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Scaling up Evidence-Based Interventions Within the US Public Health Market

Patrick H. Tolan[1]

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Abstract
The Mapping Advances in Prevention Science IV (MAPS-IV) Translation Research Task Force report provides an important enumeration of challenges and potential opportunities for improving extent of implementation of evidenced based interventions. The aspiration is for scientifically based prevention to be implemented widely enough to show population level shifts in incidence and prevalence. The MAPS-IV Task Force report by Fagan and colleagues (2019) provides a thoughtful and informative report that notes important exemplars towards that goal as well as key challenges and suggests strategies for greater impact across five publicly funded systems affecting human development. Comments are offered that center around the value of embedding prevention science within often larger and more sustained social and political forces as well as embracing scaling up within the complex funding streams in which prevention will be sustainable at scale. These include increasing attention to practical considerations that can affect how prevention is viewed, appreciated, and likely utilized as well as the ongoing challenge of how to relate evidenced based programs with the more prevalent and often preferred approaches of those deciding what is funded and what is actually implemented. This valuable contribution to Society for Prevention Research and prevention science is characterized as an important step toward strategies that might plausibly move prevention from primarily demonstration efforts to sustainable public health strategies integrated into the major systems of influence on human development.

The Mapping Advances in Prevention Science IV (MAPS-IV) Translation Research Task Force was formed to organize and increase the extent to which evidenced-based interventions (EBIs) are utilized in prevention practice, a necessity for realization of the ultimate purpose of prevention science which is to reduce incidence and prevalence of disorders and health problems. A growing roster of programs empirically demonstrating efficacy and emerging findings from effectiveness and implementation studies bring this aspiration front and center. However, as this report described well, the gap between the potential of what we know can work and what is needed for implementation to scale is large and entails multiple challenges. If we are to move from demonstration funding and operation outside the systems and institutions in which public health impact prevention must be embedded, there are several fundamental and quite challenging barriers to overcome in the attention to, appreciation for, and financial and political support for EBI-based prevention.

✉ Patrick H. Tolan
pht6t@virginia.edu

[1] University of Virginia, Charlottesville, VA, USA

The report reflects a thoughtful critical review and formulation of the impediments to moving to scale to date and the improvements that would make such a level of impact plausible. The Task Force report provides our field a useful enumeration of the elements of working in five major public systems and suggests how persistent advocacy, better and more extensive research, and hoped for recognition by funders, policy-makers, and the public could be obtained to lead to EBI-centered prevention with attendant population level changes in disease, disorders, and major psychological and social problems. A goal of the report was to outline what is needed to move EBI use from limited demonstration project level to centrality in public health efforts. This is a very good aspiration and basis for organizing the report. However, my impression is that there are some self-imposed limitations of focus of the report that render the mapping as too narrowly drawn, too removed from compelling and broad forces that affect public health practice in this country, and that ultimately raise concern that the suggested emphases and direction in the report will not lead to the sought destination. If the intent is to map what is needed to affect population level health patterns, an important consideration is to what extent the report addresses what are the most powerful and critical determinants of EBI implementation and of public health problems (Tolan, 2014).

Similarly, practical influences may be more important in affecting what impact can be realized than the strength of research or the soundness of reasoning. A report that does not delve much into history of prior efforts to realize similar change or address otherwise anticipatable major challenges and directional determinants leaves much of the important considerations unspecified. While the report is an admirable internal look at what Society for Prevention Research (SPR) and the scientists producing EBIs might do to improve the current status, this is done without the attention to the need for embedding our efforts within interests of those external to our community, major existing and competing service structures and funding bases, and agencies and profession that have more immediate and powerful control over policy levers. Moving beyond marginal impact necessitates understanding about and aligning with these larger forces.

It seems likely that any implementation to scale will occur within existing administrative and funding organization; systems with existing mandates and roles in public health and related areas. How can prevention be integrated into those mandates and serve prominent priorities, thus making a fit between funding and administrative interests and EBI-based prevention efforts? One important practical consideration for greater implementation and impact is that we work with those administrating at various levels from general policy to specific funding and performance accountability within the five public systems identified in the report, to align EBIs and future implementation research and evaluation with the driving mandates and priorities of each system. Perhaps a next stage of Task Force's work could be to map out those specific opportunities and related strategies. Such mapping would move the organization of efforts for EBIs to be central in affecting public health through a collaboration with like-minded political and professional allies, mapping that embeds what prevention science has to offer about EBIs within policy advocacy that relies on many other areas of expertise.

A second choice in focusing the report that carries important limitations is to emphasize primarily mechanisms and strategies housed within federal level public systems. This leaves the state and local implementation and operational control influences out of consideration. While mention of block grant as a source is noted, much of the decision-making about these funds are purposely left to states. Moreover, these are but a portion of the federal, state, and private funding that ultimately is locally controlled. This important and complicated determinant of how and to what extent EBIs can be the basis for shifting public health prevention is left unaddressed. For example, one has only to look at the vast variations in Medicare, Medicaid, and the implementation of provisions of the Affordable Care Act across the 50 states to see that while federal level mandates and regulatory advances are important for prevention becoming institutionalized, that it is just a beginning of moving from opportunity to realization (http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx). It may be that it is in tracking the major funding streams, emphasizing the most common variations in how that funding is utilized and mixed with state and other funding, that the requirements for enabling adequate and sustainable funding for EBIs to be implemented to scale can be tapped. Related to that interest is reviewing these streams for how EBI prevention can eventually be worked into regular budgetary processes. Not incidental to a sophisticated assessment of the funding basis needed for EBI prevention to become an institutionalized part of health services is to attend to how public/private funds mix in the current health system, as this is what is likely to be central and predominant in the future. As a corollary of this limitation, the report seemed to view funding primarily for enabling stronger demonstration (e.g., more research, larger implementation demonstration projects). While such support is certainly needed, achieving the impact aspired to in the report will require those of us used to demonstration-oriented funding to recognize that operational funding is not only more sustained but also often dwarfs what is allocated for demonstration. SPR's progress and ultimate success in its efforts to advance research on the dissemination and scale-up of EBIs may require additional learning how to work with an orientation to integration into operational funding systems and administrative lines; demonstration funding levels are relatively small compared with these larger funding streams and are almost always by definition temporary.

A third chosen limitation of focus of the report is restricting attention to how EBIs can be moved forward and increasingly used as the basis for increasing impact level. Certainly, SPR and its member hold valuing scientific evidence as requisite for advocating a given approach. This is an important principle. However, the report emphasizes how to advocate for EBIs and what system changes could increase their prominence in public health removed from other innovation interests in prevention (e.g., community-based empowerment movements, positive youth development through community-based organizations, community safety promotion) and by other levers for change (e.g., regulatory mandates, implementation influence of the *Affordable Care Act*, which mandates funding of prevention with proper certification (https://www.healthcare.gov/coverage/preventive-care-benefits/). Similarly, the report overlooks other potential approaches to advancing programming, such as large-scale randomized trials (as was used to test child welfare policies in the 1990s; Blank, 2002). Other approaches to innovation and to applying scientific evaluation can be important aligned partners for our interest in making prevention more recognized and specifically for

EBIs as central to public health. However, each also can be a competing interest pitted against the efficacy-effectiveness-to-scale implementation model that is central to the EBI promotion approach. My experience has been that while prevention is given some recognition, it is often poorly understood and is considered as an adjunct to after-the-fact interventions. Prominent in this view is that practical issues like who provides prevention, how it is regulated and paid for, and uncertainty where it is located within overall policy areas undercut advancement of it into primary consideration. If this experience has validity, then advancing prevention to affect public health depends, at least in part, on working with these other efforts and harnessing multiple methods of increasing awareness and utility. Practically, this may mean careful consideration about whether EBIs should be pitted against ground-up efforts or those that emerge from social concerns and movements, perhaps shifting to how EBIs can be positioned as essential to but not the only valued part of advancing public health through prevention. Also, promoting EBIs as the center of prevention, as featured in the Task Force report and appropriately valued by SPR, is a particular approach to intervention development and subsequent dissemination/scaling up. We need to reconcile our particular view, however justified we might believe it is, with the approaches predominating program choice and organization within health and education. This probably includes recognizing EBI application is not the preferred approach by most systems managers and end-users (e.g., local self-developed, general principles gleaned from practice experience, evidence-based practices, or toolkits for application as user prefers/needs). Consciously connecting EBIs to the other forces that can support prevention and may have more prevailing influence is a critical issue in prevention science, emerging because we have produced a roster of empirically supported programs that brings encounters with the challenges of going to scale necesitate formulating strategies for doing so that are scientifically sound.

As ultimately the validity of prevention is its impact on prevalence and incidence of disorders and related problems; the report focuses on a major challenge for the field that will be ever more important in the coming decade. The report also provides a framework for understanding of multiple considerations for helping change the status of implementation reach and suggests important strategies and, in some cases, specific steps that merit pursuit by SPR and the scientists and advocates across the broader field. As constructed and focused, the report helps to map key considerations for work with EBIs in public systems.

Another limit of focus of the Task Force's work and the resulting report was assuming that most prevention will be through publicly funded systems; however, there are many issues that arise in assessing the same issues in private systems that would diverge from this attempt to coherently organize what might "move the needle." As such, they may have substantial impact on the incidence and prevalence of the disorders/problems to be prevented. A reason given for justifying this specific focus is that at this point, there have been few sound experiments of prevention through private systems or mixed public/private funding (e.g., insurance plus public funding). In fact, it seems the case that almost all prevention purposes. Thus, focusing on some graspable understanding of what might be done to improve implementation extent and visibility within public systems seems a reasonable circumscription as a first step.

As the report shows, there is still a formidable and only faintly outlined empirical basis for even that work. While this emphasis carries substantial limitations about moving needles, the report provides a much needed coherent (and thorough) consideration of the key areas of work and the types of increased appreciation, support, opportunity, and funding that is needed for implementation at a level that is likely to have population level impact. Similarly, it is important to note that even with the growing collection of EBIs that merit scaling, the available programs focus on a relatively narrow portion of the health issues and social problems we face and fit for various populations and circumstances are mostly unknown. For example, few EBIs have been tested for variations in impact across different locales and service delivery systems. Relatively few have been tested across different community types (e.g., rural, urban, suburban) or different ethnic groups (not just applied to samples with some variation in ethnicity). Local decision-making and judgement about fit, utility, and likely benefits are likely to remain very influential on prevention programming for the foreseeable future and accordingly, it seems mapping that is recognized and addresses these considerations in strategy formulation will be more useful and has greater probability of success.

My suggestion is that for the findings of SPR and its members to reach the impact sought that is the purpose of this task force, it may be as important to increase knowledge about, attention to, and respect for the complex forces affecting the level of interest in and support for prevention. The report while providing useful enumeration of notable constraints and opportunities for moving EBIs to larger scale use, limited the focus to the mainstream process of building from efficacy trials to effectiveness studies and advocacy for use of programs that have shown benefits through these multiple stages of experimentation. Such singular focus is valuable as it shows appreciation for the unique quality of knowledge that is securable through randomized controlled trials and specific program testing. However, the current status of prevention in the main is still one of scattershot efforts, which are rarely application of such tested programs or are implemented in ways that vary substantially from what was tested in the validating studies (Tolan, 2014).

A particularly commendable aspect of the report is the mention and brief description of several important examples in which scaling up has begun and partnerships formed that exemplify collaboration with system administrators. Across these trailblazing efforts is an orientation to implement prevention services that are integrated into existing systems and align with the mandates and priorities dominating decision-making within those systems. These are to be admired, celebrated, and studied for clues on how such successes can be extended and replicated. They provide examples of going beyond promoting greater use of a given program to working with sensitive and sophisticated attention to system mandates, funding streams and priorities, and operational practices to meld the program into existing structures of implementation. It should be noted that most are the product of many years of work by a team of advocates and decision-makers to reach a level of influence on or use by the systems in which they are embedded. Also evident are adjustments to practical considerations. These exemplars point to the value of prevention science efforts and work we undertake being informed by and with appreciation for the larger frameworks and political and social influences on the roads toward that goal and the challenges in the aspiration of moving the needle.

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Compliance with Ethical Standards

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Informed Consent NA

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