote child wellbeing.

Use of Medicaid waiver. As part of New York State's amendment to its 1115 Medicaid waiver, it is attempting to redesign its Medicaid program. A component of the waiver, the Delivery System Reform Incentive Payment (DSRIP)²² provides \$6.42 billion dollars for reform and includes explicit reference to population based prevention services. The overall goal of the DSRIP is to reduce avoidable hospital admissions by 25% over the next five years. It is open to a wide array of safety net providers as well as large public hospitals that serve specific portions of Medicaid beneficiaries. The

amendment requires that applicants for waiver funding form collaborative networks to accomplish the system reform and hospitalization goals. Additionally, participant agencies must develop programs that employ CMS approved strategies in four domains. In Domain 3, the Nurse Family Partnership is explicitly identified as a perinatal intervention that is eligible for inclusion in the DSRIP program. The fourth domain involves population wide strategies where providers must select at least one but not more than two projects for inclusion in their overall plan to improve population health. Four subareas are identified as priorities in Domain 4 with two of these (1 &4) directly relevant for primary prevention in behavioral health.

1. Promote Mental Health and Prevent Substance Abuse;
2. Prevent Chronic Disease;
3. Prevent HIV/AIDS; and
4. Promote Health Women, Infants and Children.

This Medicaid waiver amendment, therefore, begins to focus on the effects of improving population health on health care utilization. While it largely emphasizes service delivery reforms, its explicit emphasis on population based strategies is encouraging and may indicate an important change in Medicaid programming to embrace broad perspectives on health cost controls in which cost containment is realized through improving the overall health of the population.

IV. Taxing Authority

States and communities have the ability to impose taxes that are earmarked for primary prevention activities. Although they can take various forms, two major types of taxing mechanisms are tax levies and excise taxes.

Special tax levies. Tax levies gain funding for prevention efforts by raising the existing property, sales or income tax rate. Either through legislation or ballot initiatives, the percentage increase in the income tax or property tax is allocated for a certain purpose, generally going into a specific fund that is administered by an oversight committee. The funds cannot be used for any other purpose other than the one designated by the legislation or ballot measure. These taxes can be imposed at the state or local level.

Tax levy case example. In 1990, Seattle voters approved a 23 cent tax on each \$1,000 in property value to be used for children's services. The Families and Education Levy was renewed by voters twice, generating approximately \$254 million from 1990-2011. In 2011, the levy was approved at 27 cents per \$1,000 of assessed property value, which is expected to generate \$235 million from 2012-2019. The Levy Oversight Committee sets priorities and makes funding decisions, sharing accountability for the funds with the Seattle City Council. Approximately half of the funds are used to increase support for students and families in school, with the other half divided between supports to prepare young children for education, school health clinics, administration, and research and evaluation.²³

Excise taxes. Sometimes called a sin tax, excise taxes are federal, state, or local taxes levied on a particular good with a specific funding purpose. Traditionally levied on alcohol, tobacco, or gambling, these taxes often have a dual purpose of dedicating funding to a particular program or agency while also reducing the incidence of alcohol abuse, tobacco use, and problem gambling. Young people are especially deterred from use when prices for alcohol and tobacco are raised, and excise taxes on alcohol and tobacco result in reductions in underage alcohol and tobacco use. States and localities can implement excise taxes on a product and ensure that the funding generated will be utilized for primary prevention.

Excise tax example. In 1998, California voters approved a 50 cent tax on each pack of cigarettes sold in the state. Revenue from the tax is used for the First 5 initiative, programs dedicated to healthy development of children from prenatal care to age five, including maltreatment prevention, education on positive parenting, public education campaigns, and other programs, training, and research.²⁴

V. Foundations

Foundations are major sources of prevention and public health funding and critical state and community implementation partners. Foundations vary from small family foundations to large, multimillion dollar organizations. Foundations are increasingly partnering with government agencies, business partners, and other donors to encourage diversification of funding and program sustainability. This section will review a particular type of foundation – the health conversion foundation – a major funder of primary prevention in many communities.²⁵ Examples of the use of foundation funding to maximize business and government investments and serve as partners in the development of primary prevention interventions will be reviewed in the implementation section of the report.

Health conversion foundations. Also called new health foundations, health conversion foundations are formed when a non-profit hospital or health system converts to a for-profit entity. Federal law requires the proceeds from the sale of the non-profit to be used for charitable purposes in the community, the result being foundations dedicated to improving the health of the population.²⁶

Health conversion foundation case example. The Colorado Health Foundation has funded Invest in Kids, a purveyor of preventive interventions, to implement Incredible Years (IY), a preventive intervention engaging parents, teachers, and students. Funds are used to prepare trainers, called peer coaches, who are now able to train teachers, administrators, and group leaders to provide IY, developing a sustainable program. IY is now statewide in Colorado.²⁷

VI. Wellness Trusts

Wellness Trusts are an idea that gained traction in the mid-2000s to serve as a pool of funding for public health activities. With recognition that the health insurance model treats illness rather than promotes health, current insurance and medical care practices do not provide incentives for prevention. The current public health system is not equipped to provide the health promotion and disease prevention activities needed to greatly improve population level health. Given these gaps, the idea of a Wellness Trust was developed and promoted by public health experts, including those at the Brookings Institution. While this was developed prior to the enactment of the ACA, some of the concepts prompting these Trusts are still relevant and are being implemented on a smaller scale in Massachusetts.

Although a national Wellness Trust has not been developed on the scale originally conceptualized by experts at the Brookings Institution, it would carve prevention out of the health insurance system and develop a new system for promotion and prevention, conceptualized as a new agency under HHS. The Trust would utilize data to set national priorities for prevention, build or employ effective systems for the delivery of preventive services, and align payment of services with identified priorities. All Americans would have access to preventive services regardless of insurance status. Individual and community needs and the outcomes of prevention interventions would be determined through a data system shared with the medical care system.

The system would be funded through contributions from private insurance, public insurance, and existing public health funds. The Trust would then develop a coordinated infrastructure of preventive interventions including the development of an electronic prevention record, support existing public health workers and train new ones, and provide significant funding to states and regions to implement, evaluate, and sustain prevention interventions.²⁸ Little additional progress at the Federal level has occurred on the Brookings' concept of the Wellness Trust following the passage of the Affordable Care Act, which, as we've noted above, makes important investments in prevention and begins to change the incentives in health insurance.

Wellness Trust case example. Massachusetts established the Prevention and Wellness Trust Fund in July 2012. The Trust provides the support and funding to promote community-based partnerships to reduce rates of preventable diseases, increase healthy behavior, promote workplace wellness programs, and address health disparities. The Department of Public Health administers the Trust with the guidance of an advisory board, which identifies priorities for the funding. Nine communities received grants in 2014 and must focus on current priority health conditions – pediatric asthma, hypertension, tobacco, and falls among the elderly – but may also address other health priorities. Several communities also included obesity, diabetes, or substance use in their partnership plans.²⁹

VII. Pay for Success Contracts/Business Investment in Prevention

Perhaps the most innovative funding mechanism for primary prevention is the development of pay for success contracts. Given the growing evidence of the effectiveness and cost savings that can be realized by states and communities when evidence-based preventive interventions are implemented, a move toward funding arrangements that use cost savings from successful prevention interventions to repay initial investments. These contracts rely on rigorous evaluation to assure that evidence-based program objectives are realized. They can engage diverse funders – both private and philanthropic and ensure savings are reinvested in prevention programming. This mechanism has the possibility of greatly increasing the amount of funding available for prevention and improving health and social outcomes.

Social Impact Bonds

Perhaps the most popular form of pay for success contracts currently being tested is the Social Impact Bond (SIB). SIBs are arrangements that join business, private investment, foundation and public interests with a social need to benefit both the investor and the population. SIBs consist of a private investor who buys a bond to provide funding for the implementation of a program that has research demonstrating effectiveness as well as cost-effectiveness data demonstrating cost savings to the government. A formal, rigorous program evaluation is used to assess the aggregate cost savings to the government entity and if anticipated cost savings are realized, they are used to repay the bond with interest. SIBs are an evolving mechanism and can be structured in multiple ways, with various stakeholders involved in different roles. However, all SIBs have common characteristics that will be reviewed here.

SIBs are based on the notion that the financial risk of a program's success is shifted from the government to an investor. The program contract stipulates the terms of repayment – if the program realizes the anticipated cost savings and outcomes, the loan will be repaid with interest. The greater the savings to the system, the greater the return on the investment is realized, up to a designated cap. The provider implements an intervention with solid research demonstrating positive outcomes and savings to the government. An intermediary assists in negotiating the terms of the contract, including the specific outcomes and savings that will be measured and the repayment schedule. An

independent researcher performs an evaluation to determine the impact and savings of the program, which then dictates the return to the investor.

Key elements of an SIB. All SIBs must have certain features. Use of the model is growing, but few SIBs are operational in the U.S. (at this writing we are aware of two that have been funded and others under consideration) and those that have been implemented have not been completed. Therefore outcomes and repayment have not been determined. It is expected that key elements of SIBs will evolve as the model is tested, but currently all SIBs require:

- An investor or group of investors who are willing to assume the risk of the success of a program. These investors are generally financial institutions with experience investing in various businesses, but can also be foundations, wealthy individuals, governments (e.g., the federal government could invest in an SIB at the state or local level) or combinations of these entities.
- A provider organization with a proven track record with a given program and/or population.
- An evidence-based practice with sufficient evidence to identify realistic program outcomes, impact on the population, and savings to the system.
- An outcome payer, generally the government agency that is able to guarantee loan repayment if outcomes are met and budgetary ability to pay for program services in out years when the savings are realized. The government agency also generally has data systems for tracking outcomes in the population.
- An intermediary organization to facilitate the negotiation of the contract, the evaluation, and repayment. As SIBs are tested, the need for an intermediary organization may be reduced, although given the newness of the model and the complexity of the contract, outcome identification, and repayment structure, an independent party is needed to facilitate the SIB.
- An independent evaluator to track outcomes and determine the impact on the population and savings to the system.^{30 31}

Variations on the SIB model. As an evolving financing model, variations to the SIB model have emerged. Foundations or other stakeholders (e.g., government entity) can guarantee some part of the investment in order to reduce the risk of the investor. In this arrangement, the foundation pledges a certain amount of the initial investment that is only paid if the minimum outcomes are not met and the investor stands to lose the entire investment. If the program realizes the desired savings, then the foundation's pledge will be reinvested in the program for sustainability or another preventive activity.

Another variation in the model, currently being piloted in India, is a Development Impact Bond.³² It is essentially an SIB, but instead of a government agency being the outcome payer, a foundation or other stakeholder is the entity that pays back the loan if savings are realized. In the case of the contract in India, a private investor provides funding to a school for girls. The expected outcome is an increase in the retention rate of female students. If evaluators deem the retention rate meets the contract, then a foundation repays the private investor. If the outcome is not met, the investor does not recoup the original investment, or only gets back a portion of the investment, depending on the terms of the contract.

Most SIB models are dependent on savings to the government sector that engages in the contract. However, many primary prevention interventions have been shown to have effects in multiple sectors (e.g., Nurse Family Partnership impacts behavioral health, general health, child welfare, education, future criminal justice, etc.). The impact on multiple sectors and multiple budgets may or may not be captured in the evaluation. Therefore, the sponsoring government agency may pay back the loan with the understanding that the sponsoring agency's budget did not recoup the cost of the program, but

other parts of the state, county or city government together realized savings that justify the full repayment of the loan.

Similarly, outcome payers may be less concerned with savings to the system than with the health and social outcomes of the program. If a program has significant benefits to the population but does not necessarily save the government money, or the financial impact is difficult to measure, then the contract may stipulate that the private investor will recoup the loan when certain health and social outcomes are realized (e.g., a percentage reduction in unemployment or a decrease in the school dropout rate).

Federal legislation. In July 2014, House members introduced a bill ([HR 4885](#)) to promote the use of SIBs by states and communities. The legislation will provide planning grants to states and communities to investigate the use of SIBs and allows the Treasury Department to pay back state investments in projects if outcomes are realized.³³ The bill is evidence of increasing interest in SIBs and the potential for innovative financing mechanisms to engage various stakeholders and improve health and social outcomes.

SIB case example. New York City has implemented the first SIB project in the U.S. to address the issue of disconnected youth. The city has contracted with an intermediary, MDRC, who has secured an investment of \$9.6 million from Goldman Sachs. Bloomberg Philanthropies has guaranteed \$7.2 million through a grant to MDRC. If the project does not meet the required outcomes, Goldman Sachs will be partially paid back with that funding. If the project does yield the savings to the city government, NYC will pay back Goldman Sachs and the funds from Bloomberg Philanthropies will be reinvested in the project. MDRC has contracted with two service providers to address the needs of 16-18 year olds at Rikers Island Jail. They will be implementing Adolescent Behavioral Learning Experience, a cognitive behavioral therapy program with the goal of reducing recidivism by 10 percent. The Vera Institute will conduct the independent evaluation to determine if the specific outcomes and cost savings have been met.³⁴

Reinvestment Compacts

Regardless of the source of funding, sustainability can be ensured when contracts stipulate that any savings generated above the amount of return required to the investor are to be reinvested in the program. Ideally, investors, whether they are individuals, foundations, businesses, or government entities, would forgo obtaining a profit when savings are realized and ensure that the savings are reinvested into the program. The contracting entity (state, locality, or provider) can stipulate that any savings generated by the program (or all the savings above a certain threshold) remains in the program and is used to fund the intervention for subsequent years or to scale up the program to serve more people. State and local agencies that implement programs with the goal of eventual cost savings should also stipulate that if savings are realized, they will not result in budget cuts but in a reinvestment in the program or similar preventive programs administered by the agency.

Summary

This review indicates a changing funding landscape with regard to health and social programming. While the block and discretionary grant programs continue to provide valuable infrastructure, operating and development funds, new incentives created by the expansion of health coverage and other components of the ACA place a new premium on population health status. Reimbursement mechanisms that utilize capitated payment methods and hold health service organizations accountable for the health of their population will both help to underwrite these changes.

Additionally, the increasing realization that investment in prevention programs results in financial savings to the community (state, locality or nation) has introduced novel private financing strategies that hold great promise for established interventions with predictable outcomes. Overall, while there is yet much work to be done, new emphasis on understanding and measuring aggregate social impact and/or holding entities accountable for reasonably expected health outcomes holds great promise for increasing the implementation and sustainability of effective primary prevention interventions.

Section Two - Implementation in a Fragmented System

From the preceding review of financing mechanisms, it is clear that primary prevention efforts are funded by numerous government departments, across state, local and federal levels of government and across the public, private and philanthropic sectors. Implementing prevention efforts in this complex three-dimensional matrix is a challenge that requires explicit consideration of the barriers introduced by these categorical funding practices. By doing so we can better capitalize on our current investments and develop an accountability structure that will gauge the adequacy of current efforts relative to the potential benefits that we can anticipate from prevention research.

The challenge of implementation, therefore, is to develop strategies to accommodate the fragmentation across government departments, sectors and geography in order to develop a coherent national approach. Our analysis is that this process is underway in an informal way with examples of work at state, local and national levels that is developing the infrastructure that may be used to address these issues more comprehensively. Clearly, financing is an important piece of this infrastructure and the financing ‘problem’ has been addressed and sometimes ‘solved’ in several different instances.

However, the financing problem is intertwined with the ability of communities to competently sustain quality prevention efforts, which involves a series of challenges that are often addressed by the implementation literature. While we won’t detail these here, the necessary elements for a successful program include *consideration of innovation, recipients’ and providers’ roles, skills, attitudes, etc., organizational functioning within macro-structures* (e.g. law, policy, custom, etc.), and *program fidelity and penetration*.³⁵ Successful programs also require a developmental progression from *exploration* through *installation, initial and full implementation*. Further, they involve *leadership, competency and organizational drivers* that must be understood and managed for successful implementation.³⁶ It is through the successful management of these implementation issues that effective programs can and should be sustainable. Given that this is a developmental process, we will provide a series of examples of developments at the national, state and local levels that are in differing stages of implementation with differing funding strategies and/or possibilities.

I. Federal Level – Leadership and Coordination

Government is organized around a series of categorical concerns. Programs within these categories target outcomes that are specific to the focus of the department. Prevention activities, therefore, are spread throughout the government with each agency concentrating on their outcomes of interest. Education, juvenile justice, child welfare, general health, mental health and addictions, among others each sponsor programs with no single entity (e.g., federal agency) providing overall strategic guidance for the cumulative effects of their efforts across the federal government.

The **Federal Partner’s Committee on Women and Trauma** is an effort to build an interagency venue from which more coordinated and perhaps focused efforts in prevention and treatment can be

launched. It is an ongoing workgroup originally convened by SAMHSA as part of the President's New Freedom Commission that has continued to meet since 2009.

"The Committee's work is guided by the recognition that the impact of violence and trauma on women is a public health problem with profound consequences for many different agencies. Initial activities focused on identifying the extent of the impact on each agency, developing a technical assistance agenda, and promoting evidence-based public health practices. The workgroup rapidly expanded in membership, coordinated two successful national roundtables, released two reports highlighting lessons learned, and gained the attention of the White House. In 2011, it became an ongoing committee."³⁷

The committee now has over 80 members from 33 federal agencies. It meets monthly and provides an opportunity for information sharing and the development of a shared sense of the impact of trauma on outcomes for the American people. While each of the individual categorical programs retains its autonomy, members of the group report that the insights gained from work with the committee have given them a broader sense of the importance and context for their individual efforts. The Committee summarizes the activities of the constituent departments in annual reports as well as sponsoring shared activities³⁸, adding *context and coherence to the individual agency portfolios and identifying opportunities for additional collaboration*. Importantly, as evidenced by its growth and longevity spanning two administrations, committee members find participation to be useful and the collegial relationships helpful. It is through the unifying theme of trauma impacting each of the programs, the developing coherence of trauma informed approaches to understanding our societal challenges and the personal relationships that are developed through participation in the workgroup that its utility is derived.³⁹ While premature at this point, the *informal leadership role* that the committee plays could provide the foundation for better rationalizing and directing federal efforts in the prevention/violence arena.

The National Institute of Justice and VAWA. Passed in 1994, the Violence Against Women Act (VAWA) provided a legislative mandate for understanding and ameliorating the incidence and effects of intimate partner violence. VAWA also was integral in authorizing the National Institute of Justice (NIJ) to take a leadership role among federal agencies and the field in promoting research, understanding, and change related to domestic violence.

When the VAWA was passed and the NIJ began its work on domestic violence, physical, sexual, and emotional violence between intimate partners and spouses, was largely viewed as private within families. However, the Act reflected changing public perception. Interpersonal violence was gaining recognition as a larger problem with implications for the criminal justice system and society as a whole. The VAWA helped identify intimate partner violence as an issue in need of research, policy change, and services for victims and families.

As part of the Department of Justice's Office of Justice Programs, the NIJ conducts and facilitates research related to crime and justice. Due to VAWA's legislative mandate, the NIJ has made significant strides related to understanding intimate partner violence and promoting policy change at the federal, state, and community levels. Although many different agencies within the federal government are concerned with intimate partner violence (e.g., CDC, ACF, DOJ), the passage of the VAWA provided a legislative definition and funds for NIJ to take a *leadership role in developing research priorities, shared language, and assessment tools, and promoting collaboration* between agencies.

The VAWA and NIJ's work also helped bridge understanding between agencies. The DOJ viewed the issue as a criminal justice problem while the CDC viewed the issue as a public health problem. Other

agencies are also concerned with domestic violence from other perspectives - ACF as a form of child maltreatment and risk to stable and intact homes, and HUD as a challenge for affordable housing and long-term, safe shelters. Despite the various perspectives, VAWA provided *legislative leadership in the development of a definition* and a mandate for research, collaboration, and policy change. The act also allowed for NIJ to take a lead on promoting research in this area, *collaborating with other agencies* to ensure that data gathering encompasses the various perspectives, and *providing data to influence policy change* at the federal, state, and community levels. The research conducted or supported by NIJ has increased understanding of intimate partner violence, including what works to prevent it, stop it, and help ameliorate the effects of the trauma.

USPSTF and Community Preventive Services Task Force. The USPSTF and Community Preventive Services Task Force serve as leaders in the promotion of clinical, programmatic, and policy interventions to improve health at the individual, family, and community levels. The Community Preventive Services Task Force was established in 1996 to identify health interventions at the population level that have sufficient research demonstrating improved health outcomes. The Task Force meets regularly to review prevention programs, services, and policies and provides recommendations that are used by policy makers, community members, providers, and other stakeholders in determining methods of preventing health problems. Unlike the USPSTF, no entities (insurers, government agencies, etc.) are required to provide the recommended programs or implement the recommended policies, but the information is available for use by stakeholders in determining the best method of intervening.⁴⁰ The Task Force has reviewed programs and policies related to the most common drivers of illness, disability, and related problems, including mental health, alcohol use, tobacco, parenting/adolescent health, health disparities, HIV/STIs/teen pregnancy, injury, and violence.⁴¹

As independent groups of experts mandated to critically evaluate the risks and benefits associated with preventive interventions and to 'grade' interventions based on this analysis, the two task forces' recommendations have considerable weight. The USPSTF's impact was expanded by the ACA. The USPSTF recommended preventive interventions (Grade A or B Interventions) must be offered by insurers as clinical preventive services at no cost to the beneficiary. This provision will likely greatly increase the number of individuals receiving clinical preventive services in primary care.

The Community Preventive Services Task Force is required to review programs, services, and policies that are intended to improve population health. Like the USPSTF, the Community Task Force evaluates efficacy and effectiveness research and provides recommendations for adoption of many programs and policies. Unfortunately, unlike the USPSTF, there is no mandate that the Community Task Force recommendations are offered in schools, workplaces, or communities. They simply serve as an independent resource for employers, organizations, communities, states, and other stakeholders to identify interventions that are likely to be effective if implemented appropriately. However, if the recommendations of the Community Task Force could gain similar authority to those of the USPSTF and a similar financing strategy identified for prevention that is analogous to health insurance for the clinical preventive services, access to prevention interventions would be greatly enhanced.

Community Preventive Services Task Force case example. Maryland has utilized the Community Preventive Task Force recommendations to promote the use of workplace wellness programs in the state. The state government identified the Task Force recommendations as programs and policies that could help reduce the rates of obesity, diabetes, and other chronic illnesses among adults. To reach that end, the Department of Health and Mental Hygiene developed an initiative called "Healthiest Maryland," with the goal of making the healthy choice the first and easiest in various settings. One

phase of the initiative, "Healthiest Maryland Businesses," engage CEOs in Maryland to begin to implement programs and policies to improve the health of workers. Engaging the leaders of businesses, nonprofits, academic institutions, and government entities provided leadership to ensure that commitment to workplace wellness started with top management. The Task Force recommendations were heavily used by employers to plan policy changes, physical plant improvements, and programs implemented to best improve the health of employees. A year after the launch of "Healthiest Maryland Businesses," 150 workplaces and 180,000 workers are taking part in the initiative.⁴²

II. The State Level – Leadership and Coordination

New York State efforts. The NYS MEB Data Capacity Work Group grew from a SAMHSA Prevention Policy Academy that required state level interagency collaboration. As a result of the Policy Academy, the NYS participants were both impressed with the strength of the science in the prevention of MEB disorders and also by how little each representative knew about the activities of their colleagues. They realized the importance of MEB health to each of their respective departments and that working together would require a “realignment of policies, language and constructs currently in place”⁴³ in order to develop a statewide agenda. *Deriving a common understanding of the language used by each of the agencies was required in order to conceptualize the statewide investment in prevention.*

The group ultimately decided that designing an integrated data set from the individual data sets maintained by each department would help to define and operationalize prevention concepts (risk, protective and wellbeing measures) and provide a common framework for planning and interagency collaboration. A draft proposal was developed that continues to be refined with a series of steps that can be used to build the data set. Significant progress occurred since the fall of 2012 with the most recent accomplishment being the Department of Education agreement to provide six indicators of student risks for MEB health disorders to the Office of Alcoholism and Substance Abuse Services (OASAS) that, in turn, will fund the stewardship and analysis of the data. The plan is to have the data integrated with other planning data maintained and housed at the NYS Council on Children and Families and made available to state and local entities for prevention planning. This relationship with the Education Department is a new and long sought collaboration that had not existed to this significant extent, prior to the policy academy and subsequent data workgroup.

Relatedly, the workgroup has had an ancillary benefit of developing working relationships at the staff level, which continues to provide opportunities for further collaboration.⁴⁴ The architecture of the draft data set displayed in Table 2 below illustrates the group’s thinking regarding the data elements that are available and that might be combined for an MEB prevention planning platform. The breadth of the indicators demonstrates the need for cross-agency collaboration and a data gathering infrastructure that considers various indicators related to healthy development and primary prevention efforts. With the exception of ‘chronic absenteeism’, the education indicators proposed by the group for the Education Department are those that will be provided.

Table 2. Proposed County Level Archival Indicators for NYS Planning and Evaluation Data

Indicator	Source	Geographic Level
Community Risk		
Poverty –Children in Food Stamp Households	Public Assistance	Zip Code
Poverty – Children eligible for S-CHIP	Health	County
Poverty – Children below 185% Poverty Level	Census	Zip Code

Violence- Hospital Discharge Diagnosis Intentional Injury	Health	Zip Code
Violence- Emergency Cases Intentional Injury	Health	Zip Code
Violence – Arrests (Adult and Child)	Criminal Justice	Sub-county
Family Dysfunction		
Children in Foster Care	Child and Family Services	Zip Code
Preventive Services Openings	CFS	County
Indicated Child Abuse/Maltreatment	CFS	Zip Code
Total Child Abuse/Maltreatment	CFS	Zip Code
Dissolution of Marriage	Health/Census	Zip Code
Parental Substance Abuse- Treatment Data	SA Authority (OASAS)	Zip Code
Parents with Social Security Disability	Public Assistance	Not Available
Substance Involvement		
Accidents Involving Alcohol	Motor Vehicles	Sub-county
Alcohol Density Outlets	Liquor Authority	Zip Code
Treated Prevalence		
Children with MH/SA Diagnosis/MH Medications	Medicaid Data	Zip Code
Population/Adults with MH/SA Diagnosis/Medications	Medicaid Data	Zip Code
Children 0-5 with MH Diagnosis	OMH – Biennial Survey	
Education Indicators		
School Lunch Program Enrollment	Ed Dept	School
Chronic Absenteeism K-3	Ed Dept	School
Math and Reading Scores Grade 3,6	Ed Dept	School
Special Education Services Age 4-10	Ed Dept	School
Suspensions/Expulsions	Ed Dept	School
High School Drop Out	Ed Dept	School

During the Policy Academy process, OASAS was invited to be the co-chair of the NYS Department of Health Prevention Agenda Substance Abuse Prevention/Mental Health Promotion Workgroup. That group, and members of the Policy Academy, were then instrumental in having MEB goals incorporated into the 2013-2017 NYS Prevention Agenda. Additionally, one member of the data workgroup, representing the Department of Health, reported recently that based on review of county plans, their two top prevention priorities were preventing chronic diseases (57 of 58 counties) and promoting mental health and preventing substance abuse (29 of 58 counties).

This finding along with comments from reviews of 58 local health departments and 148 non-profit hospital improvement plans, the insights gained from the Policy Academy and the data capacity workgroup has led to a “Quick Strike” grant request by the NYS DOH to the University of Kentucky program, funded by the Robert Wood Johnson Foundation, to support the development of quality indicators for MEB prevention and promotion, key components of infrastructure to better allocate and evaluate the impact of state investments.

Through the development of these data integration efforts on the part of OASAS, and the leadership of its SSA, as well as, SED, DOH and the CCF, the *infrastructure for collaboration and informal leadership* is being developed. To the degree to which these ideas come to fruition during the next few years, it will be possible to better *understand this state’s investments across its prevention portfolio and evaluate*

the adequacy of these investments. As such, it may be an important step in addressing fragmentation in information and investment and therefore set the stage for future realignment of resources based on local need.

Washington State efforts. Washington State is distinguished by the number of critical and challenging pieces of prevention infrastructure that it has developed. These involve both *formal components of state infrastructure* as well as more *informal working processes*. Both are important for reducing fragmentation and developing a comprehensive prevention portfolio.

Integrated data system. The formal pieces of infrastructure involve the development of a research and data analytic capacity that is facilitated both by formal organizational supports in the form of personnel resources as well as by the Department of Social and Health Services’ (DSHS) Integrated Client Database (ICDB) system, reputed to be among the best, if not the best, in the nation. It has been developed incrementally over the last 24 years. Data in the system are integrated at the person level and includes individual identifiers that allow analysis of service use and health status measures across a broad number of participating agencies both within the umbrella DSHS as well as other participating state agencies that are external to DSHS. In Figure 1 we display a schematic of the data set.

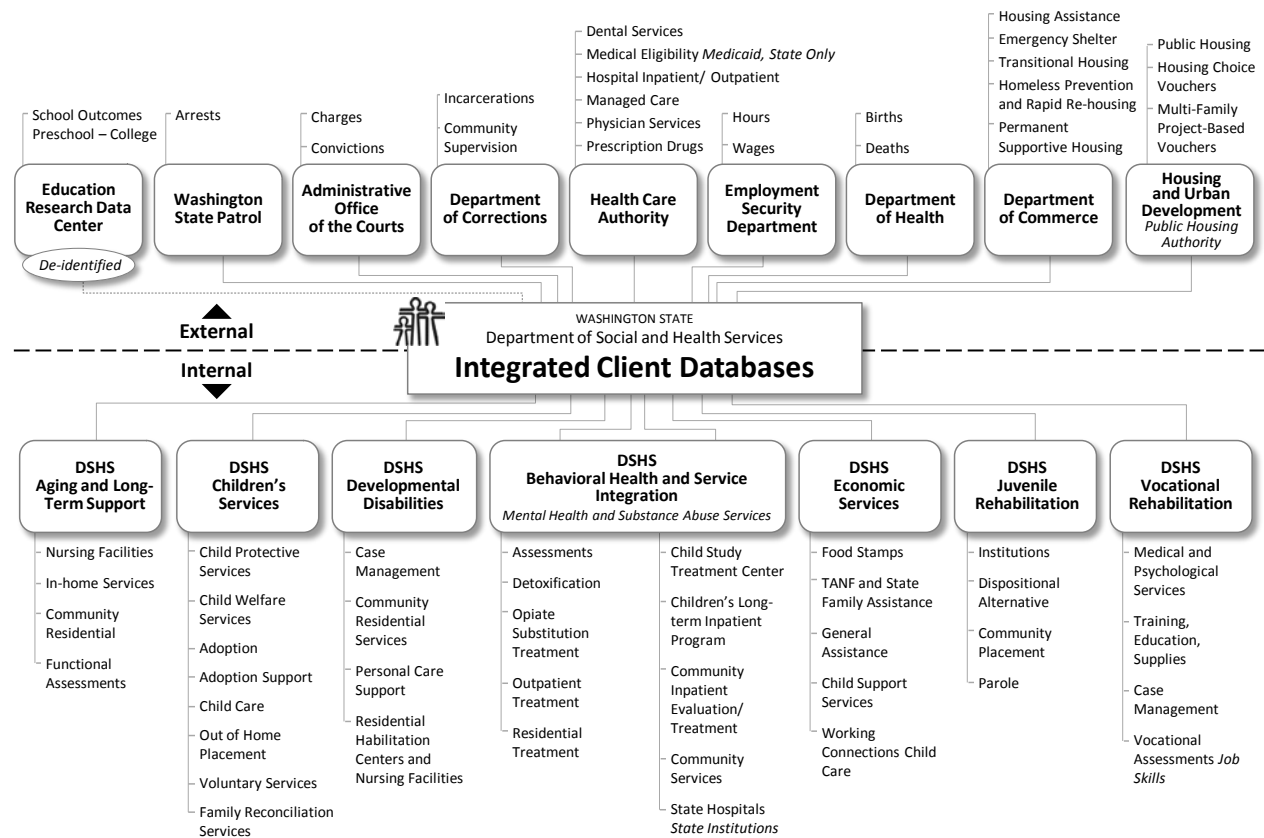


Figure 1 – Data Sets that Comprise the Washington State Integrated Client Data Base⁴⁵

As is clear from the schematic, this data base, integrated at the client level, allows for a much better understanding of the impacts of programming across human service areas than is available from single agency sources. Given the broad scale impact of prevention programming, such an integrated perspective is critical. The data system was developed incrementally over time, with new agencies’

data included when funding was available. Currently, the data system costs Washington approximately \$2.8 million per year for maintenance and basic research.

The Research and Data Analysis Division (RDA) uses these data in combination with other available data sources (such as special surveys) to provide profiles of risk and protective factors for the development of preventive programming.⁴⁶ The *organizational capacity* represented by the RDA, the ICDB and the other key data sources provides both integrated behavioral health surveillance and coordination among human service sectors' information. These key infrastructural elements help enable more efficient use of state resources across these various departments as well as a more global sense of the impact of programming.

State research capacity. Washington State is also distinguished by the Washington State Institute of Public Policy (WSIPP).⁴⁷ This group, formed by the legislature, portrays itself as a portfolio manager for the legislature, advising it on how best to invest state resources across state agencies to maximize return on investment. It was created by the legislature in 1983 and is governed by a board representing the executive and legislative branches of government as well as representatives from the public universities. WSIPP is distinguished by its development of methodologies that allow the estimation of cost benefit ratios for various state programs. They do this by expressing both program costs and benefits in monetary terms based on the research literature. It is therefore possible to estimate the return on investment from specific programs. The relationship that the WSIPP has with the legislature (their sole client) and the credibility of their methods of measuring societal impacts of various evidence-based interventions (that has been externally peer reviewed) represents critical pieces of infrastructure that states and localities can use in gauging the net cost and outcomes of an intervention. As such, WSIPP represents an extraordinarily valuable resource in estimating the consequences of *blending government funding (portfolio analysis) as well as a resource for coordinated leadership*. Its funding by the legislature represents an excellent example of the value of *infrastructure funding*. Importantly, the MacArthur Foundation and the Pew Foundation are disseminating and adapting the WSIPP methodology to a select group of states so that others can strengthen their infrastructure for evaluating the overall costs and benefits of their social investments from a statewide, multi-sector perspective.⁴⁸

Community coalitions capacity. Washington State is also a leader in explicitly expanding the focus of its community prevention coalitions beyond environmental interventions for substance use prevention to include other strategies in order to reap *maximum benefit* from these community resources. In this approach the coalitions will:

- “Consider behavioral health information such as depression, anxiety and suicidal behaviors as they develop priorities for services through their needs, resources and gaps assessment processes.
- Identify evidence-based prevention programs that have both substance abuse prevention and mental health promotion outcomes.
- Develop - if needed -- plans for transitioning from current prevention programs with a single focus on substance abuse prevention to those which have the “maximum benefit” of focusing on both substance abuse prevention and mental health promotion.”(p.3)⁴⁹

This policy direction explicitly emphasizes the relationship between mental health promotion and substance abuse prevention. It intends to design coalitions that maximally benefit their communities through the selection of programs known to accomplish both outcomes. The state Division of Behavioral Health and Recovery is a merged division of two formerly independent mental health and substance abuse divisions. It is an example of a merger that has stimulated a more integrated

approach to behavioral health – realizing that both mental health and substance use conditions have common antecedents. The implementation strategy therefore demonstrates more effective use of existing resources, which are a mix of state, federal and local funds, through *enhanced leadership, coordination, and the blending of government funding* that is facilitated by the development of successful coalitions.

Innovative financing. Finally, owing to their understanding of the broad impacts of prevention interventions and the evidence base regarding the effects of the Positive Parenting Program (Triple P), Washington is also leading the nation in supporting four of the five components of this intervention through Medicaid funding. As was discussed earlier, Washington’s thoughtful implementation of the Triple P Level 2 and 3 parent education and support interventions within selected pediatric practices extends the impact of this evidence-based practice. The program is carefully designed to control referral and access as well as to ensure quality and appropriateness of the services. This novel use of Medicaid funds in part reflects the collaborative nature of state agencies. The culture in the state agencies is one of cooperation, which helped the Medicaid authority and the Behavioral Health Division facilitate the development of the creative billing mechanism and the use of state and block grant resources to train the workforce and help ensure quality. Without individuals who appreciated the broad impact of programs like Triple P, understood their relation to healthful youth development as well as how best to use Medicaid funds, this program would not have been possible. Preliminary indications regarding the roll out of the program are generally positive but some implementation barriers have been identified and are being addressed by the prevention leadership in the state office.⁵⁰

III. Community Coalitions

In many ways, the ultimate work in primary prevention occurs at the community level where program implementation has the most direct impact on wellbeing. The design of community coalitions often directly addresses many of the challenges with system fragmentation that we have discussed. This can be accomplished by involving *key representatives from differing stakeholder groups*, increasing the likelihood that the coalition program can be successful and sustainable.

The structure, functioning and outcomes of community coalitions in behavioral health have been systematically studied through two large randomized trials: the Communities that Care⁵¹ and PROSPER⁵² interventions. Both of these interventions were shown to produce significant reductions in youth problem behaviors, including substance use, during the longitudinal follow-up of youth served in the communities where the coalitions were active. Both interventions concentrate on

- forming coalitions that include important community leaders and stakeholders,
- conducting a systematic needs assessment,
- identifying evidence-based interventions that respond to these needs,
- implementing targeted interventions that address these needs with fidelity, and
- conducting ongoing program evaluation.

The PROSPER model is further distinguished by its utilization of the Cooperative Extension Service as a key partner. Cooperative Extension has a strong history in the technology transfer field and a strong orientation toward university/community partnerships.

Not only have researchers from both the CTC and PROSPER documented the effectiveness of their interventions on youth outcomes, but also both groups have studied the developmental processes that are involved in successful coalition functioning and sustainability. Greenberg and colleagues have demonstrated that programs that were more successful in sustaining funding had better *team*

*functioning and stronger sustainability planning.*⁵³ Relatedly, the *integration of new members into coalitions, member buy-in, team member participation and team hours* spent on coalition activities that were measured in years 2 and 3 of the intervention were found to affect funding planning and sustainability leadership in years 4 and 5.⁵⁴

The CTC research team also demonstrated that the developmental factors included in the CTC demonstration increased the rates at which coalitions adopted, disseminated and sustained evidence-based prevention activities after research support for the interventions was withdrawn.⁵⁵ As might be predicted from the coalition process and membership, leaders in the CTC communities reported a greater willingness to contribute funds to the coalition activities than leaders in the control communities. The findings from both of these studies, therefore, indicate that technologies are available to help organize and implement community-based coalitions and that coalitions that utilize these technologies will produce greater community benefits, maintain higher intervention quality and be more likely to be sustained than coalitions that don't use these supports. Implementation quality is related to successful sustainability.

The Community Anti-Drug Coalitions of America (CADCA) is the organization that leads and supports the nation's approximately 5,000 anti-drug coalitions. CADCA uses a coalition model that is quite similar to those employed by PROSPER and CTC. SAMHSA's Strategic Prevention Framework (SPF)⁵⁶ is the planning and evaluation framework used by CADCA that closely parallels the approaches used by CTC and PROSPER. This model has been demonstrated to be an *effective problem solving tool* for community coalitions,⁵⁷ and, as such, will likely strengthen team functioning and effectiveness thereby increasing the likelihood of community financial support. The anti-drug coalitions have a requirement that they must obtain substantial financial external support in anticipation of the end of federal support. CADCA offers technical assistance in support of this goal.

Berks County coalition case example. The Berks County Community Prevention coalition in Reading, Pennsylvania is an excellent example of a coalition that, following its initial support from the anti-drug abuse grant, has been successful in broadening its portfolio of prevention programs beyond the environmental interventions required as an initial condition of their funding. They now embrace a broad range of prevention activities and a broad array of funders. Early in their development they realized that substance abuse problems can be prevented through both core environmental interventions and other youth programs in juvenile delinquency prevention, early childhood development, and mentoring. They therefore pursued support for a widening array of programs from a number of funding sources thereby *effectively coordinating funds from these categorical and community interests*. Their current funding sources are detailed below.⁵⁸

- [SAMHSA's Center for Substance Abuse Prevention](#)
- [U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention](#)
- [Governor's Partnership for Safe Children/Pennsylvania Commission on Crime & Delinquency](#)
- [Pennsylvania Liquor Control Board](#)
- [Pennsylvania Department of Public Welfare](#)
- [Reading Housing Authority](#)
- [Council On Chemical Abuse](#)
- [Berks County Intermediate Unit](#)
- [Service Access and Management](#)

These sources along with fundraising activities and individual donations support the impressive array of programs that respond to the community's needs including:

- BerksTALKLINE
- Celebrating Reading Families!
- Celebrating Veteran Families
- Circle of Friends-Drop In Center
- Community-Centered Healthy Marriage and Relationship Training (CCHMR)
- Education Leading to Employment and Career Training (ELECT) Program
- Kids Against Pressure (KAP)
- Nurse-Family Partnership (NFP)
- Parents As Teachers
- Parent Partner Program (PPP)
- Stay On Track⁵⁹

As is clear by the 22-year longevity of the coalition, the array of programs it offers and the broad based sources of support for its activities, the coalition model addresses several of the funding challenges highlighted in the introduction to this paper. Successful coalitions *involve community leadership, coordinate and blend government funding, and incorporate private funds* through their fundraising activities. Additionally, by operationalizing the SPF model, the coalitions *develop a surveillance system*.

Five Town Communities that Care case example. In 2003, the towns of Rockport, Camden, Hope, Appleton, and Lincolnville, Maine received monies from an NIH research grant to implement Communities that Care and develop a community coalition focused on promoting positive youth development and preventing problem behaviors. The Five Town Communities that Care (FTCTC) is now an example for other communities, especially those in rural areas, of the use of coalitions to identify problems, utilize community and program data, implement programs and environmental change, and gain credibility and buy-in to improve overall health and wellbeing of the area's youth.

The FTCTC has *diversified its funding*, both across sectors (e.g., behavioral health, juvenile justice, education) as well as from various sources (e.g., government, corporate foundations, individual donors). The coalition has identified risk factors that are common to many problem behaviors and targets interventions to address those risk factors. By doing this, the activities of the coalition are applicable to grants from many different sectors. Additionally, the FTCTC has *utilized outcome data* to convince funders, partners, and other stakeholders that their work is making an impact. The coalition gathers community level data on risk factors and problem behaviors every two years and evaluates their programs yearly. With these data, they are able to show that the reductions in risk factors due to programmatic intervention precede reductions in problem behaviors, indicating that the programs had an effect on risk factors, which in turn reduced problem behaviors at the population level.

A key to the success of the FTCTC has been the development of positive working *relationships in the community*. The coalition's work is valued by the communities in which it operates, resulting in four of the five towns including the coalition as a line item in their budgets. These dollars are not significant, but can be used as matching funds for federal or foundation grants and can underwrite other fundraising activities. Additionally, the coalition and its member organizations have developed trust over the years, clearly defining the work of the coalition and the work of its members as to ensure each entity has its discrete purpose. The FTCTC has its own *fundraising events* to attract individual donors, which has led to greater revenue for the coalition and its members. While many organizations can be territorial about its donors, the FTCTC has found that donors continue to give to their original interest but are also willing to support organizations with related but discrete causes.

A final lesson from the success of the FTCTC, coalitions must determine the needs of the community and select interventions - both programmatic and environmental - to address those issues. *Identified*

need, not funding, must drive decisions regarding the interventions used. This can be difficult with limited funds, but implementing a program simply because there are funds available may be a waste of those funds and the coalition's efforts.⁶⁰

IV. Private Purveyors of Evidence-Based Programs

It is now well known that the dissemination and quality implementation of prevention programming occurs very slowly (if at all) without special attention to systematic implementation as a supported activity. The traditional model of science to practice in most human service fields involved academics developing and testing interventions – often in laboratory-like conditions, publishing results in peer reviewed journals and hoping that their work would be adopted by prevention programs. This model was ineffective in dissemination, resulting in the now well known 17 year gap between the development of an effective practice and its implementation – often at a 50% adoption rate.⁶¹ For example, Flemings’ discovery of penicillin in 1928 did not get widely used until the mid 1940s, even with the desperate need for antibiotics in treating those wounded in World War II.⁶²

One strategy for improving both speed and quality of dissemination can involve distinguishing between the role of developers and purveyors with the latter being "... an individual or group of individuals representing a program or practice who actively work to implement that practice or program with fidelity and good effect." (p. 14)⁶³ These are skills that the developers often do not possess and activities for which they are not rewarded. *Developing businesses to serve as a purveyor can provide a critical link in the implementation process.* Several examples of such businesses currently exist in the prevention arena. We will highlight two.

Triple P. Triple P was developed and initially tested in Australia with the model becoming widely distributed throughout the U.S. and other nations. All of the intellectual property (IP) associated with the Triple P program is owned by the University of Queensland. The University has licensed the IP to a technology transfer company (Triple P International) that serves as the purveyor. Triple P International is then charged with all of the business functions associated with disseminating and implementing the program. Revenues resulting from the program are shared with the University who in turn shares portions of the royalties with all of the original developers. This partnership provides *capital resources that can be used to develop new markets* (i.e., disseminate the product), which initially puts these resources at risk. Without this capital, however, dissemination efforts are significantly weakened. The Triple P model, therefore, involves a university/technology transfer arrangement that is widely used in the licensing of other intellectual property. It helps to *formalize dissemination and implementation processes* that traditionally have been handled much less systematically.^{64 65}

Paxis. The Paxis Institute represents a somewhat different approach. It was founded by a prevention scientist as a private, for-profit corporation. Paxis seeks to better link science to practice through an explicit concentration on dissemination and implementation quality.⁶⁶ It has been largely underwritten by the efforts of its founder, Dr. Dennis Embry, who has modified and improved the original Good Behavior Game as well as developed and disseminated other evidence-based approaches (e.g., Reward and Reminder). He has engaged in *extensive marketing* of both the specific technologies that he is seeking to implement as well as of the importance of prevention methodologies for societal welfare overall. Dr. Embry has identified specific lessons from his implementation work that entities attempting to secure sustainable funding and gain community buy-in for the program have utilized. Using these strategies he has successfully implemented programs throughout the U.S. and Canada.

1. Demonstration programs must have easily *observable and measurable "early wins,"* which are identified by participants and stakeholders. For the GBG, this is typically rapid reduction in problem behaviors that are noted by teachers, administrators, students, and parents.

2. In addition to a reduction in problems, program success is often tied to an increase in *positive behaviors*, including increased pro-social behaviors, self-regulation, and feelings of hope.
3. The observable *changes affect current well-being* (helps kids, teachers, and families feel better) rather than specific reductions (present or future) in diagnosable MEB disorders.
4. First person accounts or *testimonials* can be utilized in conjunction with program evaluation data.
5. After 6-12 months, the program has an *observable effect on institutional indicators* associated with the cost and burdens related to MEB problems.
6. Marketing of the program must be done with a *positive relational frame*, utilizing language that positively demonstrates the program's outcomes (e.g., improved student well-being and school environment), rather than a discussion of problems (e.g., reduction in MEB disorders), which can inadvertently create stigma and introduce negative connotations to the program.⁶⁷

The development of these businesses provides the infrastructure to market and deliver programs, which is necessary for successful implementation. As businesses they must also develop the infrastructure to solicit and manage funds for the delivery of the program. Purveyor groups, therefore, are important links in the implementation chain that help to document need, estimate effectiveness and deliver a high-fidelity product relative to the initial design specifications from the research. Also, to the degree to which developers stay involved with the program, which is the case in both of these examples, the ongoing implementation work can further *refine the concepts and methods used in the intervention as the program is adapted to local community circumstances* (e.g., cultural differences).

Summary

These examples illustrate various strategies that can address the fragmentation of prevention funding across the three critical dimensions – government department, organizational level and funding sector. While each example illustrates a specific application in a given setting, they share common elements. All of them have an emphasis on *measurement and application of the prevention science literature*. Most of them either *blend funding* from two or more sources or help to provide the context for *better understanding across sectors* of the value, impact, and interrelatedness of these investments. Most also involve the *development of social capital* reflected in the collaborative culture and ongoing relationships of the people involved. These relationships are key to innovation within these constrained systems. The business and coalition applications, additionally, provide the concrete *infrastructure needed to market, select, deliver and evaluate interventions* such that stakeholders interested in promoting wellbeing have something to purchase of known value.

Finally, they all represent *efforts to move human service systems upstream* in order to reduce the level of behavioral health disorder burden and enhance wellbeing and productivity. Our hope is that by highlighting these efforts, we can further rationalize their strategies and value and, in so doing, encourage implementation and sustainability of preventive interventions and prompt further creative development.

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