Implementing a sustainable HIA practice: The role of training, technical assistance, and mentoring

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Washington, DC
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The genesis of HIP's TMTA program

- 2006: Created the HIA Toolkit (version 1.0)
- 2007: Started getting requests for training
- 2007 – 2008: Early trainings
- 2008: Training revision
- 2009 - 2010: Added the TA/mentoring component
- 2011: TA in earnest

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1. Created the HIA Toolkit (version 1.0) – even though there were already a million out there, because we had a deliverable for the grant, we had to do it. The one good thing that we did was to start to envision exercises and worksheets, even though the toolkit was a static document.

2. Started getting requests for training – at first it was not our mission to do any training at all, just to do HIAs, but there was a need.

3. Early trainings – many groups in the beginning – mostly public health departments – simply wanted to get trained and consider themselves proficient in HIA. But they weren't necessarily interested in actually doing an HIA. Our stand has always been that you can't consider yourself knowing how to do an HIA until you've done an HIA, so our goal was that people would actually do HIAs after. We started to change our training to focus on a specific case study pretty quickly so that people would get experience in each step with an actual potential project.

4. First training revision – Jen Lucky – took the toolkit and really took our trainings to the next level by adapting the toolkit directly into a curriculum, with worksheets and exercises. We often felt we had to force people to get enough information about the potential case study project (still do, but we hear back how important it is, so we keep pushing). The trainings were better received with the exercises and the case study strategy.

5. Adding the TA component – since our goal that people actually do HIAs after the trainings (this was before the days of groups that were funded to do an HIA and a training up front) was only some times being realized, we saw on our evaluations that people felt that they understood HIA, but didn't feel confident that they could move forward without guidance. So, we started adding into our training program a certain # of hours for post-training TA.

6. TA in earnest – our TA program began in earnest when the Health Impact Project was born and ASTHO started to provide capacity-building funding. Providing funding for TA for grantees – almost all of whom, at the beginning, were brand new to HIA – was good foresight. Over the years, we have refined our approach and now have a fairly structured TA program that continues to grow, improve- there's always room for refinement. In addition to the Health Impact Project and

ASTHO, we now provide mentoring/TA & training to CDC grantees, Gamliel & PICO organizations, planning departments, Kellogg, and others.

7. All of our training and TA, though, are responsive to the needs of the group receiving the TA.

Focused on hands on learning

TA and Training Goals

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TA and Mentoring goals

Build capacity of organizations to conduct HIAs

Have partners complete successful, quality HIAs

Build collaborations that could use HIA in the future

Increase the participants' use of health-based information and education

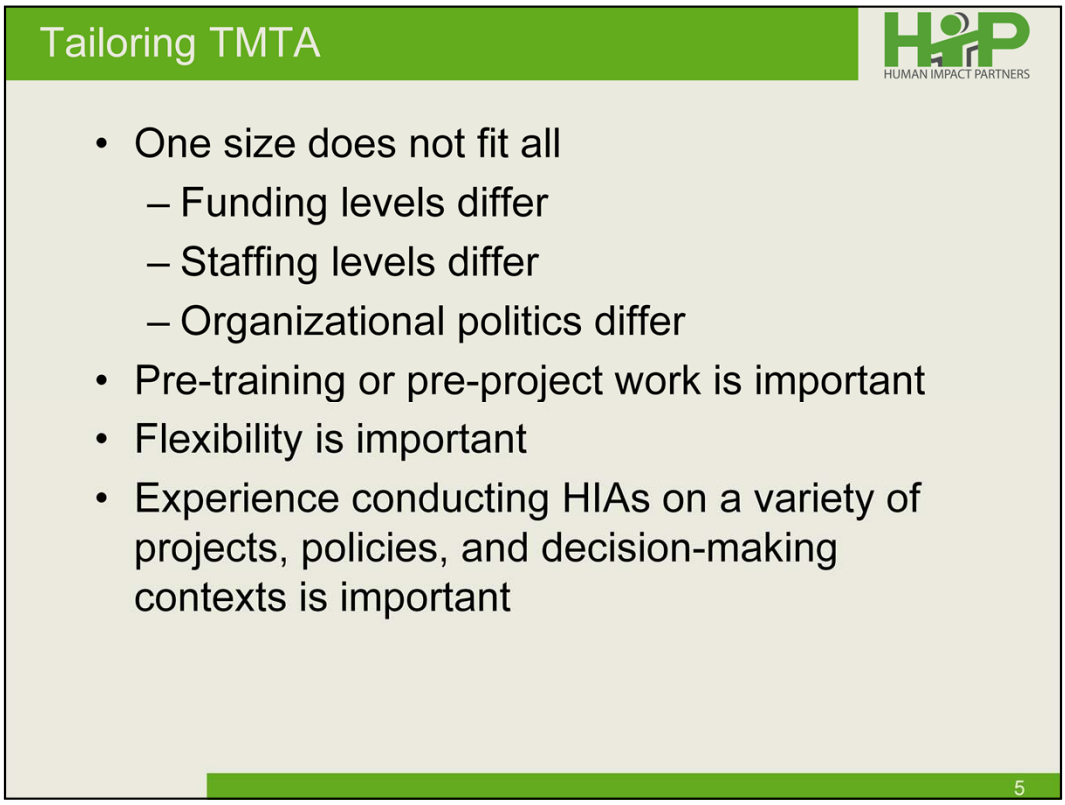
Training goals

Bring together diverse stakeholders

Develop a shared understanding about HIA

Help get a new HIA project off the ground

Discuss plans for sustaining future HIA practice



Funding levels – with very little funding, we might do an all-remote TMTA workplan (NKY);

with only a Training funded, we might do all remote and only as-needed TA/mentoring (NE)

we might incorporate pre-training or pre-project webinars to ensure the team(and potentially their stakeholders) understands different aspects of HIA (Adler & CCBH)

Staffing levels, understanding, and experience with HIA

We have gone to talk about HIA in stakeholder meetings, if appropriate

Depending on level of interest in learning how to do HIA, we might propose a joint lead/mentor role (Columbus)

We are often willing to talk with different groups (for example, funders) about HIA in the effort to help the group do some capacity building

If a group has been trained but want help getting started, we might travel there for a community scoping meeting

Organizational politics

There may be varying levels of willingness to conduct HIA in an agency, so the training and TA must reflect that

We may train about HIA but propose to do more of a HiAP project, if the agency and funder are flexible (New Orleans, Kane) – we need to be doing more of this.

Pre-training work is extensive and important

Getting the case study together – in enough detail and also enough simplicity

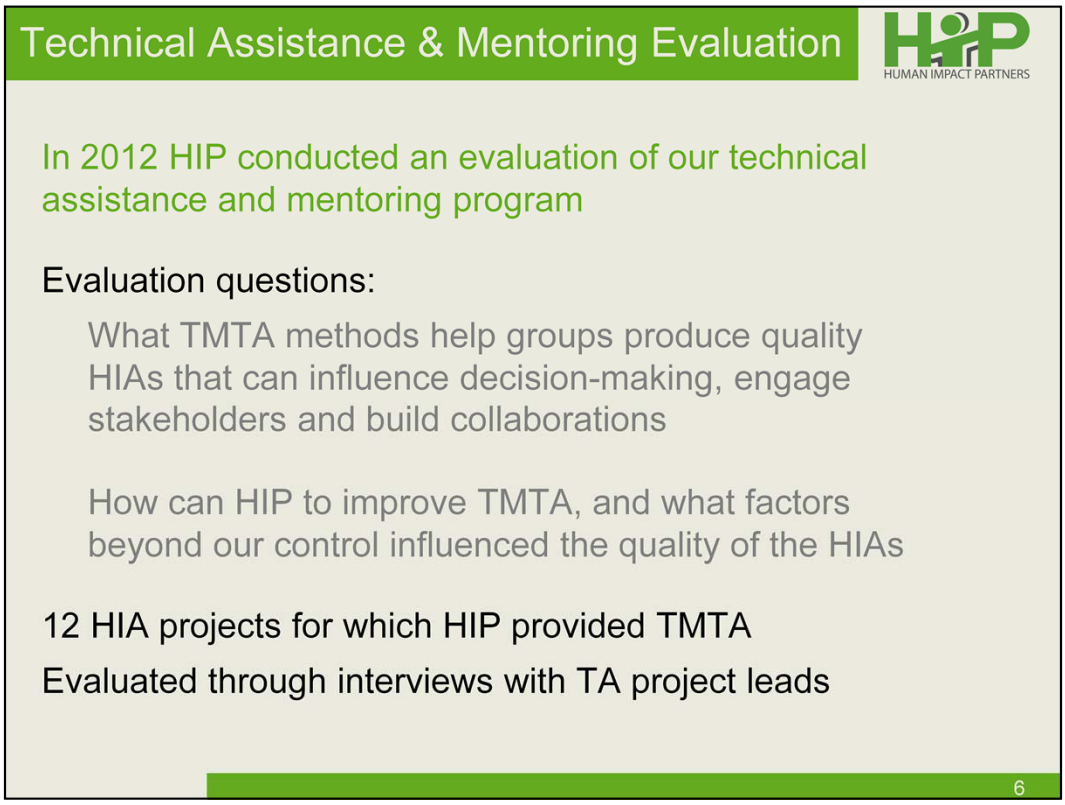
Getting the core team on board enough so they can be facilitators

If people want it, bringing HIA practitioners in that state to give examples

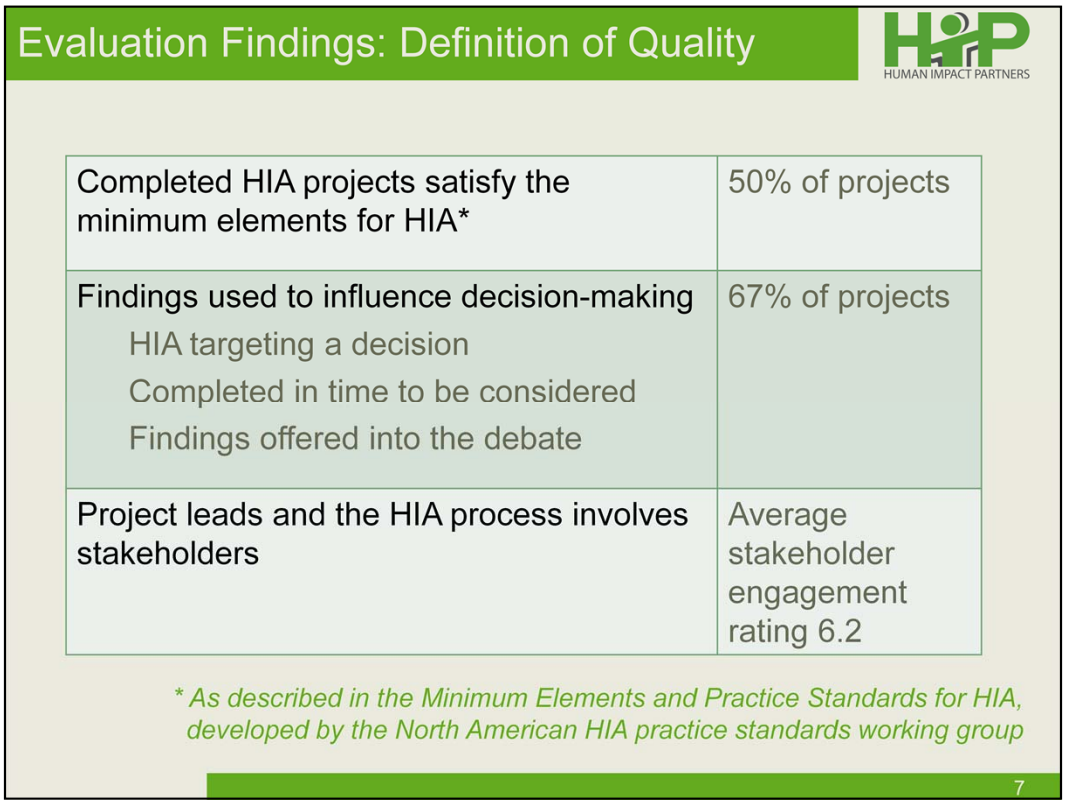
Getting a Welcome from a decision-maker or higher-up stakeholder gives the idea of HIA and the training some legitimacy

Training format often will flex according to the needs of the group (need to inform other stakeholders, only have the core team for the whole training, want to have those experienced in that state in attendance)

Getting many of the key stakeholders on the HIA at the training is key (or scoping meeting, or as part of the pre-training prep)



projects included in the evaluation were part of grant programs where our TA was initiated by a training (in most cases) and TA followed.



Also concerned with building collaborations between project teams and their partners (75% of projects had at least 2 partnering organizations that participated in the HIA in a more involved way, 75% of projects had at least 10 partner organizations or individuals complete the training, 75% of projects also expanded their networks of collaborating organizations/agencies as a result of their HIA work)

Evaluation Findings: Contributing Factors

Training	67% of projects trained
Technical Assistance and Mentoring	Helped 83% of projects
Project team readiness Experience with HIA and using health in decision-making Dedicated staff person Commitment to the project (time/resources) Relationship of HIA project team with stakeholders in the decision	Average readiness rating 5.5 42% of projects had dedicated staff person at the start
Decision being evaluated with the HIA Was the targeted decision and context right for HIA?	58% of teams selected a project that satisfied screening criteria

Evaluation Findings: Key Findings

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Having a training was associated with greater success

- Influencing decisions and engaging stakeholders

Developing an HIA scope, fulfilling "readiness" criteria, and selecting a decision target that meets screening criteria were associated with:

- Satisfying minimum elements;
- Using findings in decision-making; and
- Higher ratings for stakeholder engagement

Evaluation Findings: Supporting Data

Training	55% of trained projects satisfied minimum elements and 73% of trained projects used finding to influence decision-making Stakeholder engagement was rated an average 6.7 for trained projects and 5.3 for projects that were not trained
Developing HIA Scope	All projects that developed a documented scope mostly satisfied minimum elements and used findings to influence decision-making Stakeholder engagement was rated an average 7.4 for projects that developed a scope and 5.4 for projects that did not
Fulfilling readiness criteria	80% of projects with a higher readiness rating (7 or higher) satisfied the minimum elements and all higher rated projects used findings to influence the decision Stakeholder engagement was rated as average 8.4 for projects that were more “ready” and 4.6 for projects that were less “ready”
Decision target that meets screening criteria	71% of projects that met screening criteria met minimum elements, and 86% that met screening criteria used findings to influence decision-making Stakeholder engagement was rated an average 7.9 for projects that satisfied screening criteria and 3.8 for projects that had screening red flags

Lessons Learned for Future TMTA

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HIA project leads are best prepared for HIA when they **have experience** using health to weigh in on decisions and are **committed** to the project

A **dedicated staff person** is critical for on time completion, maintaining HIA standards, and meaningfully engaging stakeholders

In the absence of experience with HIA a **training** is necessary

TMTA provider should be **involved in screening**, but not complete scoping work for partners

Invest in more TA, training, and mentoring for **stakeholder engagement**

Expand view of success to include projects that increase consideration of health and equity in decision making – even if not a formal HIA

Leveraging external HIA TMTA support can:

- Help implement new HIA practice
- Sustain a realistic HIA practice
- Bring in ideas from across the country
- Connect to other HIA practitioners

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