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## The Use of the Data-to-Action Framework in the Evaluation of CDC's DELTA FOCUS Program

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### Abstract

The Centers for Disease Control and Prevention's (CDC's) Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) program is a 5-year cooperative agreement (2013–2018) funding 10 state domestic violence coalitions and local coordinated community response teams to engage in primary prevention of intimate partner violence. Grantees' prevention strategies were often developmental and emergent; therefore, CDC's approach to program oversight, administration, and support to grantees required a flexible approach. CDC staff adopted a Data-to-Action Framework for the DELTA FOCUS program evaluation that supported a culture of learning to meet dynamic and unexpected information needs. Briefly, a Data-to-Action Framework involves the collection and use of information in real time for program improvement. Utilizing this framework, the DELTA FOCUS data-to-action process yielded important insights into CDC's ongoing technical assistance, improved program accountability by providing useful materials, and information for internal agency leadership, and helped build a learning community among grantees. CDC and other funders, as decision makers, can promote program improvements that are data-informed by incorporating internal processes supportive of ongoing data collection and review.

### Keywords

developmental evaluation; intimate partner violence prevention; primary prevention; program evaluation

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Intimate partner violence (IPV), defined as physical, psychological, or sexual violence or stalking by a current or former partner or spouse, is a significant public health problem that affects millions of Americans each year.<sup>1</sup> According to the 2010–2012 National Intimate

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Partner and Sexual Violence Survey State Report, in the United States, approximately 32% of women and 28% of men experienced physical abuse by an intimate partner in their lifetime, and 23% of women and 14% of men experienced severe lifetime physical violence by an intimate partner (eg, being hit with something hard, being kicked, attempts to hurt by choking or suffocating).<sup>2</sup> The prevalence of psychological aggression is even higher, with 47% of both women and men experiencing this form of violence in their lifetime. Furthermore, approximately 16% of women and 7% of men experienced contact sexual violence by an intimate partner in their lifetime.<sup>2</sup>

The Centers for Disease Control and Prevention's (CDC's) National Center for Injury Prevention and Control research agenda highlights the importance of IPV prevention as a public health priority.<sup>3</sup> Much of the research and service provision for IPV is focused on secondary or tertiary prevention (eg, domestic violence advocacy, lethality assessment programs, and protective orders), but the public health approach advocates for primary prevention. To date, only a limited number of IPV primary prevention programs have been rigorously evaluated.<sup>3,4</sup> In the published research, most existing IPV prevention interventions with promising evidence of effectiveness focus on individual and relationship factors such as addressing individual-level knowledge, attitudes, behaviors, and beliefs, and building skills to promote healthy relationships,<sup>4-6</sup> rather than population-level approaches.

To more effectively impact the public health problem of IPV at a population level, prevention programs, policies, and strategies that address social determinants of health are necessary.<sup>7</sup> However, the evidence of program effectiveness at these levels is limited and needs additional development.<sup>3</sup> Given the lack of rigorous evaluations, public health has an important opportunity and role in building capacity and expertise in communities to develop, implement, and evaluate IPV prevention strategies that target population-level risk and protective factors to address these gaps.<sup>8,9</sup>

The Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) program responds to this need by implementing an IPV prevention approach that encourages the use of community- and societal-level strategies and builds practice-based evidence around such strategies through adaptive learning and a data-to-action process. In 2014, the CDC director wrote that a critical component of effective public health program implementation is timely, critical, transparent, and ongoing monitoring of data for continuous refinement and program improvement.<sup>10</sup> Therefore, in this article, the DELTA FOCUS program, which is part of CDC's response to IPV and its risk and protective factors, describes how CDC is applying the Data-to-Action Framework to develop and improve the DELTA FOCUS program over time.

## DELTA FOCUS

DELTA FOCUS is a 5-year cooperative agreement (2013–2018) that funds 10 state domestic violence coalitions, the direct recipient of the funding (referred to hereafter as grantees), to engage in primary prevention of IPV using a health equity approach. The health equity approach is focused on changing systems by addressing the social determinants of health.

<sup>11,12</sup> This means, in addition to addressing individual and relationship factors associated with IPV outcomes, DELTA FOCUS grantees work to change the environments and conditions in which people live, work, and play.<sup>12</sup> To make these changes, economic and social policies as well as processes and community norms that shape the health of individuals and communities must be addressed through prevention strategies. For example, strategies may involve integrating issues related to systems, such as education or employment, or reducing gender bias. Each of the 10 DELTA FOCUS grantees funds 1 or 2 coordinated community responses to implement strategies at the local level, for 16 coordinated community responses. Coordinated community responses are local coalitions comprising members from a variety of sectors engaged in IPV prevention.<sup>13</sup>

Centers for Disease Control and Prevention developed DELTA FOCUS knowing that the evidence base for IPV prevention was in its infancy, particularly with regard to community- and societal-level interventions and social determinants of health. In addition, CDC recognized that across the IPV prevention field, grantees would bring to the project varying levels of prevention capacity, a range of partnerships, and different political and social challenges and assets in each state and at each local site. Understanding this diversity of prevention capacity and local contexts, CDC allowed grantees to develop and implement strategies best suited to their states' needs and to adapt those strategies in response to their changing and dynamic social environments. The grantees were also responsible for evaluating the strategies they chose to implement.

The programmatic flexibility described previously, while crucial for the nature of the project, means the evaluation model for the CDC-level, cross-site evaluation (referred to hereafter as project level) of the DELTA FOCUS program is far more complex than if, for example, all grantees were implementing the same strategy. Given the confluence of these factors, CDC staff employed a developmental evaluation approach.<sup>14</sup> A developmental evaluation approach and application of the Data-to-Action Framework, illustrated by the data-to-action process described in this article, are generalizable for others interested in using ongoing data collection, analysis, and review for programmatic decision making and improvements.

### Data-to-Action

The DELTA FOCUS program is intentionally oriented toward learning and applying data-informed lessons learned in real time throughout the project rather than just gathering insights at the end of the project. When introducing a developmental evaluation approach, Patton et al<sup>14(pv)</sup> wrote, “developmental evaluation provides *evaluative* information and feedback to social innovators, and their funders and supporters, to inform adaptive *development* of change initiatives in complex dynamic environments.” The DELTA FOCUS evaluation model addresses the challenges of evaluating a multisite program that supports state domestic violence coalitions, embedded in different *complex social environments*, which are directly implementing and supporting the implementation of multiple, and often evolving, approaches to prevent IPV in communities.<sup>11</sup> To learn which approaches might contribute to the knowledge base of promising community-level IPV prevention strategies,

CDC adopted a developmental evaluation approach and the Data-to-Action Framework<sup>15</sup> to support adaptive learning and enhance evaluation practice.

As grantees' strategies evolved over time (eg, changes in which strategies were implemented and how strategies were implemented), CDC's approach to program oversight, administration, and support to grantees required flexibility. As a result, CDC staff elected to implement a data-to-action process guided by the Data-to-Action Framework to support project-wide management and continuous quality improvement. The Data-to-Action Framework was designed specifically for early-stage programs that can benefit from rapid feedback for the purposes of program development, refinement, improvement, and identification of barriers to implementation.<sup>15</sup> The 4 key elements of the Data-to-Action Framework are a team-based approach, ongoing adaptations for *early-stage* developmental programs, use of rapid feedback cycles, and generation of actionable data.<sup>15</sup> The rapid feedback cycles involved 5 steps:

1. Clarify intent of each data collection initiative.
2. Collect *good enough* data to meet the team's information needs.
3. Produce a brief memo to report results.
4. Facilitate a reflective debrief on the data.
5. Make decisions based on the data.

The DELTA FOCUS program adopted the 5-step Data-to-Action rapid feedback cycle as a framework to assist in answering 2 evaluation questions: (1) What degree do the prevention strategies implemented by grantees at state and local levels contribute to what we know about IPV prevention? and (2) How well is the national DELTA FOCUS program being implemented? In the first year, CDC staff and the evaluation contractor (further referred to as consultants) convened meetings to clarify the intent and topics (step 1 of cycle) for each data collection (step 2 of cycle) or analysis of secondary data, analyzed and produced reports (step 3 of cycle), and held debriefing meetings to facilitate learning and decision making based on the reports (steps 4 and 5 of cycle). Findings from the reports and data collections were synthesized in a final Recommendations Report, together with recommendations for a data-to-action process for the next year. See the Table for detailed descriptions of the topics, findings, and use of findings.

To execute a data-to-action process at the project level, grantees generated the materials used as a data source; the consultants, contracted by CDC, analyzed the data and generated reports; the consultants then led CDC staff, as a team, through debrief meetings to reflect on the findings; and CDC staff used the findings for programmatic decision making and improvements with grantees (see Figure 1). The reports (described in detail later) follow the 5-step rapid feedback cycle and form the structure of the data-to-action process and assist in answering the program evaluation questions (see Figure 2). At a minimum, each report is completed annually, except for Actionable Reports, which are developed multiple times throughout each year, to ensure the production and use of actionable data. Zakocs and colleagues<sup>15</sup>(p473) define actionable data as "information that helps intended users make programmatic decisions."

The Actionable Report Protocol is the planning document that guides the report and data collection topics for each year (see the Table for audiences and uses) and is generated between steps 1 and 2 of the rapid feedback cycle. The Actionable Report Protocol helps clarify the intent for each Actionable Report by determining the viability of the topic using a series of templates and guiding questions to generate and prioritize report and data collection topics based on the project team's information needs. Similarly, a Supplemental Data Collection Plan is developed between steps 1 and 2 for the same purpose. Supplemental Data Collections (SDCs) are used to collect primary data from a subset of grantees through interviews and surveys in order to seek additional information or to clarify information beyond what was provided in the data management information system.

When the topics for the reports and data collections are settled, and the data are collected and analyzed (step 2), the Actionable Reports are generated (step 3). For Actionable Reports, data grantees submitted (Action Plans, Progress Reports, Evaluation Plans, and supplemental materials shared with CDC through a data management information system) are analyzed and summarized on the basis of the topics identified in the Actionable Report Protocol. The Recommendations Report, illustrated in the Table as occurring between steps 3 and 4, is used to document findings from SDCs, synthesize findings across Actionable Reports, to summarize what was learned through the data-to-action process throughout the year (including findings from Synthesis Reports), and to make recommendations for the following year's process.

Synthesis Reports are the evolution of Actionable Reports in the final 2 years of the project. They underwent the same process and relied on the same data source as Actionable Reports but were designed to assist the project team in summarizing and describing program impacts and outcomes instead of identifying opportunities for program improvement.\* Specifically, in the first 2 years of the program, the project team needed to know what grantees were implementing in order to identify training needs, inform technical assistance to grantees on project calls and at grantee meetings, and assist grantees in forming a community of practice by identifying peers with whom they could communicate or collaborate. In the final years of the project, the team's information needs shifted to needing to know what grantees were accomplishing and the types of impact they were making at the local, state, and national levels to inform reporting and accountability to leadership. The change in information needs resulted in the shift from producing Actionable Reports to Synthesis Reports.

Once all of the reports were generated, CDC consultants guided CDC staff through debrief sessions to discuss the findings of the reports and identify opportunities for program improvements (step 4). The CDC staff would then make decisions about how to execute the program improvements (step 5). For example, in the first Actionable Report, CDC sought to understand the scope of the IPV prevention strategies and targeted outcomes of the grantees' efforts since they were given significant flexibility in deciding what to implement. In the process of developing the report, CDC staff and consultants discovered that there was substantial variability in the grantees' strategies, which presented challenges to fully

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\*When the Actionable Reports became Synthesis Reports, the Actionable Report Protocol was renamed the Synthesis Report Template.

understanding and articulating the types of strategies grantees adopted. Thus, there was a need to categorize their work, which led to the development of prevention strategy categories and outcome types.

To accomplish this categorization, CDC consultants reviewed, coded, and aggregated information from the annual work plans (ie, Action Plans) of the program grantees. Key findings from this Actionable Report included the following: a majority of strategies in Action Plans were prevention focused; identification of a typology of prevention strategies was challenging because there was wide variation in how program grantees described their strategies; prevention strategies varied in desired change (ie, outcome) and target audience; and program grantees' understanding of *types of evidence* differed from CDC's definitions. As a result, CDC created a guidance document to clarify key elements of a strategy, developed a typology of prevention strategies, and created a document defining the different evidence types. This guidance was developed and shared in enough time for grantees to include the information in their next progress reporting.

Because of these Actionable Report findings, definitions for prevention strategy categories and outcome types were developed over time and, with grantee input, discussed and described on a technical assistance call, and then used by grantees when entering data into the data management information system. A year later, when this process was complete, another Actionable Report was developed that better described the scope of the prevention strategies implemented and the strategies' measured outcomes. A similar process was used to clarify definitions of the different types of evidence. The CDC staff created a guidance document that defined the different types of evidence and provided examples, discussed this guidance on an evaluation technical assistance call with grantees, and requested that grantees update these designations on the basis of their new shared understanding. With each Actionable Report produced, CDC staff were able to describe program grantees' efforts across sites, detect any issues that could hinder CDC's evaluation or support to grantees, and provide proactive technical assistance to support grantees in the implementation and evaluation of their efforts (see the Table).

**Modifications to the data-to-action process**—The Data-to-Action Framework provides a 5-step rapid feedback cycle that guided the DELTA FOCUS data-to-action process. However, over time the rapid feedback cycle evolved so that the first step was repeated less frequently. In particular, one observation from the first Recommendations Report was that conducting separate meetings for the development of each report and data collection topic could become time-consuming. Moreover, the Recommendations Report suggested a need for more systematic methods for tracking the programmatic decisions that resulted from the reports and data collections in order to maintain accountability to and engagement in the data-to-action process. Thus, the DELTA FOCUS team decided to create a unified and systematic protocol to facilitate Data-to-Action planning and tracking for the second evaluation year; this recommendation resulted in the creation of the Actionable Report Protocol, which served as a planning document for all data collection topics at the start of the cycle. The implementation of the Actionable Report Protocol had the desired effect of streamlining the first step of the rapid feedback cycle in the development of report and data collection topics.



In addition, there remained a need to respond flexibly to shifting programmatic priorities and needs; therefore, the topics of the Actionable Reports evolved. Specifically, during project year 1, CDC staff needed to understand what was happening to identify promising prevention strategies for IPV, as well as improve technical assistance provided by CDC staff to grantees. However, in project year 4, prioritized topics shifted to include identifying opportunities to better support grantees through describing their barriers and facilitators and exploring how grantees are measuring their outcomes and learning about the overarching benefits, challenges, and lessons learned from the program (see the Table).

## Findings

Data-to-action report findings have also provided useful material and information that helps ensure that CDC staff are being accountable to both internal agency leadership and the grantees themselves. Charts, tables, and other graphics that are regularly included in the data-to-action reports have been useful when CDC staff are requested to provide updates to management and leadership at different levels of the organization. Often visuals from Actionable Reports are used when CDC staff and consultants share report findings with grantees to facilitate their collaborations with each other, improve their reporting, and/or build their capacity for IPV prevention.

In addition, the SDCs are helpful in supporting CDC staff's provision of technical assistance and building a learning community for DELTA FOCUS program grantees. The purpose of the first SDC (in project year 1) was to conduct interviews that would generate insights about how program grantees were experiencing aspects of DELTA FOCUS—communication, technical assistance, and a community of learning—so that CDC staff could take action to improve implementation. To address this purpose, CDC consultants conducted unstructured and thematic telephone interviews with a subset of grantee representatives identified by CDC staff. The SDC findings were discussed in the annual Recommendations Report. Themes emerged from the first SDC, including the following: monthly meetings with CDC staff and the in-person grantee meeting were noted as the most valuable support; all program grantees experienced positive communication with their CDC project officers; the community of practice platform and written feedback were experienced as the least valuable supports because of lack of use by peers and perceived inconsistency between CDC role as a partner and funder, respectively, and although program grantees desired to learn from and support each other, they all experienced barriers to creating the desired learning community and requested more *face time* with each other.

After debriefing the report findings CDC staff used the information to engage in a series of brainstorming sessions that resulted in the creation of a plan for programmatic improvement that was shared with program grantees, which covered topics that were identified as important to acknowledge and address. For example, on the topic of *face time*, CDC staff responded by hosting an additional grantee meeting to offer opportunities for more grantee interaction. Specifically, the seating for some sessions was arranged to facilitate program grantees doing similar work to sit together, and concurrent sessions were organized topically so that program grantees doing similar work would have the opportunity to collaborate. This program improvement was effective at achieving its goals, as a majority of attendees

indicated that the meeting helped build relationships with fellow grantees and increase *face time* as requested. As for the community of practice platform, CDC staff acknowledged the challenges and launched a listserv as an easier way to share resources and announcements with each other and partners in their DELTA FOCUS programs.

## Summary

The rapid feedback cycles urge staff involved in planning, program implementation, and evaluation to come together frequently and identify emerging challenges and ways to overcome these challenges. A data-to-action process also creates space to consider whether the evaluation is adequately capturing the necessary data and whether there are any opportunities to enhance implementation or evaluation in previously unanticipated ways. As a result, the project level evaluation of the DELTA FOCUS program is both systematic and flexible and maximizes the opportunity to engage in ongoing program improvement in using timely data and feedback to make any necessary modifications in real time. While the findings from the data-to-action process are project-specific, the process itself is generalizable across settings and at different program levels.

For example, data-to-action informs DELTA FOCUS grantees' evaluation of their prevention strategies, in part, because CDC required grantees to implement their own data-to-action process and also because CDC intentionally designed its data-to-action process to include grantees as a secondary, and at times primary, audience (see Figure 2). During project years 1 and 2, one of the Actionable Reports was focused on a topic of interest to grantees. The CDC staff solicited topics from grantees over project calls, through an electronic community of practice platform, and in-person during grantee meetings. The CDC staff and consultants presented and debriefed the findings with grantees once the reports were completed. Over time, it was clear that grantees and CDC staff were interested in the same topics (eg, what are grantees implementing and how are they evaluating their strategies). During project year 3, the CDC staff and consultants updated or repeated topics with new information. When all of the Actionable Reports were completed, the findings across the reports were shared with grantees. In project year 4, the findings of Synthesis Reports were also shared with grantees.

In terms of the requirement for DELTA FOCUS program grantees to have their own data-to-action process, grantees benefit from the very nature of having a plan in place to assess implementation progress and success along the way and then use those findings for program improvement. One benefit is the ability to make midcourse corrections in how a program is implemented, which several grantees have reported doing by either changing program content or limiting the number of participants in an activity. Grantees have also used data-to-action findings to adjust data collection methods by switching from repeated survey administration (which was causing program participant fatigue and impacting the quality of the data collected) to optimizing existing strategy activities to collect real-time data in creative ways (eg, using interactive theatrical performances to gather information from the audience). While it is not within the scope of this article to go into full detail on grantees' data-to-action processes and applications, it is important to acknowledge that the DELTA FOCUS program requirement for grantees to have their own data-to-action process resulted



in intentional, systematic processes that are beneficial and increasing the likelihood that these programs will be successful.

## Conclusion

Throughout the course of DELTA FOCUS, and representative of using a developmental evaluation approach, the data-to-action process yielded timely data that led to actionable information for CDC staff and consultants' support of the program grantees and of the IPV prevention program implementation and evaluation. In addition to programmatic improvements, the data-to-action process itself improved over time. Some of those improvements include the following:

1. Utilizing streamlined but flexible processes to maintain focus while identifying and meeting information needs (eg, the Actionable Report Protocol and process for developing the protocol).
2. Presenting the findings from the data-to-action process as briefly as possible to maintain engagement, while still maintaining sufficient clarity in evaluation reporting.
3. Developing specific and concrete recommendations for use that are likely to be adopted, while continuing to engage the team in generating ideas for action.

As suggested by the list of improvements and examples previously, and in response to the complexity of evaluating multisite programs with a variety of interventions, a structured yet flexible process is desirable because priorities and needs can change over a period of 5 years. Particularly for new or developing IPV prevention programs, the Data-to-Action Framework provides a useful evaluation approach that allows for and encourages ongoing opportunities to reflect on how the program is progressing. It may be especially helpful for multistate projects that have substantial complexity in how program goals are operationalized (ie, assists with standardization). This intentional effort to engage in a data-to-action process at the project level not only increases the quality of support and technical assistance but can also lead to outcomes that are more successful.

## Implications for Research

The IPV prevention field has a limited evidence base,<sup>3</sup> so building knowledge and understanding of locally developed prevention program processes can be useful for researchers. The potential for data-to-action processes to build practice-based evidence is great. By working in partnership with implementers, researchers can serve not just in an oversight capacity but also in a learning capacity alongside the implementers. From that vantage point, researchers can gain insights into the unique needs of local communities. This type of community-based work builds the foundation of practice-based evidence. Researchers should look to and build upon this evidence base when pursuing additional IPV prevention research questions and developing novel intervention strategies and approaches. In this way, programs such as the DELTA FOCUS program can contribute to the IPV prevention field by building practice-based evidence for community and societal-level IPV prevention strategies.

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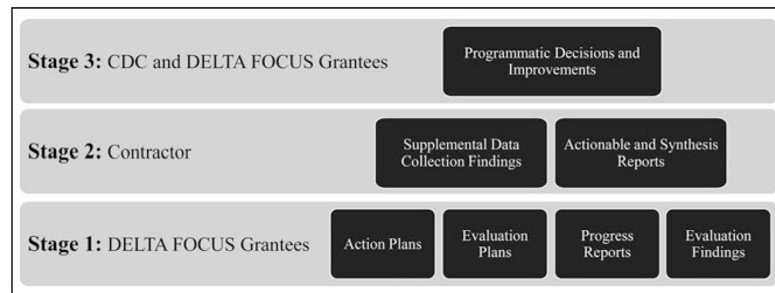
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### Implications for Policy & Practice

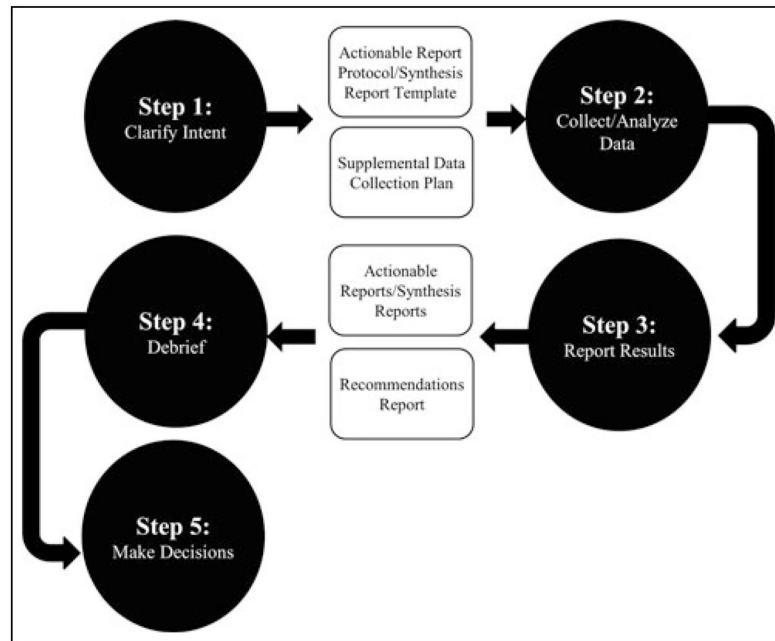
The utility of a data-to-action process for funders at the project level was evident throughout the DELTA FOCUS program. Funders often play an important decision-making role, and incorporating an internal process that supports ongoing collection and review of data promotes opportunities for broader program improvement that is data-informed. Therefore, some implications for policy and practice are listed below:

- Encourage or require the use of a data-to-action process of funding recipients.
- Partner with states and communities to learn from each other and document lessons learned.
- Gather data during the course of program implementation that can be used for program improvement.
- Strengthen programs and increase buy-in from stakeholders as a direct result of making program adjustments informed by a data-to-action process.

**FIGURE 1.**

Data-to-Action Process

Abbreviations: CDC, Centers for Disease Control and Prevention; DELTA FOCUS, Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States.



**FIGURE 2.**  
Data-to-Action Flowchart



TABLE

## Data-to-Action Report Examples

| Report Types (Audiences)  | Example Topics (Descriptions)   | Highlighted Findings   | Use of Findings   |
|---|---|--|---|
| Actionable Reports and Synthesis Reports (CDC program, science officers, grantees, and CDC leadership [secondary audience]) | <ul style="list-style-type: none"> <li>Analysis of strategy outcomes (In years 1 and 3, explored what is currently known about the IPV prevention strategies' intended and observed outcomes)</li> </ul>  | <ul style="list-style-type: none"> <li>Intended outcomes (ie, planned to be tracked or measured) and observed outcomes (ie, reported on) were concentrated at the individual and community levels of the social ecological model</li> </ul>  | <ul style="list-style-type: none"> <li>CDC used the Actionable Report findings to identify training topics and inform technical assistance to grantees</li> <li>Grantees used the strategy outcome findings to connect with peers with similar evaluation objectives</li> </ul>   |
|   | <ul style="list-style-type: none"> <li>Analysis of barriers and facilitators to strategy implementation (In year 2, summarized barriers and facilitators to strategies' success, approaches grantees use to overcome barriers, and unanticipated outcomes)</li> </ul> | <ul style="list-style-type: none"> <li>Grantees described 4 key facilitators that enabled them to create and implement their prevention strategies including               <ul style="list-style-type: none"> <li>engaging in intentional, participatory, and effective planning,</li> <li>using existing or emerging tools and research,</li> <li>employing effective formats for their prevention strategies, and</li> <li>leveraging current public visibility and momentum surrounding IPV and sexual violence.</li> </ul> </li> <li>Nearly half of grantees described key barriers as reported project delays, ambitious timelines, and time constraints as affecting their ability to implement effective IPV prevention strategies</li> </ul> | <ul style="list-style-type: none"> <li>CDC program and science officers fostered collaboration among grantees implementing similar prevention strategies so that they could support and learn from each other</li> <li>Grantees used the Actionable Report findings for program improvement (eg, borrowing approaches used by their peers)</li> </ul> |
|   | <ul style="list-style-type: none"> <li>Analysis of state and local evaluation plans (In year 3, assessed the extent to which grantees' evaluation plans</li> </ul>  | <ul style="list-style-type: none"> <li>Many evaluation plans did not consistently describe who collects data, from whom, and how often</li> </ul>  | <ul style="list-style-type: none"> <li>CDC science officers used the Actionable Report findings to plan a grantee training and disseminate</li> </ul>   |

| Report Types (Audiences)  | Example Topics (Descriptions)  | Highlighted Findings   | Use of Findings   |
|---|--|--|---|
|   | met CDC recommendations)   |  | resources to support grantees' evaluations  |
| Recommendation Reports (Supplemental Data Collection findings) (CDC program, science officers, and CDC leadership [secondary audience]) | <ul style="list-style-type: none"> <li>Identify candidates whose work should be highlighted and seek grantees' input on CDC drafted criteria for "highlight" stories and potential dissemination channels for DELTA FOCUS stories</li> </ul> | <ul style="list-style-type: none"> <li>Grantees proposed new "highlight" story criteria including:               <ul style="list-style-type: none"> <li>Cost, labor, and readiness as some strategies are more labor intensive, expensive, and require a greater degree of readiness and capacity to implement</li> <li>Feasibility of replication if a goal is to promote effective practice across grantees</li> </ul> </li> <li>Grantees suggested disseminating DELTA FOCUS stories at conferences, workshops, in peer-reviewed journals, and existing forums for sharing information on IPV prevention</li> </ul> | <ul style="list-style-type: none"> <li>CDC program and science officers used the Recommendation Report findings to identify candidates for highlight stories and solidify the selection process</li> <li>CDC and grantees used the Actionable Report findings to brainstorm about dissemination channels and share plans for dissemination at a grantee meeting</li> <li>Grantees and CDC proposing conference presentations together to describe DELTA FOCUS work</li> </ul> |

Abbreviations: CDC, Centers for Disease Control and Prevention; IPV, intimate partner violence.