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Management and Operationa L
Impacts of HIV Prevention Com-
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**Management and Operational Impacts
of HIV Prevention Community Planning**

Lessons Learned At Mid-Course
and Implications for Future Activities

Submitted to:

Program Evaluation Branch
Division of HIV/AIDS Prevention
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Table of Contents

Page Number

A. Background	2
Underlying Logic of the HIV Prevention Community Planning Process	2
Development	3
B. Context and Parameters of the M&O Indicators Development	4
Specifying the M&O-Relevant Aspects of the HIV Prevention Community Planning Process	4
Management and Operations Logic Model	4
What Is Addressed	4
What Is Not Addressed	6
Longitudinal Timeframe	6
The Management and Operational Impact Indicators	7
C. Why Monitoring Management and Operational Impact Is Important	9
Mediating Role of M&O Activities	9
Direct Impacts of Planning on Management and Operations	10
Monitoring and Conveying Successes to Stakeholders	10
D. Pilot-testing Methodology	12
Data Collection for Indicators	12
E. Lessons Learned at Mid-Course	14
I. Objectives and Intended Use	14
a. Problems with Retrospective Assessment	14
1. Incomplete Comprehensive Plans	14
2. Planning Is Various Stages of Development Across the Nation and Within Jurisdictions	15
3. Monitoring and Coordinating Community-Wide HIV Prevention Activities	15
b. Interest of Governmental and Nongovernmental Staff in These Issues	15
c. Difficulty in Aggregating Data Across Sites	17
d. Conclusions Concerning Objectives and Intended Use: A Prospective Approach to Indicator Tracking	18
II. Indicators	19

a. Correspondence Between CP and Proposed Activities	19
b. Correspondence Between CP and Proposed Non-CA300 Activities	19
c. Correspondence Between Proposed and Undertaken Interventions	19
d. Development of Application and Allocation of Award	20
e. Funding	22
f. Intramural/Extramural Mix	23
g. Staffing Patterns	23
h. Capacity Building and Infrastructure Development	24
i. Intervention Characteristics	24
j. Collaboration	26
k. Conclusions Concerning Indicators	27

Appendix A: Indicators Used in Initial Pilot Test

Appendix B: Indicators Draft List of Revised Indicators

Management and Operational Impacts of HIV Prevention Community Planning

Lessons Learned At Mid-Course and Implications for Future Activities

A. Background

HIV Prevention Community Planning was implemented nationally in January 1994 to encourage locally-determined HIV prevention priorities and evidence-based planning that addresses those priority needs. The Health Departments receiving Cooperative Announcement 300¹ (CA300) funds are responsible for both coordinating and implementing the Community Planning process. Thus, these agencies are ultimately responsible for developing the Resource Inventories and Needs Assessments that reflect the community-wide needs and resources, regardless of who provides the resources. The Supplemental Guidance to Announcement 300 also notes that “Grantees are responsible for *operationalizing* and *implementing* HIV prevention services/activities outlined in the comprehensive plan...” (emphasis added).

The Community Planning process is now in its third full year of implementation. The critical question being asked about the program is “How is community planning confirming, enhancing, and changing HIV prevention programs?” As part of the process of accounting for the successes of this process, and the areas that require further enhancement, CDC contracted with Macro International to develop and test markers, or indicators, of the management and operational (M&O) impacts of HIV Prevention Community Planning on HIV prevention programs. The contract also entailed developing and pilot testing a methodology for obtaining information on the indicators for a retrospective study. This report will discuss the experience in using the indicators and methodology, and describe recommendations for next steps.

Underlying Logic of the HIV Prevention Community Planning Process. The goal of HIV Prevention Community Planning is to improve the effectiveness of HIV prevention programs by strengthening the scientific basis and targeting of prevention interventions. The immediate result of the Community Planning process is to produce a Comprehensive HIV Prevention Plan which describes the priority populations and interventions for that health jurisdiction. Health Departments develop their application for Announcement 300 funds based on the Comprehensive Plan.

An implicit assumption is that the actual disbursement of funds by the Health Department and the implementation of HIV prevention programs throughout the community will correspond the priorities and strategies of the Community Plan. This causal chain of events is depicted in Figure 1.

¹ This Announcement was the predecessor to Announcement 706— issued in Spring 1996—that also funds HIV Prevention Programs.

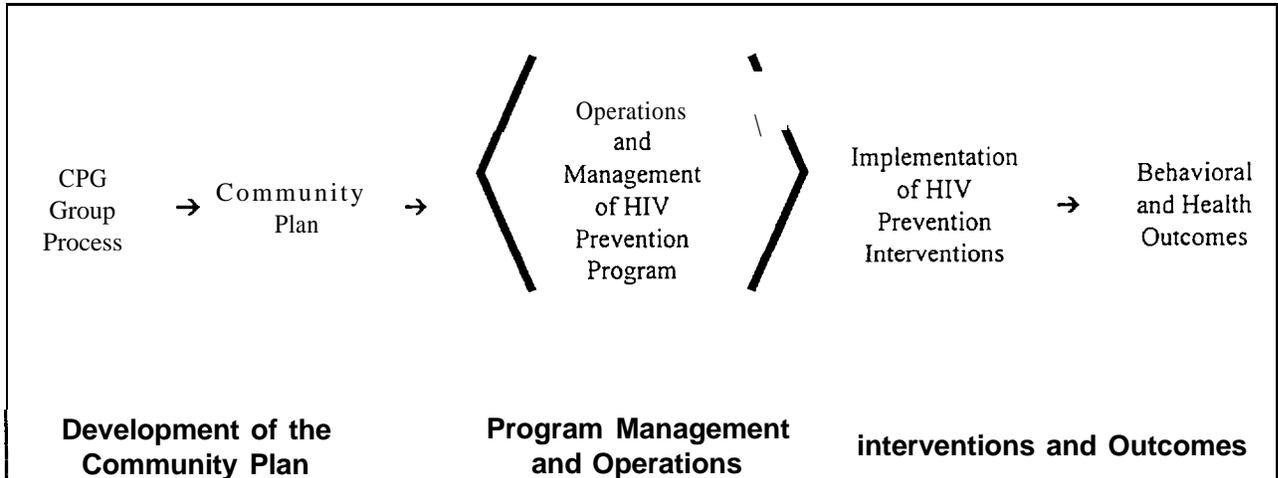


Figure 1. Chain of Events in the HIV Prevention Community Planning Process

Development. The development of the indicators was undertaken with the assistance and guidance of a broad-based group of experts and stakeholders involved in HIV Prevention Community Planning. This advisory group consisted of State AIDS Directors, Community Planning Co-Chairs, CPG members, NASTAD representatives, representatives of community-based organizations, evaluators, and CDC staff.

During a two-day meeting, review of subsequent documents, and a series of conference calls, this group helped articulate what they believed to be the critical issues that Community Planning was likely to affect. The input of this group was crucial to the development of indicators that accurately reflect the reality of HIV Prevention Community Planning in health departments, CBOs, and other community agencies.

B. Context and Parameters of the M&O Indicators Development

Specifying the M&O-Relevant Aspects of the HIV Prevention Community Planning Process. The statement of precise indicators required the establishment of clear boundaries to the arena of consideration. This required a description of the overall HIV Prevention Community Planning process and demarcation of the part of that process that was appropriate for consideration in the context of management and operations.

There are at least three major components of the overall HIV Prevention Community Planning process (also shown in Figure 1):

- the development of the Community Plan itself (including the Community Planning Group [CPG] process leading to its development),
- the operationalization, funding, and management of prevention programs and services, and
- the implementation of specific prevention services and the verification of behavioral and health outcomes resulting from those services.

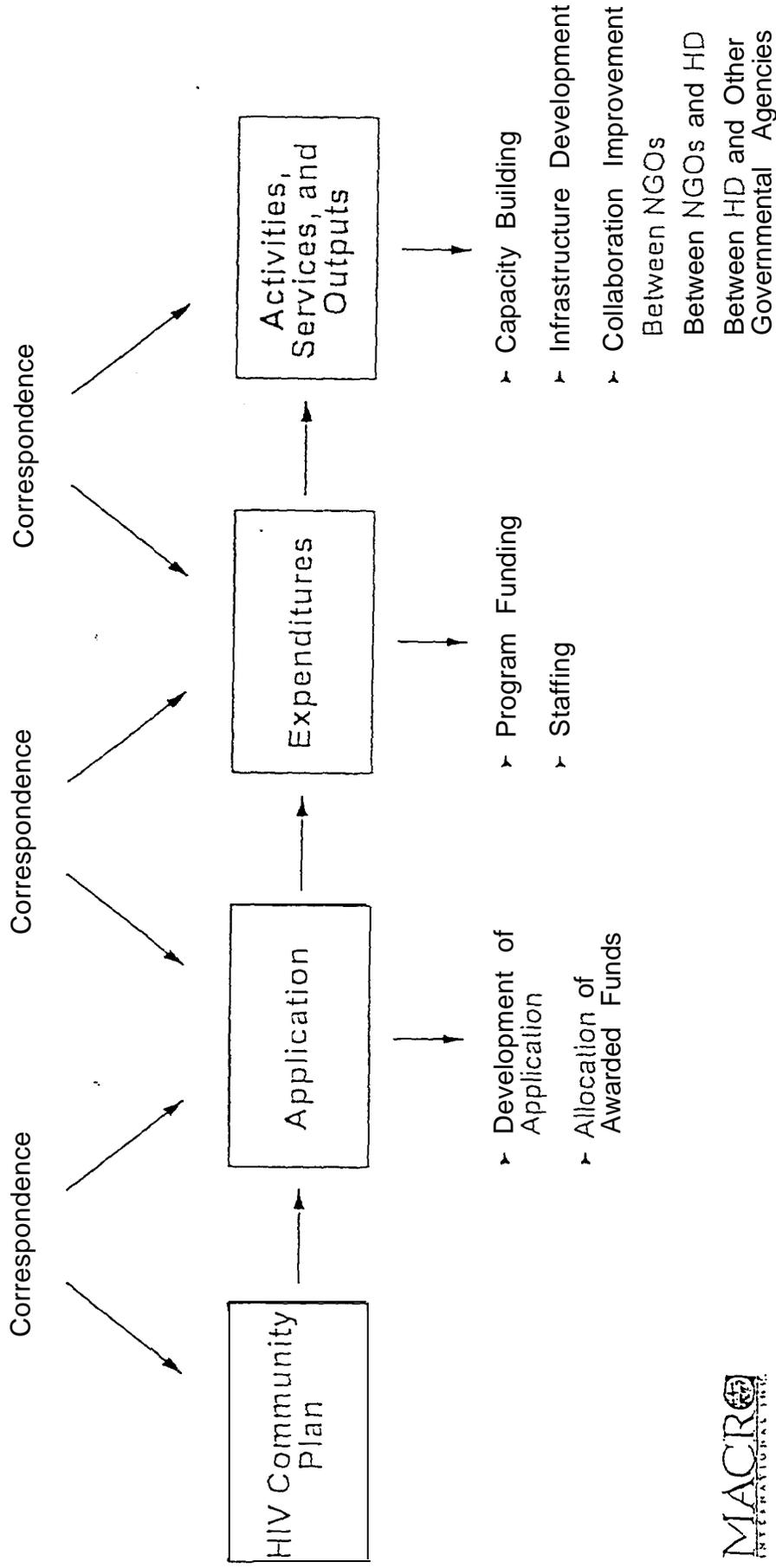
Management and Operations Logic Model. Based on the model depicted in Figure 1, one of the first steps taken in this development phase was the creation of a logic model to depict the hypothesized steps and impacts of HIV Prevention Community Planning on HIV prevention program management and operations. As seen in Figure 2—the M&O Indicator Logic Model—the management and operational impacts of Community Planning can be further subdivided into three major categories:

- **Community Planning’s impact on the Cooperative Agreement Application and the process for preparing it,**
- **Community Planning’s impact on actual health department and contractual expenditures**
- **Community Planning’s impact on outputs, services, and other activities in the community.**

The 41 indicators that were developed in the initial phase of this contract are distributed within these three categories. The full set of indicators used in the pilot phase can be found in Appendix 1.

What Is Addressed. Macro’s current task addresses issues pertaining to the pivot section of Figure 1—the program management and operations area. The development group (described in the **Background** section of this document) decided that this task should focus on the set of activities occurring once a comprehensive Community Plan has been developed and accepted, and before the actual outcomes of the implemented activities have been evaluated. Thus, the initial reference point for the indicators is the presence of the Community Plan itself, without assessment of the process by which that plan was developed.

Development of Management and Operational Indicators for HIV Prevention Community Planning



The Program Announcements for CA300, including the Supplemental Guidance for community planning, describe the relationship of HIV Prevention Community Planning to several critical aspects of the management and operation of HIV prevention programs. These aspects include

- the activities proposed in the Application and elsewhere (and their relationship to Community Plan priorities),
- measures to increase the presence of program characteristics requested in CA300,
- the extent of collaboration among health departments, CBOs, and other government agencies to enact the Community Plan and to increase the efficient use of HIV prevention funds.

What Is Not Addressed. It is also important to specify what these indicators do not address. They do not address issues regarding the formation of CPGs, their deliberations or decision-making processes, nor the quality of their primary product (i.e. the Community Plan). Neither do these indicators deal with implemented programs—the integrity or extent of their implementation, their efficacy in effecting HIV preventive behaviors, or the resulting changes in disease incidence and prevalence.

Longitudinal Timeframe. An important consideration for the development and implementation of these indicators was the temporal expectations implicit the question: “How is community planning confirming, enhancing, and changing HIV prevention programs?” Because confirmations, enhancements, and changes require some baseline point of comparison, a longitudinal approach is also needed to include a period prior to the implementation of Community Planning by the CDC. Therefore, to detect changes over time, our pilot testing undertook to examine four years of HIV prevention programs (1993-1996) to assess trends in changes from pre-Community Planning status through the third full year of Community Planning (See Table 1).

Year 0	Year 1 of Community Planning	Year 2 of Community Planning	Year 3 of Community Planning
Year before Community Planning process is initiated	CP process is initiated; CPG's are developed	Application is driven by CPG-developed plan	Community Planning process continues
1/93 -- 12/93	1/94 -- 12/94	1/95 -- 12/95	1/96 -- 12/96

Table 1. Years Covered by the Pilot Indicator Development Effort

During the first funding cycle, January-December 1993, Grantees applied for and carried out HIV prevention programs without federally mandated Community Planning. Therefore, this cycle will serve as a baseline from which to compare the effects of the national program of community-driven planning.

The second year, 1994, is the year in which Community Planning was initiated, but might be characterized as a transitional period leading to full CP implementation. The third and fourth cycles (1995 and 1996) are the first two years of funding in which Community Plans were developed prior to the applications for Cooperative Agreements. Examining these two most recent years will allow a more longitudinal look at changes that Community Planning may have influenced.

The Management and Operational Impact Indicators. The primary issues that emerged through the discussions with State, NASTAD, CBO, and other stakeholders can be categorized into five major divisions (as seen in Table 2).

- Correspondence between Community Plan strategies, proposed activities, and undertaken activities
- Quality assurance for implementation
- Evidence of science-base, cultural competence, and community-wide support
- Capacity building and infrastructure development
- Collaboration (among HDs, CBOs, and other governmental agencies)

Indicator Category	Rationale	Examples
<p>Correspondence (between Community Plan strategies, proposed activities, and undertaken activities)</p>	<p>CA300 guidance notes that “the grantee will develop an application for CDC FY95 (and beyond) funding based on the Comprehensive HIV Prevention Plan.” Priority interventions for particular populations (as stated in the Community Plan) are proposed and implemented with CA300 funds and with other resources available to the community. In addition, the Plan was not intended to be implemented only through CA300 funds, but the plan should serve as a comprehensive guide for other community providers who wish to be responsive to agreed-upon community needs</p>	<p>Evidence that some community agency— regardless of whether they receive CA300 funds- proposes and implements each intervention strategy noted for each priority population in the Community Plan OR A CBO notes that they referenced the Community Plan when applying for funds from a private foundation.</p>
<p>Quality assurance for implementation</p>	<p>Mechanisms are in place for monitoring the nature and quality of prevention services to ensure that they address CA300 requirements</p>	<p>The RFP released by a Health Department explicitly requires a description of the science-base for each intervention proposed by contractors.</p>
<p>Evidence of science- base, cultural competence, and community-wide support</p>	<p>Proposed and implemented services should demonstrate these characteristics as outlined in CA300 and the Supplemental Guidance</p>	<p>A contractor’s proposal details how they address the cultural competence in their intervention</p>
<p>Capacity building and infrastructure development</p>	<p>These are essential components of a comprehensive HIV Prevention program as noted in the Supplemental Guidance and may be necessary to assist CBOs, local HDs, and other provider to deliver prevention services and to sustain the infrastructure of organizations that deliver those services</p>	<p>A CBO offers training on grant writing or finding new sources of funding</p>
<p>Collaboration (among HDs, CBOs, and other governmental agencies)</p>	<p>Community Planning guidance notes in several places (e.g., Section D of Supplemental Guidance) the need for overall coordination of HIV prevention services within a given jurisdiction, as well as the limited ability of HDs alone to solve the complex problem of HIV prevention.</p>	<p>Health Department works with the Department of Corrections to implement counseling and testing for all entering inmates</p>

Table 2. Five Primary Categories of Indicators

C. Why Monitoring Management and Operational impacts Is Important

Program development and implementation are often viewed within organizations as creative and exciting (“We’re *doing* something!”). Determining behavioral and health outcomes provide data about the ultimate goal that programs, the public, and funders want to see. Figure 3 illustrates the typical relationship that many providers see between planning and outcomes.

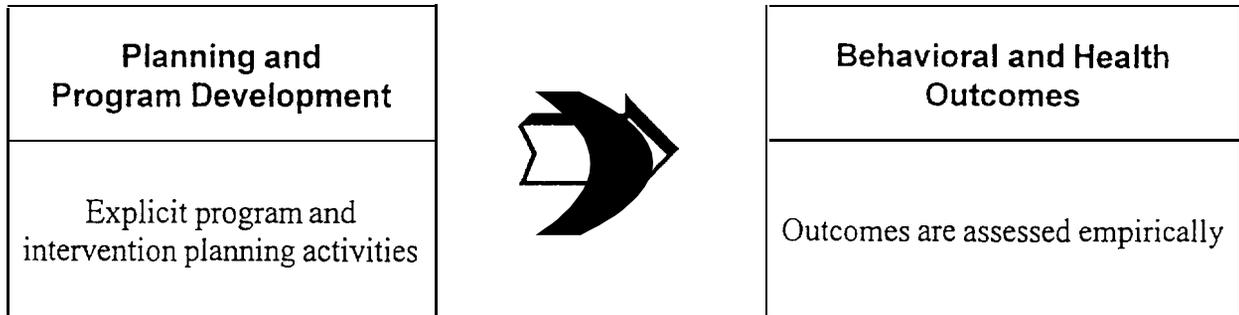


Figure 3. Traditional view of the relationship between program planning and outcomes.

Mediating Role of M&O Activities. Note that “management and operational concerns” do not appear in this all-too-standard perspective. Yet, a focus on only planning and outcomes can lead to misleading interpretations of how certain outcomes—be they promising or disappointing—came about. If an agency is concerned with ensuring desired outcomes and refining less than optimal procedures contributing to shortcomings in those outcomes, then it is not adequate to know only that planning occurred and that outcomes did (or did not) occur. Figure 4 suggests what is unknown in this situation.

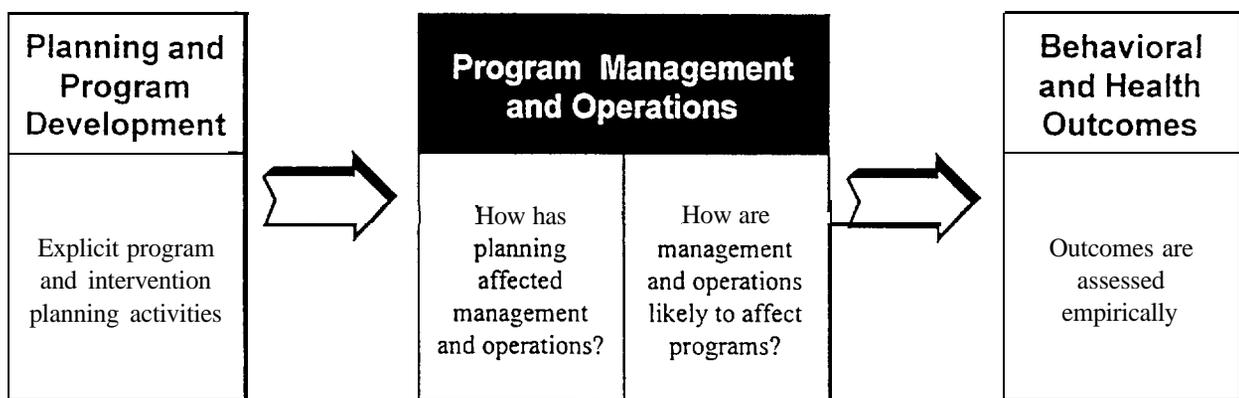


Figure 4. Mediating role of management and operational activities

Direct Impacts of Planning on Management and Operations. Paying attention to management and operational issues in HIV prevention programs also provides a direct benefit to program administrators. A great many of the activities that public, non-profit, and private HIV prevention providers must engage in are management tasks, or at least non-programmatic activities. These activities can include

- training and technical assistance for program delivery (i.e. capacity building) or for organizational sustainability (infrastructure development),
- preparation of RFPs and resulting proposals,
- execution and monitoring of contracts,
- seeking of diversified funding sources, and
- coordination of activities within the jurisdiction.

Thus, the direct management and operational impacts of HIV Prevention Community Planning could also be depicted as

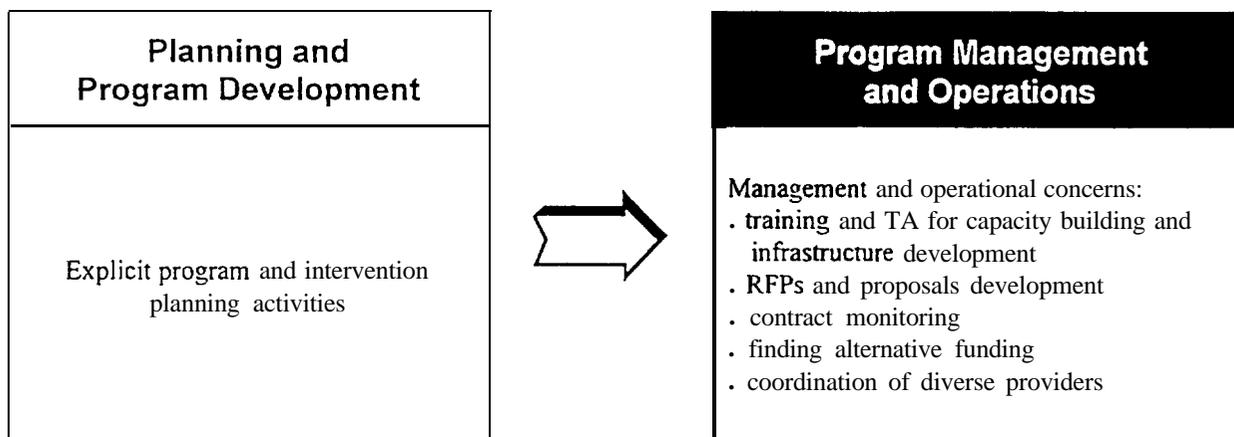


Figure 5. Direct impacts of Community Planning on management and operational activities.

Monitoring and Conveying Successes to Stakeholders. The previous two points have emphasized the value the program’s managers of monitoring management and operational impacts. Clearly, such monitoring provides to program managers data with which they can improve their programs and the administration of them. But, program administrators have many reasons to communicate the positive outcomes of their programmatic activities to a variety of stakeholders.

Maybe most evidently, monitoring HIV prevention program offers a straightforward way to provide productive feedback to the *community planning group* about the impacts of the process. Not only will such information be valuable as an information source for ongoing planning refinement, it will also serve as a reinforcement for the rigorous effort put forth by the group. Monitoring the process

also demonstrates the community's level of investment in HIV Prevention Community Planning and their commitment to the highest quality process, programs, and outcomes.

Management and operational data is often of prime importance to *decision-makers* at local, state, and national levels. Governors, state and Federal legislators, members of city councils, health commissioners, and mayors value programs' capacity to administer programs with systematic effectiveness and with thoughtful allocation of resources. A systematic means of reporting successes provides program administrators with a means of promoting achievements. Such information can be used to bolster arguments for additional funding or funding for new programs.

In addition, management and operational data provides concrete information to help maintain the support and collaboration of other prevention partners—for example, CBOs, NGOs, other health and human services agencies—as well as the general public. If the HIV Prevention Community Plan is a cornerstone around which the community can rally for an integrated, efficient approach to HIV prevention, then data about its implementation is an opportunity to keep partners informed and maintain public endorsement of the process. It is a chance for grantees to show themselves in a positive light. Stated simply, this information provides substantial material for the marketing of programmatic successes.

D. Pilot-testing Methodology

Once the draft indicators were developed, a methodology was proposed for finding evidence related to them. This methodology, based on the initial plan for the project, was retrospective. The objective was to look at the trend in impacts from pre-Community Planning through the present.

A major premise of this initial effort was that as a retrospective review, it was important for the primary sources of information about indicator evidence to be objective. Our working definition of “objectivity” was that the information was documented in a written form so that it had some degree of an “official” status as part of the program’s permanent record, and that the information was generally available to anyone attempting to find information related to the indicators. This is contrasted to information obtained orally from an interview and, thus, not part of the program’s permanent record.

A ramification of this premise is that one goal of this indicator development process was to determine the most productive sources of information for future data collections. Thus, during an initial pilot test, designed to see if objective data addressing the indicators could be found, we attempted to review an exhaustive set of documents related to the program to find relevant information.

This initial pilot test of the indicators was conducted in a state that had both a statewide planning group and seven regional planning groups. This allowed us to examine some of the implications of tracking planning-related activities in a system with multiple management and operational components within a single grantee jurisdiction.

Data Collection for Indicators. The protocol for data collection and analysis was comprised of three stages.

- **Pre-Site Visit**
- **First Site Visit**
- **Second Site Visit**

Pre-Site Visit activities consisted of both preparing the logistics of the two site visits and performing initial data gathering, collection, and analysis. Coordinating with CDC Technical Monitors and the CDC Project Officer (PO) for the state facilitated access to key program staff in the state who provided access to a wide variety of documents. The CDC Technical Monitors also provided access to the range of CDC-held documents related to this state’s HIV Prevention programs including community plans, Cooperative Agreement 300 proposals, supplemental award proposals, reports from the grantee, administrative data, and official correspondence.

The designated liaison from the state was the Community Planner. Through phone calls, electronic mail, regular mail, and fax, she was briefed on the project and helped arrange times and logistics for the site visit. The Community Planner obtained and forwarded to Macro many valuable documents

for review prior to the site visit (as was intended for pre-site visit activities). These included reports to government administrators, internal budget documents, CGP meeting minutes, and some information on programs funded by agencies other than the CDC.

The second activity in the Pre-Site Visit stage was initial data collection and analysis. We examined most of the documents in our possession prior to going on-site. Data related to the indicators was abstracted and entered into a database that was used to manage and analyze data for a given indicator across a number of data sources. This included information about the

- Priority populations proposed in the Community Plan,
- Specific strategies noted for addressing the HIV prevention needs of each of those populations,
- The interventions proposed by the Grantee with CDC and other funds for each target population.

Prior to the site visit, we compiled the data already examined to provide a base from which to begin the site visit data collection. This compilation included a review of 1) indicators for which data were found, 2) indicators which contained discrepant data, and 3) documents that remain to be seen.

The **First Site Visit** began with an Entrance Conference with the Grantee representatives and Macro staff. During this conference, we reviewed the objectives of the indicator collection generally and the potential benefits for the site, the preliminary findings (from pre-site visit data review), and the agenda for the site visit. Some new materials were discovered during this meeting.

During the first site visit, we also met with key managers of counseling and testing services (C&T), health education and risk reduction (HE/RR), social marketing, and financial and administrative services. We also met with the HIV Program Manager from one of the two large metropolitan HIV prevention programs. These meetings elicited data sources related to the indicators relevant to the particular areas. This approach allowed us probe for specific information about particular indicators. This step also provided additional data sources from which we abstracted, coded, and entered indicator-related information as we had for pre-site visit data.

Follow-up to the First Site Visit entailed further review of documents and data entry. Initial analyses were conducted using all available data to determine the extent to which the 41 indicators were embodied by the Grantee's HIV prevention programs. Remaining information gaps and discrepancies within the indicators were determined through these analyses and provided one major agenda item for the Second Site Visit.

The purpose of the **Second Site Visit** was to review the collected and compiled indicator information with the Grantee to verify it and to clarify discrepant information with additional information from documents or key informants. The summary data set and the grantees' responses were reviewed during this meeting, as were suggestions for obtaining further data for indicators that continued to be difficult to find or resolve.

E. Lessons Learned at Mid-Course

Two types of information emerged from the initial pilot test of the M&O indicators and methodology. The first type relates to the intended use and objectives of the indicators, including constituents' interests in the indicators and the issues they reflect. Second, we have learned about the indicators themselves, necessary revisions, and about the availability of information related to them. In combination, we have discovered valuable information about the methodology, logistics, and process of collecting information of this nature in health departments and from other partners like CBOs and other governmental agencies.

I. OBJECTIVES AND INTENDED USE

a. Problems With Retrospective Assessment

In many places, retrospective data is unavailable to address many of the aspects of community planning deemed critical by the expert consultants. While these categories reflect priority considerations and objectives defined by representative key stakeholders in the Community Planning process, it is likely that grantees do not share a common understanding of all these elements, much less maintain data that would reflect these objectives. A retrospective approach requires much interpretation of information that is not reported specifically in reference to the indicators. Therefore, retrospective data for many indicators is likely to be fragmented and spotty.

1. Incomplete Comprehensive Plans. In addition, the Community Plan is the reference point for this process, that is, the HIV program activities should relate to strategies outlined in the comprehensive Plan. Yet, there is wide variation in the evolution of Community Planning in different locations; this is reflected in the completeness of the resulting Plans. Some jurisdictions do not yet have a Plan that poses specific target populations, much less specific intervention strategies. At the pilot site, most jurisdictions are moving in a very productive direction toward those ends, but it is difficult to assess the impact of Community Planning on HIV prevention programs when the Plans are incomplete or non-existent.

Therefore, retrospective data in such jurisdictions have inadequate reference points in the Plan to begin to suggest that changes or enhancements might be a result of the planning process. More thorough comprehensive Plans could be facilitated by an organizing framework for the Community Plan that relates explicitly to increasingly specific activities and characteristics detailed in the Community Planning guidance.

2. Planning Is in Various Stages of Development Across the Nation and Within Jurisdictions. As with the evolution of any organizational and programmatic program, HIV Prevention Community Planning is likely to manifest incrementally its effects on program management and operations. While short-term changes are important to document and understand, these markers will provide critical information for intermediate (less than five years) and longer-term outcomes of the community planning process. Table 3 on the next page shows examples of what these expectations might look like.

This situation is somewhat analogous to a surveillance model for disease or risk factors. Data from any given point in time can be informative, but trend data (i.e. data collected over time) is needed to reflect changes in the level or extent of a condition or set of conditions. Thus, it is critical that a system for monitoring the impacts of Community Planning be in place for an extended period to capture these trends.

3. Monitoring and Coordinating Community-Wide HIV Prevention Activities. One of the largest pieces of missing information relates to jurisdiction-wide coordination of HIV prevention activities beyond the health department. At the pilot site, there appear to be few other major sources of HIV prevention activities, but there were others. These included city revenues in the two metropolitan areas, philanthropically-funded activities, and non-CA300 state funds. Most evidence of knowledge of and coordination with other programs fell into this last category.

As an issue deemed a priority for grantees in the RFP and guidance, the importance and benefits of coordination are a significant impact of community planning. Grantees are in the best position for taking the wide-view in looking at all aspects involved in the coordination and collaboration of community-wide activities to carry out the Community Plan. This would include looking at activities funded by both CA300 and non-300 funds.

b. Interest of Governmental and Nongovernmental Staff in These Issues

Staff from both state and local governments as well as at the CBO level were interested in developing capacity for improved planning and monitoring and believed that these indicators were helpful in organizing these concepts. State and local health department staff almost unanimously suggested that the same information that was not available during the pilot test was information that they believed would be extremely helpful in carrying out their roles as grantees and as health departments. Specific examples of the kinds of information that they desired included 1) more complete information about contractors' proposed and undertaken intervention activities, 2) information about the HIV prevention activities of providers not funded through the state, and 3) more information from contractors about the nature of the interventions they carry .

	Situation / Changes During Years 1-3	Situation / Changes During Years 3-5	Situation / Changes During Years d-6
CHANGES IN...			
Community Planning Group	<p>Development of Processes and Procedures</p> <ul style="list-style-type: none"> Group development Conflict Resolution <p>Consensus plan developed by productive CPG collaboration</p>	<p>Consensus plan is enhanced by increased awareness and use of data and empirical validation</p> <ul style="list-style-type: none"> increasing responsiveness to community needs and desires 	<p>CP process is institutionalized</p> <p>Balance is obtained between science-driven goals and priorities and community-supported needs and desires</p>
Cooperative Agreement Application from the Health Department	<p>Application is moderately responsive to Community Plan (some business as usual)</p> <p>Multi-year contracts which are not congruent with CP priorities are phased out</p> <p>Little description of explicit linkages between CP and Program Plan</p> <p>Little description of how other resources contribute to overall enactment of the CP</p>	<p>Incorporation of Science into Program</p> <ul style="list-style-type: none"> Application highlights evidence-based strategies & services Increased value placed on evaluation and commensurate increased requirement of it for proposed interventions 	<p>Application is in full agreement with Community Plan</p> <p>HD spearheads coalition-building and coordinated strategies between themselves and community-based providers</p>
Community Providers (including HD)	<p>Development of understanding of CP principles and intent</p>	<p>Incorporation of Science into Program</p> <ul style="list-style-type: none"> Use of epi & behavioral data Evidence-based strategies & services Increased use of evaluation <p>Enhancements are carried out by individual providers without extensive integration of strategy across providers</p>	<p>Collaboration among community providers</p> <ul style="list-style-type: none"> Coalition development Thematic and programmatic integration among providers in community

Table 3. Possible Phases of HIV Prevention Community Planning Development

Non-governmental providers of HIV prevention services—both those at the pilot site and those involved in the indicator development process—also expressed interest in the collection of more information concerning the indicator-related issues that we discussed them. The interest seemed to be based on their investment in the Community Planning process and the tenets of that process. They supported the idea of the health department taking a proactive position in ensuring that the process (and all its component objectives) is implemented as fully and successfully as possible.

The experience from the initial pilot phase of this project suggests that there is likely to be a great deal of support from staff at all levels for methods of monitoring the successful implementation of HIV prevention programs stemming from the Community Planning process. Providing concrete, practical, and useful tools to these administrators and providers will allow them to more rigorously manage the programs for which they are responsible, thereby increasing the likelihood of carrying out broadly accepted and scientifically-based interventions to reduce HIV incidence in their communities.

c. Difficulty in Aggregating Data Across Sites

An original goal of this indicator development work was to have objective markers of the impacts of HIV Prevention Community Planning that would allow aggregation of data across grantees so that statements could be made about the national program. While it does appear feasible to develop objective indicators (i.e. indicators that independent observers of a given set of data could readily agree upon), there are two obstacles *at this point* to aggregating across grantees.

First, as noted above, the Community Planning process (including its implementation) is in different stages of maturity in different sites. Therefore, sites with more thorough comprehensive Plans may be more likely to see effects of those plans in their implementation. One fundamental assumption of aggregation is that like units are being compiled. Until there is some consistency in the sophistication of the plans, the available data fails to meet that assumption.

The second obstacle is that there appears to be inconsistent definitions and reporting of concepts related to these indicators. This further contributes to the lack of comparability among the data that is set to be aggregated. More work is needed to create a common understanding of the goals of Community Planning and a vocabulary to discuss those goals and the means of attaining them.

Immediate expectations for management and operational data must be proposed with consideration to the current state of the data. A phased approach with increasingly greater expectations may be a

d. Conclusions Concerning Objectives and Intended Use: A Prospective Approach to Indicator Tracking.

The synthesis of the preceding lessons seems to suggest the value of a prospective and iterative approach to planning, implementation, and assessment, leading back to the next wave of planning. What we have been referring to as “indicators” are reflections of core concerns, objectives, and characteristics of HIV Prevention Community Planning as it has been described since its inception. An organizing framework based on these issues can serve as “vision” tools for health departments and non-governmental organizations planning efforts, as they characterize critical outcomes for the Community Planning process. The primary benefit of such a process would be a management tool that each grantee could use to improve its programs and operations in order to improve the quality and outcome of its HIV prevention interventions—the ultimate goal of the Community Planning process.

An apt analogy for the assessment aspect of a prospective approach may be the model of disease surveillance. Goals are established for levels of disease deemed acceptable, according to prevailing scientific standards (e.g., Healthy People 2000). In that paradigm, trends are tracked longitudinally and interpretation of changes in those trends (compared to a baseline) are used to note evolving or emerging issues and inform strategic and practical plans for addressing those issues.

In the case of prospective tracking of management and operational issues, the baseline is the set of circumstances extant at the inception of the planning/tracking process. *Site-specific* goals and objectives are developed for programs, management, and operations in the context of the Federal guidance for Community Planning. Trends are tracked relative the sites’ own goals and this information can provide empirical basis for refining and revising the comprehensive plans for HIV prevention.

It is likely that many jurisdictions and their planning groups already address these issues. It is equally likely there are a large number of less-developed planning groups and jurisdictions who would benefit from the use of such a framework. Some of these are likely to be jurisdictions without the same level of human and financial resources as those whose planning and development is further evolved. Recognizing the successes of some grantees is an opportunity to assist other grantees to avoid “re-creating the wheel.”

A renewed emphasis in subsequent guidance to these more detailed aspects of the HIV Prevention Community Planning process could accelerate the operationalization of these objectives and the frequency with which information concerning those objectives is noted and documented. This is another indication that the issues underlying the indicators can serve as an organizing framework that makes these objectives explicit and emphasizes that these are objectives worthy of monitoring.

II. INDICATORS

a. Correspondence Between CP and Proposed Activities

Terminology and time lags in development made it difficult to see explicit correspondence between the priority populations and strategies in the CA300 applications and those the Community Plan. To the extent that the data are available, it is relatively easy to demonstrate these relationships. For prospective data collection, the proposed framework would offer a simple organizing scheme that would make it clear what interventions were proposed to address the plan priorities.

b. Correspondence Between CP and Proposed Non-CA300 Activities

At the pilot site, there was little concentrated information available on HIV prevention efforts outside of CDC/HD funding streams. In only a few instances, were there discussions of explicit relationships between these activities and Community Planning priorities, or the use of the Community Plan as guidance for deciding on pursuing particular interventions.

Other Federal Funding	Other State Funding	Non-CDC/HD sources
<ul style="list-style-type: none">. Title III. NIMH. NIDA. CSAP	<ul style="list-style-type: none">. Corrections. Mental Health. Substance Abuse. Family Planning	<ul style="list-style-type: none">. Foundation funds

Table 4. Examples of non-CA300 sources of funds.

Monitoring of non-CA300 interventions and their corresponding funds is a necessary precursor to coordination and collaboration of activities in a community to carry out the Community Plan.

c. Correspondence Between Proposed and Undertaken Interventions

These discrete activities should be straightforward to track. While there was variable consistency at the pilot site, even in retrospective data, there should be a Progress Report reference for each contracted intervention proposed in the prior year's Program Plan. Figure 6 on the next page depicts this set of relationships. Note also that this same model could be used for minimal tracking of Non-CA300 funds as well. For prospective monitoring, a simple organizing framework, the one shown in Table 5, could be used to set up and track proposed interventions.

Lack of consistency in terminology for target populations makes it difficult to retrospectively link descriptions of various services. Without the knowledge of an “insider” to make distinctions, an intervention’s target group may appear different in a proposal and a progress report, but actually be referring to the same group.

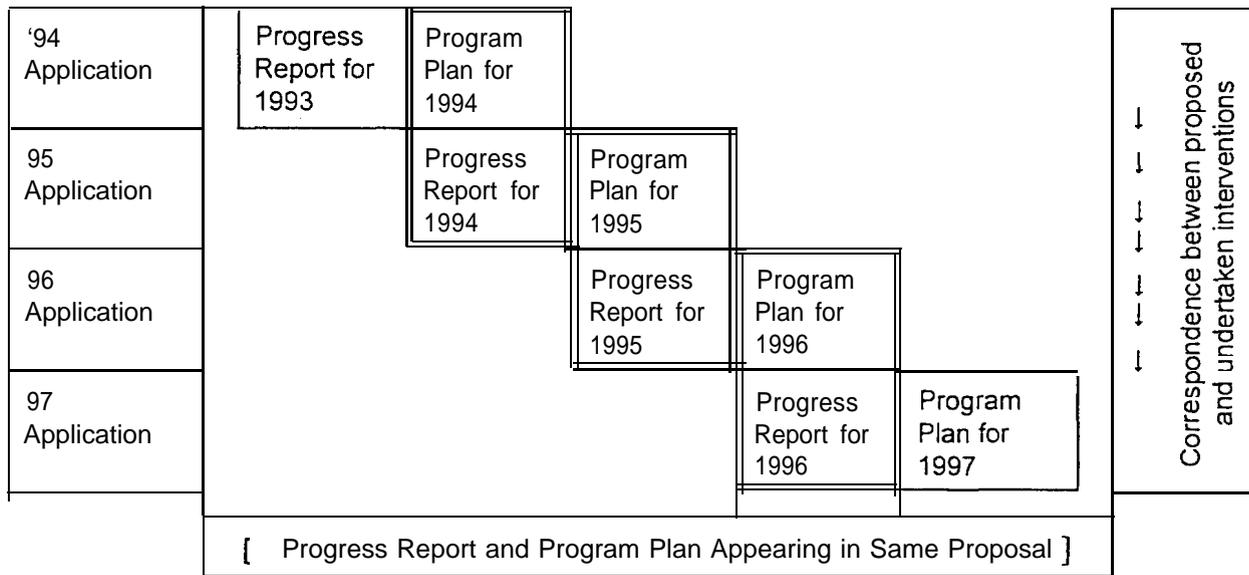


Figure 6. Activity tracking from Program Plan_(Year x) to Progress Report_(Year x+1)

d. Development of Application and Allocation of Award

Upon extended consideration, the three indicators related to CA300 Application development turned out to be less in keeping than most of the remaining indicators in that input to the Application is not an explicit aspect of HIV Prevention Community Planning; in fact, it may be discouraged in the guidance. The other indicators related to specific requirements or explicit guidance that has been provided to grantees from the outset of the Community Planning process. Thus, these indicators could be dropped without losing information about community planning’s impact.

	Community Plan Priorities	Proposed Activities	Undertaken Activities
Intervention Strategies	Target Population X		
	<i>Example:</i> Provide prevention case management at STD clinic for known IDUs	State contract proposed with local health departments to fund ½-time case manager at each STD clinic (Sept. '96)	- Case mgrs hired (Dec '96) - Progress reports indicate case mgrs have been providing intended services
Capacity Building and Infrastructure Development	Capacity Building and Infrastructure Development Priority 1		
	<i>Example:</i> Assist CBOs in developing ability to use behavioral science information in the development of their interventions	Health Department proposes to have three behavioral science faculty members from state university offer a 2-day training for statewide providers	Training is held
Evaluation, Research, and Surveillance	ERS Priority 1		
	<i>Example:</i> Develop process evaluation instrument and methodology for use by all outreach providers	Contract is proposed with a collaborative of regional CBO providers and the school of public health to develop and test such a process measure	Measure is developed, tested, and the results are presented to the CPG
Community Planning and Strategy Development	Community Planning Priority 1		
	<i>Example:</i> Foster greater CPG involvement from male prostitutes	Community planner plans to do rapport building and recruitment from male prostitutes	Recruitment occurs and a male prostitute becomes a CPG member

Table 5. Intended Correspondence Between Community Plan Priorities and Subsequent Activities

e. Funding

Funding information is complicated to extricate from the existing documents that were available for this pilot study. Two related reasons for the difficulty in tracking funding are the wide variety of funding sources (as noted in the section on “Correspondence Between CP and Proposed Non-CA300 Activities”) and the multiple funding streams that may flow to any given provider. Figure 7 depicts an example of these various funding streams. Some of these funding streams flow downstream as many as three levels—with increasing specificity available in the budgets as they move toward the most direct providers of prevention services.

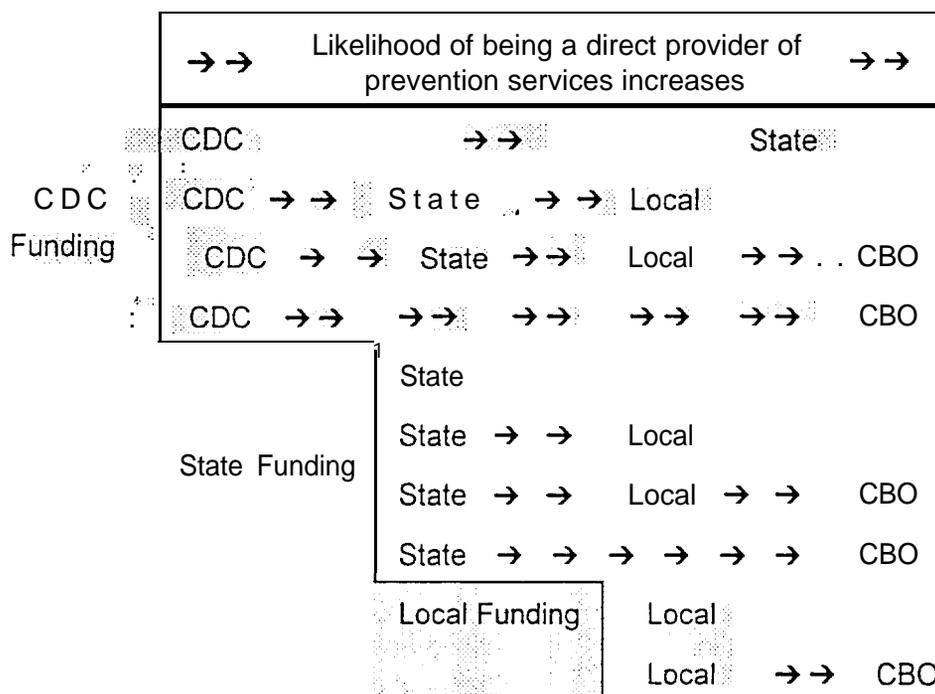


Figure 7. Variety of funding streams available to a community.

In the pilot study, it was easier to track service budgets and expenditures for specific contracted activities than for HD-conducted services. The presence of an intervention-specific proposal and the subsequent vouchers and other contract management data are discrete sources of information about particular services provided by the contractor (CBOs, local HDs, or other community providers [e.g., state Red Cross]).

At the level where CDC Funding is shown, there could be other Federal sources (e.g., Ryan White Title III prevention funds, CSAP, or NIMH). State funding might include funds designated for HIV prevention programs *per se*, but might also include resources available for HIV prevention through the substance abuse or mental health program, through family planning, or through the corrections system.

Finding consistent and complete financial information is difficult with this complicated array of resources. Given that the comprehensive Plan is designed to address all resources available within a community, it is critical that the complete set of resources be compared to it. Since it has been difficult thus far to track only the CA300 funds, sorting through and documenting these budgets and expenditures is even more daunting.

A step-wise approach seems to be appropriate here. For assessing the CA300 funding stream from CDC to the states, a format like that currently being proposed by CDC staff appears to be the most straightforward approach. Once a methodology for establishing and processing this core of information can be refined, further elaborations can be developed to include the other funding sources.

f. Intramural/Extramural Mix

The term “intramural” as used in this project, refers to those activities undertaken by grantee staff or funds used to maintain the infrastructure and operations of the grantee’s organization. “Extramural,” on the other hand, refers to money distributed by the grantee through contracts, grants, or other means to (primarily) non-governmental organizations. As noted below, though, there is some blurring of the extramural concept when money flows from the CA300 grantee to other health departments and other governmental agencies.

In the pilot site, it was straightforward to determine which interventions were extramural. Funding to CBOs or similar agencies are straightforward; that is, they are generally earmarked for particular interventions or types of interventions. Funding to local health departments may be more likely to be a lump-sum disbursement for a variety of prevention activities. Thus, determining the extramural service load will be fairly easily accomplished. Determining the intramural funding of prevention services is more difficult.

Only TA, contract management, and ComPlan had significant programmatic components at the State health department. However, if “intramural” is extended to include those activities done by local health departments (albeit through a contract with the state), then there are many more programmatic activities that are carried out by health departments. Thus, a non-quantified description of this mix would be most feasible, given the bundled budget of many health department activities (that is, the budgets do not readily distinguish operational, personnel, and other costs associated with specific activities).

g. Staffing Patterns

The intent of the staffing indicators was to ascertain the impact that Community Planning has had on the type of staff needed by health departments and CBOs and on their roles and responsibilities. Using the pilot testing methodology, we looked for documented impacts on staffing or descriptions of staff activities from which impacts might be inferred. The budget justifications were virtually the

only source of data for these indicators. They often include only standard position descriptions that do not provide much detail on the true responsibilities of the various staff.

One likely impact to be seen in many jurisdictions is the hiring of a Community Planner. It is more difficult to ascertain the changes experienced by staff whose positions were present prior to Community Planning (e.g., HE/RR or CT program managers, AIDS Directors). A more fruitful approach to determining staffing impacts of HIV Prevention Community Planning would be to conduct a series of interviews with administrators and staff about their changed roles since the inception of the planning process.

h. Capacity Building and Infrastructure Development

The term “capacity building”, as used in this project, refers to activities that increase a provider’s capability of developing and providing HIV prevention interventions. “Infrastructure development” refers to activities whose goal is to strengthen the sustainability of the organization that provides HIV prevention services. Thus, a workshop on cultural competence in street outreach would be a capacity building activity because it addresses a programmatic concern. Similarly, technical assistance on developing a public sector accounting system would help an organization enhance its ability to deal with budgets, contracts, and similar financial issues.

There were many instances of both types of activities engaged in by various players within the pilot state. One revision that needs to be made to the operational definition of these items is to restrict the range of items that can be counted as examples of capacity building or infrastructure development. For instance, a workshop of some kind is usually a clear instance of one of these, while a mention of a half-hour telephone conversation between a health department employee and their counterpart at a CBO about a programmatic issue (for instance) may or may not meet some critical threshold for inclusion.

i. Intervention Characteristics

Based on the RFP and Supplementary Guidance, special emphasis was accorded to issues of programs’ basis in scientific evidence, its cultural competence, and the community-wide support for it. Because they were deemed to be critical characteristics of interventions, we assessed three aspects. Scientific evidence included use of a scientific methodology in program development (e.g., needs assessments or focus groups), use of a described theoretical basis (e.g., the Holistic Harm Reduction Model), use of a previously evaluated program model, or evaluation of an ongoing or proposed intervention. Examples of cultural competence included use of staff who were behaviorally, culturally, ethnically, and linguistically similar to the target population; technical assistance contributing to increased cultural competence.

Quality Assurance. The Quality Assurance indicators relate to the many ways that health departments, other governmental agencies, and other community providers can **increase the likelihood** that an HIV prevention program’s activities are 1) implemented as intended, 2) possess desired characteristics, and 3) otherwise contribute to the principles of HIV Prevention Community Planning and to the grantee’s HIV prevention strategy. Thus, they call for a determination of whether there were mechanisms in place to maximize the likelihood that these characteristics would be manifest in the community’s interventions. This included the presence of requirements in RFPs, instances of technical assistance for them, or contract monitoring provisions related to these areas. Contract monitoring and technical assistance were the most common elements of this in the pilot site. There was limited evidence of RFP requirements, understandably concentrated in the regions that have several contractors and, thus, more experience with letting RFPs.

Used in the context of this process, “quality assurance” includes methods that promote both the general principles of Community Planning and the specific features of the Comprehensive Plan are actually implemented in the community. The general principles of Community Planning include many references to three core criteria for HIV prevention strategies (i.e. community-wide support, a basis in scientific evidence, and cultural competence).

Some methods of quality assurance are designed to promote this likelihood prior to the proposing of actual activities; other QA promotes this integrity through monitoring of the activities as they are implemented. Some of the examples of this type of quality assurance found in the pilot site included

- requirements contained in RFPs,
- guidelines developed by the CPG or other statewide committees,
- requests for or delivery of capacity building activities.

Other QA methods are employed to ensure high quality implementation of proposed interventions or other prevention activities—a critical link between planning and obtaining desired outcomes. While it may not be possible to perform process evaluations of every intervention taking place in the community, there are practices and procedures that are designed to monitor a minimal set of key activities or characteristics of these interventions. The two most obvious forms of this in the initial pilot site were the conduct of regular contract monitoring and the development of standard process measures for contractors in the two metropolitan areas of the state.

Evidence of Characteristics. The second, related set of indicators assessed was documentable evidence that these characteristics—scientific evidence, cultural competence, and community-wide support—were proposed for, or present in, specific interventions undertaken in the community. In the initial pilot site’s last year’s materials, there was extensive reference to the incorporation of a theoretical basis for the HE/RR activities across the state. Use of focus groups and needs assessments to drive the process were common, as well. Increasingly rigorous and pervasive evaluation criteria and plans has been introduced in the past two years.

As noted in the previous section, *evidence* can also be contrasted *quality assurance*. In particular, some types of quality assurance (e.g., RFPs or intervention guidelines) are designed to increase the likelihood that these characteristics show up in delivered interventions. Evidence, on the other hand, requires a concrete manifestation of these characteristics.

Some concrete examples of these characteristics were found in the initial pilot site. Part of their resource assessment asked programs to rate the “similarity of participants with program staff” as a measure of cultural competence. Evidence of cultural competence and use of scientific evidence were found in progress reports and in descriptions of undertaken projects in reports to Governor, legislature, and other annual reports. There were examples of needs assessments and knowledge/attitude surveys that were used to target particular intervention types and intervention content to the specific needs of target populations.

The state has also adopted a behavioral science-based approach (Holistic Harm Reduction) as a guiding framework for their HE/RR activities. There were also examples of the use of epidemiological data to improve the targeting of particular populations. There was discussion of using outcome evaluations to ensure that efficacious interventions were being employed.

j. Collaboration

Despite the call in the Community Planning guidance for “overall coordination of HIV prevention services within a given jurisdiction”, collaboration may be an issue that has not yet made the “radar screen” of some grantees involved in HIV Prevention Community Planning. There was information at the pilot site about state-level relationships, for instance, between the Bureau of STD/HIV Prevention and the Department of Corrections. They were most related to the contractual relationship for HE/RR and CT services to specific populations (i.e. incarcerated people and people with substance abuse problems). They did not seem to involve shared planning, integration of services, shared resources, or attempts at efficiency.

The type of collaborations most commonly seen among CBOs was shared intervention implementation (e.g., two CBOs collaborating on a street outreach effort). Besides, mentions of these relationships, there is limited discussion of other types of collaboration, for example, shared training activities or coordinating complementary intervention strategies for a particular priority target population. While these may exist, they were not regularly documented by CBOs in any of the materials review for the initial pilot. In both cases described above, the situation seems to rest on the fact that there is a limited focus on collaboration as an explicit objective of health departments, other governmental agencies, and CBOs.

k. Conclusions Concerning Indicators

The use of an expert panel in the development of these indicators facilitated the creation of a set that had substantial applicability to some of the crucial aspects of management and operations of HIV prevention programs. The goal of data collection at the initial pilot site was to determine the general applicability of the indicators. A wide variety of relevant data was found for many of the indicators. Yet, as expected, with a retrospective approach at a single site, there were some indicators for which little or no data could be found. Even for those, though, there were indications that the gist of the indicators was appropriate, and that data could be maintained to address the issues.

The group of indicators piloted initially addressed a wide range of issues, some of which appear to comprise a more coherent set. Through this initial pilot, some of the indicators (or groups of indicators) were found to be less feasible for use with the kinds of data currently available at most grantees' sites. Other indicators were deemed by Macro and CDC staff to be less in keeping with the thrust of the emerging core set of issues that might comprise a productive next generation of indicators.

As noted in an earlier section, the categories of indicators that seemed to comprise the most fruitful and unified include

- Correspondence Between the Community Plan, Proposed Activities, and Undertaken Activities
- Quality Assurance for Implementation
- Evidence of Key Intervention Characteristics
- Capacity Building and Infrastructure Development
- Collaboration

These categories of indicators capture a great extent of the critical issues in management of HIV prevention programs. There were several indicators subsumed under these categories that we recommend removing from the next phase of piloting with the five cooperative agreement sites. In particular, the several indicators tracking budgetary information for specific activities might be beyond the scope of the current and next phase of this project. They may be better addressed through other efforts underway at CDC.

Also related to financial issues, the intramural/extramural indicators (14 and 15) may also be beyond a reasonable scope for the next phase. The biggest obstacle in making assessments based on this issue is that it is difficult to track the use of funds used by a health department for its own staff, overhead costs, and activities implemented by its staff. Even more complicated is trying to parcel staff time to specific activities (e.g., particular interventions, administrative tasks, Community Planning, evaluation, etc.). Without such data, it is impossible to describe accurately how HIV Prevention Community Planning may be affecting the operation of and HIV prevention program. This is the issue addressed by indicators 16 and 17, which we would also recommend removing.

Indicators 7, 8, and 9 address the development of the Cooperative Agreement Application and subsequent allocation of awarded funds. There are at least two reasons for these indicators to be reviewed. First, the development of the Application occurs prior to the early boundary agreed upon for consideration in this project. That is, the reference point for this work was the presence of an accepted Community Plan. While the impact of the CPG on this development is one potential result of the Community Planning process, it is not a question in keeping with the others being asked. Secondly, even though many CPGs may be involved in the application development or budget allocation processes, these are activities deemed to be solely the grantee's purview in the Cooperative Agreement guidance. Thus, it is difficult to conceive of a standard against which to assess the presence or absence of CPG input. Technically, none is expected, yet there seems to be a trend for some level of involvement.

Appendix B shows the current suggested list of indicators to be retained for the next round of piloting and refinement. This list is, of course, a "work-in-progress" and subject to further input from CDC staff, pilot project grantees, and other stakeholders.

Appendix 1
indicators Used in initial Pilot Test

IMPACT OF HIV PREVENTION COMMUNITY PLAN ON APPLICATION

INDICATOR	
CORRESPONDENCE (of Cooperative Agreement Application to the HIV Prevention Community Plan)	
<p>1. Priority HIV prevention services and activities proposed as program objectives in the Program Plan of the Cooperative Agreement Application match those in the Community Plan</p>	<p>1. Community Plan must clearly lay out priority populations and interventions for those populations 2. Program Plan must follow similar format 3. For prospective, the documentation is secondary to thinking-</p>
<p>2. Priority target populations proposed in the Program Plan of the Cooperative Agreement Application to be served match those in the plan</p>	
<p>3. Proportion of funds budgeted in Cooperative Agreement Application which correspond to the Community Plan's priority strategies</p>	
<p>4. Proportion of funds budgeted in Cooperative Agreement Application which correspond to the Community Plan's priority target populations</p>	
<p>5. Proportion of funds budgeted in Cooperative Agreement Application which correspond to the Community Plan's other related prevention outcomes priorities (e.g., training, capacity building, infrastructure development)</p>	
<p>6. Non-Announcement 300 funds supplement Cooperative Agreement funds at the Health Department in enacting the Community Plan</p>	

INDICATOR	
USE OF COMMUNITY PLAN, CPG OR OTHER COMMUNITY INPUT IN APPLICATION FOR AND AWARD OF COOPERATIVE AGREEMENT FUNDS	
<i>Development of Cooperative Agreement Application</i>	
7. HD has explicit criteria for the budget allocation requested in the Cooperative Agreement Application that incorporates community input, including the Community Plan	
<i>Allocation of Awarded Funds (if different than Request)</i>	
8. HD has explicit mechanism for incorporating the Community Plan or community input when restructuring the Prog Plan based on awarded funds	
9. HD has explicit criteria for final allocation of awarded funds that incorporates the Community Plan or community input	

EXPENDITURES OF COOPERATIVE AGREEMENT FUNDS BY THE HEALTH DEPARTMENT

INDICATOR	VARIABLES
CORRESPONDENCE (of Cooperative Agreement Award and Expenditures)	
10. Services and activities which received Announcement 300 funds match those projected in the Revised Budget Justification	<ol style="list-style-type: none"> 1. Revised Budget Justification 2. Expenditures of Announcement 300 funds for services, activities, and other outputs
11. Services and activities which received <u>non-Announcement</u> 300 funds from the Health Department match those projected in the Community Plan	<ol style="list-style-type: none"> 1. Community Plan Priorities 2. Expenditures of Non-Announcement 300 funds for services, activities, and other outputs
12. Priority populations for which Announcement 300 funds were expended match those noted in the Community Plan	<ol style="list-style-type: none"> 1. Community Plan Priorities 2. Expenditures of Announcement 300 funds priority populations
13. Overall expenditures for strategies, activities, and outputs are proportional to their priority level as designated in the Community Plan	<ol style="list-style-type: none"> 1. Expenditures for services, activities, and other outputs 2. Strategy and population priorities as delineated in the Community Plan
INTRAMURAL/ EXTRAMURAL MIX	
14. Ratio of intramural to extramural expenditures of Cooperative Agreement funds	<ol style="list-style-type: none"> 1. Intramural expenditures of Announcement 300 funds 2. Extramural expenditures of Announcement 300 funds 3. Count of NGO contracts from Cooperative Agreement funds 4. Total expenditures on HIV prevention by the Grantee
EXTRAMURAL FUNDING	
15. Ratio of intramural to extramural expenditures of non-Announcement 300 funds	<ol style="list-style-type: none"> 1. Total amount of non-Announcement 300 funds spent on HIV prevention by the Grantee 2. Amount of non-Announcement 300 funds spent on extramural activities

STAFFING PATTERNS	INDICATOR	VARIABLES
<p>6. Distribution of <u>Grantee</u> staff to planning, programs, administration, evaluation, and other activities reflects Community Plan priorities</p>		<p>I. Count of staff with primary responsibility in -planning -program implem. -administration -evaluation -other activities</p> <p>2. Percentage time each staff spends on each activity</p> <p>Reports of staff re-assignment, re-training, overload, shortages, burnout, etc.</p>
<p>7. Distribution of <u>contractor</u> staff to planning, programs, administration, evaluation, and other activities reflects Community Plan priorities</p>		<p>I. Count of staff with primary responsibility in -planning -program implementation -administration -evaluation -other activities</p> <p>2. Percentage time each staff spends on each activity</p> <p>I. Reports of staff overload, shortages, burnout, etc.</p>

OUTPUTS, SERVICES, and ACTIVITIES

INDICATOR	VARIABLES
CORRESPONDENCE	
18. Mechanisms are in place to ensure that interventions receiving Announcement 300 funds are delivered as intended in the community	<ol style="list-style-type: none"> 1. # of funded interventions 2. Presence of quality assurance contract monitoring by grantee
CAPACITY BUILDING	
19. Mechanisms are in place for ensuring cultural competency of programs, providers, and agencies <ul style="list-style-type: none"> -linguistically appropriate -age appropriate -appropriate hours of operation 	<ol style="list-style-type: none"> 1. Instances of TA <ul style="list-style-type: none"> -offered -attended 2. Time and effort spent on Capacity Building 3. Demonstrated use of information obtained through the mechanism
20. Evidence is provided for the cultural competence of programs proposed	<ol style="list-style-type: none"> 1. Count of interventions with documented cultural competence characteristics 2. Count of interventions funded by Grantee
21. Mechanisms are in place for ensuring that programs are based on scientific evidence	<ol style="list-style-type: none"> 1. Count of mechanisms that ensure that programs are based on scientific evidence 2. Demonstrated use of information obtained through the mechanism
22. Evidence is provided for the scientific evidence of interventions proposed	<ol style="list-style-type: none"> 1. Count of interventions with documented scientific basis 2. Count of interventions funded by Grantee
23. Mechanisms are in place for ensuring that programs obtain community-wide support for strategies	<ol style="list-style-type: none"> 1. Count of mechanisms that ensure that programs have community-wide support 2. Demonstrated use of information obtained through the mechanism

INDICATOR	VARIABLES
<p>14. Evidence is provided for the community-wide support for strategies</p>	<ol style="list-style-type: none"> 1. Count of interventions with documented community-wide support 2. Count of interventions funded by Grantee 3. Materials developed by HD or CPG as feedback to community 4. Use of CP by other agencies
<p>15. Contractors and other community agencies enhance their capacity for program development</p>	<ol style="list-style-type: none"> 1. Count of instances of documented TA, training, hiring for program development capacity building activities, or other capacity building activities 2. References to enhanced capacity building as a response to ComPlan
<p>INFRASTRUCTURE DEVELOPMENT</p>	
<p>16. NGOs and other community agencies develop enhanced administrative and accounting systems</p>	<ol style="list-style-type: none"> 1. Documentation of procedures for program and contract administration and accounting 2. References to systems as a response to ComPlan 3. Attendance at Skills Building Conference) 4. Use of CDC-funded TA providers
<p>17. HD develops enhanced administrative and accounting systems and assists contractors in doing so</p>	<ol style="list-style-type: none"> 1. Documentation of procedures for program and contract administration and accounting 2. References to systems as a response to ComPlan. 3. Count of instances of local or regional providers being assisted in infrastructure development 4. References to enhanced infrastructure development as a response to ComPlan
<p>18. Use of Community Plan by NGOs as support or documentation for non-Announcement 300 funding sources</p>	<ol style="list-style-type: none"> 1. Count of documented uses of ComPlan in proposals or applications for non-Announcement 300 funds for I/IV prevention

INDICATOR	VARIABLES
29 Use of Community Plan by the ID as support or documentation of non-Announcement 300 funding sources	1. Count of documented use of ComPlan in proposals or applications for non-A306 funds for HIV prevention
30 COLLABORATION among non-governmental organizations (community, state, regional, & national)	1. Count of training events offered by an NGO and attended by staff of at least one other non-governmental organizations
31. Shared information among non-governmental organizations	<ol style="list-style-type: none"> 1. Materials 2. Newsletters 3. Curriculum 4. Scientific information (e.g., behavioral, epidemiological, or evaluation findings)
32 NGOs develop shared strategies or complementary programs	<ol style="list-style-type: none"> 1. Instances of referrals, timing of employment common 2. Count of instances in which 2 or more NGOs share funding for a specific program or component of an explicitly integrated multifaceted program
33. NGOs share sponsorship or implementation of programs	<ol style="list-style-type: none"> 1. Count of instances in which 2 or more NGOs jointly share operational costs for an HIV prevention program 2. Count of instances in which 2 or more NGOs jointly share the labor costs for at least 1 staff member 3. Count of instances in which 2 or more NGOs jointly share the space for an HIV prevention program
34. Shared training among HIVs and non-governmental organizations	1. Count of training events offered by HIVs and attended by at least one NGO
35 Shared information among HIVs and non-governmental organizations	<ol style="list-style-type: none"> 1. Materials 2. Newsletters 3. Curriculum 4. Scientific information (e.g., behavioral, epidemiological, or evaluation findings)

INDICATOR	VARIABLES
36. HDs and NGOs develop shared strategies or complementary programs	<ol style="list-style-type: none"> 1. Instances of referrals, timing of deployment in common 2. Count of instances in which an HD and 1 or more NGOs share <u>funding</u> for a specific program or component of an explicitly integrated multifaceted program
37. Shared sponsorship or implementation of programs by an HD and 1 or more non-governmental organizations	<ol style="list-style-type: none"> 1. Count of instances in which an HD and 1 or more NGOs jointly share <u>operational costs</u> for an HIV prevention program 2. Count of instances in which an HD and 1 or more NGOs jointly share the <u>labor costs</u> for at least 1 staff member 3. Count of instances in which an HD and 1 or more NGOs jointly share the <u>space</u> for an HIV prevention program
COLLABORATION between health departments and other governmental agencies (e.g., TB, STD, Substance abuse, Reproductive Health, Mental health)	
38. Shared training among HDs and other governmental agencies	<ol style="list-style-type: none"> 1. Count of training events offered by HD and attended by at least one other governmental agency. 2. Count of training events offered by another governmental agency and attended by HD staff
39. Shared information among HDs and other governmental agencies	<ol style="list-style-type: none"> 1. Materials 2. Newsletters 3. Curricula 4. Scientific information (e.g., behavioral, epidemiological, or evaluation findings)
40. HDs and other governmental agencies develop shared strategies or complementary programs	<ol style="list-style-type: none"> 1. Instances of referrals, timing of deployment in common 2. Count of instances in which an HD and 1 or more other governmental agencies share <u>funding</u> for a specific program or component of an explicitly integrated multifaceted program

INDICATOR	VARIABLES
<p>41. Shared sponsorship or implementation of programs by an HD and other governmental agencies</p>	<p>1. Count of instances in which an HD and I or more other governmental agencies jointly share <u>operational costs</u> for an HIV prevention program</p> <p>2. Count of instances in which an HD and I or more other governmental agencies jointly share the <u>labor costs</u> for at least 1 staff member</p> <p>3. Count of instances in which an HD and I or more other governmental agencies jointly share the <u>space</u> for an HIV prevention program</p>

Appendix 2

Draft List of Revised Indicators

Indicators Related to Correspondence

Indicator	Description	Example
<p>1. Priority HIV prevention services and activities proposed to be undertaken within the jurisdiction match those in the Comprehensive HIV Prevention Plan.</p>	<p>Logical linkages exist between the intervention strategies, capacity building, infrastructure development, evaluation, and other element of the Comprehensive HIV Prevention Plan and those proposed in the Application to Announcement 300/706, other applications for funding from CDC and other sources, or otherwise proposed by a prevention service provider for delivery in the grantee's jurisdiction.</p>	<p>For IDUs in State X, 75% of the interventions proposed for implementation matched an intervention strategy suggested in the Comprehensive Plan.</p>
<p>2. Priority target populations proposed to be served by the HIV prevention services within the jurisdiction match those in the Comprehensive HIV Prevention Plan</p>	<p>Logical linkages exist between the target populations identified in the Comprehensive HIV Prevention Plan and the populations that would be served by the interventions proposed in the Application to Announcement 300/706, other applications for funding from CDC and other sources, or otherwise proposed by a prevention service provider for delivery in the grantee's jurisdiction.</p>	<p>Eight of the 10 populations for which there are interventions proposed match a priority population as noted in the Comprehensive Plan.</p>
<p>3. Proportion of funds budgeted for priority HIV prevention services and activities within the jurisdiction which correspond to those in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which HIV prevention funds are budgeted for other HIV prevention interventions that correspond to those noted as priorities in the Comprehensive HIV Prevention Plan.</p> <p>Responds to the questions,</p> <ul style="list-style-type: none"> • “Are the <i>intervention strategies</i> identified in the Comprehensive Plan receiving funding commensurate with their priority status?” • “How much funding is allocated to intervention strategies not identified in the Comprehensive Plan?” 	<p>80% of funds budgeted for HIV prevention interventions correspond to services and activities noted in the Comprehensive Plan.</p>
<p>4. Proportion of funds budgeted for priority target populations within the jurisdiction which correspond to those populations noted in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which HIV prevention funds are budgeted for services and activities for target populations that correspond to those noted as priorities in the Comprehensive HIV Prevention Plan.</p> <p>Responds to the questions,</p> <ul style="list-style-type: none"> • “Are the funds allocated for various populations commensurate with their priority status as noted in the Comprehensive Plan ?” • “How much funding is allocated to populations not identified in the Comprehensive Plan?” 	<p>90% of funds budgeted for HIV prevention interventions for men-who-have-sex-with-men correspond to services and activities noted for that population in the Comprehensive Plan.</p>

Indicators Related to Correspondence

Indicator	Description	Example
<p>5. Proportion of funds budgeted for other related prevention outcomes priorities (e.g., training, capacity building, infrastructure development) within the jurisdiction which correspond to those in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which HIV prevention funds are budgeted for other HIV PREVENTION activities that correspond to those noted as priorities in the Comprehensive HIV Prevention Plan.</p> <p>Responds to the questions,</p> <ul style="list-style-type: none"> • “Are the <i>other HIV PREVENTION activities</i> identified in the Comprehensive Plan receiving funding commensurate with their priority status?” • “How much funding is allocated to other HIV prevention activities not identified in the Comprehensive Plan?” 	<p>65% of funds budgeted for capacity building and evaluation correspond to such activities noted in the Comprehensive Plan.</p>
<p>6. Proportion of non CDC Prevention funds (Ann 300/706) used in enacting the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which funds other than those applied for pursuant to Announcement 300/706 are budgeted to address the Comprehensive HIV Prevention Plan’s high priority elements.</p>	<p>0 the \$300,000 obtained from sources other than Announcement 300/706, 2/3 were budgeted for activities deemed priorities in the Comprehensive Plan</p>
<p>10. Proportion of Services and activities which received funds that match those identified in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which I-IV prevention funds are expended for interventions and other HIV PREVENTION activities that correspond to those noted as priorities in the Comprehensive HIV Prevention Plan.</p>	<p>For IDUs in State X, 75% of the interventions implemented matched an intervention strategy suggested in the Comprehensive Plan.</p>
<p>11. Services and activities which received non-Announcement 300 funds from the Health Department that match those projected in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which funds other than those received pursuant to Announcement 300/706 are used to address the Comprehensive HIV Prevention Plan’s high priority elements.</p>	<p>Of those interventions and activities carried out without Announcement 300/706 funds, 60% corresponded to priorities noted in the Comprehensive Plan</p>

Indicators Related to Correspondence

Indicator	Description	Example
<p>12. Proportion of Priority populations for which funds were expended that match those noted in the Comprehensive HIV Prevention Plan</p>	<p>Addresses the extent to which HIV prevention funds are expended for services and activities for target populations that correspond to those noted as priorities in the Comprehensive HIV Prevention Plan.</p> <p>Responds to the questions,</p> <ul style="list-style-type: none"> • “Are the <i>populations</i> identified in the Comprehensive Plan receiving funding commensurate with their priority status?” • “How much funding is expended for populations not identified in the Comprehensive Plan?” 	<p>Of all the dollars spent on HIV prevention services, 80% went to interventions provided specifically for populations deemed to be priorities in the Comprehensive Plan</p>

Indicators Related to Quality Assurance

Indicator	Description	Example
<p>19. Mechanisms are in place for ensuring cultural competency of programs, providers, and agencies</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that the interventions that are fielded in their community are culturally competent (one of the core criteria for interventions according to the Supplemental Guidance). Cultural competence entails attending to the cultural, linguistic, and behavioral norms and values of a specific target population.</p>	<p>The Request for Proposals for CTRPN requires that providers demonstrate how they and their programs will be culturally competent</p>
<p>21. Mechanisms are in place for ensuring that programs are based on scientific evidence</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that the interventions that are fielded in their community are based on scientific evidence (one of the core criteria for interventions according to the Supplemental Guidance).</p>	<p>An intervention advisory group established jointly by the Health Department and CPG recommends the incorporation of components from specific behavioral/social science theories into interventions implemented in the community</p>
<p>23. Mechanisms are in place for ensuring that programs obtain community-wide support for strategies</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that there is community-wide support for the interventions that are fielded in their community (one of the core criteria for interventions according to the Supplemental Guidance).</p>	<p>In addition to their required tasks, the CPG decides to initiate quarterly “town-hall” meetings to provide feedback about HIV prevention activities to the community at large.</p>
<p>18a. Mechanisms are in place to ensure that activities are delivered as intended in the community</p>	<p>Presence of practices and procedures that are designed to monitor key activities or characteristics required of the providers of interventions, technical assistance, evaluation, etc.</p>	<p>The Health Department establishes uniform contract monitoring procedures for ensuring that funded providers carry out interventions that incorporate the core characteristics noted in Announcement 300/706</p>

Indicators Related to Quality Assurance

Indicator	Description	Example
<p>19. Mechanisms are in place for ensuring cultural competency of programs, providers, and agencies</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that the interventions that are fielded in their community are culturally competent (one of the core criteria for interventions according to the Supplemental Guidance). Cultural competence entails attending to the cultural, linguistic, and behavioral norms and values of a specific target population.</p>	<p>The Request for Proposals for CTRPN requires that providers demonstrate how they and their programs will be culturally competent</p>
<p>21. Mechanisms are in place for ensuring that programs are based on scientific evidence</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that the interventions that are fielded in their community are based on scientific evidence (one of the core criteria for interventions according to the Supplemental Guidance).</p>	<p>An intervention advisory group established jointly by the Health Department and CPG recommends the incorporation of components from specific behavioral/social science theories into interventions implemented in the community</p>
<p>23. Mechanisms are in place for ensuring that programs obtain community-wide support for strategies</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers can implement to increase the likelihood that there is community-wide support for the interventions that are fielded in their community (one of the core criteria for interventions according to the Supplemental Guidance).</p>	<p>In addition to their required tasks, the CPG decides to initiate quarterly “town-hall” meetings to provide feedback about HIV prevention activities to the community at large.</p>

Indicators Related to Evidence

Indicator	Description	Example
<p>20. Evidence is provided for the cultural competence of programs proposed</p>	<p>Instances of processes, procedures, and other means that health departments, other governmental agencies, and other community providers have implemented in their interventions that are culturally competent (one of the core criteria for interventions according to the Supplemental Guidance). This includes clear evidence that their proposed and undertaken interventions attend to the cultural, linguistic, and behavioral norms and values of their target population.</p>	<p>Mobile counseling and testing program for IDUs uses ex-IDUs drawn from the community and trained as HIV counselors</p>
<p>22. Evidence is provided for the scientific evidence of interventions proposed</p>	<p>Instances of the use of scientific evidence in the development and implementation of HIV prevention interventions, Use of such evidence in the choice of an intervention and its implementation is one of the core criteria for interventions according to the Supplemental Guidance.</p>	<p>Training manual used by CBO for their peer outreach uses concepts of role-modeling and social reinforcement from Bandura's Social Cognitive Theory</p>
<p>24. Evidence is provided for the community-wide support for strategies</p>	<p>Instances of support for interventions from the target population, members of the larger community in which the intervention takes place, and other community stakeholders. Community-wide support for interventions is one of the core criteria for interventions according to the Supplemental Guidance,</p>	<p>CPG funds community satisfaction survey that finds that community members and other stakeholders support the current of interventions for the priority target populations</p>
<p>18b. Evidence is provided that interventions are delivered as intended</p>	<p>Presence of results or documentation from practices and procedures that are designed to monitor key activities or characteristics required of the providers of interventions, technical assistance, evaluation, etc.</p>	<p>At end of fiscal year, results of contract monitoring process show that 80% of funded interventions were implemented as intended; the other 20% lacked implementation of significant components</p>

Indicators Related to Capacity Building and Infrastructure Development

Indicator	Description	Example
<p>25a. NGOs and other community agencies enhance their capacity for program development</p>	<p>Instances in which community providers engage in activities that improve organizations' ability to develop and implement HIV prevention services. This capacity building could include (but is not limited to) the development of new skills, sharing information, development of new or improvement of existing technologies, and the acquisition of specialized staff.</p>	<p>The Community AIDS Network receives training and follow-up technical assistance in an outreach technique that is supported by a rigorous two-year evaluation in a similar</p>
<p>25b. Health Departments enhance their capacity for program development</p>	<p>Instances in which Health Department providers engage in activities that improve organizations' ability to develop and implement HIV prevention services.</p> <p>Health Departments can also benefit from increased skills and other capacities in program development and implementation. Most health departments deliver at least some of the interventions in their communities (e.g., CTRPN or social marketing). Training in innovative or evidence-based intervention techniques or the acquisition of specially trained staff are two of the ways in which a health department can increase their capacity for delivering interventions.</p>	<p>Health Department recruits and hires a staff member with special training and experience in using behavioral science techniques in public health interventions.</p>
<p>26a. NGOs and other community agencies develop enhanced administrative and accounting systems</p>	<p>Instances of activities engaged in by a community organization to increase its ability to sustain itself organizationally and financially and, thus, continue developing and delivering its services.</p>	<p>A CBO attends the National Skills Building Conference and learns about grant-writing and generally accepted accounting principles (GAAP)</p>
<p>26b. Health Departments develop enhanced administrative and accounting systems</p>	<p>Instances of activities engaged in by Health Departments to increase its ability to sustain itself organizationally and financially and, thus, continue developing and delivering its services.</p>	<p>The Health Department develops an enhanced management information system and improve its oversight of contract budgets.</p>
<p>Health Departments develop enhanced capacity for program development</p>	<p>Examples of providing the assistance received in 26a.</p>	<p>Two CBOs collaborate to deliver a training workshop on enhanced counseling for all CBOs in the region</p>

Indicator	Description	
27b. Assistance is provided for enhanced administrative and accounting systems	Instances of providing the assistance received in 26b.	Health three non-pr begin unders
28. Use of Community Plan by NGOs as support or Announcement 300 funding sources	<p>The Comprehensive Plan is designed to represent an overarching depiction of the community's HIV prevention needs and current resources, and the prevention intervention strategies for specific populations that are believed to be most likely to reduce the risk of HIV infection and its associated complications. The Plan is intended to be a blueprint for community-wide efforts to curb HIV infection, including but not limited to those efforts carried out through the Announcement 300/706 funding stream from CDC. Thus, one impact of the Community Planning process would be the increased use of the Plan as a rationale and support for garnering non-Announcement 300 funds.</p> <p>These other sources of funding could include</p> <ul style="list-style-type: none"> • Other CDC funds (e.g., surveillance funds) • Funds from other federal agencies • State/city revenues • Private foundation funds 	The Ic priorit Plan if founde
29. Use of Community Plan by the HD as support or Announcement 300 funding sources	<p>Just as non-governmental HIV prevention providers can use funds other than those from the Announcement 300/706 funding stream (via the grantee Health Department), so too do Health Departments seek and use funds from other sources. These can also include</p> <ul style="list-style-type: none"> • Other CDC funds (i.e. not Announcement 300/706) • Funds from other federal agencies • State/city revenues • Private foundation funds 	In the; surveil Depart cited i one ra propos

Indicators Related to Collaboration

<i>COLLABORATION among non-governmental Organizations (community, state, regional, & national)</i>		
30. Shared training among non-governmental organizations	Instances of collaboration among two or more non-governmental organizations involving training, technical assistance, or technology transfer	SEE EXAMPLES IN TABLE BELOW
31. Shared information among non-governmental organizations	Instances of collaboration among two or more non-governmental organizations involving shared data, information resources, reports, or other communications	
32. NGOs develop shared strategies or complementary programs	Instances of collaboration among two or more non-governmental organizations that entails developing strategic planning, coordination of effort, decreasing barriers to coordinated efforts, coalition development, or increasing the thematic and programmatic integration among providers in a community	
33. NGOs share sponsorship or implementation of programs	Instances of collaboration among two or more non-governmental organizations involving the Joint allocation of human, financial, or other resources for carrying out a specific intervention	
<i>COLLABORATION between health departments and non-governmental organizations</i>		
34. Shared training among HDs and non-governmental organizations	Instances of collaboration between a health department and one or more non-governmental organizations involving training, technical assistance, or technology transfer	SEE EXAMPLES IN TABLE BELOW
35. Shared information among HDs and non-governmental organizations	Instances of collaboration between a health department and one or more non-governmental organizations involving shared data, information resources, reports, or other communications	
36. HDs and NGOs develop shared strategies or complementary programs	Instances of collaboration between a health department and one or more non-governmental organizations that entails developing strategic planning, coordination of effort, decreasing barriers to coordinated efforts, coalition development, or increasing the thematic and programmatic integration among providers in a community	
37. Shared sponsorship or implementation of programs by an HD and 1 or more non-governmental organizations	Instances of collaboration between a health department and one or more non-governmental organizations involving the Joint allocation of human, financial, or other resources for carrying out a specific intervention	

COLLABORATION between health departments and other governmental agencies (e.g., TB, STD, Substance abuse, Reproductive Health, Mental health)

<p>38. Shared training among HDs and other governmental agencies</p>	<p>Instances of collaboration between a health department and one or more other governmental agencies involving training, technical assistance, or technology transfer</p>	<p>SEE EXAMPLES IN TABLE BELOW</p>
<p>39. Shared information among HDs and other governmental agencies</p>	<p>Instances of collaboration between a health department and one or more other governmental agencies involving shared data, information resources, reports, or other communications</p>	
<p>40. HDs and other governmental agencies develop shared strategies or complementary programs</p>	<p>Instances of collaboration between a health department and one or more other governmental agencies that entails developing strategic planning, coordination of effort, decreasing barriers to coordinated efforts, coalition development, or increasing the thematic and programmatic integration among providers in a community</p>	
<p>41. Shared sponsorship or implementation of programs by an HD and other governmental agencies</p>	<p>Instances of collaboration between a health department and one or more other governmental agencies involving the Joint allocation of human, financial, or other resources for carrying out a specific intervention</p>	

Type of Collaboration	NGOs & NGOs	HDs & NGOs	HDs & Other Government Agencies	NGOs & Other Government Agencies
Shared training	Three CBOs jointly offer a regional skills-building workshop.	A city health department's HIV prevention education staff collaborates with staff from a local CBO to offer a workshop for other CBOs on translating the Community Plan into programs	The HIV prevention unit of the state Health Department and agency responsible for substance abuse prevention cross-train HIV prevention counselors and staff of drug treatment facilities	Local Red Cross chapter and two CBOs jointly develop and offer a cultural diversity training for all HIV prevention providers in the 3-state region.
Shared information	Two CBOs collaborate on a localized newsletter about HIV prevention that is distributed to community residents and other providers	Epidemiologists in city health department work with a coalition of CBOs to provide specialized data on transgender prostitutes- a group for whom little data existed before this activity.	All affected units of a Health Department contribute to a report for the governor that describes all HIV prevention activities in the state. The report is made widely available to the public.	A School of Public Health works with the TB unit to summarize their HIV prevention activities for other local providers
Shared strategies or complementary programs	A CBO that does outreach to IDUs develops a referral relationship with another CBO that provides more intensive facility-based counseling and other services to IDUs	Working group of Health Department staff and all CBOs doing social marketing is formed to coordinate themes and messages throughout the city to increase the effectiveness of the overall HIV prevention effort	State STD prevention and control agency coordinates with other government agencies dealing with HIV prevention to reduce bureaucratic barriers to establishing systematic inreach for HIV testing and counseling in all STD clinics	State Department of Education and a youth-serving CBO collaborate on ideas for reaching school-age adolescents with HIV prevention messages.
Shared sponsorship or implementation of programs	Two CBOs contribute funds and staff to perform outreach to IDUs in the same IO-square block neighborhood.	Health Department and local CBOs develop and implement a series of health fairs in four neighborhoods	Department of Corrections offers time and meeting space for Health Department to conduct counseling with newly incarcerated inmates	State reproductive health unit works with local hospitals to increase testing and counseling of pregnant women at risk for HIV infection