

Tennessee Strategic Prevention Framework Partnership for Success (SPF-PFS) 2014–2019 Evaluation Plan

Tennessee Department of Mental Health
and Substance Abuse Services (TDMHSAS)
Division of Substance Abuse Services

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Introduction

The Tennessee Partnership for Success Rx (PFS Rx) is a five-year state and local community prevention initiative that is being implemented by the Division of Substance Abuse Services (DSAS) within the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). The project is funded through a federal Strategic Prevention Framework-Partnership for Success (SPF-PFS) grant that was awarded by the Center for Substance Abuse Prevention (CSAP) in September 2014. The SPF-PFS grant program aims to enhance state capacity to support high-need communities that are experiencing serious substance abuse problems, and to address gaps in their prevention service systems. The federal grant program builds on established state and Tribal prevention infrastructures to address two leading national substance abuse prevention priorities: 1) underage drinking among persons aged 12 to 20; and 2) prescription drug misuse and abuse among persons aged 12 to 25. The program also aims to bring SAMHSA's Strategic Prevention Framework (SPF) to a national scale by providing additional resources to expand implementation of the SPF process at the state and community levels. Funded SPF-PFS state grantees distribute funds to targeted sub-recipient communities to support local implementation of evidence-based prevention strategies, and provide communities with ongoing guidance and support in the form of technical assistance and training.

The overarching goal of the Tennessee PFS Rx is to produce changes in prevention capacity and outcomes in ten high need communities in Eastern Tennessee that will lead to measurable changes in substance abuse prevalence and related consequences statewide. The chosen prevention priority is to prevent and reduce the non-medical use of prescription drugs among youth and young adults ages 12 to 25. This priority reflects a growing acknowledgement that the misuse of prescription drugs has reached epidemic proportions within the Eastern Tennessee region, threatening the safety and health of its communities. The PFS Rx aims to reverse this escalating trend by targeting a 4.5 percent reduction in 30-day prescription drug misuse rates among youth and young adults within the five-year span of the project. Within the ten funded communities, PFS funds will support the implementation of the SPF to identify community needs, and to plan, implement, and evaluate evidenced-based strategies that positively impact policies, norms, and attitudes supporting unsafe prescription drug use. These evidenced-based and emerging practices include, but are not limited to: social media and marketing campaigns; community organizing and facilitation; policy and organizational change efforts; policy and procedural enforcement; and promotion of social alternatives.

As a condition of the grant, SPF-PFS grantees must collect and report state and community-level data annually to determine progress toward addressing the prevention priority. To meet this reporting expectation, DSAS has contracted with EMT Associates, Inc., a local evaluation research firm, to conduct a comprehensive process and outcome evaluation of the SPF-PFS grant program. This evaluation plan has been designed by EMT to comply with SAMHSA federal performance reporting requirements and to meet the informational needs of DSAS in support of program improvement and knowledge development. EMT brings a 35 year history of evaluation research in the alcohol and drug prevention field, including specialized expertise evaluating prevention partnerships that aim to build community capacity to address alcohol and drug abuse through collaborative action.

The proposed TN PFS RX Rx evaluation activities will be implemented through a collaborative effort involving EMT project team members, DSAS grant administrators, local coalition member representatives, and members of the State Epidemiological and Outcomes Workgroup (SEOW). The SEOW, which was formed under Tennessee's Strategic Prevention Framework-State Incentive Grant

(SPF-SIG), introduced a cooperative structure for providing leadership on data infrastructure development and data use to support planning around community prevention goals. The SEOW function has now been integrated into the TDMHSAS's Division of Planning, Research & Forensics (DPRF). The role of the DPRF is to compile data to evaluate program effectiveness; collect and provide performance-based outcome measures to stakeholders; identify trends in mental health and substance abuse; and provide information for decision making.

TN PFS Rx Prevention Priority and Project Goals

The TN PFS Rx will focus on **the prevention and reduction of prescription drug misuse and related consequences** as its prevention priority. This priority aligns with the Tennessee Governor's policy agenda for public safety, which identifies prescription drug prevention, treatment, and control as one of three leading public safety priorities for state. This prevention priority selection reflects an urgent and escalating concern over the growth in prescription drug use to near epidemic proportions within targeted regions of the state, as well as an acknowledgement of the dangers to health and safety posed by prescription drug misuse, abuse, and overdose. Recent data from the National Survey of Drug Use and Health (NSDUH) shows that nearly five percent of all adults in Tennessee have used pain relievers in the past year for non-medical purposes and that nearly one-third of users (31%) are drug dependent and in need of treatment. Prescription painkillers are now the primary substance of abuse among individuals receiving publicly-funded alcohol and drug treatment services. Information from Tennessee's Controlled Substance Monitoring Database (CSMD) shows that in 2010 there were enough drug prescriptions dispensed throughout the state to provide 51 pills of hydrocodone, 22 pills of Xanax, and 21 pills of oxycodone to every Tennessee resident over the age of 12. Prescribing practices within Tennessee rank the state second in the nation in the amount of opioid pain relievers (morphine equivalents) sold for every 10,000 state residents (11.8 kilograms).

Tennessee's PFS Rx community prevention initiative will address five related goals that are tied to this prevention priority, and that are aligned with the broader SPF-PFS federal grant program goals articulated by CSAP. These include the following:

Goal 1: Reducing the non-medical use of prescription drugs among persons ages 12 to 25 living in Tennessee

The first program goal is to reduce the non-medical use of prescription drugs, including prescription drug misuse, abuse, and overdose. The goal is tied to specific measureable objectives that include a 4 percent reduction in past 30-day use of prescription drugs within the population of youth 12 to 17 years of age, and a 5 percent reduction in rates within the young adult population 18 to 25 years of age. The evaluation will measure trends in population-based use rates within these age-related subgroups at both the state and coalition level, and will assess reductions in use relative to baseline rates.

Goal 2: Reducing prescription drug misuse and abuse related problems or consequences among persons ages 12 to 25 living in Tennessee

The second program goal focuses on reducing the range of negative public health and safety consequences that are attributable to prescription drug misuse, abuse, and overdose in affected communities. This goal is tied to specific measureable objectives that include: 1) a five percent reduction in rates of prescription drug related car crashes, 2) a four percent reduction in rates of prescription drug related crime, 3) a four percent reduction in prescription drug related emergency

room visits, 4) a five percent reduction in the number and percentage of babies born with Neonatal Abstinence Syndrome (NAS), and 5) a four percent reduction in the age-specific mortality rate due to prescription drug poisonings. The evaluation design supports ongoing measurement of consequence indicators within these age-related subgroups, and assesses changes in standardized rates relative to an established baseline measurement.

Goal 3: Implement the SPF process at the state and local coalition level

The third program goal is a process-oriented goal that relates to the integration of the five-step SPF planning and implementation process into existing prevention infrastructures within new and emerging coalitions in funded and satellite communities. The evaluation design will support qualitative measurement of how communities are utilizing the SPF to guide their local implementation approaches.

Goal 4: Strengthen prevention capacity and infrastructure at the state- and community-levels in support of prevention

The fourth program goal is a process-oriented goal that relates to specific activities intended to strengthen prevention capacity and infrastructure. Proposed activities include: 1) establishing peer mentoring and technical assistance programs to foster the emergence of new community coalitions, 2) enhancing data collection systems to improve measurement and facilitate data-driven decision-making, and 3) reviewing state level training and technical assistance resources, including evidence-based and emerging best practices, to strengthen the state prevention infrastructure. The evaluation design will describe state implementation of these capacity-building and infrastructure development activities and will measure perceived impacts on local coalition prevention capacity and effectiveness.

Goal 5: Leverage, redirect and realign State-wide funding streams and resources for prevention

The fifth program goal is a process-oriented goal that focuses on increased leveraging of state funds and prevention resources to maximize support for SPF-PFS project goals. Proposed activities include: 1) enhancing data collection systems to better document how prevention activities are funded and how resources are leveraged, and 2) broadening the reach of community prevention strategies to 10 higher education campuses to impact these relatively underserved young adult populations. The evaluation design will assess state and coalition level implementation of targeted activities, and will document innovations and growth in resource sharing and leveraging of funds to maximize project impacts.

PFS Evaluation Design Overview

The proposed TN PFS Rx evaluation plan is designed to promote program accountability, program improvement, and knowledge development, to serve as a tool to support and advance the work of DSAS and the prevention coalitions, and to support achievement of the five TN PFS Rx goals. The TN PFS Rx evaluation plan will fulfill several key functions including: a) clearly articulating and describing prevention approaches developed by the local coalitions to combat prescription drug misuse in their communities, b) describing and assessing the types of state technical assistance and training supports that are available to strengthen local implementation efforts, c) generating timely and relevant feedback on the implementation process for use in refining prevention approaches, d) testing the effectiveness of local strategies in producing meaningful changes in both community capacity and outcomes, and e)

reporting data findings, lessons, and recommendations that may be useful not only to federal funders and coalition members, but also to other communities seeking to combat prescription drug misuse and its consequences. The evaluation design is comprehensive and has the following key features:

Multi-Level and multi-site

SAMHSA SPF-PFS grants are awarded to state and Tribal grantee organizations to deliver central guidance and supports in the form of technical assistance and training to targeted high need communities. Funds are also directed to sub-recipient communities to support implementation of evidence-based prevention programs, policies, and practices that target changes in prevention capacity and outcomes at the community level.

The TN PFS Rx grant allocates funds to 10 local substance abuse prevention coalitions (SAPCs) that are located in the East Tennessee region of the state where prescription drug abuse problems are most highly concentrated. Seven of these coalitions have a long-standing history of community collaborative action to address alcohol and other drug abuse, while three others are more newly established. Each funded coalition will act as a regional hub to plan and coordinate prevention efforts across counties throughout the region.

The PFS evaluation will be structured to capture process and outcome information, including required performance measures, at both the state and coalition levels, with independent measurement of local context, community strategies, and outcomes for each coalition. This will allow multi-site analyses to identify coalition characteristics that contribute most to growth in prevention capacity and community outcomes. The ten funded county coalitions include: Anderson County, Blount County, Hamilton County, Jackson County, Johnson County, Sullivan County, Knox County, Putnam County, and Washington County.

The evaluation will also capture more limited process and outcome data pertaining to the 36 satellite counties that fall within three health planning regions in and adjacent to East Tennessee. These counties include: Bledsoe, Bradley, Campbell, Carter, Claiborne, Clay, Cocke, Cumberland, De Kalb, Fentress, Grainger, Greene, Grundy, Hamblen, Hancock, Hawkins, Jefferson, Loudon, Macon, Marion, McMinn, Meigs, Monroe, Morgan, Overton, Pickett, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Unicoi, Union, Van Buren, Warren, White. These counties do not receive any direct funding through the PFS grant, but are targeted for coalition mentoring and technical assistance activities that will be available region-wide.

Process-focused

The evaluation design includes a strong process component that will be used to document implementation of the TN PFS Rx grant program at the state and local coalition levels over the course of the five-year grant period. The process component will support measurement in a number of key conceptual domains including: 1) community and organizational context, 2) coalition structure and processes, 3) state and local prevention strategies, activities, and investments, including the use of evidence-based programs, policies, and practices, and 4) measures of state and coalition capacity and responsiveness to community needs.

Outcome-driven

The evaluation design will also measure the degree to which state and local level outcomes related to the prevention of prescription drug misuse, abuse, and overdose are achieved. These include measures of: 1) improved state prevention system capacity resulting from increased collaboration,

data system enhancement, resource development, and the delivery of technical support, 2) improved local prevention system capacity resulting from community collaborative action, and 3) targeted reductions in rates of prescription drug misuse, changes in intervening variables, such as perceptions of risk and harm, and reductions in associated health and safety-related consequences.

Longitudinal

The evaluation is structured to monitor outcome data over the five-year grant duration to document changing trends in use rates and consequence indicators that can be attributed to implementation of evidence-based prevention approaches.

Participatory and collaborative

The evaluation plan is guided by a participatory framework that emphasizes collaboration among DSAS grant administrators, coalition leadership, SEOW members, and the evaluation team. This approach creates meaningful engagement of key stakeholders in the evaluation process, recognizes the unique contributions of diverse partners, and ensures that findings are responsive to the needs, interests, and priorities of each of these stakeholder representatives.

PFS Process Evaluation and Performance Measurement

The **process evaluation** will describe and assess state and local program implementation. The process evaluation component incorporates a variety of activities including articulating the program logic, documenting differences between “program-as-planned” and actual implementation, identifying strengths, weaknesses, and implementation challenges, and gauging stakeholder perspectives. The process evaluation serves several purposes including determining how well programs are functioning, identifying program elements that contribute to success or failure, supporting the interpretation of outcome findings, and providing decision making feedback to the program. The process evaluation will provide the detailed documentation of the program concept and implementation fidelity that will be essential if successful program features are to be replicated elsewhere. The process evaluation will be used to answer four key process evaluation questions identified by CSAP. These include:

Process Evaluation Questions

Q1. How did the Tennessee PFS progress through the SPF steps?

SPF-PFS grantees are expected to implement the SPF at both the state and community levels. The SPF is a five-step process that involves: 1) identifying prevention needs, 2) building prevention capacity, 3) developing a strategic plan, 4) implementing effective programs, policies, and practices, and 5) evaluating prevention efforts and outcomes. The SPF helps to ensure that states and communities adopt data-driven decision making processes to develop effective prevention strategies and sustainable prevention infrastructures. The process evaluation will document SPF implementation in each of the ten funded communities and in regional satellite counties using information compiled from stakeholder interviews, coalition member surveys, and program records of technical assistance and training activities relevant to the SPF process.

Q2. Which evidence-based programs policies, and practices (EBPPP) were implemented?

The PFS funded coalitions are expected to select, implement, and evaluate evidence-based prevention programs, policies, and practices that best address the prevention priority within their community context. To support coalitions in this effort, DSAS will convene its state-level,

evidence-based practice workgroup (EBPW) to identify, review, approve, and provide feedback on all proposed interventions prior to implementation plan approval. The composition of the EBPW will include prevention researchers, state and local prevention practitioners and key community leaders with knowledge and expertise in this area. DSAS and the EBPW also recognize that EBPs have not been developed for all populations and service settings and will consider alternative forms of evidence demonstrating appropriateness and promise of effectiveness for a given community or targeted group. The EBPW has developed detailed guidelines and procedures for review of locally developed innovations to selected EBPs. The process evaluation will document EBPPPs implementation based on a content review of coalition implementation plans, reviews of quarterly reports, and quarterly analyses of records stored in the TN-WITS data system documenting coalition-supported strategies and activities (*see TN-WITS discussion for more information*).

Q3. How was fidelity of implementation ensured?

The concept of program fidelity refers to the degree to which essential components of a program are implemented as theoretically planned. Fidelity of implementation is important for reproducing outcomes that are expected from programs qualifying as evidence-based. PFS coalitions articulate their prevention approaches through a logic modeling process that guides development of each coalition's local implementation plan. The local implementation plan specifies EBPPPs selected by the coalition; quarterly reports, compiled by coalition members, document progress toward implementing planned components of the approach. This information will be reviewed on a quarterly basis to assess fidelity to the plan.

Q4. How did changes from the original plan affect performance?

The evaluation team will use information gleaned from the fidelity assessment, in combination with information generated through quarterly reviews with coalition directors, to determine where meaningful digressions from the implementation plan occurred and to determine how changes impacted implementation quality.

Performance Measurement – State and Coalition Level Process Indicators

The SPF-PFS grant outlines specific performance reporting requirements related to the process evaluation. These include **five process measures reported at the state grantee level**, and **seven measures reported at the sub-recipient, or local coalition level**. Process measures required for performance reporting purposes, listed by source, frequency collected, method of collection, and level of data, are shown in Exhibit 1 SPF-PFS Grantee and Sub-recipient Performance Measurement Framework on the following page of the evaluation plan.

Exhibit 1: SPF-PFS Grantee and Sub-recipient Performance Measurement Framework

| Measure | Source | Frequency Collected | Method of Collection | Level of Data | |
|----------------------|---|--|----------------------|---------------------|-----------|
| SPF-PFS Grantee | Number of training and technical assistance (T/TA) activities provided by the grantee to the sub-recipients to support communities | Metropolitan Drug Commission (MDC) quarterly reports | Quarterly | Administrative data | State |
| | Reach (numbers served) of T/TA activities provided by the grantee | Metropolitan Drug Commission (MDC) quarterly reports | Quarterly | Administrative data | State |
| | Percentage of sub-recipient communities that have increased the number and percentage of EBPPPs | TN-WITS | Quarterly | Administrative data | State |
| | Percentage of sub-recipient communities that report an increase in prevention activities supported by leveraging of resources | TN-WITS | Quarterly | Administrative data | State |
| | Percentage of sub-recipients that submit data to the grantee data system | EMT | Quarterly | Administrative data | Coalition |
| SPF-PFS Subrecipient | Number of active partners supporting the local PFS initiative | Coalition surveys | Quarterly/annually | Administrative data | Coalition |
| | Number of people reached by prevention category (i.e., universal, selected, indicated) | TN-WITS | Quarterly | Administrative data | Coalition |
| | Number of people reached by demographic category | TN-WITS | Quarterly | Administrative data | Coalition |
| | Number of people reached by each of the six prevention strategies (i.e., prevention education, problem identification and referral, information dissemination, environmental strategies, alternative activities, community-based processes) | TN-WITS | Quarterly | Administrative data | Coalition |
| | Number and percentage of EBPPPs implemented by coalition | TN-WITS | Quarterly | Administrative data | Coalition |
| | Number, type, and duration of evidence-based interventions implemented, by the six prevention strategies mentioned in 3d above. | TN-WITS | Quarterly | Administrative data | Coalition |
| | Number of prevention interventions that are supported by collaboration and leveraging of funding streams | TN-WITS | Quarterly | Administrative data | Coalition |

Information supporting performance measurement will be compiled from a variety of data sources and data collection activities conducted in each year of the grant funded period. These include:

Interviews with DSAS Staff and Stakeholders

Semi-structured telephone interviews will be conducted annually with DSAS administrators, and with members of the SEOW and other key state level stakeholders to inform process evaluation questions specific to the SPF, the adoption of EBPPPs, and other key elements of implementation.

Documentation of technical assistance and training activities (TTA)

The Metropolitan Drug Commission (MDC) is contracting with DSAS to administer the TTA program. The contract agreement includes requirements for documenting TTA needs, requests for services, and other measures of service delivery. This information contained in quarterly reports will be used to document the number of TTA activities implemented per funded coalition, and the number of participants reached.

Coalition Director Interviews

Semi-structured telephone interviews will be conducted with coalition directors in each of the ten funded communities during the first 6-months of the grant and will be repeated annually at the conclusion of each program year. Interviews will be semi-structured to encourage elaboration and sharing of personal interpretation and insights. Interview content will be coded and analyzed using Atlas.ti qualitative analysis software to identify core themes across respondents that are relevant to the evaluation questions. Baseline interviews will be used to profile each targeted community and to describe the coalition history, structure, and member composition. Items on the coalition director interview protocol will also be designed to support the informational needs of the national cross-site evaluation.

Coalition member surveys

Coalition member surveys will be administered to members of the ten funded coalitions on an annual basis using electronic surveys that are distributed through member rosters. Baseline member surveys will be administered within the initial planning year and will be repeated annually. The survey will support measurement in a number of key domains including member roles and affiliations, decision-making procedures and processes, support for the prevention plan, commitment to and engagement in coalition activities, perceptions of prevention capacity and coalition effectiveness, and cultural competence and coalition effectiveness in reaching groups at risk of health disparities. Key informant surveys will also be administered to representatives of satellite counties that are not directly funded through the PFS grant to document the reach of prevention strategies throughout the region and perceived value of coalition mentoring and TTA activities.

TN-WITS

The Tennessee Web-based Information Technology System (TN-WITs) is a web-based data management tool for behavioral health that is currently used by all TN prevention providers to collect NOMs and process measures. The system allows for standardized tracking of coalition activities that can be summarized for process and outcome reports linked directly to project-specific interventions and outcomes. Data entered into TN WITS is compiled by unique performance contract number and contains the following information:

- County/coalition
- Implementation date
- Associated program goal
- Priority area (e.g., prescription drug use)
- Risk category
- Activity name,
- Activity location
- Activity duration
- CSAP strategy type
- Use of evidence-based practice
- IOM intervention (universal, selected, indicated)
- Cost
- Leveraged funds
- Participation counts by age, gender, race and ethnicity
- Sector type (e.g. youth, parent, business, media)

TN-WITS data will support measurement of **two state-level process indicators** (i.e., percentage of coalitions with an increase in EBPPPs, and percentage of coalitions with an increase in strategies supported through leveraged funding), and **six coalition-level process indicators** (i.e., number reached by prevention category, demographic category, and prevention strategy; number of EBPPPs implemented; number, type and duration of interventions; and number of interventions supported by collaboration and leverage funds). Coalitions are required to record information in TN-WITS on a weekly basis, which will be summarized by the evaluation team on a quarterly basis.

The fourth SPF-PFS program goal involves enhancing the TN-WITS system to improve documentation of leveraged funding and resources. Once completed TN-WITS can then be used to measure number of strategies supported with leveraged funds as required in the performance measurement plan. TN-WITS information will also be used to document strategies and activities that address behavioral health disparities or that are successful in reaching underserved groups. These enhancements are included in the proposed project budget and will be documented through the evaluation.

Quarterly TN-WITS reviews with coalition staff

The evaluation team will conduct quarterly reviews of TN-WITS data submissions to ensure data quality and timeliness of recorded information. TN-WITS summaries will be shared with coalition directors as part of a quarterly review process to address any data inconsistencies, to clarify how information should be interpreted, and to discuss fidelity to the implementation plan. Coalition member representatives will integrate TN-WITS data into quarterly program reports that include descriptive, contextual information concerning implementation progress. The quarterly reports conform to the structure of each coalition's implementation plan to provide DSAS with a tool for easily monitoring program delivery, identifying training/TA needs, and evaluating fidelity to the implementation plan.

Reviews of quarterly reports

The content of completed quarterly reports will also be reviewed and coded as part of the process analysis to answer key evaluation questions related to the SPF process, implementation of EBPPs, and implementation fidelity. Information from quarterly reports will be submitted to CSAP through the Prevention Management Reporting and Training System (PMRTS) on a quarterly basis. Community data will be updated twice annually in May and November, and community outcome data will be reported on an annual basis.

Document review

The process evaluation will also include document reviews of any relevant products or materials that are produced by the coalitions, including attendance sign-in sheets from coalition meetings, and prevention materials and resources developed at the coalition level with PFS funds.

PFS Outcome Evaluation and Performance Measurement

The **outcome evaluation** provides measurement of critical outcomes that are linked to the program intervention and are often reflected in the stated goals and objectives. The purpose of the outcome evaluation is to determine the program's effectiveness in achieving desired change in attitudes, behaviors, and conditions targeted by the program. The outcome evaluation will be used to answer the key outcome evaluation question identified by CSAP that is associated with the first two PFS program goals.

Outcome Evaluation Question

Q1: What were the effects of the PFS initiative on consumption, intervening variables, and consequences?

The TN PFS Rx evaluation targets changes in state and local prevention capacity that contribute to 1) reductions in prescription drug misuse, abuse and overdose among youth and young adults, 2) increases in intervening variables that are shown to have a mediating effect on rates of use, and 3) measureable consequences associated with alcohol and drug using behaviors. The evaluation team will compile outcome indicators using a combination of extant data sources (e.g., national surveys, archival records) and local surveys. Baseline prevalence rates will be established for each of the required outcome indicators using current data sources.

State Outcome Indicators – Substance Use and Intervening Variables

TN SPF-PFS has selected the 30-day prevalence of pain relievers as the primary outcome measure to assess progress in reducing prescription drug misuse, abuse, and overdose within the youth and young adult populations. Baseline prevalence rates measuring 30-day use will be compiled from the NSDUH Restricted-use Data Analysis System (R-DAS) to measure past month use rates at the state level and within the three East Tennessee health planning regions. The R-DAS is an online analysis system that produces estimates that are representative of the average population combined across a two-year period. The NSDUH measures lifetime, past year, and past month use of various prescription drug types including pain relievers, OxyContin, tranquilizers, stimulants, sedatives, and any psycho-therapeutics. The most current year of data available is for 2010-12 (5.4% TN 30-day use prevalence), which will serve as the immediate baseline measurement.

The NSDUH will also serve as the primary source of state data for measuring past month prevalence of binge drinking, perceived risk and harm associated with illegal drug use, perceptions of parental

or peer disapproval, and family communication around drug use. Additionally, DSAS will monitor prevalence rates from coalition level sources (see discussion of the PFS Student Survey and the East Tennessee Young Adult Survey) that are aggregated across communities to provide regional measurement for the East Tennessee region of the state. Information on specific performance indicators of substance use and intervening variables are listed by source, frequency collected, method of collection, and level of data in Exhibit 2 SPF-PFS Grantee Outcome Measurement Framework.

Coalition Outcome Indicators – Substance Use and Intervening Variables

Coalition, or sub-recipient, outcome measures of substance use and intervening variables include three indicators of alcohol and prescription drug prevalence (i.e., past 30-day alcohol use, past 30-day prescription drug use, and binge drinking) and four additional indicators measuring disapproval of prescription drug use, perceptions of peer or parental disapproval of non-medical use of prescription drugs, perceived risk or harm of use, and family communication about prescription drug misuse. The two major sources of outcome measurement at the coalition level are the school-based TN PFS Rx Student Survey and the East Tennessee Youth Adult web-based survey.

TN PFS Rx Student Survey

The primary source of information on alcohol and prescription drug use within the youth population 12-17 years of age is the **PFS Rx Student Survey**. The student survey provides measurement of all core outcome indicators, including: 1) past 30-day use of any alcohol, 2) past 30-day binge drinking, 3) past 30-day use of prescription drugs that were not prescribed by a doctor, or that were taken only for the experience or feeling they caused, 4) peer and parental disapproval of prescription drug misuse, 5) perceived risk and harm associated with the use of prescription drugs that were not prescribed by a doctor, or that were taken only for the experience or feeling they caused, and 6) family communication around prescription drug use.

The PFS Rx Student Survey instrument is an adaptation of the SPF-SIG Student Survey administered in 2009 and the TN PFS Student Survey used in 2011 and 2013. The PFS student survey incorporates items from standardized surveys that have demonstrated reliability and validity. Specifically, the 2009 SPF-SIG student survey incorporated survey items from the Communities that Care Survey, such as individual and peer substance use (i.e., tobacco, alcohol, and illicit drugs), and perceptions of associated risks and availability of substances. The 2009 SPF-SIG student survey also included National Outcome Measures (NOMs) from the Center for Substance Abuse Prevention (CSAP), in addition to measures of school safety, prescription drug misuse, abuse and dispersion, and visibility of environmental strategies implemented in TN SPF-SIG communities. Items have been added to the current version of the PFS student survey to: (1) capture additional measures of prescription drug use patterns, access, norms and consequences to support the SPF needs assessment component, and (2) support compliance with DFC core measure reporting expectations to minimize data collection burden in communities with multiple sources of prevention funding.

The survey will be administered bi-annually to 8th, 10th, and 12th grade students enrolled in public middle schools and high schools within the 10 funded counties in East Tennessee.

Exhibit 2: SPF-PFS` Grantee Outcome Measurement Framework

| Measure | | Source | Frequency Collected | Method of Collection | Level of Data |
|-----------------------|--|--|---------------------|---|---|
| Substance Use | Past 30-day alcohol use | NSDUH | Biennial | SAMHSA estimate of annual averages | State |
| | Past 30-day nonmedical use of prescription drugs | NSDUH | Biennial | SAMHSA estimate of annual averages | State |
| | Binge drinking | NSDUH | Biennial | SAMHSA estimate of annual averages | State |
| Intervening Variables | Disapproval of use | PFS Rx Student Survey | Biennial | In person collection in public schools grades 10 and 12 | Aggregate data from all subrecipient counties |
| | | East Tennessee Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | Aggregate data from all subrecipient counties |
| | Perception of parental or peer disapproval/attitude | PFS Rx Student Survey | Biennial | In person collection in public schools grades 10 and 12 | Aggregate data from all subrecipient counties |
| | | Tennessee Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | Aggregate data from all subrecipient counties |
| | Perceived risk or harm of use | PFS Rx Student Survey | Biennial | In person collection in public schools grades 10 and 12 | Aggregate data from all subrecipient counties |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | Aggregate data from all subrecipient counties |
| | Family communication about drug use | PFS Rx Student Survey | Biennial | In person collection in public schools grades 10 and 12 | Aggregate data from all subrecipient counties |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | Aggregate data from all subrecipient counties |
| Consequences | Alcohol-related car crashes and injuries | TN Department of Safety and Homeland Security | Annual | Administrative data | State/region |
| | Prescription drug-related car crashes and injuries | NHTSA Fatal Accident Reporting System (FARS) | Annual | Administrative data | State/region |
| | Alcohol-related crime | TIBRS Tennessee Crime Online | Annual | Administrative data | State/region |
| | Prescription drug-related crimes | TIBRS Tennessee Crime Online | Annual | Administrative data | State/region |
| | Alcohol- and prescription drug-related emergency room visits | TN Department of Health, Office of Health Statistics | Annual | Administrative data | State/region |
| | Alcohol- and prescription drug-related poisonings | TN Department of Health, Office of Health Statistics | Annual | Administrative data | State/region |

Exhibit 3: SPF-PFF Sub-recipient Outcome Measurement Framework

| Measure | | Source | Frequency Collected | Method of Collection | Level of Data | |
|--|---|--|---|---|---------------------|--------|
| Substance Use | Past 30-day alcohol use | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Past 30-day nonmedical use of prescription drugs | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Binge drinking | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| Intervening Variables | Disapproval of use | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Perception of parental or peer disapproval/attitude | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Perceived risk or harm of use | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Family communication about drug use | PFS Student Survey | Biennial | In person collection in public schools grades 10 and 12 | County | |
| | | Young Adult Survey | Biennial | Online collection from social media advertising of young adults 18-25 | County | |
| | Consequences | Alcohol-related car crashes and injuries | TN Department of Safety and Homeland Security | Annual | Administrative data | County |
| | | Prescription drug-related car crashes and injuries | TN Department of Safety and Homeland Security | Annual | Administrative data | County |
| Alcohol-related crime | | TIBRS Tennessee Crime Online | Annual | Administrative data | County | |
| Prescription drug-related crimes | | TIBRS Tennessee Crime Online | Annual | Administrative data | County | |
| Alcohol- and prescription drug-related emergency room visits | | Hospital Discharge Data System | Annual | Administrative data | County | |
| Alcohol- and prescription drug-related poisonings | | Death Statistical System | Annual | Administrative data | County | |

Survey sampling plan

The PFS Rx Student Survey will be administered to students enrolled across a randomly selected sample of 65 middle schools and high schools, including 38 middle schools, 23 high schools, and 4 schools that combine middle and high school grade levels, within the 10 targeted communities served by the grant. The purpose of the sampling plan is to obtain a representative sample for each of the 10 county coalitions, so that valid statistical descriptions can be made about the population of interest at the coalition level (i.e., students in grades 8, 10, and 12 enrolled across public middle schools and high schools within each county). The stratified sample includes each of the 10 coalitions funded under the grant, and does not include comparison counties.

Schools will be asked to survey a **census** of all 8th, 10th, and 12th grade students to avoid selection bias at the classroom level. The minimum sample size was determined for each county population based on the size of the enrolled student population within targeted grade levels, the estimated baseline proportion of prescription drug use in the population based on previous PFS Student Surveys (i.e., less than 10% of students reported past 30-day use), a 95 percent confidence interval, and a sampling error of +/-2 percent. For each county, the targeted minimum sample was inflated to ensure that the minimum number of completed surveys could be achieved assuming a 70 percent response rate. Schools were randomly selected into the sample until the minimum number of students in the sampling pool was met. *See attachment 2 - PFS Rx Student Survey Sampling Plan.*

Historical response rates

The 2013 Tennessee PFS Student Survey was administered to 10th and 12th grade students enrolled in selected public high schools across 16 participating PFS communities. The survey sampling pool included 14,509 students with 9,499 completed survey responses, resulting in a 65 percent response rate project-wide. The median response rate across the 16 communities was 76 percent. Although coalitions attempted to adhere to the sampling plan, in certain communities, school administrators declined to participate in the administration, or requested to modify the sampling plan due to concerns about loss of instructional time. School administrators in Knox County, for example, opted out of administering the PFS Student Survey and instead relied on local Youth Risk Behavioral Surveillance (YRBS) data as a proxy, although the survey does not cover many of the required items used in measuring PFS community outcomes. The YRBS survey is jointly administered by Knox County Schools and the Knox County Health Department. The response rate for the 2013 Knox County YRBS was 85 percent, with 1,384 eligible students and 1,181 respondents.

Administration procedures

The baseline administration of the PFS Rx Student Survey is scheduled to launch in September 2015. The survey will be re-administered on a biennial basis in the fall of 2017 and 2019 to allow for comparison of community conditions over time.

The PFS Student Survey has historically been administered as a paper-and-pencil survey only. However, for the PFS Rx survey administration, the evaluation team has plans to develop a web-based version of the survey tool that can be accessed by schools through the TN Prevent.org website and can be administered electronically in school computer labs. The intent of the online survey tool is to reduce reporting burden and impacts on instructional time to increase school

participation and survey response rates. The online option may additionally build data system capacity by extending low cost or no-cost access to the survey to other East Tennessee counties or counties statewide. The evaluation team may also explore other options to increase school participation, which may include reducing the length of the survey and/or offering schools the option of only administering the core module. DSAS will also be seeking technical assistance from the SAMHSA TA contractor to develop additional strategies for increasing survey response rates.

Scheduling and logistical arrangements for data collection will be handled by the coalition leadership with direction and support from EMT's student survey coordinator. Once schools have agreed to participate in the student survey, the school's principal or designated contact will receive a school packet containing: 1) a letter to the principal thanking them for their school's participation, 2) instructions for distributing the permission form packets to teachers to ensure timely distribution; 3) a sample copy of the PFS Rx Student Survey form and 4) a set of instructions for teachers to administer either the paper-and-pencil or web-based survey version.

Passive permission form packets will be sent to schools at least two weeks in advance of the survey in order to allow sufficient time to permit the principal or designated contact to distribute permission form packets to each teacher, monitor their distribution, and allow time for students to take the forms home to their parents, for parents to view the survey if they so desire, and for parents to return the permission forms. Parent consent forms will be distributed to students at least three business days prior to the scheduled data collection date. The evaluation team will work closely with school principals and administrative staff in order to maximize parental permission for student participation in the student survey. Methods of increasing parental permission rates that have been successful in previous national surveys involve: including a recruitment letter from the principal emphasizing the importance of the study to the school and to the district, offering to answer parent questions, and making the survey easily available for parents to review (e.g., at the school's main office or online at the school's webpage). Survey administrators will be offered training and support throughout the survey administration time period to improve adherence to and understanding of survey administration methods, to improve data quality, and to increase buy-in among local school personnel.

Schools that opt to administer the online version of the PFS Student Survey will have students log into the web-based survey administration portal and enter survey responses directly. The online module will allow completed survey responses to be exported for analysis by the evaluation team. Completed paper-and-pencil surveys will be shipped to EMT's main offices from face auditing and scanning into the SPSS software application for analysis and will be integrated with the online responses.

Analysis of data

Post-stratification weighting will be used to ensure that the completed survey sample reflects the grade-level enrollment and gender distribution of the county public school population. PFS Rx coalitions will each receive a coalition level report summarizing student survey responses for each administration year with comparisons to baseline rates; individual schools may also request a school-level report for a minimal fee covering labor and production costs.

East Tennessee Young Adult Survey

DSAS and the evaluation team are reviewing different options for how to best capture data for the young adult population, and will be seeking input from the Center for Application of Prevention Technologies (CAPT) to explore alternatives for surveying young adults 18 to 25 years of age. One proposed approach under current consideration is to conduct a web-based survey advertised through social media and print advertisements to capture a convenience sample of young adults. Facebook and other social media newsfeeds would be visible on both desktop and mobile Facebook applications to direct survey respondents to the website URL.

The East Tennessee Young Adult Survey instrument will incorporate items from standardized surveys that have demonstrated reliability and validity (e.g., the Vermont PFS Young Adult Survey, the National Survey on Drug Use and Health (NSDUH), and the Behavioral Risk Factor Surveillance System (BRFSS). The survey would be administered on a biennial basis and would be timed to coincide with the school-based PFS Student Survey administration. The survey sample would include young adults 18 to 25 years of age residing in the East Tennessee region, defined based on self-reported county of residence. Offers of weekly raffled cash prizes would be used to incentivize participation. In addition to social media advertising, coalitions may elect to increase local survey participation through direct marketing strategies at public events by providing access to computers or tablets that can be used to access the web-based survey. Post-stratification weighting will be used to ensure the survey sample reflects the age and gender distribution of the young adult population of East Tennessee and to allow for comparison of results over time. To minimize duplication of responses, respondents will be instructed to only complete the survey once, and will be required to provide identifying information for participation in the incentive program.

The East Tennessee Young Adult Survey would include items measuring core intervening and outcome variables, including past 30-day alcohol use, prescription drug misuse, and binge drinking, included in the PFS Student Survey, adapted for a young adult population. Exhibit 4 below reports the size of the young adult population by county within specific age categories. This information will be used to gauge survey responses rates within targeted communities. Post-stratification weighting will be used to ensure the survey sample reflects the age, gender, and race ethnic distribution of the young adult population and to allow for comparison of survey responses over time.

Exhibit 4: Young Adult Population 18-25 Years within PFS Coalitions

| | 18-20 yrs | 21-25 yrs | Young Adult Total |
|-------------------|-----------|-----------|-------------------|
| Anderson County | 2,383 | 4,637 | 7,020 |
| Blount County | 4,212 | 7,484 | 11,696 |
| Hamilton County | 13,942 | 25,538 | 39,480 |
| Jackson County | 346 | 652 | 998 |
| Johnson County | 501 | 1,078 | 1,579 |
| Knox County | 22,799 | 37,828 | 60,627 |
| Putnam County | 4,398 | 7,656 | 12,054 |
| Smith County | 606 | 1,122 | 1,728 |
| Sullivan County | 606 | 9,140 | 9,746 |
| Washington County | 6,388 | 11,015 | 17,403 |
| | 56,181 | 106,150 | 162,331 |

Source: 2013 Estimated Young Adult Population Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Bridged-Race Population Estimates, United States July 1st resident population by state, county, age, sex, bridged-race, and Hispanic origin. Compiled from 1990-1999 bridged-race intercensal population estimates (released by NCHS on 7/26/2004); revised bridged-race 2000-2009 intercensal population estimates (released by NCHS on 10/26/2012); and bridged-race Vintage 2013 (2010-2013) postcensal population estimates (released by NCHS on 6/26/2014). Available on CDC WONDER Online Database. Accessed at <http://wonder.cdc.gov/bridged-race-v2013.html> on Dec 5, 2014.

State and Coalition Outcome Indicators – Consequences

An important emphasis of the TN PFS Rx performance measurement and evaluation plan is to assess changes in community health and safety conditions that are associated with prescription drug misuse, abuse, and overdose. The prescription drug related consequences, which include prescription drug-related motor vehicle crashes, criminal offenses, emergency room visits, and drug-related deaths, will be compiled from archival data sources maintained by multiple state agencies. Baseline rates will be established for each of the required outcome indicators using the most current data available for each consequence indicator. DSAS also routinely monitors changes in problem prevalence over time and annually compiles a number of supplemental indicators at both the state and local levels that provide measurement of prescription drug consumption and related consequences for individual users and their communities.

TDMHSAS is also continuing efforts to develop and enhance its state and local data infrastructure and to promote capacity to conduct data-driven needs assessment and surveillance activities. The outcome measurement component of TN PFS Rx program will be supported through the ongoing development of the Tennessee AOD Data Mart, a data warehouse for storing indicators of community substance use and related measurements. In 2009, DSAS contracted with EMT Associates, Inc. to redesign the AOD Data Mart to establish an accessible web-based repository that synthesizes information on more than 20 state, regional, and county-level indicators of alcohol and other drug abuse and related consequences. The warehouse is stored on the TDMHSAS-sponsored TN Prevent.org website that serves as a central repository of information relevant to the substance abuse prevention field. Information is publicly accessible to users of the site. EMT is currently under contract with DSAS to update and expand the AOD Data Mart to address SPF-PFS performance reporting requirements specific to measurement of prescription drug use indicators. This upgrade to the site will provide local coalitions with direct access to county-level data that can support community-level planning, needs identification, and outcome measurement.

The specific outcome measurements required for the SPF-PFS grant initiative are listed below, accompanied by a discussion of the original data sources. These required indicators will be compiled by EMT Associates, standardized for comparability across county populations, and uniformly formatted into indicator reports that are accessible by county through the AOD Data Mart. See *attachment 1 – Tennessee Partnership for Success Rx Baseline Consequence Indicator Report*.

Alcohol-related motor vehicle crashes and injuries

The Tennessee Department of Safety and Homeland Security maintains county level data on the number of alcohol-related traffic crashes involving a driver with a blood alcohol content of 0.08 or higher. Annual rates are calculated based on the number of licensed drivers per 1,000. The most current year of published incident data available is 2013, although more recent data may be available by special request. The Governor’s Highway Safety Office also publishes county level data on the number of alcohol-related traffic crashes involving a driver with a blood alcohol content of 0.08 or higher specifically for drivers ages 15 to 24. Annual rates are calculated based on the number of licensed drivers ages 15 to 24 per 1,000. The most current year of published incident data available is 2012, although more recent data may be available by special request.

Source:

Tennessee Department of Safety and Homeland Security; Research, Planning, and Development; TITAN Database. Known-Alcohol Related: Driver Alcohol Presence indicated 'Yes' or Driver Alcohol Test Result \geq .08 BAC. Tennessee Governor’s Highway Traffic Safety Office, <http://tntrafficsafety.org/data-statistics/2085>

Governor’s Highway Safety Office. Data & Statistics. Alcohol related crashes involving alcohol from ages 15–24, 2007–12. <http://tntrafficsafety.org/data-statistics/2085>.

Prescription drug-related motor vehicle crashes and injuries (fatal accidents only)

The National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS) is a census of all crashes on public roads that result in at least one fatality within 30 days of the crash. The FARS Query System provides interactive public access to fatality data through the FARS web interface. FARS system includes reports of positive drug test results, identifying 373 drug types across eight drug categories, including narcotics, depressants, stimulants, hallucinogens, cannabinoids, phencyclidine (PCP), anabolic steroids, and inhalants. DSAS will apply the methodology developed by Wilson, Stimpson, and Pagan to determine the number of drugged drivers involved in fatal accidents who test positive for prescription drugs. Prescription drugs are defined as schedule II-IV drugs (excluding cocaine and methamphetamine) that are prescribed by physicians for medical treatment, but that vary in their potential for drug abuse and psychological/physical dependence. FARS data are available by county jurisdiction and by age, gender, and race/ethnicity of the driver. Annual rates are calculated based on the number of drivers involved in fatal motor vehicle crashes testing positive for prescription drugs per 100,000 licensed drivers and as a percentage of all drivers involved in fatal motor vehicle crashes. The most recent year of publicly accessible data is 2013.

Source:

National Highway Traffic Safety Administration’s (NHTSA’s) Fatality Analysis Reporting System (FARS) <http://www.nhtsa.gov/FARS>

Reference:

Wilson, F., Stimpson, J., and J. Pagan. 2014. Fatal Crashes from Drivers Testing Positive for Drugs in the U.S., 1993–2010. Public Health Reports.

Alcohol-related crime

The TN Bureau of Investigations (TBI) maintains the Tennessee Incident-Based Reporting System (TIBRS), which provides online access to annual crime statistics by county jurisdiction. The TBI TIBRS reports information on two indicators of alcohol-related crime, including alcohol violations and offenders using alcohol. Information on alcohol violations is reported by specific offense type, including driving under the influence (DUI), public intoxication, and liquor law violations. Information on offenders using alcohol is reported as the total number of criminal offenses committed by offenders who are suspected of using alcohol immediately prior to or during the commission of a criminal offense. Offense data can be disaggregated by age category (12-17 years, 18 to 20 years, 21 to 25 years, and 26 years and over) and is standardized to age-specific rates per 1,000 population. The most current year of data available is 2013.

Source:

Tennessee Bureau of Investigation Online Reports System (TIBRS) Public Statistics Web site.
<http://tennesseecrimeonline.com/>.

Prescription drug-related crime

The TN Bureau of Investigations (TBI) Criminal Justice Information Services (CJIS) Support Center operates Tennessee's Statistical Analysis Center (SAC). TBI began recording prescription-drug related offenses in 2009. The most current year of data available is 2013. The data recording the number of prescription drug-related offenses by count was made available to the PFS Rx evaluation team by special request.

Source:

Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.

Alcohol and prescription drug-related emergency room visits

The Office of Health Statistics within the Tennessee Department of Health, Division of Policy, Planning, and Assessment maintains the Hospital Discharge Data System. Although patient-level records are no longer publicly-accessible, the Office of Health Statistics will provide summary data by special request on an annual basis. The summary will provide state and county-level counts of alcohol- and prescription drug-related emergency room episodes and inpatient hospitalizations. The evaluation team has requested data within relevant age sub-categories (12-17, 18-20, 21-25, and 26 and over); however, data may be restricted due to small cell size for small population counties. Alcohol and prescription drug related hospitalizations will be identified based on relevant diagnostic codes (ICD9) as determined by the SEOW. Rates will be expressed as a standardized rate per 1,000 population.

Source:

Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospital Discharge Data System, 2009-2012. Nashville, TN.

Alcohol and prescription drug-related poisonings

The Office of Health Statistics within the Tennessee Department of Health maintains mortality statistics for Tennessee residents by cause of death; however, patient-level records are no longer publicly-accessible. The Office of Health Statistics will provide summary data by special request on an annual basis. The summary will provide state and county-level counts of mortality attributable alcohol- and prescription drug-related causes. The evaluation team has requested data within relevant age sub-categories (12-17, 18-20, 21-25, and 26 and over). Alcohol and prescription drug related deaths will be identified based on diagnostic code (ICD10) as determined by the SEOW. Rates will be expressed as an age-adjusted mortality rate per 100,000 population.

Source:

Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Death Statistical System, 2009-2012. Nashville, Tennessee.

Children Born with Neonatal Abstinence Syndrome (NAS)

The NAS Surveillance System, Birth Statistical Database within the Tennessee Department of Health began maintaining NAS birth statistics by maternal county of residence in 2013. Weekly surveillance summaries provide the number of cases by health department region. The Kids Count division of the Tennessee Commission on Children and Youth began publishing annual county-level summaries of the number of newborn babies with clinical signs of NAS and the rate of NAS births per 1,000 live births in 2013.

Source:

Tennessee Department of Health, NAS Surveillance System, Birth Statistics Database. Tennessee Kids Count Data Center.

Other archival prescription drug indicator sources

The PFS evaluation team will work closely with the SEOW to identify potential sources of state and/or local indicator data that are not explicitly required for performance measurement, but that may contribute to the needs identification and outcome monitoring processes. Potential sources include: 1) the number and percentage of alcohol and drug treatment admissions with opioids or benzodiazepines as the primary substances of abuse, 2) the number of prescription-drug related incidents of fraud or abuse reported by TennCare, 3) the number of prescriptions filled by zip code of prescriber and age group (0-17; 18-24) and rate per capita, and 4) the number of high risk prescription drug users (i.e., number of patients who have filled a prescription for opioids from 2 or more pharmacies or two or more prescribers in a 30-day period by zip code). DSAS has already initiated a formal request to access information from the Controlled Substance Monitoring Database (CSMD) that would serve as a potential data source.

Other local measures of prescription drug use

The evaluation team will also work with local coalitions to identify additional outcome measures that are used to assess the effectiveness of strategies in reaching previously underserved populations, or in producing outcomes related to SAPC goals. Examples of these measures may include surveys of medical professionals to determine changes in prescribing practices, or focus groups on higher education campuses to determine if prevention activities reached the intended age group with the desired effect. These community specific outcomes and measurement approaches

will be identified through a review of coalition logic models during the planning phases of the program.

Behavioral Health Disparities

The Tennessee Division of Substance Abuse Services has prepared a Health Disparities Impact Statement (*see attachment 4*) to describe TN PFS Rx plans to identify vulnerable sub-populations, defined by race or ethnic identification, language, socio-economic status, or sexual minority status, and to implement interventions that address health disparities and promote better health outcomes for identified groups within the ten funded communities. The impact statement defines how high need communities were selected for funding under the grant based on prescription drug availability and community impacts, discusses access and cultural appropriateness of prevention strategies and activities, and describes how the project plans to reach out to underserved groups and be responsive to their unique prevention needs.

Most coalition strategies and activities are generally implemented at the universal population level, and include information dissemination, environmental, and community based strategies. Because it is often difficult to directly observe who is reached through community-level prevention efforts, the major focus of measurement will be on the degree to which prevention strategies and activities are purposefully oriented toward vulnerable populations (e.g., social marketing campaigns that include translated materials), and the extent to which survey-based outcome indicators disaggregated by group show evidence of reductions in key outcome indicators associated with prescription drug misuse, abuse, and overdose.

The TN PFS Rx process evaluation component will address the issue of behavioral health disparities through measurement of: 1) coalition membership composition and representation of vulnerable groups in decision-making processes, 2) the numbers and types of culturally responsive interventions implemented in communities, and the 3) estimated number of individuals reached as a percentage of their proportion in the community. The key sources of data supporting the process evaluation will include records of prevention activities entered into TN-WITS and interviews with coalition membership. The outcome component will focus on measuring differences in core survey-based outcome indicators at the community level based on race and ethnic identification and sexual minority status, as measured on student and young adult surveys.

Analysis Plan

The evaluation uses a mixed-method approach that combines qualitative and quantitative research methods and techniques to measure program processes and outcomes. The analysis plan is based on a linked-process evaluation design that fits the unique needs of a community-driven, collaborative prevention effort. The linked-process design will help determine: a) if prevention system capacity improvements occurred at the state or coalition levels; b) if targeted outcomes related to prescription drug misuse, abuse, and overdose were achieved; and c) if outcomes can be reasonably attributed to project activities. These are questions traditionally addressed through experimental evaluation designs that are not well-suited to community coalition evaluations due to the multi-level, evolving nature of

strategies, and the difficulty of identifying a viable control group. Instead, the method of causal inference involves using the detailed process analysis to inform the outcome analysis by establishing the link between coalition activities and changes in prevention system capacity, and between changes in system capacity and changes in community prevalence and consequences.

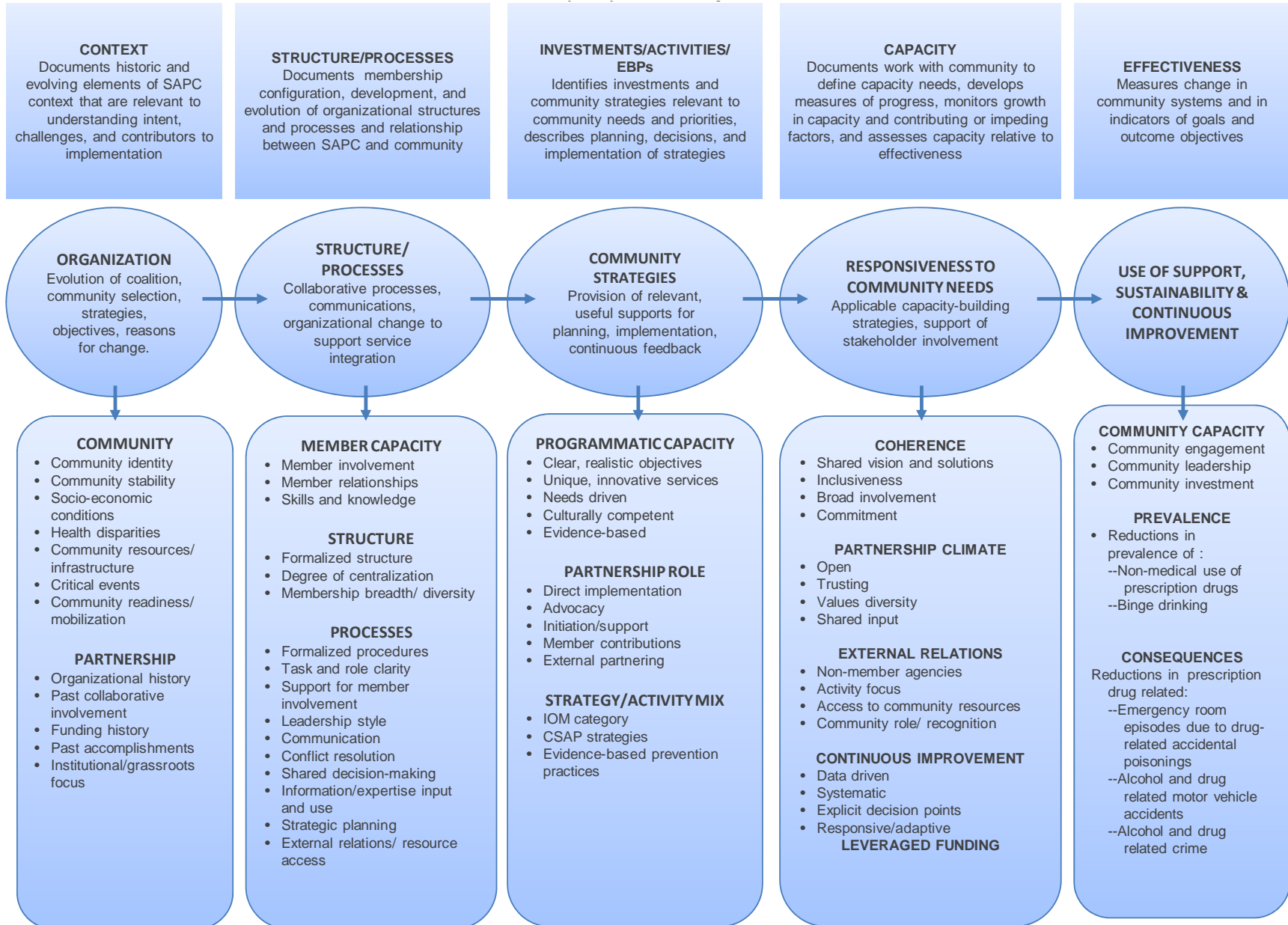
Fidelity measurement and dosage

The TN PFS Rx analysis will be guided by a conceptual framework detailed in Exhibit 5 that was developed to direct the study effort. The purpose of the framework is to establish a theoretical foundation for the TN PFS Rx program model, which helps to organize program activities and clarify relationships between coalition activities and outcomes. The conceptual model is aligned with the coalition implementation plan, which will serve as the foundation for evaluating fidelity to the program model. The implementation plan identifies each planned implementation activity by type, the associated process or output indicators, start dates, periodicity, responsible party, resources needed, expected total cost to implement, and other data elements populated from TN-WITS. Implementation plans are structured to include specific, measureable, and time-bound objectives and interim performance benchmarks that are directly linked to the intervention plan. The completed plans will provide a continuous record of inputs (i.e., resources, costs) and work accomplished (amount and quality, dosage) in implementing the activities for each plan component. The implementation plan will be reviewed in relation to information documented in quarterly reports that are submitted to the evaluation team and that will be discussed with coalition directors as part of a quarterly check-ins conducted by evaluation team staff. The purpose of this quarterly review and discussion is to assess coalition progress toward implementing elements of the prevention plan, to identify any changes to the original plan, and to assess how changes may affect the achievement of outcomes. The process analysis will additionally be informed by qualitative interviews with coalition directors and surveys with coalition membership to describe the implementation process, and to identify strengths and implementation challenges. Qualitative interview responses will be analyzed using qualitative analysis software tools to identify relevant themes.

Outcome analyses

Pre-post logic will be used to track changes in community level indicators of prescription drug misuse, abuse, and overdose, intervening variables related to prescription drug misuse, and use consequences that are reasonably linked to project activities. Data will be collected at regular intervals (e.g., quarterly, annually, or bi-annually) to allow a description of changes in community level conditions throughout the performance period and to support performance reporting requirements. This analysis should produce valid conclusions concerning the impacts of coalition activities on community conditions (providing evidence concerning the overall effectiveness of the program concept), the effectiveness of specific coalition strategies in achieving these impacts (to document lessons concerning community-wide prevention activities), and the effectiveness of specific strategies to mobilize the community and to improve community capacity. Statistical techniques used in the analysis will include descriptive statistics, cross tabulations, change analysis through calculation of effect sizes, multivariate analyses using analysis of variance, and select use of multi-level analysis (e.g., meta-analytic correlation and regression).

Exhibit 5: Tennessee Partnership for Success (PFS) SAPC Project Measurement Framework



Participation in the PFS National Cross-Site Evaluation

The TN PFS Rx Project Director and members of the evaluation team understand that all SPF-PFS grantees are required to participate in the PFS cross site evaluation and to adopt common measures and instruments to collect and report data used to monitor performance, evaluate funded programs, and meet obligations under the Government Performance and Reporting Modernization Act of 2010 (GPRAMA).

The evaluation team will support DSAS in complying with state grantee level data reporting activities, including submitting quarterly progress reports, completed the Grantee-Level Instrument-Revised (GLI-R) and participating in Project Director Interviews. The evaluation team will also work collaboratively with the ten funded coalitions to compile data supporting the completion of the SPF-PFS Community-Level Instrument. The instrument will be used to document community progress through the SPF and the implementation of specific prevention activities. Once the CLI-R has been approved by OMB, the evaluation team will conduct a full cross-walk of all components of the CLI-R with the existing data collection infrastructure (e.g., TN-WITS) to link specific items of the CLI-R with data sources. EMT will assist coalition member representatives in the collection and reporting of CLI-R measures not covered by existing grantee data collection tools and will support the grantee in the development and implementation of revised data collection tools that fully integrate the CLI-R. The CLR-R will be populated by the evaluation team on behalf of each coalition and coalition directors and members will be invited to review the instrument prior to submission to the national cross-site evaluation team.

EMT will work closely with the state DSAS and local coalitions to adhere to the Cross-Site Evaluation Data Submission Schedule by monitoring the biannual submission of the CLI-R and quarterly submissions of the Quarterly Progress Reports into the web-based Management Reporting Tool (MRT). EMT will also collect and submit community-level outcome data annually by November 1 of each year. The evaluation team will also play a lead role in preparing grantee-level outcome data, not available from the pre-populated NSDUH measures, including valid estimates of the entire grantee population, wherever possible, and aggregate epidemiological data for the sub-recipient communities.

Exhibit 6: PFS Cross-Site Evaluation Schedule

| Data Collection Type | Frequency | Responsible Party (According to PEPP) | Fiscal Year | | | | |
|---|-------------------------------|--|--|---|---|---|---|
| | | | 2014-2015 (Year 1) | 2015-2016 (Year 2) | 2016-2017 (Year 3) | 2017-2018 (Year 4) | 2018-2019 (Year 5) |
| Quarterly Progress Report | Quarterly | Submitted by Grantee Project Director or Project Coordinator | Jan. 31 2015 Apr. 30 2015 July 31 2015 | Oct. 31 2015 Jan. 31 2016 Ap. 30 2016 July 31 2016 | Oct. 31 2016 Jan. 31 2017 Ap. 30 2017 July 31 2017 | Oct. 31 2017 Jan. 31 2018 Ap. 30 2018 July 31 2018 | Oct. 31 2018 Jan. 31 2019 Ap. 30 2019 July 31 2019 |
| Grantee-Level Instrument—Revised (GLI-R) | Twice over grant period | Submitted by Grantee Project Director or Project Coordinator | April 2015 | | | | June 2019 |
| Project Director Interview | Three times over grant period | Collected by PEPP in telephone interview | Feb. 2015 | | Feb. 2017 | | June 2019 |
| Community-Level Instrument—Revised (CLI-R) | Twice each year | Entered by subrecipient community representative; submitted by Grantee Project Director or Project Coordinator | May 1 2015 | Nov. 1 2015 May 1 2016 | Nov. 1 2016 May 1 2017 | Nov. 1 2017 May 1 2018 | Nov. 1 2018 May 1 2019 Sept. 2019 |
| Community-Level Outcome Data | Annually | Grantee-level Evaluator | | Nov. 1 2015 | Nov. 1 2016 | Nov. 1 2017 | Nov. 1 2018 Sept. 2019 |
| Grantee-Level Outcome Data (Encouraged for grantees without NSDUH data) | Annually | Grantee-level Evaluator | | Nov. 1 2015 | Nov. 1 2016 | Nov. 1 2017 | Nov. 1 2018 Sept. 2019 |

Reporting Plan

The evaluation team is committed to producing interim and final products in a timely fashion that resonate with specific audiences to make the data useful and used. Moreover, the successful implementation of the evaluation and performance measurement system will require clear communication among DSAS, the SEOW, the local prevention coalitions, and the evaluation team. The evaluation team will use a variety of mechanisms to share data with PFS stakeholders, including monthly conference calls, quarterly TN WITS updates, annual evaluation reports, meeting and conference presentations, and interim data summaries, including county level reports summarizing responses to school and community based surveys. The evaluation team will work closely with grantee and sub-recipient communities to deliver timely, formative feedback that ensures accountability, knowledge development, and program improvement.

More specific details of each component of the evaluation reporting plan are discussed below:

Monthly conference calls

The PFS administrative team within DSAS conducts monthly conference calls with representatives from all subrecipient communities. The local evaluation staff member will participate in regular calls to report on the accomplished and planned evaluation activities for the month. The monthly conference call will also provide grantee and subrecipient community staff members the opportunity to ask questions and provide feedback regarding specific data collection activities.

Quarterly reporting

The evaluation team will generate TN WITS data summaries on a quarterly basis and will provide local coalitions with individual quarterly reports of key process indicators. These quarterly reports will communicate timely feedback and encourage responsive program improvement. Project-level quarterly reports will be submitted to DSAS in preparation for required cross-site evaluation MRT submission.

Conference presentations

The local evaluation staff member will attend quarterly and annual statewide meetings, including meetings of the Prevention Alliance of Tennessee, the Tennessee Prevention Advisory Council, and the TN PFS Rx Annual Retreat. At the request of key stakeholders, evaluation team members will present key outcome data to subrecipient community representatives, additional coalition grantees, and Tennessee Prevention Network prevention program providers.

Annual evaluation reports

The evaluation team will prepare annual evaluation reports for submission to DSAS and the cross-site evaluation. These annual reports will compare process and outcome measures across sub-recipient communities and/or regions to document implementation fidelity, project compliance, and outcome goal achievement.

**Attachment 1:
Partnerships for Success Rx (PFS Rx)
Tennessee Alcohol & Prescription Drug Use
Consequence Data Profile**

Partnerships for Success Rx (PFS Rx)

Tennessee Alcohol & Prescription Drug
Use Consequence Data Profile

ANDERSON COUNTY

PREPARED BY EVALUATION, MANAGEMENT, AND TRAINING (EMT)
ASSOCIATES, INC. ON BEHALF OF THE
TENNESSEE DEPARTMENT OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES (TDMHSAS)



2015

Introduction

In 2014, the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) was awarded a five-year Strategic Prevention Framework, Partnerships for Success (SPE-PFS) grant from the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the PFS grant, known locally as PFS Rx, is to reduce rates of youth and young adult prescription drug misuse, abuse, and overdose through community-based collaborative action. Ten counties in Eastern Tennessee have received funding under the grant to implement evidence-based policies and practices that have been shown to positively impact local norms, attitudes, and behaviors that support unsafe prescription drug use among youth and young adults 12 to 25 years of age.

As part of the PFS Rx initiative, funded coalitions are required to provide measurement and ongoing monitoring of community consequence indicators related to alcohol and prescription drug misuse and abuse. TDMHSAS is working to expand local prevention capacity by enhancing the data system infrastructure that supports community coalition efforts to measure trends in these targeted community outcomes. The current indicator profile was produced by the PFS Rx evaluation team at EMT Associates, Inc., in collaboration with TDMHSAS and its state agency partners. The profile was designed as a simple, easy-to-use resource to optimize prevention planning and outcome measurement at the county level by synthesizing relevant indicator data assessing the consequences of alcohol consumption and prescription drug misuse, abuse, and overdose in PFS Rx communities. The indicators selected for inclusion are part of the SPF-PFS performance measurement requirement for all funded coalitions. The profile presents historical trends and baseline rates for each coalition that will be used for future comparison in federal reporting. These include:

- **Indicator 1: Alcohol Related Motor Vehicle Crashes**
Total number of fatal and injury alcohol-involved motor vehicle accidents (i.e., alcohol presence detected, or blood alcohol content test result BAC $\geq .08$) and rate per 1,000 licensed drivers.
- **Indicator 2: Prescription-Drug Related Motor Vehicle Crashes**
Total number of drivers involved in prescription drug related fatal motor vehicle crashes and rate per 100,000 licensed drivers.
- **Indicator 3: Alcohol Related Crime – *Alcohol Violations***
Total number of criminal offenses involving alcohol violations, including driving under the influence (DUI), liquor law violations, and public drunkenness and rate per 100,000.
- **Indicator 4: Alcohol Related Crime – *Offenders Using Alcohol***
Total number of criminal offenses committed by offenders who are suspected of using alcohol immediately prior to or during the commission of a criminal offense and rate per 100,000.
- **Indicator 5: Prescription Drug Related Crime**
Total number of criminal offenses that are related to prescription-drug misuse and rate per 100,000.
- **Indicator 6: Alcohol-Related Mortality**
Total number of deaths due to alcohol-related causes by county of residence and rate per 100,000.
- **Indicator 7: Drug-Related Mortality**
Total number of deaths due to drug overdose by county of residence and rate per 100,000.
- **Indicator 8: Neonatal Abstinence Syndrome**
Total number of babies born with signs of Neonatal Abstinence Syndrome and rate per 1,000 live births.

The consequence indicator profile provides information on the consequences of underage drinking and prescription drug misuse, abuse, and overdose to county-level prevention professionals involved in data-driven strategic planning. The indicator report has been designed as a working document that will expand over time as more consequence data becomes available. We welcome your feedback and suggestions.

Indicator 1: Alcohol-related motor vehicle crashes

Baseline rate (2013): 1.1 alcohol-involved crashes per 1,000 licensed drivers and 1.5 alcohol-involved crashes per 1,000 licensed drivers 15–24 years of age (2012)

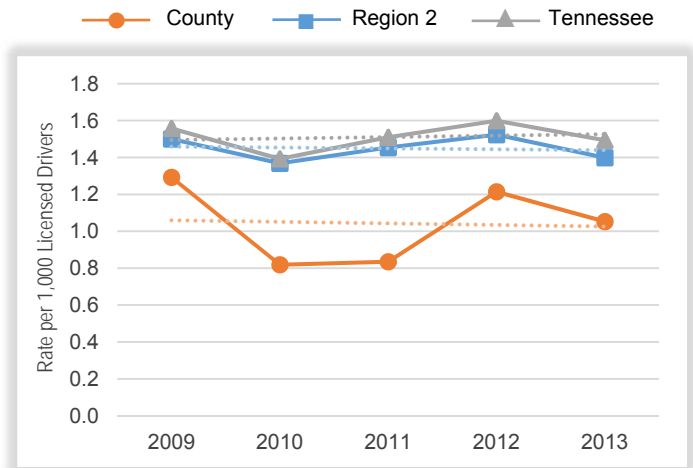
Indicator 1.1

Alcohol-related motor vehicle crashes involving drivers of all ages and rate per 1,000 licensed drivers

| Year | Crashes | County | | Region 2* | State |
|------|---------|------------------|----------------|----------------|----------------|
| | | Licensed Drivers | Rate per 1,000 | Rate per 1,000 | Rate per 1,000 |
| 2009 | 76 | 58,801 | 1.3 | 1.5 | 1.6 |
| 2010 | 48 | 58,620 | 0.8 | 1.4 | 1.4 |
| 2011 | 49 | 58,683 | 0.8 | 1.5 | 1.5 |
| 2012 | 72 | 59,298 | 1.2 | 1.5 | 1.6 |
| 2013 | 63 | 59,866 | 1.1 | 1.4 | 1.5 |

* Mental Health and Substance Abuse Services Planning Region. Region Two includes Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Jefferson, Hamblen, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union counties.

Source: Tennessee Department of Safety and Homeland Security. TITAN Database. Known-Alcohol Related: Driver Alcohol Presence indicated 'Yes' or Driver Alcohol Test Result \geq .08 BAC.



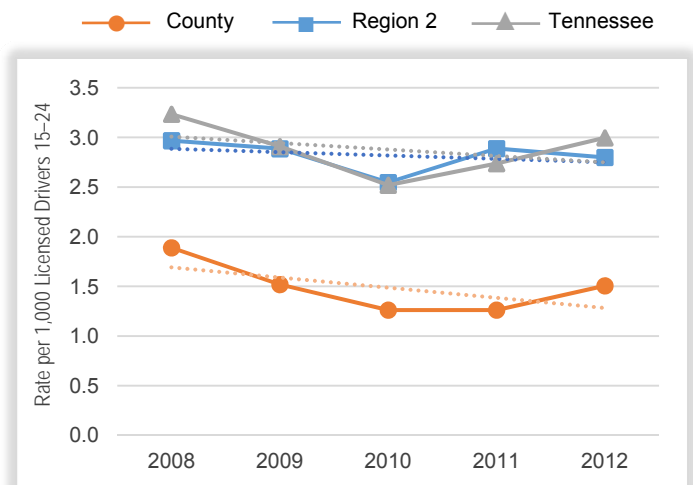
Indicator 1.2

Alcohol-related motor vehicle crashes involving drivers 15–24 years of age and rate per 1,000 licensed drivers

| Year | Crashes | County | | Region 2* | State |
|------|---------|------------------------|----------------|----------------|----------------|
| | | Licensed Drivers 15–24 | Rate per 1,000 | Rate per 1,000 | Rate per 1,000 |
| 2008 | 15 | 7,941 | 1.9 | 3.0 | 3.2 |
| 2009 | 12 | 7,901 | 1.5 | 2.9 | 2.9 |
| 2010 | 10 | 7,927 | 1.3 | 2.5 | 2.5 |
| 2011 | 10 | 7,925 | 1.3 | 2.9 | 2.7 |
| 2012 | 12 | 7,968 | 1.5 | 2.8 | 3.0 |

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Source: Governor's Highway Safety Office. Data & Statistics. Alcohol related crashes involving alcohol from ages 15–24, 2007–12.



Indicator 2: Prescription drug-related motor vehicle crashes

Baseline rate (2013): 6.7 drivers testing positive for prescription drug use involved in fatal motor vehicle crashes per 100,000 licensed drivers

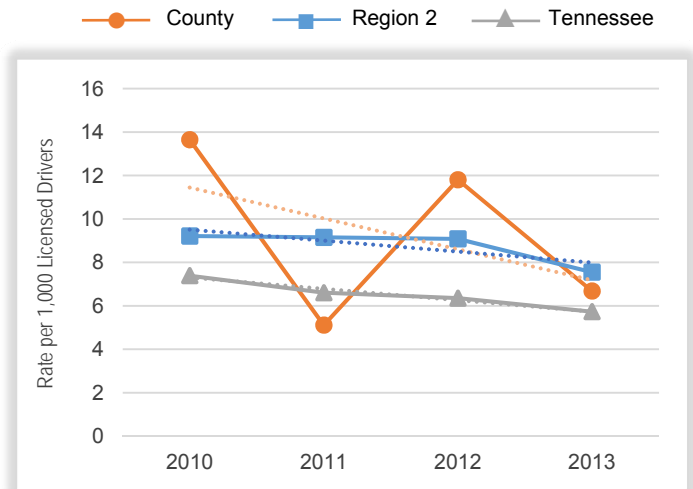
Indicator 2

Drivers involved in prescription drug-related fatal motor vehicle crashes and rate per 100,000 licensed drivers

| Year | County | | | Region 2* | State |
|------|---------|------------------|------------------|------------------|------------------|
| | Drivers | Licensed Drivers | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2010 | 8 | 58,620 | 13.6 | 9.2 | 7.4 |
| 2011 | 3 | 58,683 | 5.1 | 9.2 | 6.6 |
| 2012 | 7 | 59,298 | 11.8 | 9.1 | 6.4 |
| 2013 | 4 | 59,866 | 6.7 | 7.6 | 5.7 |

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Source: National Highway Traffic Safety Administration's (NHTSA's) Fatality Analysis Reporting System (FARS) <http://www.nhtsa.gov/FARS>.



Indicator 3: Alcohol-related crime (alcohol violations)

Baseline rate (2013): 27.0 alcohol-related offenses per 100,000 youth population 10–17 years of age and 425.1 alcohol-related offenses per 100,000 young adult population 18–24 years of age

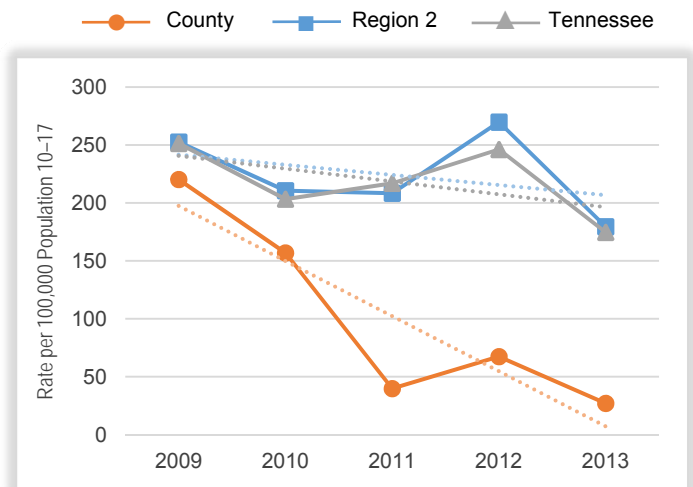
Indicator 3.1

Offenses for alcohol violations for youth (10–17) offenders and rate per 100,000 age-specific population

| Year | County | | | Region 2* | State |
|------|----------|-------------------------|------------------|------------------|------------------|
| | Offenses | County Population 10–17 | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 17 | 7,718 | 220.3 | 252.6 | 251.4 |
| 2010 | 12 | 7,648 | 156.9 | 210.6 | 203.3 |
| 2011 | 3 | 7,545 | 39.8 | 208.4 | 217.0 |
| 2012 | 5 | 7,419 | 67.4 | 269.8 | 246.1 |
| 2013 | 2 | 7,397 | 27.0 | 179.5 | 174.6 |

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Source: Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.



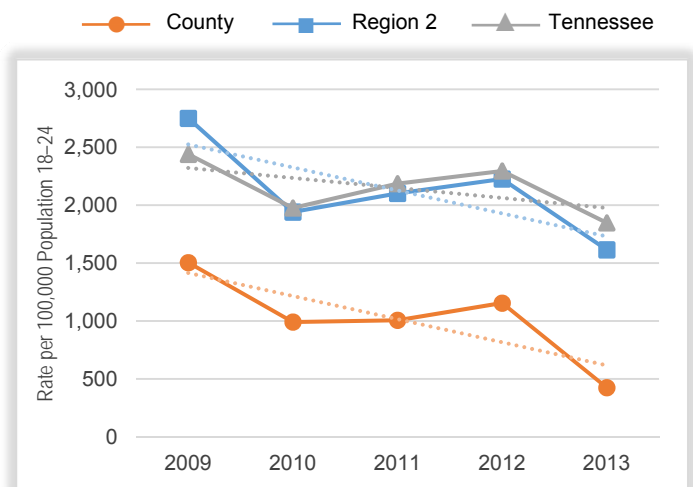
Indicator 3.2

Offenses for alcohol violations for young adult (18–24) offenders and rate per 100,000 age-specific population

| Year | County | | | Region 2* | State |
|------|----------|-------------------------|------------------|------------------|------------------|
| | Offenses | County Population 18–24 | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 87 | 5,783 | 1,504.4 | 2,750.1 | 2,439.4 |
| 2010 | 57 | 5,748 | 991.6 | 1,941.2 | 1,976.0 |
| 2011 | 60 | 5,958 | 1,007.0 | 2,101.6 | 2,186.1 |
| 2012 | 72 | 6,234 | 1,155.0 | 2,226.2 | 2,295.6 |
| 2013 | 26 | 6,116 | 425.1 | 1,614.9 | 1,847.5 |

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Source: Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.



Indicator 4: Alcohol-related crime (offenders using alcohol)

Baseline rate (2013): 40.6 alcohol-related offenses per 100,000 youth population 10–17 years of age and 637.7 alcohol-related offenses per 100,000 young adult population 18–24 years of age

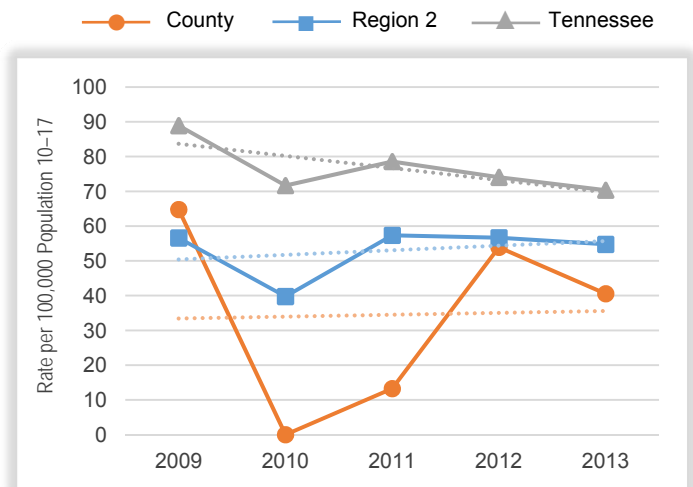
Indicator 4.1

Offenses committed under the influence of alcohol by youth (10–17) offenders and rate per 100,000 age-specific population

| Year | County | | | Region 2* | State |
|------|----------|-------------------------|------------------|------------------|------------------|
| | Offenses | County Population 10–17 | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 5 | 7,718 | 64.8 | 56.6 | 88.9 |
| 2010 | 0 | 7,648 | 0.0 | 39.8 | 71.7 |
| 2011 | 1 | 7,545 | 13.3 | 57.4 | 78.6 |
| 2012 | 4 | 7,419 | 53.9 | 56.7 | 74.1 |
| 2013 | 3 | 7,397 | 40.6 | 54.8 | 70.3 |

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Source: Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.



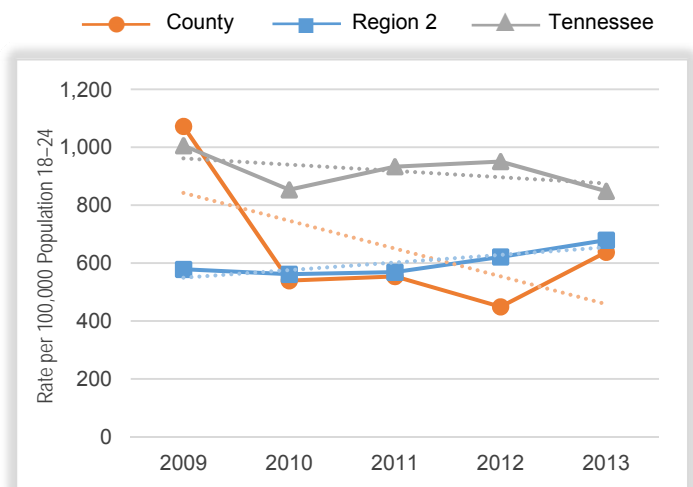
Indicator 4.2

Offenses committed under the influence of alcohol by youth (18–24) offenders and rate per 100,000 age-specific population

| Year | County | | | Region 2* | State |
|------|----------|-------------------------|------------------|------------------|------------------|
| | Offenses | County Population 18–24 | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 62 | 5,783 | 1,072.1 | 578.5 | 1,005.6 |
| 2010 | 31 | 5,748 | 539.3 | 561.5 | 853.1 |
| 2011 | 33 | 5,958 | 553.9 | 568.8 | 933.1 |
| 2012 | 28 | 6,234 | 449.1 | 621.6 | 950.8 |
| 2013 | 39 | 6,116 | 637.7 | 679.3 | 848.2 |

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Source: Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.



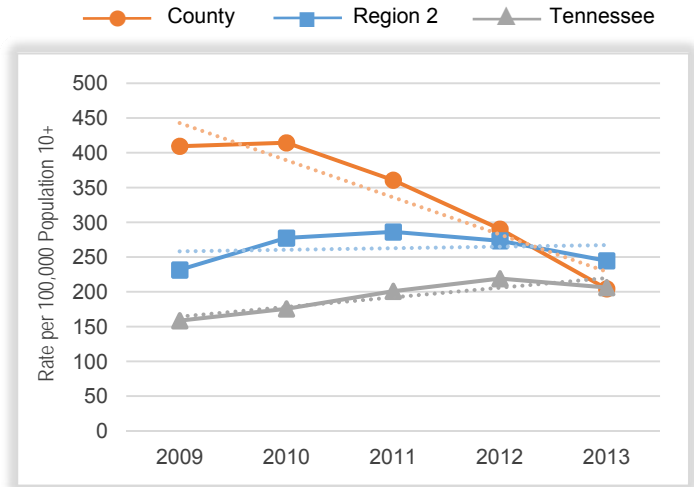
Indicator 5: Prescription-drug related crime

Baseline rate (2013): 204.4 prescription drug-related offenses per 100,000 population 10 years and older

Indicator 5

Prescription-drug related offenses and rate per 100,000 population 10 years and older

| Year | County | | | Region 2* | State |
|------|----------|-----------------------|------------------|------------------|------------------|
| | Offenses | County Population 10+ | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 271 | 66,178 | 409.5 | 231.5 | 158.5 |
| 2010 | 275 | 66,360 | 414.4 | 277.4 | 175.5 |
| 2011 | 240 | 66,545 | 360.7 | 286.2 | 200.8 |
| 2012 | 194 | 66,825 | 290.3 | 273.4 | 219.0 |
| 2013 | 137 | 67,029 | 204.4 | 244.7 | 206.2 |



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Source: Tennessee Bureau of Investigations (TBI), Criminal Justice Information System (CJIS) Support Center.

Indicator 6: Alcohol-related deaths

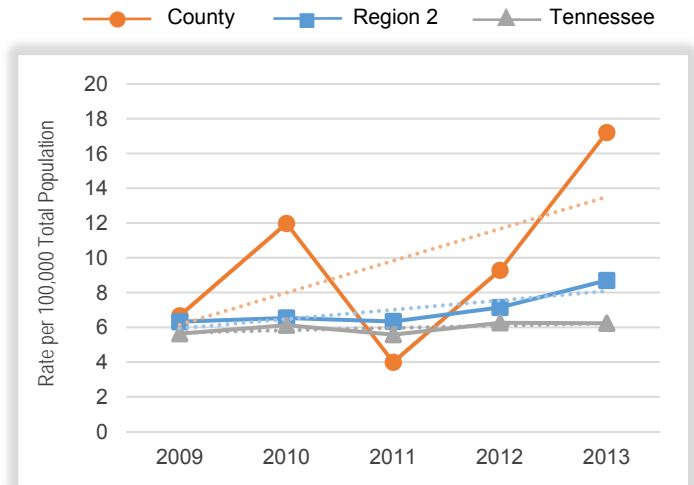
Baseline rate (2013): 17.2 alcohol-related deaths per 100,000 population

Indicator 6 Alcohol-related deaths and rate per 100,000 population

| Year | County | | | Region 2* | State |
|------|--------|-------------------------|------------------|------------------|------------------|
| | Deaths | Total County Population | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 5 | 75,031 | 6.7 | 6.3 | 5.6 |
| 2010 | 9 | 75,141 | 12.0 | 6.5 | 6.1 |
| 2011 | 3 | 75,208 | 4.0 | 6.3 | 5.6 |
| 2012 | 7 | 75,416 | 9.3 | 7.1 | 6.3 |
| 2013 | 13 | 75,542 | 17.2 | 8.7 | 6.2 |

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Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. International Classification of Diseases (ICD) version 10 cause of death codes K70, X45, X65, and Y15.



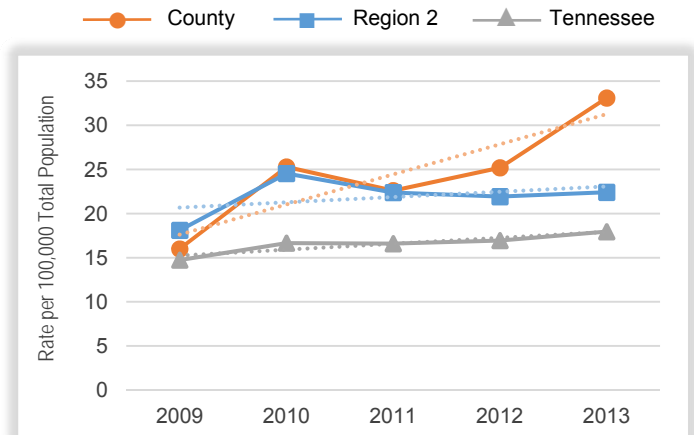
Indicator 7: Drug-related overdose deaths

Baseline rate (2013): 33.1 drug-related overdose deaths per 100,000 population

Indicator 7

Drug-related overdose deaths and rate per 100,000 population

| Year | County | | | Region 2* | State |
|------|--------|-------------------------|------------------|------------------|------------------|
| | Deaths | Total County Population | Rate per 100,000 | Rate per 100,000 | Rate per 100,000 |
| 2009 | 12 | 75,031 | 16.0 | 18.1 | 14.7 |
| 2010 | 19 | 75,141 | 25.3 | 24.5 | 16.7 |
| 2011 | 17 | 75,208 | 22.6 | 22.4 | 16.6 |
| 2012 | 19 | 75,416 | 25.2 | 21.9 | 16.9 |
| 2013 | 25 | 75,542 | 33.1 | 22.4 | 17.9 |



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Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. International Classification of Diseases (ICD) version 10 cause of death codes X40-X44, X60-X64, X85, and Y10-Y14.

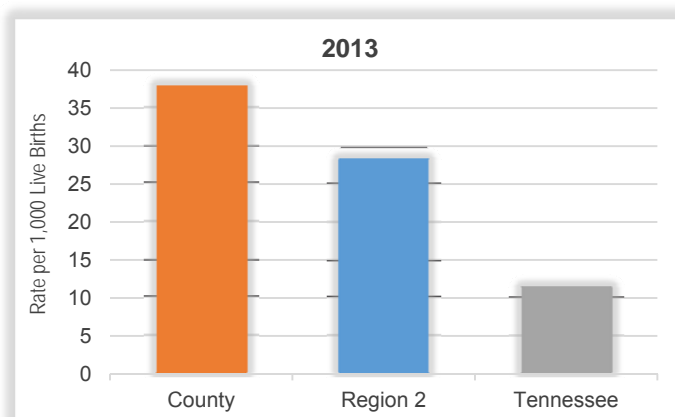
Indicator 8: Children with Neonatal Abstinence Syndrome (NAS)

Baseline rate (2013): 37.9 babies born with signs of Neonatal Abstinence Syndrome (NAS) per 1,000 live births

Indicator 8

Children born with Neonatal Abstinence Syndrome (NAS) per 1,000 live births

| Year | County | | | Region 2* | State |
|------|------------|-------------------|----------------------------|----------------------------|----------------------------|
| | NAS Births | Total Live Births | Rate per 1,000 Live Births | Rate per 1,000 Live Births | Rate per 1,000 Live Births |
| 2009 | -- | -- | -- | -- | -- |
| 2010 | -- | -- | -- | -- | -- |
| 2011 | -- | -- | -- | -- | -- |
| 2012 | -- | -- | -- | -- | -- |
| 2013 | 29 | 765 | 37.9 | 28.4 | 11.5 |



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Source: Tennessee Kids Count Data Center.

Tennessee SPF-PFS Prevention Coalition County Population and Health Disparities Subgroups

| | Tennessee | Anderson | Blount | Hamilton | Jackson | Johnson | Knox | Putnam | Smith | Sullivan | Washington |
|--|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|
| Total Population (2013) ¹ | | | | | | | | | | | |
| Total Population | 6,495,978 | 75,542 | 125,099 | 348,673 | 11,517 | 17,977 | 444,622 | 73,525 | 19,074 | 156,595 | 125,546 |
| Age (2013) ¹ | | | | | | | | | | | |
| 12–17 year olds | 507,859 | 5,574 | 9,914 | 24,377 | 856 | 1,137 | 32,131 | 5,276 | 1,651 | 11,409 | 8,602 |
| 18–25 year olds | 716,245 | 7,020 | 11,696 | 39,480 | 998 | 1,579 | 60,627 | 12,054 | 1,728 | 14,056 | 17,403 |
| Race and Ethnic Origin (2013) ¹ | | | | | | | | | | | |
| White | 75.8% | 91.3% | 92.5% | 72.5% | 96.9% | 95.2% | 84.4% | 90.1% | 94.1% | 94.7% | 90.6% |
| Black or African American | 17.3% | 4.6% | 3.1% | 20.1% | 0.8% | 2.6% | 9.3% | 2.5% | 2.6% | 2.5% | 4.5% |
| Hispanic or Latino | 4.9% | 2.4% | 3.0% | 4.9% | 1.7% | 1.7% | 3.7% | 5.7% | 2.7% | 1.7% | 3.1% |
| Asian or Pacific Islander | 1.8% | 1.3% | 1.0% | 2.2% | 0.2% | 0.3% | 2.3% | 1.4% | 0.3% | 0.8% | 1.4% |
| American Indian or Alaska Native | 0.3% | 0.3% | 0.3% | 0.3% | 0.5% | 0.2% | 0.3% | 0.3% | 0.4% | 0.3% | 0.3% |
| Income and Poverty (2013) ² | | | | | | | | | | | |
| Children in Poverty | 26.5% | 29.8% | 20.3% | 25.8% | 39.9% | 38.3% | 20.3% | 35.6% | 24.3% | 27.9% | 23.5% |
| Per Capita Income | \$39,558 | \$39,148 | \$35,310 | \$42,352 | \$33,807 | \$27,077 | \$41,533 | \$35,078 | \$34,371 | \$37,074 | \$37,387 |
| Urban/Rural (2010) ³ | | | | | | | | | | | |
| Urban Population | 4,313,329 | 49,329 | 84,317 | 313,806 | 0 | 2,661 | 396,158 | 47,791 | 3,262 | 116,507 | 92,402 |
| Urban Percent | 66.4% | 65.3% | 67.4% | 90.0% | 0.0% | 14.8% | 89.1% | 65.0% | 17.1% | 74.4% | 73.6% |
| Rural Population | 2,182,649 | 26,213 | 40,782 | 34,867 | 11,517 | 15,316 | 48,464 | 25,734 | 15,812 | 40,088 | 33,144 |
| Rural Percent | 33.6% | 34.7% | 32.6% | 10.0% | 100.0% | 85.2% | 10.9% | 35.0% | 82.9% | 25.6% | 26.4% |
| Education | | | | | | | | | | | |
| High School Enrollment (2013) ⁴ | 281,968 | 3,544 | 5,255 | 11,931 | 478 | 663 | 17,098 | 3,201 | 928 | 6,522 | 5,072 |
| Dropout Rate (2012) ² | 6.8% | 4.7% | 5.6% | 9.9% | 8.6% | 2.2% | 5.4% | 4.8% | 4.7% | 4.7% | 3.0% |
| Special Populations (2013) | | | | | | | | | | | |
| LGBTQ Youth and Young Adult Population (est.) ⁵ | 42,844 | 441 | 756 | 2,235 | 65 | 95 | 3,247 | 607 | 118 | 891 | 910 |
| Military Veterans ⁶ | 508,445 | 8,017 | 11,926 | 26,414 | 917 | 1,618 | 34,316 | 5,423 | 1,443 | 14,748 | 11,564 |

Sources:

¹ Centers for Disease Control and Prevention (CDC) Wonder, Bridged-Race Population Estimates 1990-2013 Request <http://wonder.cdc.gov/Bridged-Race-v2013.html>.

² Tennessee Kids Count Data Center, <http://datacenter.kidscount.org/data#TN/5/0>.

³ U.S. Census, 2010 Census.

⁴ Tennessee Department of Education, 2013 School-level Membership File, http://tn.gov/education/data/download_data.shtml.

⁵ Calculated according to estimated LGBTQ population (3.5% of total population).

⁶ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, Population Tables, Counties http://www.va.gov/vetdata/Veteran_Population.asp.

**Attachment 2:
PFS Rx Student Survey
School Sampling Plan**

PFS Rx Student Survey School Sampling Plan

| | 8th Population | Target Sample | | Sampling Pool | | School Count |
|-------------------|-------------------|---------------|--------------|---------------|---------------|-----------------|
| | | 10% | 50% | | | |
| Anderson County | 917 | 446 | 664 | 637 | 949 | 5 |
| Blount County | 1,522 | 552 | 932 | 789 | 1,331 | 3 |
| Hamilton County | 3,218 | 682 | 1376 | 974 | 1,966 | 7 |
| Jackson County | 124 | 109 | 118 | 156 | 169 | 2 |
| Johnson County | 167 | 141 | 157 | 201 | 224 | 1 |
| Knox County | 4,376 | 722 | 1551 | 1,031 | 2,216 | 3 |
| Putnam County | 814 | 420 | 609 | 600 | 870 | 4 |
| Smith County | 270 | 206 | 243 | 294 | 347 | 6 |
| Sullivan County | 1,685 | 572 | 991 | 817 | 1,416 | 7 |
| Washington County | 1,268 | 515 | 830 | 736 | 1,186 | 4 |
| | 14,361 | 4,365 | 7,471 | 6,236 | 10,673 | 42 |

| | 10th/12th Population | Target Sample | | Sampling Pool | | School Count |
|-------------------|-------------------------|---------------|---------------|---------------|---------------|-----------------|
| | | 15% | 50% | | | |
| Anderson County | 1,772 | 725 | 1,020 | 1,036 | 1,457 | 2 |
| Blount County | 2,604 | 834 | 1,250 | 1,191 | 1,786 | 3 |
| Hamilton County | 5,700 | 1,009 | 1,690 | 1,441 | 2,414 | 5* |
| Jackson County | 235 | 198 | 215 | 235 | 235 | 1 |
| Johnson County | 311 | 249 | 276 | 311 | 311 | 1 |
| Knox County | 8,561 | 1,072 | 1,876 | 1,531 | 2,680 | 3 |
| Putnam County | 1,553 | 685 | 944 | 979 | 1,349 | 3 |
| Smith County | 494 | 353 | 410 | 495 | 495 | 2** |
| Sullivan County | 3,254 | 890 | 1,382 | 1,271 | 1,974 | 4 |
| Washington County | 2,547 | 828 | 1,237 | 1,183 | 1,767 | 3 |
| | 27,031 | 6,843 | 10,300 | 9,674 | 14,468 | 27 |

*Includes a duplicate count of 3 schools included in 8th Grade Sample

**Includes a duplicate count of 1 school included in 8th Grade Sample

95% confidence interval with a 2% margin of error

Response distribution range from 15 to 50%

PFS Rx Student Survey Schools

| County | ID | School Name | Grade |
|---------------|---------------------|-------------------------------------|--------------------------|
| Anderson | 85 | Norwood Middle School | 8th Grade |
| | 20 | Clinton Middle School | 8th Grade |
| | 55 | Lake City Middle School | 8th Grade |
| | 75 | Norris Middle School | 8th Grade |
| | 40 | Robertsville Middle School | 8th Grade |
| | 35 | Oak Ridge High School | 10th and 12th Grade |
| | 25 | Clinton High School | 10th and 12th Grade |
| Blount | 23 | Carpenters Middle School | 8th Grade |
| | 20 | Maryville Junior High School | 8th Grade |
| | 84 | Union Grove Middle School | 8th Grade |
| | 15 | Maryville High School | 10th and 12th Grade |
| | 10 | Alcoa High School | 10th and 12th Grade |
| | 155 | William Blount High School | 10th and 12th Grade |
| Hamilton | 41 | Normal Park Museum Magnet School | 8th Grade |
| | 129 | Hixson Middle School | 8th Grade |
| | 200 | Orchard Knob Middle | 8th Grade |
| | 75 | East Ridge Middle School | 8th Grade |
| | 165 | Lookout Valley Middle - High School | 8th, 10th and 12th Grade |
| | 45 | Chatt High Center For Creative Arts | 8th, 10th and 12th Grade |
| | 59 | East Hamilton School | 8th, 10th and 12th Grade |
| | 175 | Red Bank High School | 10th and 12th Grade |
| 40 | Central High School | 10th and 12th Grade | |
| Jackson | 50 | Jackson County Middle School | 8th Grade |
| | 10 | Dodson Branch Elementary | 8th Grade |
| | 5 | Jackson County High School | 10th and 12th Grade |
| Johnson | 16 | Johnson Co Middle School | 8th Grade |
| | 15 | Johnson Co High School | 10th and 12th Grade |
| Knox | 313 | West Valley Middle School | 8th Grade |
| | 122 | Holston Middle School | 8th Grade |
| | 14 | Bearden Middle School | 8th Grade |
| | 100 | Gibbs High School | 10th and 12th Grade |
| | 90 | Fulton High School | 10th and 12th Grade |
| | 305 | West High School | 10th and 12th Grade |
| Putnam | 25 | Burks Elementary | 8th Grade |
| | 8 | Algood Middle School | 8th Grade |
| | 65 | Avery Trace Middle School | 8th Grade |
| | 85 | Cornerstone Middle | 8th Grade |
| | 90 | Upperman High School | 10th and 12th Grade |
| | 55 | Monterey High School | 10th and 12th Grade |
| | 37 | Cookeville High School | 10th and 12th Grade |

| County | ID | School Name | Grade |
|---------------|-----------|------------------------------|--------------------------|
| Smith | 15 | Defeated Elementary | 8th Grade |
| | 20 | Forks River Elementary | 8th Grade |
| | 35 | New Middleton Elementary | 8th Grade |
| | 60 | Union Heights Elementary | 8th Grade |
| | 51 | Smith County Middle School | 8th Grade |
| | 25 | Gordonsville High School | 8th, 10th and 12th Grade |
| | 45 | Smith County High School | 10th and 12th Grade |
| Sullivan | 175 | Sullivan Gardens K-8 | 8th Grade |
| | 150 | Mary Hughes School | 8th Grade |
| | 210 | North Middle School | 8th Grade |
| | 100 | Holston Middle School | 8th Grade |
| | 40 | Robinson Middle School | 8th Grade |
| | 75 | Colonial Heights Middle | 8th Grade |
| | 30 | Blountville Middle School | 8th Grade |
| | 60 | Sullivan Central High School | 10th and 12th Grade |
| | 183 | Sullivan South High School | 10th and 12th Grade |
| | 60 | Cora Cox Academy | 10th and 12th Grade |
| | 182 | Sullivan North High School | 10th and 12th Grade |
| Washington | 30 | Boones Creek Middle School | 8th Grade |
| | 110 | West View School | 8th Grade |
| | 35 | Liberty Bell Middle School | 8th Grade |
| | 65 | Jonesborough Middle School | 8th Grade |
| | 105 | University School | 10th and 12th Grade |
| | 38 | David Crockett High School | 10th and 12th Grade |
| | 37 | Daniel Boone High School | 10th and 12th Grade |

**Attachment 3:
Training and Technical Assistance
(TA) Plan**

Training and Technical Assistance Plan

The following training and technical assistance activities will be offered in FY 16:

- Substance Abuse Prevention Skills Training (SAPST) – SAPST is an introduction to the fundamentals of substance abuse prevention based on best practices. This four day training is endorsed by the TN IC&RC affiliate and provides new coalitions and/or prevention staff with a foundational knowledge for prevention work in their service area.
- Strategic Prevention Framework (SPF) Training – provided for coalitions members and staff is an advanced course that combines didactic instruction, relevant field work and individual technical assistance throughout the process. The five classroom sessions include:
 - Community Assessment Strategies
 - Capacity Assessment Strategies and logic models
 - Strategic Planning
 - Implementation/Action Planning
 - Evaluation

Following each session participants demonstrate their mastery of the subject material by completing the require activity (i.e. assessment, planning...) using the state’s SPF forms. At the beginning of each new session participants report on their activities/barriers and provide their documents for review. TA is provided throughout this process to ensure that learned information and activities are understood in the context of the community setting. The training results in a completed SPF process and community implementation of prevention activities.

- Coalition Management Techniques – provided for community members and staff to better understand the roles of fiscal agents, Executive Committee members, staff, and coalition members. This training provides the foundation for development of Coalition By-laws and membership standards.
- Budgeting and Fiscal Management – provided for Executive Committee members and staff to better understand the state’s budgeting process, budget revisions, fiscal records, and state monitoring.
- Technical Assistance is provided either at the request of a coalition or state staff based on their observation of performance. Services are delivered either onsite or through electronic methods depending on the nature and complexity of the assistants required. Areas of TA are all facets of a coalition’s functional and operational area including:
 - SPF process such as completing planning efforts, revisions to plans, data collection and evaluation among others;
 - Facilitation of planning groups for development of Coalition By-laws, communication plans, and sustainability planning among others;
 - Management of members (i.e. workgroup development, volunteer recruitment, meaningful roles...):
 - Effective media use and messages;
 - Data sources and uses
 - Grant writing and fund raising
 - Policy development and the legislative process

The list of TAs is an example of those areas that have been provided but it is not all inclusive of available supports. The goal of the TA effort is to provide just in time support to meet the coalition “where it is” in its prevention effort.

**Attachment 4:
Health Disparities Impact Statement**

Rx Drug- Partnerships for Success TN (TN PFS-Rx) Health Disparities Impact Statement

Grant Number: 1U79SP020699-01

DATA:

Definition of High Need Community: Counties included in the TN PFS Rx grant had three or more areas equal to or greater than the state rate in the following categories:

- Pain Clinics per 100,000 (TN Department of Health)
- Prescription dispense rates per capita (TN Department of Health, Controlled Substance Monitoring Database)
- Percent of admissions for primary prescription opioid treatment (TN Department of Mental Health and Substance Abuse Services, TN-WITS)
- Overdose deaths per 100,000 (TN Department of Health)
- Neonatal Abstinence Syndrome Births per 100,000 (TN Department of Health)
- Percent of population below the poverty level (US Census)

Demographics:

| Table 1: Race | | Tennessee | PFS Rx Communities |
|---|---------|------------------|---------------------------|
| White | Number | 4,921,948 | 1,215,225 |
| | Percent | 77.6% | 86.3% |
| Black | Number | 1,057,315 | 123,606 |
| | Percent | 16.7% | 8.8% |
| American Indian or Alaska Native | Number | 19,994 | 4,485 |
| | Percent | 0.3% | 0.3% |
| Asian | Number | 91,242 | 19,166 |
| | Percent | 1.4% | 1.4% |
| Native Hawaiian and Other Pacific Islander | Number | 3,642 | 843 |
| | Percent | 0.1% | 0.1% |
| One race - Some Other Race | Number | 141,955 | 20,765 |
| | Percent | 2.2% | 1.5% |
| Two or More Races | Number | 110,009 | 23,678 |
| | Percent | 1.7% | 1.7% |

Source: Census (2010)

| Table 2: Ethnicity | | Tennessee | PFS Rx Communities |
|-------------------------------|---------|------------------|---------------------------|
| Hispanic or Latino | Number | 290,059 | 47,331 |
| | Percent | 4.6% | 3.4% |
| Not Hispanic or Latino | Number | 6,056,046 | 1,360,437 |
| | Percent | 95.4% | 96.6% |

Source: Census (2010)

Table 3: Language spoken at home

| | | Tennessee | PFS Rx Communities |
|-----------------------------|---------|-----------|--------------------|
| English only | Number | 5,557,499 | 1,223,453 |
| | Percent | 93.4% | 94.8% |
| Language other than English | Number | 389,694 | 66,544 |
| | Percent | 6.6% | 5.2% |

Source: American Community Survey (2006-2010)

Table 4: Age Groups

| | | Tennessee | PFS Rx Communities |
|-----------|---------|-----------|--------------------|
| Age 0-4 | Number | 407,813 | 62,048 |
| | Percent | 6.4% | 5.7% |
| Age 5-9 | Number | 412,181 | 64,572 |
| | Percent | 6.5% | 6.0% |
| Age 10-14 | Number | 418,941 | 65,758 |
| | Percent | 6.6% | 6.1% |
| Age 15-19 | Number | 437,186 | 72,974 |
| | Percent | 6.9% | 6.7% |
| Age 20-24 | Number | 426,244 | 79,024 |
| | Percent | 6.7% | 7.3% |
| Age 25+ | Number | 4,243,740 | 738,567 |
| | Percent | 66.9% | 68.2% |

Source: Census (2010)

Table 5: Socioeconomic status

| | Percentage of families and people whose income in the past 12 months is below the poverty level | | | |
|------------|---|-------------------|----------------|---------------------------------------|
| | All families | 18 years and over | 18 to 64 years | 18 years and over - 65 years and over |
| Tennessee | 12.4% | 14.3% | 14.9% | 11.5% |
| Anderson | 12.4% | 13.9% | 14.7% | 11.1% |
| Blount | 9.0% | 10.4% | 11.3% | 6.8% |
| Hamilton | 11.1% | 12.6% | 13.5% | 8.8% |
| Jefferson | 13.1% | 16.1% | 17.4% | 10.9% |
| Johnson | 19.5% | 20.8% | 22.3% | 16.0% |
| Knox | 9.1% | 12.7% | 13.7% | 7.7% |
| Putnam | 14.4% | 20.3% | 22.0% | 13.0% |
| Smith | 14.4% | 16.1% | 16.9% | 12.6% |
| Sullivan | 12.2% | 14.1% | 15.3% | 9.9% |
| Washington | 11.6% | 15.7% | 16.7% | 11.2% |

Source: American Community Survey (2006-2010)

| Table 6: Sexual identity (sexual orientation & gender identity) | | Tennessee | PFS Rx Communities |
|--|---------|------------------|---------------------------|
| Adult Tennesseans that identify as lesbian, gay, or bisexual | Number | 163,449 | 28,616 |
| | Percent | 3.50% | 3.50% |
| Adult Tennesseans that are transgender | Number | 14,010 | 2,453 |
| | Percent | 0.3% | 0.3% |

Source: Census (2010); The Williams Institute, UCLA School of Law (2011)

ACCESS:

Policy, Practice, Programs and strategies that will be implemented

Tennessee’s PFS Rx coalitions will implement evidence-based strategies based on their community’s unique “local contributing factors” as identified in logic models and derived from an assessment of community and regional conditions. A project wide implementation plan is in the final stages of development for this project and that plan is attached. The plan is focused on decreasing the likelihood of misuse, abuse, and overdose of prescription drugs and the intervening variables for the plan include medical and non-medical access to prescription drugs. The plan is based around CADCA’s seven strategies for changing community conditions and behavior including: 1) provide information; 2) build skills; 3) provide support; 4) increase barriers to access and decrease barriers to services; 5) change consequences and incentives; 6) change the physical design of the environment; and 7) change policies. *Please note, the implementation plan is still in development and is subject to modifications.*

The following are key components of the plan: Changing statewide policies regarding the Intractable Pain Act and the Good Samaritan Law; working with medical providers around the Neonatal Abstinence Syndrome problem in the state by sharing prevention information including the importance of not prescribing narcotics to women of childbearing age; activities that focus on increasing the number of disposal options available for prescription drugs as well as safe storage of prescription drugs in homes.

SPF Purpose and ultimate goal of implementation

The purpose of implementing the SPF is to ensure that the strategies and practices implemented as part of the PFS Rx Grant are effective, culturally appropriate, and sustainable. The SPF is a 5-step planning process that includes a comprehensive community assessment that guides the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The assessment will help communities discern what their community looks like in terms of who makes up their community as well as the community consumption patterns or the way people drink, smoke and use illicit drugs. This information will ensure that the strategies that are implemented are designed specifically to prevent others from using substances in a similar manner.

The ultimate goal of SPF implementation is outcomes based prevention that focuses on population level change, emphasizing data-driven decision making. Cultural competence is a key portion of the SPF that is part of each step of the process and is always a key consideration.

Plan to develop and implement policies/ procedures to ensure adherence to the Enhance Culturally and Linguistically Appropriate Services (CLAS) Standards with the grant program for the provision of effective services.

As described above, the SPF approach will assure that activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. PFS Rx project staff will provide training and technical assistance to all sub-recipients (i.e. 10 community coalitions) to ensure each site is meeting the cultural and linguistic needs of their community. Additionally, coalitions are by their nature, made up of the community and understand that real change happens when the community is part of the assessment, planning and implementation. The phrase “Nothing about us without us” easily applies to coalition work. Thus, coalitions understand the importance of looking at the makeup of their advisory board and workgroups to ensure that the cultural and linguistic needs of their community are represented. Also inherent in community coalition’s work is the importance of strategic partnership and collaborations with diverse groups that truly represent the population and needs in their community. Coalitions have long understood that making change involves support and buy-in from all members of the community and have sought to make decisions that are built on collaboration and a spirit of win-win.

A continuous quality improvement approach will be used to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. We will use program data to monitor and manage program outcomes within a quality improvement process. We will make programmatic adjustments as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of our data collection and reporting will be to monitor/ measure project activities to optimize the usefulness of data for project staff and community members. We will also integrate evaluation findings into program planning and management on an ongoing basis (a “self-correcting” model of evaluation).

Adherence to CLAS Standards

- a. Diverse cultural health beliefs and practices- As described above, the SPF process begins with assessment. This assessment will uncover the unique health beliefs and practices of the communities that are part of this grant. The coalitions will then implement plans that are based on their knowledge of cultural health beliefs and practices.
- b. Preferred languages- Again, as described above our coalitions will assess their communities and have a grasp on the specific languages that are unique to their area. Coalitions understand that if they are truly going to make community level change it will be essential to reach people of all languages. Coalitions will be encouraged to translate key informational materials into languages that are reflective of their community.
- c. Health literacy and other communication needs of all sub-populations identified in your proposal- Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (U.S. Department of Health and Human Services. 2000). One important aspect of health literacy is numeracy skills including the ability to understand statistical averages. One of the key jobs of a coalition is to share information in a way that broadens a community’s understanding of the alcohol

and drug use in their community. Coalitions are trained on the importance of effective communication with an emphasis on social norms techniques.

USE/REACH:

Process for collecting data on populations reached

Demographic information is collected via the TN-WITS system. The following demographic information is collected: race, ethnicity, age, and gender.

How will you monitor the implementation of the grant and the use/ reach of disparate population in the grant program?

TN-WITS information is regularly monitored and will be compared against the disparate populations to ensure we are adequately serving those individuals.

OUTCOME:

Describe how you will use data or outcomes regarding disparate populations (race, ethnicity, LGBT status, etc.) to evaluate processes or make programmatic adjustments to address identified priorities and issues

Coalition work generally is at the population level. Thus, we are working to serve the population through information dissemination, environmental, and community based strategies. Population level strategies do not always allow for knowing exactly who is being impacted by coalition work. But, every effort will be made through the grant to reach out to disparate populations to ensure they are receiving the information. Thus, we will regularly review the data from TN-WITS about which populations are being served and compare that information against the disparate populations to ensure we are adequately serving those individuals.

**Attachment 5:
Confidentiality and Human Subjects
Protections Statement**

RESPONSES TO SAMSHA'S REQUEST FOR INFORMATION ON PFS PRIVACY, CONFIDENTIALITY, AND CONSENT PROCEDURES

1. Protect Clients and Staff from Potential Risks

The data used to support the SPF-PFS performance monitoring and evaluation system will be collected from three categories of respondents: employees of state agencies and agencies that participate in local coalitions, coalition volunteers, and students, young adults, and other community members who are participants in PFS sponsored activities or are members of populations of focus in the community. The SPF-PFS DSAS does not foresee any potential for serious physical, medical, psychological, social or legal risk or adverse effect to any of these respondent groups as the result of the project itself or any data collection activity.

Employees of state agencies, agencies that participate in local coalitions, and employees of coalitions themselves will be asked to report on perceptions and observations concerning coalition capacity and activities. No significant physical, medical, psychological, social or legal risks are posed for these participants. Informed participation statements will ensure that no work-related risks are present. Information will also be collected from coalition volunteers, with similar low levels of risk. They will be provided with informed consent forms explaining the purposes and use of the information they provide.

The final set of informants will be students, young adults, and other community members who are participants in sponsored activities or members of target groups in the community. While risks are very slight for this group, some reluctance or discomfort in providing some of the information may be experienced. For all data collection activities, informed consent (e.g., verbal assurances) will provide full information on the purpose and use of the data, and assure that all responses are voluntary. Students who are minors will not participate without signed parental consent (sample attached). For parents of youth in selected schools or classrooms, letters from the school principal asking them to approve their child's participation, identifying any potential risk, and assuring that there are no consequences of refusal will be sent home along with consent forms. Additional protections from risk for students completing questionnaires will include blank sheets that can be used to shield answers from others, anonymity ensured by no collection of personal identifiers, administration in privacy with trained proctors that will not circulate in the room and will answer questions in neutral and unbiased language, and aggregate reporting of data (no cell sizes less than five). In the highly unlikely event that an adverse event is experienced for any individual because of data collection (e.g., psychological stress), the event will be reported to the project director, appropriate services will be provided at project expense. The student survey instrument will also be pre-approved by state and school system officials prior to its administration and copies of the survey form will be available for review at each participating school site and district office. Parents and participants will be offered the name of a person within DSAS to contact if they have questions about their child's rights.

2. Fair Selection of Participants

The population of focus for the PFS project includes youth and young adults 10-25 years of age who reside in the Eastern Tennessee region of the state, including the targeted counties of Anderson, Blount, Hamilton, Jackson, Johnson, Knox, Putnam, Smith, and Sullivan. Subpopulations of focus within the identified communities will include youth and young adults at risk for health disparities, defined based on group characteristics, such as race/ethnicity, economic disadvantage, language preference, or sexual orientation. No individuals or categories of participants will be excluded from participating in the PFS project services.

Although specific implementation strategies have not yet been selected and will be determined through the coalition implementation plan development, it is anticipated that a core implementation approach will be to adopt universal prevention and policy-oriented strategies that focus on entire communities. Selected prevention strategies may be purposefully targeted toward specific sub-populations, for example, pregnant women within the targeted age range who are at risk for Neonatal Abstinence Syndrome (NAS), prescribing medical professionals, or young adults on college campuses. These are populations that have heightened risk for prescription drug misuse or its consequences and/or who are the populations of focus for education and outreach campaigns. Outreach strategies to recruit and select participants for any selected or indicated interventions will be established through the comprehensive planning process, and will be inclusive of all youth and young adult populations.

There will be no exclusion criteria for individuals applied in any data collection procedures. Selection for staff and key stakeholders will be for all members of the defined group; for volunteers in designated coalition organizational positions the same process will be used. For other volunteers the procedure will be primarily self selection with data response opportunities being made available to all members and participation at their discretion. For students, participation will be for all members of schools or classrooms randomly selected for administration of the survey. For other community members, selection may be receipt of e-mails inviting participation for all members of designated groups for whom e-mail contact information is available, or by voluntary access to a publicly announced web-site connection. In all cases participation is voluntary with informed consent statements available (signed parental consent for minor students).

3. Absence of Coercion

All participants will be informed verbally or through written statements that their participation in data collection, or responding to specific questions, is completely voluntary. Those who work as staff or volunteers will be assured that refusing participation has no impact on employment considerations are on participation in voluntary positions. Those respondents who are service recipients or beneficiaries will be assured that they will receive services or benefits without consideration of participation in data collection. Coalition plans will indicate any local services in which participation is required in any way (e.g., court mandate) and will include procedures for informing and ensuring these participants that participation in data collection is completely voluntary, and that services will be delivered as usual if they refuse to participate.

Students administered student survey forms will be notified on consent forms and at the time of the data collection that their participation is completely voluntary. Students will be informed that they can skip any question that they do not wish to answer and may stop taking the survey at any point without penalty.

There are no plans to compensate individuals for their participation in the data collection activities.

4. Data Collection

The proposed data collection components are tentative, and may be refined through the SAPC implementation plan development and evaluation planning process. However, DSAS anticipates that the data collection will minimally involve all community coalition directors, participating coalition members, youth attending participating middle schools and high schools within the

targeted region, medical professionals, and youth on higher education campuses. Data sources will include archival records, written and electronic surveys, in-depth telephone interviews state agency and coalition staff, documentation of coalition meeting minutes and attendance, review and coding of implementation plans and quarterly progress reports, and records of coalition implementation activities.

To ensure that data collection procedures do not infringe privacy or confidentiality, and pose no risk to participants, EMT will provide on-line and webinar training on administration procedures for all data collection, state or local, that is not conducted by EMT staff (who are thoroughly trained). EMT will also maintain an information line that will respond to questions concerning procedure from non-staff persons responsible for collecting data. Data collection procedures will fully protect privacy and confidentiality as described in the following sub-section.

Student surveys will be administered anonymously and student responses will be analyzed in aggregate to protect confidentiality. No specimens will be collected from study participants. Sample data collection instruments and interview protocols are provided in Attachment 2.

5. Privacy and Confidentiality

Privacy and confidentiality through informed consent and data collection procedures have been detailed in previous sections. With respect to data management and other protections, the following steps will be taken. 1) No names of personal identifiers will be collected on any student or public participant data. Data will be anonymous and cannot be linked to any individual. 2) When identification data is present (e.g., specified staff roles) they will be stripped from data and replaced with id #'s. Logs of #'s and identifiers will be stored under lock and key. 3) All electronic data or participant list files will be password-protected, and limited to designated secure servers. 4) All hard copy, completed data collection instruments will be kept under lock and key and destroyed after three years. 5) All staff who collect data or have access to data will sign pledges of confidentiality. 6) No data will be reported on individuals or in cell sizes less than five.

How you will use data collection instruments?

The key source of community-level data supporting outcome measurement for the SPF-PFS project is a school-based survey of middle school and high school students attending schools in participating PFS communities. The PFS student survey is an anonymous, paper-and-pencil survey instrument that captures data on prevalence, attitudes, and social norms related to prescription drug misuse. The PFS student survey will be administered biannually in the fall semester to students in grades 8, 10, and 12. Completed paper-and-pencil survey forms will be shipped to the evaluation subcontractor's corporate offices for scanning, data management, and analysis. Information gathered on the student survey will be analyzed and summarized at the school, community, and project-wide level.

Where will electronic data be stored and what security measures will be implemented to ensure that there will not be a data breach?

The evaluation subcontractor, EMT Associates, Inc., maintains secure facilities and has established protocols for ensuring the security of electronic data. EMT's server is housed in locked server room and administrative privileges are limited to IT staff. All computer systems within EMT's network are protected by a network firewall, using current and up to date configurations. Regularly scheduled security and vulnerability assessments are used to ensure all software is current (including the OS, specialized server software, and any third party

solutions). All data backups are encrypted. EMT IT standards require "strong" and elaborate passwords of all staff members, user accounts, and program scripts to minimize the possibility of a successful brute force attack.

Where will paper and pencil instruments be stored once they have been used and under what security protocols (e.g. who will have access, will they be maintained in locked file cabinets in an open area or in locked file cabinets in a secure room?)?

The PFS Student Survey is administered at each school site under the supervision of a survey coordinator appointed by the school administrator. Completed paper-and-pencil surveys are packaged and shipped directly to EMT corporate headquarters upon completion of the survey administration. Upon receipt of shipments, survey forms are immediately scanned into an electronic data file and paper-and-pencil surveys are then catalogued and filed in sealed boxes, and placed in a locked cabinet within a secured office space. Once scanning and quality assurance processes are completed, the sealed, catalogued boxes are shipped to an offsite records storage facility and are stored until the conclusion of the five year contract period.

Who will have access to this information and will the information be pulled off of the form and digitized or will it stay in a hard copy format? If digitized, who will do it and how (i.e., manually, scanned, etc.)?

PFS student survey data is collected at each school site under the supervision of the school-based survey coordinator who is an employee of the school. Completed surveys forms are packaged and shipped directly to EMT offices in Folsom, CA. The survey forms are processed onsite by EMT data entry staff under the supervision of the PFS Project Director. EMT uses Teleform© scanning technology to directly scan paper-and-pencil survey responses into an electronic, SPSS format for analysis. Hard copy survey forms are catalogued and sealed in boxes and are professionally stored. No one outside of the PFS evaluation study team will have access to survey forms, and no raw data from the evaluation study will be released to individuals outside of the project.

Who will or will not have access to information?

PFS student survey data is collected at each school site under the supervision of the school-based survey coordinator who is an employee of the school. The survey forms are processed onsite by EMT data entry staff under the supervision of the PFS Project Director. Once data is scanned into an electronic data file, the information will be analyzed by members of the evaluation team, including EMT data analysts assigned to the study and the PFS Project Director. No one outside of the PFS evaluation study team will have access to information, and no data from the evaluation study will be released to individuals outside of the project. EMT IT staff will be responsible for destroying electronic records at the conclusion of the study period.

How will the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data?

The PFS Student Survey is an anonymous survey that does not capture student names, classroom information, or school identification numbers. Four digit school and county codes will be used to identify survey sampling groups. The specific school and county code identifiers will be kept in a document separate from the complete student survey data file. When data is analyzed within subsets of students or other participants, no data will be reported in displays requiring a cell size less than five.

And also, please describe how and when the electronic and/or physical data will be disposed of after completion of the project, and by whom.

Stored hard copy surveys will be retrieved from the offsite records storage facility prior to the established destroy date and will be shredded by PFS data entry staff at the end of the contract period. Electronic data files will also be destroyed at the conclusion of the study period. Due to the low risk of disclosure of de-identified survey data responses, information will be deleted using appropriate data deletion methods carried out by EMT IT professionals to ensure that data records are irretrievable.

6. Adequate Consent Procedures

EMT will develop detailed protocols for coalitions to ensure adequate consent, privacy and confidentiality procedures in all of their independent data collection. These will be distributed and reinforced through webinar and online trainings.

School districts administering the PFS Student Survey will use passive parental permission forms to obtain parent consent for students' participation. Permission form packets will be sent to schools at least two weeks in advance of the survey in order to allow sufficient time to permit the principal or designated contact to distribute permission form packets to each teacher, monitor their distribution, and allow time for students to take the forms home to their parents, for parents to view the survey if they so desire, and for parents to return the permission forms. All consent forms and survey instruments will be translated for families who do not use English as their first languages and will be written at a 6th grade level of readability for lower literacy parents or guardians.

The parental permission form will communicate all relevant information to parents or guardians. More specifically, forms will (1) identify SAMHSA as the sponsor of the SPF-PFS project and DSAS as the project administrator, (2) indicate the school district's support for and commitment to the project, (3) clearly specify that the survey is anonymous (i.e., no student can be identified), (4) explain that the student survey asks questions about safety in schools and student behaviors and attitudes toward alcohol, tobacco, and other drug use, including student use of prescription drugs not prescribed to them (5) list any benefits or risks of participation, (6) specify that student participation is voluntary and that refusal to participate will result in no penalties, (7) explain that after agreeing to participate the student may revoke this agreement, (8) state that students may skip any question that they do not wish to answer, and (9) direct parents to contact the child's school principal/teacher or the evaluation contractor's office to obtain additional information about the study or about their child's rights as a study participant. A sample consent form is included in Attachment 3.

7. Risk/Benefit Discussion

The minimal risks to participants identified throughout this section are far outweighed by potential benefits to participants, communities and the state of Tennessee. The targeting of participants and potential beneficiaries of this project is based on research and data that demonstrate their high risk for both short and long-term negative consequences – legal, social, educational, economic, psychological, physical (e.g., injury) and health. Mitigation of these consequences will have large personal benefits, will significantly reduce social costs to communities and state, and will improve the health and productivity of the community in the longer term. The benefits are further enhanced because Tennessee is actively implementing an improved, data-based public health decision system at state and local levels. The data gathered in this project will contribute directly to this system and its continued improvement. In sum, the potential benefits of the data collected in this project are large, and the risks minimal.

8. Protection of Human Subjects

The data collected directly from individuals in the Tennessee performance monitoring and evaluation system is gathered through multiple methods, including direct and telephone interviews and surveys, in-person interviews and surveys, and internet surveys. Our comprehensive confidentiality and participant protection plan includes specific protection plans for each source. DSAS does not anticipate that we will need to comply with the Protection of Human Subjects Regulations for the proposed project. However, in the event that the performance assessment and evaluation design meets the regulation's criteria for research involving human subject, to ensure that all federal human subjects' requirements are met (45 CFR Part 46), all data instruments and data collection procedures will be approved by EMT's Institutional Review Board (IRL) prior to implementation as needed. This will include all direct data collection, including procedures currently in use.

**Attachment 6:
Passive Consent Form**

PFS Student Survey Parental Permission Form

STUDY TITLE: Tennessee Partnership for Success (PFS)
STUDY DIRECTORS: Victoria Stuart-Cassel, MPPA, Project Director, EMT Associates, Inc.

Your child's school is taking part in a study that is sponsored by the Tennessee Division of Substance Abuse Services (DSAS). The study is about alcohol, drug, and tobacco use among middle and high schools students throughout Tennessee.

SURVEY PROCEDURES

We would like your child to take part in a survey that asks a number of questions about tobacco, alcohol, and drug use and school safety. All students in grades 8, 10, and 12 who attend your child's school are being asked to complete this paper-and-pencil survey. The survey will be done in class and takes about 40 minutes to complete. A teacher or other school staff member will be there to help answer any questions.

POTENTIAL RISKS OR BENEFITS OF PARTICIPATION

Taking the survey will cause little or no risk to your child. The only potential risk is that some students might find certain questions to be sensitive. A school counselor or other school staff will be on hand to deal with any concerns your child may have. If you have questions about your child's rights by taking part in this survey, you may contact Ashley Pasquariello, PFS Survey Manager, toll-free at XXX-XXX-XXXX. A copy of the survey is at the school if you would like to see it.

CONFIDENTIALITY

The survey has been designed to protect your child's privacy. Students will not put their names on the survey. Also, no school or student will ever be mentioned by name in a report of the results. This study may help children in the future by improving efforts to reduce alcohol and drug use. Your child will get no direct benefit from taking part in the survey. The only people who will know if your child is taking part in the survey are those who need to know, such as his/her counselor, teachers, and administrators. The survey results will be kept private to the extent allowed by law, and only study staff will be allowed to look at them. If you give permission, your child will be asked to complete this survey and will not be asked to take part in any other activities for this five-year study. Survey results will be kept through the conclusion of the study period and will be stored in a locked filing cabinet, storage facility, or on a protected computer.

VOLUNTARY PARTICIPATION/WITHDRAWAL

We would like all selected students to take part in the survey but the survey is **voluntary**. No action will be taken against the school, you, or your child, if your child does not take part. Students can skip any question that they do not wish to answer. Also, students may stop taking the survey at any point without penalty.

CONSENT

Please read the section below. If you do **not** want your child to take part in the survey, check the box, sign the form, and return it to the school within 3 days. Please see the other side of this form for more facts about the survey. If your child's teacher or principal cannot answer your questions about the survey or if you have questions about this form, Ashley Pasquariello, PFS Survey Manager, toll-free at (XXX) XXX-XXXX or ashleyp@emt.org. Thank you.

Child's Name: _____ Grade: _____ School: _____

I have read this form and know what the survey is about.

NO, my child **may not** take part in this survey.

_____ Date

_____ Parent/Guardian Signature

Milan Special School District

PARTNERSHIPS FOR SUCCESS (PFS) STUDENT SURVEY FACT SHEET

What is the Student Survey?

The Tennessee Division of Substance Abuse Services (DSAS) and participating school districts jointly support this statewide student survey to assess the extent of alcohol, drug, and tobacco use among 8th, 10th and 12th grade students throughout Tennessee and to evaluate the impact of prevention efforts aimed at reducing substance use.

What is the purpose of the Student Survey?

The Student Survey is part of Tennessee's Partnerships for Success (PFS) grant from the Center for Substance Abuse Prevention. Students in grades 8, 10, and 12 will be asked to complete a survey that will be used for research purposes only. Their responses to the survey will be compiled to provide information to your school district about students' use of tobacco, alcohol, and drugs. It also provides information about school safety issues.

Does my child have to complete the survey?

No. Participation in the Student Survey is completely voluntary. Your child will not be penalized in any way if he/she refuses to participate. We are asking your permission for your child to participate in this survey. The survey will be conducted during a regular class period at school.

How do I give permission for my child to participate in the survey?

If you give permission and your child agrees to participate in the survey, you do not need to do anything. Your child will be provided with a survey form during the class period designated for the survey. If you object to your child's participation in the survey, you must complete the attached form, sign your name in the space provided and return the form to your child's school by ____, 2014. If you like, you may also contact Ashley Pasquariello, PFS Research Associate, at ashleyp@emt.org if you have questions.

Will anyone know how my child answered the questions?

No. Your child's responses to the questions will be confidential. His or her name will not appear on the survey forms and no one except the research evaluation staff will see the individual responses. The answers from all youth participants will be summarized so it will be impossible to identify your child in the responses.

What kinds of questions are on the survey?

Examples of questions to be asked in the Student Survey are listed below by subject.

- *Alcohol, tobacco, and prescription drug use:* How often (if ever) have you smoked cigarettes in the past month (30 days)? On how many occasions (if any) have you had more than a sip or two of beer, wine, or hard liquor (for example, vodka, whiskey or gin) during the last 30 days? How often (if ever) have you smoked marijuana?
- *Attitudes toward alcohol and drug use:* How wrong do you think it is for someone your age to drink beer, wine, or hard liquor (for example, vodka, whiskey or gin)? How wrong do you think it is for someone your age to smoke marijuana? In the past 30 days, how many times did you speak with a friend about a personal or family problem?
- *Antisocial behavior:* How many times in the past year (12 months) have you been suspended from school? How many times in the past year (12 months) have you taken a handgun to school?

This survey has been administered to thousands of students across the state and the vast majority experienced little difficulty in answering the questions. However, because answering questions about personal and sensitive behaviors can be uncomfortable, students are assured that they may skip any questions they do not want to answer. Students are also told that if, after completing the survey, they have any personal concerns, they should talk to their school counselor, who can direct them to resources for consultation.

What benefits are there from my child participating in this research?

Although your child will not directly benefit from completing the survey, his/her answers—along with those of thousands of others—will provide valuable information that may be used to improve prevention programs for youth.