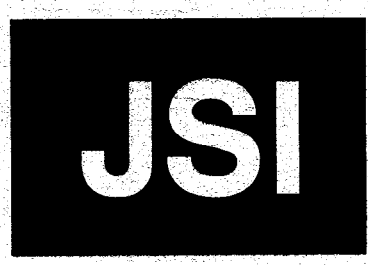
Final Report
Volume 1

AIDS REGIONAL EDUCATION AND TRAINING CENTERS EVALUATION

HRSA Contract # 240-88-0070

December 30, 1990



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numbers.

* fear and biases about AIDS among institutions and target groups.

* complicated and/or undefined service delivery networks often with the ETC as a newcomer with a learning curve.

* changing HRSA staff and priorities.

* unnaturally formed regions and institutional alliances.

* university politics and/or administrative bottlenecks.

4. Factors observed to facilitate ETC development included:

* building the ETC on an existing education structure eg. NIMH AIDS Training, **AHECs,** Family Planning.

* high level support from institutions involved in ETC.

* history of organizational or key staff involvement with HIV/AIDS.

5. Regionalization is a valid and valuable concept for the ETC program both for administrative purposes and to achieve synergy.

6. Collaboration with other AIDS related organizations is essential.

7. Several excellent curricula have been developed by the **ETCs.** Dissemination is now the challenge.

8. Intensive clinical training is in place only at a few sites.

9. Impacting professional school curricula has **proven difficult.** More innovative approaches need to be tried.

10. There is little consistency in ETC approaches to serving as **information resource centers.**

B. Evaluation:

1. Positive movement **in relation to evaluation was observed including an increased** level of activity; increased willingness to collect evaluation data; development of more standardized approaches; and **movement from counting numbers to evaluating outcome. This momentum needs to be turned into more activity. Most evaluation is still process oriented.**

2. The need to collect consistent and comparable data among the **ETCs** is as pressing as ever. **ETCs** are becoming invested in their own systems and potential for longitudinal study is diminishing as **time goes by.**

3. The level of evaluation activity on high cost, potentially high impact training (eg. train the trainers, clinical) is still disappointing.

4. Interesting evaluation approaches have not been widely shared. On the other hand there has been inappropriate "borrowing" of instruments.

III. RECOMMENDATIONS

1. Encourage increased emphasis on in-depth training aimed at influencing provider skills and behavior. Decrease emphasis on generating large numbers.

2. Provide more guidance in selected areas including: responsibilities of ETC regional office, priority training groups, preferred training approaches, output expectations in relation to training approaches, and evaluation.

3. Continue regionalization as a key component of the ETC program. Provide additional guidance on the role of the regional ETC vs. the local ETC.

4. Encourage continued collaboration with other AIDS related organizations.

5. Provide a structure for disseminating curricula, training strategies and evaluation approaches.

6. Clarify HRSA policy and expectations in relation to non-training activities particularly in the area of information services. Generally, it is recommended that information services be limited to ETC activities and training issues.

BHR sees this role as broader: clinical consultation + specialty referral

7. Encourage innovative approaches to influencing professional school curricula, recognizing that not all will succeed.

8. Clarify expectations regarding institutionalization and eventual self-sustainability.

9. Encourage more regional control of evaluation activities occurring at the local ETCs.

10. Require an identified Evaluation Coordinator at the regional ETC at least .20 FTE.

11. Collaboration, both intra-ETC and inter-ETC should be strongly encouraged.

12. Come to closure (if it hasn't been done already) on the nationally standardized documenting of training activities (outputs).

13. Encourage ETCs to maintain databases of individual participant and event data rather than aggregate information.

14. Specify minimum evaluation requirements based on the type of training. The final report contains detailed recommendations on this.

15. As the program matures, process evaluation should be de-emphasized.

16. Incorporate an evaluation segment in all train-the-trainers programs.

EVALUATION OF AIDS EDUCATION AND TRAINING CENTERS (ETCS)

SUMMARY REPORT OF YEAR ONE ACTIVITIES AND CONCLUSIONS

DRAFT-

I. Overview and Purpose of the Project

The Health Resources and Services Administration (HRSA) contracted with John Snow Inc. (JSI) to conduct an evaluation of its AIDS Education and Training Center (ETC) Program. The contract spans two years with the focus of the first year being on the four first funded ETCs; New York University AIDS Education and Training Center (NYU AIDS ETC), University of California, Davis AIDS Education Center (UCD AEC), the University of Washington's **WAMI** AIDS Education and Training Center **(WAMI** AIDS ETC) and the East Central AIDS Education and Training Center (ECAETC) based at Ohio State University. In the second year the focus will be on the second group of seven **ETCs** funded. The overall purpose of the proposed project is to describe and assess each ETC and determine the impact of the program on the knowledge, attitudes and behaviors of health care professionals providing care and treatment of HIV/AIDS. Study results are intended, to help both **HRSA and** the **ETCs** refine and improve the ETC program to maximize **impact.** This summary report highlights activities and **conclusions of the first year of the evaluation project.**

II. Study Design and Activities

As originally designed, three major strategies were to be used in **conducting the study: 1. development of case studies on** each ETC, 2. an analysis of **each ETC's** evaluation plan and results, and 3. an assessment of ETC program **impact.** For a number of reasons, most notably the lack of comparable data among the first four **ETCs,** it **was** not feasible to complete the assessment of ETC program impact. The case studies and analysis of evaluation activities, however, were completed. In addition, overview reports summarizing the **findings of** the individual ETC case studies and evaluation analyses were prepared. These documents provide a wealth of information about the **ETCs'** program structure, goals, activities and program results.

The major activities undertaken **in the** first year followed those outlined in the contract's scope of work. **Draft case** studies and analysis of evaluation plans were initially developed from a review of ETC grant documents and progress reports. Site visits were then conducted to each of the first four **ETCs.** Site visits were made by 3 JSI staff members including an evaluation specialist and AIDS expert and each visit lasted 2-3 days. Based on information and material collected during the visit, the case studies and evaluation reports were updated and revised. In addition, two overview reports were prepared, summarizing findings of the case studies and evaluation reports. Following comments by HRSA staff, these reports were finalized.

One major activity not included in the original scope of work, was undertaken. **A** meeting **was hosted** by JSI for all BTC project directors and evaluation coordinators prior to initiating the site visits. The purpose of

the meeting was to elicit input into the content and scope of the site visits and resulting reports. The meeting was also structured to include discussion on ETC evaluation activities and encourage sharing among the ETCs.

In general, the project proceeded as originally planned and few significant problems were encountered. It is expected that the second phase of the project, focusing on seven additional ETCs, will also proceed as planned.

III. Conclusions

This summary addresses only the major overall conclusions which can be drawn from the first year of the contract. The two overview reports highlight conclusions and recommendations drawn from the case studies and reports on evaluation activities, while the individual case studies and evaluation reports detail findings and conclusions on each ETC.

Overall, it is extremely difficult to reach significant conclusions about the ETC program from the first year's contract activity. Only 4 of the 13 funded ETCs were visited and each was very different. To generalize from this small and disparate sample could lead to inappropriate programmatic decisions. With this caveat in mind, four conclusions are offered for consideration by HRSA:

1. In developing its initial program guidance, HRSA purposely and reasonably decided to be flexible and non-directive. With the exception of specifying a few critical elements, each ETC was encouraged to develop its program according to the needs of its defined region and its own institutional capabilities. As a result, each ETC is unique. While all have as their main goal the training of health care professionals on HIV/AIDS, each is very different in its structure, management, specific objectives and outcomes.

   Flexibility was essential to encourage the development of regionally responsive and appropriate ETCs. In the long run, however, it will be very difficult for HRSA to monitor and oversee the operations of such disparate entities. Based on the visits to the first four ETCs, it appears that the individual ETCs and the program as a whole would benefit from more guidance and direction in selected areas.

   Specific areas where additional direction is desirable should be decided by HRSA, perhaps in conjunction with the ETCs. However, a few areas emerged as a result of the site visits. These were:

   a) The role of the central ETC project office in program management, monitoring and evaluation. How much autonomy should the satellite sites have? What minimum control elements (e.g. contracts, scopes of work, uniform reporting) should be required?

   b) The level and scope of evaluation activities expected by HRSA. Also, HRSA's expectations on output and outcome

data comparable among ETCs (see conclusion #2 for additional information).

c) The level and scope of activities other than training carried out by the ETCs. For example, what type of activities are desired, appropriate or allowed under the general expectation that ETCs serve as a resource for AIDS providers in their region?

d) The degree to which HRSA expects or encourages the development of new curricula and materials vs. adapting or modifying existing curricula.

e) HRSA's expectations regarding institutionalization of the ETC program.

2. Although there are clear and important exceptions, in general, the ETCs are not adequately evaluating their programs. It must be stressed that, because the need for training was acute, most ETCs made a conscious and appropriate decision to initially concentrate their resources on developing and providing training programs. They had neither the time or money to focus extensively on evaluation. The impressive numbers of people reached by the ETC program documents their Success.

Now that significant training and other activities are underway, however, evaluation must receive additional focus in the programs. The evaluation overview report contains several specific recommendations. In essence, HRSA must make clear their expectations in relation to evaluation. They should also work with the ETCs to quickly reach consensus on output and outcome data that should be routinely collected and centrally reported by the ETCs. Such steps are essential to allow for future assessment of ETC program impact as well as on-going justification of the ETC program.

3. As indicated in the case studies, ETC staff members include a number of highly skilled and motivated trainers and other individuals that have developed unique training modules and materials. Many of these individuals expressed interest and, to date, unfulfilled expectations for increased opportunities to share with their counterparts in other ETCs. The prevailing perception is that collective meetings of ETC Project Directors and HRSA officials are generally administrative and do not translate into shared knowledge and experience at the level of training program implementation and evaluation. Increased opportunities for sharing and education, perhaps within the concept of an annual training institute for ETC trainers and evaluators, would foster knowledge and skill dissemination between ETCs and help to promote a sense of national program identity.

4. Since its outset, a central philosophy of the ETC program has been that each ETC is "regional" in scope. The initial ETCs were encouraged to define their own multi-state region to enhance rational programming. As more ETCs were funded, HRSA became

involved in defining the boundaries of the regions and in some cases has directed regional restructuring. At this time, it is unclear whether the regional philosophy is still central to the ETC program. It is also unclear how much **HRSA** will continue to be involved in defining ETC service areas.

The ETC program is evolving just as the AIDS epidemic is evolving and some modification to initially defined regions is to be expected. Because this can be disruptive to individual **ETCs,** however, it is suggested that **HRSA** carefully consider and articulate the factors it will use in defining ETC service areas. It is further suggested that regional redefinition not take place without consulting the appropriate **ETCs.**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

HEALTH RESOURCES AND SERVICES ADMINISTRATION
Bureau of Health Professions

Memorandum

Date SEP 15 1989

From Public Health Analyst
Division of Medicine

Subject Contractor Briefing - AIDS Regional Education and Training Centers Program Evaluation

To Addressees

The first phase has been completed of a two-year project to describe the initial eleven AIDS regional Education and Training Centers funded by HRSA, and to assess the impact of the AIDS ETC program nationwide.

During Phase I of this study sponsored by the Division of Medicine, the contractor, John Snow, Inc., has described the organizational and programmatic characteristics of the first four ETCs and their individual approaches to project evaluation. These findings were then assessed to formulate recommendations about program direction.

Ms. Patricia Fairchild and Ms. Susan Klein will provide an overview of this impact assessment to all interested HRSA staff. The presentation will be held on September 27, 1989, at 1:30 p.m. in Room 9-03 of the Parklawn Building.

Betty B. Hambleton

Addressees:
Dr. Samuel Matheny
Mr. Ronald Carlson
Dr. Daniel Whiteside
Dr. Everett Rhoades
Mr. William Aspden
Dr. J. Jarrett Clinton
Mrs. Shirley Johnson
Ms. Patricia Stroup
Ms. June Horner
Mr. David Maglott
Division of Medicine Staff

HRSA 88-154
BHPR 3613

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HRSA Contract # 240-88-0070

December 30, 1990

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Patricia Fairchild, M.A., Project Director
Susan Klein, M.P.H., **M.Ed.,** M.B.A., Project Manager

Case Studies and Evaluation Reviews prepared by:

Susan Klein, M.P.H., **M.Ed.,** M.B.A., Project Manager
Waiter F. **Batchelor**
Susan Grantham, **M.P.P.**
John **Mazzullo,** M.D.
Rima Rudd, **Sc.D.**
Jonathan Stewart, M.H.A.
Steve Wroblewski, M.Div.

JSI
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AIDS Regional Education and Training. Centers Evaluation

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New York-Caribe AIDS/SIDA ETC

WAMI-0 AIDS ETC

Western AIDS ETC

Volume 2

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Volume 3

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I. EXECUTIVE SUMMARY

AIDS is a devastating illness which challenges all segments of this country's health care delivery system. As the epidemic spreads, there is an increasing need for more and better trained health professionals to care for people with HIV disease and AIDS . In response to this need, the Health Resources and Services Administration (HRSA) has funded a national network of regional AIDS Education and Training Centers (ETCs). The charge placed on each ETC is to develop and implement programs to train a broad range of health care providers to provide comprehensive services for HIV/AIDs patients.

This study was conducted to describe and assess each of the eleven ETCs which received grants in the first two rounds of HRSA funding; October, 1987 and April, 1988. Specific objectives addressed by the study were to: 1. document the development and activities of the eleven ETCs through the preparation of case studies on each center; 2. assess and guide the development of the evaluation plans and efforts of each of the ETCs; and, 3. synthesize the lessons learned from the individual and collective evaluation of ETC activities and training programs in order to improve overall ETC program performance.

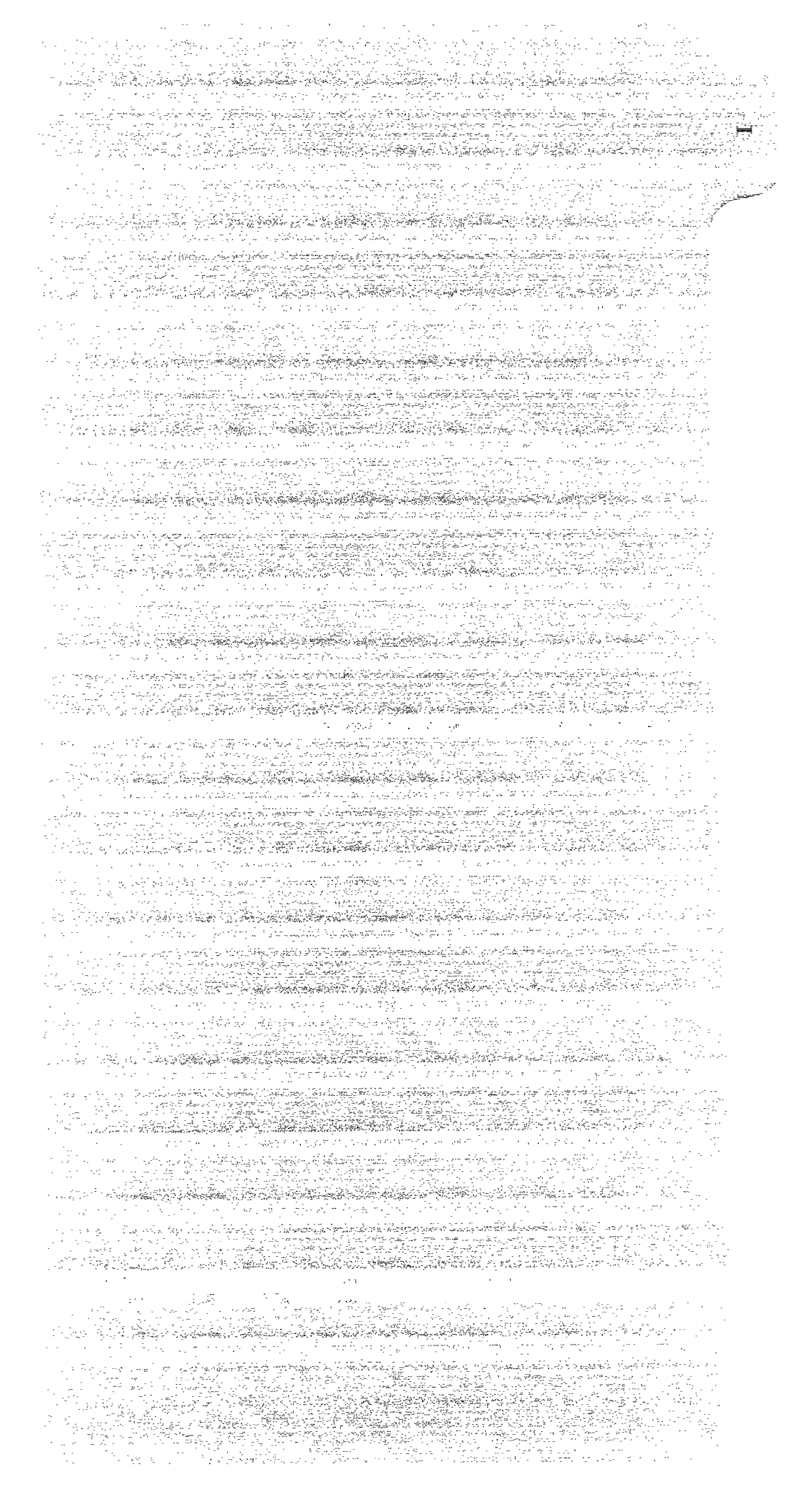
The study was conducted over a two-year period between October, 1988 and October, 1990 while the ETCs were still relatively new programs. They had been funded for approximately 16-26 months at the time most of the information was collected, and were just beginning to have data available needed to assess program outcomes. As a result, this study focused on describing ETC activities, identifying program strengths, defining program problems and challenges, and determining whether ETCs had in place the necessary evaluation systems to permit assessment of program impact in the future.

Extensive review of written material, in-depth site visits and follow-up telephone conversations were conducted resulting in a great deal of detailed information for each ETC. This information is presented in individual case studies and evaluation reports issued in separate volumes as companions to the final report. This final report summarizes findings, and presents the conclusions and recommendations drawn from the eleven ETCs participating in the study.

Several significant barriers were identified which impeded rapid and smooth ETC program development. Nevertheless, many of the programs have emerged as competent and recognized organizations in the training and education of health professionals around HIV/AIDS. Several have developed excellent curricula and training programs including train-the-trainers programs, clinical training programs, and programs to reach minority health providers and those serving minority populations.

A number of challenges remain before the ETC program reaches its full potential. In large part, success in addressing these challenges depends on HRSA developing clear and consistent policies: (1) regionalization, an appropriate approach for a national program of this scope and complexity, needs to be further defined; (2) program priorities in terms of target health professionals and training emphasis need to be clarified; (3) successful programs and curricula need to be more broadly disseminated; and, (4)

evaluation needs to be given additional direction, focus and consistency among all the ETCs.



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JSI

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II. STUDY METHODOLOGY

A. OVERVIEW AND PURPOSE OF THE STUDY

The Health Resources and Services Administration (HRSA) contracted with John Snow Inc. (JSI) to conduct an evaluation of its AIDS Education and Training Center (ETC) Program. The overall purpose of the study was to describe and assess each of eleven ETCs funded by HRSA in its first two rounds of ETC funding and to determine the impact of the program on the knowledge, attitudes and behaviors of health care professionals providing care and treatment to people with HIV/AIDS. Study results are intended to assist both HRSA and the ETCs refine and improve the ETC program to maximize impact.

The eleven ETCs included in the study were: AIDS Education and Training Center for Southern California (AETC-SC); Delta Region AIDS Education and Training Center (Delta); East Central AIDS ETC (ECAETC); Emory AIDS Training Network (EATN); Mid-Atlantic AIDS Regional Education and Training Center (MAARETC); Midwest AIDS Training and Education Center (MATEC); Mountain-Plains AIDS Education and Training Center (MPAETC); New England AIDS Education and

AIDS/SIDA

B.

ETCs

ETCs;

1,2, and 4 were accomplished. Through extensive review of material and site visits to all eleven ETCs involved in the studies, case studies and evaluation reviews have been developed for each of the ETCs. The lessons learned from these have been synthesized, and the conclusions and recommendations are included in this final report.

Objective 3, was only partially accomplished. Comprehensive criteria for assessing the short, medium and long-term impact of the ETC program on the care and treatment of people with HIV/AIDS were developed in collaboration with the ETCs. As the project proceeded, however, it became apparent that an assessment of ETC impact would not be feasible. The evaluation was conducted early in the program's development; ETCs had been funded for approximately 16-26 months at the time most of the study data was collected. At most ETCs, data needed to assess impact of select interventions was just beginning to be available. Furthermore, each ETC was collecting data in a different format and using different definitions, making assessment of impact impossible. As a result, this study concentrated on assessing whether ETCs had in place the necessary evaluation systems to permit assessment of program impact in the future. Several recommendations are included in the summary of ETC evaluation activities to assure that future assessment of impact is possible.

The study was conducted over a two-year period (October, 1988 - October, 1990), in two major phases. During phase one, which coincided with the first year of the ETC program, emphasis was on studying the four (4) ETCs funded in the first HRSA grant cycle, September, 1987. These were ECAETC, NY-Caribe, WAMI-0 and Western. During the second phase, the emphasis was on the seven (7) ETCs funded in the second grant cycle, April, 1988. In addition, during the second phase, information collected on the first four was updated.

Similar study activities were undertaken in each phase. At the beginning of each phase, written material on each ETC to be studied was collected from HRSA. This typically included the original grant application, continuation grant applications, progress reports, and in some instances, Project Officer site visit reports or other special reports. As needed, additional written material was requested from the ETCs. A draft case study and a draft evaluation review were prepared based on the review of written material.

Site visits were conducted to each ETC. The visits, typically lasting two to three days, were conducted by a three-person JSI project team consisting of an evaluation specialist, a training specialist and HIV/AIDS program specialist. A detailed site visit protocol, included as Appendix I, was used to guide the visit. The protocol was slightly modified between phase one and phase two but contained the same major elements for all the site visits as follows:

Day One

- Overview of the ETC (goals and objectives; geographic target area; organizational structure; collaborating agencies and institutions)
- Review of Program History (origin and major developmental milestones; facilitating factors and barriers; external relationships felt to be required for successful conduct; environment in which the ETC operates)

- Description of Program Structure (centralized/decentralized program model; placement within the university structure; staffing; linkages; non-federal resources available)

- Overview of Education and Training Programs (approach to education and training; target trainees; training strategies and methods; training media; co-sponsorship; relationship between strategies and goals and objectives)

- Overview of Other ETC Activities (specific activities)

- Overview of the ETC's Future Plans (for institutionalization and self-sufficiency; future training plans; anticipated changes in structure or procedures)

Dayw o

- Specific Education and Training Program and Products. (needs/demands assessments; specific strategies including ETC curriculum for professional schools; CEUs; policies, procedures and systems for managing training events/other ETC activities; role of each sub-grantee site; minority response; cost-sharing; financial control)

- Hands-on Review of Curricula and Other Training Products

- Evaluation Plan (development of the initial plan; evaluation framework and approach; locus of responsibility for evaluation activities; coordination of evaluation among sites; procedures for formative evaluation of materials; methodologies for evaluating specific interventions; monitoring second generation training activities; evaluation reports; current status of evaluation)

- Systems Review (MIS; professional support systems; inter-site communications; systems for training program management)

- Data and Document Review (project meeting minutes; needs/demands assessments; training activity records and data; other ETC activity records; subcontracts and agreements; protocols, policies and procedures; curricula/materials used; evaluation instruments; internal evaluation reports)

Day Three

- Wrap-Up
- Debriefing

Most of the on-site time was spent with the ETC regional office staff; however, at each ETC at least one subcontractor site was visited and the remaining subcontractors were interviewed by telephone following a second protocol (also in Appendix I), which focused on site-specific issues as well as the site's perspective on the ETC. In addition to the protocol, a list of ETC-specific issues and questions were prepared in advance of the visits, based on review of the written material, and were incorporated into the visit.

A great deal of information was collected during the site visits through combining interviews, material, curricula and data review, and direct observation. Based on the site visits, the draft case study and the draft evaluation report were revised.

This second draft of each report was sent to HRSA for review and comment. A third revision was made and the individual case study and evaluation reports were sent to the respective ETCs. Based on their comments, the case studies were finalized. As noted above, case study and evaluation material from the first four ETCs studied was updated during phase two of the project, primarily through telephone conversations and any new written material available. It is acknowledged that this update is not nearly as comprehensive as the initial analysis completed during phase one.

The case studies and the evaluation reviews were summarized in separate "Overview Reports" at the end of each study phase. That is, at the end of phase one, a Case Study Overview Report, summarizing the first four case studies and an Evaluation Overview Report, summarizing the first four evaluation reviews were prepared. Similarly, at the end of phase two, these reports were prepared summarizing the findings from all eleven ETCs studied. The final case study and evaluation overviews are included as chapters in this final report.

C. METHODOLOGICAL CONSIDERATIONS

In general, the study methodology was appropriate to the study goals and objectives. In particular, the overall process of developing case studies and evaluation reports by first reviewing written material and then conducting site visits proved to be an excellent way to collect extensive and detailed information about the ETC programs. In fact, given the complexity and unique characteristics of each ETC, the study could not have been done without in-depth, multi-faceted site visits.

The only significant difficulty to arise in the study was the lack of availability of data and, particularly of comparable data, with which to assess the impact of the ETCs. Given the early stage of ETC program

development at the time of the study, it is understandable that data addressing impact was not widely available. It is also understandable that data was not consistently defined among the ETCs. However, in the near future, it will be essential to assess the impact of both individual ETCs and the system as a whole. This impact assessment must look not only at program outputs (i.e. numbers of people trained) but also impact on health care providers' knowledge, attitudes, and behaviors related to HIV/AIDS. Ideally, the assessment of impact should also look at whether the ETC program has been able to influence the number of health care providers able and willing to care for people with HIV/AIDS as well as the quality of care provided. Several recommendations are provided in this final report to assist in making future assessment of impact possible.

D. PROJECT REPORTS

As noted in the discussion of project activities, several reports resulted from this study. These include:

1. A Case Study for each of the eleven (11) ETCs included in the study. The case study presents detailed information about the subject ETC including: an overview of the ETC; regional configuration and collaborating agencies; program history; program structure; training and education programs; program administration; and a summary of program highlights and future plans.

2. An Evaluation Review for each of the eleven (11) ETCs included in the study. The evaluation review includes an overview; the administration of the evaluation process; formative evaluation of products developed; approaches to project evaluation; evaluations conducted; and, summary of issues and challenges for the future.

3. Two Case Study Overview Reports one covering the first four (4) ETCs studied, the second covering all eleven (11). The final Case Study Overview Report is also included as a chapter in this final report. It highlights the experiences of the ETCs in several key areas including: regionalization; collaboration with other AIDS related organizations; clinical, train-the-trainers and continuing education training programs; reaching minority health providers; influencing health professional school curricula; information services; and, program sustainability. It also draws conclusions and makes recommendations based on the case studies.

4. Three Evaluation Overview Reports one covering the first four (4) ETCs, one covering the second seven (7), and one summarizing the evaluation activities of all eleven (11) ETCs studied. The final Evaluation Overview is included as a chapter in this final report. It addresses: administration of the evaluation process; approaches to evaluation including formative evaluation of training products, evaluation of training programs, evaluation of effectiveness, and evaluation of impact. It also makes several recommendations for strengthening ETC evaluation activities.

5. The study Final Report which summarizes the study methodology, includes the case study and evaluation overviews and summarizes study conclusions and recommendations.

III. AIDS EDUCATION AND TRAINING CENTRR PROGRAM CASE STUDY OVERVIEW

A. INTRODUCTION

The following report is an overview of case studies developed for eleven (11) AIDS Education and Training Centers (ETCs) funded by the Health Resources and Services Administration's (HRSA's) Bureau of Health Professions (BHPr). These are: East Central AIDS ETC (ECAETC); Washington, Alaska, Montana, Idaho and Oregon AIDS ETC (WAMI-0); Western AIDS ETC (Western); New York - Caribe AIDS/SIDA Education and Training Center (NY-Caribe); AIDS Education and Training Center for Southern California (AETC-SC); Delta Region AIDS Education and Training Center (Delta); Emory AIDS Training Network (EATN); Mid-Atlantic AIDS Regional Education and Training Center (MAARETC); Midwest AIDS Training and Education Center (MATEC); Mountain-Plains AIDS Education and Training Center (MPAETC); and New England AIDS Education and Training Center (NEAETC). The first four mentioned (ECAETC, WAMI-0, NY-Caribe, and Western) were the first group funded by HRSA, in September, 1987. The remaining seven were funded in the second HRSA grant cycle, in April, 1988. Four ETCs funded later by HRSA were not included in the study.

The case studies were developed in two phases. The studies for the first four ETCs (ECAETC, NY-Caribe, WAMI-0, Western) were developed in year one of the project, then up-dated at the end of year two. The studies for the remaining seven were developed entirely in year two of the project. The first step in developing the case studies involved the review of written material including grant applications, progress reports and site visit reports. A draft case study was then prepared. Subsequently, site visits were conducted to each ETC. The site visits were generally conducted by a three-person team over a three-day visit. Following the site visits and additional telephone conversations, the case studies were revised and circulated, still as drafts, to HRSA and the ETCs. As mentioned above, the case studies of the first four ETCs underwent an additional up-dating process through collection of written material and extensive telephone conversations. The final case studies incorporate information collected in all these steps.

Each case study addresses the following issues:

1. Program Overview: regional configuration, collaborating agencies, program goals;

2. Program History: regional HIV epidemiology, organizational background, ETC origin and development;

3. Program Structure: organizational roles and relationships, staffing, approaches to collaboration and regionalization, organizational qualities;

4. Education and Training Program: needs assessment activities, target

trainees , training activities, curricula and material developed or used, outputs, efforts to reach minorities, issues and successes;

5. Program Administration: administrative systems, systems for managing training programs, trainee recruitment, training sites, cost sharing/ sustainability, CEUs, library/information services, other services;

6. Summary and Future Plans: and,

7. Appendices: ETC goals and objectives and descriptions of sub-contractors.

There is a great deal of detailed information contained in each of these case studies. It is not the intent of this report to repeat this information. Instead, this overview report summarizes ETC activities and issues in selected areas central to the program's mission and goals,. These areas are: 1. regionalization; 2. collaboration with other AIDS related organizations; 3. needs assessment; 4. training programs, sub-divided into clinical training programs, train-the-trainers programs, and general continuing education training programs; 5. reaching minority providers and those serving minorities; 6. influencing professional school curricula; 7. information and resource services; and, 8. program sustainability. The critical issue of evaluation is extensively addressed in a separate overview report as well as in individual ETC evaluation reviews.

For each area discussed, particular successes as well as outstanding issues or problems are noted. It is intended, by citing successes, to provide a sampling of specific ETC accomplishments. The examples are by no means exhaustive, and the individual case studies are replete with many more noteworthy achievements. The issues and problems are presented not to indict particular ETCs or the program, but to provide HRSA and the ETCs with information to guide further program development. Taken in this context, both the successes and outstanding issues can make a positive contribution to the ETC program.

B. SUMMARY OF FINDINGS FROM CASE STUDIES

1. General Observations

Two important overall observations can be made from the case studies. The first is that each ETC is unique. In conceiving and designing the ETC program, HRSA purposely decided to be flexible and non-directive. With the exception of specifying a few critical elements, each ETC was encouraged to develop its organizational structure and training program according to needs of its defined region within the capabilities of its collaborating organizations. Initially, the ETCs were also encouraged to define their own geographic region, although HRSA often intervened to negotiate regions either during or after the application process. As a result of this flexibility on HRSA's part, each ETC is different. While all have as their main goal the training of health care professionals on HIV/AIDS, each is very different in its structure, philosophy, training program priorities and outcomes.

The second observation is that this study looked at the ETC program relatively early in its development. Sites had been funded for 16-26 months at the time of their site visit, and in many places, had to overcome many barriers to smooth program development. The site visits in year two of the project, as well as the up-dates of the first four grantees, visited demonstrated the progress made by the projects in their second and third years. With clear direction from HRSA, this progress can be expected to continue.

Observed barriers to smooth program development included:

- a rapidly evolving epidemic requiring constant revision of materials, target groups, and priori ties;
- demands to aggressively and quickly begin training programs;
- continuing fear and biases about the illness among the target health professions and even within the institutions involved;
- complicated and/or undefined service delivery networks often with the ETC as a newcomer to that network;
- an early emphasis by HRSA on producing large numbers of people trained;
- changing HRSA staff and priorities;
- unnaturally formed regions and institutional alliances, some of which had to breakdown competitive barriers; and
- university politics and/or administrative bottlenecks.

On the other side, some **ETCs** experienced fairly smooth program development. Observed factors which facilitated program development included:

- building the ETC on an existing education structure with recognized expertise in training community-based health professionals – **ETCs** which were built on National Institute of Mental Health (NIMH) AIDS training programs, established Area Health Education Center (AHEC) programs, and in one case, a Family Planning Program model, realized a developmental advantage;
- high-level support from the institutions involved in the ETC – both grantee and subcontractors, minimizing bureaucratic bottlenecks and providing needed space and administrative support;
- a history of active involvement in HIV/AIDS care or education either by the institution or key ETC staff to facilitate knowledge of and recognition by the AIDS care network.

The unique qualities of each ETC and the relatively early stage of program development place the following specific discussion in context. While there is still much to be achieved, each ETC has already contributed to the training and education of health care providers about HIV/AIDS in their region. In most places, the ETCs are poised to take on an increasingly visible and important role in combatting the illness.

2. Development and Management of a Regionalized Program

From the outset, ETCs were expected to be regional programs. While there has not been clear definition of what constitutes an acceptable region (in fact the concept has evolved with each ETC grant cycle) it is clear that HRSA wanted each ETC (with its subcontractors) to have responsibility for a specific geographic area. This geographic area may have involved several entire states, or it may have been more focused on a specific high-incidence area in part of a state. Of the eleven ETCs addressed in this study, two (NY-Caribe and AETC-SC), had regions that included sub-state areas, the remaining nine were multi-state programs.

Initially, ETCs were encouraged to identify and define their own geographical regions. After the first funding round, however, HRSA become more involved in negotiating and realigning regions with both prospective and existing grantees. This realignment, which is apparently ongoing, is in part due to HRSA's commitment to assure the entire country, including Puerto Rico and the Virgin Islands, is included in an ETC region, and that there is no overlap. Thus, as new ETCs have been funded, older ETCs have been reconfigured. Realignment also occurs to form more natural and manageable regions, as when Connecticut was moved from the NYU ETC to the New England ETC. While perhaps beneficial in the long run, there is no doubt that regional reconfiguration is disruptive in the short run, and impedes program development. To date, reconfiguration has most effected NY-Caribe and, to a lesser degree, EATN.

Regionalization of a program also implies some level of overall management at the regional level while many activities are carried-out locally. The ETCs' approach to regional management ranges from highly centralized, where the ETC regional office assumes a great deal of control over the training programs throughout the region, to highly decentralized, where each ETC subcontractors function essentially independently in their respective geographic area. Most ETCs, however, fall between these two extremes and even programs that started highly centralized or decentralized are moving to a balanced regional model.

Examples of two programs which have developed particularly functional models of regional program management are MPAETC and MATEC. Both programs cover multi-state areas and have "local" ETCs in each state, subcontracted to universities or professional organizations. MATEC has made a further geographic division, separating Illinois into northern and southern regions to recognize substantial differences in the area and AIDS demographics. In both programs, the local ETCs are fully responsible for the training in their area

while the regional office assumes a coordinating, resource and **"fill-in-the-gaps"** role.

This geographic division of responsibility seems to work well for several reasons : (1) it assures all areas of the region are covered; (2) it allows local **ETCs** to gain recognition within the AIDS care network and the political structure of their area; and (3) it avoids confusion among target groups as may occur when several arms of the ETC provide training on different topics.

Under this model, the local **ETCs** are delegated full responsibility for identifying training needs and developing and conducting training programs in their state or area. They may, and often do, draw on the regional ETC office or other subcontractors for assistance, ranging from training materials to course presentation. As a second level of responsibility, a local ETC may take the lead in developing specialized programs for use throughout the region (e.g. ; Wisconsin's dental training program), but that functional responsibility is secondary to the subcontractor's overall responsibility for a geographic area.

Regional ETC offices assume a range of responsibilities. Many are providing a great deal of direct training while others are performing more of a coordinating and resource function. In the latter cases, the regional offices are often located within or near the local ETC and are very involved in their activities. From the site visits, JSI recommends several functions for regional ETC offices. These include:

1. Develop regional strategic plan, provide general oversight, and establish general expectations for each local ETC. This should be formalized in a Scope of Work appended to the subcontract on an annual basis.

2. Assure the quality of training provided. Quality assurance may be provided through different means. MPAETC and NY-Caribe control quality by using standardized curriculum and developing a cadre of trainers to train using the curriculum. MATEC is addressing quality assurance by forming committees to set region-wide training standards.

3. Act as a regional resource for training/education materials and information. This includes developing a library of resources for use in local training, keeping track and communicating national training developments, facilitating the sharing of training curricula and materials across local **ETCs,** and coordinating training schedules.

4. Develop curricula and materials and/or conduct training as needed to fill in gaps in the local **ETCs** or as requested by the local **ETCs. ETCs** heavily involved in direct training must carefully define their role in relation to subcontractors to avoid duplication or competition.

5. Maintain close contact with HRSA regarding program issues and priorities and communicate these to the subcontractors. Similarly, maintain contact with other national and regional developments relating to HIV/AIDS including progress of the epidemic, treatment standards, service delivery models and so forth.

6. Provide grants management and allocation of available resources throughout the region.

7. Coordinate evaluation activities and reporting. Ideally, the regional office in consultation with the local sites should establish minimum, acceptable evaluation standards and criteria, with a core set of common items and definitions to be used and reported to the regional office. Evaluation data should be maintained centrally, both to reduce burden on the local sites and to alloi for regional reports and comparisons.

Although the development of truly regional ETC programs has been' difficult, it is a concept that is both appropriate and feasible for the on-going management of the ETC program. There is a great deal of program benefit to be gained through the synergy of a regional program. Each subcontractor and the regional office contributes knowledge and experience to the program, high incidence areas can serve as a resource for clinical experiences to lower incidence areas, and highly specialized materials can be developed and shared across the region. At its best, regionalization allows for local autonomy and responsiveness while building in important economies of scale and the potential for cohesive direction and accountability. Additional guidance from HRSA regarding the roles of regional versus local **ETCs,** as well as the natural development of regional organizations, will further strengthen the concept.

3. Collaboration With Other AIDS Related Organizations

Collaboration with other AIDS-related organizations is important to the **ETCs** for several reasons: 1. collaboration helps the **ETCs** stay up-to-date on the progress of the illness and the evolving needs of individuals and organizations serving people with HIV/AIDS; 2. collaboration often leads to co-sponsorship of training programs and therefore helps extend ETC resources; and 3. by working with other organizations, **ETCs** establish themselves as legitimate AIDS training organizations.

The case studies demonstrate that the **ETCs** are working closely with a wide range of AIDS-related organizations in a variety of ways. Most **ETCs** have advisory boards either at the regional or local level made up of representatives of the AIDS service delivery community. Conversely, many ETC staff participate on the boards and advisory committees of other organizations. Virtually all of the **ETCs** co-sponsor some of their training events and for some, like NEAETC and ECAETC, collaboration and co-sponsorship is an explicit goal of the ETC.

The list of specific groups collaborating with ETCs is included in each case study and is too extensive to repeat here. However, some of the more important linkages are noted.

National Institute of Mental Health (NIMH) AIDS Training Programs:

As was noted in the introduction to this section, early affiliation with NIMH AIDS Training Programs helped ETCs in their critical development phase. NY-Caribe, WAMI-0, and AETC-SC particularly benefited from their close affiliation. NIMH programs offered an existing training structure, established linkages with community groups, the core of a solid curriculum, and a strong focus on evaluation. On an on-going basis, NIMH funding of ETCs as occurred in MPAETC, Western, NY-Caribe and WAMI-0, or close affiliation of ETCs with NIMH funded programs, will benefit both programs.

Area Health Education Centers (AHEC):

Similar to affiliation with the NIMH Training Programs, affiliation with established AHEC programs also helped in program development and facilitates training program implementation. The contribution here came from the links the AHECs established with community-based providers; their expertise in developing and implementing health provider training programs; and established mechanisms for sub-contracting and program administration. NEAETC, Western and MPAETC most benefited from affiliation with existing AHEC programs. It was noted in the site visits that affiliation with AHEC programs was not automatically an advantage; in at least two instances - one where the AHEC was in its early development stages and another where the AHEC was overshadowed by a respected AIDS-care provider - AHEC affiliation worked against the ETC.

Community and Migrant Health Centers (C/MHCs):

C/MHCs are primary health care programs located in medically underserved urban and rural areas of the country. Because they are also funded by HRSA, and because they provide primary care to a high proportion of Black and Hispanic patients, they are a logical focus for ETC efforts. However, in general, ETC collaboration with C/MHCs was disappointing. Several ETCs had recently received supplemental funding to specifically address the needs of C/MHCs in their areas, but these efforts were just in the development stages at the time of the visits. Only a few (notably NEAETC, MATEC, EATN and Western) emphasized collaboration with this important group of providers as part of their overall policy.

Although the benefits of collaboration are generally acknowledged, it should be pointed out that sometimes collaboration can work to the ETCs' disadvantage. It is much more difficult to point to the specific accomplishments of the ETCs when their activities are merged with several other entities.

4. **Needs Assessment**

The **ETCs** were started in the midst of a very serious epidemic and faced immediate pressure to aggressively begin training programs. Their approach to needs assessment reflected this reality. In general, **ETCs** relied on needs assessments which had already been done and supplemented these with specifically focused assessments, targeting a particular area, discipline or training need. For some areas, this was a reasonable approach. Virginia, for example, had recently completed a very comprehensive CDC-funded statewide needs assessment, which provided excellent information for planning its training program. In others, however, this left the program with fragmented information about regional training needs, making overall planning for a regional program difficult.

Only a couple of **ETCs** (Delta, ECAETC, EATN) attempted multi-discipline region-wide needs assessments. Delta's was perhaps the most ambitious with health professionals throughout their three-state region randomly selected to receive a mailed questionnaire assessing knowledge, attitude and skills by discipline. The results of the mailed survey were used as the basis for focus group discussions by discipline. Key informant interviews were also conducted. The results of the needs assessment fed directly into discipline-specific curricula being developed by the program. Unfortunately, this thorough approach did delay the implementation of some training programs.

WAMI-0 did not conduct a region-wide needs assessment at the outset of its program. **However,** as it moved from its initial focus in the major cities of Washington and Oregon, the program recognized the importance of conducting thorough needs assessments in less familiar areas. They approached this by organizing and facilitating meetings of key AIDS service and other community leaders in each of eleven (11) targeted cities. As a result of these meetings, their program was significantly restructured. Information gained from the meetings will also serve as the basis for future evaluation of activities.

At the outset of the program, conducting comprehensive, region-wide needs assessments would have helped the **ETCs** formulate regional training strategies and plans. However, the pressures of the epidemic and urging by HRSA to quickly respond, led the **ETCs** to direct their resources and efforts elsewhere. At this stage in their development, the usefulness of a region-wide assessment has passed. Through their own training staff, information collected from training participants, input of advisory boards and collaboration with other AIDS related groups, **ETCs** have become their own key informants. Their approach of focusing needs assessments efforts on particular areas, target groups or training needs is appropriate and represents the best use of limited resources.

5. Training Programs

ETCs all have as their primary goal the training and education of health care professionals about HIV/AIDS. Each program, however, has a different

approach and emphasis. All ETCs incorporate a "Train-the-Trainers" model to some extent although the emphasis given to training of trainers varies in both scope and intensity. Similarly, most models include some in-depth clinical training opportunities designed to enhance care-giving skills relating to HIV/AIDS. A few have introduced innovative training technology into their programs. For most ETCs, the significant majority of their training can be classified as continuing education, information-oriented sessions, usually lasting from l-6 hours. Next most frequent are slightly longer sessions (l-2 days), again information-oriented, and in some cases addressing participant attitudes or skills.

These two types of sessions produce the biggest training output numbers for the ETCs, and require a relatively limited investment of resources. At the other end of the spectrum, true train-the-trainers programs which last 4-5 days and address both AIDS-related information and teaching skills, and clinical training programs which can accommodate only 2-4 people per session require extensive investment of resources both for development and implementation. The ETCs have been torn by conflicting pressures to produce impressive numbers of people trained with the need to conduct more in-depth training which more intensively impacts the ability of providers to care for people with AIDS. Most ETCs have the capability to do both and need only guidance on where to place their emphasis. To date, this emphasis has been on reaching large numbers of people, and in this the ETCs have been very successful.

Each case study itemizes the major training programs done by the ETCs and their subcontractors. The following discussion highlights some of the most innovative and successful programs being implemented by the ETCs.

Train-the-Trainers Programs

The term "Train-the-Trainers" is used loosely throughout the ETC program to apply to any program designed to encourage participants to go on to train others about HIV/AIDS. The sessions range from one-day programs for increasing the information level of participants, to 5-day sessions addressing participants' knowledge and attitudes as well as incorporating educational strategies and training skills. Some train-the-trainers programs include competency testing and a certification process; most do not. Some require and track the subsequent conduct of an agreed upon number of sessions; for many, subsequent training benefit depends on the initiative of individual participants.

Western, NY-Caribe, MPAETC, the Virginia site of MAARETC, and WAMI-0 all have comprehensive train-the-trainers programs. These programs are based on standardized curricula, last from 3-5 days and incorporate both AIDS-related information and teaching skills. All have explicit expectations about how participants will use the skills acquired to train others.

Several other ETCs have conducted specialized train-the trainers programs of note. The Kentucky site of ECAETC, the Wisconsin site of MATEC, MAARETC and Western all have implemented train-the-trainers programs for dental

professionals. MATEC's sites have implemented a broad range of train-the trainers programs including programs for mental health workers, social workers, and workers in correctional institutions. EATN developed a session for nurses and health educators. WAMI conducted two train-the-trainers programs focusing on substance abuse issues. It included sessions on organizational development or change to affect intake and risk assessment procedures in the trainees' organizations.

Train-the-trainers programs aimed at faculty of health professions schools have been held by NEAETC, NY-Caribe, AETC-SC, Delta, and Western. These sessions, also known as "faculty development" programs, generally assume that as university faculty, participants already have needed education skills. Consequently the focus is on providing AIDS-specific information.

From even this abbreviated list, it is apparent that the ETCs have been very involved in train-the trainers programs. Remaining challenges for HRSA and the ETCs include:

(1) sharing existing curricula and materials among ETCs to avoid unnecessary duplication;

(2) more clearly defining expectations for programs labeled as training-of-trainers; and

(3) tracking and assessing the impact of this resource intensive effort both in terms of the resulting competency of those trained directly and in terms of other subsequent training.

Clinical Training

As with train-the-trainers activities, the definition and scope of clinical training in HIV/AIDS varies greatly among the ETCs, ranging from half-day observations of AIDS clinics to week-long sessions including both didactic and patient care experiences. Most, though not all, of the ETCs offer some level of clinical experience for physicians. Only a few, however, offer a clinical experience designed to prepare physicians to care for people with AIDS. AETC-SC has the most intensive clinical training program among the ETCs. This ETC offers two levels of clinical training--an introductory program and an intensive program. It is the intensive program that is unique among the ETCs.

AETC-SC's intensive clinical program for physicians, nurse clinicians and physician assistants is a one-week program based at the Los Angeles County - USC Medical Center. There is a didactic introductory session, but the majority of the week is spent in direct patient care including rotations through the medical center's primary care clinic, specialty clinics and a private practice. Psychosocial issues are also addressed. UC-Irvine, a subcontractor to USC, offers a three-day version of this program and has been very successful in attracting community-based physicians. This level of commitment to clinical training comes at a cost: two physicians are supported through the

ETC grant to run the program. Approximately 100 people (50% physicians) have gone through the intensive clinical program.

Several other **ETCs** offer clinical training programs for physicians and/or nurses. EATN, several of **NEAETC's** sites, and the Virginia site of **MAAETC** all offer structured clinical experiences combining didactic and patient care aspects. Clinical experiences for other health professionals have been limited, primarily due to funding constraints and the priority given to primary care providers. However, the Florida site of EATN has developed a clinical training program for mental health professionals.

MPAETC has developed a "mini-sabbatical", which while not designed to provide an intensive clinical experience (that is offered through the STD training program at Denver General Hospital), offers broad exposure to AIDS care issues. The mini-sabbatical offers a series of rotations through different organizations providing care to people with AIDS. Specific organizations involved in the rotation are selected based on the trainees needs and last from one to five days.

The **ETCs** which have been extensively involved in clinical training programs have demonstrated that such programs are feasible and that the programs can and do attract community-based providers, including providers serving substantial minority populations. The challenges now are to:

(1) demonstrate the impact of these programs both in terms of increasing the number of providers caring for people with HIV/AIDS and in terms of the quality of care being provided; and

(2) extend these programs more widely throughout the ETC network with the recognition that these programs are expensive in comparison to the large audience informational sessions.

Continuing Education Training Programs:

As noted in the introduction to this section, the vast majority of training in terms of reported outputs conducted by the **ETCs** and their sub-contracted sites fall into the category of general training. These are typically continuing education sessions ranging in length from 1 hour to 2 days, and use a variety of instructional formats: lectures, videos, participatory exercises, panels, written exercises etc. Sessions may be multi-disciplinary or discipline-specific. Many of these sessions are co-sponsored by the **ETCs** and are conducted in response to requests by local health providers or social service agencies. Others are built into grand rounds or other continuing education sessions held by participating ETC organizations. Still others are sessions conducted by participants in ETC train-the-trainer programs.

The number and variation of such trainings offered are too extensive to list. Virtually every ETC can point to several examples of high quality continuing education offered as a result of the ETC program. Overall, one of

the most significant advances noted between year one and year two of the evaluation study was that the continuing education programs offered by most ETCs expanded in both scope and depth. Most ETCs had moved beyond presentations of basic AIDS information to focus on the more specialized needs of target trainees. A few of the ETCs began actively reaching out to selected target groups who might not themselves initiate training. The following are some interesting strategies for reaching hard-to-reach groups.

* The Nebraska site of MPAETC has an innovative approach to training institutional staff in this very low incidence state. Through their training "AIDS in the Health Care Setting," the ETC training team travels to a particular institution (e.g. hospital, nursing home) and works with their multidisciplinary staff. There is a short didactic component, but the core of the program is a problem-solving exercise. The training team leads the institution's multidisciplinary team through the care provided to a select group of patients on a previous day. The care team is then challenged to identify how the care would have been different if these patients were AIDS patients.

* Western AIDS ETC, through its network of AAETCs has developed an approach for reaching primary care physicians who might not otherwise receive training. An ETC trained physician/nurse team visits the physician in his/her office during non-patient hours. The ETC physician works with the practice physician while the nurse works with the rest of the office staff. Issues addressed can be customized according to the needs of the practice. The availability of this training was originally published by the medical society.

* AETC-SC initiated a collaborative effort to develop a workshop on Latinas and AIDS. By working closely with a number of Latino and AIDS related organizations in the Los Angeles area, the ETC was able to implement a very successful two-day program addressing highly sensitive but important issues.

* The University of Alabama site of EATN has developed an innovative program for reaching physicians in the rural areas of that state. As the medical center accepts referrals from rural physicians, training sessions are arranged in the referring community, using management of the specific case as a focus for the training.

Some of the ETCs are also using innovative training technology to enhance their training efforts. Teleconferencing has been used with varying success by several of the ETCs. ECAETC, NEAETC, MPAETC and Western continue to use this medium to reach large numbers of providers who might not otherwise be able to attend training. Other ETCs like NY-Caribe are moving away from their initial plans to emphasize teleconferencing feeling they sacrificed too much in the way of quality control.

ECAETC is pursuing a self-study strategy through Computer Assisted Instruction (CAI). Modules for physicians/physician's assistants, dentists,

nurses, and one on psychosocial issues have been developed. The modules are designed to be used on personal computers and take an average of three hours to complete. The self-study program includes a self-administered test which may be submitted as evidence of program completion for continuing education credit.

The Alabama site of EATN is pilot testing a technology known as the "Q" system. This is a computer based system through which presenters and participants interact during the course of a presentation. Presenters ask multiple choice questions to which participants respond. This immediate feedback allows presenters to determine whether issues are being grasped before moving on to new areas. In addition, responses are automatically stored in the computer for use in later evaluation studies. The system has also been shown to be very engaging for participants.

The challenges for all the ETCs in the area of general continuing education are to develop programs which go beyond simple informational sessions to impact the skills and behaviors of participants, and which actively reach out to and address the needs of hard to reach target groups.

6. **Reaching Providers Serving Minority Patients**

Since the outset of the ETC program it has been a priority for the ETCs to train minority health professionals and professionals serving substantially minority populations. Five principal strategies have been used by the ETCs to reach providers serving minority populations. First, three ETCs have included as subcontractors health professions training institutions which historically train minority (principally Black) providers. These are AETC-SC's subcontract with Drew University; ECAETC's subcontract with Meharry Medical College, and EATN's subcontract with Morehouse School of Medicine. In each of these instances, in addition to more general training responsibilities, the subcontracted institution has region-wide responsibility for developing minority focused trainings. Several other ETCs specifically include as part of their staff, staff of medical centers or hospitals serving large numbers of minority patients.

A second strategy used by the ETCs is to invite members of minority organizations to participate on advisory boards, curriculum development committees, or program planning committees. Conversely, some ETC staff have become actively involved in minority-oriented AIDS organizations. Some ETCs have also been successful in hiring staff with close ties to the minority communities.

ETCs is to reserve slots in t
programs for minority providers or those serving minorities. This has been done successfully by both AETC-SC and the Virginia site of MAAEETC in their clinical training programs.

A fourth strategy is to target systems of care serving large minority
ETCs have extended
programs to community health centers has already been noted, a few, notably

NEAETC, EATN and MATEC, have from the outset included these centers as priorities for their programs. This emphasis promises to expand as several of the ETCs have received specialized funding to work with community health centers. EATN also emphasizes training for public health department staff in both its continuing education and clinical training programs, AETC-SC has trained several public health providers in its intensive clinical training program, and the Johns Hopkins site of MAARETC, once operational, is specifically charged with reaching public health providers throughout the MAARETC region.

By far the most common strategy to reach minority providers or providers serving minority populations is to design specialized training programs. These training programs may be topically oriented toward a minority population (e.g. "AIDS in the Black Community" or "Latinas and AIDS"); or, they may be programs targeted at providers serving largely minority clientele (e.g. programs for community and migrant health centers or substance abuse counselors). Some ETCs have focused on very specific minority groups in their service area (e.g. NEAETC's support of a self-training manual in Portuguese and a video tape on Haitian cultural issues for physicians; WAMI-O's program for migrant farmworkers; and the Arizona site of Western's work with Native Americans.)

Some ETCs have taken a more integrative approach, incorporating minority issues into most of their training efforts. This is the practice in ETCs located in areas of high concentrations of minority populations (e.g. NY-Caribe with its affiliation with the University of Puerto Rico and its high incidence of infection in minority populations in New York; AETC-SC, serving the Los Angles area; and, EATN, with its affiliation with Morehouse School of Medicine and its emphasis on training providers serving in public facilities, has also taken this approach.)

Reaching minority communities and the providers serving these communities has not been easy and considerable work remains to be done. In some places, there is clear reluctance on the part of minority communities to embrace training offered by institutions historically viewed as unsympathetic to minority issues. An approach that emphasizes collaboration with providers serving minority populations and minority groups themselves, while more time consuming in development, has the best prospect for true impact.

7. Educating Professionals in Training

There are two major ways the ETCs impact the HIV/AIDS education of health professionals in training. The first is the targeting of specific ETC educational programs to professionals in training, from the undergraduate level through residency programs. The second is to encourage and facilitate the inclusion of HIV/AIDS material in professional school curricula. To date, while there have been some important successes in curriculum reform, most of the ETCs' efforts related to health professions students have been in the direct provision of training. The time consuming and politically sensitive process of changing school curricula along with the conviction in many institutions that HIV/AIDS material is sufficient has made this a difficult mandate for the ETCs to fulfill.

All of the ETCs have reached health professions students in training through their educational programs. For some ETC's reaching health professionals during their years of training is an explicit objective. For example :

1. All of NEAETC's sites provide specific student/resident focused education training programs with increases in HIV/AIDS information particularly apparent in the low incidence states of Maine, New Hampshire and Vermont;

2. Western AIDs ETC includes as a condition in their subcontracts with local AA ETCs the incorporation of AIDS material into all primary care residency programs at AA ETC institutions;

3. The Maryland site of MAAETC divides its training into "on-campus" and "of f-campus" with on-campus training focusing on all the health professions students of UMD and its affiliated teaching institutions.

Typically, training for health professions students is based on existing information presented through established teaching methods. Many lectures and symposia have been conducted for students and residents. Grand Rounds, attended by house staff and students is also a frequently used approach to presenting HIV/AIDS information. Several of the ETC's are also using "standardized patients." For the most part, the ETCs' training of health professionals has been concentrated in the institutions affiliated with the ETCs rather than on broader initiatives to reach all professionals in training.

There have also been several initiatives to directly impact the content of professional school curricula. Predictably, however, many ETCs have found curriculum reform to be a lengthy and politically sensitive process. By far the most frequently used strategy to impact professional school curricula is the training of professional school faculty through train-the-trainers or faculty development programs. It is believed, and in some ETCs like MPAETC there is supporting data, that the faculty will in turn incorporate AIDS information in their own teaching of health professional students. This is seen as a less threatening and faster approach than working with institutional curriculum committees. Other strategies to influence school curricula have included offering ETC curriculum to university faculty for use at their discretion and using university faculty as ETC faculty to encourage individual adoption of ETC material.

In addition, there have been a number of initiatives to develop and disseminate model curricula. These efforts have proven most successful when a collaborative approach that involves many institutions in the planning and development process is used, thereby instilling a sense of ownership. The Morehouse site of EATN has followed this approach with a nursing student curriculum, and MAARETC and MATEC have been similarly successful with dental school curricula.

One of the most ambitious efforts at influencing school curricula was undertaken by NY-Caribe. This ETC exists in an area having many health professions schools and with a great deal of competition among the schools. The ETC rightly felt they could not, as outsiders, recommend curricula. Instead, they held a "Faculty Institute." This Institute was carefully planned following an extensive needs assessment. It was a two-day program focusing on strategies for assuring appropriate emphasis on HIV/AIDS in curriculum, the process of curriculum development and incorporating clinical experiences into curriculum, rather than on proposing a specific curricula. The institute was attended by 40 representatives from health professions schools around the region. A follow-up evaluation to assess changes or developments in curriculum is planned.

While it is clear that the ETCs are focusing at least some of their efforts on professionals in training, significant challenges remain. The ETCs all need to develop a more comprehensive plan and specific strategy for reaching health professions students in all disciplines throughout their region. Their focus on students in their own institutions must be broadened. In addition, the ETCs must continue to introduce innovation in the education of students about HIV/AIDS. Influencing attitudes and skills will be as important as increasing knowledge to the student's long-term career decisions.

a. **Information Resources**

In addition to training health care professionals, ETCs are expected to serve as a resource for information about HIV/AIDS for health care providers and organizations in their service areas. All ETCs have taken some responsibility for serving as a source of information, but the extent to which ETCs have emphasized this function as well as the specific activities undertaken have varied considerably.

In general, information resource activities can be divided into three principal areas of activity: 1. library services; 2. telephone hotlines; and, 3. newsletters. Virtually all ETCs maintain some level of library services. The level of service ranges from collecting ma
for AIDS-related trainings which are then shared throughout the ETC network to comprehensive AIDS-related libraries which collect, catalogue and distribute general articles and statistics as well as training materials. As part of
ETCs also track ETC-sponsored tr
this information available throughout the region, usually via an electronic "bulletin-board" system. ETCs opting for the more limited approach feel the more general AIDS information can be obtained through existing university-based library services or organizations like the national AIDS clearing house. ETCs taking the expanded approach feel it is useful to serve a clearinghouse and coordinating function, assisting their constituents by sorting through and organizing the extensive range of information available.

In most cases the library function has emerged as an important activity for the ETC regional office. It is a logical and important role and helps put the regional office in a position to coordinate training efforts, identify

training gaps and assure intra-ETC sharing of resources. When the services are extended to the public, providing information helps the ETC establish its identity as a training resource.

In ECAETC, the University of Kentucky site has taken the lead in organizing information resources for the ETC. In this case, the site is performing an extensive information collection and clearinghouse function. The University of Kentucky, in collaboration with the Western AIDS ETC, has also taken the lead in developing and maintaining the ETC AIDS Resource Network (EARN) which links all ETCs in an information collection and dissemination network.

Telephone hot-lines, or warm-lines as they are more typically called, are operated by a number of the ETCs. These warm-lines, which operate on a call-back system (hence the name) most frequently provide information about training opportunities and events. The next most frequent service is clinical consultation where callers can ask specific AIDS related questions which will be routed to the appropriate AIDS expert for response. A few lines also provide referral services for clinicians looking for specialized services for their patients. In most places, use of the warm-lines for clinical consultation or referral has been disappointing. The Oregon site of WAMI-0 is an-apparent exception to this. Their phone line has served as an important resource for clinical consultation for the state. While more study of the reason for low utilization is needed, it is felt that providers are reluctant to call unknown people even if they are "experts" or to work through a third-party in requesting clinical information. However, having a central, well-publicized number for training information does seem to be an important function for the regional ETC office.

Newsletters are published by several ETCs and several sub-contractor sites. The newsletters range from up-dates on training opportunities and ETC activities to discussions of current trends in AIDS clinical issues. Interestingly, constituents have expressed strong preference for both types of newsletters, depending on the region.

In general, newsletters, centralized telephone access to training information, and centralized collection and distribution of training schedules, materials and curricula are important and appropriate functions for the ETC regional office. Such functions help the regional office perform important coordinating functions and help establish a training identity for the ETC. Other functions, such as acting as a clearinghouse for all AIDS information or acting as a clinical information or referral focus, may be needed in specific regions but may also be fulfilled through other mechanisms. Further assessment of the impact of these activities in areas where they have been implemented are needed before they are more widely undertaken.

9. Sustainability

ETCs are expected to develop means to sustain operations in the absence of federal funding. Although both HRSA and the ETCs acknowledge that

continued operation at current levels is not possible without significant outside funding, strategies have been adopted to recover partial cost of operation in the absence of HRSA funding.

Two interrelated strategies have the most potential for carrying on ETC work *over* the next several years. These are:

1. Institutionalizing ETC programs and curricula by training, through train-the-trainers programs, a cadre of trainees based in academic and institutional settings and AIDS care organizations throughout the ETCs regions. It is believed (though it still needs to be demonstrated through evaluation) that these trainers and organizations will continue to provide AIDS-related training even without direct ETC support.

2. Developing, supporting or enhancing through subcontracts, locally based entities usually on a state level. It is felt that as these local ETCs achieve recognition within their more limited geographic area, they will be in *a* position to secure local funding and contributions. While the validity of this assumption must also be objectively assessed, there are some early signs that this is an appropriate strategy. Several of the local ETCs (as well as the regional ETCs) have obtained in-kind contributions of space, staff and administrative support from their host institutions. Several others have received support for trainings from other organizations in their states including health departments.

In addition to these two strategies, ETCs have *also* pursued sources of support to augment HRSA funding. Some, notably WAMI-0, Western and MAARETC have been particularly successful in securing funding from other sources (e.g. foundations, health departments, pharmaceutical firms) to support ETC-related initiatives. EATN, NEAETC and ECAETC have received subsidy for a few specific activities. Most ETCs charge small fees for attendance at some or all of their training programs. Generally, however, these fees are established to cover costs not covered by the ETC grant (e.g. refreshments or special materials) and do not significantly augment ETC resources. Most ETCs receive some, and occasionally significant, in-kind contributions of space, staff and/or administrative support from the institutions in which they are based. All ETCs co-sponsor a portion of their training programs, sharing the expense for the program with the co-sponsoring organizations. A few ETCs are generating additional funds through innovative strategies. MATEC, for example, charges a consultation fee to agencies requesting assistance in training program development.

Although these efforts to institutionalize ETC programs and the efforts to generate supplemental revenue are taken seriously by the ETCs, none of the ETCs believe activities will go on at current levels without HRSA funding. Particularly likely to suffer in the absence of federal funds are: 1. the continuous and critical process of updating and expanding AIDS curricula; 2. updating AIDS trainers and/or replacing them as people move out of the field; 3. coordinating functions assumed by the regional offices which include

disseminating curricula and material and identifying training gaps; 4. other supporting activities particularly information services; and, 5. training outside home institution (outreach, community providers).

IV. AIDS EDUCATION AND TRAINING CENTERS EVALUATION OVERVIEW

A. INTRODUCTION

The following report is an overview of the evaluation activities planned and conducted by the eleven AIDS Education and Training Centers funded by the Health Resources and Services Administration (HRSA) in the first and second funding rounds (September 1987 and April 1988): the AIDS Education and Training Center for Southern California (AETC-SC); the Delta Region AIDS Education and Training Center (Delta ETC); the East Central AIDS Education and Training Center (ECAETC); the Emory AIDS Training Network (EATN); the Mid-Atlantic AIDS Regional Education and Training Center (MAARETC); the Midwest AIDS Education and Training Center (MATEC); the Mountain-Plains AIDS Education and Training Center (MPAETC);, the New England AIDS Education and Training Center (NEAETC); New York-Caribe AIDS/SIDA Education and Training Center (NY-Caribe); WAMI-0 AIDS Education and Training Center (WAMI-0); and the Western AIDS Education and Training Center (Western ETC). The report was prepared after reviewing the ETCs' evaluation documents and instruments, and discussing evaluation issues with ETC staff during the site visits and follow-up telephone calls. The report reflects the status of evaluation at the eleven sites in Summer 1990.

B. SUMMARY OF FINDINGS

1. Relafionship Between Project Structure and Evaluation

Among the four first generation ETCs, direction and control of evaluation activities closely parallels program structure. Three of these four ETCs are decentralized in both their program structure and evaluation activities. While some have developed or adapted evaluation tools centrally, they have been disseminated as models; sites are free to use them or not, or to modify them as they see fit. Virtually no standard evaluation methodology or approaches are being used ETC-wide. At the more centralized of these four ETCs (NY-Caribe) evaluation is also centralized. A uniform evaluation instrument is used throughout and standardized data for evaluation is available for central analysis.

Among the seven second generation ETCs, project structure is not necessarily a predictor of the degree to which evaluation activities are centralized or decentralized. In the ETC where sites are most independent--the AETC of Southern California--evaluation activities are most independent as well. Among four of the five remaining ETCs which are relatively decentralized programmatically (Delta, MATEC, MAARETC and New England), as well as EATN which combines a high degree of centrally-directed programming with a number of independently functioning subcontractors, basic evaluation procedures are standardized with some degree of coordination from the ETC

headquarters. In all of these cases, there has been and continues to be a trend toward more uniform procedures and more ETC headquarters involvement. The last of the seven ETCs, Mountain-Plains where there is a high degree of autonomy in the implementation of training activities, uniform evaluation procedures were developed collaboratively and are being coordinated centrally.

2. Administration of the Evaluation Process

Evaluation Coordinators

With the exception of AETC of Southern California, all of the ETCs have a designated evaluation person at the regional level. At Delta, EATN, ECAETC, MATEC, MPAETC, NY-Caribe, and WAMI-0, this person serves exclusively in an evaluation capacity, devoting 10-25 percent time to the ETC; the evaluator at the Western ETC devotes 50 percent time. At the New England ETC, evaluation is one of the responsibilities of the .40 FTE Project Administrator while, at MAARETC, the full time Education Coordinator also supplies the regional evaluation input.

Evaluation expertise at the program implementation site level is varied not only across the ETCs but within ETCs as well. At several of the ETCs, there have been formal plans to enhance evaluation expertise or increase time commitment of individuals to evaluation across all sites, but this has yet to occur. For the most part, commitment to evaluation at the site level beyond basic data collection has been directly related to the personal interests of individual site staff.

Evaluation Reports

Throughout the ETC network, evaluation reports are produced at a number of levels: evaluation reports of individual events; evaluation reports on a series of events; evaluation reports on selected issues across dissimilar events; and overview evaluation reports, both ETC-wide and for individual sites, for a given time period.

In most cases, reports are prepared at the site level, if at all, and are made available to the regional ETC. At others--EATN, MPAETC, New England and NY-Caribe--some or all of the evaluation reports are prepared at the regional level and returned to the implementation sites.

Two important issues have arisen with regard to evaluation reports: timeliness and usefulness. The timeliness of reports, which is as important as the information the report conveys, has been an issue for most of the ETCs. Several of the ETCs have expressed concern over this issue and are making an effort to improve turnaround time. Approaches to speeding up turnaround have included the use of mark sense coding for optical scanning/data entry (MPAETC and WAMI-0) and requiring that reports be submitted with request for reimbursement (Delta). In the case of at least one ETC site, the desire to publish before releasing preliminary data has interfered with the timely dissemination of useful evaluation information.

the utility of evaluation reports lies in their ability to serve a documentation/accountability function. In that regard, the ETCs have performed well. On the other hand, evaluation reports should also serve a guidance function. For the most part, evaluation reports, whether prepared at the site level or at the regional ETC level, have consisted of simple aggregation of data with little or no narrative discussion; interpretation being left up to the person reviewing the data. Several exceptions are noted. The New England ETC attaches a cover letter to the aggregated data it returns to its subcontractors which includes some interpretation of the data and recommendations. The Northern Illinois site of MATEC, which does a considerable amount of specialized training for other organizations such as the Chicago Health Department and the U.S. Public Health Service, prepares substantial evaluation reports for the recipient agency in which evaluation data collected in a variety of ways are integrated and interpreted, and formal recommendations made. A comprehensive evaluation report was prepared for the Western ETC's faculty development training which included a review of the literature and a description of the methodology as well as the results from participant feedback about the program and outcome evaluation (pre/post knowledge and attitude tests), a discussion of the findings, and suggestions and recommendations. In cases where evaluative research has been undertaken as a special project under the auspices of the ETC, substantive reports should be forthcoming.

3. Approaches to Project Evaluation

Project Monitoring

Within the context of this evaluation review, monitoring refers to the process by which progress toward the ETC's formal goals and objectives is tracked and reported, and goals and objectives are modified if necessary. For the most part, ETC goal statements have been directed at the activities the organizations intended to undertake, rather than the outcomes these activities were intended to produce; project monitoring has had a "process" evaluation focus with regard to institutional and program development.

While most of the ETCs continue to structure their progress reports to HRSA to coincide with their initial goal statements, emphasis on project monitoring as an evaluation activity has diminished as the ETCs have become increasingly involved in evaluation activities that speak to the quality of the programs they provide. ECAETC continues to place heavy emphasis on monitoring as an evaluation activity.

Evaluation of Outputs

Evaluation of outputs, within the context of this evaluation review, refers to the collection and analysis of data about the education and training events offered by the ETC as well as data about the participants who attend these events. Analysis may include the degree to which training targets are met and potential trainee "markets" are penetrated.

While the ETCs universally collect and report data on training events and participants, the way in which data are collected and aggregated, the variables identified, and the reporting formats widely differ among ETCs. In some cases, uniformity of data collection within an ETC was not achieved until a year or more into the project period. In other cases, the data collected was modified two or three times in the initial two-year period.

All of the ETCs, with the exception of the New England ETC, maintain or are in the process of developing an automated uniform database of training events and participants. dBASE is most often used. The nine databases that are currently operational are maintained at the regional level. The MAARETC database, based on the database created by its Maryland site, is currently being expanded to all sites. NEAETC stores its event and participant data in paper files at the regional level.

All of the ETCs collect and store descriptive data about each of the education and training events provided under their auspices. However, there is little comparability across ETCs. The variables common to most of the ETCs include only: an identifying title; date(s) held; some form of location descriptor; number of hours; and a count or estimate of total participants. The character of the databases differ as well. Delta and ECAETC's databases detail various aspects of the educational structure, process and/or content of the events; MATEC has a similar but less intense focus. Southern California, MAARETC and WAMI-0's databases tend to broadly characterize events according to their educational approaches, while EATN, MPAETC, New England and the Western ETC keep basic management-type data which essentially allows them only to identify events and distinguish between them.

At the regional level, the ETCs' participant databases generally fall into one of two categories: individual participant data or aggregate participant data. Southern California and New England receive participant data from the site level only in aggregate form, while Delta, EATN, MATEC and Mountain-Plains have access to individual participant data as well as aggregate data. MAARETC has been getting aggregate data from its sites, but with its transition to a uniform database may now be in a position to get individual data. ECAETC offers both options; at a minimum, sites report aggregate data, but may submit data on individual participants for aggregation by the regional office.

Two important concerns with regard to participant data are whether the relevant variables are captured and whether the data are complete. Overlying these concerns is the issue of comparability of data across ETCs. HRSA has expressed particular interest in knowing the degree to which primary care practitioners, particularly physicians, are being reached by ETC programs and the degree to which training programs are reaching minorities. Delta, ECAETC, EATN, MATEC, and Mountain-Plains have occupation and work-setting data on individual participants and can easily identify the number of primary care providers reached. New England receives aggregate data by profession and work setting. MAARETC, NY-Caribe, Southern California, WAMI-0 and the Western ETC currently do not have ready access to data identifying the number of primary

care providers served. With regard to minority reach, Delta, ECAETC, EATN, MATEC, MPAETC and NY-Caribe collect trainee ethnicity for individual trainees, while Southern California, MAARETC, WAMI-0 and the Western ETC are or will be collecting aggregate data or estimates. New England makes gross estimates of minority participants. Further, Delta, ECAETC, EATN, MPAETC and NY-Caribe collect data on ethnicity/minority status of participants' practices, either in terms of proportion of each ethnic group or the predominate minority. MATEC obtains aggregate data on number of participants with various proportions of minority patients.

The way data are collected strongly influences the completeness of the information, the ability to do cross-tabulations and the inferences that can be drawn from the results of the analyses. Data which are collected at registration are far more likely to be complete than data collected post-training particularly that collected as part of the evaluation process. The individual data collected by four of the ETCs is collected post-training; these ETCs also have aggregate data. To the extent that the aggregate data is registration data, completeness of the more detailed individual data can be estimated. Only a few of the ETCs have actually attempted to make estimates of completeness of data.

The number and complexity of output reports run the gamut of simple to complex, and few to many. For the most part, these reports tend to be simple documentation of events and participant characteristics. Several of the ETCs routinely generate reports on variables of special interest to HRSA. MATEC's "Minority Case Load Report" provides data on participants by ethnicity as well as minority caseload by site and ETC-wide. MATEC's "Training Productivity" report provides data on the number of primary care providers trained by site. EATN prepares pie charts detailing the work-setting and occupation of its participants.

A few of the ETCs have begun to look at outputs in a more evaluative light. The most common evaluative use of output data is a comparison of actual number of participants to the number targeted, either by type of event or by profession. MATEC has done a comprehensive analysis of changes in trainee/training patterns (Yr 01 to Yr 02). Some ETCs have begun the process of assembling output data in a way that it can be used to judge impact. EATN has begun to map participants by broad zip code in preparation to analyzing the degree of market penetration it has achieved in various geographic areas within each state.

Analysis of Program Costs

In this review, cost analysis is a generic term referring to any one of a number of ways of relating costs to program. Cost accounting refers to the compilation of costs for various cost centers, cost centers generally being various categories of training. Cost efficiency refers to input/output analysis--cost per event or cost per trainee--either overall or by type of training. Cost/benefit refers to an analysis which relates cost to outcome, while cost/effectiveness compares the cost of one type of intervention to another in achieving the same or similar outcomes.

Only four of the ETCs have done any cost analyses to date. EATN and New England have cost efficiency calculations for some of their programs using direct cost methods. EATN has calculated a "cost per trainee" for several types of events such as conferences and customized trainings; New England has calculated "cost per training day" for its faculty development workshops and for conferences. Both use these figures more for management than for evaluative purposes.

MATEC and NY-Caribe have done more extensive analysis. Using full cost methods, they have calculated "average cost per participant" and "average cost per contact hour." NY-Caribe has done a summary analysis for the three-year project period by site as well as the program as a whole. MATEC's analysis is by site for Years 01 and 02, as well as changes in these cost figures from Year 01 to Year 02.

It is generally agreed that cost analysis focusing on cost/benefit or cost/effectiveness is not feasible for a number of reasons: difficulty in identifying, classifying, categorizing and determining the cost of the program inputs that would serve as the basis of the analysis; difficulty in identifying and quantifying the program outcomes (effects and benefits); and, finally, establishing the linkages between the two.

4. **Formative Evaluation of Training Products**

In this evaluation review, formative evaluation of training products refers to the process by which training products--curricula, audiovisual materials and other items which are intended to have specific effects on trainees" knowledge, attitude, skills or behaviors--are assessed during their developmental stage to determine whether instructional objectives are being met. The results of the assessment are incorporated into modifications of the product before its final release. Formative evaluation is a collection of assessments from various perspectives including verification of the accuracy and appropriateness of the information, assessment of the sensitivity of the presentation, pretesting of visuals, and testing of the preliminary product for acceptability, effectiveness and unintended effects.

For the most part, formative evaluation of training products has been limited to "expert review" of content for accuracy and appropriateness, and occasionally feedback from users about whether they liked the product or found it useful.

Several sites report having formal protocols for formative review of curricula or products in development--Delta Region ETC, the Kentucky site of ECAETC and the Morehouse site of EATN for curricula, Southern California and the Michigan site of ECAETC for materials--but as yet, there have been no reports forthcoming which document the conduct of these reviews, their findings or the way the findings were used to improve the final product.

There have been no reported formative evaluations of audiovisual materials developed, particularly on videos, which have required significant investment of ETC resources. As a result, while these products might have been well-received by the intended audience, there is currently no documentation of their educational value.

The only notable example of formative evaluation of an ETC product comes from the Ohio State site of ECAETC in which a field test was conducted as part of the development of its computer-assisted learning package. Approximately twenty physicians tested the package on their own computers under conditions similar to the intended user environment. The computer program itself allowed respondents to document difficulties or questions as they were encountered; these annotations were printed out and returned to the ETC. Upon completing the field test, the field test subjects responded to a questionnaire about the respondent's interest in the material, the importance, practical value, and adequacy of coverage of the content, self-reported improvement in knowledge, the quality, ease of use and value of the computer-assisted format.

The Western ETC has planned an elaborate evaluation of its forthcoming mental health curriculum module including a pilot-test and more summative evaluations of effectiveness in general use.

5. Approaches to Evaluation of Education and Training Programs

Standardization of Evaluation ETC-Wide

Initially, most of the ETCs reported resistance on the part of their sites to standardized evaluation. Over the two year period, a trend toward more acceptance of uniform procedures has been noted as relationships between ETC headquarters and their sites have matured and trust built. Particular success in implementing standardized procedures has been achieved where the procedures were developed collaboratively. On the other hand, the Delta ETC has developed a comprehensive "Manual of Operation for Evaluation" centrally which has been disseminated to all of the sites, yet there has been little evidence of its use.

Collection and reporting of output data, as described above, has been the major target of standardization. Nine of the ETCs have standardized event and participant data collection ETC-wide; Southern California and MAARETC are currently in the process of doing so.

The next most common targets of ETC-wide standardization is formative and/or process evaluation of individual education and training interventions. The specific approaches to formative evaluation of events is described in Section II.E.2 below. Delta, ECAETC, EATN, MAARETC, Mountain-Plains and NY-Caribe have designated forms for use ETC-wide which solicit feedback from participants about various aspects of the training.

NY-Caribe has developed and validated a pre and post-training attitude scale which is used routinely in conjunction with all of its training

programs. Mountain-Plains has attempted to standardize procedures for assessing training effectiveness in enhancing knowledge, attitudes, belief and intended behavior (KABB) by developing a "pool" of KABB questions to be drawn upon by sites opting to do pre/post-training testing. Partially in response to requests for a standardized instrument, the Western ETC, through its San Francisco site, has developed and validated an attitude scale; it has been distributed in preliminary form to be used at the option of the sites.

EATN, New England and WAMI-0 each use relatively standardized procedures for doing follow-up on participants of selected intensive events to begin to gauge impact on practice.

Approaches to Formative Evaluation of Training Events

Formative evaluation of training events, for the purposes of this evaluation review, refers to the assessment of various aspects of the content, structure and/or process of the event with an eye toward incorporating the findings into the improvement of future events. Much of what the ETCs have called "process*' evaluation is included. In the strictest sense, preliminary evaluations of effectiveness which feed into future programs are also formative, but are considered separately.

The most commonly applied approach to formative evaluation of training events is the post-training ratings of various aspects of the event by the participants themselves using a written questionnaire. The focus ranges from global assessment of the entire program to detailed ratings of presenters, sessions and teaching methods. Sessions and topics tend to be rated on usefulness, practicality and relevance; presenters on clarity of presentation, educational skills and knowledge. These process-oriented evaluations provide documentation of the event and the way in which it was received, they are of limited value as formative evaluation because, while they may diagnose problem areas, they provide little specific direction for program improvement.

Open-ended questions which solicit post-training participant feedback provide more extensive data. "What did you like best?" "What did you like least?" and "What would you change?" are frequently asked open-ended questions. Delta ETC uses a variant on this approach, routinely asking participants to comment on "things I would change," "things I would keep," and "I would like to tell the presenter or program organizer . ..' The Florida site of EATN uses an "extended evaluation" for its more intensive programs, asking participants for substantive comments on each presenter and session, an approach which has yielded rich formative data.

As a supplement to its participant feedback, EATN routinely obtains feedback from its trainers. Its "Trainer's Evaluation" form asks for the trainer's own assessment of, among other things, what went well with the session and how well the trainees and workshop objectives had been matched. On its "Training Report Form," WAMI-0 asks "which techniques worked best?" "which techniques did not work well?" and "what kind of problems (if any) did you encounter in your training?"

Several other approaches to formative evaluation are in use in selected instances. Exit interviews are routinely held for obtaining formative data from participants in clinical experiences organized by Mountain-Plains and EATN. In a number of instances, three to six month follow-ups are done, either by mailed questionnaire or telephone interview, in which respondents are asked to comment, in retrospect, about aspects of the training that have proven most useful. The Delta ETC uses a particularly innovative approach to formative evaluation in which PWAs who have been part of a panel are asked to comment on the overall program from the perspective of the trainees' potential clients.

For the most part, utilization of formative data for program improvement has been informal. The Maryland site of MAARETC, for example, takes a more formal and strategic approach. Intensive courses are subjected to detailed formative evaluation at the outset and the results fed back into course improvement. Ultimately a maintenance level of formative evaluation is built into ongoing courses. "One-shot" presentations are subjected to broad formative questions to ensure that the course planners continue to tune into the needs of the providers and provider agencies they serve; detailed evaluation with an eye toward improving specific components of the training in such courses is deemed unnecessary.

Approaches to Evaluation of Program Outcomes

The degree to which ETCs are evaluating program outcomes varies widely not only across ETCs but among the sites of a given ETC. However, interest in conducting evaluation of outcomes has been piqued even among ETCs where little or no outcome evaluation has here-to-fore been conducted. A variety of approaches to evaluating program outcomes has been noted. The examples below are illustrative and are not intended to be an exhaustive catalogue of outcome evaluation activities.

a. Evaluation of Effectiveness

For purposes of this evaluation review, the evaluation of effectiveness refers to the assessment of the degree to which a training intervention has met its instructional objectives relative to increasing knowledge, changing attitudes, enhancing skills and stimulating the "intention to act." While not identical, effectiveness roughly coincides with "immediate impact." (Immediate impact may measure outcomes that are not necessarily related to instructional objectives.)

Pre/post-training testing is the primary method used for assessing effectiveness of training in increasing knowledge, utilizing primarily multiple choice and true/false questions. This approach has been used only sporadically among ETC sites and, where used, its use has appropriately been limited to longer programs. The value of measuring the ability of participants to memorize random and isolated facts has been called into question by some ETC evaluators.

Pre/post-training testing is also commonly used to measure changes in attitudes, beliefs and opinions felt to have relevance to AIDS caregiving. These changes are generally measured by presenting opinion statements and asking participants to rate the degree to which they agree or disagree with these statements. The NY-Caribe ETC appears to be the only site which has done significant validation of the attitude scales it uses.

Attitude assessment being done by the ETCs is beginning to move from assessments of more general attitudes such as homophobia, which are less susceptible to change via a limited training intervention, to more focused ones such as assessments of perception of personal risk, which are more likely to change in response to training. WAMI-0, in conjunction with its Substance Abuse Counselor Course, has developed a six-item scale to measure personal reaction to situations which some might consider personally risky. The scale is prefaced as follows:

> Sometimes what we know and how we feel are very different, Please read the following statements and circle the number that most closely corresponds with what you know about risk. Then circle the number that most closely describes your feelings.

The San Francisco site of the Western ETC is in the final stages of validating an attitude assessment instrument which includes scales measuring situation-based perception of risk, fear of contagion, emotions towards AIDS patients, and professional resistance.

The degree to which ETCs and their sites have borrowed pre/post-training questions or entire tests from one another, or have expressed interest in doing so, is a matter of concern. There have been a number of instances where such tests have been adopted, whole-cloth, without any consideration of whether they relate to the teaching objectives or content of the adoptive program. As a counter-example, the Mountain-Plains has made an effort to key items in its pool of KABB questions to specific units in its standard curriculum. Thus, when its sites select individual units for a particular training event, they can select only the appropriate test questions to accompany them.

Different approaches based on self-assessments have been used by ETCs. One of these approaches, the "self-efficacy" approach, calls on participants to directly assess the degree to which the training has contributed to a particular change--typically level of knowledge or degree of comfort with a particular situation or ability to perform a particular task. Effectiveness of MAARETC's Home Health Care training is assessed via an item that states: "As a result of this program, I think I'll feel more comfortable with HIV patients," asking respondents to select "a lot more comfortable," "somewhat more comfortable," and "not more comfortable." WAMI-0 uses open-ended questions to assess the effectiveness of its more intensive programs. The evaluation questionnaire used in conjunction with its train-the-trainers program asks participants to "name one skill that you have acquired or improved as a result of attending this workshop?" while that used in conjunction with its substance abuse counselor training asks participants to

"write one fact or idea from the training that you learned, and that seems important to you."

Other well-focused examples of the self-efficacy approach to determining the effectiveness of training change come from several of the Southern California sites. From the University of Southern California site:

As a result of this program, do you feel that you:

- know the current issues pertaining to HIV infection in the Latino Community?
- know what issues to cover when counseling HIV infected persons? when conducting an initial HIV evaluation?
- can conduct comfortably an initial HIV evaluation?
- can integrate sexual history taking and risk identification into one's own practice?

Paraphrasing a test item from UCLA:

On a scale of l-5, how much did attendance at the conference influence:

- your willingness to screen and care for patients with HIV infection?
- . your decision whether or not to take sexual histories on patients you're seeing for the first time?

Another self-assessment method asks participants to self-report competencies prior to training and then again at the end of training. EATN uses this approach in the assessment of its train-the-trainers program. Participants are asked to report their confidence in their level of knowledge and skill with regard to various tasks, both clinical and teaching. EATN's South Florida site uses this same approach to gauge the effectiveness of its clinical training in increasing participants' comfort level in providing care to clients who are engaged in nine specific risk behaviors.

A third approach using self-assessment is done post-training only but asks participants to make retrospective assessments of the competence levels prior to training as well as at the end of training. This approach was borrowed from the one developed by the AIDS Task Force of the Society of General Internal Medicine for its "AIDS & the Primary Care Provider" curriculum, and has been used by New England for its faculty development workshop and by the Maryland site of MAARETC in the evaluation of its HIV Counselor training.

Those ETCs that have addressed the effectiveness of training in stimulating participants to consider behavior change have done so from two

perspectives. The first looks at behavioral intention--what will they do differently. The second looks at the effectiveness of the training in reducing specific barriers to action.

In assessing training effectiveness in stimulating behavioral intention, the central issue is the phrasing of the question "what will you do differently as a result of this training?" Subtle differences in the phraseology result in significantly different answers. Abstractly-worded questions seemed to have resulted in answers which are too diffuse or conversely, too detailed, to be of value. More concretely worded questions, pointing to categories of behavior and/or time limited changes, have produced far richer responses. For instance, for EATN's train-the-trainers workshop, behavioral intent is obtained from a question on the post-training questionnaire which asks: "what three things are you likely to do differently when you return to your worksite?"

While open-ended questions may provide richer responses, the difficulty of analysis in trying to link responses to specific course objectives is increased. More direct questions provide a tighter link between specific behavioral objectives. A question used by AETC-SC's UCLA site is illustrative:

> How likely is it that you will regularly take sexual histories on patients you're seeing for the first time?"

An interesting approach to evaluating training effectiveness in reducing barriers to care is used by both the UCLA and SC site of the Southern California ETC and in the evaluation of the MAARETC Dental Program. Using a pre/post-training self-reporting procedure, participants are asked the extent to which specific issues serve as a barrier or deterrent for them in treating AIDS patients. The issues listed are specific to the training audience and relate to training activities aimed at diminishing these barriers. UCLA asks that each item be rated; MAARETC asks that the two most significant concerns be identified from a larger list.

The MAARETC Dental program uses an interesting time series design to assess effectiveness in a variety of areas. Self-reports of perceptions (the degree to which participants perceive that they are already treating infected individuals, the degree of risk they perceive that they encounter when treating HIV+ healthy individuals), readiness to act (opinion on appropriateness of treating HIV+ individuals in private practice), and intended behavior (plans to be immunized for hepatitis-B) are collected immediately pre-training and again post-training to assess immediate effectiveness. Longer term effectiveness is assessed by comparing pre-training and follow-up responses to show either the persistence of changes measured directly after training, or the development of even more favorable view after analyzing what was learned in training or reassessing attitudes back in the context of their practice. Variables analyzed in the assessment of longer term effectiveness include perceptions of the degree to which they are already treating HIV+ patients, the appropriateness of treating HIV+ healthy patients in settings like their own, and the risks they face in

treating HIV+ healthy patients, as well as attitudes which impede providers from becoming **more involved in** the care of HIV infected patients.

b. Evaluation of Impact

Evaluation of impact, for purposes of this evaluation review, refers to the extent to which participation in ETC training has led to changes in on-the-job behavior or has actually precipitated actions or events that would not have otherwise occurred. This is actually an assessment of mid-term impact. The true measure of impact is improvement in outcomes, both physical and psychological, of people with HIV/AIDS. However, this is not only extraordinarily difficult to measure, but it would be virtually impossible to, attribute any such change to a given intervention or even to the collective interventions of an ETC given the volume of potential confounding variables in the environment.

Impact on on-the-job behavior is measurable only after a participant has had an opportunity to return to work and apply newly acquired knowledge. Therefore, one would expect some lag time before impact evaluations would be undertaken. At this time, only EATN, **MAARETC, New England, the Western ETC, WAMI-0 and the UCLA site of Southern California have actually begun implementation of impact studies.**

Almost all of the impact evaluations have involved follow-up studies of one sort or another. Data for most of the follow ups have been collected from the participant; in one study, data was collected from patients of the participants. Time frames have generally been between three and six months post-training. Respondents have been followed up variously via telephone interviews and using mailed questionnaires, and, for the most part, follow-up studies are administered by the ETC headquarters.

EATN follows up on specific planned actions that participants reported at the end of training. In telephone interviews, participants are reminded of their planned actions and asked the extent to which these plans have been carried out .

4-6 months after its train-the-trainers program, WAMI-0 conducts a telephone follow-up of participants, asking, among other things, the number of trainings conducted since attending the program, the types of groups of individuals the trainings targeted, the topics covered and the approximate number of people trained. Train-the-trainers programs that have focused on substance abuse issues have included a day on facilitating organizational change, particularly regarding changing intake and history-taking procedures. Participants are followed up to assess successes and barriers to effecting change in the trainees' home institutions.

MAARETC measures the impact of its Dental Training program by comparing pre-test responses with follow-up responses to measure actual changes in behavior: immunization for hepatitis-B, HIV screening procedures in place and infection control procedures being utilized. Evaluation of the train-the-trainers component of the Dental Training program further seeks to document

impact by asking respondents to report the number of trainings, specifically in infection control, they have conducted since completing the course, as well as to report the number of individuals attending these events.

The Virginia site of MAARETC is conducting an impact assessment of its "AIDS in Adult Institutions." Mailed questionnaires ask participants "What have you done with the information you learned from the AIDS Training Program?" Explicit response choices are given with room for additional comments:

Disseminated info about HIV/AIDS to other staff
Provided training programs for other staff
Served as the HIV/AIDS resource person in my institution
Learned to protect myself from infection
Informed others how to protect themselves
Provided counseling to HIV-infected individuals
Determined my role in meeting the educational needs of clients during incarceration
Determined my role in meeting the educational needs of clients upon release into the community
Identified community resources and local AIDS service organizations

The New England ETC conducts follow-up evaluations to assess the impact of the faculty development programs and the mini-residencies. Questionnaires are mailed to.participants from the NEAETC headquarters with a cover letter signed by the trainer. A month later, blind reminders with a second copy of the questionnaire is sent to all participants to give those who have not yet responded a second chance to do so. As a result, the response rate has been very high. Impact is measured in terms of:

- identification of specific things that participants do differently as a result of having taken the course; and

- identification of new educational programs on HIV infection/AIDS that the participants have developed, coordinated or served as an instructor which can in some way be attributed to participation in the NEAETC course.

In a special study, the UCLA site of Southern California conducted phone interviews with 1,500 patients of nurses and doctors who had participated in the sexual history training. Patients were asked if the provider asked 12 different types of questions including "are you sexually active or not," "number of sexual partners you have" and "your sexual practices". They were also asked if they were offended when questions were asked about their sexual health. At the end, one question specifically asked: "Overall, do you feel that the provider has enough information about you to provide you with the best possible care?"

Mountain-Plains is in the planning stage of its follow-up evaluation. Evaluation of impact will be conducted on the first generation train-the-trainers program, second generation train-the-trainers activities, and "outreach" training conducted by both first and second generation trainers. As originally envisioned, all participants were to be surveyed three months after training to ascertain the degree to which they have utilized information from MPAETC courses. It is anticipated that a sample of participants who received training will be followed up. The follow-up will rely primarily on mailed questionnaires but telephone interviews may be incorporated into the design.

Several unique approaches to impact evaluation have been noted. The MAARETC headquarters has taken another approach examining the impact its statewide sites have or have not had on their participants by comparing data from statewide needs assessment conducted by other agencies with like items on post-training evaluations. Items such as the percentage of providers reporting "comfort in dealing with HIV infected people" are examined. While the approach is relatively qualitative, MAARETC hopes to introduce some quantification into the study.

The Western ETC has piloted an approach to impact evaluation involving chart reviews of patients of residents that have participated in one of its clinical training programs. The chart reviews focus on the degree to which participants routinely do risk assessment and risk reduction counseling. A form was used for abstracting the information documented in the patient charts.

Recently, the Western ETC has begun a study of the impact of its training in increasing the number of physicians willing to see HIV+ patients. Using a "key informant" approach, a number of the ETC sites have identified, by name, the physicians and dentists in their communities who treat AIDS patients. This list, which the ETC reports has been surprisingly easy to compile, serves as a baseline for the assessment of impact. Repeat rounds will document any increase. New names on the list can be compared with training rosters to determine whether or not new entries to AIDS practice have previously been ETC training participants.

Unique and Interesting Techniques and Methodologies

In reviewing the evaluation methodologies of the eleven ETCs, several unique and interesting evaluation techniques and methodologies were noted. Several are highlighted below.

A number of the ETCs have made use of the "standardized patient" technique in the training and evaluation of individual trainees, particularly in professional school settings. Both the Northern and Southern Illinois sites of MATEC are involved in developing AIDS-related Standardized Patient Encounters for training medical students and residents. The evaluation component involves video monitoring of the doctor-patient encounter for later viewing and analysis and a follow-up session between doctor and patient where

the patient offers a critique of the encounter. The University of Massachusetts and Brown University sites of the New England ETC have used this methodology with medical students and internal medicine residents to train them to educate and gather data from patients, and to evaluate their performance in doing so. Each student spends 15 minutes with one standardized patient. The student is asked to obtain a focused and relevant history, perform a relevant physical exam, develop a differential diagnosis, communicate their impressions and provide patient counseling. The students are then given written feedback on their performance. The USC site of Southern California is also in the process of developing a package for teaching and assessing clinical skills using standardized patients. The cases have been developed and used in two training situations. Accompanying the cases is an evaluation form for the conduct of the interview. This evaluation form contains behavioral statements that will be rated by an observer in order to evaluate the trainee's conduct of an interview with the patient. The form includes items for introduction of self, for manner of obtaining information, for feelings and attitudes revealed, for the content of the interview, and for additional comments and suggestions.

The Alabama site of EATN has purchased a technology called the "Q-Sys tern," consisting of a portable computer with 32 response pads, much like those used on TV game shows. A set of questions and multiple choice answers are programmed into the computer to correspond with the content flow of the presentation. During the course of the presentation, the presenter triggers the computer to flash the appropriate question and answer choices on a large monitor for the trainees to see. Those seated at the response pad stations key in their answer. The responses are immediately tabulated by the computer and presented on the monitor. This immediate feedback enables the presenter to ascertain whether his/her points are being grasped before moving on to a new area.' In addition, the responses are automatically stored in the computer for subsequent use in evaluation studies. The technology was found to be very engaging, keeping the trainees alert and lightening up the session. It may also turn out to be a motivational tool in that it enables trainees to position their own comprehension and attitudes, anonymously, among their peers.

The Maryland site of MAARETC utilizes a methodology for evaluating the effectiveness of its HIV Counseling training program in improving counseling skills of the participants, particularly their ability to respond quickly and appropriately to statements of clients that potentially have significant consequences. The technique makes use of a paper and pencil test administered before and after training. The test presents statements that might be typically made by clients in a pretest or posttest counseling situation. Participants are asked to write down the first thing they would say to the client following each of the statements. The responses are scored as follows: Detracts (-1); Neutral (0); Somewhat Facilitative (+1); Very Facilitative (+2). The specific statements on the pre-training questionnaire and on the post-questionnaire are not the same, but the situations they represent are-- pre-test counseling session, post-test counseling with negative result, post-test counseling session with positive result.

MPAETC tested a methodology, introduced by the Utah site, called the "educational **grid"** to assess the degree to which trainers effectively communicated their main points. Speakers were asked to list the main points they would try to make during their presentation on their Presenter Form. The Participants' Evaluation form contained a corresponding item, the Educational Intervention Grid, asking participants to list the main points that the speaker made. The speaker's lists and the participant's lists were compared and an average calculated which represented the speaker's success *in* conveying his or her main points.

The evaluation of **MAARETC's** Dental Program, both the train-the-trainers component and the training for practicing professionals, is notable for its elegant, yet simple design. The evaluation makes use of a time series design including a pretest, a **posttest** and a 3-6 month follow-up. Variables relate directly to the training objectives; questionnaire items measure these variables in subtle ways. The appropriate insertion of variables on the three instruments tap several dimensions of effectiveness and impact.

6. Evaluation of Other Project Activities

Although the **ETCs** have been involved in a number of project activities other than education and training events--initiatives to infuse AIDS content into professional school curricula, hotlines, information dissemination, for example--there has been little evaluation of such activities reported.

Several of the **ETCs** have conducted baseline surveys of the status of AIDS content in professional school curricula, most notably the extensive survey conducted by NY-Caribe in preparation for its curriculum development-oriented faculty development workshop. Evaluation of hotlines and information dissemination activities has been primarily output-oriented.

7. Status of Evaluation Activities

Collection of output data is done universally and routinely for ETC education and training events nationwide. Process/formative evaluation is carried out on the vast majority of these events. Beyond this basic level of evaluation, the degree to which the **ETCs** have undertaken evaluation varies from ETC to ETC, **and** from site to site and program to program within individual **ETCs.** Interest in and actual implementation of outcome evaluation has been increasing. Some of the **ETCs** have begun to establish a threshold, typically events of four hours to one-day in length, for conducting some outcome evaluation.

Evaluation of Train-the-Trainers Efforts

The level of train-the-trainers activities varies widely across **ETCs:**

- MATEC, **through its sites, has** been intensely involved in train-the-trainers activities, having conducted more than

50 varied train-the-trainers events in the first two years.

- Train-the-trainers was a major focus of the WAMI-0 program in the first thirty months of the program. Approximately 500 trainers have been trained through these programs; it is estimated that 300 are currently active trainers.

  NY-Caribe held a five-day summer train-the-trainers institute in each of its first two years and an abbreviated version the third year. Also in the third year, it did a faculty development course for professional school faculty focusing on curriculum development around AIDS issues.

  The Western ETC has held two five-day faculty development workshops, one for its medical faculty and one for its dental faculty. In the second year, a second five-day dental program and a faculty retreat emphasizing training skills and psychosocial issues were held. In the third year, a 3-day clinical update for faculty, a dental refresher course, and a mental health faculty seminar were held.

  Mountain-Plains has conducted one regional master trainers program, while each of its state sites has conducted at least one in-state program.

  The NEAETC conducts annual regional faculty development workshops for medical school faculty; one of its contractors, the Massachusetts Hospital Association, has conducted five programs for institution-based trainers annually.

- Delta ETC conducted two-day TOT workshops based on the ETC curriculum in Louisiana, Mississippi and Arkansas, as well as a two-day dental train-the-trainers.

  MAARETC has begun implementing a two-tiered dental train-the-trainers program through its five state sites.

  The Virginia site of MAARETC has held five week-long train-the-trainers sessions.

- The West Virginia focuses its train-the-trainers activities on medical students. Students interested in doing training are given a three-hour training-of-trainers session, focusing on educational methods and techniques.

- EATN conducted a one-week regional nurse TOT program; an agency-specific train-the-trainers program has been conducted by its South Carolina site.

- The USC site of Southern California conducted an Instructors Training Program for family practice faculty.

- The Kentucky site of ECAETC held a train-the-trainers course to orient staff to its dental curriculum.

For the most part, evaluation of these train-the-trainers activities were subjected to basic formative evaluation. Several outcome-oriented evaluations were noted.

In addition to a strong formative evaluation component, the evaluation of the New England ETC's annual faculty development program has included an effectiveness component in the form of self-reporting of retrospective pre-training and post-training knowledge or skills proficiency on 13 AIDS-related areas, along with an impact component in which subsequent trainings conducted have been identified through mailed follow-up questionnaires.

WAMI-0 has developed an extensive set of evaluation instruments for use in conjunction with its train-the-trainers program including: a workshop needs/demand planning survey; a community assessment sheet; a pre-training questionnaire which ask participants to rate their own level of confidence in the knowledge base and teaching ability in a long list of AIDS-related topics; a training plan; a training plan which provides a baseline for impact evaluation; a course evaluation form which collects process-oriented formative evaluation data; a participant evaluation questionnaire which collects data from individuals subsequently trained by train-the-trainers participants assessing the training performance of the latter; a training report form which collects output data; and a telephone follow-up form which is used to structure the follow-up survey.

EATN used a modification of the WAMI ETC's approach to evaluate its nurse train-the-trainers program including: individual daily session evaluations; pre/post-training self-reported knowledge and skills, including the knowledge and skills to be able to conduct a variety of education and training programs; a post-training action plan; a six-month informal phone follow-up by the headquarters staff to determine impact in terms of plan completion (follow-up did not include obtaining impact-oriented information on trainings conducted); a trainer's evaluation of the course; and an analysis of costs.

MAARETC dental train-the-trainers program is being evaluated using the same time series design (pre/post/follow-up) and instrumentation that is used to evaluate its "Dental Care Professionals" course with two impact-oriented auestions added to the follow-up: the number of AIDS infection control courses presented by TOT participants, and the number of individuals who attended these courses. The follow-up study is now underway and data are coming in but have not yet been analyzed.

In a comprehensive evaluation of its 1990 faculty development seminar focusing on mental health issues, the Western ETC included pre/post-training testing of knowledge, attitudes and risk perceptions. Attitudes and risk perception were measured by means of 6-point Likert-type scales while knowledge was measured via multiple choice questions. Baseline ratings and change scores were examined as a function of participants' gender, race occupational status and geographical location, as well as their previous clinical and personal contact with HIV-AIDS patients. Pre-training findings showed a positive skew in the attitudes and perceptions of risk among participants in this faculty development program. Probably because of this high baseline, overall increases in positivity were not statistically significant. One item, perception of risk from accidental needlesticks, showed a significant change in the desired direction, indicating that the program had been successful in reducing this concern.

Evaluation of Clinical Training Opportunities

Across the national ETC-network, a variety of training events have been offered that were "clinical" in nature. For the purposes of this review, "clinical" opportunities are those in which participants have the opportunity to learn and/or practice caregiving skills by interacting with HIV-infected individuals and/or others in an actual caregiving setting. Skills-oriented workshops are not considered clinical training opportunities for purposes of this review. Clinical experiences have been offered primarily to medical practitioners, but have also been organized for other professions, and have varied in the length and intensity of the exposure.

Seven of the eleven ETCs offer some type of clinical training opportunity. Evaluation of these clinical trainings have been almost exclusively formative in nature--participant feedback on the content, structure and/or process of the event. A few exceptions have been noted.

In addition to extensive formative evaluation, the South Florida site of EATN evaluates the effectiveness of its mental health clinical experience via pre/post-training testing. Changes in knowledge, opinions, as well as changes in personal level of discomfort in working with individuals with various characteristics including clients with HIV/AIDS, those engaged in high risk behaviors, as well as those with non-AIDS-related conditions are routinely measured.

The "AIDS Clinical Training Program" for physicians, offered by the USC site of the Southern California ETC, utilizes a post-training questionnaire to evaluate the experience. In addition to the formative components of the evaluation, effectiveness of the experience has been evaluated using the self-efficacy approach. Participants are asked to "rate the impact this clinical experience has had" on their knowledge and understanding; professional habits and attitudes; technical skills; clinical skills (such as Hx, Px, Dx); and management skills. Further, they are asked: "As a result of this experience, do you feel you are able to diagnose and treat HIV positive patients, AIDS patients?"

The New England ETC offers a variety of clinical training experiences. Broad evaluation, including evaluation of effectiveness and of impact, are being conducted on three of them. These clinical experiences include both a didactic and a hands-on component. The Brown University and University of Massachusetts' mini-residencies for physicians are evaluated for effectiveness by measuring pre/post-training changes in self-reported confidence in undertaking six AIDS-related primary care tasks: answering patient questions; screening/history-taking; practicing infection control; counseling HIV+ patients; providing primary care management; and utilizing appropriate community resources and referral networks. The Beth Israel Nurses' mini-residency is evaluated using a post-training questionnaire that taps three dimensions of effectiveness: effectiveness of the experience in conveying specific nursing task-related information (gathered via open-ended questions); effectiveness in promoting insights ("As a result of this mini-residency, I discovered . . . . I realized..."); and effectiveness in stimulating participant's intention to change the way they provide nursing care to people with AIDS. Both the physicians' clinical training and the nurses' clinical training have been evaluated for impact via a six-month follow-up questionnaire which asked participants to identify specific things that they are doing differently as a result of having taken the course.

The Western ETC pilot-tested a chart review methodology for assessing the impact of its clinical training for family practice residents to see whether they were incorporating risk assessment and risk reduction counseling into their day-to-day practice. The charts of 50 patients aged 12-50 who were seen for routine care in a family planning outpatient setting were sampled. The charts were reviewed for evidence of sexual history-taking; evidence of STD history-taking; evidence of substance abuse history-taking and evidence of risk reduction counseling (including counseling on condom use, other specific risk reduction strategies, and/or distribution of patient education materials). In order to link outcomes to the training, institutional influences on risk assessment and risk reduction counseling were controlled by documenting the extent to which the institution had policies regarding documentation or whether the record forms included such questions.

Program Evaluation

For purposes of this evaluation review, program evaluation refers to the analysis of multiple events with similar objectives, content, structures and/or processes to determine collective outcomes. Throughout the ETC national network, there are a number of programs which involve a more or less uniform approach to a given offering over time or in various geographic locations. While, in many cases, identical or similar instruments, often including questions on behavioral intent, have been used to evaluate the individual events, there has been little analysis that would allow generalization across the program. The Northern Illinois site of MATEC is an exception where aggregate analyses of two programs have been conducted. The first was on a series of twenty-five sessions held for personnel of the Chicago Department of Health's neighborhood clinics. In response to the question "what will you do differently?" respondents overwhelmingly indicated that they would use universal precautions, indicating a highly successful

program. The second analysis examined a series of eight 1-2 day programs put on for the Bureau of Mental Health's local mental health centers. The response to the same question yielded very non-specific and diffuse answers. "Try to be more sensitive" and "nothing different" were predominate answers, indicating a much less effective program with regard to stimulating specific action.

Three of the ETCs have done aggregate analysis of several unrelated events. NY-Caribe routinely does pre/post-training attitude testing. Early in the project, it did an interesting aggregate analysis. Sites at which most of the attendees were academically-oriented showed high positivity on the pretest; these trainees showed modest gains in positivity and expressed only moderate satisfaction with the training. Trainees at sites in the front line of health care with significant chance of contact with PWAs (predominantly those in city settings) showed only moderate positivity on pretest; they, too, showed modest gains in positivity and were only moderately satisfied with the ETC training. Trainees at more remote sites with less chance of contact with PWAs began training with low positivity toward people with AIDS but showed significant increase in positivity on posttest; these trainees expressed high satisfaction with the ETC training.

The Mountain-Plains ETC has been doing aggregate analysis of training effectiveness based on pre/post-training responses on knowledge, attitude, belief and behavior items from disparate trainings held in three states. The common factor of events included in the analysis was that each of the events were one day or longer (i.e. expected to produce some change). The aggregate analysis of nine offerings indicates that participants feel that, as a result of training, they have sufficient knowledge to protect themselves from HIV infection. Because of lack of common content, structure or process, conclusions speak only to the effects that AIDS training, in general, can have.

EATN is in the process of completing an aggregate analysis of training impact . Participants of three one or two-day conferences held in the winter of 1989-90 were followed up by telephone 12-13 weeks after training. In this follow-up they were asked, with regard to the things that they reportedly planned to do differently at the completion of training, what progress had been made. If no action had been taken, they were asked to explain.

Outside Influences on ETC Evaluation Activities

ETCs have, to some degree, been influenced by outside factors.

Subcontractors

On one hand, pressure from subcontractors has imposed constraints on the ETCs' ability to implement their evaluation plans. Subcontractors were primarily concerned with delivering programs and tended to resist evaluation as simply an added administrative burden. Further, as roles and relationships were being defined between the ETCs and their subcontractors, the subject of evaluation sometimes piqued concern over regional control versus subcontractor autonomy. In the interest of building and preserving relationships with subcontractors, ETCs have tended to "give" on issues of evaluation in such instances of potential discord.

On the other hand, subcontractors have made significant contributions to regional evaluation activities. In a number of instances, innovative evaluation methodologies developed by one of the subcontractors were adopted regionwide. Subcontractors active in evaluation have served as models, stimulating other subcontractors to do more. In one case, the database developed by one of the subcontractors has served as the basis for a uniform database used by all of the subcontractors.

Continuing Education Credits

Certifying ETC events for continuing education credit tends to have a positive influence on evaluation: training providers and trainees know that evaluation is required and are more tolerant of evaluation conducted in this context. However, where credentialing organizations have control over the evaluation approach, there is potential for lack of uniformity of approach--one for programs for which continuing education credit is sought and another for the rest of the ETC programs.

Collaborating Organizations

Many ETC programs are presented in collaboration with other organizations, with the ETC as a co-sponsoring partner or with an ETC representative as a presenter in a larger program. Many of these collaborating organizations are well-established and have long-standing management systems in place, including evaluation systems. In such collaborative situations, there is potential for competition over whose evaluation methodology will apply. All of the ETCs have reported experiencing this at one time or another. Some, like the North Carolina site of EATN, take a strong position, requiring EATN evaluation as a condition of their participation.

Since the field of AIDS players is relatively small and ETC staff often wear multiple hats, it is often difficult to determine the extent to which a given presentation should be considered an ETC event. The UTAH site of the Mountain-Plains ETC cites the use of the ETC evaluation tool as criteria as to whether to count the training as an MPAETC event.

HRSA

HRSA has always considered evaluation an integral part of the ETC program. Evaluation plans were included in each of the ETC's proposals; acceptance of these evaluation plans was implicit in HRSA's project award. During the first two project years, the ETCs looked toward HRSA for guidance as to where to place their evaluation emphasis. Only a few directives were forthcoming, such as the need to document minority participation. Beyond this, HRSA has provided little guidance in terms of the specific direction evaluation should take or level of effort ETCs should devote to evaluation activities. Some of the ETCs have taken the position that, until they are told otherwise, they will continue in the direction and at the level they deem appropriate. In other cases, perceived lack of guidance from HRSA has resulted in some degree of inertia with regard to evaluation activities, particularly in cases where the ETC has experienced pressure from its subcontractors to do less.

V. CONCLUSIONS AND RECOMMENDATIONS

The eleven AIDS ETCs included in this study are complex organizations covering broad, diverse geographic regions, encompassing several institutions and organizations either as sub-contractors or as collaborators and conducting an extensive range of HIV/AIDS training and related activities. While overall conclusions can be drawn and recommendations made, it must be recognized that, by design, each ETC is a unique program. Exceptions can be found for many of the conclusions, and recommendations must be adopted considering individual program situations.

The conclusions and recommendations presented have been drawn from the preceding overviews of the ETC case studies and evaluation reviews. Details regarding each ETC can be found in the individual case studies and evaluation reports contained in separate volumes which are companions to this final report .

A. CONCLUSIONS

This evaluation study was conducted relatively early in the development of the ETC program. In addition, there were several significant barriers to rapid and smooth program development, many of which were outside the direct control of the ETCs. Consequently, in a number of places the study observed only the beginning of functioning education and training systems. Importantly, significant progress was noted between the first and second year of the evaluation study both in the depth and scope of ETC training and education programs and in their evaluation efforts.

In the initial conceptualization and design of the ETC program, HRSA was purposely flexible and non-directive. This was done to allow ETCs to develop programs responsive to their own regional needs and organizational capabilities. As a result, it is impossible to define a "typical" ETC. The ETCs do have several aspects in common: all provide continuing education and training to a broad range of health care providers; all are trying to influence the curricula for training health professions students and residents at least at the institutions affiliated with the ETC; all are incorporating some level of train-the-trainers programs as part of their training approach; all are targeting programs to benefit minority populations; and, all are serving as an information resource to target populations in their area. Beyond these core elements, however, the ETCs differ considerably: their approach to regional management varies from highly centralized to highly decentralized; the specific roles of the regional offices versus local sub-contracted ETCs are individually defined; training emphasis as well as emphasis on other activities varies considerably between the ETCs and even among sub-contractors within the ETCs.

HRSA's flexibility in the initial stages of ETC development had the advantage of encouraging locally responsive programs. The continuing absence of clear direction and policy, however, is causing problems for many ETCs and the program as a whole. In trying to address HRSA's changing priorities and issues, the ETCs have been constrained in their ability to pursue a clearly

focused training strategy. In addition, the many differences among the ETCs make it very difficult to characterize or evaluate the program on a national basis. In an era of close scrutiny of federal expenditures, this could work to the disadvantage of the program.

The ETCs were originally designed as regional programs, typically covering a multi-state area. However, defining the roles and responsibilities of the ETC regional office versus its subcontracted and collaborating organizations was left to each ETC. Some designed highly centralized programs with the regional ETC assuming considerable responsibility for developing and implementing training throughout the region and/or closely controlling the activities of its sub-contractors. Others began as more decentralized programs. At the extreme of decentralization, the regional ETC dispersed grant funds to sub-contractors and gave the sub-contractors virtual autonomy in developing and conducting training. Regardless of where each started, many ETCs are moving to a balanced regional model where the regional ETC office assumes overall program oversight and coordinating and selected training responsibilities while delegating significant training development and implementation responsibilities to locally based ETCs.

Regionalization continues to be a valid concept, both for administrative purposes and as a vehicle to achieve synergy among AIDS training organizations with varying amounts of expertise and qualitatively different resources avaiiable to them. While there have been difficulties forming functional regions in some areas, these difficulties should not be viewed as indictments of the concept. The concept is appropriate; however, it needs further direction, supervision and time to reach its full potential.

The ETCs are effectively collaborating with many AIDS related organizations. This collaboration should be encouraged and, where necessary, expanded. However, it must be recognized that the ETCs' accomplishments may be more difficult to isolate and evaluate when they are merged with the activities of other agencies.

At the inception of the ETC program, there were few AIDS training curricula available. Those that were available by no means covered the gamut of AIDS training needs. In the first three years of the ETC program, there have been a number of excellent curricula and training programs developed by the ETCs. These include: train-the-trainers programs; intensive clinical training programs for primary care providers; specialized programs for selected provider disciplines including dentists, home care workers, mental health workers, social workers, and correctional systems workers; programs focusing on issues related to HIV/AIDS in many ethnic and racial minority populations including Blacks, Latinos, Native Americans, and West Indians; intensive programs for primary care residents; and programs for health professions students. There have also been some technologically innovative approaches to training.

Unfortunately, the implementation of these excellent and innovative **programs has been limited in most cases to the sites which developed them. There has not been much dissemination of curricula and programs** across ETCs

and even within ETCs, cross-program sharing has been limited. The isolation of excellent programs has limited the impact of the ETCs.

It has proven difficult for the ETCs to impact professional school curricula, particularly in institutions outside the ETC network. The dominant strategy of training professional school faculty with the intent that they will then incorporate AIDS/HIV information into their own teaching has merit but does not fulfill the current ETC mandate. Different approaches are needed and should be encouraged, not all of which *can* be expected to succeed.

All ETCs are serving as a source of HIV/AIDS related information in their area. The focus and extent of this effort, however, varies greatly across sites. In most cases it has proven difficult and often duplicative for the ETCs to serve as a resource for AIDS treatment information and for information on the disease and the progress of the epidemic. With limited resources, it seems that most of the ETCs should focus their services on information specifically related to AIDS training and ETC programs; including both information on training programs and schedules and providing training related material. Where gaps or specific needs can be identified, general information, clinical consultation and referral services may be offered.

From the review of the evaluation activities planned and being carried out by the eleven ETCs, it is clear that the ETCs want to do meaningful evaluation. However, implementation of evaluation has not proven as straightforward as originally anticipated. In the first three years of the program, ETCs have experienced many competing pressures for their resources. Priority has been given to building intraorganizational relationships, establishing credibility in the marketplace, and providing needed and quality programs.

Over the three-year period, there has been positive movement in the evaluation sector: an overall increase in the level of evaluation activity; increased willingness on the part of trainers and subcontractors to collect evaluation data; development of more standardized approaches; and movement from basic program documentation and formative event evaluation toward evaluation of trainee outcome. However, there is further need to capitalize on the existing momentum and convert good intentions into action.

The need to define the national ETC program in terms of its outputs is as pressing as ever. A great deal of attention has been focused, by HRSA and the ETCs, on collecting and reporting output data, yet there is still little uniformity in the data. Although the ETC committee on data has made progress in defining common data needs, the final draft of a national program and service record format has only recently been completed and no definitive action has yet been taken. As time goes on, the ETCs are becoming more invested in their own data systems, making future changes more difficult. Further, longitudinal comparability of individual ETC's data is becoming more and more compromised as decision-making about uniform requirements continues to be delayed.

The vast preponderance of evaluation activities to date has been process-oriented, the majority simply documenting participants' reactions to events, sessions and/or presenters. Only a few instances were noted in which formative evaluations were structured in such a way as to make a significant contribution in terms of adjustments in the content, structure or process of ETC programs. In only one instance was there evidence of a strategic plan to move from formative to summative evaluation.

A fair amount of outcome evaluation is in process or planned for the immediate future. Several instances of well-thought out evaluation designs were observed; however, there were many more instances in which there was little linkage between course curriculum and the outcomes measured. Several studies of the impact of various trainings on on-the-job behavior and/or implementation of planned actions are underway, and some preliminary findings are beginning to emerge. Results range from encouraging to disappointing. On the encouraging side, outcome evaluations conducted in relation to AIDS 101-type events suggest that the most often reported change was in participants' reported level of comfort in working with HIV/AIDS patients (interpersonal) and a better understanding of how to protect themselves from infection. This suggests that the most important effect of basic AIDS training is to stimulate a state of "openness to engage in the caregiving process" and perhaps "readiness to learn what to do." Findings of more task/skills-oriented training relate to the specific learning objectives of the individual event. For example, evaluation of a series of counseling courses noted an intention to be more sensitive to clients' confidentiality. In many evaluations which ask the question "what will you do differently?" the predominant answer has been "no thing" but these findings may be more an artifact of faulty instrumentation than of lack of impact. Truly disappointing, however, is the fact that only a very few of the potentially high impact, and often high cost, programs--training-of-trainers and, particularly, clinical training--incorporate a solid evaluation of effectiveness and impact.

Finally, there have been a number of interesting and innovative evaluation techniques developed and enlightening evaluations conducted around the ETC network. Unfortunately, on one hand, there has not been as free-flowing an exchange of evaluation methodologies and potentially helpful results either inter-ETC or intra-ETC, as there could have been, while on the other hand, a good deal of the exchange that has taken place has resulted in inappropriate and inapplicable "borrowing" of instrumentation.

B. RECOMMENDATIONS

In order to ensure that the following recommendations are practical, most have been drawn directly from the collective experiences of the eleven ETCs themselves:

1. ETCs are beginning to develop in-depth training programs aimed at influencing provider skills and behavior. HRSA should support this focus by reducing their emphasis on counting numbers of people trained and

instead emphasizing the provision of intensive skill oriented training. These intensive trainings, however, should be accompanied by more careful evaluation of their impact.

2. Although it is important to recognize individual regional and programmatic differences, more direction is needed from HRSA to help guide ETC program development. Further guidance would be particularly helpful in: defining the roles and responsibilities of the regional ETC office in relation to local ETCs; specifying priority target training groups (e.g. community-based primary care providers versus institution-based providers versus professionals in training versus allied health professionals) and preferred training approaches (e.g. train-the-trainers versus clinical training versus continuing education versus training professionals in training); defining training output expectations in line with preferred training approaches; and, defining expectations regarding program evaluation both in terms of consistency of data reporting among ETCs and in terms of type and scope of evaluation activities.

3. A regionalized approach to AIDS education and training should continue to be a major element in ETC policy. To support regionalization, HRSA should issue additional guidance on the appropriate role to be assumed by the ETC regional offices in relation to local ETC sites. In general, appropriate functions for the regional office include: strategic planning, general oversight, regional coordination of training and curricula development, quality assurance, distributing training curricula and materials, developing curricula and conducting training as needed to fill in gaps, communicating with HRSA contracting and grants management, and coordinating evaluation activities and reporting.

   Appropriate functions for local ETCs include: collaboration with AIDS-related organizations, identifying training needs and gaps in their area of responsibility, training development and implementation.

4. HRSA should continue to emphasize collaboration with other AIDS related organizations at both the regional and local level. This can be done by: encouraging co-sponsorship of training programs; support ETC staff participation on advisory boards and task forces; encouraging the formation of advisory boards at the local level which emphasizes membership outside of ETC affiliated institutions; facilitating coordination with related federally funded programs including community health centers, AIDS service demonstration programs, NIMH training grants, and Title X family planning training grants.

5. HRSA should provide a structure for identifying and disseminating curricula and material which effectively address priority target groups and/or training approaches. While some of this is done informally among the ETCs, excellent programs are still limited to selected sites even within ETCs. Programs involving intensive resources for either development or implementation such as train-the-trainers programs, clinical training programs, comprehensive discipline-specific curricula,

computer-based training modules and video productions should be the focus for dissemination.

6. Further clarification is needed on the range and scope of activities expected of ETCs outside their training and education activities; particularly in the area of information services. In general, it is recommended that ETCs focus their limited resources on providing information and material directly related to training. However, in areas where other resources are lacking, other services such as treatment hot-lines, referral services, and general library services may be necessary.

7. HRSA should encourage innovative approaches for influencing the content of professional school curricula, especially in institutions outside the ETC network. As with any truly innovative program, not all of these approaches will succeed.

8. Clearer guidance is needed from HRSA on its expectations regarding the institutionalization and eventual self-sustainability of the ETC programs. Some ETCs are pursuing institutionalization more aggressively than others although virtually all agree that substantial outside funding is essential to maintain operations for the foreseeable future.

9. Evaluation should be more centrally controlled even, and perhaps particularly, at ETCs that are highly decentralized and autonomous, to ensure comparability and 'completeness of data. Promotion of standardized approaches to evaluation and evaluation designs, and coordination of evaluation activities is an appropriate function of the project's evaluation coordinator. Compliance with the ETC's evaluation program should be a condition of participation in the overall program. The ETC should monitor this compliance on an ongoing basis and provide technical assistance to sites that are having difficulty. Centralized data analysis is a way of simultaneously maintaining control and taking some burden off of the sites.

10. All ETCs should designate a person at the regional level to take responsibility for evaluation activities. That person should have a strong grounding in practical approaches to evaluation. At least .20 FTE should be allocated to evaluation activities. In cases where that individual has other program responsibilities, the .20 FTEs should be "protected time" for evaluation.

11. Collaboration, both intra-ETC and inter-ETC, on evaluation approaches and methodologies should be strongly encouraged. An evaluation committee should be established at each ETC with representation from each subcontractor/site with the ETC evaluation coordinator convening the committee and taking an active role in promoting such collaboration between meetings. Annual meetings of ETC evaluation coordinators should be sponsored by HRSA.

12. While a data committee comprised of representatives from several of the ETCs has been actively working to develop data recommendations, HRSA

should ultimately define the set of standard data requiremehts for documenting all ETC education and training offerings in order to be able to characterize its program nationally in terms of federal priorities. (Precedents for federally-mandated reporting already exist within HRSA, for example, BHCDA's BCRR).

13. Databases of individual participant and event data, rather than aggregate data, should be maintained at the regional ETC level to allow for more in-depth analyses.

    Since the number of participants filling out evaluations is always less than the total number of participants, it would be useful to get a comparison of demographics of registrants versus those participating in evaluation in order to be able to generalize from the results of the evaluation.

    It may be useful to track trainer characteristics, particularly staff, versus affiliated versus per diem in order to correlate with trainee assessments or outcomes to see if one approach is better than another.

14. HRSA should specify minimum evaluation requirements. The following may be considered for discussion purposes:

    a. All Offerings

       Participant feedback should be routinely solicited at all offerings provided under the auspices of the ETC programs. Questions should be designed to identify specific areas where improvement could be made, not simply a documentation of how well the program or its components were received.

       The effects of the offerings should be evaluated in a way that both anticipated and unanticipated outcomes are captured. Use of the adult learning theory model of self-assessment may be helpful in this regard. Some examples of ways to capture this data include open-ended questions phrased as follows:

       - "As a result of having attended this workshop, I know . . . I feel . . . I believe . . . I can (do) ..."
       - "I leave this conference with the following new or additional knowledge . . . . . skills . .../ I leave this conference with the following changed views, beliefs . . . "

    b. Offerings on Which Substantial ETC Resources Have Been Expended

       Tests of random bits of knowledge are of little practical benefit. Evaluation of effectiveness of an event in communicating specific facts should be limited to instances where specific bits of factual

knowledge are critical to the activities participants are being trained to carry out.

All offerings, except for conferences and other primarily informational sessions, on which substantial ETC resources have been expended should be evaluated in terms of the degree to which the training has stimulated a state of "openness to engage in the caregiving process,, and "readiness to learn what to do. " Offerings in this category include:

- offerings of four hours or more;
- offerings replicated more than once (i.e. substantially the same content, format and presenters);
- offerings for which a formal ETC curriculum provides the structure;
- in-service training customized for a specific organization; and,
- didactic components of clinical offerings/practica.

In order to be a true test of the effectiveness of the offering, the specific attitudes, beliefs and behavioral intentions should be directly related to the specific objectives of the offering. The approach to capturing this information--pre/post-testing, pre/post self-reporting, post-only self-reporting--should be selected according to the dimension to be measured. It is important that indiscriminate borrowing of questions and instruments be eliminated; adaptation is encouraged provided that borrowed items specifically relate to the course objectives.

c. Offerings Aimed at Changing On-the-Job Behavior (Regardless of Length or ETC Effort)

At a minimum, evaluation of any offering which is aimed at changing on-the-job behavior should include a post-training inquiry of "intention to act." The wording of these questions should be as specific as possible and should directly relate the course objectives and content. Allow for qualitative as well as quantitative differences. For example:

"In my practice, I intend to:

- Do a routine and comprehensive sexual history on all of my patients;

. Do a routine but selective sexual history on all of my patients;

. Do a comprehensive sexual history on patients I believe might be engaging in high risk behaviors;

. I do not feel it appropriate to do a sexual history given the nature of my practice;

. Other . . ."

d. Offerings on Which Significant ETC Resources Have Been Expended

All offerings on which significant ETC resources have been expended should be evaluated in terms of impact, in other words, the on-the-job behavior resulting from the training: implementation of new practices, changes in previous practice, new roles and tasks taken on, etc. Where planned action was captured post-training, the degree to which it was implemented along with barriers to implementation should be determined.

Offerings in this category include:

- offerings of twelve (12) hours or more;
- in-service training customized for a specific organization; and,
- clinical offerings/practica.

The assessment of on-the-job behavior may be done by collecting participants' self-reported behavior or client-reported behavior through mailed questionnaire, by telephone interview, by direct observation, or by chart review. On-the-job behavior of in-service training participants may be reported by the participants' institution/agency.

e. Train-the-Trainers Programs

Train-the-trainers (TOT) programs need better definition. It has been applied to AIDS training of university faculty, and institution-based trainers as well as preparing a cadre of ETC/subcontractor trainers. It is highly questionable whether some training, such as AIDS updates for faculty, should be considered TOT. TOT should imply not only some commitment to go on to do future AIDS training, but also to comply with training standards and reporting requirements set by the ETC.

The ETCs should control the quality of training being provided by trainers trained under its auspices, i.e. trainers should not being

giving out misinformation or displaying biases. Therefore, individual participant assessment should be conducted as well as evaluation of the training program itself. ETCs should assess the knowledge base and sensitivity of all graduates of its train-the-trainers programs, even when these programs assume content expertise and focus only on training skills. This is best accomplished by observing trainers in action before certifying them as having successfully completed the program. In cases where participants are less content-sophisticated, pre/post-training testing may be appropriate.

HRSA is particularly interested in the impact of train-the-trainers programs in terms of the diffusion effect. If the definition of train-the-trainers assumes a close and ongoing association between the ETC and its train-the-trainers graduates, getting counts of second generation trainees should not be problematic. Counts can be obtained through periodic telephone or mail survey, or preferably via ongoing reporting.

f. Efforts to Impact Curriculum

At a minimum, an ETC's efforts to impact the curricula of professional schools should be evaluated in terms of process.

Where a significant amount of the ETC's effort will be invested in influencing curricula in its service area, more elaborate evaluation should be done. In such cases, an evaluation of impact should supplement the process evaluation. At a minimum, this requires a baseline survey of the status of HIV/AIDS prior to ETC efforts.

A variety of qualitative methods could be employed including focus group discussions, case studies, etc.

This minimum set of requirements should not be construed as the only evaluation to be performed. The ETCs may be conducting more extensive and interesting studies and should, in no way, be dissuaded from doing so.

Even though progress has been made in gaining subcontractor participation in evaluation activities, it should be noted that the ETCs would probably welcome a directive from HRSA as a mandate from the funder would give them more leverage in achieving compliance, particularly in politically sensitive situations.

15. As programs mature, basic process evaluation of events should be de-emphasized, and intensive formative evaluation should give rise to a maintenance level of evaluation for quality control and management purposes.

16: ETCs should have an explicit plan for moving from formative to more summative evaluation. While some experimentation with instrumentation is

functional, continued revision makes longitudinal comparability of evaluation data difficult.

17. All train-the-trainers programs should include a session on evaluation, including both an orientation to the ETC's evaluation methodologies and instruments, and a presentation of general concepts so that trainers can tailor evaluations to their particular programs.

18. Many ETC products--curricula and media presentations--have been developed for wide distribution. A great deal of the ETCs' efforts and funds have been devoted to developing products. However, insufficient effort has gone into their evaluation. While most have been subjected to "expert reviews," none have had an extensive formative evaluation including an evaluation of both intended and unintended outcomes.

    It is recommended that HRSA call a moratorium on the development of products which may be duplicative of existing products until more extensive evaluation of current products has been performed. It is further recommended that HRSA require that all ETC products developed henceforth undergo more rigorous evaluation.

19. The ETCs should be encouraged to do cost efficiency analyses; however, analyses of cost/benefit and cost/effectiveness are probably neither appropriate nor feasible.

    HRSA should develop the methodology by which cost efficiency analysis is done, with particular attention paid to definition of the cost centers and the cost allocation method(s) (e.g. direct cost, full cost, etc.) to be used.

20. ETCs should be encouraged to prepare or have subcontractors prepare formal evaluation reports for all events which intend to influence attitudes or/and behavior. These reports should include interpretation, conclusions and recommendations. Reports should be made available to HRSA for review at site visits.

Appendix A

Site Visit Protocol

AIDS BTC EVALUATION PROJECT

SITB VISIT PROTOCOL

The Health Resources and Services Administration (HRSA) has contracted with JSI to perform an evaluation of the regional AIDS Education and Training Centers (ETCs) initiative, which began in late 1987. The study will describe and assess the **AIDS ETCs in terms of their program development, goals, achievements and evaluation plans. Based on the experiences** of the **ETCs,** effective and efficient structures, systems and methods for provider education and training will be described. **In** reviewing the evaluation plans of each ETC, emphasis will be placed on delineating impact measures for ETC activities that are commonly applicable. The intent of this review process will be to **assist and** enable the **ETCs** and **HRSA to** further develop and refine the overall AIDS ETC program through their ongoing evaluations of the effectiveness and impact of various program approaches.

As part of the study, a three member team will make site visits to each ETC. One member of the team will focus on the education and training program issues of the ETC. A second **team member will focus on program history, structure and administration, and the third team member will** focus on the evaluation plans of the project. Each site visit will last three days. One of these days will include a visit to a sub-grantee site by at least one team member. **In** addition, if possible, all sub-grantee sites will be interviewed by telephone. The site **visit will** consist of five components:

1. BTC Presentation: **The ETC** will present an informal overview of the program, including a review of program **history, program structure and their education and** training programs. Included in this presentation will be a description of any program-unique innovations that the ETC chooses to highlight.

2. Staff Interviews: Interviews will be conducted with the key individuals involved in program development, administration and technical direction. It is anticipated that four to seven key people will be interviewed at each site, including the Project Director (Principal Investigator), any Co-PDs, program administrator(s) and the evaluation specialist(s). The specific people to be interviewed at each site will be determined well in advance of the site visit and confirmed in writing.

3. Systems **Review:** A review of the systems currently used to manage **he ETC** will be conducted. This will include systems for program management and monitoring and for interagency coordination and communication. Direct observation of the systems will include documentation of systems flow, outputs and usage.

4. **Data and Document Reviev:** Supplemental documents, **materials and data** will be reviewed at the time of **the visit.** This will include relevant project meeting minutes; training activity records and data; other ETC curricula materials developed and/or used; evaluation tools; internal evaluation reports of specific training events, methods or strategies. During the site visit, it will be determined if copies of any specific documents will be requested.

5. **Sub-grantee Site Reviews:** At least one member of the site visit team will visit a sub-grantee site. This visit will attempt to incorporate a sub-grantee presentation, staff interviews, systems review and data and document review as described above. In addition, phone interviews will be formally arranged to provide a means of information gathering at the remainder of the sub-grantee sites.

A letter will be sent to the Project Director of each ETC at least two weeks in advance to detail plans for the site visit. In addition **to** confirming the visit dates, the letter will specify staff to be interviewed (including dates and times of all interviews), detail preparation required by the site for the visit, describe the site-specific visit protocol and, if possible, specify the data/materials that will be reviewed during the visit. The detailed site-specific visit protocol will also confirm visit times and dates of the sub-grantee visit and times and dates of the telephone interviews to the other sub-grantee sites.

The **site** visit protocol follows. It has **been arranged by day and includes questions** and issues that will be addressed.

SITE VISIT PROTOCOL

I. **Day One:** The first day will be devoted to allowing the ETC to introduce their staff and to present their program. This is envisioned as an informal setting, providing ample opportunity for discussion and questions and answers between the site visit staff and the ETC staff. The ETC's presentation should address the questions and issues listed below.

A. Overview of the ETC

1. What are the overall program goals and objectives?

2. What is the geographic target area? Who are the target trainees?

3. What is the organizational structure of the ETC?

4. What are the collaborating agencies and universities?

B. Reviev of Program History

1. Describe the origin of the ETC and major developmental milestones.

2. What were/are some of the issues in the development of the project, such as facilitating factors or barriers to program development?

3. What external relationships are thought to be required for the successful conduct of the program? How were they approached and what was the outcome?

4. Provide an overview of the ETC within the geographic target area including:

   - How the target area and population was determined; have there been significant changes since ETC start-up?
   - The incidence of AIDS and particular issues within the region
   - The scope of AIDS education and training for professionals in the region prior to the ETC

C. Description of Program Structure

1. Describe the ETC program model. Is it centralized or decentralized? What is the management structure?

2. How is the ETC placed within the university structure? Is it

an independent body or has it been integrated into a pre-existing AIDS/education office, program or network?

3. Describe ETC staffing, including:

   - Project staff, roles and qualifications
   - Consultant staff, roles and qualifications
   - Staff recruitment/training

4. What is the nature and extent of ETC linkage with other programs (e.g.: AHECs, AIDS Service Demonstration Projects, NIMH, ATEUs, NIDA, STD programs, etc.)?

5. What other non-federal resources, if any, have/will supplement the ETC program (e.g.: state, local, private)?

D. Overview of Education and Training Programs

1. Describe the ETC's philosophy/approach to education and training.

2. Who are the target trainees?

3. What are the program's training strategies and methods?

4. How do the training strategies and methods differ for different professions or groups?

5. What are the training media used (e.g.: presentations, lectures, workshops, training of trainers, clinical, video, computer, self-teaching, etc.)?

6. What other agencies collaborate with the ETC for co-sponsorship of training? What is the nature and extent of this co-sponsorship?

7. How do the training strategies and objectives relate to the overall program goals and objectives?

E. Overviev of Other ETC Activities

1. Describe other activities that the ETC has engaged in to serve as a focal point for ongoing training, information and support of area health professionals.

2. What specific services are being offered (e.g.: hotlines, referral networks, newsletters)?

F. Overview of the ETC's Future Plans

1. Describe plans for institutionalization and self-sufficiency of the ETC.

2. Outline future training plans (new materials/curriculum, new training strategies, priority target areas)

3. Describe new or anticipated major changes in ETC systems and procedures.

G. Critical **Success Factors of the BTC**

- Organizational strengths and qualities
- Developmental issues
- Training issues, successes, innovations
- Administrative strengths and qualities

H. **Program-unique** Innovation: This will be a presentation on the specifics of one program, training, curricula, etc., which the ETC chooses to highlight.

II. **Day Two:** One team member will visit a sub-grantee site on day two. The other two team members will address education and training programs and products; evaluation plans; and communication and information systems. The two team members will also collect the documentation necessary for completing the review. In addition, telephone interviews will be done to gather information from the other sub-grantees.

A. **Education and Training Program and Products**

1. What were/are the procedures for conducting a training needs/demands assessment? Who was involved? What were the results?

2. What are the specific strategies for including the ETC curriculum in the course offerings of undergraduate and graduate medical education programs?

3. Describe the **CEUs** being offered for the various training programs.

4. What are the policies, procedures and systems for managing training events?

- Marketing
- Trainee recruitment/selection
- Registration
- Output/outcome reports

5. What are the policies, procedures and systems for managing other ETC activities, such as hot-lines, referral networks, newsletters, etc.?

6. Describe role of each sub-grantee site.

- Target area
- Target population
- Role and responsibilities
- Coordination between and communication with ETC

7. What specific strategies have been incorporated to market and recruit for minority providers and providers who serve minority communities or high-risk groups?

8. What is the extent of ETC cost-sharing and self-sufficiency?

   - Volunteer trainers
   - Other in-kind
   - Participant fees
   - Other revenue generation (e.g.: State, other funding)

9. Describe the policies and systems for financial control of payments made between collaborating and cooperating agencies and individual consultants.

10. Hands-on review of curricula and materials developed/used.

B. Bvaluation Plan

1. What was the process for developing the initial evaluation plan? Who was involved?

2. Describe the evaluation framework and approach.

   - Philosophy toward evaluation
   - Components and structure of the evaluation plan
   - Priorities, areas of emphasis

3. Who is responsible for evaluation and in what way are they responsible?

4. How are the evaluation activities coordinated between ETC sites and between other cooperating/co-sponsoring organizations?

5. Describe the procedures for assessing training penetration and the effectiveness of marketing/recruitment efforts.

6. Describe the process and persons responsible for formative evaluation of curricular components and materials.

7. Describe the evaluation plan for each of the specific education and training interventions.

   - Evaluation design
     - Format
     - Variables and measures
     - Controls (comparison groups, baseline data)
   - Evaluation methodologies
     - Sampling
     - Instruments
   - Analysis
     - Analytic Framework
     - Statistical Methods

8. What are the specific plans and systems for monitoring and evaluating the activities of second generation trainers (from training of trainers programs)?

9. What are the type, content and schedule of evaluation reports? Who receives the evaluation results?

10. What is the current status of the evaluation?

    - Tasks accomplished
    - Findings to date
    - Problems encountered

C. Systems Reviev. Systems to be reviewed include the following:

- Management information systems
  - Training activity databases
  - Training and education materials database
  - Organizations/mailing list database
  - Trainer/trainee databases
  - Program cost and revenue monitoring systems
- Professional Support Systems
  - Library/resource file system
  - Newsletters
  - Hotline/referral/consultation system
  - Teleconference/cable system
- Inter-site communications systems
  - Electronic mail system
  - Reporting system
- Systems for training program management
  - On-going needs assessments
  - Recruitment
  - Registration

- Consultant/facility payment
  Participant fee collection and recording

1. **What** is the purpose or reason for the system?

2. Who is responsible for the system?

3. What is the source of the system/database?

4. What is the cost of systems development and operation?

5. Give examples of the use and effectiveness of the system.

D. **Data** and Document Reviev. Where applicable, supplemental data, documents and materials to be reviewed at the time of the visit will include:

1. Project meeting minutes

2. Needs and demand assessments

3. Training activity records and data

   - Total number of education and training programs
   - Date and location of specific events
   - Length of specific training events
   - Objectives/expected outcomes of training events
   - Format of training (workshop, teleconference, lecture, etc.)
   - Number and disciplines of health professionals attending teaching and ed. programs
   - Number of minority professionals and/or professionals serving minority and high-risk communities in attendance
   - Attendees* professional/institutional associations
   - Number of "Trainers" trained
   - Number of "second generation" trainees
   - Cost per trainee
   - Participant fees

4. Other ETC activity records

   - Numbers and types of materials developed
   - Hotline/referral network activity
   - Information requests
   - Activity promoting linkages/integration of organizations

5. Inter-organizational subcontracts/agreements

6. Protocols, policies and procedures

7. Training curricula/materials developed and/or used

8. Evaluation instruments

9. Internal evaluation reports

- Training materials development
- Specific training events
- Training outputs
- Training outcomes
- Overall program progress

III. Day Three

A. **Wrap-up.** This session will be used to gather any missing information/materials/data that may be required, to ask any last minute questions and to clarify any areas of confustion.

B. **Debriefing.** The JSI site visit team will provide a summary of its findings to ETC staff.

TELEPHONE INTERVIEW PROTOCOL

On Day Two and Day Three of the site visit, telephone interviews will be conducted with each of the sub-grantee sites. The issues to be addressed during this interview follow.

I. Program Overview

A. What are the goals and objectives of your specific program and how were the goals and objectives developed?

B. What is the geographic target area for which you are responsible?

C. What is the nature of the epidemic in your target area?

D. What do you consider the unique features of your site's program? Are there specific local conditions that underlie these unique features?

II. Education and Training Program

A. What groups are you targeting, and how did you come to target these specific groups? What efforts have been made to reach minority providers? What efforts have been made to reach high-risk populations?

B. Is the direction/flavor/philosophy of your program determined at the site level or at the project level?

C. Describe a particular program, training, curricula you have developed/used at your site.

D. What barriers have you faced in developing and/or implementing your programs? How have they or will they be resolved?

E. With regard to the education and training programs you provide, what kind of evaluation/feedback loop do you use for program improvement?

III. Program Structure

A. What type of communications/sharing take place between your site and the project and among all sub-grantee sites? Have there been communications problems? If so, which have been overcome and which remain?

B. For what kind of things do you rely on the project staff? Is there any additional support you would like from the project?

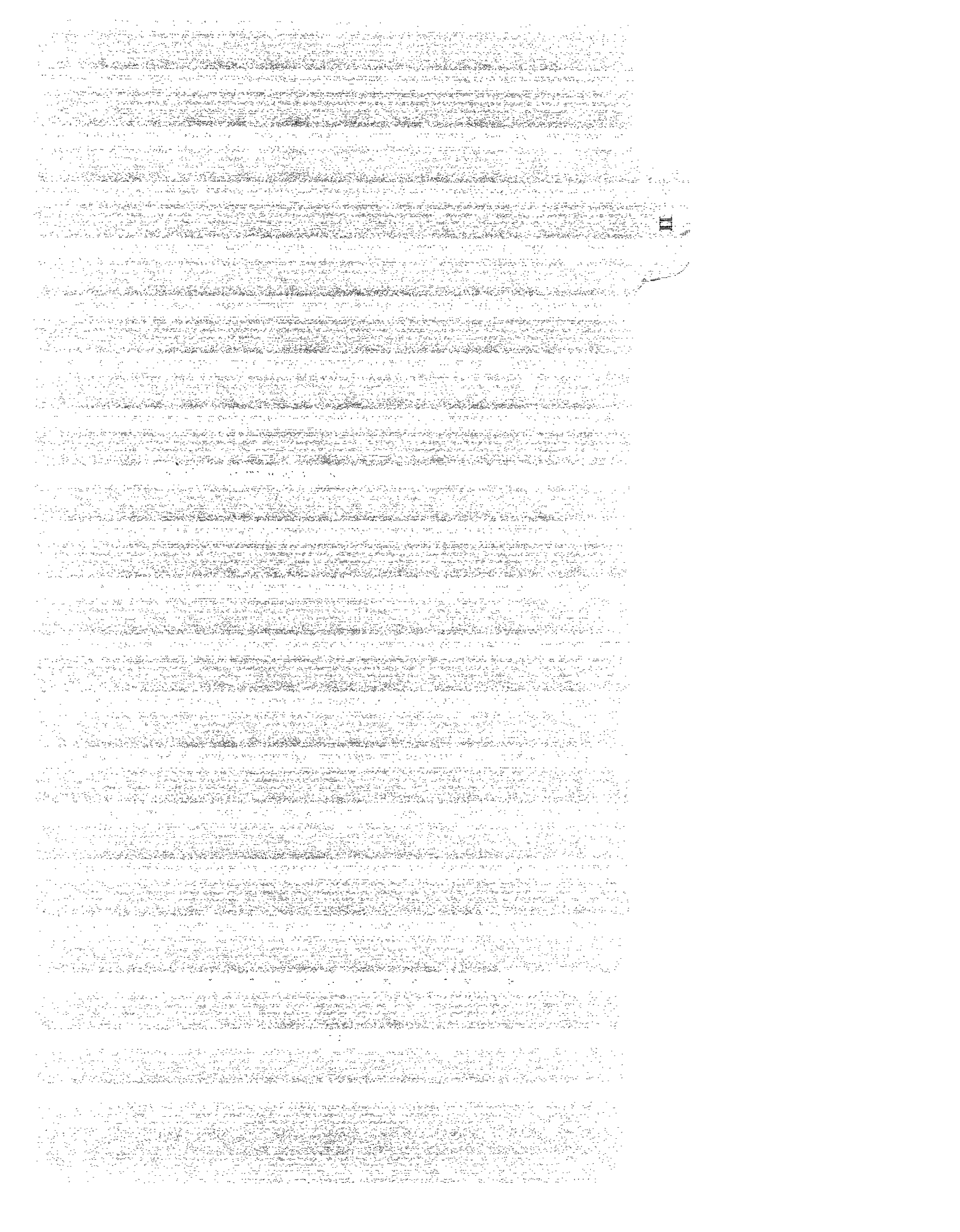
C. What is the relationship, at the level of the site, between the ETC and cooperating agencies (e.g.: AHEC, NIMH, etc.) in terms of structure and/or activities?

IV. Summary

A. What are your site's strengths, and how are they funneled back into the overall ETC project?

B. What lessons have you learned in the development or conduct of your program that would be useful for new programs starting up?

C. What are the future plans of your site?



Final Case Study Overview

AIDS REGIONAL EDUCATION AND TRAINING CENTERS EVALUATION

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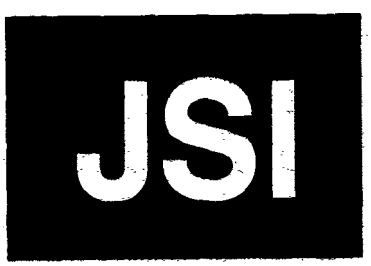


JOHN SNOW, INC.

AIDS EDUCATION AND TRAINING CENTER PROGRAM

CASE STUDY OVERVIEW

I. INTRODUCTION

The following report is an overview of case studies developed for eleven (11) AIDS Education and Training Centers (ETCs) funded by the Health Resources and Services Administration's (HRSA's) Bureau of Health Professions (BHPr). These are: East Central AIDS ETC (ECAETC); Washington, Alaska, Montana, Idaho and Oregon AIDS ETC (WAMI-0); Western AIDS ETC (Western); New York - Caribe AIDS/SIDA Education and Training Center (NY-Caribe); AIDS Education and Training Center for Southern California (AETC-SC); Delta Region AIDS Education and Training Center (Delta); Emory AIDS Training Network (EATN); Mid-Atlantic AIDS Regional Education and Training Center (MAARETC); Midwest AIDS Training and Education Center (MATEC); Mountain-Plains AIDS Education and Training Center (MPAETC); and New England AIDS Education and Training Center (NEAETC). The first four mentioned (ECAETC, WAMI-0, NY-Caribe, and Western) were the first group funded by HRSA, in September, 1987. The remaining seven were funded in the second HRSA grant cycle, in April, 1988. Four ETCs funded later by HRSA were not included in the study.

The case studies were developed in two phases. The studies for the first four ETCs (ECAETC, NY-Caribe, WAMI-0, Western) were developed in year one of the project, then up-dated at the end of year two. The studies for the remaining seven were developed entirely in year two of the project. The first step in developing the case studies involved the review of written material including grant applications, progress reports and site visit reports. A draft case study was then prepared. Subsequently, site visits were conducted to each ETC. The site visits were generally conducted by a three-person team over a three-day visit. Following the site visits and additional telephone conversations, the case studies were revised and circulated, still as drafts, to HRSA and the ETCs. As mentioned above, the case studies of the first four ETCs underwent an additional up-dating process through collection of written material and extensive telephone conversations. The final case studies incorporate information collected in all these steps.

Each case study addresses the following issues:

1. Program Overview: regional configuration, collaborating agencies, program goals;

2. Program History: regional HIV epidemiology, organizational background, ETC origin and development;

3. Program Structure: organizational roles and relationships, staffing, approaches to collaboration and regionalization, organizational qualities;

4. Education and Training Program: needs assessment activities, target

trainees, training activities, curricula and material developed or used, outputs, efforts to reach minorities, issues and successes;

5. Program Administration: administrative systems, systems for managing training programs, trainee recruitment, training sites, cost sharing/ sustainability, CEUs, library/information services, other services;

6. Summary and Future Plans: and,

7. Appendices: ETC goals and objectives and descriptions of sub-contractors.

There is a great deal of detailed information contained in each of these case studies. It is not the intent of this report to repeat this information. Instead, this overview report summarizes ETC activities and issues in selected areas central to the program's mission and goals. These areas are: 1. regionalization; 2. collaboration with other AIDS related organizations; 3. needs assessment; 4. training programs, sub-divided into clinical training programs, train-the-trainers programs, and general continuing education training programs; 5. reaching minority providers and those serving minorities; 6. influencing professional school curricula; 7. information and resource services; and, 8. program sustainability. The critical issue of evaluation is extensively addressed in a separate overview report as well as in individual ETC evaluation reviews, so it is not discussed in this report.

For each area discussed, particular successes as well as outstanding issues or problems are noted. It is intended, by citing successes, to provide a sampling of specific ETC accomplishments. The examples are by no means exhaustive, and the individual case studies are replete with many more noteworthy achievements. The issues and problems are presented not to indict particular ETCs or the program, but to provide HRSA and the ETCs with information to guide further program development. Taken in this context, both the successes and outstanding issues can make a positive contribution to the ETC program.

II. SUMMARY OF FINDINGS FROM CASE STUDIES

A. General Observations

Two important overall observations can be made from the case studies. The first is that each ETC is unique. In conceiving and designing the ETC program, HRSA purposely decided to be flexible and non-directive. With the exception of specifying a few critical elements, each ETC was encouraged to develop its organizational structure and training program according to needs of its defined region and within the capabilities of its collaborating organizations. Initially, the ETCs were also encouraged to define their own geographic region, although HRSA often intervened to negotiate regions either during or after the application process. As a result of this flexibility on HRSA's part, each ETC is different. While all have as their main goal the training of health care professionals on HIV/AIDS, each is very different in its structure, philosophy, training program priorities and outcomes.

The second observation is that this study looked at the ETC program relatively early in its development. Sites had been funded for 16-26 months at the time of their site visit and, in many places, had to overcome many barriers to smooth program development. The site visits in year two of the project, as well as the up-dates of the first four grantees visited, demonstrated the progress made by the projects in their second and third years. With clear direction from HRSA, this progress can be expected to continue.

Observed barriers to smooth program development included:

- a rapidly evolving epidemic requiring constant revision of materials, target groups, and priorities;
- demands to aggressively and quickly begin training programs;
- continuing fear and biases about the illness among the target health professions and even within the institutions involved;
- complicated and/or undefined service delivery networks often with the ETC as a newcomer to that network;
- an early emphasis by HRSA on producing large numbers of people trained;
- changing HRSA staff and priorities;
- unnaturally formed regions and institutional alliances, some of which had to break down competitive barriers; and
- university politics and/or administrative bottlenecks.

On the other side, some ETCs experienced fairly smooth program development. Observed factors which facilitated program development included:

- building the ETC on an existing education structure with recognized expertise in training community-based health professionals - ETCs which were built on National Institute of Mental Health (NIMH) AIDS training programs, established Area Health Education Center (AHEC) programs, and in one case, a Family Planning Program model, realized a developmental advantage;
- high-level support from the institutions involved in the ETC - both grantee and subcontractors, minimizing bureaucratic bottlenecks and providing needed space and administrative support;
- a history of active involvement in HIV/AIDS care or education either by the institution or key ETC staff to facilitate knowledge of and recognition by the AIDS care network.

The unique qualities of each ETC and the relatively early stage of program development place the following specific discussion in context. While there is still much to be achieved, each ETC has already contributed to the training and education of health care providers about HIV/AIDS in their region. In most places, the ETCs are poised to take on an increasingly visible and important role in combatting the illness.

B. Development and Management of a Regionalized Program

From the outset, ETCs were expected to be regional programs. While there has not been clear definition of what constitutes an acceptable region (in fact the concept has evolved with each ETC grant cycle) it is clear that HRSA wanted each ETC (with its subcontractors) to have responsibility for a specific geographic area. This geographic area may have involved several entire states, or it may have been more focused on a specific high-incidence area in part of a state. Of the eleven ETCs addressed in this study, two (NY-Caribe and AETC-SC), had regions that included sub-state areas, the remaining nine were multi-state programs.

Initially, ETCs were encouraged to identify and define their own geographical regions. After the first funding round, however, HRSA become more involved in negotiating and realigning regions with both prospective and existing grantees. This realignment, which is apparently ongoing, is in part due to HRSA's commitment to assure the entire country, including Puerto Rico and the Virgin Islands, is included in an ETC region, and that there is no overlap. Thus, as new ETCs have been funded, older ETCs have been reconfigured. Realignment also occurs to form more natural and manageable regions, as when Connecticut was moved from the NYU ETC to the New England ETC. While perhaps beneficial in the long run, there is no doubt that regional reconfiguration is disruptive in the short run, and impedes program development. To date, reconfiguration has most effected NY-Caribe and, to a lesser degree, EATN.

Regionalization of a program also implies some level of overall management at the regional level while many activities are carried-out locally. The ETCs' approach to regional management ranges from highly centralized, where the ETC regional office assumes a great deal of control over the training programs throughout the region, to highly decentralized, where each ETC subcontractors function essentially independently in their respective geographic area. Most ETCs, however, fall between these two extremes and even programs that started highly centralized or decentralized are moving to a balanced regional model.

Examples of two programs which have developed particularly functional models of regional program management are MPAETC and MATEC. Both programs cover multi-state areas and have "local" ETCs in each state, subcontracted to universities or professional organizations. MATEC has made a further geographic division, separating Illinois into northern and southern regions to recognize substantial differences in the area and AIDS demographics. In both programs, the local ETCs are fully responsible for the training in their area

while the regional office assumes a coordinating, resource and **"fill-in-the-gaps"** role.

This geographic division of responsibility seems to work well for several reasons : (1) it assures all areas of the region are covered; (2) it allows local **ETCs** to gain recognition within the AIDS care network and the political structure of their area; and (3) it avoids confusion among target groups as may occur when several arms of the ETC provide training on different topics.

Under this model, the local **ETCs** are delegated full responsibility for identifying training needs and developing and conducting training programs in their state or area. They may, and often do, draw on the regional ETC office or other subcontractors for assistance, ranging from training materials to course presentation. As a second level of responsibility, a local ETC may take the lead in developing specialized programs for use throughout the region (e.g. Wisconsin's dental training program), but that functional responsibility is secondary to the subcontractor's overall responsibility for **a** geographic area.

Regional ETC offices assume a range of responsibilities. Many are providing a great deal of direct training while others are performing more of a coordinating and resource function. In the latter cases, the regional offices are often located within or near the local ETC and are very involved in their activities. From the site visits, JSI recommends several functions for regional ETC offices. These include:

1. Develop a regional strategic plan, provide general oversight, and establish general expectations for each local ETC. This should be formalized in a Scope of Work appended to the subcontract on an annual basis.

2. Assure the quality of training provided. Quality assurance may be provided through different means. MPAETC and NY-Caribe control quality by using standardized curriculum and developing a cadre of trainers to train using the curriculum. MATEC is addressing quality assurance by forming committees to set region-wide training standards.

3. Act as a regional resource for training/education materials and information. This includes developing a library of resources for use in local training, keeping track and communicating national training developments, facilitating the sharing of training curricula and materials across local **ETCs,** and coordinating training schedules.

4. Develop curricula and materials and/or conduct training as needed to fill in gaps in the local **ETCs** or as requested by the local **ETCs.** **ETCs** heavily involved in direct training must carefully define their role in relation to subcontractors to avoid duplication or competition.

5. Maintain close contact with HRSA regarding program issues and priorities and communicate these to the subcontractors. Similarly, maintain contact with other national and regional developments relating to HIV/AIDS including progress of the epidemic, treatment standards, service delivery models and so forth.

6. Provide grants management and allocation of available resources throughout the region.

7. Coordinate evaluation activities and reporting. Ideally, the regional office in consultation with the local sites should establish minimum, acceptable evaluation standards and criteria, with a core set of common items and definitions to be used and reported to the regional office. Evaluation data should be maintained centrally, both to reduce burden on the local sites and to allow for regional reports and comparisons.

Although the development of truly regional ETC programs has been difficult, it is a concept that is both appropriate and feasible for the on-going management of the ETC program. There is a great deal of program benefit to be gained through the synergy of a regional program. Each subcontractor and the regional office contributes knowledge and experience to the program, high incidence areas can serve as a resource for clinical experiences to lower incidence areas, and highly specialized materials can be developed and shared across the region. At its best, regionalization allows for local autonomy and responsiveness while building in important economies of scale and the potential for cohesive direction and accountability. Additional guidance from HRSA regarding the roles of regional versus local **ETCs,** as well as the natural development of regional organizations, will further strengthen the concept.

C. Collaboration With Other AIDS Related Organizations

Collaboration with other AIDS-related organizations is important to the **ETCs** for several reasons: 1. collaboration helps the **ETCs** stay up-to-date on the progress of the illness and the evolving needs of individuals and organizations serving people with HIV/AIDS; 2. collaboration often leads to co-sponsorship of training programs and therefore helps extend ETC resources; and 3. by working with other organizations, **ETCs** establish themselves as legitimate AIDS training organizations.

The case studies demonstrate that the **ETCs** are working closely with a wide range of AIDS-related organizations in a variety of ways. Most **ETCs** have advisory boards either at the regional or local level made up of representatives of the AIDS service delivery community. Conversely, many ETC staff participate on the boards and advisory committees of other organizations. Virtually all of the **ETCs** co-sponsor some of their training events and for some, like NEAETC and ECAETC, collaboration and co-sponsorship is an explicit goal of the ETC.

The list of specific groups collaborating with ETCs is included in each case study and is too extensive to repeat here. However, some of the more important linkages are noted.

National Institute of Mental Health (NIMH) AIDS Training Programs:

As was noted in the introduction to this section, early affiliation with NIMH AIDS Training Programs helped ETCs in their critical development phase. NY-Caribe, WAMI-0, and AETC-SC particularly benefited from their close affiliation. NIMH programs offered an existing training structure, established linkages with community groups, the core of a solid curriculum, and a strong focus on evaluation. On an on-going basis, NIMH funding of ETCs as occurred in MPAETC, Western, NY-Caribe and WAMI-0, or close affiliation of ETCs with NIMH funded programs, will benefit both programs.

Area Health Education Centers (AHEC):

Similar to affiliation with the NIMH Training Programs, affiliation with established AHEC programs also helped in program development and facilitates training program implementation. The contribution here came from the links the AHECs established with community-based providers; their expertise in developing and implementing health provider training programs; and established mechanisms for sub-contracting and program administration. NEAETC, Western and MPAETC most benefited from affiliation with existing AHEC programs. It was noted in the site visits that affiliation with AHEC programs was not automatically an advantage; in at least two instances - one where the AHEC was in its early development stages and another where the AHEC was overshadowed by a respected AIDS-care provider - AHEC affiliation worked against the ETC.

Community and Migrant Health Centers (C/MHCs):

C/MHCs are primary health care programs located in medically underserved urban and rural areas of the country. Because they are also funded by HRSA, and because they provide primary care to a high proportion of Black and Hispanic patients, they are a logical focus for ETC efforts. However, in general, ETC collaboration with C/MHCs was disappointing. Several ETCs had recently received supplemental funding to specifically address the needs of C/MHCs in their areas, but these efforts were just in the development stages at the time of the visits. Only a few (notably NEAETC, MATEC, EATN and Western) emphasized collaboration with this important group of providers as part of their overall policy.

Although the benefits of collaboration are generally acknowledged, it should be pointed out that sometimes collaboration can work to the ETCs' disadvantage. It is much more difficult to point to the specific accomplishments of the ETCs when their activities are merged with several other entities.

D. Needs Assessment

The ETCs were started in the midst of a very serious epidemic and faced immediate pressure to aggressively begin training programs. Their approach to needs assessment reflected this reality. In general, ETCs relied on needs assessments which had already been done and supplemented these with specifically focused assessments, targeting a particular area, discipline or training need. For some areas, this was a reasonable approach. Virginia, for example, had recently completed a very comprehensive CDC-funded statewide needs assessment, which provided excellent information for planning its training program. In others, however, this left the program with fragmented information about regional training needs, making overall planning for a regional program difficult.

Only a couple of ETCs (Delta, ECAETC, EATN) attempted multi-discipline region-wide needs assessments. Delta's was perhaps the most ambitious with health professionals throughout their three-state region randomly selected to receive a mailed questionnaire assessing knowledge, attitude and skills by discipline. The results of the mailed survey were used as the basis for focus group discussions by discipline. Key informant interviews were also conducted. The results of the needs assessment fed directly into discipline-specific curricula being developed by the program. Unfortunately, this thorough approach did delay the implementation of some training programs.

WAMI-0 did not conduct a region-wide needs assessment at the outset of its program. However, as it moved from its initial focus in the major cities of Washington and Oregon, the program recognized the importance of conducting thorough needs assessments in less familiar areas. They approached this by organizing and facilitating meetings of key AIDS service and other community leaders in each of eleven (11) targeted cities. As a result of these meetings, their program was significantly restructured. Information gained from the meetings will also serve as the basis for future evaluation of activities.

At the outset of the program, conducting comprehensive, region-wide needs assessments would have helped the ETCs formulate regional training strategies and plans. However, the pressures of the epidemic and urging by HRSA to quickly respond, led the ETCs to direct their resources and efforts elsewhere. At this stage in their development, the usefulness of a region-wide assessment has passed. Through their own training staff, information collected from training participants, input of advisory boards and collaboration with other AIDS related groups, ETCs have become their own key informants. Their approach of focusing needs assessments efforts on particular areas, target groups or training needs is appropriate and represents the best use of limited resources.

E. Training Programs

ETCs all have as their primary goal the training and education of health care professionals about HIV/AIDS. Each program, however, has a different approach and emphasis. All ETCs incorporate a "Train-the-Trainers" model to

some extent, although the emphasis given to training of trainers varies in both scope and intensity. Similarly, most models include some in-depth clinical training opportunities designed to enhance care-giving skills relating to HIV/AIDS. A few have introduced innovative training technology into their programs. For most ETCs, the significant majority of their training can be classified as continuing education, information-oriented sessions, usually lasting from l-6 hours. Next most frequent are slightly longer sessions (1-2 days), again information-oriented, and in some cases addressing participant attitudes or skills.

These two types of sessions produce the biggest training output numbers for the ETCs, and require a relatively limited investment of resources. At the other end of the spectrum, true train-the-trainers programs which last 4-5 days and address both AIDS-related information and teaching skills, and clinical training programs which can accommodate only 2-4 people per session require extensive investment of resources both for development and implementation. The ETCs have been torn by conflicting pressures to produce impressive numbers of people trained with the need to conduct more in-depth training which more intensively impacts the ability of providers to care for people with AIDS. Most ETCs have the capability to do both and need only guidance on where to place their emphasis. To date, this emphasis has been on reaching large numbers of people, and in this the ETCs have been very successful.

Each case study itemizes the major training programs done by the ETCs and their subcontractors. The following discussion highlights some of the most innovative and successful programs being implemented by the ETCs.

1. Train-the-Trainers Programs

The term "Train- the-Trainers" is used loosely throughout the ETC program to apply to any program designed to encourage participants to go on to train others about HIV/AIDS. The sessions range from one-day programs for increasing the information level of participants, to 5-day sessions addressing participants' knowledge and attitudes as well as incorporating educational strategies and training skills. Some train-the-trainers programs include competency testing and a certification process; most do not. Some require and track the subsequent conduct of an agreed upon number of sessions; for many, subsequent training benefit depends on the initiative of individual participants.

Western, NY-Caribe, MPAETC, the Virginia site of MAAHETC, and WAMI-0 all have comprehensive train-the-trainers programs. These programs are based on standardized curricula, last from 3-5 days and incorporate both AIDS-related information and teaching skills. All have explicit expectations about how participants will use the skills acquired to train others.

Several other ETCs have conducted specialized train-the trainers programs of note. The Kentucky site of ECAETC, the Wisconsin site of MATEC, MAARETC and Western all have implemented train-the-trainers programs for dental professionals. MATEC's sites have implemented a broad range of train-the

trainers programs including programs for mental health workers, social workers, and workers in correctional institutions. EATN developed a session for nurses and health educators. WAMI conducted two train-the-trainers programs focusing on substance abuse issues. It included sessions on organizational development or change to affect intake and risk assessment procedures in the trainees' organizations.

Train-the-trainers programs aimed at faculty of health professions schools have been held by NEAETC, NY-Caribe, AETC-SC, Delta, and Western. These sessions, also known as "faculty development" programs, generally assume that as university faculty, participants already have needed education skills. Consequently the focus is on providing AIDS-specific information.

From even this abbreviated list, it is apparent that the ETCs have been very involved in train-the trainers programs. Remaining challenges for HRSA and the ETCs include:

(1) sharing existing curricula and materials among ETCs to avoid unnecessary duplication;

(2) more clearly defining expectations for programs labeled as training-of-trainers; and

(3) tracking and assessing the impact of this resource intensive effort both in terms of the resulting competency of those trained directly and in terms of other subsequent training.

2. Clinical Training

As with train-the-trainers activities, the definition and scope of clinical training in HIV/AIDS varies greatly among the ETCs, ranging from half- day observations of AIDS clinics to week-long sessions including both didactic and patient care experiences. Most, though not all, of the ETCs offer some level of clinical experience for physicians. Only a few, however, offer a clinical experience designed to prepare physicians to care for people with AIDS. AETC-SC has the most intensive clinical training program among the ETCs. This ETC offers two levels of clinical training--an introductory program and an intensive program. It is the intensive program that is unique among the ETCs.

AETC-SC's intensive clinical program for physicians, nurse clinicians and physician assistants is a one-week program based at the Los Angeles County - USC Medical Center. There is a didactic introductory session, 'but the majority of the week is spent in direct patient care including rotations through the medical center's primary care clinic, specialty clinics and a private practice. Psychosocial issues are also addressed. UC-Irvine, a subcontractor to USC, offers a 3-day version of this program and has been very successful in attracting community-based physicians. This level of commitment to clinical training comes at a cost; two physicians are supported through the ETC grant to run the program. Approximately 100 people (50% physicians) have gone through the intensive clinical program.

Several other **ETCs** offer clinical training programs for physicians and/or nurses. EATN, several of **NEAETC's** sites, and the Virginia site of MAAETC all offer structured clinical experiences combining didactic and patient care aspects. Clinical experiences for other health professionals have been limited, primarily due to funding constraints and the priority given to primary care providers. However, the Florida site of EATN has developed a clinical training program for mental health professionals.

MPAETC has developed a "mini-sabbatical", which while not designed to provide an intensive clinical experience (that is offered through the STD training program at Denver General Hospital), offers broad exposure to AIDS care issues. The mini-sabbatical offers a series of rotations through different organizations providing care to people with AIDS. Specific organizations involved in the rotation are selected based on the trainees needs and last from one to five days.

The **ETCs** which have **been extensively** involved in clinical training programs have demonstrated that such programs are feasible and that the programs can and do attract community-based providers, including providers serving substantial minority populations. The challenges now are to:

(1) demonstrate the impact of these programs both in terms of increasing the number of providers caring for people with HIV/AIDS and in terms of the quality of care being provided; and

(2) extend these programs more widely throughout the ETC network with the recognition that these programs are expensive in comparison to the large audience informational sessions.

Continuing Education Training Programs:

As noted in the introduction to this section, the vast majority of training in terms of reported outputs conducted by the **ETCs** and their sub-contracted sites fall into the category of general training. These are typically continuing education sessions ranging in length from 1 hour to 2 days, and use a variety of instructional formats: lectures, videos, participatory exercises, panels, written exercises etc. Sessions may be multi-disciplinary or discipline-specific. Many of these sessions are co-sponsored by the **ETCs** and are conducted in response to requests by local health providers or social service agencies. Others are built into grand rounds or other continuing education sessions held by participating ETC organizations. Still others are sessions conducted by participants in ETC train-the-trainer programs.

The number and variation of such trainings offered are too extensive to list. Virtually every ETC can point to several examples of high quality continuing education offered as a result of the ETC program. Overall, one of the most significant advances noted between year one and year two of the evaluation study was that the continuing education programs offered by most

ETCs expanded in both scope and depth. Most ETCs had moved beyond presentations of basic AIDS information to focus on the more specialized needs of target trainees. A few of the ETCs began actively reaching out to selected target groups who might not themselves initiate training. The following are some interesting strategies for reaching hard-to-reach groups.

* The Nebraska site of MPAETC has an innovative approach to training institutional staff in this very low incidence state. Through their training "AIDS in the Health Care Setting," the ETC training team travels to a particular institution (e.g. hospital, nursing home) and works with their multidisciplinary staff. There is a short didactic component, but the core of the program is a problem-solving exercise. The training team leads the institution's multidisciplinary team through the care provided to a select group of patients on a previous day. The care team is then challenged to identify how the care would have been different if these patients were AIDS patients.

* Western AIDS ETC, through its network of AAETCs has developed an approach for reaching primary care physicians who might not otherwise receive training. An ETC trained physician/nurse team visits the physician in his/her office during non-patient hours. The ETC physician works with the practice physician while the nurse works with the rest of the office staff. Issues addressed can be customized according to the needs of the practice. The availability of this training was originally published by the medical society.

* AETC-SC initiated a collaborative effort to develop a workshop on Latinas and AIDS. By working closely with a number of Latino and AIDS related organizations in the Los Angeles area, the ETC was able to implement a very successful two-day program addressing highly sensitive but important issues.

* The University of Alabama site of EATN has developed an innovative program for reaching physicians in the rural areas of that state. As the medical center accepts referrals from rural physicians, training sessions are arranged in the referring community, using management of the specific case as a focus for the training.

Some of the ETCs are also using innovative training technology to enhance their training efforts. Teleconferencing has been used with varying success by several of the ETCs. ECAETC, NEAETC, MPAETC and Western continue to use this medium to reach large numbers of providers who might not otherwise be able to attend training. Other ETCs like NY-Caribe are moving away from their initial plans to emphasize teleconferencing feeling they sacrificed too much in the way of quality control.

ECAETC is pursuing a self-study strategy through Computer Assisted Instruction (CAI). Modules for physicians/physician's assistants, dentists, nurses, and one on psychosocial issues have been developed. The modules are designed to be used on personal computers and take an average of three hours

to complete. The self-study program includes a self-administered test which may be submitted as evidence of program completion for continuing education credit.

The Alabama site of EATN is pilot testing a technology known as the "Q" system. This is a computer based system through which presenters and participants interact during the course of a presentation. Presenters ask multiple choice questions to which participants respond. This immediate feedback allows presenters to determine whether issues are being grasped before moving on to new areas. In addition, responses are automatically stored in the computer for use in later evaluation studies. The system has also been shown to be very engaging for participants.

The challenges for all the ETCs in the area of general continuing education are to develop programs which go beyond simple informational sessions to impact the skills and behaviors of participants, and which actively reach out to and address the needs of hard to reach target groups.

F. **Reaching Providers Serving Winority Patients**

Since the outset of the ETC program it has been a priority for the ETCs to train minority health professionals and professionals serving substantially minority populations. Five principal strategies have been used by the ETCs to reach providers serving minority populations. First, three ETCs have included as subcontractors health professions training institutions which historically train minority (principally Black) providers. These are AETC-SC's subcontract with Drew University; ECAETC's subcontract with Meharry Medical College, and EATN's subcontract with Morehouse School of Medicine. In each of these instances, in addition to more general training responsibilities, the subcontracted institution has region-wide responsibility for developing minority focused trainings. Several other ETCs specifically include as part of their staff, staff of medical centers or hospitals serving large numbers of minority patients.

A second strategy used by the ETCs is to invite members of minority organizations to participate on advisory boards, curriculum development committees, or program planning committees. Conversely, some ETC staff have become actively involved in minority-oriented AIDS organizations. Some ETCs have also been successful in hiring staff with close ties to the minority communities.

A third strategy taken by some ETCs is to reserve slots in their training programs for minority providers or those serving minorities. This has been done successfully by both AETC-SC and the Virginia site of MAARETC in their clinical training programs.

A fourth strategy is to target systems of care serving large minority populations. While the disappointing degree to which ETCs have extended their programs to community health centers has already been noted, a few, notably NEAETC, EATN and MATEC, have from the outset included these centers as priorities for their programs. This emphasis promises to expand as several of

the ETCs have received specialized funding to work with community health centers. EATN also emphasizes training for public health department staff in both its continuing education and clinical training programs, AETC-SC has trained several public health providers in its intensive clinical training program, and the Johns Hopkins site of MAARETC, once operational, is specifically charged with reaching public health providers throughout the MAARETC region.

By far the most common strategy to reach minority providers or providers serving minority populations is to design specialized training programs. These training programs may be topically oriented toward a minority population (e.g. "AIDS in the Black Community" or "Latinas and AIDS"); or, they may be programs targeted at providers serving largely minority clientele (e.g. programs for community and migrant health centers or substance abuse counselors). Some ETCs have focused on very specific minority groups in their service area (e.g. NEAETC's support of a self-training manual in Portuguese and a video tape on Haitian cultural issues for physicians; WAMI-O's program for migrant farmworkers; and the Arizona site of Western's work with Native Americans.)

Some ETCs have taken a more integrative approach, incorporating minority issues into most of their training efforts. This is the practice in ETCs located in areas of high concentrations of minority populations (e.g. NY-Caribe with its affiliation with the University of Puerto Rico and its high incidence of infection in minority populations in New York; AETC-SC, serving the Los Angles area; and, EATN, with its affiliation with Morehouse School of Medicine and its emphasis on training providers serving in public facilities, has also taken this approach.)

Reaching minority communities and the providers serving these communities has not been easy and considerable work remains to be done. In some places, there is clear reluctance on the part of minority communities to embrace training offered by institutions historically viewed as unsympathetic to minority issues. An approach that emphasizes collaboration with providers serving minority populations and minority groups themselves, while more time consuming in development, has the best prospect for true impact.

G. Educating Professionals in Training

There are two major ways the ETCs impact the HIV/AIDS education of health professionals in training. The first is the targeting of specific ETC educational programs to professionals in training, from the undergraduate level through residency programs. The second is to encourage and facilitate the inclusion of HIV/AIDS material in professional school curricula. To date, while there have been some important successes in curriculum reform, most of the ETCs' efforts related to health professions students have been in the direct provision of training. The time consuming and politically sensitive process of changing school curricula along with the conviction in many institutions that HIV/AIDS material is sufficient has made this a difficult mandate for the ETCs to fulfill.

All of the ETCs have reached health professions students in training through their educational programs. For some ETC's reaching health professionals during their years of training is an explicit objective. For example:

1. All of NEAETC's sites provide specific student/resident focused education training programs with increases in HIV/AIDS information particularly apparent in the low incidence states of Maine, New Hampshire and Vermont;

2. Western AIDs ETC includes as a condition in their subcontracts with local AA ETCs the incorporation of AIDS material into all primary care residency programs at AA ETC institutions;

3. The Maryland site of MAAETC divides its training into "on-campus" and "off-campus" with on-campus training focusing on all the health professions students of UMD and its affiliated teaching institutions.

Typically, training for health professions students is based on existing information presented through established teaching methods. Many lectures and symposia have been conducted for students and residents. Grand Rounds, attended by house staff and students is also a frequently used approach to presenting HIV/AIDS information. Several of the ETC's are also using "standardized patients." For the most part, the ETCs' training of health professionals has been concentrated in the institutions affiliated with the ETCs rather than on broader initiatives to reach all professionals in training.

There have also been several initiatives to directly impact the content of professional school curricula. Predictably, however, many ETCs have found curriculum reform to be a lengthy and politically sensitive process. By far the most frequently used strategy to impact professional school curricula is the training of professional school faculty through train-the-trainers or faculty development programs. It is believed, and in some ETCs like MPAETC there is supporting data, that the faculty will in turn incorporate AIDS information in their own teaching of health professional students. This is seen as a less threatening and faster approach than working with institutional curriculum committees. Other strategies to influence school curricula have included offering ETC curriculum to university faculty for use at their discretion and using university faculty as ETC faculty to encourage individual adoption of ETC material.

In addition, there have been a number of initiatives to develop and disseminate model curricula. These efforts have proven most successful when a collaborative approach that involves many institutions in the planning and development process is used, thereby instilling a sense of ownership. The Morehouse site of EATN has followed this approach with a nursing student curriculum, and MAARETC and MATEC have been similarly successful with dental school curricula.

One of the most ambitious efforts at influencing school curricula was undertaken by NY-Caribe. This ETC exists in an area having many health professions schools and with a great deal of competition among the schools. The ETC rightly felt they could not, as outsiders, recommend curricula. Instead, they held a "Faculty Institute." This Institute was carefully planned following an extensive needs assessment. It was a two-day program focusing on strategies for assuring appropriate emphasis on HIV/AIDS in curriculum, the process of curriculum development and incorporating clinical experiences into curriculum, rather than on proposing a specific curricula. The institute was attended by 40 representatives from health professions schools around the region. A follow-up evaluation to assess changes or developments in curriculum is planned.

While it is clear that the ETCs are focusing at least some of their efforts on professionals in training, significant challenges remain. The ETCs all need to develop a more comprehensive plan and specific strategy for reaching health professions students in all disciplines throughout their region. Their focus on students in their own institutions must be broadened. In addition, the ETCs must continue to introduce innovation in the education of students about HIV/AIDS. Influencing attitudes and skills will be as important as increasing knowledge to the student's long-term career decisions.

H. Information Resources

In addition to training health care professionals, ETCs are expected to serve as a resource for information about HIV/AIDS for health care providers and organizations in their service areas. All ETCs have taken some responsibility for serving as a source of information, but the extent to which ETCs have emphasized this function as well as the specific activities undertaken has varied considerably.

In general, information resource activities can be divided into three principal areas of activity: 1. library services; 2. telephone hotlines; and, 3. newsletters. Virtually all ETCs maintain some level of library services. The level of service ranges from collecting materials, curricula and videos for AIDS-related trainings which are then shared throughout the ETC network to comprehensive AIDS-related libraries which collect, catalogue and distribute general articles and statistics as well as training materials. As part of this information effort, most ETCs also track ETC-sponsored trainings and make this information available throughout the region, usually via an electronic "bulletin-board" system. ETCs opting for the more limited approach feel the more general AIDS information can be obtained through existing university-based library services or organizations like the national AIDS clearing house. ETCs taking the expanded approach feel it is useful to serve a clearinghouse and coordinating function, assisting their constituents by sorting through and organizing the extensive range of information available.

In most cases the library function has emerged as an important activity for the ETC regional office. It is a logical and important role and helps put the regional office in a position to coordinate training efforts, identify training gaps and assure intra-ETC sharing of resources. When the services

are extended to the public, providing information helps the ETC establish its identity as a training resource.

In ECAETC, the University of Kentucky site has taken the lead in organizing information resources for the ETC. In this case, the site is performing an extensive information collection and clearinghouse function. The University of Kentucky, in collaboration with the Western AIDS ETC, has also taken the lead in developing and maintaining the ETC AIDS Resource Network (EARN) which links all ETCs in an information collection and dissemination network.

Telephone hot-lines, or warm-lines as they are more typically called, are operated by a number of the ETCs. These warm-lines, which operate on a call-back system (hence the name) most frequently provide information about training opportunities and events. The next most frequent service is clinical consultation where callers can ask specific AIDS related questions which will be routed to the appropriate AIDS expert for response. A few lines also provide referral services for clinicians looking for specialized services for their patients. In most places, use of the warm-lines for clinical consultation or referral has been disappointing. The Oregon site of WAMI-0 is an apparent exception to this. Their phone line has served as an important resource for clinical consultation for the state. While more study of the reason for low utilization is needed, it is felt that providers are reluctant to call unknown people even if they are "experts" or to work through a third-party in requesting clinical information. However, having a central, well-publicized number for training information does seem to be an important function for the regional ETC office.

Newsletters are published by several ETCs and several sub-contractor sites. The newsletters range from up-dates on training opportunities and ETC activities to discussions of current trends in AIDS clinical issues. Interestingly, constituents have expressed strong preference for both types of newsletters, depending on the region.

In general, newsletters, centralized telephone access to training information, and centralized collection and distribution of training schedules, materials and curricula are important and appropriate functions for the ETC regional office. Such functions help the regional office perform important coordinating functions and help establish a training identity for the ETC. Other functions, such as acting as a clearinghouse for all AIDS information or acting as a clinical information or referral focus, may be needed in specific regions but may also be fulfilled through other mechanisms. Further assessment of the impact of these activities in areas where they have been implemented are needed before they are more widely undertaken.

I. Sustainability

ETCs are expected to develop means to sustain operations in the absence of federal funding. and the ETCs acknowledge that continued operation at current levels is not possible without significant

outside funding, strategies have been adopted to recover partial cost of operation in the absence of HRSA funding.

Two interrelated strategies have the most potential for carrying on ETC work over the next several years. These are:

1. Institutionalizing ETC programs and curricula by training, through train-the-trainers programs, a cadre of trainees based in academic and institutional settings and AIDS care organizations throughout the ETCs regions. It is believed (though it still needs to be demonstrated through evaluation) that these trainers and organizations will continue to provide AIDS-related training even without direct ETC support.

2. Developing, supporting or enhancing through subcontracts, locally based entities usually on a state level. It is felt that as these local ETCs achieve recognition within their more limited geographic area, they will be in a position to secure local funding and contributions. While the validity of this assumption must also be objectively assessed, there are some early signs that this is an appropriate strategy. Several of the local ETCs (as well as the regional ETCs) have obtained in-kind contributions of space, staff and administrative support from their host institutions. Several others have received support for trainings from other organizations in their states including health departments.

In addition to these two strategies, ETCs have also pursued sources of support to augment HRSA funding. Some, notably WAMI-0, Western and MAARETC have been particularly successful in securing funding from other sources (e.g. foundations, health departments, pharmaceutical firms) to support ETC-related initiatives. EATN, NEAETC and ECAETC have received subsidy for a few specific activities. Most ETCs charge small fees for attendance at some or all of their training programs. Generally, however, these fees are established to cover costs not covered by the ETC grant (e.g. refreshments or special materials) and do not significantly augment ETC resources. Most ETCs receive some, and occasionally significant, in-kind contributions of space, staff and/or administrative support from the institutions in which they are based. All ETCs co-sponsor a portion of their training programs, sharing the expense for the program with the co-sponsoring organizations. A few ETCs are generating additional funds through innovative strategies. MATEC, for example, charges a consultation fee to agencies requesting assistance in training program development.

Although these efforts to institutionalize ETC programs and the efforts to generate supplemental revenue are taken seriously by the ETCs, none of the ETCs believe activities will go on at current levels without HRSA funding. Particularly likely to suffer in the absence of federal funds are: 1. the continuous and critical process of updating and expanding AIDS curricula; 2. updating AIDS trainers and/or replacing them as people move out of the field; 3. coordinating functions assumed by the regional offices which include disseminating curricula and material and identifying training gaps; 4. other

supporting activities particularly information services; and, 5. training outside home institution (outreach, community providers).

III. CONCLUSIONS AND RECOMMENDATIONS

The eleven (11) ETCs included in this study are complex organizations covering broad, diverse geographic regions, encompassing several institutions and organizations either as subcontractors or as collaborators and conducting an extensive range of HIV/AIDS training and related activities. While overall conclusions and recommendations can be drawn from the case studies, it must be recognized that, by design, each ETC is a unique program. Exceptions can be found for many of the overall conclusions, and recommendations must be adopted recognizing individual program situations. The conclusions and recommendations presented in this summary are drawn from the case studies and the discussion in this overview report. Conclusions and recommendations related to evaluation of the ETC program are included in a separate evaluation overview.

1. This evaluation study was conducted relatively early in the development of the ETC program. Because there were significant barriers to rapid and smooth development, in many cases the study observed only the beginning of an effective regional education and training system. Importantly, significant progress was noted as the ETCs evolved between the.first and second year of the evaluation study.

2. The ETCs have several aspects in common: all provide continuing education and training to a broad range of health care providers; all are trying to influence the curricula for training health professions students and residents at least at the institutions affiliated with the ETC; all are incorporating some level of train-the-trainers programs as part of their training approach; all are targeting programs to benefit minority populations; and, all are serving as an information resource to target populations in their area. Beyond these essential elements, however, the ETCs differ considerably: their approach to regional management varies from highly centralized to highly decentralized; the specific roles of the regional offices versus local sub-contracted ETCs are individually defined; training emphasis as well as emphasis on other activities varies considerably between the ETCs and even among subcontractors within the ETCs.

   The ETC program was purposefully designed to allow for unique responses to different regional needs. If more consistency is now required, as it may be to be able to characterize and evaluate the ETC program, further guidance is needed from HRSA. Further guidance would be particularly helpful in: defining the roles and responsibilities of the regional ETC office in relation to local ETCs; specifying priority target training groups (e.g. community-based primary care providers versus institution based providers versus professionals in training versus allied health professionals) and preferred training approaches (e.g. train-the-trainers versus

clinical training versus continuing education versus training professionals in training); defining training output expectations in line with preferred training approaches; and defining expectations regarding program evaluation both in terms of consistency of data reporting among ETCs and in terms of type and scope of evaluation activities.

3. The ETCs were originally designed as regional programs, typically covering a multi-state area. However, defining the roles and responsibilities of the ETC regional office versus its subcontracted and collaborating organizations was left to each ETC. Some designed highly centralized programs with the regional ETC assuming considerable responsibility for developing and implementing training throughout the region and/or closely controlling the activities of its sub-contractors. Others began as more decentralized programs. At the extreme of decentralization, the regional ETC dispersed grant funds to subcontractors and gave them virtual autonomy in developing and conducting training. Regardless of where each started, many ETCs are moving to a balanced regional model where the regional ETC office assumes overall program oversight and coordinating and selected training responsibilities while delegating significant training development and implementation responsibilities to locally based ETCs. Regionalization continues to be a valid concept, both for administrative purposes and as a vehicle to achieve synergy among AIDS training organizations with varying amounts of expertise and qualitatively different resources available to them.

   This evolving, regionalized approach is appropriate and should be encouraged and supported by HRSA. It combines the benefits of having responsive and recognized training organizations at the local level with the economies of scale, potential for sharing of expertise and material, and synergy of a larger program. It also helps HRSA fulfill its commitment to assure all areas of this country are served by and AIDS ETC.

   While there have been difficulties forming functional regions in some areas, these difficulties should not be viewed as indictments of the concept. The concept is appropriate, however, it needs further direction, supervision and time to reach its full potential.

4. The ETCs are effectively collaborating with many AIDS-related organizations. This collaboration should be encouraged and, where necessary, expanded. However, it must be recognized that the ETCs' accomplishments may be more difficult to isolate and evaluate when they are merged with the activities of other agencies.

5. At the inception of the ETC program, there were few AIDS training curricula available. Those that were available by no means covered the gamut of AIDS training needs. In the first three years of the ETC program, there have been a number of excellent curricula and

training programs developed by the ETCs. These include: train-the-trainers programs; intensive clinical training programs for primary care providers; specialized programs for selected provider disciplines including dentists, home care workers, mental health workers, social workers, and correctional systems workers; programs focusing on issues related to HIV/AIDS in many ethnic and racial minority populations including Blacks, Latinos, Native Americans, and West Indians; intensive programs for primary care residents; and programs for health professions students. There have also been some technologically innovative approaches to training.

Unfortunately, the implementation of these excellent and innovative programs has been limited in most cases to the sites which developed them. There has not been much dissemination of curricula and programs across ETCs and even within ETCs, cross-program sharing has been limited. The isolation of excellent programs has limited the impact of the ETCs. One important function for HRSA in the near future should be to facilitate the identification, dissemination and adoption of outstanding training programs.

6. It has proven difficult for the ETCs to impact professional school curricula, particularly in institutions outside the ETC network. The dominant strategy of training professional school faculty with the intent that they will then incorporate AIDS/HIV information into their own teaching has merit but does not fulfill the current ETC mandate. Different approaches are needed and should be encouraged, not all of which can be expected to succeed. Approaches which have been successfully tried by some ETCs, such as faculty institutes or collaborative curriculum development efforts, need to be documented and shared among the ETCs.

7. All ETCs are serving as a source of HIV/AIDS related information in their area. The focus and extent of this effort, however, varies greatly across sites. In most cases it has proven difficult and often duplicative for the ETCs to serve as a resource for AIDS treatment information and for information on the disease and the progress of the epidemic. With limited resources, it seems that most of the ETCs should focus their services on information specifically related to AIDS training and ETC programs; including both information on training programs and schedules and providing training related material. Where gaps or specific needs can be identified, general information, clinical consultation and referral services may be offered.

8. Clearer guidance is needed from HRSA on its expectations regarding the institutionalization and eventual self-sustainability of the ETC programs. Some ETCs are pursuing institutionalization more aggressively than others although virtually all agree that substantial outside funding is essential to maintain operations for the foreseeable future.

Individual Case Studies. Included in the Following Order:

AIDS Education and Training Center for Southern California

Delta Region AIDS Education and Training Center

East Central Region AIDS Education and Training Center

Emory AIDS Education and Training Center

Mid-Atlantic AIDS Regional Education and Training Center

Midwest AIDS Training and Education Center

Mountain-Plains AIDS Education and Training Center

New England AIDS Education and Training Center

New York-Caribe AIDS/SIDA Education and Training Center

WAMI-O AIDS Education and Paining Center

Western AIDS Education and Training Center

JOHN SNOW, INC.

AIDS Education and Training Center For Southern California

Case Study

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA

CASE STUDY

I. PROGRAM OVERVIEW

The AIDS Education and Training Center (ETC) for Southern California serves a five county area of Southern California: Los Angeles, Orange, Ventura, Riverside and San Bernadino. The central site of the ETC is the University of-Southern California with primary satellite sites at UCLA, UC Irvine and Drew University. Although USC is the primary grantee and "central site" of the ETC, the four institutions essentially operate as equal and independent sites linked by formal communication of activities and progress, ad hoc inter-institutional program development committees, and informal sharing of resources.

The four sites are currently delivering three levels of training. Level 1 trainings are didactic sessions to increase awareness, understanding and knowledge; Level 2 trainings are brief clinical experiences in clinics, hospitals and community practices; Level 3 trainings are intensive clinical preceptorships involving the direct care of patients with HIV/AIDS. The clinical training programs of the ETC-SC are an important and distinguishing element of the center.

The disciplines represented among the trainees of the ETC include physicians, nurses, nurse practitioners, physician assistants, dentists, psychologists, social workers, students in these professional schools, emergency room staffs, and residents in general internal medicine and family practice.

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The ETC-SC was designated to concentrate specifically on the Los Angeles area as its "region". This relatively small regional designation was created due to the large population and extent of the HIV problem in the LA metropolitan area. In 1989, Los Angeles surpassed San Francisco in the reported number of AIDS cases for that year, second only to New York for U.S. cities. Over 2,000 AIDS cases were reported in Los Angeles in 1989 and the expected number of infected individuals is in the hundreds of thousands. Also of import to the USC-ETC in development of its training program is the ethnically diverse population (12% Black; 31% Hispanic) in Los Angeles County.

B. Organizational Background

The four institutions collaborating in the ETC-SC have each been very active in HIV education, training and care provision prior to the ETC project.

The Los Angeles County-USC Medical Center is the primary teaching facility for the USC School of Medicine. The hospital cares for more HIV patients, both inpatient and through its multidisciplinary outpatient clinic, than any other facility in Southern California. The outpatient clinic is currently experiencing over 2,000 HIV related visits per month. The center sponsors an active inservice education program for health professionals and maintains activities related to AIDS in pediatrics, social work, perinatal HIV infection, psychiatry workshops and support groups. USC is also the site of an AIDS Treatment and Evaluation Unit in collaboration with UC Irvine and other institutions in the California Collaborative Treatment Group. Dr. Lee, the ETC Principal Investigator, is also the Regional Director of USC's Area Health Education Center (AHEC).

The UCLA AIDS Clinical Research Center, funded by the University-wide Task Force on AIDS, was established in 1983 and has been addressing the HIV educational needs of health care providers since that time. The Center sponsors bi-monthly meetings and publishes AIDS Medical Update to inform community-based physicians on developments in AIDS care. The Center has co-sponsored programs with NIAID, AIDS Project Los Angeles, Gay and Lesbian Community Services Center and the UCSD Owen Clinic. Dr. Charles Lewis, the UCLA site director for the ETC project, is also Project Director on a National Institute of Mental Health funded AIDS training program for health care professionals. This project has developed twelve instructional modules on the psychosocial and neuropsychiatric issues of AIDS which have been made available to the ETC.

The UCI Medical Center also holds a Multidisciplinary AIDS Clinic and is the lead institution in the California Collaborative Treatment Group which offers and evaluates experimental protocols for HIV care. Drew University serves the primarily black and hispanic community of South-Central Los Angeles. Drew sponsors an AIDS clinic, staffed largely by volunteers from the health professional community, and an HIV testing program. The director of the clinic, Dr. Wilbert Jordan, also started an Adopt an AIDS patient program with area churches to provide social support.

C. ETC Origin and Development

The University of Southern California, through Dr. Peter Lee and the Department of Family Medicine, originally attempted to form an ETC with UC-San Francisco and UC-San Diego. An application was eventually presented in the first funding round, but a grant was awarded to the ETC currently based at UC-Davis which then drew in UC-SD. UCLA, through Dr. Lewis, was brought into the process in the second funding round. At this point, the concept was formulated of drawing on existing continuing medical education relationships to focus the ETC efforts on the Los Angeles metropolitan area through three levels of training.

The USC Department of Family Medicine was actively supported by the Dean of the School of Medicine throughout the process. This was an important source of support because there was some initial resistance within the institution to the idea of increased involvement of primary care physicians in HIV care at the medical center. This resistance was somewhat overcome when the ETC was able to fund a clinician in the AIDS clinic. This placement

correspondingly opened the door for the clinic based training programs which have developed into a great resource for the center.

As with some other ETCs, after initial funding, much of the first six months was occupied by the subcontracting process, recruitment of key 'personnel and preliminary organizational development. However, the ETC was simultaneously active in needs assessment activities, development of information and resource services and a significant amount of training at all three defined levels. This high level of early activity may be attributed to a number of factors including: the industry of the individuals comprising the ETC-SC; the relative "head start" experienced by the ETC-SC as a result of the inclusion of pre-established AIDS training programs within the organizational framework; and as a consequence of pre-existing responses in the health care community to the advanced phase of the epidemic in Los Angeles. The responses included a relatively high level of inter-institutional cooperation and collaboration and the pre-existence of comprehensive HIV clinics capable of offering training opportunities to residents and other health professionals.

It was initially proposed that each of the four primary sites would also establish one or more secondary training sites in the Region. This plan is not being pursued by the ETC at this time.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

The organizational structure of the ETC is intended to be a "mixed form model" in which the hierarchical structure between institutions, with USC as prime contractor and UCLA, UCI and Drew as primary subcontractors, is mixed within a matrix of Task Forces associated with each University. Task Forces are comprised of five to ten (5-10) faculty and community health practitioners who have expertise in a given field or discipline. The Task Forces variously contribute members to ETC-associated Working Groups thus composed of region-wide, inter-institutional representatives. The Working Groups operate under the direction of the Program Director based at USC who in turn functions under the guidance of the Steering Committee composed of the Regional Site Directors.

The extent and effectiveness of this structure has differed between disciplines. A successful example of this approach is the Dental Working Group which has been particularly active in needs assessment, curriculum development, materials identification, program planning, materials development and networking. In contrast, the Task Force/Work Group model has not gotten off the ground for Nursing due to a variety of minor individual delays and organizational impediments.

In practice, the four participating organizations operate fairly independently with formal or informal collaboration between sites occurring on an as needed basis. The structural form or 'grand plan' for inter-institutional collaboration is fairly amorphous.

The "service area,, for each organization roughly follows established patterns of health care and referral in the L.A. metropolitan area. Each of the four participating institutions has trainee target groups as described in Section IV. Although each site operates independently, each follows the three level training format. In addition, each site has taken on a characteristic role that distinguishes their contribution to the ETC. USC has taken the lead in offering the Level III clinical experience through the USC/LAC HIV clinic. Drew has taken the lead in developing materials and programs targeting the African American community. UCI is the most active implementor of Level I and II trainings to community based providers. UCLA has adopted a role as the leader for curriculum and materials development, particularly video modules, and in providing training of trainers in the use of the modules.

B. Staffing

Peter V. Lee, MD, Principal Investigator, has overall administrative responsibility for all components of the project. Dr. Lee is the Chairman of the Department of Family Medicine at USC and Director of the USC Regional AHEC . He chairs the Steering Committee and the Core Executive Committee of the ETC.

Jerry Gates, Ph.D., Program Director, serves both as the USC site director and as overall program director. He has responsibility for daily operation and management of the USC training sites, including organization of the task forces and the development, implementation and evaluation of the program activities. He provides consultation in curriculum development and evaluation to the other participating sites.

Dr. Gates is assisted in coordination of training activities by Sue Mertz, MA, Education Specialist. Erin Quinn, M.Ed., M.P.A., is the Contract Administrator and also involved in planning and implementation of specific training events. Peter Katsufrakis, MD, is the Clinical Education Coordinator for the ETC clinical training programs at USC and a clinician in the Interdisciplinary AIDS Clinic.

Lenoir Zemmar, MD, is the Site Director for ETC activities at Drew University and is Director of the Division of General Internal Medicine. He is principally assisted by Wilbert Jordan, MD, who is Director of Graduate Medical Education and Director of the AIDS clinic at King/Drew Medical Center.

Jeremiah Tilles, MD, is the Site Director for ETC activities at UC-Irvine. Dr. Tilles is Chairman of the Department of Medicine and Principal Investigator on the California Collaborative Treatment Group. He is principally assisted by Donald Forthall, MD, who is the Clinical Education Coordinator for the ETC clinical training programs at UCI and by Sheila Fitzgibbons, RN who is the site's training specialist.

Charles Lewis, MD, Sc.D., is the Site Director for ETC activities based at UCLA. Dr. Lewis is Chief of the Division of Internal Medicine and Principal Investigator for the NIMH AIDS Training Program. He is principally assisted by Mary Ann Lewis, RN, DPH, who is responsible for ETC program

development for nurses and by Maria Hayes-Bautista, RN, MPH, who is responsible for program development targeting the Latino Community.

C. Approaches to Collaboration, Integration and Regionalization

1. Approaches to Collaboration

The ETC directors believe that the organizational structure chosen for the program, which includes both inter-institutional working groups and advisory board input, fosters ongoing communication with the community and other institutions at all levels of the project. Also important, as noted previously, is the high level of pre-existing collaboration that has occurred in response to the potentially overwhelming extent of the HIV epidemic in the area.

The ETC program has not developed a close relationship with the clinical trials group, except peripherally through the clinic at USC and through the direct involvement of Dr. Tilles at UCI. The ETC relies on each institution's existing referral network as the resource for networking. Regionalization was easily accomplished based on the shared history of geographic subdivision for the four schools.

An important linkage, developed through Dr. Lewis at UCLA, is with the Kaiser Permanente Medical Plan of Southern California. Following on the success of a one-day continuing education program for a large medical group in the system, Kaiser has determined to extend the program as a mandatory requirement for all participating physicians -- numbering about 3,000. This decision was in part the result of the evaluation which included follow-up with trainees' patients and demonstrated a significant impact on frequency of sexual history taking.

The ETC site at King/Drew is part of the Black L.A. AIDS Commission (BLAAC); a 30 agency commission addressing the service and policy issues of HIV in the black community. The site staff are also active in the South Central LA Hospice Committee which is currently developing a hospice to be opened in 1991.

At UCI, an important point of collaboration has been linkage with the Orange County Health Department which has an AIDS demonstration program with a liaison nurse program and with the Long Beach County Health Department which is a CDC STD site. The UCI site has provided joint trainings with the Orange County Health Department and has worked with the Long Beach Health Department to add courses on HIV in the STD training program. The linkage with the CCTG through Dr. Tilles has also been seen as important, because it facilitated the involvement of a predeveloped network of AIDS providers. CCTG sponsored grand rounds have been particularly effective in attracting community/county based physicians to programs at the UCI Medical Center.

2. Approach to Integration

The relationship with the NIMH training program through Dr. Lewis at UCLA was identified as a very important point of integration. The program was described as leaving a "strong imprint" on the ETC by virtue of its pre-existing programs, materials, and evaluation activities.

D. Organizational Qualities

An important characteristic of the ETC for Southern California is the fact that each participating institution has its own character and operates essentially independently, but develops and implements programs within a shared framework with common objectives. This arrangement has both advantages and disadvantages for the overall ETC-SC organization.

The primary advantages are that each site is allowed to draw on its own areas of strength, concentrate on uniquely identified areas of need, and operate within pre-established channels of communication and collaboration within each site's section of the "region". The program is built on "comfortable, stable relationships between sites that keep going on their own" with minimal centralized direction.

The primary disadvantage is found in the flip side of this arrangement. Inter-institutional communication and sharing of resources has not always been optimized to avoid duplication of effort and to allow coordinated evaluation of ETC programs. Although this has not presented a large problem to date, the ETC has identified a need to promote greater communication, collaboration and sharing of resources between sites without bringing the decentralized nature of the program into imbalance.

An important and distinctive quality of the ETC-SC organization is the successful emphasis on clinical training. This emphasis has been enabled by two primary factors. One factor is the accessibility of and institutional support for the use of major medical center outpatient clinics for training community based providers. The second and more distinctive reason is found in the ETC-SC staffing structure. Rather than relying on volunteer or limited percentage time of otherwise busy clinicians to serve as clinical preceptors, the ETC-SC funds almost two full-time physicians (Drs. Katsufrakis and Forthall) based in outpatient clinics to serve as clinician/educators for the Level 3 training programs of the ETC.

IV. RDUCATION AND TRAINING PROGRAM

A. Needs Assessment Activities

Each primary site has the flexibility to develop programs to meet local provider needs. The educational objectives developed for the training programs are based on current awareness of the educational needs of those who are required to provide care for HIV infected patients. Each institution has the responsibility to assess the training needs of health professionals within its targeted area and tailor programs to meet the identified needs. Each site

has varied in their approach to the needs assessment. For example, through the efforts of Dr. Lewis and other UCLA faculty a survey of physicians' attitudes and practices was designed and administered. This survey initially involved all primary care physicians in Los Angeles County and later was expanded to a random sampling of physicians throughout California. The statewide survey involved local medical societies and was co-sponsored by the two California-based **ETCs** and the California Medical Society. Utilizing the telephone survey instrument developed by Dr. Lewis, another research team surveyed Los Angeles oral surgeons, dentists and periodontists.

The Regional Advisory Council organized by the USC ETC serves as a broad based forum for community input to assist the Project Director with the ongoing assessment of the needs of the various health professions and communities and to advise on program development and priorities. Membership in the council includes community representatives and health professionals from a variety of disciplines, agencies and institutions. The individual task forces appointed at each of the four sites also serve as mechanisms to assess and prioritize the educational needs and then to develop program plans that address the needs. Currently at the UCLA site there are two active task forces: Nurses and Hispanic Physicians. At USC there are five: Medical Education, Nursing, Dental, Behavioral Sciences and Communications and Computer Information Services.

Assessment of needs has also been conducted in conjunction with the various training activities at each of the sites. For example, at the **UCI** site a needs survey was administered for the training program for nurses. Clinical aspects of HIV care were identified as major areas of interest and need.

At USC, 150 participants completed a 20 item survey during a Physician Assistant Review Course. From this survey 18 **PAs** were identified as potential candidates for intense clinical training. The USC AIDS Policy Task Force also recommended that the ETC conduct an assessment of the entire faculty regarding their state of preparation to supervise the care of HIV patients.

Drew is currently in the process'of developing a needs assessment targeting minority providers. The implementation of an overall needs assessment, as well as other components of the ETC program at Drew, have been somewhat delayed by the initial subcontracting process and then by larger political/financial issues beyond the domain of the ETC affecting the entire King/Drew Medical Center. Many of these issues have now been resolved and the ETC training programs at Drew are now able to go forward. The site staff have identified particularly high training needs and have been focusing their programs on psychosocial issues as well as basic clinical and etiologic information. Another need is for culturally appropriate training materials. The Drew site is in the process of developing minority-focused trigger tapes and a video module for Sexual History Taking and HIV counseling that are attuned to issues in the black community.

B. Training Activities

Each of the sites in the ETC are delivering three levels of training. Level 1 trainings are didactic sessions to increase awareness, understanding and knowledge; Level 2 trainings are brief clinical experiences in clinics, hospitals and community practices; Level 3 trainings are intensive clinical preceptorships involving the direct care of patients with HIV/AIDS.

1. Target Trainees

The disciplines represented among the trainees include physicians, nurses, nurse practitioners, physician assistants, dentists, psychologists, social workers, paramedics, students in these professional schools, emergency room staffs, and residents in general internal medicine and family practice. The four primary sites have major responsibility for different groups of providers, based on their areas, population, demography, health care resources and the institution's own resources, mission and expertise. Each of the sites has targeted their respective faculty, residents and students for training activities. However, the ETC sites have also been very active in recruiting and reserving spaces for trainees of all disciplines, especially physicians and mid-level providers, from community-based organizations.

2. Training Objectives, Methods and Activities

o Education to Increase Awareness, Understanding and Knowledge

Learning objectives for Level 1 training are based on current awareness of the educational needs of the professionals who are required to care for people with HIV infection. Level 1 training objectives identified by the USC site are to help the trainees:

- identify patients who are at risk for HIV infection;
- utilize HIV testing services effectively;
- evaluate HIV infected patients for common medical problems;
- counsel patients regarding sexual activities and safer sex;
- treat common, non-serious medical problems associated with HIV infection in the ambulatory care setting;
- keep aware of recent advances in clinical topics in AIDS and HIV infection;
- refer patients to appropriate local social and medical facilities;
- understand personal attitudes regarding AIDS and high risk behaviors;

- understand special needs of high risk groups.

o Introductory Clinical Training

Level 2 training activities are designed to help participants utilize knowledge gained in the clinical setting; to confront any personal concerns about dealing with HIV infected persons; and to apply a multidisciplinary approach to caring for infected persons in an ambulatory care setting. The objectives of this level of training are to enable trainees to:

- personally take an appropriate history from a patient being evaluated for HIV disease;
- conduct an appropriate physical examination on a patient with possible HIV disease;
- participate in the diagnostic and therapeutic planning for patients with suspected HIV infection;
- participate in the evaluation and care of HIV infected persons in a model ambulatory setting utilizing an interdisciplinary approach;
- describe the responsibilities of other health care professionals when dealing with HIV infected patients.

All four sites have been active in Level 1 and 2 trainings, although **UCI** has been the most active in taking programs into the surrounding community. The **UCI** site has increasingly worked with nurse and paramedic programs in the many area junior and community colleges and has also provided training to private **VNA's** and **homecare** companies (AIDS and the Health Care Worker). Trainings are adapted for different types of health care workers in an organization depending on job responsibilities (e.g. home health workers; social workers; and supervising **RNs).**

o Intensive Clinical Training

Level 3 training activities are designed to enable trainees to investigate patients with known or suspected HIV infection for associated medical problems; treat the majority of complications of HIV infection in the ambulatory setting; and to become knowledgeable on available educational materials for AIDS education. Trainees who have completed Level 3 will have the ability to:

- Provide appropriate initial examination and subsequent health surveillance;
- Counsel the patient regarding maintaining their own health and reducing risk of transmission to others;
- Recognize and treat common minor complications of HIV infection;

- Recognize early signs and symptoms of major complications, and appropriately treat or refer for definitive treatment.

Level 3 programs are one week in duration and have been developed for physicians, physician assistants and nurse clinicians. Providers completing Level 3 training are expected to return to their local community as more capable HIV caregivers and to serve as a resource to other providers for the management of the HIV patient.

The Los Angeles County-USC Medical Center is the designated site for the Level **3** clinical training, although there is some activity in Level **3** at each of the four primary sites. The one week program for primary care providers at USC includes an introductory didactic session during the morning of the first day followed by an afternoon in the intake and STD clinics. Over the next three days, a morning session is conducted on CMV disease, two half-days are spent in the primary care clinic, one half-day in private practice setting caring for HIV infected people, and sessions are spent in the pulmonary and dermatology clinics. On the final morning, psychosocial issues of HIV are addressed. The trainees who participate in this level of training also have the opportunity to be student teachers and participate in the training of other participants in Levels 1 and **2.**

UCI conducts a three-day intensive clinical rotation and can accommodate about 1 physician per month. The format is similar to USC, but a little more didactic in concentration. To date, trainees have mostly been **UCI** faculty or physicians from the County medical system. The **UCI** site is also holding a similar program for undergraduates and residents at the Long Beach VAMC. King/Drew also offers Level 3 training in their clinic for medical students and residents, but it has not been too popular yet. The Drew staff are considering trying to integrate the training into a general medicine or primary care rotation.

The ETC also undertakes several special initiatives that cross-cut their Level 1, 2 and 3 trainings:

o **Education and Training Activities for Dental Professionals**

To meet the educational needs of the dentists in the region the ETC has implemented several activities. The activities have included the development of an AIDS video in collaboration with the Riverside Department of Health; design of a training module for dental students; development of a half-day Level 1 program on HIV for practicing dentists, and a Level **2** workshop on dental care and HIV/AIDS offered in collaboration with AIDS Project LA.

o Education and Training for Community and Migrant Health Center Staff

The ETC procured additional funding for training clinicians at community and migrant health centers. Dr. Debbie Cohen, a USC-based physician responsible for this supplemental program, has developed training interventions which will focus on safer sex and safer sex counseling, HIV testing and counseling, and diagnosis and primary care treatment of the HIV/AIDS patient. A training needs assessment is currently being conducted by on-site collection of general information on the area health centers and

populations served. The Drew site has made arrangements with the Watts Health Foundation to do quarterly HIV training for their staff throughout the system. In the future, the Drew site staff hope to move towards conducting Level -3 training in conjunction with WHF in their centers.

o Initiatives to Impact Professional School Curricula

Each of the sites is involved in influencing the HIV associated curricular content of their respective professional schools; primarily by virtue of their academic positions, rather than as a consequence of the ETC presence. In addition, the UCLA site was instrumental in facilitating meetings of representatives of the 40 AD and 7 BA nursing programs in southern California for the purpose of stimulating increased integration of HIV related curriculum into nursing programs.

3. Curricula and Materials

A number of AIDS curricula planning outlines, self-instructional programs and videotaped simulated patient interviews had been developed prior to ETC funding. The tapes and modules developed by Dr. Lewis as part of the NIMH AIDS training project were made available to ETC participants, as was a train-the-trainer program for nurses at the King/Drew Medical Center. Dr. Lewis' materials include twelve modules with trigger tapes for training in the affective domain, including Sexual History Taking, Sexual Counseling, Ethical Dilemmas, Neuropsychiatric Complications of AIDS, Job-Related Burnout, and Coping and Adaptation.

Additional tapes are being developed under ETC funding, including a tape for specific use in trainings of Latino providers. The video/module development process starts with recruitment of key informants to participate in a focus group for needs assessment. The video is then scripted; actors are recruited; and the video is filmed and edited. A formative review is then conducted by the same focus group, before the final product is ready. An instructor's guide with training objectives, techniques, handouts and references is then developed as a companion to the video. The UCLA program uses the modules directly in their own trainings or will make them available to others under the condition that users of the modules participate in a train-the-trainer program with Dr. Lewis.

The ETC-SC, in conjunction with the Department of Medical Education at USC, is in the process of developing an objective format for teaching and assessing clinical skills using standardized patients. Several standardized cases have been developed to teach history taking and counseling skills. Physical examination and selected patient management skills are also hoped to be taught through the use of standardized/simulated patients. Further work is in progress toward establishing and documenting expected learning objectives, behaviors, and skills, as well as methods and tools for assessing trainee progress toward meeting objective standards. Ultimately, it is intended that this format will be made available in a package for ready transfer and application in a variety of teaching settings.

C. Efforts to Reach Minorities

Drew University serves the primarily black and hispanic community of South-Central Los Angeles. The medical school provides undergraduate and graduate training to large numbers of minority students. The LAC/USC Medical Center, including the multidisciplinary HIV clinic, also serves a largely Hispanic community. At both the USC and UCI sites, spots are reserved in the Level 3 clinical training programs for minority providers or providers from the county systems which serve predominantly minority communities. The ETC-SC has sponsored several conferences with minority providers as target audiences and provides numerous workshops or small presentations through its faculty to minority providers. One conference of note was a two day regional conference on Latinas and AIDS co-sponsored by the Multicultural Area Health Education Center. A number of representatives from Latino-oriented community-based organizations were brought together to form an advisory panel for development of the conference.

The UCLA Assistant Site Director, Maria Hayes-Bautista, has primary responsibility for developing linkages with the Latino health care community to encourage program input, participation and co-sponsorship, as well as to encourage a network of Latino providers of HIV care. As part of this effort, the UCLA site will be doing a needs assessment of Latino providers. A one-day workshop is being targeted to the 340 physician membership of the Chicano-American Medical Association (CHAMA). Training videotapes targeting the Latin0 community, including one on Sexuality in the Latino Community, are also in the process of development. The UCLA site has cooperated with the UCLA-based Chicano Studies Research Center, directed by Dr. David Hayes Bautista, for issue and policy development workshops such as a national teleconference on Latinos/Hispanics and AIDS held in the Fall of 1989; (the ETC is doing the evaluation).

D. Training Issues and Successes

The ETC-SC has been able to implement a high level of training right from the onset of the program as a result of existing resources, networks of collaboration, and the industry of the participating individuals and professional education departments. About 11,000 trainees have been trained in two years, exceeding the projected total by about 4,000. This total includes about 3,100 community physicians and over 1,700 health professionals that have attended programs beyond Level 1.

Perhaps more importantly, the ETC is offering an intensive "Level 3" clinical experience to interested providers that will enable them to more confidently embark on actual patient care of HIV-infected individuals. The ETC-SC determined early on that a lot of "AIDS101" training was already available in their region and, therefore, the ETC needed to concentrate their energies on clinical training.

The strengths of the program are the direct clinical experience and supervision provided and consultative relationships facilitated for primary care providers and nurse clinicians. Applicants for the nurse clinician program are given course assignments that begin prior to the clinical

experience, including readings and a needs assessment of their home institutions. Through this process, the nurse becomes involved in identifying institutional or agency weaknesses and strengths that affect care to the HIV/AIDS patient.

Development of the clinical component of the ETC was reportedly a major effort to 'move the institution' (USC Medical School); requiring strong commitment of top administration and a commitment of HIV care in the Family Medicine program. A few minor procedural barriers were also encountered along the way. For example, the two-day clinical rotation at Children's hospital which is part of the nurse clinician program required additional contracting procedures to allow clinicians from outside of the institution to provide care to patients. Space is currently the limiting factor for greater Level 3 training activity. For interested applicants, the Level 3 programs are intensive one week courses, so time is a main constraint to interested applicants.

The affiliation with the pre-existing NIMH AIDS training program at UCLA left an important imprint on the ETC-SC training programs. The lesson that "there is a relationship betw'een comfort and competence; programs must address the cognitive, skills and affective domains together to get change" is put into practice in the Level 2 and Level 3 programs of the ETC. The UCLA site also demonstrated the value of focused evaluations in their assessment of the impact of training on physicians' sexual history taking practices. The results of the evaluation played a significant role in convincing the administration of Kaiser-Permanente to extend the training program to all of its physicians in southern California. The lure of health services research in the form of training coupled with impact evaluation has also enabled the UCLA site to interest a number of family planning residency sites in hosting training programs.

The ETC has actively reached out to community-based providers in the county and community health center systems. A very important component of their activities in this area has been the practice of reserving (and filling) spots in the clinical training programs for providers to large minority populations. The ETC, most notably the UCI site, has also been successful in getting to private practice, community-based physicians through community hospitals. The UCI site has found that the activity of the CCTG helps in this regard with many physicians attending CCTG-sponsored grand rounds.

There are several areas of the training program that the ETC has targeted for improvement. First, the ETC has determined that more avenues and more frequent opportunities for sharing of resources, experiences and plans are needed. There have been several instances where the work of individuals on specific training programs would have benefited from the work of individuals at other sites. Although frequent dialogue occurs at the level of site directors, communication at other levels of the organization would also be fruitful. Secondly, the ETC is attempting to be more active in developing linkages with community-based AIDS organizations and providers. Although some networking in this area has already occurred, the ETC believes that greater efforts are required to bring the academically based ETC closer to the level of the community. Finally, the ETC has not had a commonly shared approach to

evaluation between the sites in the first couple of years of its existence. Although the program is decentralized in nature and has concentrated its energies on program development, it is recognized that the lack of a coordinated evaluation activities has lessened their ability to assess overall impact and progress in the region.

V. PROGRAM ADMINISTRATION

A. Administrative Systems

1. Coordination

The regional AIDS ETC has a central administrative, education and communication core unit at USC responsible for assisting the four primary training sites with curriculum development, preparation of educational resources, evaluation instruments, follow-up materials and record keeping. While basic content materials are collected and distributed from USC, each primary site has the responsibility of selecting materials and specific objectives most appropriate to its own resources and trainees involved in the programs. Resources of the USC Department of Medical Education are also available to the project.

2. Marketing

Marketing of the ETC-SC, as such, has been a discussion point within the ETC. In general, the ETC has not been marketed as an organization, because of concern that this would meet with resistance in an area where there are many existing resources for professional education.

B. Systems for Managing Training Events/Programs

The USC and UCI sites have training coordinators that are responsible for managing the logistics of training events. Each site also has several individuals providing administrative support. The' ETC has assembled a large mailing list for general purposes, but has found that it is more useful to develop targeted mailing lists for specific programs and events.

Each of three subcontractor sites sends activity reports to the parent site at USC. The subcontract terms of reference are not specific with quantifiable objectives or activity level expectations, however these are detailed in annual plans developed for the continuation grant applications. The central site core team periodically visits each site to assess progress and current issues. The major format for inter-site communication and monitoring is monthly meetings at the site director level.

The ETC has not developed a training calendar and has no plans for doing so. Instead, the ETC-SC has worked through existing channels and relationships, often site specific, to promote its programs generally. Targeted marketing in the form of mailings and brochures has been employed, however, to promote and recruit participants for specific events, such as the Latinas and AIDS conference. The UCI site has been the most active in

marketing its site specific programs through mailings of flyers and brochures to organizations such as community hospitals and home care agencies. The UCI ETC site, in conjunction with the CCTG, produces a quarterly AIDS newsletter for distribution in a three county area. More recently, the USC site has developed several brochures for common use by all of the sites, including one describing clinical training programs.

C. Training Sites

The primary ETC sites have different resources for Level 2 and 3 training. At USC, the multidisciplinary AIDS clinic provides a primary care model of care for the HIV patient and incorporates specialty clinics. At UCLA there is the Medical Ambulatory Clinic, Kaposi's Clinic and a special dental clinic. The King/Drew Medical Center has a twice weekly AIDS Clinic and the General Medical Clinic for Level 2 training. UCI has an AIDS Clinic with multidisciplinary activity involving medical and nursing specialists in Level 2 and Level 3 training. Some of the clinical training for students and residents is also taking place at the nearby VA Medical Center in Long Beach.

All of the continuing education facilities associated with the four participating health sciences centers have been made available and are being utilized by the project. Facilities chosen to be "secondary training sites" have not yet been identified.

D. Cost Sharing; CEUs

The ETC-SC offers CEUs and CMEs for their course offerings for all Level two and three trainings through the sponsoring institutions. Applications are made per program for other training events. In some cases obtaining CEUs is discretionary for the participant, but the ETC will assist in the application. In the C/MHC program, for example, participants must arrange for their own CMEs at this point.

Most programs are provided at no cost to the participant. In the case of some of the larger conference programs, minimal participant fees are charged. The ETC has attempted to offset the cost of these types of programs by seeking co-sponsorships. For example, for the "Latinas and AIDS" program the ETC charged $55 per participant and partially subsidized the program through funding from the Multi-Cultural Area Health Education Center.

E. Library/Information Services

The ETC-SC has established an electronic bulletin board service. This service can be accessed free of charge via modem. The service currently includes information on professional meetings and conferences, referral resources, literature resources, and an electronic mail function. The ETC is also considering the addition of AIDS treatment protocols and clinical case presentations to the list of bulletin board services. The information service was marketed through a direct mailing to 500 individual physicians

involved in HIV care and later to key hospitals and other health care professionals.

VI. SUMMARY AND FUTURE PLANS

The ETC-SC has been able to implement a high level of training right from the onset of the program as a result of existing resources, networks of collaboration, and the industry of the participating individuals and organizations. An important characteristic of the ETC for Southern California is the fact that each participating institution has its own character and operates essentially independently, but develops and implements programs within a shared framework with common objectives. Another important and distinctive element of the ETC-SC is the offering of an intensive "Level 3" clinical experience to area primary care providers that will enable them to more confidently and competently provide actual patient care of HIV-infected individuals.

The ETC staff are convinced of the need for training that goes beyond simple presentation of information to involvement of the participants in cognitive, skill and affective learning. The ETC has also practiced the philosophy that its programs should augment, rather than replace existing programs and that targeted trainings addressing a specific audience or need are better than numerous "canned" presentations.

In the near future the ETC-SC intends to increase its focus on Level 2 training, in place of more Level 1 training, particularly on the topics of sexual history taking and HIV counseling. Continued emphasis will be placed on Level 3 clinical training, on the development and use of trigger tapes, and on activities to train individuals as HIV trainers. The program for community and migrant health centers will also receive priority in the coming months. Another goal is implementation of a common plan for impact evaluation. (For a description, see the evaluation case study for this ETC.)

The ETC has planned several new initiatives including development of a Level 3 program focusing on the care of the asymptomatic HIV-infected individual. The ETC will be carrying out new activities to increase provider confidence and competence by "helping physicians to know their referral basis". One of the more important areas of activity related to this effort is the work of the UCLA site to foster a Latino HIV treatment network through collaboration, training and support of area Latino physicians. Finally, the ETC-SC staff believe that "institutionalization" of HIV care in the primary care setting will not occur without significantly affecting the student training level. Therefore, the ETC will continue to work through its associated staff towards greater integration of HIV topics and experiences in professional school curriculum.

Delta Region AIDS' Education and Training Center

Case Study

DELTA REGION AIDS EDUCATION AND TRAINING CRNTRR

CASE STUDY

I. PROGRAM OVERVIEW

The Delta Region AIDS Education and Training Center (AIDS ETC) was initiated in April 1988 to serve Louisiana, Mississippi and Arkansas. The major participating institutions and organizations are Louisiana State University, Tulane University School of Public Health and Tropical Medicine, The University of Mississippi School of Medicine, the University of Arkansas School of Medicine and Charity Hospital at New Orleans.

The goals of the Delta Region AIDS ETC are to: (1) improve services to patients with AIDS by providing education and training to primary care providers; and (2) prevent transmission of AIDS by encouraging these providers to teach prevention to their patients. The program targets training interventions to primary care physicians, nurses, social workers, dentists and dental hygienists, infection control practitioners and other allied health workers. The specific objectives of the program are to:

- Determine the region specific and state specific educational needs of the targeted professions;
- Develop educational program strategies and content for targeted health professionals based on an analysis of training needs and resource availability;
- Schedule and deliver educational workshops, faculty development training, problem solving conferences, and self-instructional programs (televised and independent study) yearly in each state;
- Establish and maintain a regional information and education resource center;
- Design and implement an evaluation mechanism that assesses the quality and effectiveness of the Center-sponsored education programs and information services.

The first eighteen months of the program were primarily spent establishing an administrative structure, conducting an extensive needs assessment, developing curricula, training ETC faculty and establishing resource/communication centers. More recently, training activity has increased in communities around the region through the efforts of discipline-specific program committees of the ETC and in the health professions schools through the efforts of the university based ETC faculty.

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The pattern of HIV in the Region approximates the national pattern with most cases concentrated in large urban areas, primarily New Orleans, with a gradual dissemination to smaller urban and rural communities. About 65% of HIV cases have occurred in metropolitan New Orleans and even more receive their care there. AIDS incidence per 100,000 population in Louisiana during 1989 was 10.3; fifteenth highest in the country. The incidence rates for Mississippi and Arkansas were relatively low at 5.6 and 2.9 respectively, although it is a gradually increasing problem.

B. Organizational Background

Health care education in Louisiana is largely accomplished through the LSU and Tulane systems. The LSU system includes medical schools in New Orleans and Shreveport, and schools of Nursing, Dentistry and Allied Health Professions. LSU and Tulane have a history of cooperation in the areas of health care delivery and research. The state's public system of Charity Hospitals is staffed by faculty and residents of all three medical schools.

Charity Hospital at New Orleans serves as the clinical center of both the LSU and the Tulane AIDS programs. An outpatient clinic specializing in the care of HIV infection opened at Charity Hospital in 1987 and is the site of an AIDS Treatment and Evaluation Unit. It is the major HIV disease referral center for the region with 1,200 currently active cases. The program also includes a 'Continuity Clinic" with case management offered through the New Orleans AIDS Project. The New Orleans AIDS Project was formed by a consortium of community groups, including the New Orleans AIDS Task Force, Project Lazarus, Upjohn Health Care Services, Hotel Dieu Hospice, and Desire Narcotics Rehabilitation Center, and receives funding from the Robert Wood Johnson Foundation.

The University of Mississippi is the only medical school in the state and the major referral center. Except for a residential house for AIDS patients in Jackson sponsored by the Mississippi Gay Alliance, an organized system of care for HIV infected patients did not exist in Mississippi at the time the AIDS ETC was funded. Most of the care was being provided through hospital based internists with consulting back-up from the nine infectious disease specialists in the state.

In Arkansas, the Division of Adolescent Medicine of the University of Arkansas Medical Center, in cooperation with the Arkansas Department of Health, coordinates the training efforts of the ETC. The Arkansas Department of Health has offered the three day CDC HIV counseling course and has funded public or professional training efforts through the Arkansas AIDS Association, the Arkansas Medical Society and the University's Division of Adolescent Medicine.

C. ETC Origin and Development

The Delta Region AIDS ETC originated primarily from within the already existing affiliations and relationships of the AIDS program of Charity Hospital at New Orleans. The key program faculty were instrumental in coalescing their colleagues in the region around the grant. Linkages outside this network appear to have materialized very gradually throughout the first eighteen months of the program. Subcontracts that were initially proposed with the City of New Orleans Health Department and the New Orleans AIDS Project were not implemented, although individual consultants from these organizations have been drawn upon. The subcontract with the University of Mississippi was not executed until the beginning of 1988.

The key faculty of the Delta ETC were essentially starting from scratch in developing the training program, because there was very little pre-existing HIV training for health professionals in the region on which to build. The only exceptions were the independent activities of the individual faculty members in their roles as academicians, state health department trainings for public health nurses, and an initiative in 1987 of the NASW chapters in the area to conduct focused trainings for their membership.

The establishment of the administrative/resource center at Charity Hospital and recruitment of staff are considered significant achievements of the program. Contracting issues that arose within and between institutions during center development have provided this perspective and are considered as "learning experiences". Development of the Delta Region ETC from the formative committee phase to an operational organization appears to have been a formal and calculated process, but not without some conceptual difficulties.. The organizational development process of the ETC also seems to have contributed to a relatively slow programmatic development. This situation has not gone unrecognized by the ETC. The staff are currently re-evaluating the programs structural relationships and procedures for the purpose of enhancing effectiveness of program implementation.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

The Delta Region AIDS ETC is administered by the LSU Medical School in New Orleans in collaboration with Tulane University. The program is considered as essentially a joint venture between the two institutions with each sharing equal responsibility. The project director and associate director are from LSU and Tulane respectively. State directors for the ETC in Arkansas, Mississippi and North Louisiana have also been identified from the faculty of each of the respective medical schools.

Profession specific volunteer Program Committees have been formed for medicine, nursing, social work, dental and infection control/allied health, These committees are described as the "driving force" for the ETC and have taken the lead in developing curriculum, planning programs and budgeting resources. The primary collaborating organizations are strongly represented in the makeup of the Program Committees, especially LSU and Tulane, although

there are individuals from other organizations and institutions in the three-state region included as well. Depending on the committee, the Program Committees may operate as regional committees or as essentially three separate state committees with infrequent communication and resource sharing.

In addition to the program committees, central resource centers for each state have been established at each of the major participating institutions. In addition to the administrative/resource center at New Orleans, a resource center has been established at LSU-Shreveport for the northwestern part Louisiana, although it has not been very active to date.

Initially, an advisory committee was to be formed to provide general program oversight, however it has been determined that this body would be redundant to the Program Committees and Executive Committee. An Executive Committee is responsible for overall ETC policy, development and direction. The Executive Committee is composed of the Project Directors, State Directors, Program Directors, Evaluation Director and the full time ETC staff. The members of the committee based in New Orleans meet regularly, while the full committee is expected to meet at least annually.

B. **Staffing**

Robert L. Marier, MD, served as the first Project Director for the Delta Region AIDS ETC until May 1, 1990. He will continue to be closely associated with the ETC in an advisory capacity in the future. He is Professor of Medicine and Assistant Dean for Charity Hospital at LSU School of Medicine. In addition he is Chairman of the AIDS committee and Medical Director of Charity Hospital.

William Brandon, MD, the current Project Director, has recently relocated to New Orleans from Pennsylvania. As Project Director, he is responsible for the administration of the grant and serves as chairman of the executive committee. Dr. Brandon will be working 40% time on the grant. He is also involved with the HRSA AIDS Demonstration Program and the clinical trial unit at Charity Hospital.

Elizabeth Bennett, Ed.D., serves as the Associate Project Director. Dr. Bennett is Associate Professor and Head of the MCH Section of Tulane University, School of Public Health. She is filling the role for Dr. Erma Manancourt who is on a one year leave of absence. Dr. Manancourt was instrumental in planning and conducting the ETC's initial needs assessment.

Ann Fitzgerald, MPH, Education Director, is responsible for the development of the training center's curriculum and educational materials. She is also responsible for training project staff in educational techniques. Ms. Fitzgerald is also the project coordinator for the HIV/AIDS training conducted with ETC curricula in community health centers. This component of the program is funded under a different grant.

Michael Pejsach, Ed.D., is the Evaluation Director. Dr. Pejsach is an Assistant Professor in the Health Communication and Education Department at

the Tulane University School of Public Health. He is responsible for the monitoring and evaluation of the Delta Region ETC programs.

Gwen Foxworth, RN, MSN, is a the Clinical Program Manager. Ms. Foxworth has recently joined the staff of the Delta Region AIDS ETC. This position is an evolving position which will initially provide research on clinical issues for updating the curriculum of the ETC. Additionally, Ms. Foxworth will provide an outreach to various communities for course offerings and recruiting faculty from various communities.

Administrative staff for the Delta Region ETC include Bart Reilly as Project Manager (Administrative), Ann Musselman as Information Coordinator, David McCain as Communications Administrative Assistant and Missy Massey as Business Coordinator. Part or full-time administrative coordinators are also based at Tulane, Shreveport, Jackson and Little Rock.

The ETC Program Directors are: Gay Lynn Bond, MSW. Pronram Director of Social Work; Joel1 Bowab. MT (ASCP) CIC. Program Director for Infection Control; George Risi, MD; Program Director for Medicine; Penelope Dralle, PhD, Program Director for Mental Health; Elizabeth Humphrey, RN, EdD, Program Director for Nursing; and John Ritchie, DDS, MEd, Program Director for Dentistry.

State/Area Coordinators are: Stanley Chapman, MD, Associate Professor of Medicine and Chief of the Division of Infectious Disease, University of Mississippi School of Medicine; Robert Bradsher, MD, Associate Professor of Medicine and Chief of the Section of Infectious Disease, University of Arkansas School of Medical Sciences; Pattie Van Hook, MD, Associate Professor (Family Medicine) LSU School of Medicine in Shreveport.

C. Approaches to Collaboration, Integration and Regionalization

An administrative center for the AIDS Education and Training Center was established at Charity Hospital. This space is also shared with the administrative staffs of the AIDS Service and Demonstration Grant supported by RWJ and HRSA and of the AIDS Clinical Trial Unit.

The ETC Project Staff and Program Committees work with community groups such as the New Orleans AIDS Task Force, New Orleans AIDS Project, Metropolitan AIDS Advisory Committee, Northwest Louisiana AIDS Task Force, and the Arkansas AIDS Foundation to coordinate activities and co-sponsor events. The ETC has also co-sponsored program offerings with the AHECs in Louisiana and Arkansas. A major collaborative effort was the national conference for primary care physicians held in conjunction with the Ochsner Clinic and the Louisiana Association of Family Physicians.

In addition to having sponsoring institutions based in New Orleans, Shreveport, Jackson and Little Rock, the ETC's strategy for regionalization has emphasized development and involvement of faculty from across the region. Each Program Committee has tri-state representation comprised primarily of individuals from the participating organizations, although the large majority

of participants are from LSU and Tulane. The ETC has also supported grant applications to develop HIV programs by other organizations in the region.

D. Organizational Qualities

The Executive Committee provides overall direction to ETC activities and the large administrative staff provide resource, information and administrative support for programs at the request of program committee members and faculty. The primary structure or "the heart of the ETC" is the Program Planning Committees. The Program Directors, working with their committees have been involved in curriculum development, program planning, and event planning and implementation and evaluation, including marketing and recruitment of trainees. The reliance on program committees is purposeful and intended to promote institutionalization of training capability within the region. The Program Committee members have been fairly constant in the first few years, although a sub-sample of the most active "core faculty" has been informally identified,

One issue that has arisen for the ETC is the reliance on individuals who are already heavily involved in multiple activities and programs related to AIDS, including both volunteer members of the program committees and the professional members of the ETC staff. On one hand, the intertwining of various programs and individuals has had a synergistic affect on training activity and communication in the region. However, a consequence of this situation is also the potential for a high level of exhaustion and staff turnover. As with a number of the other ETCs, making time for ETC activities among the many competing activities of the ETC staff has been identified as a barrier to ETC success.

Another organizational issue faced by the Delta Region ETC is the need to clarify the roles, responsibilities and lines of communication between the program committees, the state resource centers, and the central ETC site and staff in New Orleans. Currently, coordination between the various Planning Committees for program development and delivery and the guidelines or expectations for the activities of each Committee have been somewhat ad hoc. ETC planning and resource support decisions have been intermingled within a duality of the Regional-State line of organization and the Executive Committee-Program Planning Committee line of organization. In some cases, the roles of the resource centers have not been well communicated or well developed, while in other cases a similar situation exists for the program planning committee in a particular state. The lack of specificity in the organizational structure has, at times, fueled historical friction in institutional identities adopted by individuals, such as the rivalry that exists between LSU and Tulane, and between New Orleans and Shreveport. This is incidental to the ETC, however, and is not expected to present a problem once roles are clarified and lines of communication are improved.

Recognizing these organizational issues, the ETC has taken a number of corrective actions. First, the ETC has added Ms. Foxworth to the staff for the expressed purpose of providing consistent and proactive support to the training activities of the ETC faculty. This change has been made in the attempt to maintain the practice of using individuals that serve as role

models within their disciplines as trainers, while reducing the time demands placed on these individuals. The latter is also to be accomplished by steps the ETC has taken to more clearly communicate and facilitate the specific resource and functional supports that the ETC can provide for training events through the planning, implementation and evaluation stages. Finally, the ETC is going through a new phase of strategic planning as a result of some significant staff changes, including Dr. Brandon as the new director. During this period, the roles and functions of the various components of the ETC will be reviewed and updated. Organization-wide planning meetings are being held to clarify activities, objectives and relationships for each of the participating institutions.

IV. EDUCATION AND TRAINING PROGRAM

The Delta Region ETC has set forth a structural process for program development. The guidelines utilized in implementing the Delta Region's education and training program are as follows: 1) Identify and assess the training needs and resources in the region; 2) Identify and train faculty for curriculum development and implementation, pretesting content materials and delivery strategies; 3) Support local programs on a long term basis; and, 4) Include all participants, providers, educators in the decision making process.

A. Needs Assessment Activities

The first major activity of the Delta Region AIDS ETC was to conduct an extensive assessment of training needs in the region. A written survey provided an overview of general areas of concern to health professionals in the region. The names of over 3000 health professionals were randomly selected from the state licensing boards throughout the three state region of Arkansas, Louisiana and Mississippi. The survey contained a multidisciplinary section which assessed the knowledge, attitudes and skills of the practitioners; six profession specific sections addressed the knowledge, attitude and practice issues for that group.

The results of the survey provided information for a discussion guide for focus groups. These focus groups consisted of health care practitioners who work with minority populations and substance abuse counselors. Key informant interviews were also conducted with fifteen practitioners who are involved in HIV activities outside of the metropolitan New Orleans area.

The ETC is currently performing a survey of nursing schools in Louisiana regarding curriculum on HIV to assess needs for assistance in curriculum development. The ETC site in Mississippi is also conducting their own focused training needs assessment for practicing nurses in the state.

B. Training Activities

1. Curricula and Materials

The Delta Region AIDS ETC used significant development time in the production of a multidisciplinary curriculum and profession specific curricula based on the information from the needs assessment process and a review of existing curricula. The process of curricula development for each topic included the following steps: development of the basic technical elements by individuals with training and expertise in the area; editorial review; review by educators for clarity and correct grammar; determining relevance to target training groups; and evaluation and feedback. The discipline specific curricula have been developed for medicine and social work. The infection control committee started to develop a curriculum, but then decided that a "consulting package" of materials, handouts and administrative instructions would be more beneficial to the faculty in the region. The discipline-specific curriculum for Nursing was yet to be completed at the time of the site visit.

Beginning with the second project year the center had planned to produce and sponsor at least two televised AIDS education programs on Cable community access channels in each state and publish, publicize and disseminate self-instructional AIDS Education Kits. The ETC has put together a version of a self-instructional kit, although this has not received priority and has not been disseminated. The ETC also proposed audio visual interventions using recordings of selected workshops, case conferences, ETC promotional pieces and other AV materials and instructional manuals for self or group instruction. Through local cable community access stations these programs were to be provided at least once a year. The ETC had not acted on this idea at the time of the site visit.

The Arkansas ETC has produced a video of a panel of people with AIDS discussing the impact of HIV/AIDS on their lives. This video is utilized by trainers in other course offerings.

2. Training Activities, Objectives and Methods

o Faculty Development/Train-the-Trainers

The ETC-developed curricula was presented to selected ETC faculty in a two-day train-the-trainer format. Identification and recruitment of the health care professionals selected as ETC faculty or speakers were based on the following criteria:

- Availability and commitment to serve as speaker on a volunteer basis;
- Previous experience in training or education;
- Demonstrated sensitivity to the AIDS/HIV issues;
- Willingness to travel;

- Professional degree;
- Experience with and/or commitment to underserved populations;
- Current experience with PWAs and related social systems; and
- Agreement to follow ETC training/educational guidelines.

The faculty development workshops were intended to ensure a cadre of trained trainers throughout the region to implement the ETC curricula. This is consistent with the ETC goal of decentralized education. Faculty Development Workshops have been held in New Orleans, Jackson, Little Rock and Shreveport. The faculty then customize the developed curricula to their own needs and to the specific training intervention and target audience.

In Arkansas, a state-wide faculty development training was conducted for 30 multidisciplinary participants who were also trained on the-use of the ETC curricula.

o Profession-Specific and Multidisciplinary Training

The Delta Region AIDS Education and Training Center used a phasing in process in developing profession-specific course modules. Although it was delayed by several months, the following schedule was originally proposed: Year 01 was to address Physicians, Dentists, Nurses,and Infection Control Professionals; Year 02 was to address Allied Health Personnel, Social Workers and Public and Mental Health Workers. Within each discipline, the ETC also considers that there are two target groups; those requiring "AIDS 101" and those needing more advanced knowledge and skills training. The education and training modules are structured to include one or more of the following: written handouts/manuals, audio and videotapes and other visual aids. These modules can then be delivered in lecture presentations, televised formats, computer assisted mediated instruction,, self-instructional courses and intensive one-day workshops. The bulk of this training is being done by the faculty, often members of the Program Committee; many are volunteers. Most of the faculty have attended an ETC faculty development workshop.

The Delta Region AIDS ETC has also conducted regionwide AIDS Clinical Skills Workshops. These training activities are multidisciplinary workshops. The first series of ETC multidisciplinary problem-solving workshops began in November of 1988 in collaboration with the Metropolitan New Orleans Infectious Diseases Group. The workshops are in a grand rounds format and are held monthly for two hours and attended by a wide variety of providers identified through professional and hospital associations. The focus of the developed modules for these Clinical Skills Workshops addressed the base line knowledge, skills and attitudes that are relevant to understanding the HIV infected patient regardless of the professional affiliation.

The Dental curriculum has been developed and implemented through faculty of the Dental School. The five modules are implemented in two day train-the-

trainer workshops. The faculty work through the professional societies in each state to organize the faculty development workshops. This association with the professional organizations helps to overcome one identified barrier, lack of interest in low prevalence states.

In addition, the Mississippi ETC holds annual, one-day, multi-disciplinary updates. The Mississippi site has also introduced continuing education programs for physicians in the form of a series of grand rounds. Trainings for social workers in Mississippi are being conducted, essentially independently of the Mississippi site, by the Social Work Program Committee in the state.

o Training Activities with Partial ETC Support

In addition to training programs planned and presented directly by the ETC, the Delta Region AIDS ETC also provides resource and logistic support to other organizations wishing to sponsor programs. The policy as determined by the Executive Committee is that the ETC will recognize a program as an ETC sponsored program when the workshop is designed specifically for health care workers and the course is evaluated using the tools designed by the ETC Evaluator.

o Education and Training for Community and Migrant Health Center Staff

The Delta Region AIDS ETC has been funded by HRSA to provide training for Community and Migrant Health Clinics. The objectives of this component of the program are to extend training and support services to C/MHCs and to facilitate collaboration with existing organizations and facilities on behalf of C/MHCs. The Delta ETC has formed a Southern AIDS Education and Training Network for C/MHCs in conjunction with Texas and Oklahoma ETC and the Emory AIDS Network. The ETC is modifying its curricula to address issues of public health, rural health, and the medically underserved and is producing a newsletter for the C/MHC network in the south. Through the C/MHCs, the project is attempting to form Prevention Task Forces including community representatives.

The Arkansas ETC has worked with the state AHEC, the state medical society, Arkansas State Department of Health, AIDS Interfaith Network and the community health centers to conduct training interventions in the state.

The Mississippi site is also involved in providing training to C/MHCs through the supplemental grant. A two-day conference on counseling and testing was held for about 20 participants from health centers as this was identified as a critical need.

o Initiatives Impacting Health Professions Education

Medical students at LSU have a variety of learning experiences on HIV disease, many with Dr. Risi. Starting in the sophomore year, four hours are included in introductory clinical medicine to prepare students for their first encounter with an AIDS patient including presentations on infection control, lessons and inherent biases in AIDS care, and discussion with a PWA. In the Junior year, a more structured approach for patient care and

management, including history taking, is included in the medical block. In the senior year, there is an optional ID rotation.

At the University of Mississippi, a six lecture series for third year medical students and ongoing lectures for pharmacy, nursing and allied health (OT/PT) students has been introduced.

C. Efforts to Reach Minorities

One of the program objectives as initially proposed was to "recruit minority providers into the ETC program". This was dropped as a specified objective in the first program year when the ETC modified its list of five objectives to include "program development ". The ETC planned to recruit training participants from and maintain ongoing communication with minority professional associations such as the National Association of Black Nurses and the National Association of Black Social Workers. The ETC similarly planned to recruit from minority institutions such as Jackson State University in Mississippi, Southern University, Grambling College, and Dillard University in Louisiana.

Although contacts have been made, the ETC has met with varying degrees of success in reaching out to and including minority communities in the program. The response from minority providers, schools and individuals to ETC efforts for trainee recruitment or program co-sponsorship was described as lukewarm to resistant. Some of the reasons for this are thought to be the academic base of the ETC and the perception in the Delta region that AIDS is still a gay, white disease.

Representatives from public health departments and community health agencies were included as key informants in the initial needs assessment. Approximately 15% of the ETC's training program participants to date have been minorities and about 40% serve a significant population of minorities in their practices. The ETC has organizationally responded to minority recruitment with the addition of Gwen Foxworth as the Clinical Program Manager who will outreach into minority communities for faculty as well as for course offerings.

D. Training Issues and Successes

The Delta Region AIDS ETC spent a substantial amount of development time in conducting the needs assessment and designing the curriculum for the. project courses. The needs assessment conducted by the ETC was ambitious and comprehensive. It provided a baseline for informing and targeting program development.

On their own initiative, the Delta Region ETC contacted other ETCs to inquire about sharing available curricula and materials. In particular, material provided by the WAMI program and the Mountain Plains ETC were found useful and incorporated by the Delta Region ETC, thus avoiding unnecessary duplication of effort.

A very systematic approach was initially employed toward program development. However, this approach was also time consuming and was eventually overtaken by the competing need to produce trainings and trainees. This in turn impacted on the strategic and administrative coordination of some aspects of the ETC's program during the second year. However, entering into the third year, this somewhat fragmented situation is being addressed as the different parts of the program are being pulled together.

The ETC has also relied on dedicated volunteers to staff program planning committees and implement course offerings. Some of the program committee members have flourished under this arrangement, while others have been frustrated. The ETC directors are aware of the need for increasing the level of support and considering the need to add trained faculty on staff so that more health care providers can be trained on HIV/AIDS with the developed curricula.

Another training issue is the recognized need to develop a clinical training experience. Although Charity Hospital is a major AIDS referral center, the HIV clinic has not been used as a training site for community physicians to date. However, a short preceptorship that would be open to interested physicians throughout the region is in the planning phases. Initially, a preceptorship is being established by the Delta Region AIDS ETC for Emergency Room Residents. These physicians will complete a one month rotation through the inpatient and outpatient AIDS units of Charity Hospital. This program is intended to serve as a pilot program for other rotations for physicians of multiple disciplines.

The initial faculty development workshop concentrated on imparting adult learning theory and skills. The ETC learned that it was important to include a good deal of information for their faculty as well. It was also determined to conduct thematic conferences for faculty development such as Sexual History Taking. This type of intervention was needed throughout the region and was attended by practitioners from all disciplines.

As with many training programs, the Delta ETC has had some difficulty in attracting physicians to their course offerings. The program has learned that generally physicians will not attend unless there are physicians on the faculty. One major success on this score was the national conference for Primary Care Providers which was well attended by physicians. The ETC program hopes to make this an annual event and the premier conference on HIV for primary care practitioners.

One indicator of success in Louisiana is the fact that the number of physicians listed in the Health Department referral resource file as willing to accept HIV referrals has increased from 12 to over 100 since the ETC began operations.

V. PROGRAM ADMINISTRATION

A. Systems for Managing Training Events/Programs

The ETC's discipline specific Program Planning Committees are primarily responsible for planning training programs in their respective areas as has been described. Each committee has been allotted $10,000 to support their offerings. The ETC also responds to requests for events or support. Such requests usually come from their faculty and only infrequently from health care facilities and organizations outside the ETC structure. Contacts for training in social work, for example, have come from individual contacts of the program committee volunteers.

A form has been drafted for event planning and development procedures. Regional sites are responsible for collecting initial informationpertaining to request for education events including type and title of activity, time and location, size and background of the audience, the kind of support required and whether participants would like to receive continuing education credits. All such requests are to be cleared by the state program coordinators and forwarded to the regional Center in New Orleans. The central ETC office provides support for production of presentation materials such as slides and overheads.

The ETC produces and distributes a monthly newsletter for "faculty" (defined broadly to include individuals on ETC program planning committees, people who have gone through the Faculty Development workshops, and others. The newsletter includes variously a calendar of upcoming events, summaries of past workshops, listings of resource materials available at the center and pertinent administrative issues.

The ETC did not maintain a database on trainees throughout the region until it was requested to do so by HRSA. File folders for each individual event were centrally maintained.

The ETC has not formulated a specific marketing strategy to date, although the ETC is considering distributing a newsletter following on the format of the faculty notes, but reaching a larger audience. Part of the low key marketing approach is by design, because the program is attempting to be decentralized; part is because formal program marketing has not been perceived as a priority. Reliance on the contacts of ETC faculty in each state is the primary mode of event marketing and participant recruitment. The ETC does sponsor exhibits at professional association meetings and is planning development of a promotional brochure with inserts. The marketing for the primary care physicians conference was performed by Ochsner.

B. Cost Sharing

Whether or not participant fees are charged varies by program and by program committee. In general, there are no participant fees except for some of the more substantial conferences and updates to cover break costs. The infection control committee also invites and charges trade exhibitors to some of its offerings.

As described, the Delta Region AIDS ETC has also been funded to provide training for Community and Migrant Health Clinics. These supplemental funds were awarded to the ETC in collaboration with the Texas and Oklahoma ETC and the Emory AIDS Network. Funding began October 1, 1989. The Delta Region AIDS ETC has also recently applied for training funds from the National Institute of Mental Health.

The LSU School of Medicine has made funds available for equipment and travel. LSU and Tulane through Charity Hospital have provided space for the administrative offices.

C. CEUs

The ETC offers CMEs and CEUs from LSU, Tulane, the University of Mississippi, and the University of Arkansas as applicable. The program will assist participants to secure continuing education credits from other institutions in the region. The responsibility for arranging for CEUs for specific programs is on the program committees.

D. Library/Information Services

One of the primary objectives of the Delta Region AIDS ETC was to establish a regional information and education resource center(s). A Resource Center has been established at the central office in New Orleans with computer links to the satellite resource centers to be established at Shreveport, Jackson, and Little Rock. A computerized bulletin board offering information on AIDS was to be available to system users and ETC faculty via modem. However, this is not currently operational due to system difficulties. The database includes: case conferences for physicians, dentists, social workers, nurses, and infection control personnel; the ETC Calendar of events; ATEU protocols; bibliography of educational materials; current AIDS Statistics; and names and telephone numbers of key people and programs. A reading and computer access area has been established at the central office and is available in the afternoons to ETC faculty. Audio visual equipment has been purchased and a resource assessment tool has been developed to identify useful non-print resources.

The central ETC office will also perform information and resource searches. Upon request, computerized and manual searches can be initiated to identify print and nonprint materials that address general and technical aspects of prevention and treatment.

The Delta Region AIDS ETC has developed a linkage with the University of Texas ETC for developing a helpline. This helpline was originally developed for the Texas ETC and will be housed in Texas. There will be an 800 number established as part of this linkage in the Delta region with expected start-up in the Fall of 1990. The helpline was created to provide technical assistance to providers in four ways: answer basic questions by mailing developed literature packets to all callers; answer quick questions; conduct literature searches for customized requests; and provide consultant referrals as well as the names of trained faculty of the Delta Region AIDS ETC. The helpline is

intended for the spectrum of health professionals in the Delta region. All calls will be logged and there will be a follow up to evaluate if needs were met. The ETC will reimburse consultants that are called upon.

In addition to the resource services of the regional ETC, the Mississippi site has established a resource center. The resource center has been advertised through the State Health Department newsletter, but has been used mostly by residents to date. The Mississippi site has received and adapted the various curricula developed in New Orleans and they have also supplemented it with their own training materials. A significant amount of the site's activity occurs through contacts made by Dr. Chapman through his role in providing ID consults. He feels that an important factor in program success is identifying an interested individual to be the resource person and training facilitator for a community or area of the state.

VI. SUMMARY AND FUTURE PLANS

As is characteristic of many ETCs, the Delta Region ETC is staffed by many dedicated and hard working health professionals. Through the efforts of these individuals, the ETC has developed excellent curricula and materials for both multi-disciplinary and discipline specific training. In addition, a significant amount of training and information resources have been made available to other health professionals throughout the region by the ETC.

The ETC is currently trying to balance its roie as a central regional program, while maintaining decentralized responsiveness to local and state needs and pre-existing relationships. It is also trying to reconcile the dual lines of communication that exist in the state resource center versus program committee structure. The ETC has attempted to not be directional or controlling as a training program, but instead to assume a networking and facilitating role. However, the ETC is also realizing that, in some cases, faculty require more explicit direction and support and that a central training plan and timetable are required to meet overall program objectives. The program is also attempting to reconcile the various responsibilities and occasionally competing relationships of the many large institutional entities involved in the program.

In the future, the ETC hopes to increase the roles of the Arkansas and Mississippi sites as resource centers to program committee faculty in their respective states. It also expects to clarify the role and relationships of the ETC in support of its faculty and increase the specificity of procedures for training event planning and monitoring. The ETC hopes to increase marketing activities for programs, while maintaining a balance with its decentralized identity. The ETC also expects to work on improving the evaluation loop to provide immediate feedback to program directors for program and faculty improvement.

Activities for the immediate future of the ETC include assimilation of recent staff changes and consolidation of their impact on the organizational structure and operations. Two major activities for the near future are development of a clinical preceptorship for physicians at Charity Hospital and implementation and marketing of the helpline.

The ETC intends to begin co-sponsoring training programs with the AHECs in Arkansas and Louisiana. The ETC hopes to repeat its success with the conference for Primary Care Physicians by making it an annual event that will draw participants and speakers from around the country. The ETC also expects to expand its efforts with the C/MHC programs in recognition of the high risk population served by these centers.

East Central AIDS Education and Training Center

Case Study

CASE STUDY

EAST CENTRAL AIDS EDUCATION AND TRAINING CENTER (ECAETC)

I. Program Overview

The East Central AIDS Education and Training Center (ECAETC) is a collaborative effort among public and academic institutions in Ohio, Kentucky, Michigan, and Tennessee. The ECAETC program in this four-state region draws upon expertise and resources available at each of its primary participating institutions: the Ohio State University; the University of Kentucky; Meharry Medical College; the University of Michigan; and, the Cincinnati Board of Health. Through the Cincinnati Board of Health and the Meharry Medical College in particular, the resources of other institutions have been brought under the ECAETC umbrella as well. Programmatically, ECAETC maintains a dual focus, both on materials development as well as on informational, educational and training activities.

The ECAETC program is intended to assure baseline knowledge and affect relevant attitudes among health care workers. Primary care physicians, dentists, nurses, allied health professionals, physician assistants, clinical counselors, as well as first responders comprise the target trainee groups. Training aimed at enhancing baseline knowledge has been formalized into a core interdisciplinary curriculum. In addition, profession-specific materials and' curricula have been developed and are geared towards identified health professional groups. The training opportunities are offered through a variety of modalities: teleconferences, presentations, one-day and two-day training workshops, large conferences, and self instruction via Computer Assisted Instruction (CAI). The project organization and workplan call for independent as well as cooperative efforts on materials development and the provision of educational activities with a recognition of specific areas of expertise within each of the individual sites.

A. Cooperating Groups and Agencies

ECAETC's primary mechanism for providing training is through co-sponsorship of programs with a variety of outside organizations--health care providers, professional organizations, and AIDS-interest groups. Thus, dozens of cooperative relationships have been formed.

The Tennessee site represents a major contact point for more formal cooperation between ECAETC and other agencies. Structurally, the Tennessee site is located in the AHEC Program of Tennessee, a program of Meharry Medical College. On the level of program implementation, the site works with a coalition of Tennessee state and academic institutions and programs. In the development of its products, the Tennessee site has involved additional organizations such as Nashville CARES.

Other participating sites, particularly Ohio State, have reached deep into their organizations to draw on resources not directly under the rubric of ECAETC. Many additional resources have been made accessible to the ETC through the Cincinnati Health Department's subcontract with the University of Cincinnati. The Kentucky site is in the process of developing a close working relationship with the six local **AHECs** in that state, particularly those associated with the University of Kentucky. The Kentucky AHEC program is a relatively new program but is quite active.

Through its advisory committee structure, ECAETC has established cooperative relationships with a variety of regional and national organizations. The Criteria/Assessment Advisory Committee is essentially a regionally-based group and expands the range of agencies cooperating with ECAETC to include:

- Kentucky Department for Health Services
- Columbus City Health Department
- STD Center of the Cincinnati Health Department
- Office of Substance Abuse, Lansing, MI.
- Alternative Lifestyles - Cleveland OH
- AIDS Psychobiology Program, Ann Arbor, MI
- Huxworth Blood Center, Cincinnati
- AIDS Project, Detroit, MI

The Professional Liaison Committee is intended to offer a national perspective in development of the ECAETC and in dissemination of experiences of ECAETC. This committee is composed of representatives from:

- American Medical Association
- American Academy of Family Physicians
- American Nurses Association
- American Dental Association
- American Society of Allied Health Professions
- Association for Clinical Pastoral Education
- National Association of Community Health Centers
- National Hospice Association
- American Osteopathic Association
- National Association of Social Work
- National AIDS Network
- American Public Health Association

B. Program Goals and Objectives

Central to the direction, management and evaluation of the project is a comprehensive set of goals and objectives which cascade down from broad to specific in typical Management by Objectives (MBO) format--"Project Goals" to "Major Project Objectives" to "Specific Measurable Objectives"--the last level providing guidelines and time frames for accomplishment. The entire goals/objectives framework is written in functional terms which establish the way in which the program is to unfold rather than delineate outcomes of the individual programs. The goals and objectives fall into five functional categories: the organizational function; the materials development function, the education and training function, the information

collection and dissemination function, and undergraduate/graduate curriculum development and infusion function. The goals and major program objectives are listed in Appendix I. The goals and objectives statement was prepared during the planning phase and covers all three years of the project period.

II. Program History

A. Origin and Developmental Hilestones

The original grant application was described as being the result of a "Herculean effort" on the part of those at the five cooperating institutions, many of which had originally viewed one another as competitors rather than as potential collaborators. At the bidders conference, the Ohio State University representative invited the regional "competition" to join with OSU. Subsequently, a formal meeting was held at Ohio State in June 1987 following the initial HRSA Technical Assistance Workshop in May 1987. Prior to this meeting, consideration and communication of the respective roles and relationships of each institution had already taken place. With approximately 25 persons in attendance representing each of the five sites, the planning of the project's purpose, goals, administrative structure and evaluation plan was initiated. One week later a second meeting was held at the Cincinnati Board of Health to review and critique progress on the respective developmental efforts. By the end of that week, each site had submitted a site-specific workplan and budget. These individual workplans were assimilated into the final application and formalized via Memoranda of Agreement.

The central development process was conducted democratically with each of the five sites holding one vote. Each site was responsible for arranging support in their own area and outlining the site specific workplan. Thus, each site had been encouraged to contribute their specific areas of expertise and the development of the regional program reflects the cumulative capabilities of the various collaborators.

B. Institutional Background

The Ohio State University, University of Kentucky, and University of Michigan each sustain broad involvement in undergraduate and graduate health professions education, bio-medical research and provision of health care to the residents of their respective states. Responsiveness to AIDS education and service delivery issues is clearly acknowledged as being within the scope of these areas of responsibility and activity. Furthermore, the Meharry Medical College, dedicated to education, training, and research to ameliorate problems associated with the health of minorities, had assumed a major role in the care of AIDS patients in the metropolitan Nashville area. The Cincinnati Board of Health has had a strong AIDS focus in the Sexually Transmitted Disease Center, had worked collaboratively with the University of Cincinnati Medical College on AIDS related workshop format for health professionals, and had been delivering regular AIDS updates to a wide variety of health professionals and community workers.

III. Program Structure

A. Geographic Target Area

ECAETC's service area includes the states of Ohio, Michigan, Kentucky, and Tennessee. Three sites--Kentucky, Michigan and Tennessee--are statewide in their orientation. In Ohio, the Cincinnati Board of Health in collaboration with the University of Cincinnati Medical School provides AIDS-related programs in metropolitan Cincinnati and surrounding areas and Ohio State provides programs in the remainder of the State.

The emphasis on telecommunications as a training medium allows a broad conceptualization of the geographic target area and the accessibility of training sites.

B. Institutional Roles and Relationships

The Ohio State University is the lead institution and the official location of ECAETC. While ECAETC is structurally affiliated with the Department of Family Medicine within the College of Medicine and the University Hospitals, it functions as an independent entity. Figure 1 shows ECAETC's position within the Ohio State University structure. Ohio State administers the project through contractual arrangements with the other four entities. The program activities of ECAETC are conducted through its five implementation sites. Each of the sites, including Ohio State, has a Site Director to conduct the business of the site. The Project Director, Co-Project Director and Evaluation Coordinator, all situated at Ohio State, manage the overall project in concert with the Site Directors. The overall Administrative Organizational Plan for the ECAETC is shown as Figure 2.

Each site, including both Ohio sites, is responsible for sponsoring 1-3 day training workshops of core interdisciplinary, profession specific or train-the-trainer nature. This is described more fully in the next section on training strategies. Each of the sites is also responsible within their States/areas for compiling information about resources and programs, responding to requests for information and technical assistance, and for fostering interagency linkages. Each of the universities in consortium with ECAETC have medical or health science libraries which help serve this function. In addition, each site has activities which are specific and unique to that site. Highlights of these activities are noted below.

1. Ohio State University

The Ohio State site, affiliated with the Department of Family Medicine within the College of Medicine and the University Hospitals is newly located at a separate research office facility on campus. Within the regional program, the site at Ohio State has primary responsibility for developing training programs suitable for the Ohio Medical Education Network and satellite teleconferencing and is developing Computer Assisted Instruction modules. The Ohio site is also taking responsibility for

developing profession-specific curricula and materials for primary care physicians, dentists, nurses, and allied health professionals.

2. The Cincinnati Board of Health and the University of Cincinnati

The Cincinnati site of ECAETC is housed jointly at the Cincinnati Health Department and at the Medical Center Information and Communications (MCIC), University of Cincinnati. Through the involvement of the Cincinnati Board of Health ECAETC has a direct link to a CDC sponsored Regional Training and Prevention Center on Sexually Transmitted Diseases (STD). ETC staff also provide linkage to the Greater Cincinnati Task Force on AIDS and the Northern Kentucky Task Force on AIDS. Furthermore, ECAETC is associated with a NIDA Training Program for Drug Abuse Counselors through Dr. Rucker in Cincinnati.

The Cincinnati Health Department in collaboration with the University of Cincinnati Medical Center, is responsible for identifying and disseminating updated information on AIDS/HIV. Regularly scheduled AIDS Update Training sessions are offered through the Board of Health to a variety of health professionals and outreach workers. The AIDS Update programs are beyond the "AIDS 101" offerings and now offer more specialized programs targeted to specific health care workers.

As part of the ECAETC program, The University of Cincinnati Medical Center maintains a database of selective, pertinent articles on a variety of clinical topics for distribution to physicians. In addition, the Board of Health has subcontracted with the University of Cincinnati to perform monthly computer searches to identify literature and other materials related to HIV. The University has been collecting, cataloging, and storing pertinent materials and has a well developed and sophisticated HIV/AIDS related library. Plans also call for the development of mechanisms for obtaining input and for sharing information with public health departments, community health centers, and the homosexual community. The facilities are well equipped to serve this function.

Regular issues of AIDS LINK, the ECAETC newsletter, are developed by the University of Cincinnati Medical Center. Collected abstracts and information are disseminated to ECAETC sites and other interested institutions and associations through this newsletter. The newsletter also lists information on seminars, symposia, in-service programs, and existing academic AIDS courses and programs in the region which have been identified by the ETC sites. The AIDS LINK mailing list is currently over 3,000.

3. University of Kentucky

The Kentucky site of ECAETC is housed at the University of Kentucky's Department of Allied Health Education and Research, College of Allied Health Professions. After Ohio State, the University of Kentucky has the largest role of the collaborating agencies of the ETC in terms of budget and responsibilities. The ECAETC staff at the University of Kentucky are directing the effort to identify, assess, annotate, and share information on AIDS training materials that already exist. In addition, the Kentucky

site has taken responsibility for EARN -- the ETC AIDS resource network to develop a listing and guide of ETC developed materials.

The Kentucky site is also responsible for developing all train-the-trainer materials for the project, drawing on its experience with the Teaching Improvement Project Systems (TIPS). Since 1975, the TIPS program has received a variety of federal and foundation funding to design, develop, and disseminate materials and workshops for train-the-trainer programs on such topics as health promotion and disease prevention, geriatric patient education, and health care management. Train-the-trainer materials are to be developed for the core interdisciplinary curriculum and for each of the profession-specific training modules.

Currently, the Kentucky site is focusing more strongly on training as well. Because the state of Kentucky has passed mandatory education requirements for health care professionals, the ETC site will be responding to requests for assistance in the design and delivery of training programs.

4. University of Michigan

The Michigan site of ECAETC is housed at the Office of Continuing Medical Education of the University of Michigan Medical School and Medical Center. Through the site director, Mr. Cliff Allo, ECAETC is associated with a NIDA Training Program for Drug Abuse Counselors. The major role of the University of Michigan in ECAETC relates to its expertise in continuing health sciences education as well as its ability to produce quality educational materials. Consequently, the first year efforts of this site were directed toward dissemination of continuing education.

The original project plans called for this site to develop two training packages. One was to be for remote community primary care providers and the other for tertiary care centers. However, it was found that the development of an EMT training module was more relevant to local needs and the site's experience. Thus, an EMT training module was added to the original statement of work for The University of Michigan and the University has already completed its development.

The Michigan site takes an active role in coordinating efforts among various programs within the state and specifically works with the Michigan AIDS education providers work group which includes three universities (two with NIMA grants) and which meets quarterly to identify needs and coordinate educational activities.

5. Meharry Medical College

The Tennessee site is housed at the AHEC Program Office of Meharry Medical College. During the first two years of the project, the Tennessee site was implemented through the ECAETC Tennessee Consortium consisting of the West Tennessee AHEC, Middle Tennessee AHEC, the AIDS Program of the Tennessee Department of Health and Environment, Tennessee State University School of Nursing, Vanderbilt University AIDS Project, and Meharry Medical College, Department of Family and Preventive Medicine. This consortium enabled the Tennessee site to develop strong relationships with various

agencies and institutions. Formal meetings of the consortium are no longer held but the Tennessee site continues to work closely with the various institutions. Members of the consortium and others from local communities conducted a needs assessment as a team effort with various professional organizations and are now organizing programs in various towns. The major agenda was to go beyond "AIDS 101" to impact a larger number of practitioners. Different member organizations take turns coordinating the effort and offering programs. In addition, cooperative working relationships with several Nashville based volunteer community AIDS service and advocacy organizations have also been noted.

Earlier in the first stages of ETC activities, Meharry Medical College through the AHEC was assigned responsibility for conducting the training needs assessments of primary care physicians and other health professionals in the ECAETC region. A formal needs assessment survey of health care providers, primarily from Tennessee, was completed.

The Meharry Medical College originally assumed responsibility for the development of the psychosocial segments of the core interdisciplinary training curricula. However, the responsibility for the development of the core curriculum, in its entirety, has shifted to the Kentucky site. Meharry has been designated as the lead organization for developing materials and trainings on minority issues and has reached providers within their area as well as nationally. The Tennessee site is currently developing programs to reach health care practitioners in rural practice through the EPPA program (Educating Practitioners About AIDS).

C. Staffing

Because the sites are a real functional part of the overall ETC, ECAETC project as well as ECAETC site staff are noted here. As one would expect in the development of a new program, changes in staff have taken place during the start up phase and over time.

1. Project Staff

Lawrence L. Gabel, Ph.D. - Project Director. Dr. Gabel currently directs the Graduate Education and Research Section of the Department of Family Medicine. Dr. Gabel is also a member of the Central Ohio Committee for Childhood Education on AIDS and the AIDS Advisory Group to the Medical Center. As Project Director, Dr. Gabel oversees planning and implementation of the project, recruits staff, consultants, and manages the budget . Dr. Gabel's organizational skills have been commended by site staff and he has assumed the major role of organization builder and maintainer.

Michael F. Para, M.D. - Co-Project Director. Dr. Para is a full-time Associate Professor at Ohio State with a primary appointment in the Division of Diseases where he is responsible for the AIDS/Infectious Diseases Clinic of University Hospitals. Dr. Para co-chairs the AIDS Advisory Group of the Medical Center and is a member of the Ohio State University AIDS Task Force as well as the Ohio Health Department AIDS Advisory Committee. His activities include chairing the Assessment

Advisory Committee and co-directing, planning, piloting, and implementing the AIDS curricular materials and model education and training programs. Dr. Para has given over 200 AIDS presentations. In 1986, he was awarded the Michael Greer Humanitarian Award by the Columbus gay community.

James Pearsol, M.Ed. - Center Director. Mr. Pearsol has served in several capacities within ECAETC. He currently functions as both the Center Director and the Director for the OSU site. Mr. Pearsol has served in the Division of Research and Evaluation in Medical Education of the Ohio State University College of Medicine. He is a candidate for a doctoral degree in evaluation from the University of Illinois.

Neil Smith, M.S. - Evaluation Coordinator. Mr. Smith currently serves as the evaluation coordinator. Mr. Aron served as the year two evaluation coordinator and Mr. Pearsol as the year one evaluator. The evaluation coordinator is charged with the design and implementation of an overall evaluation plan. In addition, he is to advise on changes in curriculum and model programs based on evaluation data. The evaluation coordinator reports to the project Director and to the Center Director, participates in all site director meetings and reports on evaluation activities.

2. Site Staff

a. Ohio State University

James Pearsol, M.Ed. - Site Director. Effective June, 1988, Mr. Pearsol replaced the original Site Director and assumed the role of Site Director for the ECAETC site at Ohio State. In this capacity, he is responsible for coordinating program administration and implementation to attain ECAETC goals and objectives in Ohio, excluding Cincinnati.

Educational Coordinator. This position, which had been held by Ms. Susan Farmer, is currently open and will be filled in September.

Professional Representatives from primary care medicine, Dr. Tennyson Williams, from nursing, Dr. Edna M. Menke, from dentistry, Dr. George G. Blozis and Dr. Joen Haring, and from allied health, Mr. George Manuselis develop and advise on profession-specific materials and trainings of the OSU site. Secretarial support is-also funded. The OSU site is supporting the cost of three project personnel at 15% time. These are, Mr. Ron Comer, the Director of the Division of Computer Services, Mr. Jan Hollet, the director of Continuing Medical Education, and Mr. Mark Springer, the Director of Biomedical Communications. In addition, representatives on the two advisory committees are reimbursed.

b. University of Kentucky

William Pfeifle, Ed.D. - Site Director. Dr. Pfeifle is an Associate Professor in the Department of Allied Health Education and Research and devotes 30% time to the project. As of September, 1990, Dr. Pfeifle will be the project P.I. for this site. Until now he has had primary responsibility for administration and implementation of the ETC activities at the Kentucky site. In addition, he is designated to serve as a master

trainer for train-the-trainer components of th site director will be assumed by Dr. Terry Collins as of September, 1990.

Betty Spohn - Curriculum Consultant. Ms. Spohn is the Director of the TIPS project at the University of Kentucky. As Co-Site Director during the start up phase, she had worked with Dr. Pfeifle on program administration and implementation. She reviews and approves all materials produced by Kentucky site staff and also serves as a master trainer.

Judy Stephenson - Site Coordinator. Ms. Stephenson, a full-time ECAETC staff member, is responsible for the day-to-day coordination of the site as well as coordination with external organizations, particularly the local AHECs, on AIDS training issues. In addition, she oversees the operation of the AIDS Resource Center at the Kentucky site. Ms. Stephenson has taken the lead in ETC information and resource activities on a national level.

Paula Parise and Ann Crowe serve as full time Curriculum Development Specialists. Ms. Parise is responsible for developing the two dental modules which comprise the dental curriculum, while Ms. Crowe is responsible for the development of the counseling curriculum.

Michael Howe - Information Specialist. Mr. Howe, a full time ECAETC staff member, is responsible for collecting, reviewing and cataloging AIDS educational materials and maintaining the AIDS Instructional Materials Database.

Professional representatives, Dr. Gary Levine and Dr. Kathleen Beine, physician representatives, Dr. Robert Calmes, dental representative, Mr. Ben Bogia, pastoral counselor representative, Mr. Glen Combs, physician assistant representative assist in the development and implementation of education programs as well as serving as ECAETC liaison with their respective professional communities. A full-time secretary supports the staff.

c. University of Michigan

R. Van Harrison, Ph.D. - Site Director. Dr. Harrison is the Director of the Office of Continuing Medical Education at the University of Michigan. As Site Director, at 10% time, he is responsible for the overall coordination, leadership and direction of the Michigan portion of the ECARTC.

Patricia Barr, B.S.- Site Coordinator. Ms. Barr is responsible for the day-to-day operation of the site.

The University of Michigan site is also scheduled to have two physician representatives to assist in the development and implementation of educational materials.

d. Tennessee /Meharry University

Judith N. Presley, M.S. - Site Director. Ms. Presley replaced Ms. Edwina Hamby in the second year of the project. Ms. Presley is the interim assistant director of the AHEC Program of Tennessee at Meharry Medical College and serves as the Statewide Research and Evaluation Associate with the AHEC program. In addition to her responsibilities of Site Director, Ms. Presley serves as the Evaluator for the site.

Victoria L. Harris, Ed.D. - Project Coordinator. Beginning in the second year of the project, Dr. Harris assumed the role of Project Coordinator. As such, she coordinates the training activities.- She is also on the faculty of Meharry Medical College.

In addition to the individuals listed above, the following individuals from the Tennessee coalition donate time to the project: Brock, MPH, Training/Education Representative from the Middle Tennessee AHEC, Glenn Davis, MD, Public Health/Professional Representative from the Tennessee Department of Health and Environment AIDS Program, Rupert Francis, MD, Physician Representative from the Meharry Medical College, Carolyn Mayo, PhD, Training/Education Representative from Meharry Medical College, Pat Sharpe, PhD, Nursing:Professional Representative from the Tennessee State University, and Lois Wagner, MSN, Nursing Professional Representative from Vanderbilt University. The site is also funded for a 40% time administrative assistant.

e. Cincinnati Board of Health and the University of Cincinnati

Ronn Rucker, Ed.D.- Site Director. Dr. Rucker serves as the Site Director for Cincinnati at 50% time. He is responsible for supervising all training and service activities related to AIDS within the-Cincinnati Health Department,including those of the ETC, and is also responsible for supervision of the counseling and health education staff of the AIDS Control Program. Dr. Rucker is currently directing a three year grant from the National Institute of Drug Abuse focused on AIDS and drug abuse. This activity (50% time) compliments the ECAETC work.

Evelyn Hess, M.D. - Co-Supervisor/Project Coordinator. Dr. Hess is the Director for the Division of Immunology at the University of Cincinnati and the clinical director of the Health Department's STD program. Dr. Hess is a founding member of the Greater Cincinnati Task Force on AIDS and is also a member of the Northern Kentucky Task Force on AIDS and the Ohio Department of Health's AIDS Advisory Committee. She serves as the clinical faculty liaison and supervisor to the Cincinnati site.

Rebecca Herrin, M.P.A. - AIDS Education Coordinator. Ms. Herrin is responsible for administrative tasks associated with the trainings and for preparation and distribution of the quarterly newsletter.

Mr. Roger Verny - Co-Supervisor/Project Coordinator. Mr. Verny is responsible for the overall information systems support at the University of Cincinnati Medical Center Information and Communications (MCIC).

In addition, the Cincinnati Health Department is also funded by the grant for a 50% time administrative assistant.

IV. Education and Training Program

A. Needs Assessment Procedures

The ECAETC plan calls for the conduct of four needs assessments variously addressing the AIDS training needs and concerns: of primary care physicians and other primary care health professionals; of organizations serving low-income and minority populations (e.g. public health departments and community health agencies); of providers of care to high-risk populations; and of academic institutions which train health care professionals.

1. Primary Care Providers

A formal project-wide assessment was conducted by the Tennessee site during the first year of the project. The assessment, conducted in written survey format, was designed to tap both training needs and demands:

- o Respondents perceptions of their needs for information;
- o Knowledge of symptoms, concomitant conditions;
- o Personal concerns and attitudes toward risks involved in treating AIDS patients;
- 0 Current practices;
- o Perceptions of the needs of their patients for information, reassurance and counseling;
- o Knowledge of referral sources; and,
- o Preferred learning modalities.

A pilot survey was conducted in Tennessee by a market research firm. Following this pilot, a sample of 12,200 individuals including physicians, dentists, nurses and other health care professions in Kentucky, Ohio, Michigan, and Tennessee was drawn; each of the ECAETC sites contributed the names of 1000 physicians to this sample. The surveys were mailed by and returned to the Tennessee site. (Additional surveys were sent to rural Tennessee physicians in order to obtain data for a paper to be delivered at a rural health conference.)

1,404 questionnaires were returned, yielding a response rate of 11.5 percent. The majority of the respondents, 78 percent, were from Tennessee. The skew in the response is thought to be due to lack of identification of Ohio, Kentucky and Michigan providers with a survey emanating from Tennessee. Of the respondents, about 35 percent of the respondents were dentists, 22 percent were physicians, 26 percent nurses, and 17 percent other health care professionals. Approximately one third of the respondents were from urban areas, just less than one third from suburban areas, and about 29 percent from rural areas.

While the results may not be generalizable across the region as a whole, the analysis yielded useful information for Tennessee. Findings were encouraging. A clear majority of the participating health care professionals noted they would treat HIV-positive patients in their office or in a hospital setting; more than one fourth indicated that they would,

with some reservation, treat patients. Providers indicated that the areas of greatest need for additional information were in AIDS/HIV diagnostic procedures and AIDS counseling resources or referral sources.

2. Providers to Minority and High Risk Populations

ECAETC reports that the objectives of these two assessments were accomplished through the meeting and work of the Criteria/Assessment Advisory Committee which has met periodically with Project staff. This committee and the informal network with professional associations and agencies provided the ECAETC with recommendations and insights about the needs within the region and within the various professional organizations. This is essentially an unstructured, key informant approach to needs assessment. To supplement this information, ECAETC staff reports utilizing the results of the Baltimore Multidisciplinary Conference.

3. Academic Institutions that Train Health Care Professionals

ECAETC had plans to use a "discrepancy model" for needs assessment purposes preliminary to planning of interventions directed at impacting professional school curricula. Accreditation guidelines for professional schools, and national/state professional association guidelines were to be used as the standards against which need was to be judged. A survey instrument, similar to the one used by the AAMC, had been drafted and piloted, but the project was abandoned. As is true in many other sites, ECAETC has faced many issues and difficulties in attempting to influence institutional curricula.

B. Activities Development and Review

The Criteria/Assessment Advisory Committee is responsible for advising the project in the area of technical content. Its representatives are drawn from hospitals, state and city health departments, STD centers, mental health providers, drug treatment programs, Area Health Education Centers **(AHECs),** alternative lifestyles organizations, minority populations, and population centers with high AIDS incidence.

Early in the first year, this Committee met to produce a master list of AIDS content/criteria statements. Input from this committee was used to assess the concerns of the high-risk populations and agencies which serve low income and minority populations. In addition to advising on training needs, this committee is to provide input into formative and summative evaluations of training materials as they are developed throughout the project.

C. Target Trainees

ECAETC targets the broad spectrum of health care professionals as candidates for its training. As the program has gotten underway, target groups have been redefined and refined, particularly in conjunction **with** the development of specific curricula and materials, as noted below. Two examples are worthy of note. Initially, physicians and physicians' assistants were seen as two separate target groups. While their

credentials differ, their functions are often similar and therefore they are now considered as a single group for the purpose of education and training. Conversely, allied health care workers were initially targeted as a single group; but it was quickly noted that this broad category consists of a wide variety of professions: medical technologists, respiratory therapists, physical therapists, occupational therapists, emergency medical personnel, etc, each of which are in need of quite different profession-specific training. Additional specific target groups are emerging: both Kentucky and Tennessee are focusing on rural health care providers, the Ohio State and Cincinnati sites have included a focus on nursing home personnel. The Cincinnati site is additionally targeting home health care nurses.

D. Training Strategies

From **ECAETC's** goals and objectives statement, a number of education and training strategies can be identified. Included are development of written and mediated educational materials, dissemination of ECAETC-developed programs for training caregivers, training of trainers to deliver training according to ECAETC-developed curricula, and enhancement of the ability of resource people around the region to provide education and training on AIDS issues within the context of their own professional responsibilities.

1. Specific Training Strategies and Methods

Ten specific education and training strategies, to be implemented during the project period, can be identified from **ECAETC's** goals and objectives. These include interdisciplinary and profession-specific training programs ranging from one to two hour presentations to one half to three day workshops; computer assisted instruction; cable video distribution; teleconferences; annual conferences; training of trainers; training institutes; as well as the development of curricular material and infusion of AIDS content into the curricula of health professions schools. In addition, ECAETC sites provide a variety of educational programs of local interest.

Core Interdisciplinary Training: The core interdisciplinary level of training is to include materials which should be common to all health care professionals. Specifically, the content is intended to address baseline knowledge, skills and psychosocial elements related to caring for AIDS patients and their families in the primary care setting.

The original plan identified the University of Cincinnati as the lead organization to pull the core interdisciplinary training materials together, with Tennessee providing the psychosocial component. During the first year of the project, responsibility for the development of the entire core interdisciplinary curriculum was shifted to the Kentucky site. The draft of the core material was completed in May 1990 and is currently under review.

Profession-Specific Training: Each site is encouraged to establish its own programming, using local opportunities and resources. Overall, the

profession-specific materials and programs are being targeted as shown below.

- o Physician Training--ECAETC physician training strategies recognize the differences in roles and therefore training needs between those physicians practicing in high incidence urban areas and low incidence rural areas. The former will be actively involved in the treatment of AIDS patients and therefore need training to improve their treatment and caregiving ability; the latter serve as community resources and educators, and their training needs reflect this role.

  The concept of shared care is being developed as a physician training model at Ohio State University. Drs. Williams and **Para** are particularly interested in and developing a mechanism for two way information dissemination between the community based primary care physician and the specialist involved in the care of AIDS patients. Dr. Williams has been working closely with primary care physicians and has prepared a series of small pieces about HIV family practice for state journals. Drs. Williams and **Para** are considering the use of an 800 number for community practitioners who can then access information through a voice mailbox.

  Educational video tapes and computer software have been developed for physicians.

- o Dental Training--Dental training is to be aimed at dentists, dental hygienists and dental assistants. Training focuses on the two broad areas of infection control and oral manifestations of HIV/AIDS. The specific content of the training is to be adapted to the professional mix of the audience and their practice settings, as well as the amount of time available for the program. The Kentucky site reports that the training of trainers material and the instructional unit for dentists is now complete.

  Dental specific educational videotapes, instructional modules, and computer software programs have been developed.

- o Nurses Training-- Staff at OSU had gathered materials to be used for self teaching modules for nurses. In addition, a monograph focused on Nursing and AIDS has been re-written and is currently under review by all sites. The Kentucky site reports that training materials for nurses and midwives are now in the review cycle and are being field tested. In addition, educational videotapes and computer software programs have been developed.

- o Allied Health Training--As noted above, allied health workers were initially a single target group. As the development of training programs began, it was quickly realized that numerous professions are represented under this title, each needing training specific to the jobs they perform. In the first year of the project, a media-based training program on infection control for emergency medical personnel was produced by the Michigan site. An in-house survey among Allied

Health Professionals at Ohio State University enabled the staff to compile core topics and produce a workbook that is profession specific. This material was then sent to Kentucky for critique and review. An educational videotape has also been developed for first responders.

o Counselor Training--Initially, the profession-specific counseling training was to be geared toward pastoral counselors. Early in the project, the focus was broadened to include generic counseling interventions. The Kentucky site reports that by year end, 1990, the Training-of-Trainers unit for counselors will be completed.

Ohio Medical Education Network (OMEN): OMEN offers one-hour programs based upon slide/tape and video presentations with live, two-way telephone interaction coordinated from the OSU site. Three programs were earmarked for year one, and six programs in each of the two subsequent years. Each program is expected to reach an average of 1700 physicians. The programs (spanning the time from November, 1987 through May, 1990) include:

- Acute Viral Infections of the Central Nervous System
- Criteria for Blood Transfusions: Should We Reexamine Old Standards
- AIDS and the Primary Care Physician
- Plasma Exchange for Auto-Immune Hematologic Disease
- Helping HIV-Infected Patients: Nursing Implications
- Infection Control in the Office
- Ethical and Policy Issues in the AIDS Era
- HIV Infection: Management After Diagnosis
- Blood Safety: Transfusion Transmitted Diseases
- HIV Update: Diagnosis & Treatment
- HIV/AIDS in the Emergency Room
- AIDS and the Health Professional
- Home Care & Home Therapy for the AIDS Patient
- HIV/AIDS in Labor & Delivery

Computer Assisted Instruction (CAI): ECAETC is pursuing a self-study strategy via Computer Assisted Instruction. CAI modules are being developed by the Ohio State site and disseminated throughout the region. Initially three modules were to be developed: one for physicians and dentists; a second for nurses; and a third for physicians' assistants and allied health care workers. After development of the first module began, it was determined that the physicians and dentists were in need of quite different content, and therefore the plan was modified to include separate modules for physicians and dentists. The physician's module was determined to serve the needs of physicians' assistants, as well.

Each module is on floppy-disk for use on a personal computer and is designed to take an average of three hours to complete. The content of each is designed to take the learner from the knowledge level to the problem solving level, simulating patient and family management. The self-study program includes a self-administered test which may be submitted as evidence of program completion for continuing education credit.

The educational computer software currently listed includes:

- o AIDS: Vignettes for Physicians
- o AIDS: Vignettes for Dental Professionals
- o AIDS: Vignettes for Nurses
- o AIDS and HIV Disease: Psychosocial Interventions for Health Care Workers (to be available Fall, 1990)

Ohio Cable Health Network: Four one-hour televised programs were scheduled to be produced and shown on the Ohio Cable Health Network each year; however, more effective and efficient means of reaching the same target groups, such as teleconferences, were identified and the cable strategy was dropped.

Teleconferences: Two-hour teleconference programs, based on the OMEN concept but with the use of satellite transmission, were planned for program year two. This program concept allows for live two-way discussion via telephone networking. This strategy is projected to reach a regional, interdisciplinary audience of 200,000 health care professionals per program. ECAETC has hired two Graduate Research Associates to plan and coordinate this component of the program.

The first teleconference, AIDS Research Forum VII: AIDS in the Black Community, conducted by the Texas-based **MediVision,** was held March 15, 1989 and was sponsored by the ECAETC at the Ohio State University and AIDS Medical Resource Center. This program was geared to health care professionals of all kinds. The Satellite Teleconferences (spanning the time from December 1988 through May 1990) include:

- o II Pan American Teleconference on AIDS
- 0 Alternative Treatments of HIV Disease
- o AIDS: Identifying Community Resources
- o AIDS in the Black Community
- o AIDS in the Primary Care Setting
- o Sexual Transmission: Asymptomatic HIV
- o Satellite Broadcast of Fifth International Conference on AIDS, Montreal
- o HIV/AIDS: Substance Abuse Issues
- o HIV/AIDS: Nursing Home and Home Care Issues
- o HIV/AIDS: Legal and Ethical Issues
- 0 HIV/AIDS: New Treatments and Therapies

Annual Conference: A large interdisciplinary annual conference was scheduled to be held each year for approximately 1,000 health professionals. The first of these conferences, The Primary Care Response to AIDS, held September 23-24, 1988 and was reported to be very well received although falling short of the number of professionals the ECAETC intended to reach. **Of the** nearly 200 participants,.37 percent were dentists, 19 percent doctors, and 16 percent nurses.

Training of Trainers: Based on its experience with the TIPS program, the Kentucky site has been designated as the focal point of train-the-trainers activities for the ECAETC project. Kentucky is responsible for both development of its own train-the-trainers curricula and the curricula developed by other sites.

The train-the-trainers model offered by the Kentucky site consists of both a training skills component and an orientation to a specific curriculum. The train-the-trainers program is typically supported by a package of materials including the TIPS materials on training skills, the curriculum itself, and a facilitator's manual that assists the trainer in customizing a training program for a sub-specialty, a more limited time frame or to emphasize a specific issue within the curriculum.

In spite of beginning with a solid model and a well-established process for train-the-trainers program development to follow, the ECAETC train-the-trainers program has been slow to come to fruition. Part of the reason for the limited train-the-trainers activity is the fact that, using the TIPS model, a train-the-trainer experience is based on a specific curriculum and cannot be designed until the curriculum itself is completed. For example, once the dental curricula was complete, attention could be turned to the development of train-the-trainers activities and the identification and enrollment of professional leaders in the dental community who are prepared to be trainers. In addition, interested parties are enrolled in clinical experiences to enhance their credibility as AIDS dental trainers. The TOT and instructional unit for the dental program has been completed.

Another cause for delay in train-the-trainers development stems from a lack of a common definition of "curriculum" among the sites. Thus, some materials which had been submitted for transformation into a train-the-trainers experience were either not fully enough developed or did not lend themselves to such transformation.

An hour and a half train-the-trainers segment had been presented as part of a joint program with the Midwest AIDS Training and Education Center (MATEC) given in June 1989 in Chicago for public health professionals. To spur further progress, alternative models and methods for providing train-the-trainers experiences are under consideration. Among the possibilities suggested by the Kentucky site are that the Kentucky site trainers can travel to other sites on request and offer a TOT or the various sites can come to Kentucky to enroll in the basic TIPS workshop to learn how to train trainers.

Training Institute: A Training Institute for trainers and educators in the region was originally planned to be held once each year in Lexington. It has since been decided to combine the Institute concept and activities with the Annual Conference. The Institute activities at the first conference consisted of a day's presentation of AIDS content to dental faculty to facilitate their teaching.

Development of Curricular Material and Infusion of AIDS Content into the Curricula of Health Professions Schools: One of ECAETC's objectives is to develop suggested AIDS curricular components for infusion into existing health professions curricula at undergraduate, graduate and professional levels. Recognizing that curricula are determined by institutional faculty and are rarely adopted from outside sources, ECAETC's strategy for impacting the health professions schools is consultative rather than proactive, offering its products, and information and technical assistance services to professional school faculty. An early activity in this area was a curriculum development workshop conducted by the Tennessee site to assist the School of Nursing faculty in integrating AIDS content into its curricula. The Michigan site reports that faculty have been involved in the development of simulated patient exercises for medical students (specifically focused on HIV related risk assessment and sexual his tory). The first scenarios have been developed and are used as an optional part of the curriculum.

Other Caregiver Training: Overall, program goals and objectives focus on standardized training programs, both core and profession-specific, to be disseminated and replicated throughout the ECAETC region. In addition to these activities, the various ECAETC sites sponsor/co-sponsor a variety of programs developed in conjunction with other professional groups and organizations. In Cincinnati, for example, regularly scheduled AIDS Update programs are cosponsored by the ECAETC and the Health Department and are offered to a wide variety of health workers. ECAETC and the School of Allied Medical Professions, Ohio State University, co-sponsored a training, "AIDS: An Allied Health Perspective" in both year one and year two. ECAETC and the Tennessee State University/Meharry Medical College cosponsored a course "Infectious Diseases and Infection Control in the Dental Office". ECAETC and the University of Michigan Medical School cosponsored a training, "AIDS and Primary Care Providers in Michigan". This is just a brief sampling of programs, some of which are one, two or three day offerings.

2. Curricula and Materials Developed/Used

The initial plan called for curricula and training materials to be developed, drawing on the results of the needs assessment survey and a search of materials that had been developed previously by the various ECAETC sites and others in the region, as well as on input from meetings of the Site Directors and the Criteria/Assessment Advisory Committee. For a variety of reasons, the data garnered from the needs assessment did not prove very useful for regional purposes, and the survey of regionally developed materials had a relatively low yield. The TIPS train-the-trainers materials, however, were identified as a significant regional resource to be incorporated into the ECAETC program. As planned, the Criteria/Assessment Advisory Committee prepared an extensive list of training issues to be addressed. This document potentially provides a framework for a comprehensive curriculum development effort.

ECAETC has been very active in curriculum and materials development, with responsibility being shared among several of the sites. The Kentucky

'and Ohio State sites have taken the lead in the development of curricula and written resource materials, while Michigan and Ohio State have focused on the production of media-based educational materials. A number of the materials were recorded on video from live formats for wider circulation.

Drawing on their previous experience and organizational strengths, the Kentucky and Michigan sites have offered protocols for curriculum and media development respectively for the general benefit of the ETC. The curriculum development process follows a prescribed schedule which includes: research and readings; development of specific objectives; drafting of the content; internal and external reviews; rewriting; field testing; rewriting; and, final printing. The media development protocol follows a similar process, also proceeding in phases: analysis (determination of learner baseline and instructional needs to be filled by the product, and existing resources); design/development (determination of content, sequence and media to be used); production (development of instructional objectives; preparation of content outline and visual notes, drafting of script, initial review, script rewrite and storyboarding, preliminary media production, review, pilot testing, final media production, assembly and editing, and duplication); full field trial; and evaluation.

The core interdisciplinary curriculum is basically informational, covering topics that provide the educational foundation on AIDS needed by all categories of health care workers: basic science; epidemiology; transmission; testing; diagnosis; treatments; infection control; personal preventive behavior; psychosocial aspects; community resources; and legal and ethical considerations. A separate module covering counseling interventions is to be included as part of the core interdisciplinary curriculum and is also in final stages of development.

The dental curriculum is the first of the discipline-specific curricula to have been completed under the protocol described above. The curriculum, The Dental Perspective On AIDS and HIV Disease, consists of two modules: Infection Control and Dental Management. The first of these is intended for all categories of dental health care workers who have direct contact with patients or instruments used to treat patients, and is aimed at enabling such individuals to implement effective infection control techniques, thus minimizing the already low potential for spread of AIDS in dental practice. The latter is more specifically appropriate for dental providers and is intended to enable these practitioners to identify clinically the oral manifestations that accompany HIV infection, to provide dental management for a person with HIV infection and to take appropriate action when a dental worker may have been exposed to HIV infection.

The discipline-specific curriculum for nurses is in its final stages of development, but has not been reviewed for this report.

A number of media-based materials have been completed and are being actively marketed by the ETC:

o HIV/AIDS: Testing and Risk Assessment	videotape/discussion leader guide

o HIV/AIDS: Epidemiology for Primary Care Health Professionals	videotape/discussion leader guide
o AIDS: Identifying Community Resources	videotape/discussion leader guide
o First Responders: Infection Control from Theory to practice	videotape/discussion leader guide
o AIDS in the Primary Care Setting	videotape/discussion leader guide
0 Psychoneurological Aspects of AIDS for the Primary Care Provider	videotape/discussion leader guide
0 AIDS Precautions in Labor, Delivery, and the Nursery	videotape/discussion leader guide
0 AIDS in the Black Community: The Physician's Role	videotape/discussion leader guide
o The Dental Perspective on AIDS and HIV Disease: Infection Control	training module
o The Dental Perspective on AIDS and HIV Disease: Dental Management	training module
o A Core Curriculum on AIDS and HIV disease	instructional unit
o Nutrition and HIV: Your Choices Make a a Difference	booklet
o AIDS Instructional Materials for Health and Mental Health Professionals	resource guide
o AIDS: Vignettes for Physicians (with continuing education post test)	self instructional software
o AIDS: Vignettes for Dental Professionals (with continuing education post test)	self instructional software
0 AIDS: Vignettes for Nurses (with continuing education post test)	self instructional software
o AIDS and HIV Disease: Psychosocial Interventions for Health Care Workers (with continuing education post test)	self instructional software
o AIDS in the Black Community: The Physician's Role (with continuing education post test)	self instructional software

Other educational materials and media are in various stages of development.

3. Evaluation

Evaluations of the developed materials are performed through expert review. Training-specific evaluations are currently process oriented (generally asking participants to rate program success). Participants are asked to rate the session regarding appropriateness of content, completeness of content, and use of audiovisuals. In addition, participants are asked to indicate applicability of content to practice as well as to indicate the most and least valuable aspects of the program.

None of the sites have had the opportunity, thus far, to develop or implement program evaluations that measure trainee outcomes (attitude, knowledge, or behavior) nor has the project's evaluator developed

evaluation tools that measure these dimensions for use by the sites. Project staff clearly recognize the need to document the effects of their programs. They have indicated that, while they do not plan to focus on outcome evaluation, now that the organization is well established and running smoothly, they will make an effort to expand their current tool to include one or two simple proxy measures of outcome. They have also indicated interest in instrument sharing with other ETC programs.

4. outputs

ECAETC sites have co-sponsored and, in a few cases solely conducted, a variety of HIV/AIDS related workshops, seminars, and presentations geared to the health care professional. In so doing, ECAETC is able to reach physicians, nurses, dentists, allied health workers, first responders, and others including health science students in various settings throughout the region.

In the first year, ECAETC reports a total of 121 presentations and programs offered to health professionals. Over 15,000 health care professionals, including almost 6,000 physicians were reached through these efforts. An additional 2,000 health science students bring the number to over 18,000.

Of the 121 education and training activities, 60 presentations and programs were reported by the Cincinnati site with an average attendance of 130; 9 presentations and programs by the Michigan site with an average attendance of about 115; 49 presentations and programs by the Ohio site with an average attendance of over 150; and an additional three presentations and programs by the Tennessee site with an average attendance of nearly 70. Kentucky reports its activities in terms of contact hours, 90 contact hours in all for just over 1,000 health professionals and health sciences students.

In the second year, 76 programs were presented during the period August, 1988 to January 1988. Of these, 3 were co-sponsored or supported by Cincinnati with an average attendance of 35; 20 were conducted solely by the Kentucky site with an average attendance of 40; 1 conference was co-sponsored by the Michigan site with 171 in attendance; and 23 were conducted or co-sponsored by the Tennessee site with an average attendance of 50. The Ohio site was involved in holding 29 programs including the annual conference, five replications of two OMEN programs and one teleconference with a reported reach of 6,718 participants, the vast majority of which are estimates of the audiences served via the telecommunications efforts.

A summary of education and training activities, updated in Spring of 1990 and including projections for the summer of 1990, are as follows:

Summary of Education and Training Activities
Type of Program/Number of Participants

	Type of Program	Number of Participants
250	1 to 2 hour presentation	33.000
67	1/2 to 1 day workshop	5.075
7	2 to 3 day conference	1.250
12	OMEN Programs	12,700
		8,200
11	Satellite Teleconferences	27,100
		119,250
		6,000

ECAETC has summarized the distribution of trainees as well:

Summary of Professionals Served

Professional Group	% of Participants Served	Number
Nurses	25%	9,825
Physicians	14%	5,502
Dental Professionals	7%	2,751
Counselors/Social Workers	8%	3,144
Allied Health Professionals	12%	4,716
First Responders	5%	1,965
Students	10%	3,930
"Other"	19%	7,467
	TOTAL:	39,300
Estimates of Participants reached through Satellite, Video and Audio Teleconferences		173,000
	ESTIMATED TOTAL:	212,300

The media-based products developed to date are listed above.

E. Effort To Reach Minorities

ECAETC notes that five percent of their program participants are minorities. Certainly, the potential for minority involvement is strong. The most evident example of minority involvement in the ECAETC is the direct participation of the Meharry Medical College. Meharry is an institution dedicated to education, training and research to ameliorate problems associated with the health of minorities and the disadvantaged. It can be anticipated that the continuing education relationship between this institution and its graduates will result in training outreach to many

minorities, especially black health professionals. While training activities for minorities and on minority issues have been taking place, specific products have been slow to develop. ECAETC's first major teleconference in the spring of 1989 addressed "AIDS in the Black Community" and a number of products have been developed and delivered.

As described previously, ECAETC used input from the Criteria/ Assessment Advisory Committee to assess the concerns of high-risk populations and agencies which serve low-income and minority populations. The Committee make-up includes representatives from State and City Health Departments and the minority community. Through the Program and Service Record which is described in Section V, the ETC is tracking trainees that are also from a minority population.

V. Program Administration

A major success of ECAETC is the development of a regionwide organization which enables the individual sites to function cooperatively as well as independently. While three of the sites are a four to five-hour drive from the project office in Columbus, ECAETC management has not allowed this distance to create a barrier. Through the use of a detailed planning document, scopes of work, written documentation, and administrative support systems, ECAETC has made this region more manageable. A consensus approach is taken with decisions and developments. Staff members at individual sites commend the strong effort and leadership style of the administrator.

A. Administrative Systems

1. Management Control Mechanisms

The first line of management control for ECAETC is its three-tiered statement of goals and objectives, the final tier of which includes identifiable tasks to be completed as well as target completion dates. This document serves as a workplan against which progress can be measured.

Responsibilities of each of the sites are spelled out in the Statements of Work included in Memoranda of Agreement. These Statements of Work were prepared by the sites themselves during the initial planning phase, in collaboration with project management, according to their areas of interest and expertise. Midway through the project, they were updated to reflect changes in roles.

At ECAETC, there is an emphasis on the documentation of all activities. Forms have been developed to collect information on programs presented as well as requests for information. Procedures for data collection and maintenance of databases are also documented. Minutes of all meetings--project staff meetings, site directors' meetings, and advisory committee meetings--are compiled and circulated.

2. Management Information Systems

ECAETC reports four areas included in their management information systems: Training Activity Database, Organizations/Mailing List Database, Individual Trainee/Trainer Database, and a system for monitoring event-specific and overall program cost and revenues. Software for maintaining these databases include spreadsheet programs and Notebook II.

Data on training activities is collected via the Program and Service Record and stored in spreadsheet format. The database contains a record for each activity: sponsoring site; date; contact hours; objectives; an indication of whether it was sponsored, co-sponsored or assisted by the site; training method(s) used; media support; number of participants by profession; number of minorities by ethnic affiliation; and urban/rural distribution of providers. The database is updated on a monthly basis and provides the data necessary for reporting on numbers and types of trainings and trainees.

Another database is used to manage ECAETC's mailing lists containing organizations, organizational representatives, and individuals with whom ECAETC wishes to keep in contact.

Yet another database is maintained to document and track networking and information dissemination activities throughout the ETC. A brief form is used to record the nature, scope and outcome of each substantive contact by site staff at each site for the purpose of networking/linkage/request for information.

Overall costs of ECAETC are recorded and monitored at the Center using a system in place in the Department of Family Medicine--the Expenditure Tracking System--developed by the Ohio State University. At each site costs and revenues from conferences and workshops are monitored through the individual organization's established accounting system.

3. Coordination

ECAETC places strong emphasis on coordination, recognizing that such coordination is critical when trying to create and maintain a sense of organization among disparate entities. The project staff, in particular the project director, have assumed a strong coordinating role. At the project level, there are regularly scheduled staff meetings. Site Directors' meetings are usually attended by two or more staff members from each site. The Site Directors are responsible for implementing the program in their service area. Systems to support coordination have been set up, notably the use of CompuServe for electronic mail, providing linkages between sites and enabling the rapid transfer of documents among sites.

B. Systems for Managing Training Events

ECAETC reports that the management of training events is essentially handled by the outside agency with whom the site is collaborating. It is usually the co-sponsoring agency that has direct responsibility for

marketing, trainee recruitment, registration, and outcome reports. ECAETC participates directly in designing and marketing instrumentation, selection of trainees, and preparation of evaluation forms which lead to outcome reports.

1. Marketing

ECAETC has been actively involved in marketing itself since the project began. An extensive booklet, prepared in 1988, describes ECAETC and the overall ETC program. A simple brochure about the ETC, containing a return card by which interested parties can request that their names be put on ECAETC's mailing list, has been widely disseminated. Exhibit posters are used at meetings and conferences. The February 1989 issue of Ohio Medicine carried a lengthy article about ECAETC, its programs and products. ECAETC's newsletter serves as a marketing tool both for ECAETC as an organization and for its training events and products.

ECAETC publishes a flyer-style calendar announcing the regionwide training events for a six month period. Brochures for the ECAETC-sponsored training events are prepared by the primary organization sponsoring the event and therefore vary in format. While ECAETC's name is always listed as a co-sponsor, it is not necessarily prominently displayed. ECAETC also markets its products through journals and via displays at meetings.

2. Trainee Recruitment/Selection

Recruitment of trainees is accomplished through brochures, listings in professional journals and institutional mailings. The program also hopes the Professional Liaison Committee will be useful in recruiting trainees through their respective associations. Trainees are expected to self-select into the training programs. CEUs are offered for all activities. Thus, it is anticipated that the dual attraction of CEUs and an important learning opportunity will be sufficient to recruit the desired number and type of trainees.

3. Registration

Registration systems and procedures are the responsibility of the cosponsoring associations or agencies.

4. Output/Outcome Reports

The ECAETC Program and Service Record is used by each site to document the nature and scope of its training activities. The data are compiled semiannually by site and type of health professional served.

C. Training Facilities

For the most part, space and other training facilities are provided by the university or public agency with which the ECAETC site is affiliated, or by the outside agency with whom the site co-sponsors the event.

Worthy of special note is the newly renovated space ECAETC has been given at Ohio State University. This includes office space, classrooms, a library, and conference room space for display and use of ECAETC products as well as other Department of Family Medicine research and education products.

D. Cost-Sharing

At ECAETC, cost-sharing comes mainly in the form of space and in-kind administrative support. Sites also receive administrative office space and in-kind contributions related to postage and mailing labels, and volunteer training. Participant fees for participation in workshops and trainings are used to cover program costs. In addition, ECAETC reports that they have been successful in obtaining funding from outside sources, such as sponsorship from Proctor and Gamble for the annual regional conference.

E. **CEUs**

Continuing education credit is offered for physicians, nurses, dentists, allied health professionals, and others as needed. These are all described as program specific CEU offerings.

F. Information Services

The "information collection and dissemination function" is a major thrust of **the ECAETC** program. Each of the sites has responsibilities in this area, although several of them have focused on information services more intensely than others.

Each site is responsible for identifying area training and continuing education opportunities. This information is maintained in a database by the OSU site.

The Cincinnati site produces a periodic newsletter, AIDS Line, which contains a calendar of training events as well as updates on technical and clinical issues related to HIV/AIDS. The newsletter is distributed primarily to associations and organizations rather than to individuals.

The libraries at each of the universities and medical schools serve as resources for each of the sites. ECAETC is particularly proud of its association with the Medical Center Information and Communications (MCIC) at the University of Cincinnati. MCIC offers an array of products and services including free access to an on-line bibliographic database and a variety of searching services, an automated on-line public catalog, an updated HIV/AIDS related collection of films, texts, articles, and teaching tools as well as a computer compact disc AIDS library. MCIC has consolidated information and communications to support patient care, research, and education. Through this center, ECAETC is able to collect, update, disseminate and track AIDS-related clinical articles of interest to community practitioners. This on-line clinical database includes 3-4 key articles on a number of HIV/AIDS topics.

A formal Resource Center has been established at ECAETC's Kentucky site which is staffed by a resource specialist and is equipped to serve a clearinghouse function as well as to do literature searches. The most visible project of the Resource Center is its Instructional Materials Database. More than 90 AIDS resource materials, primarily audiovisuals, have been identified, obtained, reviewed for their educational relevance, catalogued and entered into the database. The citations, along with their evaluations, have been published in hard copy, in a format that can be updated. This document is indexed by title, author and media. The database will soon be expanded to include textbooks as well.

The Tennessee ECAETC site, in collaboration with Nashville CARES and Vanderbilt AIDS Project, have published the booklet, Nashville Responds to AIDS: A Community Resource Guide which identifies organizations in Tennessee and Nashville that provide information/education on AIDS, and emergency and financial assistance, health services, legal assistance and social services to people with HIV/AIDS.

ECAETC, through its Kentucky site, is a co-coordinator with the University of California/Davis ETC of the ETC AIDS Resources Network (EARN). EARN is collaborative effort among the ETCs nationwide to make efficient and effective use of existing AIDS resources. In addition to coordinating initial organizational efforts, the Kentucky site will conduct bi-monthly searches and organize mailings on specific topics of interest on an ongoing basis.

VI. Summary and Challenges for the Future

ECAETC is a regional "center" consisting of five implementation sites, managed by a project staff in consort with the directors of each of the sites. Sites are responsible for providing and promoting information, education and training activities, and for developing curricula and materials to support these activities. Responsibility for the development of curricula and materials has been apportioned among the sites, according to their respective areas of expertise, with the intent that the programs and product collectively would form "the ECAETC program."

As an organization, ECAETC began as a confederation of competitors. Through the efforts of ECAETC's individual sites, sustained by the leadership of the project director, disparate organizations have come together to form a solid organizational base poised to address professional AIDS related training needs of the region. The organizational structure supports the expertise present at individual sites, enabling sites to focus on those particular activities that draw on their unique strengths and serve local needs. There is, within each site, a strong regional identification and, at the same time, a good deal of respect evidenced for the central administrative efforts.

Several innovative and well developed products have emerged from this organization. A dental curriculum and other curricula currently underway follow a strong model for curricula designed to meet specified behavioral objectives. Programs delivered through computer assisted instruction offer an innovative approach to training the health care professional.

Telecommunication programs provide opportunities to reduce geographic distances and reach dispersed professional audiences. Media products complement live training events. Information services and library facilities at various institutions enable ECAETC to serve health professional students and health care practitioners regarding HIV/AIDS information.

The organization, the systems and the expertise are clearly in place, not only to reap the benefits, but to achieve real synergy from the collaboration among the ECAETC components. Many outstanding contributions have been made.

In spite of the attention paid to communications, occasional gaps still appear. However, this has been recognized and all agree that communications between the project staff and the sites, as well as among the sites themselves need improvement. Now that a strong regional organization has been established, there is the feeling that this can be attended to.

ECAETC's strategy of providing its sites with an organizational structure which encourages independent development of programs and products presents several challenges for the future. Organizational flexibility that allows for diversity of approach among the ECAETC sites has, at once, spurred creativity but has delayed progress as well. The ECAETC program is replete with examples of the former. One example of the latter can be found in the curriculum development/train-the-trainers area where one site must build on the work of another. The lack of consensus as to what constitutes a curriculum and degree of materials development necessary to form the core of a train-the-trainers experience has resulted in the production of some materials that cannot readily be converted into a "program." Some degree of common direction is necessary to make collaborative efforts productive and efficient. **ECAETC's** challenge for the future is to recognize when independent direction has the potential of being counterproductive and to find a mechanism for achieving a common ground.

In a number of instances, sites share the same interests, but have had limited opportunity to work collaboratively. During the first two years of project activity, the Kentucky site was developing the dental curriculum materials while the OSU site also moved ahead with materials development for dentists and the **Meharry** site, designated as the focal point for minority activities, was only tangentially involved in the planning for the teleconference addressing minority issues. By enhancing its mechanisms for collaboration, ECAETC can minimize the potential for duplication of effort and maintain the harmonious spirit it has worked so hard to build.

Increasing opportunities for collaboration on program and product development has implications for the long term, as well. Sharing of products, once developed, enhances the knowledge base of those who adopt them, but it does not increase the recipient sites' ability to replicate the development process. At various sites there is a great depth of technical expertise in such areas as curriculum development, media production, evaluation and the like. Through collaboration, not only will

product and program development be expedited, but these skills can be transferred as well, thus building longer term regional competence. Some of these collaborative efforts are underway already at ECAETC--for instance, Tennessee has requested the assistance of Kentucky to capitalize on the latter's expertise in curriculum development--and these efforts are greatly applauded.

Curricula for core and discipline-specific training programs are targeted for development in order that training programs in these areas can be standardized and utilized throughout the region as identifiable ECAETC products. As should be expected, this type of development takes time. In the meanwhile and contemporaneous with this effort, individual sites are conducting general educational activities geared to local needs. When the core and discipline-specific curricula are finally in place, ECAETC sites will face the challenge of switching gears somewhat after two years of functioning autonomously and primarily co-sponsoring training events with outside agencies under the ECAETC umbrella, to marketing these ECAETC training products among their collaborating agencies and their professional constituents.

ECAETC has "reached" a large number and variety of health care professionals with its programs and has been prolific in its production of education and training materials. However, many of the numbers come from telecommunications efforts for which only estimates are available. Reaching targets is a short term objective; changing behavior and the way care is provided to AIDS patients is the ultimate objective of the national ETC program. To date, ECAETC has limited its evaluation activities to subjective feedback from experts and recipients. In order to document its contribution to the impact of the ETC program nationwide, it will be necessary for ECAETC to begin to capture data on changes in knowledge, attitudes, intentions, skills, and professional behaviors brought about as a direct result of their education and training efforts.

Building on the expertise of ECAETC's component sites was an excellent way to launch a new organization and a new program. Organizationally, this strategy recognized the value of each of the sites and minimized the chance that turf issues would interfere with the building of the new and cohesive entity. Programmatically, of course, the strategy enabled the ETC to build on a technically solid foundation. The challenge for ECAETC, now that it has passed through the most critical phase of organizational development, is to create an "ECAETC program" which is more than simply the sum of its parts. At this time, more program direction from the project level would not be inappropriate: an assessment of whether the training needs around the region have changed; development of a comprehensive training plan; and identification of resources both within the current ECAETC structure, or outside it if necessary, needed to implement the training plan.

Appendix I

Goals and Objectives

Appendix I

Goals and Objectives

Project Goal I - Organizational Function: Promote and assist in the establishment of organizational arrangements within or among state and local agencies, health care professions schools and programs, and health professions associations which will improve the development and dissemination of educational materials and the multifaceted delivery of AIDS education and training.

Major Project Objective **I.A:** Establish and maintain the East Central Region AIDS Education and Training Center for Health Professionals (ECAETC) at the Ohio State University in collaboration with the University of Kentucky, **Meharry** Medical College, University of Michigan, and Cincinnati Board of Health.

Major Project Objective **I.B:** Align the respective Scopes of Work such that the appropriate personnel can undertake the task of facilitating the exchange of AIDS information and expertise and by providing training to those for whom AIDS educational programs can make a difference in the prevention, diagnosis, counseling and management of patients and their families.

Project Goal II - Materials Development Function: Research, design and develop AIDS training materials for use with health care professionals.

Major Project Objective **II.A:** Determine baseline knowledge related to diagnosis and treatment and awareness of community resources related to counseling and management.

Major Project Objective **II.B:** Determine the extent to which AIDS training materials already exist, assess their availability and cost, assess their potential usefulness and/or applicability to ECAETC training efforts, and include in data bank for dissemination.

Major Project Objective **II.C:** Research, design and develop written and mediated AIDS training materials as necessary to address deficits in existing training materials.

Major Project Objective **II.D:** Research, design and develop train-the-trainer experiences and programs developed with the express purpose of preparing key individuals to replicate AIDS training experiences and to do so in an effective manner.

Project Goal III - Education and Training Function: Disseminate AIDS training programs for health care professionals.

Major Project Objective **III.A:** Disseminate ECAETC-developed AIDS training programs on local, state, and regional levels.

Major Project Objective **III.B:** Disseminate ECAETC-developed train-the-trainer programs on local, state, and regional levels.

Major Project Objective **III.C:** Provide technical assistance in the design and implementation of appropriate AIDS in-service and continuing education programs for health care providers.

Project Goal IV - Information Collection and Dissemination Function: Collect and disseminate to the health care community information on AIDS research, clinical care, educational programs and instructional resources.

Major Project Objective **IV.A:** To disseminate updated information regarding HIV to the various health care communities served by the ECAETC .

Major Project Objective **IV.B:** To disseminate information regarding AIDS education and training resources, curricular materials, and courses.

Major Project Objective **IV.C:** Provide advice, assistance and educational services in support of AIDS training in ECAETC region hospitals, agencies, associations, colleges and universities, and other organizations/entities.

Project Goal V - Undergraduate and Graduate Curriculum Development and Infusion Function: Assist health professions schools in the selection and implementation, and evaluation of AIDS education course materials and curriculum improvements.

Major Project Objective V.A: Determine status of health professions educational programs regarding AIDS components of current didactic and clinical curricula, including resource personnel and materials both used and needed.

Major Project Objective V.B: Adapt recognized curriculum development guidelines, processes and criteria to a format which can be used by institutions in the analyses and development of AIDS didactic and clinical curricula in their health profession programs.

Appendix II

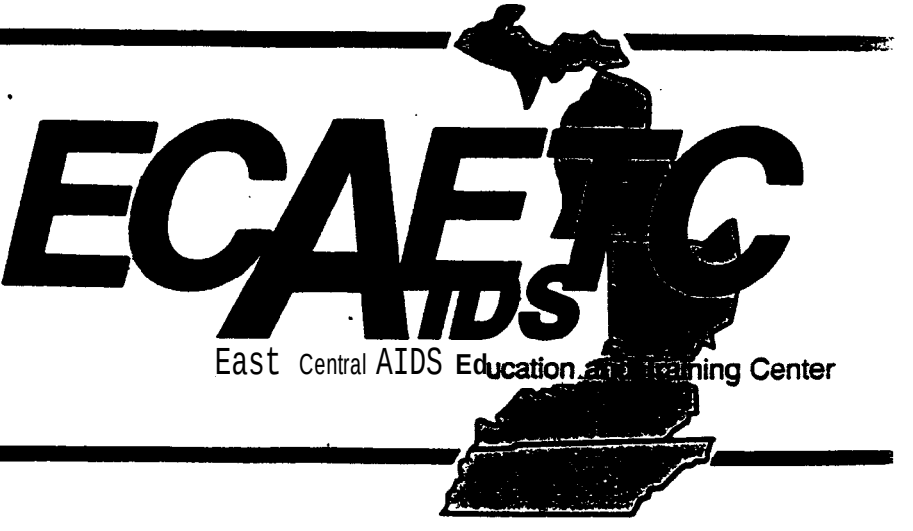
ECAETC Program Titles

ECAETC PROGRAM TITLES:

LISTED BY DATE

1987 - 1990

AUGUST' 17, 1990



	SLIDES FOR PROMO TAPE
	HIV ISSUES FOR PRACTITIONER
	HIV IN PRISONS
	FAMILY PRACTICE GRAND ROUNDS-AIDS AND 1 DEGREE CAR
09/15/87	COLUMBUS & YOU - THE AGE OF AIDS
09/17/87	INFECTION CONTROL FOR DENTISTRY
09/20/87	AIDS: OUR RESPONSE AS A HEALING COMMUNITY/ HOW AI
09/24/87	AIDS: THE CHALLENGE OF TODAY
10/02/87	AIDS PREVENTION FCR DENTAL HYGIENISTS
10/03/87	AIDS: "THE MIND, THE GLANDS, & THEIR FAR-REACHING
10/07/87	ASEPS IS UPDATE
10/14/87	WHAT HEALTH CARE F'ROVIDERS SHOULD KNOW ABCUT AIDS
10/16/87	THE AIDS SYNDROME
10/16/87	FRONTIERS CHEST RADIOLOGY
10/17/87	PREVENTION OF AIDS FOR DENTAL AUXILIARIES
10/19/87	WHAT YOU BETTER KNOW ABOUT AIDS
10/22/87	AIDS
10/24/87	AIDS UPDATE
10/26/87	AIDS MYTHS AND PROTOCOLS
10/28/87	PREVENTION OF AIDS FOR DENTISTRY
10/28/87	CLINLICAL ORAL PATHOLOGY - SECTION ON AIDS
11/01/87	ACUTE VIRAL INFECTIONS OF THE CENTRAL NERVOUS SYST
11/11/87	INFECTION CONTROL OF DENTAL HYGIENISTS
11/12/87	TESTING AND SCREENING OF AIDS
11/13/87	EPIDEMIOLOGY OF THE ACQUIRED IMMUNODEFICIENCY SYND
11/16/87	CHILD ABUSE AND NEGLECT
11/17/87	AIDS
11/19/87	AIDS-IMPLICATIONS RELATED TO DISCHARGE PLANNING &
11/19/87	PREVENTION OF AIDS FOR DENTISTRY
11/20/87	AIDS POLICY: AN INTERPROFESSIONAL APPROACH
11/30/87	HEPATITIS/AIDS
12/4/87	CRITICAL CARE MEDICINE
12/05/87	PREVENTION OF AIDS FOR DENTISTRY
12/18/87	PREVENTION OF AIDS FOR DENTISTRY
1/4/88	AIDS: ETHICAL DILEMMAS FOR HEALTH CARE PERSONNEL
1/4/88	AIDS ETHICAL DILEMMAS FOR HEALTH CARE PERSONNEL
1/6/88	MEDICAL DILEMMAS SURROUNDING THE AIDS PATIENT
1/6/88	ETHICAL DELIMMAS SURROUNDING THE AIDS PATIENT
1/12/88	AIDS UPDATE AND OVERVIEW
1/13/88	PHYSICIANS AND HIV
1/13/88	MANAGEMENT OF HIV POSITIVITY THROUGH THE SPECTRUM
1/20/88	AIDS: PROGRESS AND PROBLEMS
1/20/88	AN OVERVIEW OF THE AIDS EPIDEMIC
1/21/88	INFECTIOUS DISEASE CONSIDERATIONS - DENTISTRY SYMP
1/30/88	AIDS AND SOCIAL WORK
2/1/88	AIDS
2/1/88	THE MEDICAL ASPECTS OF AIDS
02/01/88	CRITERIA FOR BLOOD TRANSFUSIONS
2/3/88	MIDWINTER FAMILY PRACTICE
2/4/88	AIDS
2/4/88	INFECTIOUS DISEASES
2/5/88	THE EPIDEMIOLOGY OF AIDS
2/9/88	AIDS AND THE LAW ENFORCEMENT OFFICER
02/17/88	OVERVIEW OF AIDS
2/19/88	AIDS UPDATE
02/19/88	SEXUALLY TRANSMITTED DISEASES - SECTION OF AIDS
2/23/88	LOCAL ASPECTS OF THE AIDS EPIDEMIC
2/25/88	THE AIDS VIRUS AND ITS TRANSMISSION
2/25/88	HIV INFECTION AND TRANSPLANTATION
3/1/88	AIDS LIFELINE SPECIAL
3/1/88	PUBLIC SERVICE ANNOUNCEMENTS FOR CH 10
03/01/88	MEDICAL STUDENTS SPEAKERS BUREAU FOR AIDS
03/05/88	"CONSIDERING AIDS"
03/09/88	PREVENTING AIDS IN DENTAL LAPORATCRIES

ALL ECAETC EVENTS & ACTIVITIES BY DATE FROM PROJECT START TO 8/16/90

3/14/88	AIDS
3/15/88	AIDS: TESTING AND IMPLICATIONS
3/15/88	AIDS: TESTING AND IMPLICATIONS
3/17/88	AIDS: DEVELOPMENT OF VACCINES AND TREATMENT
3/18/88	AIDS: FATHOGENESIS AND NATURAL HISTORY
3/25/88	AIDS
4/5/88	LEARNING TO LIVE & WORK IN A SOCIETY TOUCHED BY AI
4/7/88	HISTORY AND BACKGROUND OF AIDS
04/08/88	INFECTION CONTROL FOR AIDS PATIENTS
4/9/88	AIDS AND INFECTION CONTROL - THE LATEST
4/15/88	OBSTETRICS - GYNECOLOGY
4/16/88	PERSPECTIVES ON AIDS
4/19/88	AIDS
04/20/88	INFECTION CONTROL - PREVENTION OF AIDS
4/21/88	AIDS UPDATE AND NEW THERAPIES
4/22/88	AIDS EDUCATION FOR HEALTH FROFESSIOINALS
04/22/88	TEACHING INFECTION CONTROL TO DENTAL AUXILIARIES
04/23/88	CLINICAL ORAL PATHOLOGY - SECTION "AIDS UPDATE"
04/23/88	REVIEW OF AIDS
04/26/88	AIDS AND OSHA
5/3/88	AIDS
5/3/88	AIDS
5/6/88	CT-MRI
5/13/88	AIDS UPDATE
5/13/88	HIV ANTIVIRAL THERAPY - WHEN TO USE AZT
5/13/88	INTERNAL MEDICINE
5/13/88	AIDS UFDATE
5/13/88	AIDS UPDATE
5/17/88	AIDS AND YOUR JOB
5/23/88	AIDS
5/25/88	ANTIVIRAL THERAPY FOR HIV
5/27/88	A MEDICAL DESCRIPTION OF AIDS AND ITS EFFECTS ON S
6/4/88	AIDS AND FIRST RESPONDERS
06/18/88	AIDS ECAETC TABLE CLINIC
6/20/88	SUMMER CONFERENCE - FAMILY FHY
06/28/88	PREVENTION OF AIDS FOR DENTISTRY
7/1/88	PEDIATRIC AIDS
7/1/88	PEDIATRIC AIDS
7/9/88	ADVANCED INFECT DISEASES
7/12/88	AIDS IN THE WORKPLACE
7/12/88	AIDS IN THE WORKPLACE
7/15/88	AIDS & EMERGENCY WORKERS
7/15/88	AIDS TESTING
7/15/88	COMMUNITY AGENCIES
7/15/88	AIDS AND EMERGENCY WORKERS
7/19/88	AIDS IN THE WORKPLACE
7/19/88	AIDS IN THE WORKPLACE
07/26/88	DENTAL INFECTION CONTROL
7/26/88	TRAINING THE TRAINERS
7/26/88	TRAINING THE TRAINERS
8/2/88	AIDS 101
8/2/88	AIDS 101
8/5/88	PEDIATRIC BOARD REVIEW
08/10/88	AIDS EDUCATION 4 TRAINING WORKSHOP
8/16/88	SOCIAL SIDE OF AIDS
8/16/88	SOCIAL SIDE OF AIDS
8/26/88	AIDS ECAETC TABLE CLINIC
8/26/88	AIDS IN THE WORKPLACE
08/31/88	CLINICAL ASPECTS OF AIDS
09/01/88	DENTAL INFECTION CONTROL
9/2/88	AIDS AND HEALTH CARE
9/2/88	AIDS AND HEALTH CARE
09/06/88	DENTAL INFECTION CONTROL
09/09/88	ORAL PATHOLOGY FOR ORAL SURGERY

ALL ECAETC EVENTS & ACTIVITIES BY DATE FROM PROJECT START TO 8/16/90

09/10/88	ORAL PATHOLOGY FOR ORAL SURGERY
9/12/88	AIDS 4 MENTAL HEALTH WORKERS
09/12/88	DENTAL INFECTION CONTROL
9/12/88	AIDS AND MENTAL HEALTH WORKERS
9/12/88	AIDS AND MENTAL HEALTH WORKERS
9/14/88	AIDS AND MENTAL HEALTH WORKERS
9/14/88	STD Training class
9/14/88	AIDS AND MENTAL HEALTH WORKERS
9/16/88	AIDS & MENTAL HEALTH WORKERS
9/16/88	AIDS AND MENTAL HEALTH WORKERS
09/17/88	DENTAL INFECTION CONTROL
9/20/88	
9/20/88	AIDS AND DIALYSIS FOR NURSES
9/20/88	UNKNOWN
09/27/88	DENTAL INFECTION CONTROL
9/28/88	DENTAL INFECTION CONTROL
09/29/88	DENTAL INFECTION CONTROL
10/1/88	AIDS AND PRIMARY CARE PROVIDERS
10/01/88	AIDS AND THE PRIMARY CARE PHYSICIAN
10/4/88	HEPATITIS B VACINNATION
10/5/88	HEPATITIS B VACCINATION
10/6/88	INFECTION CONTROL
10/06/88	DENTAL INFECTION CONTROL
10/09/88	"AIDS UPDATE"
10/17/88	AIDS: 2ND NATIONAL NURSING CONF
10/17/88	AIDS: 2ND NATIONAL NURSING CONF.
10/18/88	MEHARRY AIDS SYMPOSIUM
10/18/88	MEHARRY AIDS SYMPOSIUM
10/20/88	AIDS IN WORKPLACE
10/20/88	AIDS IN THE WORKPLACE
10/21/88	PSYCHOSOCIAL ISSUES
10/21/88	INFECTION CONTROL
10/21/88	DENTAL INFECTION CONTROL
10/21/88	PSYCHOSOCIAL ISSUES
10/24/88	AIDS IN DENTAL PRACTICE
10/24/88	ORAL PATH FOR ORAL SURG
10/24/88	AIDS IN DENTAL PRACTICE
10/25/88	TN ASSOC PRIMARY CARE CONFERENCE
10/25/88	ORAL PATH FOR ORAL SURG
10/25/88	TN ASSOC PRIMARY CARE CONFERENCE
10/26/88	HIGHER EDUCATIONS RESPONSE TO AIDS
10/29/88	TNA RESEARCH DAY
10/29/88	TENNESSEE NURSES ASSOCIATION RESEARCH DAY
11/04/88	EARLY CLINICAL MANIFESTATIONS OF AIDS
11/9/88	INFECTION CONTROL
11/9/88	AIDS AND PERSONEL POLICIES
11/11/88	PSYCHOSOCIAL ISSUES
11/11/88	PSYCHOSOCIAL ISSUES
11/13/88	CONFERENCE FOR GENERALISTS IN MEDICAL EDUCATION
11/15/88	EVALUATION OF AIDS EDUCATION & TRAINING
11/15/88	LECTURE ON AIDS / PART OF ORAL PATHOLOGY COURSE FO
11/15/88	AIDS AND YOU
11/16/88	AIDS UPDATE
11/17/88	AIDS
11/17/88	GRAND ROUNDS OSU OB/GYB
11/18/88	AIDS: AN ALLIED HEALTH PERSPECTIVE
11/18/88	AIDS: AN ALLIED HEALTH PERSPECTIVE
11/21/88	INFECTION CONTROL
11/23/88	INFECTIOUS DISEASE CONTROL
11/28/88	AIDS AND THE CHURCH
11/28/88	AIDS AND THE CHURCH
11/28/88	HEPATITIS & AIDS FOR DENTISTS
11/29/88	DISPELLING THE MYTHS OF AIDS
11/29/88	DISPELLING THE MYTHS OF AIDS

11/29/88	NURSES'S ROUNTABLE DISCUSSION
11/29/88	GRAND ROUNDS RIVERSIDE
11/29/88	NURSES'S ROUNDTABLE DISCUSSION
11/29/88	NURSES'S ROUNDTABLE DISCUSSION
11/29/88	DISPELLING THE MYTHS OF AIDS
11/30/88	AIDS AND SOCIAL WORK
11/30/88	AIDS AND SOCIAL WORK
12/1/88	PHYSICIAN'S ROUNTAELE DISCUSSION
12/1/88	PHYSICIAN'S ROUNDTABLE DISCUSSION
12/3/88	ST ANTHONYS GRAND ROUNDS
12/03/88	GRAND ROUNDS ON AIDS
12/05/88	PLASMA EXCHANGE FOR AUTO IMMUNE HEMA - DIS
12/6/88	FAMILY PRACTICE RESIDENTS AIDS EDUCATION
12/6/88	RIVERSIDE FAMILY PRACTICE.
12/06/88	CE/OSU DENTAL HYGIENE FACULTY
12/7/88	AIDS: A CUMMUNITY RESPONSE
12/07/88	PSYCHO SOCIAL ASPECTS OF AIDS
12/7/88	AIDS: A COMMUNITY RESPONSE
12/7/88	AIDS: A COMMUNITY RESPONSE
12/7/88	AIDS: A COMMUNITY RESPONSE
12/9/88	SECOND FAN AMERICAN TELECONFERENCE ON AIDS
12/9/88	SECOND FAN AMERICAN TELECONFERENCE ON AIDS
12/13/88	OHIO DEPT HEALTH 'HIV
12/13/88	CLINICAL COURSE OF HIV
12/14/88	AIDS PHYSICIAN PEER GROUP
12/14/88	HIV MANAGEMENT OF PATIENT
12/15/88	Lousiville Drug Conference
1/14/89	VOLUNTEER TRAINING
01/17/89	CE/MANSFIELD DENTAL SOCIETY
1/18/89	AIDS UPDATE
01/19/89	AIDS - TRAINING
1/20/89	REGULATORY, LEGAL, ETHICAL & CLINICAL PERSPECTIVES
01/26/89	NEW THERAPIES
01/31/89	AIDS & YOUR JOB; A PROGRAM FOR HEALTHCARE WORKERS
02/02/89	AIDS -NURSING STUDENT COURSE
02/17/89	AIDS AND SEXUALITY
02/20/89	DIAG AND MANAGEMENT OF STD
02/21/89	HIV TO ODH HIV COUNSELOR
02/21/89	AIDS: IDENTIFYING COMMUNITY RESOURCES
02/22/89	AIDS 4 PHYSICAL THERAPY
02/23/89	AIDS & EYE PROFESSIONAL
2/25/89	CLINICAL ORAL PATHOLOGY
02/25/89	AIDS *AND* VETERINARIANS
03/03/89	ADV IN INFECTIOUS DISEASE
03/06/89	HELPING HIV-INFECTED PATIENTS: NURSING IMPLICATIO
03/07/89	AIDS UPDATE
03/08/89	AIDS UPDATE
3/10/89	CURRICULUM WORKSHOP ON AIDS
3/10/89	CURRICULUM WORKSHOP ON AIDS
03/11/89	GERIATRICS & HEALTH CARE ISSUES
03/14/89	AIDS MORNING REPORTS
3/15/89	AIDS IN THE BLACK CUMMUNITY
03/15/89	AIDS IN THE BLACK COMMUNITY
03/17/89	FAMILY PRACTICE - 1989
3/24/89	INFECTION CONTROL DENTAL OFF
3/24/89	INFECTION CONTROL
3/24/89	
3/28/89	-
3/28/89	
3/29/89	ERAD.
3/29/89	HIV IN CLINICAL PRACTICE
04/02/89	FP
04/03/89	ION CONTROL IN THE OFFICE
04/04/89	ETHCAL & ICY ISSUES IN THE AIDS ERA

ALL ECAETC EVENTS 4 ACTIVITIES BY DATE FROM PROJECT START TO 8/16/90

04/04/89	AIDS - MEDICAL STANDPOINT
04/05/89	NURSE TO NURSE: HIV EPIDEMIC IN PERSPECTIVE
04/12/89	AIDS & HEALTH COMMISSIONERS
04/13/89	CHANGES IN OB/GYN
04/13/89	EARLY SIGNS OF HIV
4/14/89	PHYSICIAN ASST SEMINAR
04/14/89	AIDS & THE PHYSICIAN ASSISTANT
04/16/89	HEALING WEEKEND
04/18/89	CHIC HIV TESTING COUNSELOR COURSE
4/19/89	AIDS INFORMATION RESOURCE
04/19/89	AIDS IN THE PRIMARY CARE SETTING
04/21/89	HIV - ALLIED HEALTH
04/24/89	HIV AND NURSING PRACTICE
04/26/89	HIV AND HEALTH CARE PROFESSIONAL
4/27/89	AIDS AND THE HUMANITARIAN APPROACH
4/27/89	AIDS AT WORK
04/27/89	AIDS AT WORK
04/28/89	CLINICAL TRIALS
05/01/89	RENTAL HEALTH - AIDS
05/02/89	AIDS UPDATE
05/05/89	AIDS: CFC
05/08/89	HIV INFECTION: MANAGEMENT AFTER DIAGNOSIS
05/13/89	AIDS TREATMENT WORKSHOP
05/17/89	USE OF GANCICLOVIR IN AIDS
5/17/89	NEW PERSPECTIVES HIV ILLNESS
05/19/89	OPHTHALMOLOGY SPRING CONFERENCE
05/19/89	SEXUAL TRANSMISSION: ASYMPTOMATIC DIAGNOSIS
5/20/89	SEMINAR FOR PHYSICIANS
05/20/89	AIDS: UPDATE FOR DENTISTS
5/23/89	AIDS AND NUTRITION
05/24/89	MANAGEMENT OF OUTPATIENTS WITH HIV
6/1/89	FIRST RESFONDERS
6/7/89	AFRICAN AMERICAN MINISTERS SUMMIT CONFERENCE ON AI
6/8/89	TELECONFERENCE: MONTREAL INTERNATIONAL AIDS CONF
6/8/89	INTERNATIONAL CONFERENCE ON AIDS
06/08/89	V INTERNATIONAL CONFERENCE ON AIDS
07/06/89	AIDS IN THE PRIMARY CARE SETTING
07/17/89	EMT'S & AIDS & HEPATITIS
7/19/89	EDUCATION FOR PHYSICIANS
7/27/89	CARE OF PERSONS WITH HIV
8/2/89	HIV AND ENT SURGEON
8/3/89	HIV TREATMENT
8/4/89	HIV AND FAMILY PRACTICE
8/5/89	HIV AND FAMILY PRACTICE
8/8/89	HIV COUNSELING
08/16/89	AIDS IN THE PRIMARY CARE SETTING
08/19/89	AIDS IN THE PRIMARY CARE SETTING
8/25/89	ADV IN INFECTIOUS DISEASE
8/27/89	AIDS
9/1/89	PRIMARY CARE AND HIV
9/6/89	AIDS RISK REDUCTION AND INTERVENTIONS FOR PERSONS
09/10/89	THIRD INTERNATIONAL CONFERENCE ON AIDS EDUCATION
9/12/89	HIV AND LEGAL ISSUES
9/13/89	NUTRITIONAL ASPECTS OF AIDS FOR DIETICIANS
9/15/89	NEWER TREATMENTS FOR HIV
9/20/89	AIDS BEYOND THE BASICS
9/20/89	AIDS:BEYOND BASICS
9/23/89	TREATMENT UPDATE
09/23/89	EFFECTIVE STRATEGIES FOR MANAGING THE EPIDEMIC
9/26/89	AIDS IN OHIO
09/27/89	AIDS TEST UPDATE
10/2/89	A IDS UPDATE-RADIO TALK SHOW
10/3/89	HIV COUNSELOR-TRAINING
10/7/89	Seminar for Physicians

ALL ECAETC EVENTS & ACTIVITIES BY DATE FROM PROJECT START TO 8/16/90

10/15/89	PEDS BOARD REVIEW
10/19/89	AIDS MEDICAL STUDENT LECTURS
10/19/89	STUDENT AMA - AIDS AND MEDICINE
10/20/89	AIDS AND THE SOCIAL SCIENCES
10/21/89	Physicians Volunteer Training
10/21/89	AIDS AND THE SOCIAL SCIENCES
10/21/89	ORAL MANIFESTATIONS OF HIV INFECTION
10/26/89	OUR CHURCH HAS AIDS CONF
10/27/89	CARING FOR HIV/AIDS: MICH
11/01/89	AIDS TREATMENT UPDATE
11/2/89	FERINATAL PROBLEMS
11/03/89	AIDS OVERVIEW FOR OB-GYN
11/03/89	HIV MANAGEMENT
11/7/89	EDUCATIQN FOR PHYSICIANS
11/8/89	AIDS AND ASOLESCENTS
11/09/89	HI V
11/11/89	HIV UPDATE / REVIEW COURSE
11/11/89	HIV & HEMOPHILIA
11/13/89	HIV AND DISEASE
11/14/89	SEMINAR FOR NURSING HOMES
11/16/89	AIDS/HIV AND DENTAL HYGIENE
11/16/89	ORAL MANIFESTATIONS OF AIDS
11/17/89	AIDS EDUCATION AND PREV FROG IN KENTUCKY:STATUS RE
11/21/89	MANAGING AIDS IN PRACTICE
11/21/89	MULTIDISC - AIDS UPDATE
11/27/89	AIDS/HIV 4 DENTAL PRACTICE
11/29/89	AIDS - NEWER THERAPIES
11/29/89	OHIO HEALTH CARE ASSOC. FALL CONFERENCE
12/01/89	AIDS THE CONTINUING DILEMMA
12/1/89	AIDS/HIV MICHIGAN
12/04/89	AIDS - LIFE CHOICES
12/06/89	ISSUES IN HIV MANAGEMENT
12/7/89	AIDS BASICS
12/09/89	STRATEGIC ISSUES IN PHARMACY
12/09/89	AIDS - SYMPOSIUM
12/11/89	MEDICAL ETHICS AND HIV
12/12/89	MEDICAL UPDATE
12/14/89	HIV COUNSELORS
12/20/89	AIDS THERAPIES
12/21/89	AIDS AND SURGEONS
12/26/89	AIDS CASE MORNING REPORT
1/25/90	AIDS PREVENTION
1/26/90	IMPACT HIV IN DENTISTRY
1/31/90	HIV IN CLINICAL PRACTICE
2/1/90	DENTAL TRAIN-THE-TRAINER ON HIV/AIDS DISEASE
02/05/90	BLOOD SAFETY: TRANSFUSION TRANSMITTED DISEASES
2/6/90	AIDS RESOURCES
02/13/90	INTRODUCTION TQ AIDS
2/14/90	SUBSTANCE ABUSE ISSUES
02/14/90	HIV/AIDS: SUBSTANCE ABUSE ISSUES
02/16/90	ORAL MANIFESTATIONS OF AIDS
2/20/90	INTRO TO AIDS
02/26/90	HIV UPDATE DIAGNOSIS & TREATMENT
2/28/90	AIDS IN PRIMARY CARE
3/2/90	INTRO TO AIDS
3/4/90	INTRODUCTION TO AIDS
03/05/90	HIV/AIDS IN THE EMERGENCY ROOM
03/07/90	AIDS UPDATE
03/08/90	AIDS UPDATE
3/9/90	ORAL CANCEROUS MANIF HIV
3/9/90	NUTRITIONAL ASPECTS OF AIDS
3/9/90	NUTRITIONAL ASPECT OF AIDS
3/10/90	ADV IN INFECTIOUS DISEASE
3/13/90	NUTRITIONAL ASPECT OF AIDS

ALL ECAETC EVENTS & ACTIVITIES BY DATE FROM PROJECT START TO 8/16/90

3/14/90	NUTRITIONAL ASPECTS OF AIDS
3/14/90	NURSING HOME AND HOME CARE ISSUES
03/14/90	HIV/AIDS NURSING HOME & HOME CARE ISSUES
3/20/90	FAMILY PRACTICE UPDATE
3/22/90	NUTRITIONAL ASPECTS OF AIDS
03/26/90	AIDS & THE HEALTH PROFESSIONAL
03/26/90	AIDS UFDATE -MENTAL HEALTH
3/28/90	NUTRITION AND AIDS
3/31/90	AIDS SUMMIT CHRISTIAN EDUCATION
04/02/90	HOME CARE & HOME THERAPY FOR THE AIDS PATIENT
04/03/90	AIDS EDUCATION - RESOURCES FOR HOSPITAL PRACTITION
04/03/90	HIV AIDS IN THE LABOR & DELIVERY AREA
04/04/90	NURSE TO NURSE II: MANAGING THE HIV EPIDEMIC
04/04/90	NORTH CQAST SPRING MEETING: CLEVELAND DENTAL SOCI
04/12/90	HIV/AIDS UPDATE DISTRICT OAFP MEETING
4/18/90	LEGAL AND ETHICAL ISSUES
04/18/90	HIV/AIDS: LEGAL & ETHICAL ISSUES
04/24/90	FLACK HEALTH CARE PROVIDERS
4/28/90	ORAL LESIONS ASSOCIATED WITH AIDS
04/28/90	ORAL MANIFESTATIONS OF HIV INFECTION
5/1/90	AIDS EDUCATION
05/02/90	AIDS - SUBSTANCE ABUSE
05/08/90	A IDS UPDATE
5/9/90	AIDS BEYOND THE BASICS
05/09/90	AIDS BEYOND THE BASICS /THE ABOVE DATE
05/09/90	AIDS UPDATE
5/10/90	HIV AND AIDS: LEGAL AND ETHICAL ISSUES
5/10/90	AIDS AND HIV DISEASE: TRAINING FOR NURSE-MIDWIVES
05/12/90	HIV/AIDS: A PRIMARY'CARE DISEASE OF THE 90'S
05/14/90	ORAL MANIFESTATIONS OF HIV INFECTION
05/14/90	ORAL MANIFESTATIONS OF HIV INFECTION
5/15/90	NEW TREATMENTS AND THERAPIES
05/15/90	HIV/AIDS NEW TREATMENTS AND THERAPIES
5/17/90	HIV AND AIDS: LEGAL AND ETHICAL ISSUES
5/22/90	AIDS EDUCATION
5/24/90	HIV AND AIDS: LEGAL AND ETHICAL ISSUES
5/24/90	INTRODUCTION TO AIDS
5/25/90	ORAL LEGAL BARRIER TECH
5/25/90	AIDS-ASSOCIATED ORAL LESIONS
5/29/90	NUTRITION AND HIV
05/30/90	AIDS: MENTAL HEALTH
05/31/90	UPDATE - TESTING
6/1/90	AIDS-ASSOCIATED ORAL LESIONS
6/12/90	LEGAL AND MEDICAL ISSUES
6/l. 5/90	AIDS IN THE NURSING HOME
6/20/90	COMP MGMT OF HIV DISEASE
6/21/90	HIGHLIGHTS OF THE VI INTERNATIONAL CONFERENCE ON A
6/22/90	HIGHLIGHTS OF THE VI INTERNATIONAL CONFERENCE ON A
6/23/90	HIGHLIGHTS OF THE VI INTERNATIONAL CONFERENCE OF A
6/23/90	HIGHLIGHTS OF THE VI INTERNATIONAL CONFERENCE ON A
06/25/90	- M E N T A L H E A L T H
6/26/90	CARING FOR AIDS PATIENTS
6/29/90	INTRODUCTION TO AIDS
7/1/90	INTRODUCTION TO AIDS
7/10/90	ECAETC AHEC I N F O R M A T I O N
07/11/90	AIDS UPDATAE
07/12/90	AIDS UPDATE
07/13/90	COMMUN TY AIDS RESOURCES
07/13/90	cOMMUN I TY a IDS rESOURCES

Emory AIDS Training Network

Case Study

EMORY AIDS TRAINING **NETWORK**

OVERVIEW

The Emory AIDS Training

Emory-based to the

curriculum for nurses h
developed, and those for other health care professions are in process.
been produced.

EATN's

EATN's ns of AIDS incidence,

Georgia-17.2), ged from high (Florida-28.8 and
Alabama-

5.3). Blacks represent a disproportionately high percentage of AIDS cases in all five states, from 38 percent of total AIDS cases in Florida to a high of 57 percent of total AIDS cases in South Carolina.

Epidemiologic patterns within the five-state region in terms of transmission, age, gender and race are similar with several notable exceptions. Heterosexual contact accounted for 14.2 percent of total AIDS cases in Florida, the second highest proportion of heterosexually transmitted AIDS cases in the nation, as well as the highest incidence of Hispanic AIDS cases in the region.

B. Organizational Background

The Emory University School of Medicine is the grantee for the Emory AIDS Network. The EATN program is lodged within the Division of Community Medicine. In addition to capitalizing on the experience within the Division of Community Medicine and the established networks with community organizations, the Division provides the organizational base for the EATN's strong primary care focus.

Emory University School of Medicine is affiliated with five Atlanta area hospitals. Of these five, the Crawford W. Long and Grady Memorial Hospital serve the majority of the city and state's adult AIDS patients. Grady Hospital and a non-affiliated hospital share in the care of the state's pediatric AIDS patients.

The Centers for Disease Control are located adjacent to EUSM. Emory University and the CDC have a long history of collaboration in education and research. Approximately 50 CDC scientists hold faculty appointments with the School of Medicine. This expertise is also available to the Emory AIDS Training Network.

Morehouse School of Medicine, one of the EATN's major subcontractors, is one of the nation's most renowned institutions for the education of minority students, and provides the EATN with a linkage to the region's health care providers who serve minority and inner city populations. In addition, Morehouse is the site of an Area Health Education Center with a local network of centers that include Atlanta and Dublin, Georgia and Tuskegee, Alabama. The AHEC is devoted to continuing education for all health professionals, educational opportunities for health science students and residents, and consumer health information for community members. Prior to joining the EATN, Morehouse, through its AHEC program, was already providing AIDS continuing education for physicians and the allied health professions, and had a contract with the Georgia Department of Human Resources to do an outreach program to provide information about minority issues and AIDS to community leaders and citizens within the Metro-Atlanta area.

Prior to its affiliation with the EATN, the Florida Mental Health Institute of the University of South Florida had been heavily involved in AIDS continuing education to community providers, sponsoring colloquia and participating in conferences sponsored by other organizations. The Institute

began sponsoring a twice-monthly support group for professional caregivers working with people affected by AIDS in 1987.

C. **ETC** Origin and Development

Emory submitted a proposal to establish Emory AIDS Training Network (EATN) in the first round and was approved but not funded. The EATN received funding in the second round in April 1988. The EATN's proposed catchment area included Florida, Georgia, Alabama, Louisiana, Arkansas and Mississippi. Upon funding, the region was modified at **HRSA's** request. Louisiana, Arkansas and Mississippi, which were funded as part of the Delta ETC, were excluded; North and South Carolina were not otherwise covered and were added to EATN's region.

EATN's initial strategy was to deliver the bulk of the training centrally, with a minimum of **subcontracting**--Morehouse and the University of South Florida being the primary subcontractors identified at the outset. The post-funding annexation of North and South Carolina resulted in a modification. in the subcontracting strategy, requiring the identification of appropriate subcontractor organizations in those states. Expansion of subcontracting was complicated by the limited budgets available; the addition of the Carolinas was not accompanied by an increase in federal funding and the-EATN felt that it had to honor its budget commitments to Morehouse and South Florida.

Ultimately, three new subcontractors were integrated into the EATN, but start-up was a little slow. Initial negotiations in South Carolina were with the South Carolina Area Health Education Center at the Medical University of South Carolina who subsequently declined an EATN subcontract. Ultimately, the University of South Carolina School of Public Health became that state's subcontractor eight months into the grant year. The subcontract with the North Carolina Primary Care Association was affected in 1989. In addition, a new subcontractor, the University of Alabama at Birmingham, was selected for the state of Alabama. All began with relatively small budgets which have been increased significantly over the course of the project.

Originally, the Emory ETC grant was lodged within the Health Education Track in the Department of Community Health of the Medical School. In positioning itself to become a separate school of Public Health, the Division of Public Health was moved out of the Department of Community Health. The ETC grant remained with the Department of Community Health and the EATN moved up to divisional status. This has enhanced its status and enables the EATN to tap University resources more readily and facilitates high level communication.

In the EATN's year 02, HRSA funded a new ETC centered at the University of Miami. This caused confusion both at the regional level as well as within the State of Florida, especially because the catchment area for the Miami ETC was not decided upon until several months after the notice of award. The catchment area for Miami was eventually defined as Dade and Monroe Counties, in the tip of Florida, and the four medical schools in the state. Al though the official delineation has helped, there is still some confusion among some of the collaborating agencies and organizations in Florida as to which ETC is responsible for what areas and programs.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

The original plan was that the program headquarters would provide a training team that would develop and conduct the majority of programs throughout the region receiving input on other functional areas from the subcontractors. Except for the State of South Carolina, it was not originally envisioned that the subcontractors would serve as the lead training organization in their respective states. Thus, the original plan called for a centralized program, both administratively centralized as well as programmatically. However, the subcontractors have evolved quite autonomously from the central office and consider themselves (with the exception of the North Carolina subcontract and the Morehouse subcontract) to be the lead health professional training organization in their states. The structure, therefore, is not clearly defined. The Emory-based staff are still operating under a centralized model, while three of the subcontractors are operating under a decentralized model.

The activities of the central office include the following:

- administering and monitoring the grant;
- gathering and disseminating relevant information and materials to the subcontractors;
- maintaining an HIV/AIDS training and education resource library;
- designing a regional evaluation strategy;
- providing a leadership and support role to the subcontractors; and
- maintaining training databases and analyzing regionwide data.

Additionally, the central office has a core training staff who design and conduct training programs throughout the region. A core group of in-house trainers allows ample opportunity for creative planning, enables a quick incorporation of new AIDS information into training events and guards against a biased or one-sided training approach.

EUSM is assisted in the implementation of the grant through key subcontractors, with subcontracts based on functional areas of expertise. In several of the cases, the subcontractor's role has changed over time.

The Morehouse School of Medicine Area Health Education Center (MSM AHEC) focuses on the planning, design and implementation of training programs for minority and inner-city populations and on curriculum development. MSM's focus, to date, has been on curriculum development. Also through its AHEC networks in Georgia and Alabama, MSM has assumed the role of educating rural health care providers in Georgia. The training of non-rural health care professionals in Georgia is being done by the Emory-based EATN trainers.

Originally, the Florida Mental Health Institute's Center for AIDS Education for Health Care Providers had a regional mandate to provide mental health-related AIDS training throughout the region and to be the primary

provider of AIDS training in Florida. In practice, the CAEHCP has not played a regional role. However, in year 03, particularly if Emory is awarded the NIMH grant for the region, CAEHCP will provide trainings with a mental health focus throughout the region.

Initially, the role of the South Carolina subcontractor was to afford access to the allied health training provided by the community college system. University of South Carolina School of Public Health has evolved into the lead AIDS training organization in the state.

The University of Alabama at Birmingham was chosen for its clinical perspective. While that clinical perspective remains, UAB has taken on wider responsibility for AIDS training in the state.

The North Carolina Primary Health Care Association (NCPHCA) was chosen based on its primary care focus. It is not directly involved in delivering training, but rather serves as a training broker and a catalyst for AIDS training throughout the state.

B. Staffing

All EATN core staff are affiliated with the Emory University School of Medicine as either full-time employees or adjunct faculty.

Kathleen R. Miner, Ph.D., M.P.H., is the Project Director, responsible for the management and administration of all the EATN functions. Dr. Miner has over 11 years of experience training health providers and administering health education programs in governmental and academic settings. Dr. Miner is the chairperson of the DeKalb County, Georgia, Task Force on AIDS and is the Health Promotion and Education Coordinator at EUSM. Dr. Miner serves the project on a 50 percent basis.

Felicia J. Guest is the Deputy Director for Training. Ms. Guest coordinates all training delivered by the EATN. She also conducts trainings and develops instructional materials for EATN programs. Ms. Guest is an experienced health care provider trainer with over 12 years of training experience and has been involved for 15 years in the writing of instructional materials targeted toward health care providers. Ms. Guest supervises the five core EATN trainers.

Robin Y. Swift, M.P.H., is the Faculty Consultant of the EATN program. Ms. Swift's responsibilitiesare to coordinate the research and planning functions of the EATN. Additionally, Ms. Swift conducts some training sessions. Ms. Swift has seven years of experience in health teaching and two years experience as a statewide AIDS education coordinator and planner. Ms. Swift developed and wrote a comprehensive AIDS five-year plan for the State of Georgia. Ms. Swift also has extensive experience in managing federal-funded projects in the areas of family planning, sexuality education and AIDS.

Sandra Huckaby, R.N., M.P.H., is the Deputy Director for Program. Ms. Huckaby's responsibilities are on the administrative side of the project and

for the liaison function with the subcontractors. Ms. Huckaby supervises the support staff.

The EATN includes a cadre of in-house trainers reflecting EATN's philosophy that only top-notch, in-house trainers can assure a consistently excellent training operation. They include Cameron Coltharp; Debra Morris, Kimberly Sessions, and Dennis Jarvis. Ivory Kimbrough serves as the Education Coordinator. The Project Director, the Deputy Director for Training, the Deputy Director for Program and the Faculty Consultant also serve as the key faculty of the EATN. To complement the areas of expertise of the in-house trainers, the EATN draws from a roster of per diem training consultants.

Project support is provided by a fulltime administrative assistant and a fulltime secretary. The total regional office EATN staff is 12.5 full-time equivalents.

Four active consultants also support project activities: Sumner Thompson, M.D., Medical Consultant, an infectious disease specialist who works out of Grady Hospital; Richard Levinson, Ph.D., Evaluation Consultant, an associate professor in EUSM's Division of Community Health and Acting Branch Chief for Research and Evaluation at the Center for Health Promotion and Education, U.S. Centers for Disease Control; Candace Coffey, R.N., Nursing Consultant; and Frederick Kennedy, Ph.D., Management Consultant

Appendix II includes an organizational chart of the EATN.

C. Approaches to Collaboration, Integration and Regionalization

1. Approaches to Collaboration

EATN core staff sit on the boards of a number of AIDS-related organizations in the Atlanta area and make use of their extensive informal networks. Subcontractors were selected, in part, because of their formal and informal relationships with other agencies and organizations involved with the care of patients with AIDS, which have expanded the collaborative efforts to other states in the region.

o Collaboration with Other Federally-Funded Projects

AID Atlanta is the holder of a HRSA Services Demonstration Grant focusing on case management . By virtue of the fact that the EATN's project director sits on the board of directors of AID Atlanta, there is open communication between the two organizations.

Similar collaborative potential exists between the EATN and the HRSA Pediatric Demonstration Project. The pediatric case management project, a collaborative effort between Grady Hospital and the state Department of Human Resources, was conceptualized and funded with assistance from EATN staff.

The only formal ATEU is based at the University of Miami. While it is not lodged directly within the Comprehensive AIDS Program, the same players are involved, thus limiting the collaborative potential between the EATN and

the ATEU. While not formally an ATEU, the Alabama subcontractor is also the recipient of federal AIDS drug research funds, through which the EATN is networked at the cutting edge of AIDS research.

Currently, the only NIMH grant in the region is held by the Comprehensive AIDS Program of the University of Miami. The collaboration between the NIMH grantee and the EATN is somewhat constrained by the competitive situation between the two parent organizations over ETC funding. In spite of this competition, EATN and its subcontractor in Florida have developed good working relationships between clinicians/trainers involved in the NIMH project, and used them as trainers in the EATN program. In April 1990, the EATN itself submitted a proposal to be an NIMH grantee

Informal collegial relationships are the basis of extensive collaboration between the EATN and CDC. CDC staff often serve as faculty for ETC programs and, reciprocally, EATN staff are invited to participate in AIDS conferences sponsored by CDC. The University of Alabama subcontractor provides all HIV-related training for the CDC-supported STD Training Center in Birmingham.

o Collaboration with the AHEC Program

There has been considerable collaboration with AHECs regionwide, predominately at the subcontractor level. The Morehouse subcontract is lodged within the AHEC program of the School of Medicine and, through this structure, three local AHEC centers have been drawn into the EATN programs (Atlanta, Georgia; Dublin, Georgia; Tuskegee, Alabama). Morehouse has provided education and training programs to rural based providers that have been facilitated based on this prior association.

In South Carolina, SCATN has developed a collaborative relationship with the statewide South Carolina Area Health Education Centers and together have provided training at seven sites to nearly 300 participants. AHEC representatives sit on the advisory board to the program.

As part of its role as catalyst and broker, the North Carolina Primary Health Care Association works closely with the statewide AHEC system, one of the strongest in the country. For instance, it has facilitated AIDS training programs sponsored by the AHECs by paying for trainer travel.

The University of Miami Comprehensive AIDS Program is also the seat of an AHEC program in Florida. Because of the competitiveness between the two organizations, collaboration is limited.

o Collaboration with Other AIDS Resources in the Community

The EATN Deputy Director for Training and the Faculty Consultant spend one afternoon each week at the Grady AIDS clinic counseling AIDS patients, providing a needed service while at the same time keeping current on relevant training issues and reaffirming their credibility as AIDS caregivers.

2. Approach to Regionalization

In terms of regional structure, the Emory AIDS Training Network is a highly centralized training program upon which is superimposed a patchwork of autonomous subcontractors, one in each state in the catchment area. In theory, each of the subcontractors was chosen because of a unique area of expertise to contribute to the regional effort as well as having stature and credibility as an AIDS resource within its own state.

D. Organizational Qualities

Prior to the establishment of the EATN, there were not many agencies or organizations involved in training health care professionals in the region. Based on its professional connections and the strong reputation that the EATN' staff had in conducting high quality trainings, EATN has been able to become the premier AIDS/HIV training program in the region.

The strength of the Emory AIDS Training Network lies in its clarity of focus, first on its primary care/public health target and second on what constitutes "training. " EATN has a solid primary care and public health focus that is consistent with the strong tradition in the region of county health departments serving the health care needs of low income people. The backbone of this focus comes from locating the EATN in the Public Health program in the Department of Community Health, School of Medicine. The operationalization of this focus was greatly facilitated by a key staff member's 10 years of experience in family planning training for the region's primary health care/public health community. As a result of this prior experience, the EATN was able to "hit the ground running" with a wide network of primary care providers in place as well as a reputation for quality training.

The EATN is ever-cognizant that "training" is a behavior-oriented undertaking. An undertaking in which absorption of information and attitude change are intermediate steps toward this end and an undertaking in which content and process must be tailored to the job requirements and the degree of receptivity of the group being trained. The ETC is also mindful that effective learning of tasks and skills is not facilitated by mass instruction but rather takes place in smaller, homogeneous groups and an interactive environment. Most of the training done by Emory staff has focused on information-giving and skill-building, with an average program length of a half day. These programs serve 20 to 100 participants, with the average being 40 participants per offering. Initially, about 80 percent of the EATN's offerings were designed according to what the program staff felt was needed in the region and then widely marketed to see who would respond. Over time, that pattern has shifted significantly; currently, 90 percent of the trainings done are custom designed in response to specific requests.

EATN's challenge for the future lies in better defining its regional concept and then managing to optimize the expertise and resources available to it. The regional concept, both in terms of structure and function, of the Emory AIDS Training Network has become somewhat muddied. The program is managed as one core regional program side by side with five autonomous

programs. As previously noted, the Emory-based staff provide training throughout the region, the rationale for this approach being to maintain quality control. Subcontracts were let in each state on the premise that the contractors had areas of expertise or a perspective that would supplement that of the Emory group, a strategy designed with synergy in mind. Unique areas of expertise have manifested themselves in a number of cases--mental health in Florida, community health centers in North Carolina, curriculum development at Morehouse, clinical management at Alabama--but the synergy has yet to materialize. The challenge remains for EATN to find mechanisms for extracting the best each contractor has to offer and put it to use for the benefit of the entire region. This applies not only to the expertise of subcontractors but that of the Emory staff as well.

The organizational structure, under which the central EATN provides training in the same catchment area as its autonomous subcontractors, has been reported as a potential source of problems. Subcontractors have expressed concern that independently scheduled and presented events under the same general aegis cause confusion among their target groups.

The autonomy of the subcontractors also calls into question the ability of the EATN to control the quality of all trainings sponsored under its auspices. While the quality of most of the subcontractors' training appears to be good, it is simply unknown. By working more closely with its subcontractors, the EATN could gain control over trainings beyond those it provides directly. But managing quality outside Emory's immediate purview takes resources away from other things, namely the provision of direct training. Herein lies the trade-off and another challenge for EATN for the future.

All of this perhaps speaks to the need for a more coordinated regional effort. If this is to be accomplished, EATN will have to re-examine its organizational structure. As currently constituted, the management structure of the EATN consists of a Project Director, a Deputy Director for Training and a Deputy Director for Program. The Project Director appropriately deals on a policy level and provides the interface with both HRSA, the university and other ETCs; the Deputy Director for Training coordinates and directs the central training, as well as acting as a trainer; and the Deputy Director for Program is responsible for contractual matters and coordination. In spite of the fact that each of these three managers is enthusiastically pursuing her assigned role, structurally a management gap still exists. The task of defining, organizing and managing a fully integrated regional effort requires someone whose designated job it is to work closely with subcontractors, programmatically rather than administratively, and from a strategy point of view rather than from a day-to-day operational perspective.

IV. EDUCATION AND TRAINING PROGRAM

A. Needs Assessment Activities

A defined role for the central EATN staff is to closely monitor epidemiologic trends, new technologic advances, and legislation that has health care implications for AIDS patients with an eye toward incorporating

this state-of-the-art knowledge into EATN training programs. This information is gathered through formal literature searches as well as establishing informal intelligence-gathering networks, CDC and the North Carolina Primary Care Association figuring prominently into the latter.

In terms of formal assessments, the EATN focus regionally is on demands assessment rather than needs assessment. It has developed demands assessment forms for region-wide use entitled "Your Training Needs: For AIDS and all HIV Infection Issues." Using this form, health care providers are asked to assess their own need for training in a number of subject areas on a five-point scale ranging from "don't need training at all" to "urgent need for training." One survey was targeted toward clinicians and one was targeted toward other health care professionals. The results of the latter assessment indicated the following areas in which training is needed most urgently:

- Ethical/Confidentiality/Discrimination Issues
- Issues Working with the Chemically Dependent (IVDUs)
- Women and Children with HIV Infection
- Minority Issues
- Neuropsychiatric Manifestations of HIV Infection
- SSI, Medicaid, General Assistance and Economics
- Coping with Anxiety and Burnout

In 1988 prior to participation in the EATN, the Florida Mental Health Institute conducted a formal needs assessment which it subsequently drew on to guide the strategic planning for its ETC activities. This assessment involved a survey of attitudes and knowledge about HIV/AIDS among the staff of community mental health centers and publicly-funded drug abuse treatment programs throughout the State of Florida. The State of Florida also mandated three-hours of HIV/AIDS training for all licensed health professionals. This served as a de facto needs assessment for the University of South Florida subcontractor.

B. Training Activities

1. Target Trainees

EATN's target groups include physicians, dentists, nurses, nurse practitioners and other allied health professionals, mental health professionals, chaplains, and social workers. Professionals targeted for EATN work in primary care settings, including community health centers, private physicians' offices, dentists' offices, public health clinics and prison clinics, as well as in hospital settings.

2. Training Activities, Objectives and Methods

The EATN distinguishes between education and training opportunities, and offers both. Education is defined by the EATN to be the acquisition of cognitive information and skills, and training is defined as the acquisition of communicative or technical skills that can be used for improved work performance.

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EATN's approach to organizing its training activities has shifted significantly over the course of the first two grant years. Initially, the EATN developed major courses it felt were needed and then marketed them to the health care providers in the region. In several cases, the response was disappointing. As the response to the AIDS epidemic matures and more health care providers become involved, the emphasis of central EATN has shifted away from AIDS 101, general AIDS update, and training on counseling for HIV testing which it feels is now best left to the individual states to pursue. The subcontractors rather than the central EATN are now more likely to sponsor major conferences, with assistance from the EATN in the form of co-sponsorship, specialty presenters, and planning and evaluation assistance.

The EATN central training staff now more often responds to requests with customized trainings that are more "clinical" in nature and are designed for the specific trainee audience. Current EATN training focus is on topics such as clinical assessment and management, psychological and neurological assessment, skills for mental health professionals, methodologies for HIV-infected substances abusers. Accompanying the shift in direction has been a shift in intensity. The average training event in year 02 lasted more than 4 hours, with 37 events (excluding clinical tutorials) lasting six hours or more.

Ongoing programs and initiatives conducted by the EATN and its subcontractors are described below. See Appendix III for a more comprehensive description of each of the subcontractor's programs.

o Faculty Development/Training of Trainers

The focal point of the **EATN's** train-the-trainers activities was its planned annual one-week summer internship program for 15 interns who would serve as AIDS trainers and resources in their own communities, training both health providers and community groups. This program met with logistical snags and has never been implemented.

Several train-the-trainers events have been held. In September 1989, EATN held a one-week train-the-trainers program for nurses and health educators. The event, held in Atlanta, attracted 12 participants from Georgia, Alabama, and South Carolina, all but one of whom was directly responsible for in-service training or nursing education.

In October 1989, the CHEP/AHEC in Dublin, Georgia, affiliated with Morehouse, presented "Teaching AIDS: Methods and Concepts" for over 40 health educators, nurses, mental health workers and other health providers. The workshop included a review of AIDS statistics,prevention, and transmission and most current strategies for teaching about AIDS, in addition to instruction on how to remain up-to-date on AIDS information and resources.

The Atlanta AHEC which had previously planned train-the-trainers activities identified other pressing priorities and has deferred implementation of its train-the-trainer event. The train-the-trainer program of the PALSS (Palmetto AIDS LIfe Support Services of South Carolina) outreach worker to be offered by SCATN has also been postponed.

o Generic AIDS Education Programs

In the spring of 1988, the Florida legislature mandated three hours of HIV/AIDS training for all licensed individuals. EATN's CAEHCP responded by offering an "HIV Update for Health Care Providers." The update program is for physicians, dentists, dental hygienists, psychologists, school psychologists, mental health counselors, marriage counselors, family therapists, social workers, nurses and nursing home administrators. The program has been approved to meet the requirements set forth by the applicable professional licensing board. The HIV Update Program consists of the following components:

- Epidemiology
- Clinical Manifestations and Treatment of AIDS
- HIV in the Workplace
- Legal Issues
- Cultural Considerations in Prevention, Treatment and Counseling
- Neuropsychological and Mental Health Issues

Initially, there was a heavy emphasis on large AIDS update conferences and generic "AIDS 101." As the epidemic progressed and providers became more AIDS-aware, EATN regional staff focused more heavily on practice-oriented training. The development of "AIDS 102," which included current practice in HIV screening and testing, management of infected asymptomatic patients, current treatment directions and indications, current legal and policy issues, and current assessment of care delivery, was a product of this progression. AIDS 102 has been offered in North and South Carolina and Alabama and will continue to be offered in year 03 for a total of 15 events regionwide.

Individual subcontractors also saw the need for moving beyond the introductory level in their generic course offerings. Based on discussions with the AHEC's Council for Allied Health Professionals, the South Carolina AIDS Training Network designed a one-day program for allied health professionals entitled "Beyond AIDS 101." The AHEC Council approved of the training plan, and it is now being conducted for health care professionals recruited through the seven AHECs. The program is mostly didactic and includes a question and answer session near the end of the day. Each training has between 30 and 75 participants from several disciplines including administrative workers, clergy, therapists, social workers and emergency medical technicians.

o Clinical Training

- a clinical tutorial for physicians and nurses held at Grady Memorial Hospital, (affiliated with Emory University), Atlanta, GA
- a clinical tutorial for primary care residents, also open to community physicians and nurses, offered through the Infectious Disease Department of the Medical School at the University of Alabama at Birmingham;
- a mental health clinical tutorial in Florida offered through the Florida Mental Health Institute at the University of South Florida; and,
- a clinical training opportunity for nurses organized by Morehouse in collaboration with the Georgia Nurses Association and Grady Memorial Hospital.

The Grady Memorial tutorial is described below; the clinical experiences offered by the Florida and Alabama subcontractors are described in Appendix III under the program activities of the respective subcontractors.

The tutorial at Grady Memorial Hospital, which the EATN central office staff were instrumental in establishing, is conducted in the Immunodeficiency Clinic. The tutorial operates under the direction of the medical consultant to the EATN, Dr. Sumner Thompson.

The clinical tutorial is two days long. Each session has four participants and has been repeated, to date, four times for a total of 16 people trained. Each participant is assigned a clinical preceptor who usually has similar training as the participant. The clinic schedule is not changed. There is no stacking of the clinic with "interesting" cases and the pace of the clinic is not slowed to accommodate the participant. They aim for a "real-life" experience. From 9:00 to 3:00 on both days, the attendees are in the clinic. From 3:00 to 5:00 on both days, there are didactic sessions. These didactic sections cover the following issues: Clinical Manifestations and Management of HIV Disease; Diagnosis and Management of Opportunistic Infections; Epidemiology of HIV/AIDS; and The Personal Experience of Treating HIV Infected Patients.

The majority (60 percent) of participants have been doctors and nurses from the public health system. The physicians who work in public health in Georgia are usually involved to some degree in a part-time private practice as well. The rest of the participants have been varied. For instance, a nurse practitioner involved with hemophiliacs attended as well as a nurse from a large infectious disease division. Eighty percent of the participants have been from Georgia, with the rest from of South Carolina.

The cost for these sessions is $150, which does not include housing or travel. The price is high because the participants are provided with several handouts, including three books and many journal articles.

o Initiatives to Impact on Professional School Curricula

Impacting on curriculum in health professional schools has been difficult for all of the **ETCs.** Morehouse, however, seems to have developed a successful process **for getting** its nursing curriculum (described in the next section) implemented into nursing school programs. The collaboration among the nursing schools-in the state and their representation on the advisory board has been instrumental in getting the curriculum implemented into nursing schools. Mary Davis, a full-time staff member on the Morehouse subcontract, is responsible for facilitating the implementation process. The Morris Brown College School of Nursing has approved the integration of the nursing curriculum into its course structure and will serve as a pilot site. Mary Davis, through her professional associations, also managed to secure a spot on the agenda of the quarterly meeting of the Georgia Board of Nursing. She presented the curriculum and then asked for feedback and interest. Those expressing interest in integrating the nursing curriculum into their undergraduate nursing programs were Emory University, Clark/Atlanta University, Georgia Southern University, Georgia State University and the University of Hawaii. Mary Davis is currently following up with these nursing schools. The same implementation process will be used for the other three curricula being developed by Morehouse (physicians, social workers, and allied health professionals).

3. Curricula and Materials Developed or Used

The bulk of the formal curriculum development activities are proceeding under the Morehouse subcontract. Morehouse is working simultaneously on developing curricula for nursing professionals, social workers, physicians and allied health professionals. Separate committees have been established to develop each curriculum comprised of faculty members from the advisory board as well as consultants.

The nursing curriculum, entitled "Nursing Throughout the Spectrum of HIV Disease, " was completed in early 1990. The draft, compiled by the curriculum committee, underwent a wide external review, including members of the EATN training staff. The task of managing and integrating input from individuals and groups from a number of different institutions was a difficult one. However, the comprehensiveness and the richness of the final product is attributed to the incorporation ideas from these different perspectives. The curriculum contains the following modules:

- Introduction to AIDS
- HIV-Related Concepts: Attitudes, Assessment and Infection Control
- HIV Disease and Maternal Health
- Child Health and Adolescent Nursing Pertaining to HIV/AIDS
- Psychosocial Aspects of AIDS

- HIV Disease and Community Health Nursing
- HIV Disease and its Implications for Nursing Management
- Inpatient Care of the Adult with HIV Disease (Medical - Surgical)
- Cultural Aspects of AIDS

Each module includes: a unit **pre/post** test; a basic unit overview; objectives for the unit; sub-unit overviews; sub-unit objectives; pre-unit, in class, post-unit learning activities; references; and supplementary audio visual materials. The curriculum will be used both for incorporation into nursing school programs and for nursing continuing education units.

Three other curricula are being developed, under the Morehouse subcontract, for social workers, physicians, and allied health professionals. The review and implementation process will be similar to that of the nursing curriculum. All curricula have a minority focus. The physician curriculum has been completed, but there is an issue over copyright. The curriculum will not be circulated until this problem has been resolved.

A variety of training materials have been developed by both the EATN training staff and the subcontractors.

- lecture outlines and slides have been developed by the Emory-based staff on the topics Women and AIDS, Psychosocial Support with Persons with HIV.AIDS, and Ambulatory Care for Persons with HIV/AIDS. These packages have been customized for specific groups and used by EATN staff and consultants for presentations; they have been made available to instructors throughout Emory University as well.

- several dozen handouts that can be drawn upon to support a wide variety of training activities have been developed by the Emory-based staff. These include one-page epidemiological and technical fact sheets, clinical guidelines and protocols, "how to" posters, planning tools, teaching/training guidelines, self-tests, values clarification exercises, informational flyers for patients and loved ones, and reference lists.

- a set of over 100 slides was developed by the Emory-based staff for use in clinical training. The slides cover the basic epidemiology of HIV, clinical presentations of persons with HIV, the spectrum of opportunistic infections, and the course of the disease. EATN staff and consultants make use of the slides at conferences and individual presentations as well.

- the EATN arranged for the production of two 15-minute slide presentations on the emotional impact of AIDS diagnosis, called "Remembering Tom" and "Self Por trai ts. "

- the Morehouse AHEC has produced two clinical slide sets on virology and one slide set on transmission, epidemiology and prevention.

- Because SCATN has had continuing difficulty in getting primary care physicians, many of whom have yet to see their first HIV+ patient, to attend training, the subcontractors are designing an information and education packet for primary care physicians to be distributed throughout the state. The packet includes clinical, referral and support information, and is intended to give physicians, especially primary care physicians in the rural area, a source to turn to when they see their first patient. This project is planned for year 03. Dr. Harry Struthers, who currently sees HIV positive patients and who does work in rural areas will provide consultation on this project.

  A dental packet, following a similar format, will also be completed in year 03 of the project under the direction of a dentist who serves as an advisory board member to SCATN.

4. Outputs

In year 01 of the grant, the EATN reached a total of 7,116 health care professionals through its central training activities and those of its subcontractors; in year 02, the total was 12,114.

Demographic information is available on 62 percent of the trainees reached in year 02. Of those trainees for which information is available, 21 percent were physicians, 21 percent were nurses, 8 percent were dentists, and 25 percent were other health care professionals. The remaining 26 percent were administrators and other professionals. By work setting, 16 percent were from private practice settings, 15 percent from hospital settings, 11 percent from student training settings, and 9 percent from health department settings.

C. Efforts to Reach Minorities

Morehouse's participation in the EATN provides the ETC with a strong minority perspective. All curricula being developed by Morehouse have a minority focus, as do the most of the trainings Morehouse has conducted. Continuing education training sessions are being done for the Georgia Black Nurses' Association and Chi Eta Phi, a nursing sorority. In October 1989, it offered a program entitled "AIDS in the Black Community" in two locations in metropolitan Atlanta. A conference conducted by jointly by Morehouse and the Emory-based staff, "HIV Infection and AIDS in the Minority Community," drew a regional audience from South Carolina, Georgia, Florida, and Alabama.

EATN has analyzed data based on the largest ethnic group served by the training participant. In year 02 of the grant, out of approximately 5,000 trainees for which data was available, 20 percent those trained served a majority of black patients/clients, 3 percent served a majority of Hispanic/Latino patients/clients, and 5 percent served a majority of other minority patients/clients.

D. Training Issues and Successes

The EATN, which targets health care professionals of all disciplines, uses professional trainers primarily from the public health discipline. Whenever a program targeting medical professionals is run by non-medical personnel, there is a potential problem with credibility, yet no such problem has materialized at the **EATN.** This is due, in part, to the reputation of the staff and the public health tradition in the region. Further, the EATN has been careful to pair a physician and a trainer together to make all **medically-** oriented presentations, and has expanded the staff participation of its **part-** time physician/trainer to three days a week. The fact that, to date, more than 21 percent of **EATN's** overall participants and 14 percent of the participants at Emory-sponsored events have been physicians, indicates that the ETC does not have a credibility problem with the medical community.

One of **EATN's** major strengths is the skill and talent of its central training staff. For the most part, the training staff members are professional trainers and health educators with expertise in curriculum design, educational materials development, application of appropriate instructional strategies as well as having demonstrated communication skills. In addition, each trainer has had "clinical" experience as an AIDS caregiver: HIV counselor, case manager, support group organizer, volunteer "buddy," hotline volunteer, etc. and keeps up on the latest scientific information on HIV/AIDS. These trainers provide AIDS training not only in Georgia but throughout the region.

Another strength of **EATN's** training program is the systematic way in which the central staff keeps current on AIDS information and disseminates it throughout the network. This not only ensures state-of-the-art training, but consistency of message.

As the EATN program was originally envisioned, each subcontractor was to offer expertise in a particular functional area to the regional program. While the functional areas have been developed (for example, Morehouse - curricula development and minority focus; University of South Florida - mental health; NCPHCA - primary care focus), these strengths have only infrequently **been extended** beyond their local constituency. Developing and implementing a strategy that will capitalize on the strengths of the subcontractors to the benefit of the entire region will be a future challenge for the EATN central office staff.

The issue of what role the central office staff should play in the actual delivery of training outside of Emory's immediate catchment area is one that is receiving continuing attention. As noted, there has been some confusion generated when training events have been conducted by the central staff independent of the other EATN subcontractor in that state. In Georgia, Morehouse, through its AHEC system, is recognized as the appropriate institution to reach rural providers, whereas the EATN staff sees itself as covering the rest of the state. It would serve the EATN well to have its training markets and those of its subcontractors in the other states more clearly defined in order to maintain positive collaborative relationships with its subcontractors as well as to present a more integrated set of training opportunities to the target trainees in the local catchment areas.

By its own assessment, EATN has good quality control over the training managed out of the EATN headquarters, but little or no quality control over the training of its subcontractors. Recognizing this weakness, EATN is trying to do better. In the future, one of the Emory training staff will be assigned to attend the trainings of the subcontractors, and to work with the deputy for program to develop strategies to enhance the overall training quality as well as specific skills.

V. PROGRAM ALMINISTRATION

A. Administrative Systems

1. Program Management and Control Systems

Day-to-day management of the EATN program is the responsibility of the Deputy Director for Administration. She is responsible for overseeing all subcontract activities: subcontract negotiation, workplan review, invoice approval, and review of monthly reports. To date, at least one site visit has been made to each subcontractor.

o Annual Workplan

The ETC's broad statement of goals and objectives serves as a framework for its annual workplan. Annually, the activities that are to be conducted in the subsequent year in conjunction with each project objective are specified along with timeframes for their completion. This provides not only direction for the coming year but provide indicators against which performance and progress can be measured.

0 Contracts Management

The system for handling contracts with subcontractors operates relatively smoothly. The EATN has developed a good working relationship with the Office of Sponsored Programs, which is the university arm responsible for contract management. It is the responsibility of the Office of Sponsored Programs to make sure that the terms of the contract are consistent with the invoice processing system.

In the first program year, it took approximately six weeks to finalize the EATN subcontracts, much of which was due to problems on the subcontractors' end. The Office of Sponsored Programs assisted the EATN in structuring its budget for its grant submission. Turn around time for subsequent contract renewals has been about three days.

0 Financial Management

Most subcontractors invoice monthly; North Carolina invoices quarterly. The invoices are submitted directly to the university, forwarded to EATN for approval, and returned to the university for payment. Checks are generally cut within a week.

In addition to the official accounts for the grant kept by the university, the EATN keeps a parallel set of accounts. The chart of accounts in the university's system is not set up to facilitate management decision-making. EATN's accounts, kept on an accrual basis, allow the EATN to track its funds for planning and management purposes. The system has also enabled the ETC to identify errors made by the university accounting department, mainly charges billed to the wrong account, so that they can be corrected. Subcontractors informally report accrued expenditures in relation to their budgets on a monthly basis.

The EATN has established a separate income account apart from its regular grant account to provide some flexibility. The account revenue comes primarily from registration fees and from honoraria paid to EATN for speaking engagements. This income is used for refreshments and may, in the future, be used for discretionary equipment. This income account is not subject to the university's indirect costs.

2. **Management Information Systems**

EATN has designed an extensive database. Reports from this database are generated whenever needed. Specific reports include:

- number of trainees by state
- number of trainees by profession
- number of trainees. by work setting
- number of trainees by number of HIV-infected persons served in last six months
- number of trainees by largest ethnic group in patient/client population
- number of trainees by ethnic group
- number of trainees by zip code
- event title, location of event, date of event, intended audience, sponsor, event duration, CEUs, number of registrations completed.

EATN typically generates many of these reports in graphic format to highlight the data presented.

3. **Communication and Coordination**

The primary mechanism for coordination within EATN is the quarterly meetings that are held for all subcontractors.

One method the EATN uses to communicate to its regional constituency, including but not limited to subcontractors, is a monthly letter to each of them. This letter summarizes AIDS activities in the state for the coming month. This approach to coordination has been generally well-received by most subcontractors, but the South Carolina subcontractor, who prefers that it be the focal point of AIDS training in the state, has requested that EATN discontinue the letter to their state.

While CompuServe is available as a communication mechanism within the Network, it is used primarily by the Florida subcontractor.

4. Marketing the ETC

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AIDS" posters ("Information About Can Be Shared") and a button ('Latex: The Moral Fiber of America"). The EATN regularly displays at national conferences.

Two of the subcontractors have established a name unique to the grant: South Carolina AIDS Training Network; and the Center for AIDS Education for Health Care Providers at the University of South Florida. In the case of the latter, several press releases have been issued and all faculty make a point of referencing the Center in interviews and statements. The brochures marketing the various trainings are professionally produced. This strong marketing effort adds credibility and a sense of identity to the Center.

5. Coordination

cross-fertilization and feedback take place to obvia additional advisory groups to guide the EATN program in Georgia. On the

B. Systems for **Managing** Training Events/Programs

1. **Marketing** Training Events

The EATN produces a regionwide training calendar approximately every six months which lists upcoming training events. The calendar is disseminated to a mailing list of over 4000 health care agencies and providers.

In addition, the Emory-based training staff and each subcontractor do their own marketing of individual training events, via a more detailed brochure and more targeted mailing lists.

2. Trainee Recruitment/Selection

Initially, about 80 percent of the **EATN's** offerings were designed according to what the program staff felt was needed in the region and then widely marketed to see who would respond. Over time, that pattern has shifted significantly; currently, 90 percent of the trainings done are custom designed in response to specific requests.

3. Registration Fees

Nominal registration fees are charged for EATN offerings to cover the cost of the training rooms and refreshments. Fees are set at a level just high enough to minimize the number of "no-shows," $15-20 for the typical offering and $50-150 for clinical tutorials.

4. Quality Control

By its own assessment, EATN has good quality control over the training managed out of the EATN headquarters, but little or no quality control over the training of its subcontractors. Recognizing this weakness, EATN is trying to do better. In the future, one of the Emory training staff will be assigned to attend the trainings of the subcontractors, and to work with the deputy for program to develop strategies to enhance the overall training quality as well as specific skills.

5. Output/Outcome Reports

At each training conducted by the EATN training staff or by a subcontractor, participants are asked to complete a form entitled "How Did We Do." These forms are forwarded to the EATN office for input into the regional database mentioned above.

C. Training Sites

Classrooms and auditoria in the medical, dental, nursing and theology schools of Emory University are available for EATN events. Additionally, Grady Memorial, an EUSM affiliated hospital, is the sites for clinical tutorials. Other university centers in the Atlanta area, including the Atlanta University Complex, Georgia Institute of Technology and Georgia State University are willing to make arrangements for the use of their facilities

for EATN events. The Emory AIDS Training Network also has access to the large number of hotels and conference centers in the Atlanta area. Finally the primary subcontractors facilitate site arrangements through their respective organizational connections.' Training sites were not mentioned as a problem by either the subcontractors or the central office staff.

D. Cost Sharing

As a private university, Emory has not provided a great deal in the way of in-kind contribution to the ETC. Its major contribution to cost sharing is the office space and its maintenance supplied to the EATN free of charge. From its point of view, the University also provides in-kind contribution in the form of a discount on its indirect cost rate. Emory's usual indirect rate is 52 percent with the minimum being 10 percent, but for the EATN grant, the HRSA-required rate of 8 percent is charged on all expenditures from the central grant except equipment. In addition, the 8 percent indirect rate is only charged on the first $25,000 of a subcontract, to a maximum of $2000. Subcontractors are held to charging 8 percent even though they are not technically required to do so.

Fees are charged for many of the EATN offerings; although the philosophy is to avoid levying fees that would serve as a barrier to participation.

B. **CEUs**

CEUs; es and nurse practitioners need r i d a , all health professionals are required to have continuing education with regard to **HIV/AIDS.** It is generally felt that having **CEUs**

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F. Library/Information Services

EATN operates a warmline, designed to assist callers to access information about EATN training events, clinical referrals and AIDS education materials. The log kept of these calls indicates that most calls were for information on EATN training offerings and for technical assistance or training planning assistance.

Information and materials from the National AIDS Information Clearinghouse (NAIC) have been assembled for distribution to trainees and **warmline** callers throughout the region. All subcontractors have access to NAIC.

EATN does not currently produce a newsletter. The ETC appreciates the value of this type of communication tool and is currently considering undertaking such an activity.

'EATN maintains a small reference library at its headquarters, but feels that it is inappropriate to build a large AIDS library when there is such ready access to nearby university libraries. Additionally, training materials developed by EATN and those developed elsewhere but used routinely in EATN trainings are well-organized and readily accessible at the EATN headquarters. In Florida, the CAEHCP maintains a comprehensive library specifically related to AIDS and mental health issues/interventions.

G. Other Services

In addition to its primary role as a provider and a coordinator of AIDS education and training, EATN staff do limited consulting on AIDS policy issues with a potential for changing the health care system.

H. Sustainability

At the center of its strategy for sustainability, EATN counts on the durability of Emory University itself. By building a strong network onto this base, it hopes to sustain AIDS training efforts beyond the institutional and geographical boundaries of Emory.

More specifically, the EATN strives to establish itself as a credible and professional entity for AIDS training. Disseminating its regional training calendar to a large mailing list has been part of the implementation of this strategy. It has strongly targeted the public sector health provider market during the grant period in order to establish a permanent market niche.

VI. SUMMARY AND FUTURE PLANS

The Emory AIDS Training Network is centered at in the Department of Community Medicine of the Emory University School of Medicine. For the most part, affiliation with Emory University has been facilitative. However, the

university bureaucracy with regard to staffing has posed a impediment during the start-up phase and more recently with regard to EATN salary increases. As a private university, Emory's ability to provide in-kind contribution to the ETC program has been limited.

The Emory AIDS Training Network is a highly centralized regional training program overlaid with one independent subcontract in each of the five states of its region. Initially, the Emory-based staff and its subcontractors operated much like separate entities. There was little evidence of a regional strategy or little in the way of coordination between EATN and subcontractor training activities. This shortcoming has been recognized by the ETC and efforts are underway to achieve a more integrated program.

The roles of the subcontractor within their respective states differ from state to state: several subcontractors are the primary training providers in their state; others provide specialized training to a more limited group of target trainees; one does not provide training at all but serves as a catalyst for the other training resources in the state. In addition to their role within the state, each of the subcontractors was identified as having an area of expertise to contribute to the regionwide effort. To date, however, subcontractors have done little on a regional basis. Developing a strategy to capitalize on the strengths of the subcontractors for the benefit of the wider region will be a challenge for the EATN as it proceeds with program development.

In spite of organizational shortcomings, the EATN has definitely filled a void. Before the establishment of the EATN, there were only a few organizations involved in AIDS training of health care professionals, Florida and to some extent North Carolina being notable exceptions. Based on prior reputations, professional connections, and the quick organization of the EATN program, the Network has become recognized as the premier AIDS training entity in the region.

The EATN underscores the importance of being able to change and adapt along with the course of the epidemic. Changes in program emphasis as well as organizational approaches have helped to make the EATN more and more responsive to the training needs of the region. In the future, the Emory-based staff will expand the clinical training opportunities and broaden outreach to institutions providing training to health professions students. The University of South Florida will expand its current efforts as well as provide regional assistance to other EATN members in the development and delivery of mental health training in the area of AIDS. Morehouse will continue its trainings focusing on minority issues as well as trainings focusing on rural health settings. Additionally, it will finish the development of its curricula and begin the implementation into health professional schools. The University of Alabama at Birmingham will expand its community-based training, conducting regional HIV seminars for physicians, nurses, and social workers across the state and will expand its clinical tutorial program and collaborate with the CDC-funded STD Training Center in Birmingham to offer HIV education to its students. The University of South Carolina AIDS Training Network plans to implement graduate level public health preservice training courses at the University of South Carolina, and will develop two self-instructional packets for physicians and dentists and an

HIV/AIDS education program for correctional health workers. The North Carolina Primary Health Care Association will develop bilingual programs and materials for training migrant/community health center providers. NCPHCA will also coordinate Emory's participation in training programs sponsored by the AHECs and the AIDS Control Branch of the Department of Environment in North Carolina. Regionally, NCPHCA will offer assistance in the development and implementation of migrant and community health center AIDS training.

APPENDIX I

Goals and Objectives

GOALS AND OBJECTIVES

GOAL I (Organizational):

Establish a regional center for the delivery of high-quality AIDS education and training to health professionals in public and private practice, government and voluntary agencies, professional associations and health professions schools/training programs in the states of Florida, Georgia, Alabama, North Carolina and South Carolina.

Objectives:

1. Establish and equip an AIDS Education and Training Center within the Department of Community Health, Emory University School of Medicine, to provide clinical and didactic AIDS education and training to a broad range of health and ancillary care providers within the six-state southern region.

2. Identify and contract a regional network of target audiences/individuals who will be the recipients of project training, education and materials.

3. Execute a plan to continue operation in the absence of federal funds.

GOAL II (Needs Assessment):

Assure that the content of training and education material represents the best clinical, epidemiological and health resource management information currently available about AIDS; that it meets the needs of target audiences; that it is sensitive to cultural differences and to changing trends in the epidemic.

Objectives:

1. Analyze demographic and epidemiologic information about AIDS in order to anticipate changes in training content, disease management and prevention strategies.

2. Conduct needs assessment activities to assess current level of AIDS knowledge of target training audiences, trainees' perceptions of current training needs and trainees' assessment of projected training needs.

GOAL III (Training Delivery):

Design and conduct AIDS training and education programs for health and helping professionals in both the public and private care sectors.

Objectives:

1. Design training workshops and curricula to address the AIDS training/education needs of target audiences of health professionals.

2. Conduct training for target audiences in the diagnosis, management and counseling of HIV-infected persons.

3. Design and implement a train-the-trainer program to certify educators for around the region as qualified AIDS trainers.

4. Introduce AIDS into preservice education programs for health professions students.

GOAL IV (Materials Development/Distribution):

The ETC will research, design, develop, distribute and evaluate educational materials, clinical care manuals and audiovisuals that are designed to target selected care providers and training audiences with current, practical information about the diagnosis, management and counseling of HIV-infected persons in ambulatory care/private practice settings. The emphasis will be on high quality materials that can be easily replicated and quickly disseminated to target audiences, and on materials that are culturally sensitive to the needs of a variety of audiences.

Objectives:

1. Research the current availability and cost of existing AIDS education materials, analyze their content and usefulness and create a training resource library.

2. Evaluate the usefulness and effectiveness of its developed AIDS education and training materials.

GOAL V (Education):

Using formative, impact, process and outcome evaluation measures, the Emory AIDS Training Network will evaluate the effectiveness of its training and education programs and materials.

Objectives:

1. Involve members of ETC's target training audiences in the development of training programming, curriculum and materials (formative evaluation).

2. **Apply** impact and process evaluation methods to the conferences, multi-subject regional conferences, workshops and preservice/inservice education programs conducted by the ETC or its subcontractors.

3. Evaluate the performance of summer training interns.

APPENDIX II

RATN SUBCONTRACTORS AND THEIR ACTIVITIES

UNIVERSITY OF SOUTH FLORIDA

CRNTRR FOR AIDS EDUCATION FOR HEALTH CARR PROVIDERS

A. Organizational Background

The EATN subcontract for the state of Florida was given to the Department of Community Mental Health, Florida Mental Health Institute, a Division of the University of South Florida (USF), The Department of Community Mental Health is divided into three areas: Continuing Education; Clinical Services; and Research.

B. Structure and Staffing

1. Structure

Although involved in AIDS training before the subcontract. with EATN, the grant monies provided an impetus to establish a Center for AIDS Education for Health Care Providers (CAEHCP) within the Continuing Education Division. In establishing the CAEHCP, the ETC program has become institutionalized in the Department of Community Mental Health.

The goals of the Center are as follows:

1. To provide basic AIDS education to all health care providers in Florida;

2. To provide specialized AIDS training to mental health professionals;

3. To serve as a clearinghouse for HIV information and learning materials for health care professionals; and

4. To provide consultation regarding mental health issues in HIV disease to requesting public agencies.

The strategic direction of the Center is decided at the site level with input on regional direction provided by EATN. Although the original scope of work included the entire state of Florida, this changed somewhat when the Miami Education and Training Center was funded. The funding of the Miami ETC has removed Dade and Monroe Counties as well as the Florida four medical schools from EATN's catchment area.

2. Staffing

The Director of the Center is Michael D. Knox, Ph.D., Chairperson and Associate Professor of the Department of Community Mental Health. Dr. Knox, who is a psychologist by training, serves the project on a 10 percent basis and is the Center Director. The Center Coordinator is Martha F. Anker, Ph.D., serving the project on a 50 percent basis. Dr. Anker, who is also a psychologist, is the Director of the Continuing Education Division. The

structure of the Center within the University and other key staff are indicated in Attachment A-l. There is also a diverse Center faculty, including a lawyer, a HRS State AIDS Program Administrator, a Philosophy instructor and an Infectious Disease specialist.

C. Education and Training Activities

1. Needs Assessment

A formal needs assessment was done by the Florida Mental Health Institute in October 1988. A survey of attitudes and knowledge about HIV/AIDS was distributed to randomly selected community mental health centers and all publicly funded drug abuse treatment programs in Florida. The direction for the mental health portion of CAEHCP's program is largely based on this formal needs assessment.

2. Response to State Mandated AIDS Training

In the spring of 1988, 'the Florida legislature mandated three hours of HIV/AIDS training for all licensed individuals. This legislation served as a de facto needs assessment. The Center has fulfilled this role for health care providers by providing an HIV Update for Health Care Providers. The update program is for physicians, dentists, dental hygienists, psychologists, school psychologists, mental health counselors, marriage counselors, family therapists, social workers, nurses and nursing home administrators. The program has been approved to meet the requirements set forth by the applicable licensing board. The HIV Update Program consists of the following components:

- Epidemiology
- Clinical Manifestations and Treatment of AIDS
- HIV in the Workplace
- Legal Issues
- Cultural Considerations in Prevention, Treatment and Counseling
- Neuropsychological and Mental Health Issues

Trainers selected by the Center staff conduct the program. Generally, each program features six speakers. The program is evaluated using the regional "How Did We Do" form.

3. Mental Health Clinical Tutorial

South Florida's CAEHCP offers a mental health clinical tutorial consisting of a three-day intensive program targeted toward mental health professionals and results in certification as an "HIV Mental Health Specialist. " The goal of the program is to provide mental health professionals with the skills necessary to become HIV/AIDS treatment resources within their own agencies or institutions.

Upon completion of the workshop, which includes both a didactic and an experiential component, participants are prepared to perform the following activities:

- conduct psychological assessment and intervention that is appropriate to individuals affected by HIV;
- instruct clients in reducing their risk for HIV infection;
- train staff members to operate educational groups for HIV prevention among clients;
- develop and operate HIV/AIDS support groups;
- develop inservice programs on HIV/AIDS and mental health; and
- access appropriate resources for information, consultation and referral regarding HIV/AIDS.

To select participants, two priorities have been set: 1) professionals working within the public mental health system, including community mental health centers, state psychiatric hospitals, and departments of mental health services in correctional facilities; and 2) participant racial/ethnic and geographic diversity. Four to six participants attend at one time. The participant group is kept small to allow for maximal discussion, participation and interaction.

The tutorial includes practical training through observation and/or participation in HIV-related mental health assessment and intervention in the clinical division of the Department of Community Mental Health. The faculty involved in the tutorial are six psychologists, two physicians (one of whom is a psychiatrist), one rehabilitation counselor, one professor of philosophy and ethics, and one attorney. The topic areas include:

- mental health overview;
- medical, psychiatric, and historical issues;
- neuropsychological assessment (Immunodeficiency Clinic, Florida Mental Health Institute);
- HIV/AIDS medical update;
- suicide risk assessment;
- depression and cognitive therapy;
- psychoeducational AIDS module for chronically mentally ill adults;
- prevention and client training;
- issues of chronic and terminal illness; and
- ethical issues.

As part of the tutorial, participants attend a support group sponsored by the Tampa AIDS network, a panel discussion with one panel member being a patient living with AIDS, and attending the quarterly network meeting for health care providers.

11 sessions were scheduled in year 02. As of April 1990, 49 participants had been through the tutorial. The majority of the participants was from the State of Florida; however, four other states have also had a participant. Most participants, to date, have been psychologists; other participants have included nurses and social workers. One attendee was from the State of Wyoming and involved in the Mountain-Plains Regional AIDS ETC. This participant will be coordinating the NIMH effort in Wyoming. The tutorial qualifies for 20 continuing education units and participants are asked to pay **$35** plus travel and board to attend.

D. Interagency Coordination

CAEHCP communicates with the EATN through a CompuServe electronic mail sys tern. Monthly progress reports and budget updates are also submitted to EATN .

E. Regional Relationship

The relationship between CAEHCP and EATN has been a good one. The EATN has let the subcontract operate fairly autonomously. CAEHCP feel that it is a significant benefit to have the EATN deal with the federal funder on their behalf. This facilitates administration for CAEHCP and allows more time to concentrate on trainings.

MOREHOUSE SCHOOL OF MEDICINE

A. Organizational Background

The Morehouse School of Medicine (MSM) is a subcontractor to EATN. MSM was chosen because of its expertise in designing and implementing training programs for minority and inner-city populations and for providers who care for minority and inner-city populations. MSM was also included in the EATN because of its expertise in reaching rural areas through its Area Health Education Center (AHEC) Program. MSM is associated with three AHEC sites: one in Atlanta, Georgia; one in Dublin, Georgia; and one in Tuskegee, Alabama.

B. Staffing

The scope of work under the subcontract is for MSM to both develop and implement curricula in medical and health professional schools and provide trainings on HIV/AIDS to health professionals in the State of Georgia. The key staff involved in the Morehouse effort are: Daniel Blumenthal, M.D.; Mary Davis, R.N.; Clementine Marrow, M.A.; Meryl McNeal, Ph.D., and William Alexander, M.D.

C. Interagency Coordination

The MSM works closely with the Morris Brown College Nursing Program, Emory University/N.H. Woodruff School of Nursing, Clark-Atlanta University School of Social Work, Clark-Atlanta University Allied Health Program, Georgia Nurses Association, Black Nurses Association, Auburn University School of Pharmacy, Auburn University School of Nursing, Georgia State University School of Nursing, University of Georgia School of Pharmacy and Chi Eta Phi Nursing Sorority. Representatives from each of these schools and associations and the Directors of the three AHECs sit on the advisory board for the AIDS Education and Training Project of the MSM.

D. Education and Training Activities

1. Curriculum Development

Morehouse is working simultaneously on developing curricula for nursing professionals, social workers, physicians and allied health professionals. Separate committees have been established to develop each curriculum comprised of faculty members from the advisory board as well as consultants.

The nursing curriculum, entitled "Nursing Throughout the Spectrum of HIV Disease," was completed in early 1990. The draft, compiled by the curriculum committee, underwent a wide external review, including members of the EATN training staff. The task of managing and integrating input from individuals and groups from a number of different institutions was a difficult one. However, the comprehensiveness and the richness of the final product is attributed to the incorporation ideas from these different perspectives. The curriculum contains the following modules:

- Introduction to AIDS
- HIV-Related Concepts: Attitudes, Assessment and Infection Control
- HIV Disease and Maternal Health
-
- Psychosocial Aspects of AIDS
- HIV Disease and Community Health Nursing
- HIV Disease and its Implications for Nursing Management
- Inpatient Care of the Adult with HIV Disease (Medical – Surgical)
- Cultural Aspects of AIDS

Each module includes: a unit **pre/post** test; a basic unit overview; objectives for the unit; sub-unit overviews; sub-unit objectives; pre-unit, in class, post-unit learning activities; references; and supplementary audio visual materials. The curriculum will be used both for incorporation into nursing school programs and for nursing continuing education units.

Three other curricula are being developed, under the Morehouse subcontract, for social workers, physicians, and allied health professionals. The review and implementation process will be similar to that of the nursing curriculum. All curricula have a minority focus. The physician curriculum has been completed, but there is an issue over copyright. The curriculum will not be circulated until this problem has been resolved.

2. Community-Based Training

The Morehouse School of Medicine has also conducted several **community-**based trainings. These trainings focus, for the most part, on AIDS in the minority communities and AIDS trainings conducted through the three **AHECs.** One conference, **"HIV** Infection and AIDS in the Minority Community," drew a regional audience from South Carolina, Georgia, Florida and Alabama.

Additionally, four continuing education training sessions will be conducted for the Georgia Black Nurses' Association and Chi Eta Phi, a nursing sorority, using modules out of the curriculum. Participation in this program is free of charge.

The year 03 objectives of MSM are to continue with the development, implementation and dissemination of its curricula. Another program planned is one to train pastoral care counselors in black communities in counseling and addressing the mental health needs of people with HIV infection and AIDS. Pastoral counselors are seen by Morehouse as being in an opportune position to play an increasing role in AIDS education activities due to their consistent contact with the black community.

3. Clinical Training

The "Nursing Throughout the Spectrum of HIV Disease" curriculum is being used for continuing education programs being conducted by Morehouse. One program was conducted in response to an education and training needs

assessment done by the Georgia Nurses' Association. Based on the results of this needs assessment, a three-day workshop was developed by Morehouse incorporating both didactic and experiential training. The didactic part of the training will use the curriculum as a guide. The experiential portion of the program is carried out at the Grady Infectious Disease Clinic. This part of the program includes attending case meetings of inpatients as well as going on rounds with the attending physician. This arrangement was made possible by Dr. Sumner Thompson who serves as a medical consultant to the EATN. The training was co-sponsored by the Georgia Nurses' Association. Participants were charged $50 to participate in this program plus a $10 continuing education fee.

4. Impact on Professional School Curricula

The collaboration among the nursing schools in the state and their representation on the advisory board has been instrumental in getting the curriculum implemented into nursing schools. Mary Davis, a full-time staff member on the subcontract, is responsible for facilitating the implementation process. The Morris Brown College School of Nursing has approved the integration of the nursing curriculum into its course structure and will serve as a pilot site. Mary Davis, through her professional associations, also managed to secure a spot on the agenda of the quarterly meeting of the Georgia Board of Nursing. She presented the curriculum and then asked for feedback and interest. Those expressing interest in integrating the nursing curriculum into their undergraduate nursing programs were' Emory University, Clark/Atlanta University, Georgia Southern University, Georgia State University and the University of Hawaii. Mary Davis is currently following up with these nursing schools.

A. Organizational Background

who serves as the Principal Investigator (funded at 10 percent time); Herman Allen who serves as the Administrator of the project at 25 percent time; and Eva Allen, a graduate student in Public 'Health, who takes care of the logistics of the training programs. In year 03, the SCATN plans to hire a full-time Assistant Project Director.

2. Advisory Committee

The SCATN has an advisory board consisting of members from all over the state and in a variety of disciplines. The board meets quarterly. Board members are from several different agencies and organizations, including USC School of Public Health, Midlands Technical College (largest trainer of allied health professionals in the State), South Carolina Medical Association, Richland Memorial Hospital, Greenville Memorial and the state AHECs. This has been a very active board and is instrumental in assisting in the planning the strategic direction of SCATN.

c. Education and Training Activities

1. Needs Assessment

The SCATN has taken a proactive approach to planning trainings. SCATN staff found that most health care professionals in the state had participated in at least one AIDS/HIV class or session and were not really interested in further training in the area. This is in part due to the low incidence of AIDS in the state. The SCATN staff, however, decided that this was denial and the staff contacted organizations which they thought needed the training. After presenting the SCATN and its training strengths, most organizations contacted were enthusiastic about the training possibilities. SCATN staff and the organizations then work together in identifying the particular training needs and the SCATN staff develop a program to address these needs.

2. Community-Based Training

The SCATN also responds to requests for training. One such request came from the Adoption Service Division of the Department of Social Services. The request was to provide AIDS/HIV training to their staff in order that the staff could then train foster parents in the care of AIDS/HIV children. The trainees included social workers, nurses and other health professionals. The trainers included an AIDS/HIV health instructor who works extensively with the SCATN program who also was a foster parent to a child who had died of AIDS.

The SCATN is planning on conducting this type of training all over the state.

There are seven AHECs in the State of South Carolina. AHEC programs are planned by discipline-specific councils, and several representatives from the AHEC sit on the advisory board. The SCATN approached AHEC's Allied Health Professionals Council to discuss possibilities for training. Based on discussions with this group, the SCATN designed a one-day program for allied health professionals entitled "Beyond AIDS 101." The Council approved of the training, and it is now being conducted for health care professionals recruited through the seven AHECs. The program is mostly didactic and includes a question and answer session near the end of the day. Each training has between 30 and 75 participants from several disciplines including administrative workers, clergy, therapists, social workers and emergency medical technicians.

SCATN has also done several other AIDS/HIV trainings reaching physicians, dentists, nutritionists, mental health workers, hospice nurses and community voiunteers, among others. These trainings are conducted by skilled trainers listed on a training roster maintained by the EATN. The Principal Investigator chooses the trainers most appropriate for each session. The evaluation form and registration form developed by the regional office are used in all of the above mentioned trainings.

The SCATN staff have noted that it is difficult to get primary care physicians to attend trainings. Many physicians have yet to see their first patient who is HIV positive; and, thus, do not see the need for further training. To reach these physicians, SCATN is going to design an information and education packet for primary care physicians to be distributed throughout the state. The packet will include clinical, referral and support information. The objective in designing and distributing this packet is to give physicians a source to turn to when they see their first patient. The packet is especially intended for primary care physicians in the rural areas. This project is planned for year 03. A physician, Dr. Harry Struthers, who currently sees HIV positive patients and who does work in rural areas will be hired to consult on this project.

An advisory board member, who is a dentist, thought this packet would be a good idea for dentists also. This project will also be completed in year 03, with this same advisory board member most likely to lead the effort.

Other plans for year 03 are to develop a curriculum for use in Allied Health Professional Schools. The goals of this curriculum are to enable health students to incorporate universal infection control precautions into their practice setting and to enhance the interpersonal skills of allied health students in dealing with seropositive individuals in their practice settings. The curriculum will address the practice needs of students in nursing, practical nursing, medical technology, radiologic technology, nuclear medicine technology, surgical technology, dental hygiene, dental assistantship, respiratory therapy, pharmaceutical technology, medical laboratory, medical assistantship and medical records technology programs. The curriculum will be developed jointly by the University of South Carolina School of Public Health, the Midlands Technical College and the AHEC Allied Health Council.

3. Training for Correctional System Health Care Staff

SCATN in planning a program for the health care staff of the South Carolina Correctional System. The program will be a day and a half long and include a didactic component, small group sessions and role playing. Approximately 100 participants are expected, including physicians, nurses, counselors and prison chaplains. The program will provide preservice and inservice HIV/AIDS education and training, including special focus workshops on cultural sensitivity and HIV, substance abuse issues, social service support needs of inmates, special needs of female inmates and pre-release counseling about HIV/AIDS.

D. Regional Relationship

The SCATN approach to its subcontract with the Emory AIDS Training Network (EATN) is that SCATN will have a statewide focus. This has proved difficult to implement. EATN has its own training program that it carries out in all states throughout the southeast region, independent of the programs of the particular subcontractor located in each state. SCATN would prefer that instead of working independently on trainings in South Carolina, EATN would work in collaboration with the SCATN program. This collaboration does not necessarily mean conducting the program jointly, but rather collaborating on the planning of trainings jointly. This opinion was expressed to the EATN staff, and they were very responsive to the issue. The Principal Investigator of SCATN feels comfortable with the resolution of the problem.

Communication between the South Carolina AIDS Network and the Emory AIDS Network is quite good. As mentioned previously, EATN was very responsive in dealing with **SCATN's** earlier concern about regional versus state trainings. The Principal Investigator suggested that the region could further facilitate the sharing of resources throughout the region. Two methods suggested for doing this are to establish a regional newsletter and to distribute to each state ETC materials that have been developed in other states within the region.

UNIVERSITY OF ALABAMA AT BIRMINGHAM

A. Organizational Background

The subcontract with the University of Alabama at Birmingham (UAB) is lodged in the Infectious Disease Department of the Medical School. The subcontractor has established an identity as the **UAB/AIDS** Training Center, but in recognition of its ETC funding, also refers to its participation in the Emory AIDS Training Network. Capitalizing on the resources and expertise of the Infectious Disease Department, the subcontractor is exploring strategies to expand the pool of AIDS resources to the primary care and public health sectors, especially those in less urban areas.

B. Staffing

The activities of the UAB subcontractor are coordinated by Peter Pappas, M.D. Dr. Pappas devoted 20 percent time to the project. He is supported by Rebecca Langner, R.N. who provides 40 percent time to the project, Susan Wilder, M.S.W., who provides 20 percent time to the project, and William Weaver, Ph.D., who provides 10 percent time to the project.

C. Education and Training Activities

1. Community-Based Training

The subcontractor has also cosponsored two conferences on clinical AIDS issues for primary care physicians, with some nurses in attendance. The conferences, in Mobile and **Decateur** (the former cosponsored with the University of Southern Alabama), targeted high incidence urban areas. The subcontractor also sponsored a two-day nursing/social work seminar for 100 participants in Birmingham.

To extend its programs outside of the urban areas, the subcontractor has begun to market itself to local medical societies and to piggyback on the structure of the Centers for Disease Control-funded STD clinic run by the Public Health Department in **Jefferson County.** The subcontractor is beginning to capitalize on the linkages between rural referring physicians and the 1917 Clinic, accepting speaking engagements organized by the local referring physician using the management of the patient's specific conditions as the focal point and drawing card of the training.

2. Clinical Training

At the heart of the physician training program is a clinical experience held in conjunction with the Department's weekly multidisciplinary AIDS research and teaching clinic, known as the 1917 Clinic (named after the clinic's street address). The clinic, which operates one afternoon per week, is staffed by residents and attending physicians, medical social workers, **dieticians,** a dermatologist, a dentist/oral pathologist, and a registered nurse. A psychologist is also available for consultation. The clinical experience includes an orientation to the clinic, an opportunity to observe initial physician interviews, and involvement in the examination process and

subsequent case discussions. The clinical experience is structured so that participants are involved in four to six consecutive clinic sessions, supplemented by weekly "chalk talks. "

The clinical experience was originally organized to train general internal medicine and primary care residents in the university system. It has recently been opened up to community physicians and nurses. Marketing has been mainly through word of mouth but is being expanded to take advantage of the resources of the STD Training Center. Community caregivers have expressed interest, but participation has been limited. To date, six nurses from community hospitals and one or two community physicians have taken advantage of the clinical experience. Their participation has been limited to attendance at only one clinical session due to factors of distance and limited time away from their practice. A physician at one of the prisons has recently made a commitment to participate in the clinical experience for as long as it takes for him to become comfortable in treating HIV positive patients.

D. Regional Relationship .

The UAB views its participation in the EATN quite positively. It appreciates the expansion of its training efforts that have been made possible through EATN funding. While it markets its training as emanating from the UAB AIDS Training Center, it always acknowledges its EATN support.

The subcontractor has expressed concern over the independent planning and marketing trainings simultaneously and collaterally by the EATN and the UAB, primarily because of the potential to induce competition for trainees and for the confusion that might be caused among prospective trainees. The subcontractor acknowledges that coordination has improved significantly.

The UAB subcontractor's major contribution to the regionwide program is its pilot testing of a technology known as the "Q System." The "Q System" is a portable computer with 32 response pads, much like those used on TV game shows. A set of questions and multiple choice answers are programmed into the computer to correspond with the content flow of the presentation. During the course of the presentation, the presenter triggers the computer to flash the appropriate question and answer choices on a large monitor for the trainees to see. Those seated at the response pad stations key in their answer. The responses are immediately tabulated by the computer and presented on the monitor. This immediate feedback enables the presenter to ascertain whether his/her points are being grasped before moving on to a new area. In addition, the responses are automatically stored in the computer for subsequent use in evaluation studies. The subcontractor pilot tested the "Q System' at a resident research conference and found the technology to be very engaging, keeping the trainees alert and lightening up the session. The technology may be particularly motivating for the laggards in the group as it enables trainees to position their own comprehension and attitudes, anonymously, among their peers.

NORTH CAROLINA PRIHARY HEALTH CARE ASSOCIATION

The EATN subcontractor in North Carolina is the North Carolina Primary Care Association (NCPHCA). The EATN activities of the NCPHCA are coordinated by its executive director, Steven Shore. The organization's Migrant Health Specialist and its Communications Director contribute 12 days and 15 days per year respectively to the EATN effort.

The North Carolina Primary Care Association (NCPHCA) has three defined roles within the EATN's program:

- to broker the existing training resources within the state of North Carolina;
- to provide the primary health care focus to the regional program; and
- to give the regional program national visibility.

In North Carolina, there are many established players in the AIDS training arena: four medical schools; an AHEC system, which is one of the strongest in the country; and a state Red Cross chapter devoted to AIDS education. With its small subcontract, it would not have been appropriate for the NCPHCA to try to position itself as a training provider, even among its constituency of community and rural health centers. The first two years have been spent primarily making contacts on both the provider and recipient side, concentrating on its role as a broker of training services. During this time period, a state advisory board was also formed. In Year 03, the subcontractor will expand its role, serving as a catalyst. It will co-sponsor events, providing honoraria and travel through its budget, and speakers and materials from elsewhere in the Network. Without these additional resources, its cosponsoring partner would not otherwise be able to put on the event. As a cosponsor, NCPHCA will be able to hold its cosponsoring partners accountable to EATN standards of training and require EATN evaluation. NCPHCA also serves as a conduit for disseminating resources developed in other parts of the Network. For instance, the AHECs have been made aware of the curriculum being developed at Morehouse and are anxious to have it when it is completed.

The NCPHCA helped to give EATN access to the publicly funded primary care market by getting EATN-sponsored programs onto the agenda of the annual Region IV Primary Care Conference for the past two years. In the 1989 conference in Atlanta, the EATN presented a medical care update. In 1990, it made a presentation on case management in rural areas. This presentation was very useful in recruiting trainees into the EATN clinical training program at Grady Memorial Hospital.

NCPHCA, as a representative of HRSA 330-funded primary care providers in North Carolina, provides a linkage to another branch of HRSA. This is a unique relationship within the national ETC network. Through NCPHCA's national primary care network of 600 health centers serving 6 million people, EATN has the opportunity for national visibility with regard to primary care and AIDS.

Mid-Atlantic AIDS Regional Education and Training Center

Case Study

MID-ATLANTIC AIDS REGIONAL EDUCATION AND TRAINING CENTER

CASE STUDY

I. PROGRAM OVERVIEW

The Mid-Atlantic AIDS Regional Education and Training Center (MAARETC) has its headquarters at the University of Maryland at Baltimore (UMAB). As funded, MAARETC's region covers the states of Maryland, Delaware, Virginia, West Virginia and the District of Columbia--modified from an earlier proposed southeastern U.S. region which also included Alabama, Florida, Georgia, North Carolina/and South Carolina.

MAARETC's stated goal is to provide a framework through which institutions and organizations within the region can collaborate effectively and benefit from each other's expertise. In each state in MAARETC's region and in the District of Columbia, MAARETC has established an Area Resource Center (ARC) through a subcontract agreement. The subcontracts are with the following organizations:

- Delaware Area Resource Center - Delaware Medical Center;
- DC Metro Area Resource Center - Georgetown University Hospital;
- Maryland Area Resource Center - University of Maryland Medical School;
- Virginia Area Resource Center - Medical College of Virginia, Virginia Commonwealth University;
- West Virginia Area Resource Center - West Virginia University; and
- Public Health Area Resource Center - Johns Hopkins University, School of Hygiene and Public Health.

The state ARCs are responsible for implementing the mission of MAARETC in their respective states. The Public Health Area Resource Center at Johns Hopkins is different from the other ARCs in that it has a regional mandate to provide AIDS education and training to health care professionals in the public sector. MAARETC operates under a decentralized program structure; each ARC is responsible for identification of training needs, network building, and the design and delivery of its own training programs in response the needs of the area.

The goals and objectives, as stated in the original proposal, are listed in Appendix I.

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The incidence of AIDS cases varies throughout the Mid-Atlantic region, and the epidemiologic patterns resemble those seen in other mixed urban/rural regions across the U.S. While gay men still constitute the highest prevalence of AIDS cases, the incidence among IV drug users, minorities (especially blacks and Hispanics), women and children constitute a large and growing proportion of the cases. The increase in incidence among ethnic minorities underscores the need for cultural sensitivity to this changing case mix.

B. Organizational Background

The University of Maryland at Baltimore, the locus of professional education within the University of Maryland system, has a history of providing patient care services, research and legal services for patients with AIDS. In addition to its academic departments, UMAB has a strong continuing education program. The UMAB schools of pharmacy, dentistry, medicine, nursing, law and social work have each conducted continuing education training courses, short workshops or topical seminars on AIDS. UMAB's resource base, coupled with its continuing commitment, facilitates the AIDS education and training activities of MAARETC and MARC within the University as well as providing a pool of AIDS experts to the ETC.

The MAARETC program is placed within the Division of Interprofessional Programs in the Office of the President along with two other professional education programs with a community focus: a state-funded geriatric program; and a drug and alcohol program. The position within the President's Office facilitates the coordination of resources campus-wide and communication among the six professional schools comprising UMAB, as well as providing the general leverage and influence associated with the Office of the President.

Six Area Resource Centers have been established as subcontractors to respond to the training and educational needs on a more local level. These six ARCs are described briefly below:

- Initially, Maryland state activities were coordinated by the MAARETC headquarters. The Maryland Area Resource Center was organized as a separate entity in April 1989, and is located in the AIDS Unit of the Infectious Disease Division, School of Medicine, at UMAB with Dr. Jonathan Cohn as principal coordinator. MARC works in collaboration with the AIDS Administration of the Department of Mental Health and Mental Hygiene. MARC is one of many AIDS players in Maryland and attempts to take a coordinating role.

- The Virginia Area Resource Center is located at the Medical College of Virginia at Richmond which was heavily involved in AIDS education and training before the inception of the regional ETC program. Dr. Lisa Kaplowitz of the Department of Medicine, Division of Infectious

Diseases, a recognized AIDS authority in the state, heads the Virginia Area Resource Center effort. The Virginia ARC, which was in full operation by September 1988, is the primary AIDS training resource in the state.

- Wilmington Hospital serves as the Delaware Area Resource Center. Dr. Dean Winslow, Chief of Infectious Disease is the coordinator for this ARC. The Delaware ARC was fully operable by September of 1988, and although the subcontractor did not have a lot of previous AIDS experience, the ARC is now viewed as the primary AIDS training resource in the state.

- The West Virginia University at Morgantown is the location of the ARC in that state. The center is physically located in Morgantown, West Virginia, but activities are coordinated through the School of Medicine's Charleston Continuing Medical Education Office. Beginning in February of 1989, Drs. **Rashida** Khakoo and Melanie Fisher took over the coordinating function, serving as **co-**principal investigators. By September 1988, the West Virginia ARC was in full operation and, like the Delaware ARC, has come to be viewed as the primary AIDS training resource in the state.

- The Johns Hopkins Public Health Area Resource Center was established in April 1989 to address the regional training needs of health care providers practicing in public health settings. This ARC is located within the Johns Hopkins University School of Hygiene and Public Health. It has been relocated from its original home in the MCH division to the Preventive Medicine Residency program. Dr. Andrew Sorensen, the School's Associate Dean, is the principal coordinator for this area resource center.

- The District of Columbia Metro Area Resource Center is located in **Georgetown** University. The principal coordinator for this center left in December 1988. As a result, the activities of this ARC have been slow to develop. Drs. Stephen Peters and Vijay **Melnick** have since taken on the role of Associate Principal Coordinators with Ed **Cowen** as the **fulltime** Program Coordinator and activities,have picked up in year 02 of the grant.

C. **ETC** Origin and Development

UMAB submitted a proposal for ETC funding in **HRSA's** first application round and was approved but not funded. MAARETC was funded in the second round. The original intent was that the ETC would cover nine states in the southeast Atlantic region and the District of Columbia. In post-approval negotiations with HRSA, the geographic region was limited to the Mid-Atlantic

states: Maryland; Virginia; West Virginia; Delaware; and the District of Columbia.

Dr. Brandt who, at the time, was Chancellor of the University of Maryland at Baltimore and former Assistant Secretary of Health and Human Services was the original Principal Investigator of MAARETC. Dr. Brandt was responsible for the development of the ETC proposal. Dr. Brandt's approach was to build partnerships among institutions with demonstrated capabilities for treatment, education, service, and prevention.

Year 01 of the grant was spent developing the subcontracts with the partnership institutions identified in the pre-grant stage by Dr. Brandt. This turned out to be a slower process than originally anticipated due to changes in key personnel and difficulties in negotiating subcontracts. For example, although Johns Hopkins University and the School of Medicine at UMAB had been identified as key institutions, it took nine months to hammer out roles that suited both of these institutions as well as suiting the regional aims of MAARETC. In the State of West Virginia, the Principal Coordinator of the ARC was changed. This staffing change also resulted in a change in the contractual arrangements from the Continuing Education Division of West Virginia University to the University Research Foundation. Staffing problems also impeded the progress of the District of Columbia ARC; the full-time ARC staff person resigned in year 01 and the Principal Coordinator was on sabbatical for six months.

In addition to staffing changes at the Area Resource Center level, the project staff at the headquarters changed as well. Dr. Brandt resigned in April 1989. Dr. Moses Pounds, formerly the Education Coordinator of MAARETC, took over the position of Principal Investigator. The new Education Coordinator, Dr. John Bonnage, was hired in July 1989. Further, the highly centralized program model originally developed proved inappropriate as several of the ARCs were far more experienced in the AIDS field than the headquarters MAARETC staff, and there was a shift to a more decentralized model. Although the MAARETC headquarters staff appear to have been able to do this successfully, the transition was not an easy one and continues to present challenges to the administration of the regional program. As a consequence of all of these staffing changes, the MAARETC program was relatively slow in getting off the ground.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

The responsibilities of the headquarters staff are to manage and administer the grant, to provide support to the Area Resource Centers, to gather and disseminate materials and resources, to produce the bi-monthly newsletter, and to develop an evaluation plan. The headquarters staff is also involved in some curriculum development and has taken on the leadership role in planning the dental program and the home health program, both supplemental funding initiatives.

The Area Resource Centers are responsible for responding to the education and training needs of health professionals in their catchment areas. This includes defining the nature and scope of the epidemic in their regions, defining the educational and training needs of health professionals in their region, enhancing existing and cultivating new relationships with key clinical, academic, and service organizations, and developing training plans that respond to the needs of their region.

The Area Resource Centers concentrate their efforts in the geographic region in which they are located, the Johns Hopkins ARC being the exception. As the only public health school in the region, the JHU ARC has a mandate to plan and implement programs targeted toward health professionals in public health settings throughout the entire region.

The development of a regional strategy for MAARETC is the responsibility of the headquarters staff with participation and input from all of the ARCs and, it was hoped, the National Advisory Board. Organizations with representatives on the advisory board include the Public Health Foundation, the Coalition of Hispanic Health and Human Services Organizations, the National Medical Association, the Veteran's Administration, the Institute of Medicine, and the American Psychiatric Association. Subcontractor meetings, held twice a year, serve as a forum for strategic planning of the MAARETC program, information and resource sharing among the ARCs, networking, and problem solving.

Development of MAARETC curriculum outlines and materials is the responsibility of the Curriculum and Evaluation Council. This council is comprised of representatives from each of the Area Resource Centers. The Education Director serves as Chairperson of this Council. ARC staff are responsible for developing program content and materials tailored to their local needs.

B. Staffing

Edward N. Brandt, MAARETC's original Principal Investigator, was succeeded by Dr. Moses B. Pounds in April of 1988 who, from September 1987 to April 1988, served as the Education Director of MAARETC. Dr. Pounds is currently the ETC's full-time director. Prior to joining the ETC, Dr. Pounds was an Assistant Professor in the Division of Behavioral Sciences and Health Education, Department of Health Policy and Management, at the Johns Hopkins University. Dr. Pounds has a Ph.D. in medical anthropology and a strong interest in AIDS in minority ethnic communities. Dr. Pounds has been appointed to the Baltimore Mayor's AIDS Coordinating Council and serves as a representative on the AIDS Educational Review Committee for Baltimore City Health Department.

John Bonnage, Ph.D., was appointed in year 02 to be the Education Director, succeeding Dr. Pounds in this position. As the full-time Education Director, Dr. Bonnage is responsible for curriculum development, curriculum revisions, and evaluation. Dr. Bonnage's previous experience was as a Project Director for the NIMH AIDS Education contract in Washington D.C. In the NIMH project, in addition to his management responsibilities, Dr. Bonnage developed

educational materials, including an AIDS Primer, training modules, and audio-visual materials. As Education Director, Dr. Bonnage also serves as the Chairperson of the Curriculum and Evaluation Council.

Ms. Adriene Dawkins is the Newsletter Editor and Resource Coordinator. This position is quarter time. Ms. Dawkins maintains the resource center for the ETC and responds to requests for information from the Area Resource Centers. Her work also involves research, on a by request basis, for the headquarters staff and ARCs using the Regional Medical Library (RML) located on campus. Additionally, Ms. Dawkins has primary responsibility for producing the quarterly newsletter.

Ms. Charlyn Cassady, M.Ed, R.N., was hired as a Project Assistant. Ms. Cassady is a Ph.D. candidate. Her dissertation research is a study of home health care providers working with persons with AIDS. Ms. Cassady was instrumental in the development of the curriculum outline for home health care providers, an initiative of the headquarters staff under supplemental funding monies from HRSA.

Malinda Orlin, Ph.D., M.S.W., is the Acting Executive Assistant to the President of the University of Maryland at Baltimore. Although not involved programmatically with the project, Dr. Orlin performs the liaison function between the Office of the President and the ETC project, as well as between other university departments and other state agencies and the ETC project.

A full-time Secretary is also assigned to the project.

C. Approaches to Collaboration, Integration and Regionalization

1. Approach to Collaboration

o Collaboration With Other Federally-Funded AIDS Projects

UMAB Dental School has a HRSA Service Demonstration Project to provide direct dental care to AIDS patients. The "Plus Program," as it is known, is a tertiary referral center staffed by attending physicians and serves approximately 65 patients, most of whom are very ill and have severe dental problems. The program sees 4-5 new referrals per week. The Plus Program provides the MAARETC dental program with a wealth of teaching materials, particularly clinical slides.

The AIDS Administration of the Maryland Department of Hygiene and Mental Health has a local HRSA AIDS Service Demonstration Project Grant. MAARETC, through MARC, works with other agencies to recruit and train additional clinical providers under the terms of that grant.

The Division of Family Medicine of the University of Maryland Medical School is the recipient of a HRSA/Bureau of Health Professions training grant for training family medicine residents. Through the ETC, the experience is enriched. The Family Medicine housestaff receive clinical and didactic training which includes required rotations through the Infectious Diseases

clinic and the Primary Care Infectious Diseases clinic as well as supplemental lectures and interactive workshops on HIV care.

Collaboration with HERO, the NIMH grantee, is primarily carried out through the Maryland Area Resource Center. Specifically, MARC/MAPEC, HERO, Chase-Brexton Clinic and Morgan State University jointly sponsored a program entitled "PWA Empowerment" which combined an interactive satellite video conference presentation of the AIDS Satellite Television Network with a Baltimore-based panel of guests.

Collaboration with other federal programs was further demonstrated in January 1989. MAARBTC hosted a meeting at the UMAB for east coast (HHS Regions I, II, and III) ETC representatives and Service Demonstration Project directors. The two-day meeting allowed these two groups to discuss common concerns and collaboration strategies between the projects. Four papers were prepared by the staff or consultant staff of MAARETC to be presented at this meeting. The papers included the following:

- Dawkins, Adriene E., "Sex: Beyond Taking a Sexual History," MAARETC, University of Maryland at Baltimore, January 1989.
- Pounds, Moses B., 'Burnout: Issues for Education and Policy, " MAARETC, University of Maryland at Baltimore, January 1989.
- Williams, Valerie N., "AIDS and Substance Abuse: The Challenge for Clinicians and Educators," MAARETC, University of Maryland at Baltimore, January 1989.
- Wooten, Ruth K., 'Interventions: HIV, AIDS, Counseling and Testing," MAARBTC, University of Maryland at Baltimore, January 1989.

o Collaboration With Other AIDS Resource Groups

The Area Resource Centers are responsible for nurturing and developing associations with federal programs, state programs, health departments, and other organizations with missions similar or complementary to the ETC goals. Most ARCs have established advisory boards of representatives from these key organizations. The advisory boards serve to define area needs, to establish collaborative relationships, and to share resources.

The extent of collaboration with these other programs or organizations depends on the particular ARC. The Johns Hopkins University (JHU) ARC has found collaboration and coordination with other programs and organizations to be difficult and to require more resources than their budgets allowed.

The DC ARC also has had some difficulty establishing collaborative relationships with the community service organizations. This is partly due to the large number of AIDS "players" prior to the DC ARC being established. The DC ARC is in the process of determining what its training niche will be. The DC ARC is, however, working collaboratively with the Centers for

Interdisciplinary Research in Immunologic Disease (CIRID), a federally-funded program directed toward community health professionals, the Children's Hospital's CHAMP (Children's HIV and AIDS Model Program), and the **Whitman-**Walker Clinic, a community-based organization that provides public education and some medical professional education about HIV and AIDS.

In some of the other states, where the incidence of AIDS cases is not as high, determining what role the ARC should play was an easier process. Each ARC has worked with their local **AHECs,** AIDS Service Demonstration Projects (where operable), NIMH Provider Training and community and migrant health centers.

o Collaboration at a National Level

Taking advantage of the proximity to Washington, D.C., a National Advisory Board was created with representatives from national organizations concerned with the prevention of AIDS. Organizations with representatives on the advisory board include the Public Health Foundation, the Coalition of Hispanic Health and Human Services Organizations, the National Medical Association, the Veteran's Administration, the Institute of Medicine and the American Psychiatric Association. The Advisory Board network was intended to enable MAARETC to remain current on policy issues and avail itself of the expertise of these organizations. This advisory board was scheduled to meet approximately every six months but has only met sporadically.

2. Approach to Regionalization

MAARETC takes a rather decentralized approach to regionalization. There is one subcontractor, known as an Area Resource Center (ARC), in each state responsible for education and training activities statewide. The **ARCs** have a great deal of autonomy as to the nature and content of the programs they offer under broad ETC guidelines except in two areas--home health and dental--where **ARCs** are responsible for implementation of these MAARETC regional programs in their state. The MAARETC headquarters' function is primarily administrative and consultative.

D. Organizational Qualities

The **MAARETC** got off to a relatively slow start due primarily to staffing changes at both the headquarters level and the ARC level. Dr. Brandt, the original Principal Investigator of the grant, developed the program design of MAARETC and identified the key players in the region. Any top management upheaval requires a transition period and, in the case of MAARETC, slowed the progress of the project. The new Principal Investigator and Education Coordinator have done a good job during this transition period of taking over where Dr. Brandt left off, and are to be commended for their efforts to revise the program's fundamental structure from a highly centralized one to a more appropriate decentralized model.

Several of the **ARCs** were also slow to develop. The West Virginia ARC and the DC ARC were plagued with staffing changes and, in the case of DC, with the absence of the Project Coordinator for six months because of medical reasons.

Politics played a role in Maryland, The politics were partly based on proposal competition and partly based on the difficulties in differentiating the role that the University of Maryland Medical School would play versus the role that Johns Hopkins University would play. As a result of these difficulties, the Johns Hopkins ARC did not come on board until April 1989. Difficulties in the contracting process slowed the development of the Maryland ARC. This ARC was not established under its present structure until April 1989.

The sentiment was expressed at the headquarters that _a certain amount of tension between MAARRTC and the ARCs is inherent in the relationship. However, much of the tension arising at the ARC level may be a result of their misinterpretation of the regional role. Several of the ARCs expressed concern about a health professions education and training program being managed by non-clinical staff. This position does not recognize the fact that program management does not require possession of clinical skills but rather requires an ability to appropriately mobilize both the training and the clinical skills of others within the overall program framework.

Tension has also arisen with regard to the amount of autonomy that the ARCs are allowed. The concept of a regional ETC is predicated on the fact that synergy can be produced by working together: the regional ETC has something to offer the subcontractors; individual subcontractors have something to contribute to the wider regional effort and to each other as individual subcontractors. This being the case, rather than exerting too much control, MAARETC probably has not exerted enough leadership. There does not seem to have been an active sharing of ideas and resources among the ARCs as has developed in some of the other ETCs.

The desire for more ARC involvement in MAARETC strategy decisions and in defining regional project priorities is a legitimate concern. The headquarters staff is aware of these concerns and the ARCs acknowledge that they have been increasingly responsive and flexible. The ARCs have also indicated that there has been more program consistency of late; thus, enabling the MAARETC project to run more smoothly.

This will be a continuing challenge to the headquarters MAARETC staff to nurture its relationship with its subcontractors and, perhaps more importantly, a spirit of regional cooperation and collaboration so that the project may reach its full potential.

IV. EDUCATION AND TRAINING PROGRAM

A. Needs Assessment Activities

Consistent with MAARETC's decentralized program structure, the task of defining the nature and scope of present and future AIDS education and training needs is the responsibility of each of the Area Resource Centers. In most cases, the Area Resource Centers have carried out this task in collaboration with the wider AIDS provider community. Where recent needs assessments have been carried out by other organizations, their findings were utilized rather than duplicating these efforts.

All ARCs

ARCse

HHS Region III, the same region as the District. Results will be shared with the University of Pittsburgh AIDS ETC, whose catchment area includes the City of Philadelphia.) This survey is being done in conjunction with the Federal Employees Occupational Health Division.

In November 1988, the West Virginia ARC, collaborating with the WVU School of Medicine, the West Virginia Department of Health, the West Virginia Hospital Association, the Charleston Area Medical Center and the West Virginia School of Osteopathic Medicine, was involved in a statewide survey of the AIDS education needs and attitudes and perceptions of health care workers. The

(1988-89),
conducted for the Virginia Department of Heal
for Disease Control (CDC), virtually all categories of health care professionals were surveyed: physicians, dentists, counselors, social workers, registered nurses, licensed practical nurses, emergency medical technicians, funeral directors and embalmers. The survey attempted to ascertain their experience with AIDS/HIV, their treatment practices, their adherence to uniform procedures, their willingness to treat, their knowledge about HIV infection and AIDS, their sources of AIDS information, and their attitudes toward mandatory testing, services for HIV positive individuals and underwriting of payment for treatment. Survey results were reported in detail by profession. From the detailed data, Dr. Bradford prepared a special overview expressly for the Central Virginia ARC, which relies on the document,

"1988-1989

are

B. Training Activities

1. Target Trainees

MAARETC's target population encompasses and the bro social service professionals and students in the caregiving professions.

- health professionals in practice, including physicians, nurses, dentists, pharmacists, social workers, and allied health care workers;
- students preparing for careers in these professions; and
- provider staff of public service agencies.

Each ARC more specifically targets trainees based on the results of both formal and informal needs assessments, paying particular attention to providers who are already involved in AIDS care to some extent and those who are about to be thrust into the fray.

2. Training Activities, Objectives and Methods

MAARETC's training activities fall into two categories:

1. enhancement of professional expertise for those entities and organizations who have current expertise with HIV and AIDS; and

2. training a cadre of professionals who can serve as "trainers" for their own professional organizations and workplaces.

The Area Resource Centers design their own training programs to meet local needs, while at the same time keeping the aims of the regional program in mind. The content of programs offered varies throughout the region and is generally dependent on the baseline knowledge of health care providers with respect to HIV/AIDS. However, the general approach to training begins with the provision of information on an AIDS 101 level for all health care providers. This is combined with additional content focusing on skills and procedures that participants need to practice more effectively in their specific professional settings. To support the **ARCs** in providing this type of training, the headquarters staff, working with the **Curriculum Evaluation** Committee, developed two curriculum outlines for distribution to all ARCs: "Clinical Manifestations and Treatment of HIV Infection" and "Epidemiology, Transmission, and Prevention of AIDS and HIV Infection." The **ARCs** use these modules in varying degrees.

To a large extent, the trainings that have been offered are primarily didactic, although the Virginia and Maryland **ARCs** in particular have a more experiential focus. MAARETC subscribes to the principle of peer education; i.e., physicians train other physicians and nurses train other nurses. For ancillary care providers, discipline-specific trainers are used as well as physicians and nurses. MAARETC believes this approach gives the trainer more credibility in front of his/her peers. Although peer education is not a formal ETC policy, the ARCs, for the most part, are applying the concept in their trainings.

Examples highlighting some of the training and education programs offered by the ETC are listed below. Further training activities of each of the subcontractors are included under the descriptions of the **ARCs** in Appendix II.

o Regionwide Programs

The MAARETC received supplemental funding from HRSA to design programs targeting home health care professionals and dental professionals. These two programs will be implemented regionally. While implementation will be the responsibility of the ARC, the design and strategy was developed centrally.

Regional Home Health Care Training. For the home health initiative, a Project Assistant, Ms. Charlyn Cassady, was hired. Ms. Cassady is an R.N. with a master's degree in education. She is also a Ph.D. candidate with dissertation research in the area of home health care providers working with

persons with AIDS. All of the ARCs identified home health care nurses to work with the headquarters staff on the development of the curriculum. These state representatives, the Project Assistant, and the Education Director locked themselves in a conference room and hammered out an outline to provide training to home health care providers. The headquarters staff then took the responsibility of fleshing out this outline. The ARCs have begun to offer programs under this initiative. A follow-up meeting of the group will be held based on the feedback from these initial programs. The modules developed are described in the next section.

Regional Dental Training Program. The MAARETC regional dental program is coordinated by Louis DePaola, D.D.S., at the University of Maryland Dental School. The program targets the gamut of dental practitioners and dental health students in the region, making use of a train-the-trainers based diffusion model. Dr. DePaola works with a dental coordinator located in or near a MAARETC-affiliated ARC in each state--the representatives of the dental programs at the West Virginia University (Dr. William McCutcheon), the Medical College of Virginia (Dr. Richard Friedman), and Howard University (Dr. John Boyd), as well as a representative of the Delaware Department of Health and Social Services (Dr. Donald Cowan). The dental coordinator at the AIDS Administration of the Maryland State Health Department (Michael Ward) has been an active participant in the regional working group. The state coordinator is responsible for training a small cadre of master trainers, primarily dental school faculty. These master trainers then go on to train other trainers, as well as doing direct training of the target population. Through the structure of the diffusion model, in-service faculty development is built into the program (dental school dean to key dental school faculty to the larger dental school faculty).

The program aims to change some fundamental practices among dental practitioners. The first objective of the program is to stimulate the use of infection control procedures by raising awareness of who is and is not infected (i.e. its hard to know because the disease affects a wide spectrum of people). The second objective is to induce dental providers to treat diagnosed cases by providing them with information on simple clinical management techniques.

The content for the program was arrived at through a meeting of the state dental coordinators in February, 1990, with the curriculum used at the University of Maryland Dental School serving as the core of the program. The content of this curriculum parallels that of other dental curricula used in the region (one prepared by the Maryland Dental Society; another developed by Dr. Friedman at the Medical College of Virginia and funded by the Virginia Department of Health) as well as the soon-to-be released curriculum of the American Association of Dental Schools. A highlight of the dental module is the extensive set of slides that accompanies it, thanks to the University of Maryland Dental School's involvement in a dental HRSA Services Demonstration Project.

Train-the-trainers sessions, "AIDS Education and Training for Dental Health Care Workers," are being held in each of the states, beginning with West Virginia in April 1990 and scheduled for completion with a July session

in Virginia. These sessions were designed to bring the master trainers up to speed on AIDS information and issues.

"AIDS: A Challenge for Dental Professionals," the program presented to community practitioners by MAARETC's cadre of trainers, is a full-day offering which includes such topics as HIV risk assessment by the dental professional, state and federal regulations affecting the dental practice, oral manifestations and clinical management, as well as infection control procedures. A discussion of the psychosocial implications generally involves a discussion by a PWA. This program is currently being implemented by all of the ARCs except Virginia, which is still relying primarily on the "study club" approach--a l-2 hour evening presentation.

As an incentive to attend training, continuing education credit is available in each state except Virginia (West Virginia through West Virginia University at Morgantown, Washington through Howard University, and Maryland and Delaware through the University of Maryland at Baltimore).

o Train-the-Trainers Activities

For the most part, MAARETC train-the-trainers activities are content-oriented, with the exception of those being carried out in West Virginia which focus on teaching skills. In addition to the train-the-trainers activities carried out in conjunction with the regionwide dental program described above, a number of the ABC's have undertaken train-the-trainers activities as well.

The Virginia ABC, in collaboration with the Virginia Department of Health, conducts a week long HIV train-the-trainers program. Participants are recruited from public and private institutions by the local health departments. Potential participants must send in applications signed by supervisors to confirm that participants will have the opportunity to fulfill their teaching responsibilities as part of their regular work following the training. Providers serving minority populations have been encouraged to participate. As of April 1990, five sessions have been held reaching a total of 180 trainees. Although most are health care or social service providers, participants include professionals outside of the health field as well. The Virginia ABC has been serving as faculty on all of the sessions. A comprehensive resource guide has been developed to assist the participants in their training efforts.

The Delaware ARC's strategy to reach primary care providers is to train a cadre of master trainers, who will serve as resources and trainers in their own communities. Master trainers include a pharmacist, a nurse, an x-ray technician and a paramedic. The training of master trainers consists of an HIV/AIDS core, participation in a clinical program, instruction in adult training methods and observing trainings. The training ultimately provided to other health care professionals by the master trainers is targeted at an AIDS 101 level.

The West Virginia ARC's approach to training of trainers is to train medical students. A majority of the medical students trained in West Virginia end up staying in the state. Students interested in doing training are given

a three-hour training-of-trainers session, focusing on educational methods and techniques.

o Clinical Training

The Virginia ARC offers a clinical preceptorship pr Infectious Disease Clinic of the Medical College of Virginia. The program consists of a half day of didactic training and a half day of participation in the daily routine of the HIV clinic. The VAEC is planning to expand the program to two days.

MARC currently provides enriched clinical training to the UMAB primary care housestaff to supplement the AIDS clinical training that they receive as a normal part of their residency experience and training provided through a special training grant for family medicine residents. The Maryland ARC is currently developing a broad set of clinical experiences for primary care providers in community practice. MARC's clinical training activities are described in more detail in Appendix II.

The DARC uses an "orientation model" for providing clinical experience. Physicians practicing in the Infectious Disease Clinic serve as peer-to-peer trainers for physicians and preceptors for medical students in the medical management of HIV patients. Participants in this program include medical residents, family practice residents and dental residents. This program was opered up in year 02 to include nurses and social workers.

If ETC funding continues after the current grant period, it is anticipated that a clinical training component will be added to the MAAEETC dental program.

o Multidisciplinary Training

The West Virginia ARC developed a four-hour multidisciplinary session to be presented to all second-year medical, dental, pharmacy and nursing students. This session was developed in response to the mandate that requires all health science students to take four hours of AIDS training. The session focuses on the legal, medical, social and ethical issues in AIDS.

o Continuing Education in au Academic Setting

The DC ARC sponsors a colloquium series for physicians twice a month. Various speakers are arranged by the ARC. Faculty from Georgetown participate as well as physicians from a variety of other settings, such as private practitioners and medical group practitioners from all over the DC area. The DC ARC is planning a nurses' colloquium based on the same format.

o Activities to Impact Professional School Curricula

The cross-fertilization between the dental schools in the region, under the aegis of the MAAEETC dental program, is felt to have had a significant impact the HIV/AIDS curricula of the respective dental schools, placing the region on the cutting edge of HIV training. Taking the University of Maryland as an example, first year students receive 2 hours of didactic AIDS

information as well a preclinical simulation in the use of universal precautions. Second year students receive AIDS 101 instruction, as well as training in AIDS work-ups, diagnosis, and treatment planning as well reinforcement in infection control. In the third and fourth years, students clinical training includes routine care of AIDS patients, beginning with low-risk procedures such as doing radiographs and taking dental impressions and progressing to emergency treatment and dental surgery. It is felt that within a year or two, care of AIDS patients will be a considered by dental graduates as a normal part of their practices.

In all other areas, however, the efforts to incorporate AIDS content into professional school curricula have been largely unsuccessful. The ARCs have encountered a variety of barriers including limited available time to add other topic areas and the belief that current content is sufficient. The ARCs have chosen alternative strategies of targeting health professions students such as encouraging student participation in AIDS/infectious disease clinics, the clinical preceptor program (as in Virginia), the training of trainers program for medical students (West Virginia), and by encouraging student participation in lectures and workshops. The focus of these efforts; thus far, has been mainly on medical students and, to a lesser degree, nursing students.

3. Curricula and Materials Developed or Used

Originally, it was planned that a full-scale curriculum would be developed for use regionwide. Two preliminary modules were developed: "Clinical Manifestations and Treatment of HIV Infection;" and "Epidemiology, Transmission, and Prevention of AIDS and HIV Infection." The intensity of effort to develop these two modules made it clear to MAARETC that developing a full-scale curriculum would be impractical. The ARCs as well felt that developing a full-scale curriculum and updating a full-scale curriculum would take too much time away from other training activities.

The two modules contain an introduction, training objectives, and an outline of training content. Suggested educational techniques that pertain to a particular topic are printed in the margins. The modules include overheads and slides. Portions of both modules were adapted from the Mountain-Plains Regional AIDS ETC Curriculum for Trainers, The ARCs are using these two modules to varying degrees in conducting their trainings.

The curriculum for the regional dental program contains an extensive list of learning objectives, a five-page content outline, and supporting materials including charts, graphs and a rich set of clinical slides that is periodically updated.

The core curriculum for home health care providers is more an outline of issues to be covered rather than a curriculum. The underlying assumption in its development is that those using the outline will be knowledgeable trainers and able to fill in the substance under each topic heading. The last page of the outline is on tips and techniques for conducting trainings.

The HIV counselor training, an important part of the MARC program, is guided by an extensive standard curriculum, prepared initially by the AIDS

Administration of the Maryland DHMH and enhanced by MARC/MAPEC. The module includes instructional goals and objectives, a workshop agenda and trainee's reference manual.

In addition, MARC/MAPEC produced a program syllabus, a collection of reference materials published in conjunction with its October 1989 symposium "AIDS: A Challenge to Primary Care."

4. **Outputs**

The original aim was to train a minimum of 1000 health professionals in each grant year. At the end of year one, MAABETC had trained 13,773 health care professionals. Of this 13,773, 22 percent were physicians, 14 percent were nurses, 12 percent were dentists, and 52 percent were other health care professionals (this category includes pharmacists, social workers, lawyers, allied health professionals and a miscellaneous category of health professionals). Sixty-five percent of the participants were trained through the Maryland ABC.

C. Efforts to Reach Minorities

The Maryland ABC cosponsored a two-part training program for black health care providers entitled "Confronting AIDS in the Black Community." The cosponsors of the program were the Baltimore Urban League and Chi Delta Mu. The working relationship established with these two organizations is anticipated to assist the ABC in future training efforts targeted at minorities.

Most of the minority trainees have been reached through the organizations and programs in which they work, such as community and migrant health centers, hospitals, and public health clinics.

D. Training Issues and Successes

Several of the ARCs have conducted extensive, formal needs assessments, or have access to formal needs assessments conducted by other organizations. This data should assist them in targeting their trainings more effectively. The documentation of the needs should also serve as a good source of baseline information from which to judge the impact of future training programs.

Although output data have not been specifically analyzed with regard to trainee subspecialty or practice setting, descriptions of the training efforts suggest that the ETC has not only targeted primary care providers but has been successful in reaching them:

- The regionwide home health care and the dental initiatives, as implemented by the individual ARCs, have a strong primary care focus.
- The Maryland ARC programs cater almost exclusively to the needs of primary care and frontline providers. Their clinical training

opportunities for family practice and other primary care residents, their annual AIDS symposia, their local "grand rounds" programs are examples of their primary care-oriented initiatives.

- The Virginia ARC has reached primary care providers through its training of trainers program being conducted in collaboration with the Virginia Department of Health. Virginia is also actively recruiting primary care physicians for other training programs by enticing them with **CMEs** and by finding prestigious sponsors.

- The DC ARC, in coordination with another federally-funded program (Centers for Interdisciplinary Research in Immunologic Disease - CIRID), is cosponsoring an AIDS program targeted for community health professionals, as well as having primary care participation in its colloquium program for physicians.

- The Delaware ARC attempts to reach primary care providers through its master trainers program. The future collaboration between the ARC and the CPCRA (Community Programs for Clinical Research) program, with a mission to provide research protocols in community settings where patients with HIV infection receive their primary care, is expected to result in increased clinical training for primary care providers in Delaware.

- After the results of the needs assessments are completed, the. Johns Hopkins ARC's programs will target exclusively primary care providers.

Another of **MAARETC's** training successes has been its emphasis on practice-oriented rather than merely information-oriented programs, in both its regionwide programs and programs developed by the local ARCs. Appendix II contains many examples of such programs.

A number of creative, innovative and successful training programs, developed by the individual ARCs, hold potential for replication across the MAARETC system, yet the ETC has not yet fulfilled its potential in this regard. **MAARETC's** challenge for the future is to develop mechanisms for sharing successes and working more collaboratively across ARCs.

V. PROGRAM **ADMINISTRATION**

A. Administrative Systems

1. Program **Management** and Control **Mechanisms**

Management control of the regional program takes a rather loose form, relying primarily on coordination, encouragement and technical assistance from the headquarters staff.

Scopes of work are established for the subcontractors, but these scopes **of work are broad and do not obligate the subcontractor to complete any particular number of programs or to reach a set number of trainees;**

Other coordination activities include the submission of progress reports that are required quarterly from the subcontractors, the regional meetings that are held twice a year, the newsletters that will eventually be produced every two months. The Principal Investigator also initiates a conference call to all subcontractors every two months. An agenda including the date and time of the call is sent out prior to allow the subcontractors advance notice of what the discussion issues are.

Site visits to the **ARCs** by the headquarters staff are becoming the important coordination mechanism, and are one of the primary functions of the Education Coordinator. His collaborative approach to providing technical assistance to the **ARCs** has gone a long way toward instilling a spirit of cooperation between the headquarters administration and the ARCs.

2. **Management** Information Systems

No training regionwide database exists. The MAARETC is waiting for direction from HRSA on this issue.

The payment of bills is handled through the Grants and Contract Office of the University, although they-are tracked on a Lotus spreadsheet by the secretary at MAARETC headquarters.

B. Systems for **Managing** Training Events/Programs

1. Marketing

There is no formal regional marketing plan; for the most part, marketing of individual programs is left up to the ARCs. Marketing efforts have included newspaper articles, event-based brochures, use of MAARETC letterhead, word of mouth, and the MAARETC newsletter.

2. Trainee Recruitment/Selection

The **ARCs** are responsible for trainee recruitment and selection. Many programs are offered on a by-request basis; in these instances, participants self select. The train-the-trainers programs in Virginia and Delaware have actively recruited participants who have a willingness to be trainers as well as the opportunity in their work settings to provide trainings. The **ARCs** have also used the captive audience tactic; i.e., taking trainings to professional medical association meetings, and in the case of West Virginia, to medical students who are required to have four hours of AIDS training. Overall the **ARCs** have taken a more passive rather than active approach in trainee recruitment and selection.

3. Output/Outcome Reports

The subcontractors are required to submit quarterly progress reports. The headquarters administration aggregates this information and compiles tables. MAARETC does not, to date, maintain a regional training database.

C. Training Sites

The subcontractors of MAARETC are all located in university settings, except for the Delaware ARC. Thus, university auditoria, conference rooms, and classrooms are available for conducting education and training programs. Several ETC programs are cosponsored with partner organizations, with the partner trainer frequently providing or arranging for the training site. The clinical facilities at the Medical College of Virginia, UMAB and the Medical Center of Delaware have been used to conduct clinical training sessions. Identification of training sites was not indicated as a problem by any of the ARCs or by the headquarters staff.

D. Cost Sharing

The institutions that subcontract to the MAARETC share in the costs of the ETC program. The subsidization is in the area of overhead costs, such as office space, utility costs, phone costs, subcontract administration costs, and supply and equipment costs. Some institutions provide salary support in that ARC staff time is, in some cases, donated to the project.

Collaborative trainings have reduced costs also because the other agency often pays for space rental, speaker honoraria, etc. Participants are charged fees to attend certain trainings. These fees can be waived if they prove a barrier to participation.

E. CEUs

Several programs offered by the ARCs offer CEU credit. As all of the subcontracts are with universities, except Delaware, arranging CEU accreditation has been facilitated.

F. Library/Information Services

The headquarters staff and the Maryland ARC have direct access to the University of Maryland Health Sciences Library, which serves as a Regional Medical Library (RML). The purpose of the RML program is to provide health science practitioners, investigators, educators and administrators in the U.S. with timely, convenient access to health care and biomedical information resources. The RML at the University of Maryland is one of seven regional libraries coordinated by the National Library of Medicine. The resources available through the RML network can be accessed by the other ARCs through research requests submitted to the MAARETC Resource Coordinator.

The headquarters staff produces a newsletter, the "Mid-Atlantic Forum." Eventually, this will be produced every two months. Originally the newsletter

focused on clinical articles and/or education and training articles. Feedback at the regional meeting of the **ARCs** indicated that the interest was more in MAARETC news and HRSA news. These suggestions were adopted. The February 1990 newsletter included the following: an article on the home health care initiative; an article on the dental initiative; a graph showing cumulative AIDS cases by state; HRSA news; and a calendar of regional events.' A mailing list of approximately 400 is kept at MAARETC headquarters. Additional copies of the newsletter are bulk-mailed to the **ARCs** for their distribution.

A MAARETC library is maintained at headquarters. The library includes newsletters from other organizations active in the AIDS epidemic, curricula and materials from other **ETCs,** and relevant videos from all over. The Resource Coordinator is responsible for maintaining the library and for responding to requests for information. The headquarters also has a slide projector, a video machine, and an overhead projector.

G. Other Services

Both the MAARETC headquarters and the **ARCs** also provide referral services. Through the networks established by the MAARETC project, individuals and organizations can be referred to the agencies and services they require. Referral requests can also be satisfied for educational media, including books, journals, specific articles, and audio/visual materials.

The headquarters staff and the **ARCs** also serve as advocates for persons with AIDS and health, social service and legal professionals who deal with the epidemic. Advocacy is done through the provision of background information for policy formation, for research, and for briefings of legislative committees. The MAARETC also responds publicly via the radio, television, and newspaper to various issues related to AIDS.

H. Sustainability

MAARETC's plan for sustainability calls for the accumulation of the fees charged to attend training events over the grant period as well as soliciting both public and private funds for support of future ETC activities. To date, the fees collected have been minimal and have mostly been used to defray costs that are not allowed under the ETC contract, such as meal costs when trainings are offered around meal times. MARC, in particular, has been successful in obtaining outside funding for its programs from pharmaceutical firms and private foundations. If funds were cut in the near future, it is the general consensus among the headquarters administration and ARC staff that the MAARETC would cease to exist as an organization.

VI. SUMMARY AND FUTURE PLANS

The MAARETC program got off to a slow start. This was primarily due to the staffing changes at both the regional level and at certain ARCs. There has been some tension in the relationships between the MAARETC headquarters and some of the subcontractors. However, the headquarters staff is aware of

the issues and has begun to address these issues. The program has had more consistency and direction of late. This will no doubt, become increasingly the case as the new management team at the headquarters becomes more comfortable in its role.

Despite the slow start, most of the ARCs have been very active in conducting education and training programs. Reaching primary care providers has been a success of the MAARETC program. The dental initiative and the home health care initiative will draw on and augment this success.

The future plans are to have the ARCs further augment their training activities. The results of the needs assessments being done by JHU will soon be completed, enabling that ARC to undertake training programs targeted toward health professionals in public settings. The Virginia ARC has plans to expand its clinical program. Also, the potential increased clinical training for primary care providers through the collaboration of the Delaware ARC and the CPCRA program is exciting.

Managing the six subcontracts in a cooperative and collaborative manner is a complex process. There have been some rough spots along the way for the MAARETC program. However, with the headquarters staff now stabilized and the subcontracts fully established, the MAARETC project is beginning to come together.

APPENDIX I

MAARETC's Goals and Objectives

GOALS AND OBJECTIVES

The goal of the AIDS Regional Education and Training Center is to provide a framework through which institutions and organizations within the South East Atlantic region can collaborate effectively and benefit from the expertise of each other.

The aim of the project is two-fold: 1) enhancement of professional expertise for those entities and organizations who have current experience with HIV and AIDS, and 2) training a cadre of professionals who can serve as "trainers" for their own professional organizations and workplaces. The project objectives are to:

1. raise awareness and build skills of providers in both ambulatory care settings and community hospitals so that they will recognize, diagnose and appropriately manage the entire spectrum of HIV infection, including medical, psychiatric and psychosocial ramifications.

2. provide in-depth training for individuals already actively providing care for patients with HIV infection, AIDS or ARC.

3. recruit and train health care providers to serve as trainers for other health professionals throughout the region.

4. quickly disseminate new or updated information about the diagnosis and management of HIV infection.

5. incorporate curricula developed by the Center into the regular education and training programs of health professionals.

APPENDIX II

MAARETC Area Resource Centers

VIRGINIAAREARESOURCE CENTER

A. Organizational Background

The Medical College of Virginia has since the beginning of the AIDS epidemic been the major referral hospital in Central Virginia for the care of HIV and AIDS patients as well as being an HIV Test Site funded by the Virginia Department of Health. As the epidemic has progressed the efforts in dealing with AIDS have become increasingly decentralized.

In April of 1986 the Medical College of Virginia (MCV) in Richmond contracted with the Virginia Department of Health to establish a program to educate health care providers and members of state agencies about HIV. At the same time an ambulatory Infectious Disease Clinic serving primarily patients with HIV disease was started. The educational program was expanded in April of 1988 when the Division of Infectious Diseases at MCV contracted with MAARETC to become the Virginia Area Resource Center (VARC).

In 1989 the General Assembly of the State of Virginia decided to allocate funds to establish Regional Resource Centers (RRC) in other parts of the State of Virginia. Each of the **RRCs** were to provide HIV education, training and consultation to health care providers in the designated areas. At present three **RRCs** have been established in the North, Eastern, and Central regions (the central region located within the Medical College of Virginia). The Virginia Area Resource Center subcontracts with each of the **RRCs.** A fourth RRC in the Western region is planned to start in the Summer of 1990. The **RRCs** all have toll-free resource hotlines for health care providers.

AIDS cases have been reported from all parts of Virginia. As of March 1, 1990, over 1,500 cases of AIDS were reported. The risk-transmission categories correspond with the national averages, with the majority of cases occurring among gay men and a growing proportion among intravenous drug abusers.

B. Structure

1. Staffing

Dr. Lisa Kaplowitz, the Director of the HIV clinic, is the Director of the VARC as well. In addition to Dr. Kaplowitz, the VARC can avail itself of a multi-disciplinary team of health professionals including other faculty from the Division of Infectious Diseases, the Department of Nursing and the Department of Social Work. These faculty have all been involved in statewide trainings of physicians, nurses, mental health workers, social service providers, government officials, and members of the business community. The VARC faculty was expanded to involve the Department of Dentistry, a pastoral counselor and representatives from a substance abuse program.

The core program staff for the Central Area Resource Center include the following:

- Lisa Kaplowitz, M.D., Project Director. MAARETC provides 10 percent of Dr. Kaplowitz' salary.

- Linda Lesniak, B.S.N., R. N.,C., AIDS Education Coordinator. Ms. Lesniak's full-time salary is supported approximately 50 percent by MAARETC funds.

- Charlotte Syran, M.S.W., Coordinator, Community Outreach and Support Services. This is a 25 percent position funded by MAARETC.

- Gail Connors, Program Support Technician, 50 percent provided by MAARETC.

- Judy Bradford, Ph.D., Evaluator. Dr. Bradford is the Director of the Survey Research Laboratory, Virginia Commonwealth University. Less than 5 percent of Dr. Bradford's salary is provided by MAARETC.

- Recently Fay Parpart, M.S., R.N., was hired to assist Ms. Lesniak in her AIDS education coordination activities.

- Robert Higginson, P.A., was also recently hired by Virginia Area Resource Center to conduct some of the clinical training of health professionals and to provide direct clinical services.

- Sara Monroe, M.D., serves as clinical faculty to the project.

2. **Advisory Committee**

A statewide advisory committee meets on a quarterly basis to discuss policy and program issues. The committee members include representatives from the Virginia Department of Health and local health departments, health professional organizations, health professional schools, AIDS Services Organizations, the American Red Cross, other voluntary organizations, the three Regional Resource Centers. The committee meeting has proved to be a valuable forum not just for providing advice to the ARC but also for coalition building and exchange of ideas.

c. **Interagency Coordination**

The Virginia ARC is tied in with the comprehensive AIDS services network and is represented on a multitude of AIDS policy development groups, including the newly developed Richmond AIDS Consortium. The purpose of the consortium is to access investigational treatment for HIV patients who would otherwise not obtain treatment. The consortium meets monthly to discuss clinical research protocols and medical management of complications of HIV infection. The consortium currently consists of 16 physicians; although there is a concerted effort to recruit others, especially physicians serving minority populations.

D. Education and Training Activities

1. Needs Assessment

A comprehensive statewide needs assessment was conducted by the Evaluator of the VARC, Dr. Judy Bradford. This needs assessment was supported by CDC funds provided via the Virginia State Department of Health. MAARETC provided funds to extend the needs assessment to involve correctional facilities. Needs of many different population groups have been documented. The purpose was to generate data to enhance and monitor the effectiveness of AIDS educational programs. The current task is to provide technical assistance on needs assessment and evaluation to all organizations who are involved in the various aspects of the AIDS epidemic and educate the institutions about how they can collect and utilize their own data.

Questionnaires were used to gather data from college students and physicians, dentists, counselors, social workers, registered nurses, licensed practical nurses, emergency medical technicians, funeral directors and embalmers. Additionally, a team of substance abusers and prostitutes were recruited and trained to conduct personal interviews of other substance abusers and prostitutes to obtain their view of educational needs. As a follow up to this needs assessment, a questionnaire was sent to correctional system personnel in the Central Region of Virginia.

Comprehensive individual survey results were reported in detail. A brief summary was published to review the major findings from each of the surveys and give recommendations for AIDS education and outreach to each of the groups studied.

The findings from the needs assessment were not surprising to the people who are involved in AIDS education and training. However, the needs assessment provided documentation to convince opinion leaders and policy makers that training is necessary, and supported the trainers' intuition as to the needs for AIDS training.

The needs assessment instruments have been shared with other **ETCs.**

2. Regional AIDS Trainer (RAT) Program

In collaboration with the Virginia Department of Health, a week long HIV train-the-trainers program has been developed. Participants are recruited from public and private institutions by the local health departments. Potential participants must send in applications signed by supervisors to confirm that participants will have the opportunity to fulfill their teaching responsibilities as part of their regular work following the training. Providers serving minority populations have been encouraged to participate. As of April 1990, five sessions have been held reaching a total of 180 trainees. Although most are health care or social service providers, participants include professionals outside of the health field as well. The Virginia ARC has been serving as faculty on all of the sessions. A comprehensive resource guide has been developed to assist the participants in their training efforts.

3. Clinical preceptorship program

A clinical training program is held in the Infectious Disease Clinic of MCV. The program consists of a half day of didactic training and a half day of participation in the daily routine of the HIV clinic. The program is open to health care providers from all parts of Virginia. One participant was from North Carolina. The VARC is planning to expand the program to two days.

4. Other training activities

Most of the other training activities are provided in response to requests. Some groups are actively recruited for training, especially primary care physicians. As an incentive to get physicians to attend programs, The VARC attempts to find sponsors that are likely to attract physicians and to offer CMEs for participation. Programs are also developed for medical staff meetings and other meetings where there is a captive audience.

Several home health educational programs have taken place in the last few months in the three RRCs. The Virginia ARC has found interactive teaching methods to be helpful in general and in the home health program in particular. Rather than relying on didactic teaching, one of the methods used in teaching home health workers was to ask them to solve a series of different nursing problems for AIDS patients. This was used as a way of illustrating how solving problems with AIDS patients does not differ from that of other patients.

Future groups to be targeted include emergency medical technicians and providers in community and migrant health centers.

E. Other Services

An AIDS resource library funded by the Virginia Department of Health offers the following three AIDS related services:

- On-line services for accessing bibliographies;
- Copies of articles and backup references to inform providers from which sources the desired information can be accessed; and
- Current awareness services for providing a daily summary of articles that have appeared in journals and newspapers about AIDS. This summary is distributed through electronic mail via the RRCs.

The availability of this extensive library service is quite unique and extremely useful since a major problem with AIDS services and education is keeping up to date with the latest developments in policy and treatment.

The Virginia ARC is also developing a demographic database of patients and resources in the local counties to be utilized by providers.

F. Regional Relationship

It is not possible to distinguish exactly which functions are supported as part of the MAARETC and which are primarily supported by state, CDC or other funding sources/programs. This is partly due to a highly integrated network of public and private programs and institutions that collaborate very well; but also to the fact that AIDS educational programs were already in existence when MAARETC linked up with MCV in 1988. Thus in Virginia, MAARETC has primarily served as an expansion of already established programs.

The main initiatives that the MAARETC has allowed the Virginia ARC to do that would not otherwise have happened include:

- The establishment of a statewide advisory committee, required by MAARETC, that proved to be an effective means of expanding collaboration throughout the state and providing cohesiveness to the network of programs.
- The educational program targeted for home health workers was initiated and funded by MAARETC. This has been a well received and successful program.
- The dental educational program has become somewhat more comprehensive as a result of MAARETC funds.

Overall, more educational programs have been implemented than would otherwise have been possible and MAARETC funds have enabled the Virginia ARC to develop more comprehensive training programs and to implement these programs in more remote rural areas.

Concern was expressed by the VARC staff about the lack of state involvement in the regional MAARETC decision making process. Considering the decentralized nature of the program, staff felt that too much control was exerted by the headquarters staff. As is the case with several of the other ETCs, it will be a future challenge to maintain the delicate balance between state autonomy and a regional program.

MARYLAND AREA RESOURCE CENTER

A. Organizational Background

Initially, Maryland state activities were coordinated by the headquarters MAARETC staff. In October 1989, the Maryland ARC (MARC) began operation as an entity as part of the AIDS activities of the Infectious Disease Division of School of Medicine of the University of Maryland (UMAB) under the direction of Dr. Jonathan Cohn. Taking on responsibility for operating the MARC represents an extension of the University's ongoing commitment to AIDS professional education which first became manifest as a program under a grant to the University Hospital from the AIDS Administration of the Maryland State Health Department. This ultimately resulted in the hiring of Dr. Cohn as joint clinical and education coordinator for the UMAB AIDS activities.

B. Structure and Staffing

1. Structure

The direction and coordination of MARC is provided by a small administrative core. Members of the clinical staff of the AIDS patient care program in the Schools of Medicine and Dentistry serve as the core faculty which participates in program development and implementation. The extended faculty, representing the six professional schools and the University Hospital link MARC activities with those of their respective faculties. Trainers and consultants from outside the University are also recruited to participate in specific offerings.

2. Staffing

Currently, the administrative core staff for MARC includes:

- Jonathan Cohn, M.D., Project Coordinator. His time is contributed by UMAB.
- Sylvia Scherr, R.N., Education Coordinator. 50% of her time is covered by MAARETC.
- Secretarial support

In the prior year, MAARETC provided support for a Resource Coordinator and an administrative assistant.

By far, the greatest amount of MAARETC support goes for consultants and training teams.

C. Interagency Coordination

Maryland is a relatively small state with a wealth of potentially competing AIDS training resources. In response to the environment in which it

operates, the Maryland ARC has entered into a unique form of collaboration with other AIDS training resources in the state. The Maryland ARC, together with the School of Medicine, the University Hospital and the Maryland State Health Department, formed a formal AIDS training coalition known as the Maryland AIDS Professional Education Center (MAPEC). Almost all professional training provided by one of the four participating organizations is offered under the auspices of MAPEC with collaboration from the remaining agencies. MARC sees itself in a leadership role in the continuing effort to bring together the several agencies providing AIDS education to professionals in the state.

D. Education and Training Activities

Because of the highly collaborative training efforts under the auspices of MAPEC, it tends to be difficult to sort out the MARC/MAARETC contribution. For its part within the MAPEC network, MARC has targeted clinically-oriented training for primary caregivers, principally physicians and mid-level practitioners. In addition, MARC is involved in the education and training of other health care providers. Wherever possible, training emphasizes the multidisciplinary nature of AIDS care.

MARC has taken the leadership role or acted as a major partner in a significant number of training opportunities for health care providers, not only within the university but also community-based programs provided around the state.

1. On-Campus Programs

MARC's university-based activities tend to build on and enhance existing clinical training within UMAB. As part of the UMAB residency program, first year housestaff rotate through the high-volume Adult AIDS Clinic and an infectious disease clinic which offers care to symptomatic patients. MARC enhances this experience by providing one-to-one training and supervision by the clinical coordinator and other AIDS clinical faculty, and supplements it with presentations and discussions of pertinent journal articles.

Second and third year housestaff attend Family Medicine Clinic once a week for a month, where they care for primarily asymptomatic AIDS patients. During the second month, the weekly session focuses on family therapy. House officers provide one-to-one counseling to AIDS clients, their partners and their families, closely supervised (via a one-way mirror) and coached

MARC

MARC, , supports two distinct weekly talk series on AIDS topics of clinical interest to house officers, nurse practitioners and family medicine faculty. These are marketed widely throughout the University through the MAPEC monthly calendar of AIDS educational activities.

2. Off-Campus Programs

MARC has a two-pronged objective in its training of community-based providers. First, MARC aims to bring new providers into AIDS/HIV care by teaching the fundamentals of casefinding and management of early HIV infections, and by addressing the fears and biases which prevent some practitioners from undertaking the care of HIV infected persons. The second area of focus is to advance the skill level of primary care providers already involved in AIDS patient care by enhancing their technical knowledge about management of opportunistic infections and other complications, and by addressing issues such as the care of terminally ill patients and staff burnout.

MARC's annual AIDS symposium is illustrative of the operationalization of the two-pronged approach. The first of these, held in October 1989 was an introductory two-day conference, entitled "AIDS: A Challenge to Primary Care,', aimed at stimulating interest in entering the arena of AIDS care. (It was attended by 400 participants, approximately half physicians and half nurses.) The second, scheduled for November 1990, is being designed to expand the AIDS care competence of both new providers and current providers. The design includes topics of general interest to both the neophyte and the experienced AIDS provider in the morning of both days. The afternoon sessions will feature two tracks: identification and management of the asymptomatic and early symptomatic patient for the less experienced providers; and management of severe HIV disease and AIDS for the AIDS care veterans.

Strategically, each of the offerings is crafted with a specific outcome in mind, and once designed, the offerings are proactively marketed as a "program" to the target audience around the state. An example of this approach has been MARC's successful HIV Counselor Training. This 4-day program is offered every six weeks and is attended by an average of 20 participants. The program, which began targeting counselors at the state counseling and testing sites located in the county health departments, has expanded its focus and is open to others as well. Another example of this type of program is one designed to help community physicians to "get their feet wet,, in AIDS care. In 1990, MARC, together with the AIDS Administration, began a program of outreach to the private practitioner in the form of local "grand rounds." This series of trainings focuses on office management of HIV disease and is being coordinated through county health departments, local hospitals and medical societies. Parallel with this "program,, approach, MARC emphasizes responsiveness to requests for customized, agency-specific training.

In the near future, MARC plans to offer a new series of clinical training opportunities for community providers. It will begin by opening the weekly infectious disease clinic, at which symptomatic AIDS patients are seen, to non-University providers for clinical observation by 2-3 community based health care professionals at a time. It is hoped that this type of experience will be expanded to include other outpatient settings such as community health centers, and will include clinical observations and case presentations on a variety of different patients as well as practical information on legal issues and ways of managing AIDS care within the larger private practice.

3. MARC's Implementation of Regionwide Programs

In addition to the programs of its own design, MARC is actively implementing the MAARETC home health and dental programs in its catchment area. In addition to the regular regional home health program, **MARC** offers a modified, half-day, version of the curriculum for home health aides which is more experiential and less didactic.

In the first year, the MAARETC dental program operated independently in the state of Maryland. With the shift in the organizational base of MARC in the second year, dental training activities in Maryland continue to be implemented by the Dental School faculty but are coordinated through MARC. The principle component of the MAARETC dental program, "AIDS: A Challenge for Dental Professionals" is being marketed to community-based providers primarily through the local dental societies. This broad program is being supplemented with specific topical programs such as infection control and oral manifestations. In 1989, six trainings were held, two in Baltimore and four in the surrounding counties, and attracted nearly 500 dentists, dental hygienists and assistants. Ten additional offerings are scheduled for the first nine months of 1990.

JOHNS HOPKINS UNIVERSITY AREA RESOURCE CENTER

A. Organizational Background

Johns Hopkins University (JHU) became a subcontractor of MAARETC in the Spring of 1989. The ARC program is under the auspices of the School of Hygiene and Public Health. It took a long time to bring JHU on as a subcontractor due to lengthy negotiations among JHU and the University of Maryland at Baltimore with regard to the roles each would play in the region.

The ARC was given a mandate to focus on health care professionals in the public sector and professionals who work within the realm of public health, but who may not be directly engaged in caring for persons with HIV/AIDS. This latter group includes health educators, community health nurses, maternal and child/adolescent health providers, health care providers in correctional facilities, occupational and preventive medicine professionals. Chief medical officers (CMO) and chief executive officers (CEO) of business corporations are also going to be invited to participate in programs. Getting the participation of CMOs and CEOs is seen as important in meeting the needs of employees who return to the work force after recovery from an episode of illness related to HIV infection. JHU will fulfill this role throughout the entire region.

B. Structure and Staffing

The key staff at the JHU Area Resource Center (ARC) include Andrew Sorensen, Ph.D., School of Hygiene and Public Health, who is the Principal Investigator, and Donna Peterson, M.H.S., Sc.D., Department of Maternal and Child Health, School of Hygiene and Public Health, who is the Education Coordinator. Dr. Ivan Hanson served as Interim Education Coordinator.

C. Interagency Coordination

The JHU ARC has found coordination and collaboration with programs throughout the region to be difficult. Although this is part of the ARC's responsibility, the JHU ARC staff feel that there is not enough money in the subcontract to take on this effort. The ARC staff suggested that this task might be more effectively done by the headquarters staff.

D. Education and Training Activities

1. Needs Assessment

Before beginning any programs, the JHU ARC is undertaking a formal needs assessment process. The first step in this process was to meet with public health officials/commissioners in all states to hear their perceptions of what the education and training needs were in their respective states.

The second step in the needs assessment process was to send out a survey to all county health officials in the five-state region. This survey was

developed in collaboration with the National Association of County Health Officials. Dr. Hanson has an extensive background in survey research, thus, facilitating the development of the survey. The survey was also pretested before being widely distributed. Results from this survey have just begun to come back in.

The ARC is also conducting a survey of physicians and nurses who work in federal settings in the District of Columbia and in Philadelphia. (Philadelphia is included because it is part of the same HHS region as the District. The JHU ARC plans to share the results of this survey with the University of Pittsburgh AIDS ETC, whose catchment area includes the City of Philadelphia.) This survey is being done in conjunction with the Federal Employees Occupational Health Division. Dr. Hanson and a student will analyze the results of both of these surveys. After the results of these two surveys have been analyzed, JHU will then begin to design and implement programs to address these identified needs.

DISTRICT OF COLUMBIA AREA RESOURCE CENTER

A. Organizational Background

The DC ARC was slow in getting started due to several staffing changes. There is not much collaboration among AIDS groups or other medical schools in the DC area. One group that the ARC has collaborated with has been the Whitman-Walker Clinic, a community-based organization that has been successful in providing **eduction** to the general public about AIDS/HIV as well as to some medical professionals. This linkage was facilitated through the Education Director at the MAARETC headquarters. The ARC has not formed an advisory committee. Also, a strategy has not been formulated to target programs directed toward health care providers who serve minority patients. No groups have been identified in the DC area with this networking ability. One concern of the ARC is that there may be a glut of AIDS programs being given in the DC area and that providers are tired of attending them.

B. Structure and Staffing

The District of Columbia Area Resource Center (DC ARC) is located in Georgetown University Hospital. The key staff of the ARC are Dr. John Bellanti, Principal Coordinator; Dr. Stephen Peters and Dr. Vijay **Melnick,** Associate Program Coordinators; and Mr. Edward **Cowen,** Education Coordinator. Mr. **Cowen** was contributing to the project in a 50 percent capacity and recently increased his contribution to 100 percent of his time.

C. Education and Training Activities

1. Needs Assessment

The DC ARC bases its programming decisions on an informal needs assessment process, depending on the feedback received by key staff from their colleagues and peers and based on requests for training received from individuals, groups and organizations in the DC area.

2. AIDS Colloquia

At the suggestion of the Education Director at the MAARETC headquarters, a colloquium series for physicians is being held twice a month. The program started in December 1989 and is scheduled to run through May 1990, Various speakers are arranged by the ARC. Faculty from Georgetown participate as well as physicians from a variety of other settings, such as private practitioners and medical group practitioners from all over the DC area. Participants pay a fee of $120 for the entire series or $20 to attend individual sessions. These sessions also qualify for CME and are evaluated by the Georgetown CME committee. Dr. Peters attends each session, thus, ensuring the continuing quality of the program meets DC ARC standards. The DC ARC is planning a nurses' colloquium based on the same format.

3. Co-Sponsored Offerings

In November of 1989, the DC ARC cosponsored, with a drug company, a program on nutrition for **dieticians.** Approximately 100 **dieticians** attended the program, both hospital based **dieticians** as well as private practice **dieticians.** The program was a day long and used a didactic teaching approach. Dr. Peters was one of the speakers. The program qualified for continuing medical education (CME) credit and was evaluated by the division at Georgetown responsible for administering the CME program. These evaluations are passed back to the ARC, which in turn sends them on to MAARETC.

The DC ARC is also coordinating its efforts with the Centers for Interdisciplinary Research in Immunologic Disease (CIRID), another federally funded program. The ARC will cosponsor with CIRID an AIDS program directed toward community health professionals. The ARC effort in this program will be to contribute background information as well as to provide speaker information to CIRID.

The ARC is also going to cosponsor a program with the Children's Hospital's CHAMP (Children's HIV and AIDS Model Program) program. This will be a two-day program targeted toward alternate care givers. The ARC's role will be to provide background information for the program.

4. DC ARC's Implementation of Regionwide Programs

In April 1990, the ARC held a home health care conference. This program was based on the curriculum designed by the headquarters staff under the supplemental funding initiative. This program is the first one directed toward the home health care audience in the DC area and has been extensively advertised by the ARC.

5. Impact on Professional School Curricula

To impact on Georgetown medical school curricula, the ARC is forming an internal education committee that will review all curricula for HIV/AIDS content. This committee idea has been approved, and the committee will be formed in the near future.

DELAWARE AREA RESOURCE CENTER

A. Organizational Background

The Delaware Area Resource Center (DARC) is located at the Medical Center of Delaware. The Infectious Disease Clinic at the Medical Center is the major provider of care to patients with HIV/AIDS in Delaware as well as serving residents of New Jersey, Maryland and Pennsylvania. Patients of the clinic are served both as inpatients and outpatients;

B. Structure and Staffing

1. Staffing

The key staff at the DARC are Dr. Dean Winslow, Chief of Infectious Diseases at the Medical Center and Principal Coordinator of the project; Arlene Bincsik, R.N., M.S., Education Coordinator; and Patricia Lincoln, R.N., B.S.N., Education Coordinator.

2. Advisory Board

The DARC team collaborates with an 18 member advisory board that meets every two months. The advisory board includes the following representatives: dentist, paramedic, alcohol and drug abuse agency representatives, private physicians, advocates for persons with AIDS, and a state legislator. The advisory board takes a very active role in the project.

C. Education and Training Activities

1. Train-the-Trainers

DARC's strategy to reach primary care providers is to train a cadre of master trainers, who will serve as resources and trainers in their own communities. These master trainers will represent a variety of health professions as well as be geographically dispersed throughout the state. Master trainers include a pharmacist, a nurse, an x-ray technician and a paramedic. The training of master trainers consists of an HIV/AIDS core, participation in the orientation model program (described below), instruction in adult training methods and observing trainings. The training given by the master trainers is at an AIDS 101 level.

2. Clinical Training

The DARC also uses an "orientation model" for providing clinical experience. Physicians practicing in the Infectious Disease Clinic serve as peer-to-peer trainers for physicians and preceptors for medical students in the medical management of HIV patients. Participants in this program include medical residents, family practice residents and dental residents. This program was opened up in year 02 to include nurses and social workers.

3. Other Training

The DARC has also made an effort to reach pharmacists, a discipline they see as neglected with respect to AIDS education. One of DARC's master trainers is a pharmacist who will assist in providing trainings for persons with this background.

D. Other DARC Activities

The Infectious Disease Clinic at the Medical Center was awarded a CPCRA (Community Programs for Clinical Research on AIDS) contract by the National Institute of Allergy and Infectious Diseases. The purpose of the contract is to provide research protocols in community settings, where patients who are infected with HIV receive their primary care. The target population includes women, IV drug users, children and people of color, who are currently under-represented in the AIDS Clinical Trial Groups. The key staff for this contract include all of the key staff for the DARC project. The collaboration between the two projects is expected to enhance the provision of clinical training for providers.

As a direct result of the CPCRA contract, a clinic will be opened in the southern part of the state. This is currently an underserved area. The attitude among providers in this area of the state has been that the AIDS problem is an upstate problem. The establishment of this clinic will assist in reaching and training primary care providers in this area as well as serving as a much-needed facility.

E. Regional Relationship

The DARC sees the regional role as having evolved over time. There is more consistency in program strategy now than there has been in the past. The regional role has improved since the hiring of the Education Director. The DARC feels that the evaluation of ETC programs could be made to be more standard and that this is a role the regional office can play.

WEST VIRGINIA AREA RESOURCE CENTER

A. Organizational Background

The contract with the West Virginia Area Resource Center (WVARC) was initiated in April 1989. Originally the contract was with Dr. Morgan in the Continuing Education Division of West Virginia University (WVU). The contract is now with the West Virginia University Research Foundation.

B. Structure and Staffing

1. Staffing

Dr. Rashida Khakoo and Dr. Melanie Fisher serve as Co-directors of the WVARC. Ms. Kathy Boetchal is the Coordinator of the WVARC.

2. Advisory Committee

The WVARC works with an advisory committee comprised of members from throughout the state, including the Osteopathy School, the Charleston Medical Center, the Community Health Department, the Huntington AIDS task force and the Morgantown Hospice, among others. Members of the advisory committee represent various health disciplines, including physicians, a dentist, a physician's assistant, and health educators. The advisory board was established in year 02 of the grant and meets quarterly.

C. Interagency Coordination

The WVARC, collaborating with the WVU School of Medicine, the West Virginia Department of Health, the West Virginia Hospital Association, the Charleston Area Medical Center and the West Virginia School of Osteopathic Medicine, conducted a statewide survey of the AIDS education needs and attitudes and perceptions of health care workers. The greatest need areas for education were identified as the legal and patient management aspects of treating AIDS patients. As a result of this survey, all training sessions conducted by the WVARC contain a legal component.

D. Education and Training Programs

1. Train-the-Trainers Activities

The WVARC's approach to training of trainers is to train medical students. A majority of the medical students trained in West Virginia end up staying in the state. Students interested in doing training are given a three-hour training-of-trainers session, focusing on educational methods and techniques.

2. WVARC Offerings

Dr. Khakoo, in conjunction with another medical doctor, developed a four-hour multidisciplinary session to be presented to all second-year medical, dental, pharmacy and nursing students. This session was developed in response to the mandate that requires all health science students to take four hours of AIDS training. The session focuses on the legal, medical, social and ethical issues in AIDS.

In year 03 of the grant, WVARC is planning on hitting the southern part of the state with a program for first responders (police, firefighters, prison workers) adopting a curriculum developed by the Centers for Disease Control.

3. Co-Sponsored Offerings

The WVARC has also conducted several seminars on HIV/AIDS throughout the state in conjunction with the AIDS Division of the State Department of Health.

4. WVARC's Implementation of Regionwide Programs

In year 03, WVARC will also continue to do its home health program. This program was being conducted prior to the regional initiative by the WVARC. To date, WVARC has trained over 70 staff of home health agencies. WVARC also conducts a training of trainers for registered nurses who want to do home health care.

E. Regional Relationship

The relationship between WVARC and the headquarters is satisfactory. The headquarters staff is seen as very responsive to issues arising in the field. The headquarters staff is also seen as a good resource for AIDS related materials, and the subcontractor meetings have proved a valuable vehicle for sharing information. During the telephone interview to West Virginia, it was stressed that the headquarters staff should remain "flexible" as to what is going on in each of the states. Although this point was not fully elaborated upon, it appeared that the West Virginia office thought that each state acting fairly autonomously was the best strategy for the region to follow.

Midwest AIDS Training and Education Center

Case Study

MIDWEST AIDS TRAINING AND EDUCATION CRNTRR

CASE STUDY

I. PROGRAM OVERVIEW

The Midwest AIDS Training and Education Center (MATEC) was funded in April 1988 to serve the six-state region consisting of Illinois, Indiana, Iowa, Minnesota, Missouri and Wisconsin. MATEC headquarters is located at the University of Illinois at Chicago and is lodged within the Department of Medical Social Work of the College of Associated Health Professions in collaboration with the Colleges of Nursing and Medicine. This office coordinates seven regional education and training sites in the six states. The Missouri site is operated collaboratively by two subcontractors. Participating institutions include:

- University of Illinois at Chicago, Department of Medical Social Work (Northern Illinois);
- Southern Illinois University at Springfield, School of Medicine (Southern Illinois);
- Indiana University' at Indianapolis, School of Medicine;
- University of Iowa at Iowa City, College of Medicine;
- University of Minnesota at Minneapolis, School of Public Health;
- Missouri Department of Health Bureau of AIDS Prevention at Jefferson City;
- University of Missouri School of Medicine at Columbia; and
- the State Medical Society of Wisconsin at Madison.

MATEC training and education activities are targeted to physicians, dentists, nurses, social workers, pharmacists, psychologists, counselors, health administrators, laboratory workers and staff from community-based AIDS organizations and city and state agencies. Programmatically, MATEC pursues two basic types of activities: training of trainers, and direct training of health care professionals. Moreover, MATEC offers organizational development services and maintains a centralized resource center.

The goals of MATEC relate to organizational development, the provision of education and training, the development of a health professions support system, and the provision of evaluative data. The specific goals and objectives are listed in Appendix I.

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The incidence and prevalence of AIDS within the MATEC region is moderately low in comparison with the coastal regions, but growing rapidly. As of December 1987, the number of cases in the five states in MATEC's original region (excluding Missouri) was 2,073. By December 1989, the cumulative number of cases for those same states had grown to 5,227. With the addition of Missouri, the MATEC region's official case total was 6,451 as of December 1989. The incidence--cases per 100,000 population--in the MATEC states as of December 1989 was: 9.9 in Illinois; 8.5 in Missouri; 5.7 in Indiana; 4.3 in Minnesota; 2.8 in Wisconsin; and 2.0 in Iowa. As would be expected, Chicago reports the bulk of reported cases of AIDS within the region --representing 2,856 of all 6,451 diagnoses within the region.' Chicago also reports the bulk of cases among Black and Hispanic persons, among IV drug users, and among women and children.

As noted in the grant application, the official incidence statistics belie the true, larger caseload of HIV spectrum patients--since many individuals have returned home to the Midwest states following diagnosis of HIV/AIDS in large coastal cities.

B. Organizational Background

MATEC's regional headquarters is located within the Department of Medical Social Work, College of Associated Health Professionals, at the University of Illinois at Chicago (UIC). UIC has a Health Sciences Campus with Colleges of Medicine, Dentistry, Pharmacy, Nursing, Associated Health Professionals, and a School of Public Health. Together with the University of Illinois Hospital, these institutions educate more than 3,800 health professionals each year.

The Department of Medical Social Work has 47 faculty. The faculty participate in the education of medical, dental, public health, allied health students, and graduate social work students. The department is also responsible for providing clinical social work services in the University Hospital and Clinics, and thus, has been involved in the psychosocial treatment of HIV/AIDS patients cared for in these settings. The department has also been active with programs and policies involving AIDS, such as assisting in the development of a Policy and Educational Committee on AIDS for the University Hospital, establishing multiple-family psychoeducational groups, and assuming leadership roles in developing confidential monitoring procedures and discharge planning/social work intervention protocols.

Southern Illinois University School of Medicine, MATEC's Southern Illinois subcontractor, emphasizes training ethnic minorities, women, and students interested in rural medicine. Also within the Southern Illinois

University are Schools of Nursing, Dental Medicine, and Technical Careers and Allied Health Career Specialists. The medical school is affiliated with four Family Practice Satellite Centers that have been used as a base for Southern Illinois MATEC programs. AIDS education and training programs have been developed by the Infectious Disease Division of the Department of Internal Medicine, including substantial continuing medical education course work. Faculty members from the Schools of Medicine and Nursing have been active on local AIDS task forces.

Indiana University Medical Center, **MATEC's** Indiana subcontractor, is affiliated with the University Hospital, Wishard Memorial Hospital, and a veterans administration hospital. There is substantial patient care and biomedical research activity at the University and through other private and government agencies. Little AIDS education and training was available for health professionals prior to the MATEC grant.

The University of Iowa, **MATEC's** Iowa subcontractor, is the state's primary health professions education institution, with Colleges of Medicine, Dentistry, Nursing and Pharmacy. It operates the nation's largest **university-**owned teaching hospital--University of Iowa Hospitals and Clinics. AIDS education had been included in all health sciences colleges, and in continuing education programs sponsored for medicine, dentistry and nursing. A need for coordinated AIDS education and training programs across the state has been identified--following the models of the statewide community-based primary care training program, and the statewide epidemiology education and consultation program.

Minnesota MATEC activities are provided through a subcontract with the School of Public Health at the University of Minnesota. Both the School of Public Health and the University as a whole have provided leadership in the fight against AIDS. School of Public Health faculty have collaborated with and participated in AIDS programs and AIDS policy formulation with the Minnesota AIDS Project, the State AIDS Advisory Committee, the State Department of Corrections, the State Department of Education, and the State Department of Human Services. A University Senate Task Force on AIDS was appointed in 1987 to coordinate a university response to AIDS that could also serve as a model for a state coordinated response to AIDS. The University's Schools of Sociology, Anthropology and Public Health have each developed a graduate level course on AIDS.

Missouri **MATEC's** two subcontractors, the Bureau of AIDS Prevention in the State Department and the Medical School of the University of Missouri at Columbia have a history of working collaboratively on AIDS issues. The Bureau of AIDS Prevention contracted with the Medical School to provide AIDS education for physicians before MATEC arrived. The Bureau itself has been engaged in epidemiology, public and professional educations, HIV testing, and case management programs for some time. This is an activist Health Department combined with an activist medical school.

The State Medical Society, **MATEC's** Wisconsin site, represents 75 percent of all practicing physicians in the state and has developed relationships with the University of Wisconsin and the Medical College of Wisconsin. With a staff of 70, the Medical Society is involved with legislative affairs, law and legal affairs, communications and public relations, research and policy

analysis, insurance, public affairs, governmental regulations, health education, evaluation and continuing medical education. The Society's Task Force on AIDS, formed in 1987, maintains a speakers bureau, has developed a series of policy objectives regarding HIV/AIDS in Wisconsin, and provides communication to the **State** Medical Society membership through the Society's newsletter.

C. BTC Origin and Development

The Department of Medical Social Work submitted a grant proposal in the first round of **HRSA** funding. This initial effort was planned to be a joint program between Northwestern University and the University of Illinois. The plan was to get the program up and running in the Chicago area and to extend it outward over time. This first application was not intended to begin a regional effort. Northwestern withdrew from the proposal just before the deadline. This first proposal was not funded.

In the second round of proposals, the program was restructured as a regional effort. During the proposal development, a substantial amount of effort was put on coalition-building in order to develop a cohesive regional approach. These efforts involved community organizing, institutional development and negotiations with a number of entities including the universities in each state with health sciences centers; the American Medical Association (AMA); the state chapters of the various health professional associations; and existing HIV/AIDS-related task forces, committees, and community-based organizations. These alliances were considered essential to establishing an effective region-wide effort. University health sciences centers were the focal point of coalition building in each state with the exception of Wisconsin. In Wisconsin, the University of Wisconsin had been reluctant to participate given the limited funding of the project; instead, the Medical Society of Wisconsin became the lead agency in that state.

The proposed region included five states: Illinois, Indiana, Iowa, Minnesota and Wisconsin. When the project was funded by HHSA, an understanding was reached that the state of Missouri would also be added to the regional configuration.

The relationships established in the development stage carried over as implementation was begun. Subcontracts were struck with university health sciences centers in each state but Wisconsin, and with the Medical Association of Wisconsin. In Missouri, in addition to the subcontract with the Bureau of AIDS Prevention; the two were to work collaboratively as the MATEC Missouri site.

The negotiation and approval of contracts between the MATEC headquarters in Chicago and the other six regional sites of the ETC took longer than expected, and resulted in delays in hiring staff and offering programs. Also, the staff resources that were planned for the Chicago site (for the Northern Illinois region) needed to be increased significantly--in recognition of the much higher incidence and prevalence of AIDS in this region, and the consequent increased complexity of education and training needs.

The importance placed on coalition-building at the regional level filtered down to the intrastate level. Each state has developed an advisory committee (or coordinating council) comprised of representatives from the state medical associations as well as representatives from organizations already active in the AIDS epidemic. These advisory committees have proven helpful as far as identifying education needs in each state and in determining the direction of the ETC program in each state.

In the second year of the project, MATEC applied and received supplemental funding to plan and conduct education and training programs targeted specifically to community and migrant health center (C/MHC) staff. This program will also be implemented in a decentralized manner with direction and support from regional headquarters.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

MATEC is administered by the Department of Medical Social Work at the University of Illinois at Chicago and is the site of the regional headquarters. MATEC operates its programs through the coordination of seven regional sites involving eight organizations. Six of the seven sites operate under a subcontract from the Chicago headquarters. The seventh site, Northern Illinois, because it is also located within the Department of Medical Social Work, is budgeted as a line item in MATEC's budget. However, the relationship between regional headquarters and the Northern Illinois site is the same as the relationships with the other sites.

Illinois is traditionally viewed as two separate regions--"upstate" and "downstate"--both geographically and politically. For this reason, MATEC established two regional sites in the state of Illinois. This decision was further supported by the intensity of the epidemic in the Chicago area, which clearly needs a focused effort. Northern Illinois MATEC holds responsibility for programs in Chicago and other areas north of Interstate 80. Given the proximity of the Northern Illinois site to the regional headquarters, there is close collaboration between the two. However, they are operated as separate entities within the department. Southern Illinois MATEC is responsible for programs south of Interstate 80.

Activities of the Missouri MATEC are supported through a subcontract with the State Department of Health's Bureau of AIDS Prevention, which in turn subcontracts with the University of Missouri at Columbia's Medical School Department of Continuing Medical Education. The two work collaboratively as the Missouri MATEC site. The MATEC site is physically located in the middle of the state (with the only two large population areas, St. Louis and Kansas City, located at the east and west edges of the state).

Each of the seven sites has full responsibility for activities in its catchment area: identifying needs, designing education and training curricula and programs to respond to these needs, conducting programs, and marketing programs.

MATEC has a Coordinating Council composed of the regional staff, the seven Site Directors, and representatives from the American Medical Association, American Dental Association, National Association of Social Workers, American Hospital Association, American Psychological Association, American Nurses Association and Northwestern University. The responsibility of the Coordinating Council is to identify each profession's and region's education and training needs, develop a regionwide plan for meeting these needs, discuss resources and support required to implement programs, and share information and program successes and barriers.

Each regional site has an Advisory Council composed of representatives from health professions schools, health professional associations, governmental agencies, and community-based agencies. The role of the Advisory Council is similar to that of the Coordinating Council, but on a state level.

Originally, the regional headquarters of MATEC had planned to be more active in developing curricula and in developing and implementing training and education programs. However, as a result of discussions with the state contractors, the regional headquarters' role shifted to emphasize its support function. The regional headquarters is responsible for managing the grant, including budgeting and reports and communications with HRSA, serving as a resource (administrative and programmatic) to the state offices, producing the MATEC newsletter, and maintaining a centralized training database. Strategic planning is the responsibility of all, with implementation left to the state offices. Decentralization and site autonomy are intended to enable states to respond more effectively to local needs instead of trying to make a blanket approach work in different states'with different political structures, different geographies, and varying natures of the epidemic.

B. Staffing

The Chicago regional headquarters includes a Project Director, an Associate Project Director, an Administrative Director, a Program Specialist, and a person recently hired to direct the C/MHC supplemental funding initiative as a Project Coordinator. The regional headquarters also draws on the expertise of faculty from the University of Illinois colleges of medicine, nursing, public health, and dentistry, as well as other faculty within its own College of Allied Health Professionals.

Each state office is staffed in a different manner. All have at least a Site Director, not necessarily full-time, and in some cases, a Project Coordinator as well. With the award of the supplemental funds for the community and migrant health center initiative, each site has increased its staff time or added new staff to respond to this initiative.

1. Regional Staff

Nathan Linsk, Ph.D. is the MATEC Project Director. Dr. Linsk is Associate Professor and Research Coordinator in the Department of Medical Social Work, College of Allied Health Professions, University of Illinois at Chicago. He represents the University at the Chicago AIDS Foundation Service Provider's Council, has taught federal probation and parole officers about services issues for people with AIDS, and has pioneered in the development of multi-family educational groups for families--including patients with HIV/AIDS. He has provided leadership in AIDS advocacy and educational program development and is an active participant in AIDS service development.

Judith Cooksey, M.D., M.P.H. is the Associate Project Director. Dr. Cooksey is Assistant Professor of Medicine and Associate Vice Chancellor for Health Services, at the University of Illinois at Chicago. She is chairman of the AIDS Advisory Committee at the University Hospital, and also chairs the education subcommittee. Dr. Cooksey played an integral role in the proposal development stage, particularly in coalition-building. Her current role on the project is in maintaining these relationships with health professions associations and community-based agencies as well as serving as an advisor to the project.

Barbara Schechtman, M.P.H. serves as the Administrative Director. Ms. Schechtman previously worked at Planned Parenthood of Wisconsin, where she was Associate Executive Director for Administration and Planning from 1985 to 1988.

Elyse Nowak, R.N., Masters of Theatre, is the Project Coordinator. Ms. Nowak was recently hired to provide administrative support and coordination to the community health center supplemental funding initiative. She has several years of both administrative and- clinical experience. Her past positions have been with public television and with Rush/Presbyterian/St. Luke's Hospital.

The Program Specialist resigned in May 1990. MATEC is currently searching for a person with a strong training background to fill this position. The responsibilities of the Program Specialist are to maintain the resource library, distribute relevant 'materials to the states, and assist in program research at the request of the sites. The MATEC program has begun to develop an effective distribution system from its resources and publishes a quarterly newsletter. If the person hired for this position has a strong training background, this experience should assist in the identification of relevant materials to be sent to the sites.

2. **Site Directors**

Joan Dworkin, Ph.D. is the Northern Illinois Site Director. Dr. Dworkin is Assistant Professor, Department of Medical Social Work, College of Associated Health Professions, University of Illinois at Chicago. She is a member of the University Hospital AIDS Advisory Committee, and has taught Psychosocial Issues in AIDS to hospital staff. She assisted in developing an AIDS survey for hospital and clinical staff and is currently involved in research on the knowledge, attitudes and fears of health care workers

regarding AIDS. She is also a member of the Legislative Advisory Committee of the Governor's AIDS Interagency Advisory Council.

Larry Von Behren, M.D. is the Southern Illinois Site Director. Dr. Von Behren is an Infectious Disease Specialist at Southern Illinois University. He chairs the Medical Committee of the Springfield Area AIDS Task Force, helped to develop the Alternative Test Site in southern Illinois, and serves on the Medical Advisory Committee of the Illinois Speaker of the House's Medical Advisory Panel on AIDS.

Judith Johnson, M.D. is the Indiana Site Director. Dr. Johnson is Clinic Director for the AIDS Clinical Research Group of the Infectious Disease Division, Indiana University Medical Center. She is also Chief of the AIDS Section, Chronic and Communicable Disease Division, Indiana State Board of Health.

Charles Helms, M.D., Ph.D. is the Iowa Site Director. Dr. Helms is Associate Dean and Associate Professor at the University of Iowa College of Medicine. He is an infectious disease physician, was a Robert Wood Johnson Health Policy Fellow working with the US Senate Committee on Labor and Human Resource during 1985-86, and has been a consultant on AIDS to the Iowa Medical Society.

Jim Rothenberger, M.P.H. is the Minnesota Site Director. Mr. Rothenberger is with the School of Public Health, University of Minnesota and has a long history of work with sexually transmitted diseases, education and health behavior change programs. He is involved with many aspects of HIV programming in Minnesota.

Ted Northup and Barry Kling are the Missouri Co-Site Directors. Ted Northup is Chief, Bureau of AIDS Prevention, Missouri Department of Health (Jefferson City); Barry Kling is Director of Continuing Medical Education,, University of Missouri School of Medicine (Columbia). This is a close professional partnership, with excellent communication between the co-directors, synergistic sharing of ideas, and a strong mutual commitment to AIDS efforts.

Mark Adams is the Wisconsin Site Director. Mr. Adams is a lawyer with the State Medical Society of Wisconsin at Madison.

C. Approaches to Collaboration, Integration, and Regionalization

The MATEC Coordinating Council and the regional Advisory Councils provide ready access to collaboration with various professional associations, health professions schools and community-based AIDS organizations. Other formal or informal linkages have also been established. For instance, Chicago staff members sit on the AIDS Foundation of Chicago Service Providers Council, the Howard Brown Memorial Clinic Board, and the Chicago Department of Health AIDS Advisory Committee and the Minnesota Site Director chairs the AIDS Program Evaluation Committee for the Minnesota Department of Education. Other examples include the coordinated efforts of the Continuing Medical Education Division of the University of Missouri and the Missouri State Health Department; bimonthly meetings held by the Indiana site with the Marion

County Health Department and the Damien Center; and frequent telephone contact between the Wisconsin site and the Milwaukee AIDS Project and Madison AIDS Support Network.

Collaboration with other federally-funded programs is the responsibility of each subcontractor. The NIMH AIDS grant in the region is with Northwestern University. The Co-Director of the NIMH project serves on the MATEC Coordinating Council and the Northern Illinois site Advisory Council. Illinois, Indiana, and Minnesota are all sites of NIAID AIDS Treatment Evaluation Unit and Clinical Studies Groups. In each of these three states a representative from the program is either on the advisory board of the MATEC subcontractor or serves as a consultant to the ETC project.

Regionalization of the MATEC program has been facilitated by the Coordinating Council meetings. These meetings are held three times a year and are two days in duration. They provide a forum for information sharing, problem solving and regional strategy development. Time is also spent in work groups to focus on specific issues that have arisen. Examples of issue areas for which work groups have been formed include program data collection, marketing the MATEC, long-term care, research, training of trainers programs, and centralized curriculum. Most state contractors reported that the Coordinating Council meetings were beneficial, especially the resource sharing and network-building opportunities provided.

D. Organizational Qualities

The degree of program centralization/decentralization is often a sensitive issue in regional programs. In the MATEC region, this issue has been managed well, allowing for state autonomy, yet not forfeiting a regionwide strategy. At the time the proposal was written, the regional headquarters intended to involve itself more in developing curricula and in planning and conducting trainings. The subcontractors, however, were against such a centralized program and wanted to be able to respond to local needs in the manner they saw fit. The regional staff, focusing on getting a strong commitment to the project from the subcontractors, recognized the need for flexibility on this issue and opted for more of a support and leadership role rather than a direct role in developing programs.

Originally, the leadership role of the regional headquarters focused on consensus building and cultivating the "regional" concept of the program. The Coordinating Council meetings were the primary vehicle for this focus. Formal Coordinating Council meetings have developed over time to provide a forum for a team approach to tackling issues and activities.

The regional headquarters' leadership role has evolved over the years of the grant. As it has gained credibility with the sites, the staff has been able to take a more proactive role; this role varies according to its relationship with the subcontractor. Some sites need and ask for very little beyond opportunities to meet and share; other sites want assistance with training goals and materials. The Central Office conducts monthly conference calls with all sites and conducts site visits at least annually.

In the beginning, any sort of regional standard applied to program activities would not have been acceptable. However, as a more collaborative relationship has been established, there is more openness to sharing and mutual decision-making and the Coordinating Council has become willing to discuss possible regional standards. For example, while all sites were expected to do training-of-trainers (TOT) programs, it was not clear what the definition of a training of trainers was. A work group was convened to discuss this issue and develop a regional definition. Another example is the willingness to tackle the problem of quality assurance. The Council is currently trying to develop regional quality assurance standards. Initially, the regional headquarters asked only for reporting information with a focus on program counts. Now, broader planning and reporting has been established, with sites presenting work plans, objectives for activities, and progress toward meeting these objectives.

IV. EDUCATION AND TRAINING PROGRAMS

A. Needs Assessment Activities

Neither the regional headquarters nor the ETC subcontractors have conducted formal needs assessments, although some state subcontractors (Wisconsin, Indiana, and Missouri) are using the results of formal needs assessments done by their Departments of Health. The subcontractors generally rely on an informal needs assessment process based on feedback from their peers and from representatives on their advisory boards who are actively involved with the epidemic. Both formal and informal needs assessments are also done for each client before designing a training program. Most sites report that they have examined current education and training services, have identified gaps, and have moved to address these gaps.

Further needs assessment surveys are under consideration. The Minnesota site plans a survey of health professional schools, the Missouri site is planning surveys of the educational and training needs of physicians, nurses, and selected allied health professionals through joint sponsorship with health professional associations and state departments of health, and the MATEC regional headquarters is planning a survey of dental professionals.

B. Training Activities

1. Target Trainees

MATEC broadly targets nurses, physicians, dentists, dental technicians, social workers, family nurse practitioners, emergency technicians, psychologists, pharmacists, and other allied health workers. Also targeted were morticians, police, firemen, corrections workers, and state legislators. Each site is responsible for focusing its efforts on the above professionals as appropriate based on educational needs.

2. Training Activities, Objectives and Methods

The training approach includes a wide variety of formats for a wide variety of single discipline and multidisciplinary health professional and

health professions student audiences. The overall purpose of the trainings, as stated in the original proposal, is '*improving and increasing providers' expertise and comfort in serving patients with or at risk of HIV infection and AIDS." Each MATEC site is responsible for the development and implementation of its training programs. Programs are categorized as either training of trainers or direct training for reporting purposes.

o Training of Trainers

Training of trainers has been a major focus of the MATEC program and a wide variety of train-the-trainers activities have taken place across the region.

Multi-Disciplinary Training of Trainers. The Northern Illinois site held a multidisciplinary training of trainers, entitled "Irrational Fear of AIDS," for hospital staff. The staff included physicians, nurses, dentists, counselors, public health clinic staff, and community AIDS educators. Follow up on this program indicated that 45 staff were trained who, in turn, provided 59 programs to 693 other health care providers.

Training of Trainers in Nursing. The Wisconsin site training of trainers program for nurses is based on the Mountain-Plains AIDS ETC (MPAETC) curriculum. Trainers from MPAETC came to Wisconsin to conduct a two-day training program. The training included didactic sessions, small group break-out sessions, adult teaching methods, training on how to use the curriculum and role playing. Fifty nurses attended including practicing nurses, nurse administrators and nurse faculty.' Each of the participants was provided with a full Mountain-Plains curriculum and each participant agreed to conduct two trainings per year. A six-month follow up done by the Wisconsin MATEC indicated that approximately 50 percent of the participants had conducted further trainings. The nursing faculty members indicated that parts of the curriculum had been incorporated into their classes.

The Iowa site has focused its training of trainers on nurses in infection control. In Iowa, there are eight nurse trainers, each responsible for a region of the state. These nurses conduct education and training programs for health care workers in their regions both at the hospital level and community level. The Iowa MATEC provides these nurses with an annual AIDS update and supplies them with resources, tapes, and slides.

In Indiana, the Indiana MATEC conducted three one-day training of trainers programs for supervisory and/or staff development nurses in the home health, long-term care, and school settings. The objective of these programs is to enable participants to teach AIDS at a 101 and 102 level.

Further, the Northern Illinois site conducted a three-hour program for nurses, called "Techniques for AIDS Education."

Training of Trainers in Dentistry. The dental training of trainers at the Wisconsin MATEC, entitled "Transmissible Disease Education," has trained 60 dentists to be preceptors in their communities. This program is two days in duration and is offered on a Friday and Saturday to minimize time away from practice. A curriculum and slides have been developed specifically for this program. The focus is on Hepatitis B as well as HIV/AIDS. The first day is

didactic and concentrates on the presentation of clinical information. The first half of the second day is spent on infection control and office routine. The second half of day two includes a tour of the Transmissible Disease Clinic and a hour and a half on adult education techniques and how to use the handouts for training. The program was developed in conjunction with the Wisconsin Dental Association and Marquette University in Milwaukee.

Training of Trainers in Social Work. The Northern Illinois site also developed a six-month training series for social workers, with the last session of which was a training of trainers. The program was designed in collaboration with the Illinois Chapter of the National Association of Social Workers. The topic areas covered include case management, psychodynamics, psychotherapy and peer support services, burn-out prevention, and educating other staff.

Training of Trainers in Mental Health. The Indiana MATEC, under contract with the Division of Addiction Services, Indiana Department of Mental Health, has developed and conducted a train-the-trainers program for drug and alcohol counselors on HIV infection, HIV and chemical dependency issues, risk reduction, counseling, and testing. Both a one-day and a three-day program tailored to the needs of each clinic have been developed. The Department of Mental Health is currently sponsoring the site to continue with this program in order that all drug and alcohol counselors in the state will be reached. The Indiana MATEC is planning to develop a manual for this training-of-trainers program and possibly a training videotape for use throughout the MATEC region and by other ETCs.

Training of Trainers in Correctional Settings. The Indiana MATEC, sponsored by the Indiana Department of Corrections, is conducting training of trainers programs in correctional settings. Correctional facilities around the state identified staff who were willing to become trainers and to attend a six-hour training. Staff members included correctional officers, prison counselors, prison teachers, and some health care professionals. In addition, the Indiana MATEC is conducting training of trainers specifically for nurses in correctional settings. These are two-day programs focusing on HIV antibody testing and pre/post test counseling for HIV infection. This program is based on the Centers for Disease Control Training of Trainers model and has been modified to be applicable to this setting. The Indiana MATEC is planning a follow up letter to these trainees to determine the types and numbers of programs they have conducted since their training.

o Clinical Training

Clinical training is being developed in the MATEC region. Currently, there is an introductory clinical experience for dentists included as part of the Wisconsin MATEC dental train-the-trainers program described above, involving an afternoon tour of the Transmissible Disease Clinic. The Center has developed and tested several HIV patient simulation scenarios.

A fairly substantial clinical training experience for medical providers in community health centers is part of the community and migrant health center initiative described below. The ongoing first mini-fellowship for physicians began December 1989.

o Direct Training

A wide variety of direct training programs have been offered through each of the MATEC sites. These trainings have ranged from one hour to two days. From April 1989 through May 1990, the average length of the direct training programs offered was three and a half hours. Trainings have been both multidisciplinary and discipline specific and have reached a wide variety of health professionals. Several trainings have also been conducted for audiences not traditionally identified as health care providers, such as clergy, hospital food service, housekeeping and security staff, foster parents, and city, county and state administrators. Several sites stressed the importance of using persons with AIDS for panel discussions and for role plays and provided for this opportunity frequently in the development of trainings.

o Initiative Impact Curricula in Health Professions Schools

Integrating AIDS into health profession school curriculum has been a difficult process for all ETCs due to the several levels of review and approval required, turf issues and belief that current AIDS content of curricula is adequate. The MATEC site is no exception, although some sites have been successful in taking advantage of opportunities in elective courses and seminars.

The regional headquarters is attempting to develop a curriculum for dentists and dental auxiliary staff. A meeting was convened of all representatives from all 10 dental schools in the region as well as expert resources from outside of the region. The curriculum is expected to include four modules, slide/tape presentations on AIDS epidemiology, oral manifestations, and infection control, and a videotape on ethics and legal issues. The curriculum is almost finished, but the project is currently on hold because the dentist taking the lead role for this project is leaving the university. The regional headquarters has plans to finish the curriculum.

The Northern Illinois site is planning to develop a social work curriculum for social work students following the same process as the dental curriculum.

o Initiatives to Involve Community and Migrant Health Centers

The programs to be offered under the supplemental funding for community and migrant health centers are in the development stages. To date, the efforts have concentrated on informing all 62 health centers in the region that this focus exists, on assessing education and training needs, and on identifying barriers to program development. Examples of barriers identified include rural health center issues versus urban health center issues, C/MHCs not wanting to be considered "AIDS clinics", and differences in levels of receptivity in each health center.

This effort will be managed similar to other MATEC programs in that the regional headquarters will provide a leadership and support role and each MATEC site will be responsible for the planning and implementation of specific activities.

Currently, the MATEC sites in HHS Region V are under contract to the Public Health Service to conduct trainings for the medical staff of C/MHCs. These trainings include a mini-residency segment which was first offered in December, 1989. The supplemental funds programs will probably follow this same type of format and include a clinical training segment.

3. Curricula and Materials Developed or Used

As noted, the regional headquarters is completing the development of a curriculum for dentists to be used in dental schools, and the Northern Illinois MATEC site is planning to develop a curriculum for use in social work professional programs.

The Site Director of the Indiana MATEC has compiled a manual entitled "Outpatient Management of HIV-Infected Adults." The goal was to produce a very practical, non-academic manual focusing on early clinical interventions; i.e., preliminary assessment, early symptoms, commonly used medications, etc. The initial audience was medical students, although the regional headquarters and the Indiana site are discussing wider distribution and marketing of the manual. The outline of the manual is as follows:

Evaluation of HIV Positive Adults
Early Interventions
- An Approach to Patients with Cough and Fever
- Common Gastrointestinal Problems in HIV Positive Adults

Neurologic Manifestations of HIV Infection
Fever of Cryptic Origin
Common Dermatologic Dental Problems in HIV Positive Adults
Commonly Used Medications

Each chapter of the manual includes an outline, summary of information, and reference articles. References will be updated quarterly.

The Minnesota MATEC is developing a manual called "Living with HIV." It is targeted toward people who are learning to live with the virus. The outline of this manual is as follows:

- Overview of HIV
- Nutrition
- Alternative Therapies

Psycho-social
- Personal Experience
- Spiritual Reflections
- Insurance
- Legal Considerations
- Clinical Trials
- Health Records
- Health Coverage
- Resources

The manual also includes appendices for resources and on AIDS classifications.

4. Outputs

From April 1989 to May 1990, MATEC, as a region, had conducted 40 training of trainers events. Faculty development and medical student peer education programs are included in this number. These. 40 programs reached 800 participants. Information on occupation was available for 99.5 percent of these participants. Of this, 48 percent were registered nurses and 8 percent were physicians. The MATEC regional headquarters also calculates "total contact time," defined as participants multiplied by training hours. Total contact time for TOT programs was 6,786 hours, an average of 8.5 hours **of** training per participant.

There were 527 direct trainings during the same time period, reaching 26,233 participants for a total contact time of 89,428 hours, an average of 3.5 hours of training per participant. The occupation category is known for all but only 12 percent of these participants. Of the 88 percent known, registered nurses accounted for 25 percent, **physicians for** 18 percent, and social workers/counselors for 10 percent.

C. Efforts to Reach Hinorities

This region has a fairly low minority population, even in most of the major cities other than Chicago. While there have been some specific programs targeted toward minority health professionals or health professionals serving minority populations **("AIDS** in the Black Community, "AIDS in the Minority Community"), most of the minority trainees have been reached through the organizations/programs in which they work (drug abuse counseling programs, hospitals, hospital support staff, public health clinics, health professions schools).

Race/ethnicity is known for approximately 85 percent of the participants: 13 percent were black, 2 percent Latino, and 2 percent Asian. Approximately half of the participants (11,000) provided information on their minority patient loads. Of those reporting, 2,596 participants (24 percent) had a minority patient load greater than 26 percent.

D. Training Issues and Successes

Although actual numbers are not known, the MATEC program focuses heavily on primary care providers. A number of the training of trainers programs have had this focus. Direct trainings have been held for staff in primary care settings including neighborhood health clinics, community mental health clinics, long-term care facilities, and community health centers, among others. The supplemental funding received for community and migrant health center programs will draw on this strength.

A major strength of the MATEC sites is their responsiveness to organizational needs. The sites often view themselves as education and training consultants, offering a wide variety of services to their clients. For instance, the Northern Illinois site focuses on organizational development. **Their training staff go into an organization and find out what** structure currently exists. They then advise on who needs to be involved, on

what committees need to be formed, and on how trainings can be institutionalized in the future. Only after these structures are in place do they begin the needs assessment and training design. MATEC sites are thus providing a broader service than simply the provision of training.

v. PROGRAM ADMINISTRATION

A. Administrative Systems

1. Program Management and Control Mechanisms

Scopes of work are developed annually to serve as contracts between the regional headquarters and the MATEC sites. Attachments to this scope of work include a site's work plan that details measurable education and training objectives, the budget agreement, and the reporting requirements to the regional headquarters. Quarterly, each site is required to submit progress to date on its work plan.

The Administrative Director at the regional headquarters has also made an initial attempt to calculate the cost effectiveness of its programs. To account for the intensity of trainings, a total contact hours figure is calculated. Total contact hours is equal to number of participants multiplied by the length of the training. Total costs are divided by total contact hours for a cost per training. Cost per training can be compared across sites as one measure of cost effectiveness.

2. Management Information Systems

The MATEC regional headquarters has designed systems to manage the documentation of trainings. The training database developed on DBase III+ is comprehensive and provides quick access to a wide range of descriptive information of all trainings completed by the sites. The Administrative Director at the regional headquarters is responsible for maintaining the database. The compilation began in April 1989.

Several training activity reports can be generated from the regional headquarters database. Direct training or train-the-trainers reports can be run detailing MATEC site, program title, total participation, minority participation, target audience, and participation by occupation. Reports can also be generated listing minority patient load and service setting of participants.

3. Marketing the ETC

The first stage in marketing is creation of a strong project image. To support this, the MATEC has developed its own stationery. This was a cooperative effort by the Coordinating Council. Each site uses this stationery that has MATEC's name spelled out in large letters and the address of each of the regional sites listed under it. Name recognition is strong in Chicago and most sites report a growing awareness. In addition, the MATEC regional headquarters staff produce a newsletter. This is widely distributed and serves also as a marketing tool.

B. Systems for Managing Training Events/Programs

Training programs are organized independently through each of the sites in the MATEC region. The regional headquarters has suggested that each site maintain a training activity file for each program conducted. These files contain the curriculum or training outline used, marketing information, participant data, other resources used, and the results of any evaluations conducted. If only to maintain the files, this requirement ensures that programs are well planned. However, the MATEC sites are all strong in program development, and the purpose of this requirement was for documentation.

Sites are requested to send at least two copies of brochures, flyers, outlines, and any other products of the training to the regional headquarters.

1. Marketing of Training Events

Each site is responsible for marketing its own programs. Marketing in most cases is through word of mouth through contacts with colleagues in professional societies, health professions schools, public health departments, and other organizations and agencies concerned with the AIDS epidemic. Brochures and flyers are also developed by the sites for marketing purposes.

2. Trainee Recruitment/Selection

The Site Directors are approaching a range of potential audiences through contacts with health professions schools, professional societies, and health care organizations. Trainee selection varies by site and by program. When trainings are being conducted for a specific audience, for example, the Department of Corrections or the Public Health Service, trainees are selected by the host institution. For the nurse training of trainers held in Wisconsin, an effort was made to choose nurses who were in positions that would allow them the opportunity to train others. In other instances, specific professionals are targeted or specific occupational settings are targeted, although participation is open within these parameters. Currently, most sites operate on a demand basis and are somewhat reluctant **to "market" their programs, fearing that if they generate too many requests, they may not be able to meet demands.**

3. Output/Outcome Reports

Each site must submit to the regional headquarters a Program Data Form for each training conducted. This form includes occupation, occupational setting, and race/ethnicity participant information, minority patient load of participants, content of the program, method of instruction, and media used in presentation. This data is then entered into a DBase III+ database for a regional compilation of statistics.

C. Training Sites

A wide range of training sites are being used including hospitals, clinics, universities, and governmental offices. Arranging for training sites

was not reported as an issue by the subcontractors or the regional headquarters staff.

D. Cost Sharing

Often events are co-sponsored, with the co-sponsoring organization sharing the costs. Income generation is a major thrust of MATEC. MATEC sites often act as consultants selling their education and training services; thus, a fee is negotiated to cover the cost of services. Participation fees are also required for some of the training programs offered. The objective is to recover costs and to become self-sustaining without erecting barriers to participation.

E. CEUs

Most sites reported offering CEU and CME credit for various programs. Since most of the regional sites are located in health professions schools, the process for obtaining accreditation is well known. The state of Indiana does not have a CME requirement for physicians.

F. Library/Information Services

The regional headquarters collects, reviews and disseminates materials for training health care professionals about AIDS. These include videos, slides, curricula and publications. These materials are made available to all sites through a listing in the newsletter and by display at the Coordinating Council meetings. Materials have been requested frequently. Materials developed by the sites are also collected and disseminated through the regional headquarters to the other sites. There are plans to assess additional needed materials and to determine the most effective method of distribution. Maintaining the resources library and circulating material is one of the responsibilities of the Program Specialist.

Other than Northern Illinois which has access to the regional headquarters resource library, the regional sites have varying amounts and types of information available. This ranges from incidence data to referral services to training materials and audio/visual resources to bibliographies to descriptive brochures about the MATEC project.

G. Other Services

The regional headquarters has produced three newsletter issues to date. The intention is to distribute the newsletter quarterly. Each of the sites will take a turn producing a lead article with either a clinical or education and training focus. Each newsletter also includes comments from the MATEC Director, a resource list, and a three-month detachable calendar of MATEC events.

Approximately 5500 newsletters are produced. The majority is bulk mailed to the MATEC sites to cover their mailing lists. The regional headquarters

also has its own mailing list that includes the other ETCs, universities, federally-funded projects, and select state legislators.

H. Sustainability

Income generation is MATEC's sustainability strategy. Many of the subcontractors view themselves as consultants, selling their training expertise to community-based agencies, health departments, and other state and local offices. They usually offer the client a full range of services from conducting a needs assessment to planning the training to conducting the training. A cost for services is then negotiated. Accommodation is made for organizations that are unable to pay.

The regional headquarters staff has motivated this focus on income generation and is currently developing a plan to facilitate the reporting of monies generated in this manner.

VI. SUMMARY AND FUTURE PLANS

This is a complex and geographically large education and training center that appears to be making steady progress in developing and implementing a wide range of training programs on AIDS. Some of the states in the region are obviously further along in their development of AIDS programs than others; the regional headquarters is working with all sites on continuing to develop their programs. The MATEC program, to date, has focused successfully on building an organizational structure that is flexible. In the MATEC program, subcontractors are allowed their state autonomy, yet a regionwide strategy has not been forfeited. Overall, the ETC model is based on a supportive regional headquarters role with training and education activities decentrally located in the subcontracted sites. The structure and working relationships are in place for MATEC to continue to move forward in its mission.

One of the primary foci of the MATEC program is the emphasis on organizational development, both development of MATEC as an organization and assisting other agencies in developing organizational competence to provide AIDS education and training.

This emphasis was evident in the proposal development stage, in the program development stage, and continues to be an emphasis in the implementation stage. For example, in the proposal development period, the focus was on coalition-building. The primary authors of the proposal contacted academic institutions, health professional associations, community-based organizations involved in HIV/AIDS, and state and local leaders for their commitment to the project. The majority of these commitments is still intact; several of these early relationships turned into active participants on the project, either serving as the primary subcontractor to the MATEC program or serving in an advisory capacity at either the regional or state levels.

The regional headquarters staff's skills in organizational development were again demonstrated in the early stages of the MATEC program. The focus was to build a regional program without building a centralized program. State subcontractors wanted to be able to respond to local needs and not have a

program "imposed" upon them. Thus, the regional headquarters staff's original role was originally limited to playing a support position; i.e., providing resources and facilitating communication. As subcontractors came to know and work with other subcontractors and with the regional headquarters staff, a regional feeling has evolved. This sense of region has in turn allowed for a more centralized approach to several issues. As a group, the subcontractors and regional headquarters staff have devised a training database and a centralized reporting process. They are currently working on a regional approach to evaluation and to quality control of its education and training offerings. Thus, the organizational design has worked well for MATEC. The sites appreciated the "light hand" during the development stages. Now that a collaborative effort has been established, there is more openness to sharing and mutual decision making. As a result, the regional headquarters predicts greater uniformity and quality assurance for train-the-trainers programs and the development of a coordinated approach to evaluation.

Organizational development has become an integral part of Northern Illinois' training and education strategy. Before conducting a training, the Northern Illinois staff advise the participating agency on organizational structure; for example, they advise on who needs to be involved in training and on what committees need to be formed, with the ultimate goal of institutionalizing future trainings. Only then do they continue with the needs assessment and training design. This approach is unique and is worth documenting to serve as a model for other sites in the MATEC region as well as for a strategy that other ETCs may find useful.

A particular training success has been MATEC's focus on primary care providers. Primary care settings have included neighborhood health clinics, community mental health clinics, long-term care facilities, and community health centers. The community health center supplemental funding initiative will draw on this strength. Additionally, this initiative will provide for the opportunity of conducting clinical training within the region.

MATEC's future plans are to continue offering training of trainers programs as well as direct training. State sites are being encouraged to offer more training of trainers as the demand for training is more than can be handled by the MATEC. Impacting on curricula will be a focus in year 03 as well; the regional headquarters will continue with the development of the dental curriculum and the Northern Illinois Site Director will tackle the development of a social work curriculum. Also, in year 03, the community health center initiative will finish the development stage and move into the implementation stage. Two issues that the regional headquarters and coordinating council will tackle in year 03 are quality assurance and regional evaluation.

APPENDIX1

GOALS AND OBJECTIVES

GOALS AND OBJECTIVES

I. Organizational:

Develop a Midwest AIDS Education and Training Center as a collaborative venture between public academic health care centers, professional associations, and public health and community organizations;

II. Education and Training:

Provide education and training to primary care providers and other health professionals, as well as health professional students, in the diagnosis, management, counseling and prevention of HIV infection. Include in each training program guidelines for the use of consultants, a multidisciplinary team approach, and methods to address needs in specific target populations (high risk groups and minorities);

III. Continuing Education Dissemination:

Provide updates of new and timely information about HIV infection to primary and secondary health care providers;

IV. Ongoing Health Professional Support:

Serve as a support system for area health professionals; and

v. Evaluation:

Evaluate program outcomes and introduce refinements.

Mountain-Plains Regional AIDS Education and Training Center

Case Study

HOUNTAIN-PLAINS REGIONAL AIDS EDUCATION AND TRAINING CENTER

CASE STUDY

I. PROGRAM OVERVIEW

The Mountain-Plains Regional AIDS Education and Training Center's (MPRAETC) region covers the second largest geographic area of any of the ETCs and includes some of the most rural and low HIV/AIDS incidence states in the country. MPRAETC is headquartered at the University of Colorado Health Sciences Center in Denver with eight statewide AIDS ETCs based at the following locations:

- University of Colorado Health Sciences Center
- University of Kansas Medical Center
- University of Nebraska Medical Center
- University of New Mexico
- University of North Dakota School of Medicine
- University of South Dakota School of Medicine
- University of Utah
- University of Wyoming Family Practice Program

The direction of the MPRAETC program is determined by the Project Management Team comprised of regional office and state ETC staff.

MPRAETC's stated goal is to establish a permanent multidisciplinary cadre of local health professionals who are dispersed throughout both urban and rural areas to serve as resources in their communities for the care of HIV positive individuals. To achieve this goal, MPRAETC developed a two-tiered training-of-trainers approach. The training-of-trainers programs draw on the MPRAETC curriculum, developed collaboratively by all eight state ETCs. This curriculum is the heart of the MPRAETC program. The intensive effort mounted to develop the curriculum proved to be a great team-building exercise, thus instilling the sense of a truly "regional" program.

Two programs, the first generation train-the-trainers program and the "mini-sabbatical" program are coordinated from the regional office. The implementation of all other programs is decentralized. Each state ETC is responsible for conducting second generation train-the-trainers activities, but beyond that, the state ETC decides the direction and scope of its programs.

The goals and objectives of MPRAETC have been included as Appendix I.

During the spring, numerous meetings were held with Robert (Chip) Schooley, M.D., the new chief of infectious diseases at UCHSC as of July 1990. The goal is to integrate his service and research (ACTG) activities with the regional ETC effort. His clinics are now part of our mini-sabbatical and he is co-director of the Colorado AIDS ETC as of August 1990

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The eight state region of the MPRAETC accounts for approximately 2 percent of the AIDS cases nationwide. Fifty-six percent of the region's AIDS cases are found in the State of Colorado. In the year ending May 1990, the AIDS incidence per 100,000 population in the region ranged from 0.7/100,000 in South Dakota to 10.3/100,000 in Colorado, all states having rates lower than the U.S. rate of 13.2/100,000 for the same time period. There have been 23 pediatric AIDS cases (under 13 years of age) recorded in the region since the epidemic began.

B. Organizational Background

The regional office of the Mountain-Plains ETC comes under the umbrella of the SEARCH/AHEC program of University of Colorado Health Sciences Center (UCHSC). The Health Sciences Center encompasses the Schools of Medicine, Dentistry, Nursing, Pharmacy, allied health programs (dental hygiene, medical technology, physical therapy and child health association), the graduate school, as well as four teaching hospitals.

UCHSC has also been a major provider of educational services to practicing health professionals throughout the state, particularly through its SEARCH/AHEC program. The SEARCH (Statewide Educational Activities for Rural Colorado's Health) program was started in 1979 to provide regionalization and decentralization of the educational activities of the UCHSC. Four Colorado Area Health Education Centers (AHEC) were funded through the SEARCH program of the UCHSC.

UCHSC has institutional experience with AIDS at the clinical level through the AIDS clinic at the University Hospital and its affiliated facilities which collectively treat approximately 80 percent of the HIV infected people in Colorado.

The statewide ETCs are based at public institutions that have health professional education, public health and clinical service missions related to AIDS:

- The Colorado State ETC is also located in the SEARCH office of the UCHSC. This location of the Colorado State's ETC program has greatly enhanced collaboration among the state ETC, the AHECs, and the regional office.

- The Kansas ETC is part of the University of Kansas Medical Center. It is conducted through the Division of Health Care Outreach and Continuing Education. The four Kansas AHECs are also headquartered out of this Division.

The Nebraska ETC program is conducted by the staff of the Viral Syndrome Clinic (VSC) at the University of Nebraska Medical Center. The VSC was established in 1985 to meet the needs of HIV-positive persons. Extensive educational outreach is conducted through the VSC.

The New Mexico ETC operates under the auspices of the University of New Mexico's Medical School located in Albuquerque, New Mexico. The University of New Mexico Hospital is caring for approximately 75 percent of all AIDS patients in New Mexico requiring hospitalization and outpatient clinical services. An AIDS clinic also exists at the Veteran's Administration Center in Albuquerque, an affiliate of the University Hospital.

The state ETC of North Dakota is situated in the University of North Dakota School of Medicine. The AHEC program in North Dakota is also affiliated with the Medical School. Medical school training, residency and continuing education programs take place at four campuses developed around the four **AHECs** serving each quadrant of the state.

The South Dakota ETC is lodged within the University of South Dakota's Medical School. The AHEC program in this state administers the ETC program.

The Utah ETC is part of the University of Utah School of Medicine. The School of Medicine is part of the larger Utah Health Sciences Center that also includes the Colleges of Pharmacy, Nursing, and Health. The School of Medicine and its affiliated University Hospital serve as a major referral, research and health profession training center for several states including states within the Mountain-Plains ETC region and several states outside of the region.

- The Wyoming ETC is located within the University of Wyoming's Casper Family Practice Residency Center. The focus of the Residency Center is on rural health care, and all residents rotate to rural practice sites within Wyoming. The Residency Center also has a mission to provide educational services for health professionals throughout the state. Wyoming does not have an AHEC program.

The organizational structure of the Mountain-Plains Regional AIDS ETC is shown in Appendix II.

c. ETC Origin and Development

The Mountain-Plains Regional AIDS ETC was organized at a high level within the university systems of the participating states. The ETC was conceptualized by the Director of the SEARCH-AHEC system when the ETC program was announced by HRSA. The Director "marketed" the program to the Chancellor of the University of Colorado. The outreach and training tradition within the University of Colorado made the ETC mission understandable and acceptable. The Chancellor gave the program his full support.

In turn, the Chancellor of the University of Colorado marketed the program to the chancellors of the universities in the other seven states which had agreed to participate. These chancellors were then able to enlist support for the program from their state's governor. Where a school of medicine existed, the chancellors delegated responsibility for the state ETC program to the dean. Implementation of the state ETC programs was assigned to a department within the university with a joint clinical/educational focus. This support from the highest office in the state and at the highest level of the university ensured commitment to the ETC project and accountability for program activities in all eight states.

The development of the Mountain-Plains ETC in this manner was a direct result of the geography and culture of the region. Among all of the ETCs, Mountain-Plains is the second largest in land mass (the first being WAMI because it includes Alaska). Both interstate and intrastate distances are enormous. The terrain and weather conditions also contribute to the difficulty of travelling interregionally. These issues and the "western orientation" of independence and self-determination shaped, to a large extent, the necessity of decentralized program implementation.

III. PROGRAM STRUCTURR

A. Organizational Roles and Relationships

The regional staff consists of the Project Director, the Project Coordinator, the Assistant Project Coordinator, an Evaluation Specialist, a Budget and Finance Manager and a secretary. Each state ETC is staffed, at a minimum, by a Project Director and Project Coordinator. The ETC's goals, objectives and strategies are determined by the Project Management Team, comprised of the regional ETC staff, and each of the state ETC's Project Director and Project/Education Coordinator.

The regional staff provides support for each state as well as taking responsibility for centralized activities such as grant and subcontract administration; information dissemination; evaluation; and coordinating regional training program such as the first generation train-the-trainers program and the mini-sabbatical program.

Each state ETC takes responsibility for implementing its own program. This centralized strategy/decentralized management approach works well for the MPRAETC.

B. Staffing

RickiAnn Saylor, Ph.D. was the Project Director and Principal Investigator through year 01 of the grant. Dr. Saylor was responsible for writing the original proposal and instrumental in getting the program off the ground. She resigned as the Project Director and Principal Investigator in June of 1989 and was replaced by Richard Call, D.D.S. As Principal Investigator, Dr. Call represents the ETC at national meetings, presides over management team meetings, oversees the formulation of state ETC contracts and makes site visits. Dr. Call is currently the AHEC Director for the State of Colorado, under whose auspices he devotes 25 percent time to the ETC. He also serves on the faculty of the dental school, and has several years of experience with rural health care programs.

Lorraine Adams, M.S.W., is the Project Coordinator. Ms. Adams is responsible for the daily operations of the MPRAETC and maintaining communication with each statewide ETC. She is also involved in coordinating the mini-sabbaticals. This is a full-time position and is funded 100 percent by the HRSA grant. Ms. Adams has over 15 years of experience in the medical/social work field and a strong administrative education and preventive health background.

Elizabeth Johnson, M.P.H., is the Assistant Project Coordinator. Ms. Johnson joined the ETC staff in January of 1990. She spends approximately 50 percent of her time on the ETC project at the regional level as well as devoting time to both the Colorado State ETC and the Colorado State AHEC program. Her experience and interest is in both health care administration and in cross-cultural education.

Carol Vojir, Ph.D., devotes 10 percent time to MPRAETC evaluation activities. Dr. Vojir serves as a psychometrician to the SEARCH/AHEC program in addition to the design and execution of ETC evaluation efforts.

Donna Anderson, Ph.D., provides approximately 40 percent time to the MPRAETC, participating at the regional level as well as serving as the Program Coordinator for the Colorado State ETC. In addition, she is the Project Coordinator for the NIMH AIDS training program. Dr. Anderson's background is in Medical Sociology.

The other two key staff are Tom Kautzky, M.B.A., who oversees the financial management of the grant and Donna Jones who is the Project Secretary.

C. Approaches to Collaboration, Integration and Regionalization

1. Approach to Collaboration

There are not many organizations or programs involved in the care of persons who are HIV positive in the Mountain-Plains region, with the exception of the Denver area. Collaboration with those organizations which do exist was initiated during the development of the proposal. Each state agreeing to participate in the ETC grant identified the relevant programs in their state and sought their commitment and cooperation. It appears that all of these prior commitments were followed up after the grant was awarded.

There are a number of examples of collaboration among the states in the region. For instance, a relationship developed through MPRAETC set the stage for co-management of an AIDS patient by Nebraska and Kansas clinicians; the New Mexico and Nebraska ETCs co-facilitated training events in Wisconsin and North Dakota; and a physician from North Dakota attended the clinical program established by the New Mexico ETC.

2. Approach to Integration

There is close programmatic association between the ETC and the AHEC programs in Colorado, Kansas, New Mexico and North and South Dakota. Nebraska, Utah and Wyoming have no AHEC programs. This AHEC association has been especially helpful in Colorado, Kansas, and North and South Dakota, where it has greatly assisted in the networking efforts of the state ETCs, in the dissemination of information, and in the identification of trainers. The AHEC program in New Mexico, on the other hand, is a relatively new program in the state and is struggling to manage with shrinking funds. An AHEC representative sits on the New Mexico advisory board and the two programs are moving ahead simultaneously. While states with strong AHEC programs have been a very advantageous alliance for the ETC, the New Mexico AHEC program is collaborative but has not been necessarily provided this same advantage.

The Mountain-Plains ETC is also integrating its activities with other federally-funded initiatives such as the HRSA Service Demonstration grant and the National Institute of Mental Health (NIMH) grant. Denver General, one of the key mini-sabbatical training sites for the ETC, received funding for a Service Demonstration grant in September of 1989. The regional staff of the ETC met with the Principal Investigator of the Service Demonstration grant immediately after the grant was awarded to plan maximum interaction between the projects and maximum integration of activities.

The University of Colorado received the region's only NIMH AIDS education grant in September of 1989. The NIMH program has been superimposed on the HRSA/ETC infrastructure, thus minimizing marginal costs and facilitating program coordination. SEARCH/AHEC provides the integrating structure for the two initiatives. Richard Call, the AHEC Director, is the Project Director for both grants. The mental health content perspective is provided by the Chairman of the Department of Psychiatry who serves in the capacity of Co-Director on the NIMH grant. Donna Anderson (the Colorado ETC Program Director) serves as the Regional Project Coordinator of the NIMH grant, a position parallel to the Project Coordinator position for the ETC grant. At

the state level, the ETCs serve as the focal point of the NIMH activities. Programmatically, a mental health module has been added to the ETC curriculum and psychosocial issues will be highlighted throughout the curriculum, where appropriate. In New Mexico, an M.S.W. was hired to coordinate the NIMH activities in that State. She shares office space with the State ETC staff. The Wyoming ETC staff have increased their time commitments as a result of the NIMH AIDS grant.

3. Approach to Regionalization

The ETC is highly decentralized, consisting of eight autonomous state ETCs with a regional staff that provides coordination, technical assistance and undertakes activities which are best implemented on a regionwide basis. State ETC participation in the Management Team helps to support a regional perspective, while the collaborative development of the Mountain-Plains curriculum proved to be an important contributor to the ETC's regional cohesiveness.

D. Organizational Qualities

The Mountain-Plains Regional AIDS ETC is an outstanding example of the synergy that can be produced through a regionalized approach. It has achieved a high degree of participation from its various components and is organizationally stable. The success of this ETC has not come accidentally. It results from the way in which the ETC was formed originally, its organizational structure, and skillful management by the regional ETC staff.

The initial commitment of each of the participating universities, at the highest level, to the ETC in its developmental stage built in strong local accountability. Thus, while the individual state ETCs are contractually obligated to the regional ETC for its scope of work, the state ETCs are also accountable for their performance to their own university chancellor.

The roles of the regional ETC and the state ETCs are clearly delineated. Structurally, the regional ETC provides the framework and the glue of the organization. Functionally, the regional ETC assumes responsibility for activities that benefit from economies of scale, such as interface with funding agencies (HRSA and NIMH), grants management, resource dissemination, coordination of curriculum development, training of first generation trainers, clinical experiences, evaluation, statistical analysis, and reporting. The state ETCs have full responsibility for implementation of all activities within their states.

Managerially, the ETC staff maintain a delicate balance, encouraging autonomous functioning of the state ETCs while maintaining control without appearing controlling. In the implementation of the Project Management Team approach, MPRAETC derives the maximum regional benefit from the expertise and skills found at the state level. In the management of the regional ETC program, both peer support and peer pressure are effectively brought to bear. The state ETCs voice unanimous satisfaction with their participation in the ETC program and praise the efforts of the regional ETC staff.

The regional approach continues to provide benefits to the participating states. It is a valuable forum for cross-fertilization. It reduces isolation of those spear-heading the AIDS fight on the state level where the number of professionals dealing with the epidemic is minimal. It has expanded training opportunities that would not have otherwise been available; for example, clinical experience through the mini-sabbatical that is not available in the provider's home state and where training in a neighboring state might actually be more geographically accessible than trainings in the home state. The regional approach has even provided opportunities for co-management of patients via informal consultation across state lines; for instance, hemophilia patients.

IV. EDUCATION AND TRAINING PROGRAM

A. Needs Assessment Activities

The responsibility of educational needs assessment is left up to each state ETC. Most needs assessments have been informal in nature. The needs assessments are based on the perceived needs noted by those involved in the care of individuals with the disease, first generation trainers, and AHEC programs. The discussion and feedback is between state ETC staff and their peers as well as through the advisory boards established in each state.

Some of the states in the region draw on more formal needs assessments to guide program activities:

- Each of the six regional contractors of the Colorado ETC conducted a facility level needs assessment in the first year to assist them in planning their educational programs.
- The Colorado State ETC has collaborated with the Colorado Department of Health STD/AIDS Program on an HIV knowledge, attitude, beliefs and behavior study among registered nurses and physicians in the state.
- In collaboration with the state Division of Emergency Medical Services, the Colorado ETC conducted a needs assessment for EMTs.
- The Kansas ETC has done a formal curriculum needs/interest assessment in the schools of nursing, physician's assistants and social work.
- The New Mexico ETC is collaborating with the State Department of Health in the conduct of a knowledge, attitude and behavior survey of dental professionals to more efficiently target trainings toward this group.

- In South Dakota, a formal demands assessment targeted towards physicians, dentists, nurses, emergency medical technicians and social workers' was conducted statewide. The response indicated interest across the disciplines in attending the train-the-trainer workshops.

B. Training Activities

1. Target Trainees

MPRAETC targets a broad range of professions in its education and training programs: dental personnel; emergency medical technicians; nurses; physician assistants; physicians; public health workers; and social workers.

The trainee targets have remained the same throughout the evolution of the MPRAETC except that the ETC is rethinking the targeting of public health workers as a group because they tend to identify more directly with their professional discipline. Dentists have been a particularly hard group to reach in the Mountain-Plains region, which may lead to a more intensive targeting effort for this group.

In addition to those specifically targeted, other health professional groups and health-related personnel have been trained, including mental health counselors, dieticians, laboratory personnel, Department of Corrections personnel, home health aides, hospital food service personnel and independent living staff.

2. Training Activities, Objectives and Methods

The following assumptions underlie MPRAETC's approach to training:

- AIDS education must be disseminated throughout both urban and rural communities of all states and this education must be relevant for providers in their local practices;

- current anxiety among some health providers must be addressed through an applicable education strategy; this strategy must incorporate behavioral change theories;

- train-the-trainer programs and AIDS education programs should be focused on primary care providers, not only on tertiary care providers, as in the past; train-the-trainer programs must reach all health care professionals from both urban and rural communities; and

- AIDS education and training programs should develop both a multidisciplinary and interdisciplinary approach to care; while

training must at times be discipline specific, health care professionals need to work together to meet all the needs of an HIV positive individual.

There are essentially three vehicles through which MPRAETC provides education and training: first and second generation training-of-trainers; "clinical" training in the form of mini-sabbaticals; and community-based trainings referred to as "outreach" training.

o Training of Trainers

The primary goal of the ETC is to establish a permanent multidisciplinary cadre of local health professionals who are dispersed throughout both urban and rural areas to serve as resources in their communities for the care of HIV positive individuals. The strategy for attaining this goal has been to utilize a two-tiered train-the-trainers model through which first and second generation trainers are trained. First generation trainers are drawn from among the state ETC staffs, faculty from the medical institutions hosting the statewide ETC and key community health providers. All first generation trainers were trained in Denver, Colorado, during year 01. This training included AIDS content as well as an orientation to the regional curriculum which is to serve as a guide for their subsequent trainings.

First generation trainers, in turn, trained second generation trainers. Second generation training is the responsibility of each state ETC. The format and content of second generation training activities vary from state to state. Selection and recruitment of second generation trainers is locally determined as well. Once trained, these second generation instructors serve as resources for community-based educational activities and assist in disseminating the MPRAETC curriculum throughout their state. In most states, there was a condition imposed on second generation trainers that they would provide a specified number of future trainings.

For the most part, this two-tiered system has worked well in the region. First generation trainers, for the most part, have been very active in their state ETC programs. In most states, first generation trainers are either part of the state ETC staff or sit on the state ETC advisory board. Inducing second generation trainers to conduct trainings has been a concern of all states. While some second generation trainers have shown a commitment above and beyond what was expected; others have required prodding to follow through on their commitment.

MPRAETC train-the-trainers activities have extended beyond the geographic boundaries of the region. In response to an invitation from the Wisconsin site of the Midwest AIDS Education and Training Center (MATEC), and in collaboration with that ETC, two of MPRAETC's state ETC coordinators conducted a training-of-trainers program for nurses in Wisconsin. This training centered on the use of MPRAETC's comprehensive, multidisciplinary curriculum described below.

o Clinical Training

Two formal "clinical" training programs, known as "mini-sabbaticals," are available through the MPRAETC program: one offered through the regional MPRAETC office and one offered through the New Mexico and Nebraska ETCs.

MPRAETC Mini-Sabbatical. MPRAETC's mini-sabbatical program, organized and coordinated through the regional office, was initiated in early 1989 and is offered monthly in Denver.

This mini-sabbatical was designed to provide a broader clinical experience than the already existing intensive clinical training program available at Denver General Hospital. The Denver General program focuses on the clinical management of HIV/AIDS and other STDs, while the MPRAETC mini-sabbatical program provides an opportunity to experience the whole range of services needed in HIV care. The MPRAETC mini-sabbatical is multidisciplinary, offering relevant experiences for both health care providers and social service professionals.

While this mini-sabbatical is open to all practicing professionals in the region, its primary target audience is its cadre of first and second generation trainers, particularly those from areas with low incidence of HIV infection and those without much previous experience with HIV patients with first-hand knowledge about HIV/AIDS. The mini-sabbatical experience provides these trainers with a personal experiential base to draw upon in their training, thus increasing both their own comfort and their credibility in the eyes of their trainees.

Participants are recruited by the state ETCs. MPRAETC schedules participants from different disciplines at the same time, the intention being that, within the group, they will share their experiences from different perspectives.

The mini-sabbatical experiences are pre-scheduled and occur at monthly intervals. Each mini-sabbatical is set up as a series of rotations with different organizations providing various types of care to HIV/AIDS patients. The total mini-sabbatical period varies in length from one to five days, the average being four days which seems to be the maximum amount of time most providers can be absent from their practices. Participants are interviewed in advance as to their interests, and rotation schedules are individualized within the "master plan" which ensures that all participants are exposed to a broad spectrum of care, both clinical and psychosocial.

Rotations are generally a half day to a day in length. The regional ETC is flexible with regard to scheduling rotation sites, recognizing that the primary responsibility of the participating sites is patient care and that educational responsibilities are secondary. Because of space constraints and in order not to interfere with patient care, the number of participants in each rotation is kept small; some rotations are limited to one or two participants.

Sites at which rotations are available and the clinical experience provided at each include:

- Denver Health and Hospitals – Clinical inpatient and outpatient care, including counseling. Participants take part in patient rounds and follow the daily clinical management of HIV/AIDS patients.

- University Hospital, University of Colorado Health Sciences Center – Clinical inpatient care; training on infection control procedures, testing, and counseling in an ambulatory care setting.

- Veterans Administration Hospital – Clinical outpatient care in the Infectious Disease Clinic; training on infection control procedures.

- Colorado AIDS Project – A community AIDS services organization; the Director of Client Services discusses the needs of HIV/AIDS patients, the Director of Education talks about different educational approaches, a member of the People with AIDS Coalition of Colorado gives the patient's perspective on the disease.

- The Denver Nursing Project in Human Caring – A unique nursing center that provides holistic outpatient care; the center provides medical treatment including aerosolized pentamidine along with psychosocial support, patient education, alternative treatment (including massage, special pressure point technique, etc.), aerobics, and social gatherings. The participants observe these activities and meet with HIV/AIDS patients in a more informal way.

- The Hospice of St. Johns – Terminal care of AIDS patients including special psychological and medical needs; participants are exposed to terminally ill patients and gain insight into the psychological, medical, and practical issues, such as psychological support of significant others, writing a will, and the need for special kinds of pain medication.

- Kaiser Permanente – Health Maintenance Organization; case management of HIV/AIDS patients. The participants are exposed to the multifaceted aspect of clinical care and how it is managed in a comprehensive manner.

- Visiting Nurses Association (part of the HRSA Service Demonstration Grant) – Home health agency that provides case management and home health nursing. Participants follow a nurse who makes home visits.

Since the training is normally limited to a few days, the clinical part of the training is not regarded as extensive enough by itself to enable the providers to care for HIV/AIDS patients without obtaining further information. However, the training helps providers understand the process of HIV care and how to access more information. The mini-sabbatical experience is designed to get beyond the clinical aspects of the disease and to enable participants to meet the people who are affected by it. During the mini-sabbatical, participants have opportunities to hear from HIV/AIDS patients as well as talk with them on a one-to-one basis about what it feels like to live with AIDS.

The service needs of the patients are emphasized rather than the details of the way a particular facility runs its program. This approach is intended to provide participants, particularly those coming from rural areas where an HIV services network is lacking, with ideas for how care needs can be met within the confines of the smaller rural health care settings. As part of the debriefing sessions with the Project Coordinator at the close of the mini-sabbatical, the participants are asked to think through how they are going to incorporate what they have experienced into their own work environment.

Participation in the mini-sabbatical program offers participants the opportunity to link up with other providers in the program and to develop contacts for future reference. This is particularly important for the participants who are geographically isolated in remote rural areas.

Continuing education credits for family practice physicians are provided by the American Academy of Family Practice. Participants from other disciplines have not requested continuing education credits. Since the program for each mini-sabbatical training varies somewhat, an individual application to an accrediting body has to be made.

Financial arrangements between the regional ETC and the rotation sites are negotiated on an individual basis. About half of the organizations offering their time and sites as part of the ETC's mini-sabbatical program do so free of charge; the others range from $150 to $300 per monthly session.

New Mexico. The New Mexico ETC has also developed a mini-sabbatical program. The program, which is more clinical, is offered through the AIDS clinic at the University of New Mexico Hospital. The program provides hands-on experience in caring for AIDS patients by having the mini-sabbatical participant involved in patient rounds and in case management meetings. As of July 1990, two physicians, two physician assistants, and three nurses had participated in the program. The New Mexico ETC also sponsored a dentist and a dental hygienist's clinical training, which took place in San Antonio, Texas.

Nebraska. A number of opportunities for clinical training have been made available through the Nebraska ETC. One such experience was provided through the virology lab at the Viral Syndrome Clinic. A dentist from North Dakota was able to observe various AIDS tests being conducted and how precautions were implemented in the lab. The Viral Syndrome Clinic also provided a one-month patient care experience for four physician assistant students and a three-month rotation for two chief residents.

o State-Level Training

Education and training activities initiated at the state level are referred to as "outreach training." The nature of these trainings varies widely from state to state. A description of the training activities of each state ETC is provided in Appendix III.

Training offered by state ETCs is generally available to providers throughout the region. Because access routes do not always coincide with the geopolitical boundaries, participants often take advantage of trainings offered in nearby states. In other cases, participants travel to other states to take advantage of specialized training not available in their own state.

Many of the training events provided at the state level are provided at the request of a health care institution. The state ETC, upon receiving a request, may itself provide the training, calling on one of its first or second generation trainers to do the training. If it is not an appropriate request for the ETC, the requesting organization is referred to another agency that can provide the training.

One unique and potentially high-impact training approach used by the Nebraska ETC is an "institution-based" training entitled "AIDS in the Health Care Setting." An ETC training team is dispatched to a small town hospital, nursing home, etc. in response to a request. The training team leads the host institution through the care they provided to a selected group of their patients on the previous day. The participants are then challenged to identify how the care would have been different had those same patients been AIDS patients. The ETC training team also recommends policies and procedures that have implications for the care of HIV positive individuals.

Teleconferencing has been used quite effectively in North Dakota. This success is due in part to the familiarity of the method; the isolated areas of North Dakota are used to being reached in this manner.

o Initiatives to Impact Curricula in Health Professions Schools

MPRAETC's strategy for impacting the AIDS content in health professions curriculum, both undergraduate and residency programs, relies on recruitment of faculty from health professions schools as ETC's first and second generation trainers. The dissemination of the MPBAETC curriculum to professional schools is also central to this strategy. Building on the knowledge base acquired in the train-the-trainers program and their positions within their respective universities' training programs, MPBAETC trainers have taught courses themselves, served on curriculum committees, offered the MPBAETC curriculum to colleagues as a resource, and organized special AIDS education events.

The number of such interventions by the MPBAETC faculty are too numerous to list. In this low-incidence region, preparing health professions students to care for HIV/AIDS patients in the normal course of their practices may, in the long run, turn out to be one of the most significant contributions of the ETC program.

o Other Training Activities

The regional office sponsored two COSTEP (Commissioned Officer Student Training and Extern Program) students during the second year of the grant. The COSTEP program offers students in health-related fields opportunities to familiarize themselves with career opportunities and to be trained in a professional setting.

3. Curricula and Materials Developed or Used

MPRAETC's comprehensive, multidisciplinary "Curriculum for Trainers" is a central feature of its program. It serves as the basis of the first generation train-the-trainers program, is used in many of the second generation train-the-trainers activities, provides a guide for most of the "outreach" training done at the state level, and provides a resource for the ETC's initiatives to impact professional school curricula. In addition, it has been widely disseminated and has been adopted or adapted by a number of the other regional ETCs.

It was not the ETC's original intent to develop such an extensive curriculum; however, after a review of existing curricula developed by other ETCs, by the Centers for Disease Control, and by the California Nurses' Association, it was decided that none fit all the needs of the wide range of provider groups targeted by MPRAETC.

The curriculum development process, which was highly participatory, was in and of itself a significant contributor to the success of MPRAETC as an organization. The process began with the formation of a curriculum committee in late August 1988 consisting of the Project Management Team and other identified experts. The committee totaled 30 participants representing different disciplines from each of the 8 states in the region. A two-day meeting of this curriculum committee was held. The committee first broke down into multidisciplinary groups to share ideas and teaching experiences. Subsequently, the committee regrouped into discipline-specific groups where a preliminary outline of each module was decided upon. Writing assignments were distributed among the committee members. Drafts submitted by the authors were edited, organized and reformatted for consistency by a small subgroup consisting of regional office staff and the New Mexico site coordinator. Within three months of the initiation of the process, the curriculum was published and used at the first generation train-the-trainer conference held in Denver.

Writing the modules and organizing this whole effort in such a brief time frame was a remarkable accomplishment. Developing the curriculum was one of the first major tasks of the Project Management Team and proved to be an excellent team-building exercise. Moreover, because all state ETCs participated in the curriculum development, a feeling of curriculum ownership evolved; thus, making the first generation trainers willing and enthused about using "their" curriculum to conduct second generation trainings.

The curriculum consists of two components, a core curriculum and a discipline-specific curriculum. The core curriculum, defined as an "essential

base of information about HIV/AIDS that all health professionals need to know," includes the following modules:

- Epidemiology/Prevention
- Immunology/Virology
- Clinical Manifestations/Treatment
- Psychosocial Issues
- Ethical/Legal/Policy Issues
- Educational Methodology

The discipline-specific curriculum includes modules for the following professional groups:

- Dental Workers
- Emergency Medical Technicians
- Nurses
- Primary Care Physicians/Physician Assistants
- Social Workers
- Mental Health Workers (to be added July 1990)

The curriculum does not contain a separate module directed at public health workers. Consideration is being given to appending a section to each discipline-specific module to extend its applicability to the public health setting.

Each module contains the following elements:

- Brief introduction on the content of the module;
- Learning objectives - a brief outline of what information the learner will be able to obtain from the module. This section is designed to guide the trainer in presenting the content;
- Content synopsis - highlights the key elements to be presented and provides an overview of the subject. The synopsis is designed so that a trainer can easily extract from it; thus, facilitating the development of overheads, slides, etc.
- Suggestions for teaching strategies and learning activities - general guidelines for adult education including ideas on how to present the content of the module. This section is particularly helpful when teaching about AIDS, not only because the training involves stigmatized topics that require new ways of thinking, but also because HIV/AIDS patients often take active participation in their health care, presenting a new challenge to medical providers. Innovative and challenging teaching

approaches are often helpful when attempting to overcome some of these barriers.

- References and bibliography - selected readings illustrating content areas. This section needs to be updated on a regular basis.

The curriculum affords much flexibility and is designed to be used for the gamut of training activities from brief presentations to extensive training. It is very comprehensive, yet organized in such a way that the trainers can easily extract from the content what is needed for their particular training session.

As a result of the rapid development of HIV-related research, AIDS information has the tendency to become quickly outdated. The MPRAETC curriculum was conceived as a living document, with frequent updates as needed. In the beginning of 1989, minor revisions were made and the second edition was published. A third edition will entail a more extensive revision. In addition to a factual update, this revision will include a mental health module (supported by a NIMH grant), a hemophilia module (as a Center of Excellence activity), as well as a nutrition component added to various modules where appropriate. The format of the third edition will be modified slightly. Instead of containing a full copy of each article in the "selected readings," an annotated bibliography will be included in the curriculum. (The state ETCs will be provided with copies of the articles to be reproduced and distributed on request). The third edition is expected to be published in August, 1990.

All first generation trainers received copies of the curriculum at their train-the-trainers workshop. The state ETCs report that the curriculum is being used in all ETC training. In fact, in instances where trainers have several institutional affiliations, the use of the ETC curriculum in a training is often used as the criteria to differentiate between what constitutes an ETC training and a training conducted under the auspices of the trainer's other institution. The full curriculum, or specific modules of the curriculum, are being used not only within the region but also across the country by other ETCs, health departments, and AIDS service organizations, among others.

Several "spin-off" curricula have been developed by state ETC staff in response to specific needs. For instance, an abridged version of the MPRAETC curricula has been developed for Emergency Medical Service (EMS) training personnel in the state of New Mexico. The intention of this abridged curriculum was to address the needs of EMS educators and learners more specifically. Excerpts have been taken from the general guidelines of the original MPRAETC curriculum and translated into a concrete and relevant discussion about specific EMS work procedures.

MPRAETC had once considered developing a separate curriculum to be used in conjunction with its initiatives with health professions schools. Instead, it was decided to focus ETC efforts on making the comprehensive curriculum available to undergraduate health professions schools and to provide technical assistance on the integration of the material.

4. **Outputs**

As of November 1989 (half way through year 02 of the grant), 40,240 persons had been trained through the MPHAETC program. All states have held at least one second generation training conference. Forty-five percent of those trained fall into the target training group; i.e., dental personnel, emergency medical technicians, nurses, physician assistants, physicians, and social workers. Thirty-five percent of the total trained are **labelled** as "general public" and include students, teachers, and community groups.

The mini-sabbatical program, offered by the regional office, trained 33 providers through June 20, 1990 with the following backgrounds:

• Dentist	4
• Nurses	18
• Physicians	11
• Physician assistants	3
• Social workers	6
• Medical student	1
• Public health	1

These participants came from every state in the region, except Kansas. Additionally, the New Mexico ETC mini-sabbatical program trained two physicians and three nurses as of March 1990.

C. Efforts to Reach Minorities

The largest minority populations in the Mountain-Plains region include Hispanics, particularly migrants, as well as various Native American Indian tribes. **Each** state ETC is responsible for undertaking activities targeting the minorities in their areas. Most states in the Mountain-Plains region collaborate with local groups working with minority communities in order to reach providers who care for minority populations.

Examples of specific activities undertaken to target minorities include:

- At the Colorado AIDS ETC, the AIDS Education Coordinator has compiled a comprehensive bibliography on Hispanic AIDS Health Education materials.

- In Colorado, one of the second generation trainers has taken on the responsibility of riding a migrant bus in order to take advantage of a captive training audience to teach prevention and avoidance of high risk behaviors.

- A variety of efforts to reach minorities include AIDS prevention sessions directed at migrants, **Ute Indians, and minority high school students.**

D. Training Issues and Successes

The MPRAETC can point to its comprehensive curriculum, as well as the process by which it was developed, as one of the greatest successes of its program. In addition to the production of an excellent product that has served the ETC well, the process afforded the added benefit of instilling a sense of ownership of the curriculum. All state staff in the region are committed to its use and to continually updating the curriculum to maintain its effectiveness. Moreover, the participatory process not only brought about a sense of cohesion and team spirit among members of the Management Team, but also contributed heavily to the establishment of a regional rather than a parochial perspective on the part of the state ETCs.

The two-tiered training-of-trainers model has worked well. Due to the rural geography of the region, developing a large cadre of trainers was necessary in order to reach the more isolated primary care providers. Two problem areas were encountered in the implementation of this model. The first concerns the issue of quality control. Although using the regional curriculum provides guidelines for standardized training, it is still difficult for state ETC staff to monitor the quality of the sessions conducted by their second generation trainers. The use of a regional evaluation form has proven helpful in providing state staff with limited feedback. A second problem area encountered in the model's implementation has been getting second generation trainers to fulfill their training obligation. The state ETCs have tried to deal with this issue by having the second generation trainers sign an informal "contract" to conduct future trainings, by careful selection of second generation trainers, and by continual encouragement. The state ETCs, as well as the regional office, are aware of these issues and have taken positive steps to deal with them. Generally, these impediments have not been insurmountable and have detracted little from the overall success of the ETC's train-the-trainers efforts.

The regional mini-sabbatical program can also be counted among the ETC's successes. Because the region is a low incidence region, many primary care providers do not have direct clinical experience in caring for HIV/AIDS patients. The mini-sabbatical provides this opportunity. Although the training is not extensive enough to enable providers to care for HIV/AIDS patients without obtaining further training, the mini-sabbatical helps providers to understand the process of care and how to access other learning opportunities. Graduates of the program serve as a resource person in their own states.

Besides the mini-sabbatical program, the bulk of ETC training in several of the states has been primarily information-oriented rather than skills-oriented. While an emphasis on informational offerings may be appropriate in low-incidence states, there are prevention strategies that providers should be pursuing, amenable to skills training from these state ETCs.

The multitude of curriculum initiatives undertaken by MPRAETC trainers in their roles as faculty members of health professions schools may, in the long term, turn out to have a significant impact on AIDS care practice regionwide.

V. Program Administration

A. Administrative Systems,

1. Program Management and Control Mechanisms

Having lodged the ETC within the AHEC system has significantly facilitated the contracting/payment process of the ETC. The decentralized system of the ETC parallels that of the AHECs. The "management products," such as contracts and grants management procedures, needed to manage the ETC project were already in place and functional.

0 Contracts Management

Although the University of Colorado has a long history of contracting with private sector vendors, the process of contracting with other public entities in other states (state universities) initially proved to be an obstacle. The University had tight contracting requirements that did not really apply to the ETC contracts. Interstate negotiation on such issues as jurisdiction in case of tort and indemnification took place at the level of the office of the state attorney general.

The fact that ETC funding is dependent on annual appropriations complicated the process of contracting with the other states. To minimize problems associated with an annual contracting process, the ETC developed a system of three-year contracts, contingent on ETC continuation funding. The contracts make reference to the fact that there may be annual "modifications in budget and scopes of work," thereby rendering each annual modification purely administrative.

Contracts between the regional ETC and state ETCs consist primarily of "general provisions" with the substance being incorporated as an individualized "scope-of work," addressing the goals of both the regional and state ETCs in the attachments. More detailed scopes of work are also prepared for administrative purposes, budgeting and program monitoring, but are not incorporated into these contracts.

0 Financial Management

Because of the AHEC precedents, coupled with the attentiveness of the ETC financial. officer, few problems have been encountered with regard to funds flow. The few that have occurred have been due to the internal university system of the state ETC. Where these have occurred, MPRAETC's financial officer has informally intervened and has facilitated the process.

The internal project reports and documents are reconciled to the UCHSC's official accounting records. Generated revenues are held in a separate account established and monitored by UCHSC's Office of Grants and Contracts. To date, the only revenues were derived from the sale of the regional curriculum. It is expected that proceeds will be utilized to maintain existing manuals with updates of scientific findings.

2. Management Information Systems

Several management information systems are maintained at various levels of MPRAETC:

- Training Activity Database--state ETCs report planned training events to the regional office on a quarterly basis and MPRAETC reports these to HRSA for inclusion in the NAIC calendar.

  Training events held are reported by the state ETCs to the regional office semi-annually.

  The regional ETC keeps records on all regional mini-sabbatical training.

- Organizations/Mailing List Database--both the regional and the state ETCs maintain extensive mailing lists used in conjunction with the dissemination of the AIDS NewsLink.

- Trainer/Trainee Databases--Maintained by individual state ETCs.

- Program Costs and Revenue Monitoring System--Program costs are reviewed on a recurring basis through the UCHSC's monthly Financial Reporting System which documents all costs.

3. Communication and Coordination

Quarterly project team meetings (regional staff) are held to facilitate coordination. Full Management Team meetings are held three times a year.

Communication between the regional ETC and the state ETCs is informal and frequent. Telephone communication with the more active state ETCs is as frequent as three times a week; with the less active ones perhaps three times a month. All of the sites have fax capabilities, facilitating urgent written communications. For less urgent written communication, such as report compilation, compatible computer hardware and software is used at all sites (WordPerfect 5.1 run on IBM compatible computers). Data is transmitted by modem in some cases and by diskette sent via overnight mail in others.

B. Systems for Managing Training Events/Programs

1. Marketing Training Events

No formal marketing strategy exists. Each state ETC is responsible for its own marketing activities. Most state ETCs' marketing efforts include distributing brochures for individual training events, disseminating the MPRAETC newsletter and local networking. Some state ETCs contribute state-specific inserts for the regional newsletter. The Colorado ETC developed a

listing of AIDS education material available in Spanish for dissemination throughout the region.

2. Trainee Recruitment/Selection

Trainee recruitment for both state and regional training is a state ETC responsibility. A great deal of attention is paid to the identification and selection of participants for the train-the-trainers programs. A key recruitment strategy is to ensure that participants chosen to be trainers are from a wide variety of disciplines as well as geographically dispersed throughout their states to ensure coverage in rural areas. In addition, second generation trainees are generally selected on the basis of previous training in AIDS related topics and work schedule flexibility to allow the additional task of AIDS education.

3. Output/Outcome Reports

Each state is responsible for collecting data for training output reports on **MPRAETC's** mark sense form. The raw data are compiled into reports by the regional ETC and the reports are returned to the states.

Activity reports are compiled in each state for summary submission to the regional ETC. The regional ETC then compiles individual state reports into a regionwide report to HRSA. Semiannual reporting by the state **ETCs** to the regional ETC was initially formatted by the individual states with the expectation that this would enable the state **ETCs** to better address their own strategies. The regional ETC was asked by the state **ETCs** to give more structure to the reporting process. Currently, all reports from the state **ETCs** follow the same reporting format, facilitating compilation of region-wide reports as well.

C. Training Sites

Each state is responsible for managing its own trainings. All state **ETCs** have access to the conference rooms and other training facilities of the university in which they are located. Additionally, cosponsoring agencies provide some of the training sites.

D. Cost Sharing

Cost-sharing takes place on a number of levels: administratively; operationally; and interprogrammatically. On the administrative level, considerable cost-sharing comes from the various universities involved in the regional ETC. At the regional level, the University of Colorado has made a significant in-kind contribution to the ETC. Richard Call, the ETC Project Director, devotes 25 percent time to the ETC program, all of which is covered by the **SEARCH/AHEC** program, of which he is also director. In addition, Tom Kautzky, the administrator of the regional ETC program, is financed for 40 percent time on the ETC project by the university. Further, the university **has made a three-year commitment of office space for the** ETC at no cost to the grant, as well as furniture, equipment, telephone and other office support

services. The host universities of the state ETCs have also made similar in-kind contributions. In addition, the UCHSC agreed to an indirect rate of 8 percent instead of its negotiated rate of 40 percent.

Several of the state ETCs, notably Utah, have been involved in cost-sharing at the operational level by piggybacking their ETC educational activities onto other professional conferences. This has also resulted in sharing program planning costs, facilities costs, and particularly marketing costs.

The integration of the NIMH program and the ETC program is expected to yield cost savings.

E. CEUs

Most of the ETC's educational activities are short presentations. To the extent that they are included in a larger conference, CEUs are obtained by the sponsoring organization. CEUs are not sought for free-standing short presentations as it is not cost-effective. Each state ETC has its own mechanism, through the AHEC or through the university, for obtaining CEUs for their longer programs.

Continuing education credits for physicians participating in MPRAETC's mini-sabbatical program are provided through the American Academy of Family Practice.

F. Library/Information Services

The regional ETC designs and disseminates a quarterly newsletter, the AIDS NewsLink. The newsletter has also been used to provide updates to the MPRAETC train-the-trainer curriculum. Feedback on the newsletter, however, showed that trainers were more interested in clinical updates. A Clinical Advisory Committee was established comprised of physicians (state ETC program directors) in order to coordinate the.submission of clinical articles to the newsletter. The format has changed to accommodate this. Several of the states have also contributed to the newsletter with state-specific articles.

Approximately 5000 copies of the newsletter are published. The regional office does a mailing from its mailing list. Additionally, the regional office bulk mails newsletters to each state to be distributed within the state. The newsletter is also mailed to all of the national ETC projects as well as identified subcontractors in all 50 states.

Reproduction of any or all of the newsletter is encouraged. For example, the South Dakota AHEC did a full-page spread in its own newsletter using excerpts from the AIDS NewsLink, thereby reaching virtually all health providers in the state with the ETC message.

The library function is not a priority of the ETC. The ETC feels that its annual curriculum update, in a sense, serves the library function.

Further, MPRAETC uses the clearinghouse function of the other ETCs and EARN to minimize duplication of effort.

G. Other Services

While the federal "center of excellence" initiative is no longer a priority, the Mountain-Plains Regional AIDS ETC is continuing on its path to develop a center of excellence in Hemophilia and HIV because of the resources available in the region. Two organizations play key roles in providing service to hemophiliacs. The first is the National Hemophilia Foundation (NHF), and the second is the Office of Maternal and Child Health that supports the Regional Hemophilia Diagnostic and Treatment Centers. The center of excellence is a collaborative effort between these two agencies and the University of Nebraska. The other state ETCs involved in this effort are the Universities of Colorado, New Mexico and Utah, each with an affiliated Regional Hemophilia Treatment Center.

Jonathan Goldsmith, M.D., an oncologist/hematologist, is leading the center of excellence effort. Dr. Goldsmith is the Project Director of the Nebraska AIDS ETC and the Director of the Nebraska Regional Hemophilia Treatment Center at the University of Nebraska School of Medicine. Lorraine Adams, Project Coordinator for the regional ETC, facilitates the integration of the center of excellence activities into overall regional ETC activities. The activities planned for the center of excellence are as follows:

- Develop a module to add to the Mountain-Plains train-the-trainer curriculum on hemophilia and hemophilia-specific issues for health care providers dealing with HIV disease. The time line for completion of this task is the summer of 1990.

- Review the entire Mountain-Plains train-the-trainer curriculum for hemophilia content and implement modifications based on this review. Drafts of these modifications are currently being completed. These drafts will be reviewed by a hemophilia expert from the Centers for Disease Control and by the Chairperson of the National Hemophilia Foundation AIDS Education Committee prior to incorporation into the curriculum.

- Develop a mechanism for updating the hemophilia curriculum information on an ongoing basis. This will be part of the regional curriculum update process.

- Develop a mini-sabbatical with an emphasis on hemophilia and HIV/AIDS to be offered at the University of Nebraska Medical Center and to facilitate the development of similar programs in Colorado, New Mexico and Utah. Interaction with the staff and clients of the Nebraska Regional Hemophilia Center has been included in two dental mini-sabbaticals and two nursing mini-sabbaticals.

- Provide appropriate hemophilia and HIV/AIDS to the regional newsletter. Articles regarding hemophilia and the Center of Excellence were published in the fall and spring issues of 'AIDS Newslink.

- Enhance the current liaisons between the state **ETCs** and the National Hemophilia Foundation's AIDS Education Committee and the AIDS Education Committee of the World Federation of Hemophilia to promote the sharing of educational materials.

  Enhance the visibility of the **ETCs** at regional, national, and international hemophilia meetings. A poster on the dissemination of information about Hemophilia and HIV disease was presented at the 1989 National Hemophilia Foundation annual meeting. Similar presentations are planned for future national and international Hemophilia conferences. Dr. Goldsmith has also disseminated information about the Center of Excellence through his capacity as Associate Medical Director of the National Hemophilia Foundation.

H. Sustainability

The Mountain-Plains Regional ETC has identified two strategies to sustain its program efforts in the absence of federal funding. The first is to institutionalize its curriculum and to train a permanent, multidisciplinary cadre of local health professionals to serve as expert resources in their communities. To a large extent, this has already been accomplished. The participatory process through which the curriculum was developed created a sense of ownership among the state **ETCs,** each of which reports a commitment to using it. The two-tiered, train-the-trainers model has put in place a large cadre of trainers, widely distributed across the eight-state region.

The second strategy is to rely on public institutions versus private institutions, with the expectation that the eight states would take over the program when HRSA grant monies come to an end. This strategy has been furthered by the decentralized management approach, allowing maximum autonomy of program implementation at the state level. The decentralized approach allows each state ETC to create the program structure necessary for the institutionalization of the program.

In spite of the fact that the ETC is actively operationalizing both strategies, it is the opinion of the regional staff and most of the state ETC staffs that the program would atrophy significantly in the absence of federal funding. First, the curriculum has been and should continue to be a **"living"** document which, because of the rapidly changing nature of the epidemic, needs to be updated frequently. As the epidemic evolves in the region, it is anticipated that there will be a corresponding need to shift from the current information-based curriculum to a more practice-oriented one. During the project period, MPRAETC has produced and will continue to produce curriculum updates; without HRSA funding, there is no identified institution

to pursue this activity on behalf of the region. Although all states are committed to continually updating and expanding the curriculum, this activity may cease without the coordination heretofore provided by the regional office.

Moreover, although there has been extensive training to produce a cadre of local health professionals, some would cease to continue trainings and others would move away, decreasing the number of experts over time. Also, the task of updating the trainers clinical knowledge and training methodologies has not been institutionalized outside of the ETC program. Trainer selection criteria differs from state to state. To the extent that those selected have a mandate from their home institution to be trainers, they will carry on their missions after the grant period. However, where current grant funds are being used to fund outreach training, the sustainability model holds only in cases where institutions, such as AHECs, will continue to fund such activities in the future.

The regional coordination function will not be institutionalized under the current sustainability strategy. Thus, the coordination effort, the mini-sabbatical program and the regional newsletter probably would not exist in the absence of federal funding,

VI. SUMMARY AND FUTURE PLANS

The Mountain-Plains Regional AIDS ETC is an outstanding example of a regional organization. From its initial conceptualization through to its current day-to-day operation, every aspect supports its regional concept. The decentralized organizational structure under which the MPRAETC program operates is exactly appropriate for the makeup of the region and has worked well, with a balance between regional direction and autonomous state implementation of programs. The few organizational problems that have occurred have been dealt with in the normal course of program management.

Years 01 and 02 activities have been quite successful. The two-tiered training-of-trainers approach has established a large cadre of trained professionals who are able to serve as resources in their communities. A regional curriculum has been developed and serves not only as a resource for MPRAETC trainers, but is used by numerous other AIDS training organizations around the country. The mini-sabbatical program has offered practicing health care professionals an opportunity for hands on experience in the care of HIV/AIDS individuals.

The ETC does not consider its training strategy extensive enough to train providers fully to care for HIV/AIDS individuals, but expects that, collectively, its programs have given providers, especially rural providers, a good knowledge base. As providers begin to see HIV positive individuals in their communities, it is anticipated that they will draw on this base and on the network of experts in the region to care for the individual in the community instead of having to refer the person to the larger urban centers for care.

MPRAETC's plans for year 03 will focus on four activities. The first activity is curriculum revision. Each module of the curriculum will be

updated as necessary, The revision will also include writing a mental health module, developing a hemophilia module, and adding nutrition components to appropriate modules.

The second focus of year 03 will be the NIMH train-the-trainer program. The regional ETC will sponsor a regional train-the-trainer conference for mental health professions in October, 1990.

The third focus will be to involve health professions schools. With the achievement of organizational stability and with programs for practicing health care providers underway, the ETC plans to turn its attention next to professional school education. The state **ETCs** will emphasize enhancement of HIV/AIDS curriculum in these schools.

The fourth focus of activities in year 03 will be minority outreach. Each state will devise plans to strengthen activities with minority populations through the training of minority providers and the training of providers who care for minorities.

Thus far, the MPRAETC has had the luxury of operating in an environment where the incidence of AIDS is low and therefore the urgency for training health care professionals to deal with the epidemic has been significantly less than for most of the other **ETCs.** The true test of **MPRAETC** will come in the future as the incidence escalates in the region. By all current readings, the **MPRAETC** appears to be well-positioned to meet this challenge.

APPENDIX1

GOALS AND OBJECTIVES

C. GOALS AND OBJECTIVES

The core theme underlying this proposal is the development of a framework that will provide for joint collaborative efforts among the major medical institutions, while providing each state with the maximum degree of self-determination and autonomy. This is done so that state-based activities will have local ownership and relevance as well as the commitment to be continued after the federal funding ceases.

This project will establish a regional Mountain-Plains AIDS Education and Training Center, based at the University of Colorado Health Sciences Center, and designed to accomplish the following goals:

Goal 1. Develop an eight-state consortium of public institutions committed to the coordinated development of a multi-disciplinary decentralized educational network of health care providers.

Objectives

a. Establish a project management team of representatives from each medical institution. The team will meet on regular basis to ensure coordinated regional and state level educational efforts.

b. Establish, through the project management team, appropriate linkages to AIDS treatment centers, professional societies, providers, AIDS organizations, and other constituencies throughout the region.

Goal 2. Establish eight Statewide AIDS ETCs devoted to identifying and meeting the educational needs for AIDS education in each state.

Objectives

a. Establish multi-disciplinary teams of AIDS trainers in each state, to include (but not be limited to) the following disciplines: primary care physicians, dentists, nurses, public health personnel, socialworkers, EMTs, physiciansassistants.

b. Develop state-specific plans for decentralized AIDS education, using the existing AHEC networks in Colorado, Kansas, New Mexico, North Dakota, and South Dakota. In states where no AHEC exists, Nebraska, Utah and Wyoming, appropriate primary care educational networks currently in place will be used.

b.1 Augment individual state resources, as needed, by shared cooperative efforts with neighboring states and the regional ETC.

Goal 3. Provide accessible AIDS education to multi-disciplinary primary care providers in each state, with a special focus on rural practitioners, and those providing care to minority populations.

Objectives

a. Develop decentralized outreach educational programs that are both multi-disciplinary and discipline-specific for each state. The programs must be accessible to both urban and rural providers.

b. Coordinate and provide clinical educational activities for practicing professionals in the diagnosis, treatment, and management of AIDS and HIV positive individuals.

Goal 4. **Establish a permanent multi-disciplinary cadre of local health professionals who will remain dispersed throughout both urban and rural areas to continue to serve as resources to their communities when federal funding ends.**

Objectives

a. Develop and prepare "two generations" of trained health professionals to be AIDS educators.

a.1 the "first generation" faculty, representing each Statewide ETC, to be trained in Year 01 at a regional faculty development conference provided by the Mountain-Plains ETC.

a.2 the "second generation" faculty to be recruited from local and rural communities and trained in Year 02 at state level faculty development conferences, by each statewide ETC.

Goal 5. **Develop and implement an AIDS curriculum that is multi-disciplinary and designed to provide competence in AIDS related knowledge, skills and attitudes.**

Objectives

a. Design an inter-disciplinary core curriculum that includes the unique features and needs of each state, including cultural issues related to minority populations.

b. Design and implement discipline-specific curricula that address knowledge, skills and attitudes needed by each discipline in the treatment of AIDS.

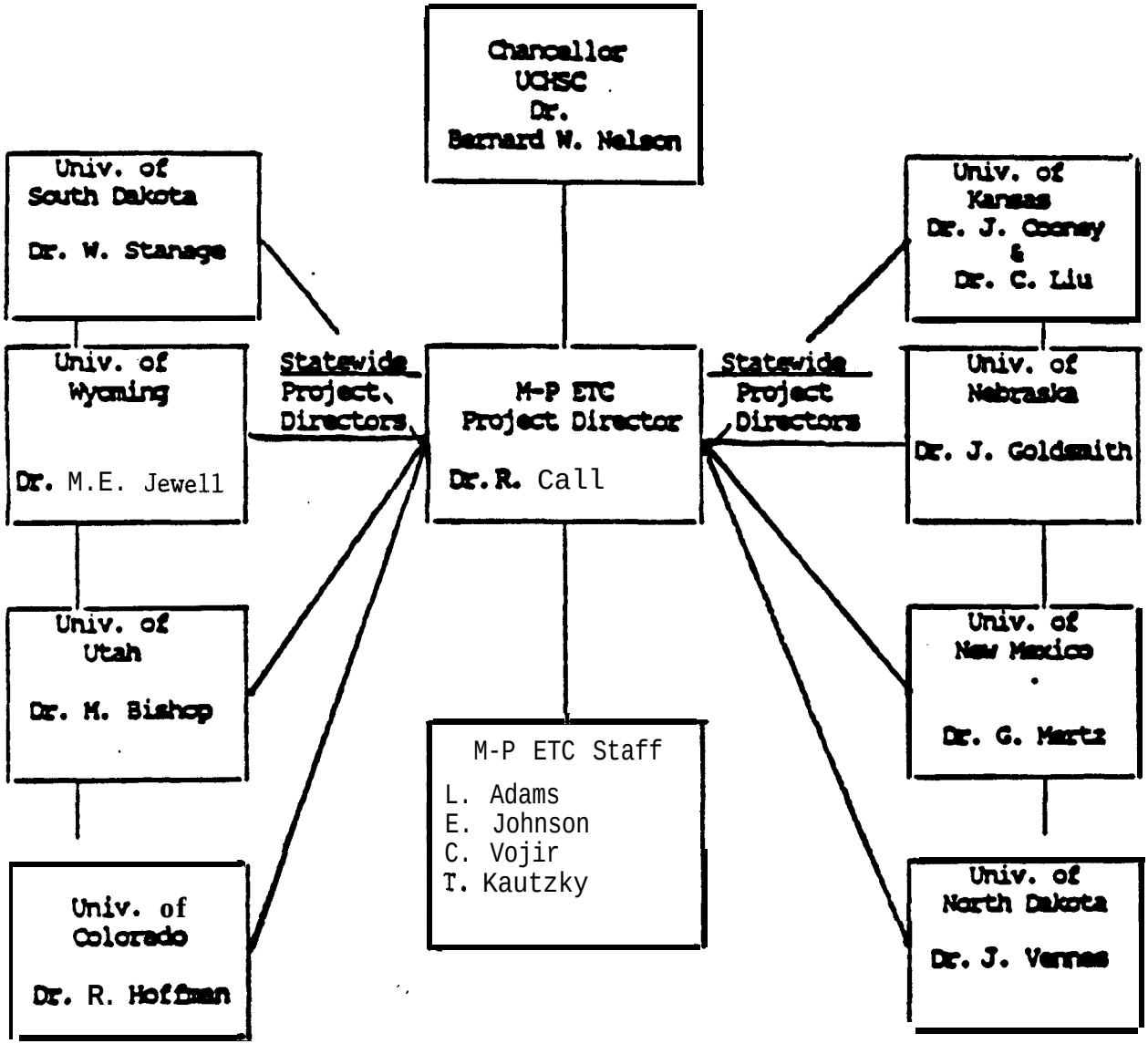
c. Utilize existing educational systems and resources already developed by previous AIDS ETCs, as well as other sources, such as the AIDS organizations in each state.

d. Provide for the implementation of AIDS education into undergraduate health professions curricula, by developing model undergraduate curricula and strategies to institutionalize the curricula at each university.

APPENDIX II

ORGANIZATIONAL STRUCTURE

FUNCTIONAL RELATIONSHIPS OF THE MOUNTAIN-PLAINS ETC



APPENDIX III

STATE ETC's AND THEIR ACTIVITIES

COLORADO AIDS ETC

A. Organizational Structure and Staffing

1. Structure

The Colorado ETC, which has been operational since April 1, 1988, is a partnership between the Colorado State Health Department and the University of Colorado. The structure of the Colorado ETC parallels that of the regional ETC. It is a decentralized program, with four local AHEC offices responsible for program implementation primarily in the rural areas and the Colorado Community Health Network responsible for program implementation in the metropolitan Denver area. (Initially, the El Paso County Health Department had been responsible for activities in its county, but because of personnel limitations, dropped out of the ETC program in the second year with responsibility for ETC activities delegated to the Southeastern Colorado AHEC) . An AIDS Education Coordinator has been designated at each of the sites. Quarterly meetings of these coordinators are held. Formal contracts; including scopes of work, are executed between the Colorado ETC and the local agencies. The scopes of work for the first year were relatively uniform, focusing primarily on organizational development issues: conduct of needs assessments; establishment of an advisory board; selection of first generation trainers: promotion of the ETC program; providing minimal education and training; and, participation in evaluation activities. The State of Colorado has 54 percent of the AIDS cases in the region (as of July 1, 1990).

2. Staffing

Richard Hoffman, M.D., M.P.H., Chief of the Infectious Disease Control Division and State Epidemiologist, at the Colorado Department of Health is the Colorado ETC's Project Director. Donna Anderson, Ph. D., M.P.H. is the Project Coordinator. Marcia Michels is the project secretary.

Activities in the Northeastern Region (Centennial AHEC) are coordinated by Nancy Mayer, in the Southeastern Region by Judy Weaver, R.N., in the South Central Region (San Luis Valley AHEC) by Charlotte Le Donne, R.N., in the Western Region by Shelley Nielson R.N., and in metro Denver by Beth Johnson, M.P.H. of the Central Office.

3. Advisory Committee

The Colorado ETC has an advisory committee composed of representatives from state professional societies of the seven target disciplines. The advisory committee was to meet semiannually; however, participation has been less than anticipated and a reorganization is being considered. Advisory committees of the area ETCs have been more active.-

B. Program Activities

1. Needs Assessment

Each of the regional offices completed a facility-level needs assessment in year 01 which they used to plan their educational programs.

Profession-specific needs assessment information was also obtained. The ETC, in collaboration with the Colorado Department of Health STD/AIDS Program conducted a needs assessment of over 2,000 physicians and nurses. This needs assessment focused on knowledge, attitude, beliefs, and behaviors. In collaboration with the state Division of Emergency Medical Services, the ETC conducted a needs assessment for EMTs. The results of these two needs assessments have not yet been reported. In addition, the ETC obtained needs assessment data on dentists from a KABB survey done by the State Department of Health.

2. Training of Trainers

The Colorado ETC has 23 first generation trainers, the largest cadre of first generation trainers in the region: 4 in the northeast; 4 in the southeast; 3 in the south central; 6 in the west; and 6 in the central metropolitan area. Candidates for first generation trainers were identified by the area ETCs, with final approval coming from the state ETC. Each area ETC was encouraged to develop a multidisciplinary team consisting of, at a minimum, a physician, a nurse and a dentist, although the latter proved difficult to recruit. Selection criteria included a good working knowledge of HIV information, clinical experience with HIV infection either through prior experience or, alternatively, a willingness to participate in the MPRAETC mini-sabbatical program, and a commitment to provide at least three training sessions in the first program year.

Strategies for selecting second generation trainers were developed at the second quarterly meeting of the area coordinators. As planned, three train-the-trainers conferences for second generation trainers were held--one in the first year, yielding 29 additional trainers, and two in the second year producing 104 new trainers. Because of demand, a fourth conference was held, in the Denver metro region which produced 29 trainers. In all, Colorado has 185 first and second generation trainers.

3. Outreach Training

Most of the area ETCs' programs are offered directly through one of two mechanisms: second generation trainers go back to their own institution and set up in-house training programs; or, first and second generation trainers respond to requests for presentations to outside groups. In the first 20 months, 168 educational sessions were provided to 6,609 participants.

The state ETC provides programs for the larger geographical area. The Colorado ETC has co-sponsored the Annual Rocky Mountain Regional Conference on AIDS for the past two years with the Colorado AIDS Project, the Colorado State Department of Health and the Denver Department of Health. Each of the conferences has reached approximately 600 to 800 people from the eight-state region, primarily health care providers working in the field of AIDS.

4. Initiatives to Impact Professional School Curriculum

Impacting on the AIDS content of professional school curriculum in Colorado is being pursued primarily through several of the **ETC's** second generation trainers who also hold faculty appointments. In one case, a faculty member of the University of Denver School of Social Work is involved in a broad curriculum revision that involves educating her colleagues about HIV/AIDS. In three other cases, faculty members have added AIDS content to their own teaching. In addition, the Colorado ETC sponsors the STAT Project (Students Teaching AIDS to Other Students) in which first and second year medical students are trained to provide AIDS information to junior and senior high school students.

C. Regional Relationship

The Colorado ETC share office space with the regional ETC staff and have a close working relationship.

A. Background

As of July 1, 1990, 379 cases of AIDS were reported from Kansas. In addition, it is estimated that a considerable number of Kansas AIDS cases have been diagnosed and reported in other states. The health care system in Kansas is starting to see a rapid increase in symptomatic patients. Over 90 percent of cases are among homosexual men. A small proportion of cases were diagnosed among minority populations; no cases of AIDS, to date, have been diagnosed among Native Americans.

B. Organizational Structure and Staffing

1. Organizational Structure and Background

The Kansas AIDS ETC (KAETC) utilizes the network of five Area Health Education Centers (AHECs) to implement its program activities. A central state office at the Kansas University Medical Center in Kansas City has a coordinating, supervisory and administrative function. The AHECs have a good geographic spread; they were in existence and well-functioning before the start of the KAETC. Three of the AHECs are state supported. The other two were originally offices of continuing education.

2. Staffing

The principal staff of KAETC include Drs. James Cooney and Chien Liu, both Co-Project Directors and Dr. Donna Sweet, Associate Project Director. Dr. Sweet is the primary author of the physician module of the curriculum and has conducted trainings in several of the other Mountain Plains States. In addition, since the Fall of 1989, Michael Robinson, M.S. has been working for the project as the Coordinator.

3. Advisory Committee

The Kansas ETC has an active steering committee. The members of this committee include representatives from each of the health professional associations and the Kansas Department of Health and Environment. Three formal meetings with the steering committee, the KAETC principal staff, the directors of the five AHECs and student representatives from the Students Teaching AIDS to Students (STATS) project have been held. The first meeting was a planning meeting before funding of the project, the second was an initial organizational meeting, and the third meeting became the second generation training conference.

C. Program Activities

The Kansas ETC serves as a vehicle for disseminating information about AIDS by providing a name, a structure and support to AIDS education in the state. The organizational and coordinating activities in the KAETC central

office have succeeded in getting the medical community actively involved in AIDS prevention and care.

1. Needs Assessment

KAETC has relied on the AHECs for needs/demands assessment for its community-based professional education programs. The state ETC has done a formal curriculum needs/interest assessment in the schools of nursing, physician's assistants and social work.

2. Training of Trainers

KAETC has pursued training of trainers in a slightly different manner than the other state ETCs. Since the number of health professionals in this rural state is very limited, the KAETC decided to combine the task of training second generation trainers with the training of health professionals who did not intend to commit themselves to becoming trainers, and therefore, the KAETC second generation training-of-trainers program was open to all health professionals. Participants in second generation training conferences were recruited by the state AHECs. Almost half of the participants in the second generation training conferences have conducted further training sessions. Additionally, many second generation trainers provide education outside the health professional community for social groups, churches, schools, etc. Almost all of the first generation trainers are heavily involved in training. For the most part KAETC has been able to reach their target group, which includes the same health professions targeted by the regional ETC. Over the two-year period, 23,000 individuals have been trained--many of whom were not health professionals.

One of the future challenges faced by the Kansas ETC, as well as the entire region, will be to find ways of updating the second generation trainers.

3. Clinical Training

Possibilities for mini-sabbaticals in Kansas do exist. However, there has not been much interest and the mini-sabbaticals have not been actively promoted. No one from Kansas has attended the Denver mini-sabbatical. Dr. Sweet, at the Wichita campus of Kansas University, has, on an informal basis, had family practitioners accompany her during her clinical work. The future of mini-sabbaticals is one of the items to be discussed with the steering committee.

4. Outreach Training

The Kansas "outreach" training of primary care providers has, to a large extent, been skills-oriented. The KAETC staff feel that this training, using the regional curriculum, coupled with access to local clinical experts, is sufficient to prepare practitioners to begin to take care of patients.

Physicians and dentists were originally difficult to reach; however, the active participation of the state dental association and the state medical society has helped to recruit these two groups. Making time for training was

one of the barriers in reaching these providers; trainings held in conjunction with professional meetings and conferences have proved to be a successful way of reaching these two groups.

Continuing education credits are made available for several medical professions. CMEs seem to be a strong incentive for physicians to attend trainings.

5. Initiatives to Impact Professional School Curriculum

The KAETC has provided technical and moral support to the nursing, medical and allied health students who conduct training in schools (the STATS program). This initiative has been very active in Kansas. The nursing school has made the STATS training part of their nursing curriculum.

D. Interagency Coordination

The KAETC has built a strong relationship with the Kansas Department of Health and Environment and has helped influence their policy on a number of HIV related issues. This relationship has opened up possibilities for other collaboration between the medical center at Kansas University and the Health Department. The KAETC has moved the medical center more out in the community to serve an educational function rather than merely clinical services.

E. Regional Relationship

The staff of the KAETC expressed admiration for the regional staffs ability to create a friendly and effective working relationship with the state ETCs. Materials go back and forth quickly and the regional ETC has managed to operate smoothly in spite of the change in leadership.

NEBRASKA AIDS EDUCATION AND TRAINING CENTER

A. Organizational Background

The Nebraska AIDS ETC operates under the auspices of the University of Nebraska Medical Center Viral Syndrome Clinic. The Viral Syndrome Clinic (VSC), which was established in 1985 to meet the needs of HIV-positive individuals. Because it had been involved with educational outreach efforts, it seemed to be the appropriate organization to take on the state ETC role. Although the Nebraska State Department of Health submitted an unsuccessful competing application for a statewide ETC, they have worked cooperatively with the UNMC-based Nebraska ETC.

B. Structure and Staffing

The Nebraska ETC has only one subcontract, with the Nebraska AIDS Project, for a hotline to refer calls on health care issues. Since there is no AHEC system in Nebraska, a training network, with informal links to other AIDS training providers such as the Nebraska Red Cross AIDS Education Coalition and the Nebraska AIDS Project, was developed.

Jonathan C. Goldsmith, M.D. serves as the Director of the Nebraska ETC; Lanyce Keel serves as the AIDS Education Coordinator. The Nebraska ETC has an active advisory committee, composed of first generation trainers, which meets semiannually.

C. Program Activities

The Nebraska ETC is a centralized program. All requests for training are funneled through the state ETC, often via the state health department. The ETC matches the request with the most appropriate trainer(s) from among its first and second generation trainers. Often first and second generation trainers are paired together as co-trainers similar to a buddy/mentoring sys tern. Trainers are paid on a fee-for-service basis by the ETC. In some cases, the trainee travel has been subsidized by the ETC. The ETC takes the lead in recommending co-sponsorship of educational programs and initiating joint ventures to meet educational needs.

The training strategy of the Nebraska ETC targets providers in urban areas to receive technical information regarding treatment issues and rural health care professionals to receive basic information and consultative services. By the end of the second year, the ETC reached nearly all of the state's 1264 social workers and 155 physician assistants, 600 EMTs, approximately 20% of the state's 2783 physicians, a smaller proportion of nurses and dental professionals, and a variety of other health care workers.

1. Needs Assessment

Training needs were identified by reviewing needs assessments conducted by the Nursing Division, Department of Continuing Education, University of Nebraska Medical Center and through a key informant approach which included

representatives from the AIDS Program of the Nebraska Department of Health, the Nebraska Department of Social Services, the Douglas County Health Department, the American Red Cross, the University of Nebraska College of Nursing and the University of Nebraska College of Medicine.

2. Training of Trainers

Thirteen first generation trainers were selected to be trained by MPRAETC . First generation trainers were selected by the Nebraska ETC based on a number of criteria which included: belong to one of the eight target disciplines; work setting particularly rural; experience with/interest in client services to AIDS patients; and support for AIDS education from the trainer's employer. In selecting the cadre of first generation trainers, geographic distribution across the state was also a consideration.

Second generation trainers had to meet the same criteria as the first generation trainers except that they did not necessarily have to have AIDS experience. Formal letters of application were required, along with three letters of recommendation attesting to the applicant's teaching expertise. Second generation trainers were primarily recruited by first generation trainers. Fifty second generation trainers were trained in the fall of 1989. Of these, 30 were active six months later.

3. Clinical Training

A number of opportunities for clinical training have been made available through the Nebraska ETC. One such experience was provided through the virology lab at the Viral Syndrome Clinic. A dentist from North Dakota was able to observe various AIDS tests being conducted and how precautions were implemented in the lab. The Viral Syndrome Clinic also provided a one-month patient care experience for four physician assistant students and a three-month rotation for two chief residents.

4. Outreach Training

The Nebraska ETC has been active in providing outreach training. The Nebraska ETC tends to downplay their involvement in training activities. For instance, what they refer to in their reports as "networking," is often active co-sponsorship of educational offerings, beginning with participation on conference planning committees through providing speakers for the event.

One unique and potentially high-impact training approach used by the Nebraska ETC is "institution-based" training entitled "AIDS in the Health Care Setting." The ETC training team is dispatched to a small town hospital, nursing home, etc. in response to a request. Before initiating training, the training team reviews the institution's policies and procedures that have implications for care of HIV positive individuals. If there are no procedures, the team makes recommendations. The training may begin with a short didactic component but quickly progresses to a problem-solving exercise. The training team leads the institution's multidisciplinary team through the care they provided to a selected group of their patients on the previous day. The multidisciplinary team is then challenged to identify how the care would have been different had those same patients been AIDS patients.

Another of the Nebraska ETC's training interventions aimed at provider behavior change is the "clinical consultative conference." The first of these half-day programs was held in late March 1990; annual updates are planned. This intervention was organized on the premise that most providers have or can easily get the knowledge necessary to provide care and that what prevents them from being actively involved in AIDS care are residual concerns. The clinical consultative conference is structured to change the attitudes and allay the concerns, under the guise of providing information. The agenda includes an information update aimed at demystifying AIDS, a presentation of the epidemiological picture of AIDS in Nebraska, practical advice regarding Medicaid reimbursement and legal issues, and issues of special interest, such as managing HIV disease in surgery. To support the participants' transition into practice, a manual was prepared consisting of information on the spectrum of HIV disease, excerpted from the MPHAETC curriculum, as well as resource people available for consultation throughout the state.

The ETC tried to reach small, rural hospitals through its teleconferencing network that includes 15-20 sites within the state, as well as sites outside of Nebraska. Two programs were presented--one aimed at nurses and the other on medications. This effort was found not to be cost-effective.

There is not a major emphasis on CEUs in the Nebraska program. They are most often offered in co-sponsored programs and in major programs offered to nurses and social workers. The train-the-trainers conference offers CEUs for nurses. The ETC will apply for CMEs for its physician's conference through the Nebraska Medical Association.

5. Initiatives to Impact Professional School Curricula

In addition to distributing the MPHAETC Curriculum for Trainers to University of Nebraska Medical Center faculty members, the Nebraska ETC succeeded in having some "heavy curriculum time devoted to AIDS' by instigating the proclamation of "AIDS Education Day" at the College of Medicine. Attendance was mandatory for all second-year medical students and included an examination. One hundred and twenty-five medical and pharmacy students attended the day-long event.

6. Training Materials

In responding to the potential complacency of a low incidence state, the Nebraska ETC has produced a video entitled "Nebraska AIDS Experience" to bring the impact of the epidemic down to a more local level.

D. Sustainability

While the ETC has no identifiable source of funds to sustain program efforts beyond the project period, it is felt that the University could take on the continuing professional education mission in the future, evolving into a sort of prototype AHEC. The ETC felt that the biggest loss would be the inability to update materials.

NEW MEXICO AIDS ETC

A. Organizational Background

New Mexico is a relatively low incidence area. As of July 1, 1990, there had been 290 AIDS cases in the State, including one pediatric case. IV drug use accounted for approximately 5 percent of the AIDS cases. The majority of the AIDS patients are found in the Albuquerque and Santa Fe areas, the city of Santa Fe having the highest per capita rate of AIDS in the region. There are several Native American Indian tribes, all with different cultural norms. About 3.5 percent of the population of New Mexico is black. Minorities are disproportionately represented in number of AIDS cases when compared to their population numbers.

In spite of the low incidence, state leaders recognized the importance of preparing for the epidemic early. A prominent public health official took an active role in the early days of the epidemic. Acknowledgement of the importance of preparing for the epidemic can also be credited to two state legislators who had relatives with the disease; the legislators became early advocates for action.

The State Public Health Department has remained active in combatting the epidemic; and collaboration between the ETC program and the Public Health Department has been very productive. Further assisting in the coordination of the ETC effort in the state was the precedent of cooperation, coordination and collaboration established at a Centers for Disease Control Conference held in Texas in 1986. This spirit carried over into the state and facilitates the coordination and collaboration in the ETC effort. The University of New Mexico also assisted in the writing of the grant proposal, thus, becoming committed to its successful implementation.

This cooperative spirit was further nurtured during the developmental phase of the state ETC program by involving every organization in the state that may have some interest in AIDS. This early contact established cooperation among the organizations, avoided duplication of effort and made the ETC a recognizable AIDS education and training resource within the state.

B. Structure and Staffing

The New Mexico AIDS ETC (NMAETC) program operates under the auspices of the Medical School of the University of New Mexico, located in Albuquerque, New Mexico, and is a centralized program. The direction of the ETC program and its activities is planned by the state staff in conjunction with the advisory board.

The Project Director of the New Mexico AIDS ETC is Dr. Gregory Mertz. Dr. Mertz is an Associate Professor of Medicine at the University and is on the medical staff of the Infectious Disease Department of the University of New Mexico Hospital and the Albuquerque Veterans Administration Hospital (also university affiliated). Dr. Mertz has an active case load of patients with AIDS, all of whom he sees in the AIDS clinic at University Hospital. This clinic serves the majority of inpatients and outpatients with HIV infection in New Mexico.

Dr. Lucy Bradley-Springer is the Program Coordinator of the NMAETC and serves the project full-time. Dr. Bradley-Springer is a registered nurse and completed her doctoral work in Educational Instruction and Curriculum. She has over ten years of experience in health education and instruction.

In the winter of 1989, with intervention from the MPBAETC regional staff, the NMAETC secured office space within the Health Sciences and Services Building allowing the entire ETC staff to be located in one spot for the first time since the commencement of the project. This has assisted greatly in the management of the project. Also, the person responsible for coordinating the state component of the NIMH grant is located in the same office, facilitating communication and coordination between these two programs.

The advisory board consists of all first generation trainers in the state, including an AHEC representative.

C. Program Activities

1. Needs Assessment

The Public Health Department, with assistance from the ETC and the ETC advisory board is conducting a knowledge, attitude and behavior survey of dental professionals. The goal of this survey is to more efficiently target trainings geared toward this group. The results of this survey will be shared with the ETC. The dentist assisting in this effort is an ETC board member.

2. Training-of-Trainers

Seven first generation trainers have been trained, several of whom represent-more than one area: dentistry/public health; nursing/AHEC; public health education; social work; nursing/infection control; emergency medical services ; and primary care physicians/physician assistants.

In May 1989, the NMAETC held a three-day conference in Santa Fe to train its second generation trainers. Seventy-two participants attended from all target disciplines, except emergency medical technicians (EMT). The participants were geographically dispersed throughout the state. The conference consisted of both AIDS content and training methodologies. Break out sessions by both multi-disciplinary and discipline-specific groups were held. During the discipline-specific break out sessions, participants practiced training strategies on their peers. The cost was $85 per participant. All participants received a copy of the full curriculum.

A difficulty for the New Mexico AIDS ETC was convincing infection control nurses to become second generation trainers. Infection control nurses had a good background in information about HIV and did not wish to sit through another "AIDS 101" Conference. The Program Coordinator's approach to this problem was to offer infection control nurses a half-day session instead of the typical two-day training-of-trainers program. The Program Coordinator conducted the training, focusing on how to use the regional curriculum and on various training methodologies rather than the medical aspects of AIDS.

Approximately 20 nurses participated in this half-day training and became educators for NMAETC.

All second generation trainers are expected to conduct at least two trainings. As of March 1990, approximately 40 percent of the second generation trainers had documented at least one training. The Program Coordinator is trying different techniques to encourage the trainers to follow through on these sessions. Such techniques include writing letters reminding trainers of their commitment while congratulating them on their progress, sending evaluation results back to the trainers for encouragement, and forwarding requests for training that are received by the state ETC office.

The New Mexico ETC has a total of 161 first and second generation trainers. Twenty-one percent of these trainers work with minority populations.

Future NMAETC plans are to hold a conference in November of 1990 to bring together all first and second generation trainers. This will be a two-day conference . The first day agenda includes clinical update sessions, special tracts (dental perspectives, EMS concerns, nutritional management, and long-term survivors: the psycho-social components and cross cultural approaches to healing), and historical and cultural perspectives on sexuality. The second day will consist of an introduction of the third edition of the regional curriculum. The afternoon of the second day will be devoted to training second generation trainers in mental health, based on the mental health module being added to the curriculum as a result of the NIMH grant.

3. Professional Schools

The New Mexico AIDS Education and Training Center sponsored a conference for faculty at schools of nursing in the state. Many of the faculty are now using the Mountain Plains curriculum in their schools. NMAETC also developed and implemented an eleven hour course (required) on HIV for second year medical students.

4. Clinical Training

A mini-sabbatical program is offered through the AIDS clinic at the University of New Mexico Hospital. The program offers hands-on experience in caring for AIDS patients by having the participant involved in patient rounds and in case management meetings. As of June 30, 1990, two physicians, two physician assistants, and three nurses have participated in the program.

The NMAETC also sponsored sending a dentist and dental hygienist to San Antonio for clinical training.

5. Outreach Training

The emergency medical technicians are important primary providers in the State of New Mexico. They are also very well organized in the state. The Emergency Medical Service (EMS) Academy is located across the street from the ETC. The Academy has three centers placed throughout the state that are responsible for conducting training activities. Through discussions with the

Academy, the ETC has taken responsibility for the AIDS part of the EMT training.

Each of the three EMS sites received a complete regional curriculum. However, to reduce reproduction costs, an abridged curriculum, specific to EMTs, was also developed. The modules for the abridged curriculum were lifted directly from the larger curriculum. This abridged curriculum is sufficient to serve most of the education needs of the EMT trainers. If any EMT wants the full curriculum, s/he has the option of contacting the local EMS site. The abridged curriculum includes the following sections:

- Spectrum of HIV Infection, Epidemiology and Prevention
- Immunology and Virology
- Ethical, Legal and Policy Issues
- Educational Methods
- Emergency Medical Technicians Discipline-Specific Curriculum
- Appendices

In addition to the EMT focus, The NMAETC hosts AIDS-specific issues classes for nurses, social workers and other health professionals. These classes cover various issues, such as psychosocial issues, legal and ethical issues, etc. These classes are one hour in duration. The NMAETC also sponsors a monthly class on a clinical aspect of AIDS for physicians. These classes are also one hour in duration. The New Mexico ETC also responds to requests for trainings. Generally Dr. Bradley-Springer, the Program Coordinator, is the trainer for these sessions.

D. Interagency Coordination

The AHEC program is not well established in the state. The northeast AHEC was the only AHEC in the state when the Program Coordinator joined the ETC. A new AHEC has recently been established in the south. A representative from the AHEC program sits on the advisory board. There has been close collaboration and cooperation between the two programs, although the close association has not been as advantageous as in states where the AHEC program is more established. The AHEC program sponsored a first generation trainer to go to Denver for training and sponsored six trainers at the second generation training conference in Santa Fe. The AHEC program also assisted in organizing the second generation training conference.

E. Regional Relationship

The relationship between the state ETC and the regional office ETC has been mutually supportive. There is constant, usually daily, communication via the telephone. The NMAETC staff view the regional meetings of the project management team as invaluable for networking, sharing of ideas and feedback on project activities. The NMAETC staff feel that the correct level of centralization and decentralization has been achieved. NMAETC staff were intensely involved in developing the regional curriculum. The Program Director wrote one module of the curriculum, and the Program Coordinator was involved in both the writing of specific parts of various modules as well as playing a key role in the editing phase of the curriculum.

NORTH DAKOTA AIDS ETC

A. Program Overview and Structure

The North Dakota AIDS ETC operates under the auspices of the University of North Dakota School of Medicine. The staff of the North Dakota AIDS ETC (NDAETC) includes the Co-Project Directors, Dr. John Vennes and Dr. Robert Tight. Drs. Vennes and Tight both serve the project in about a 10 percent capacity. Dr. Vennes wrote the immunology and virology module of the regional curriculum. Ms. Sue Caswell is the Project Coordinator and contributes approximately 40 to 50 percent of her time to the project.

The NDAETC has established both an advisory committee and a first generation training committee. The purpose of the first generation committee is to provide support to the second generation trainers while the purpose of the advisory committee is more broad based. Both committees meet via teleconferencing quarterly.

B. Interagency Coordination

The ETC works closely with all organizations involved in AIDS in the state, including the Governor's AIDS task force and the State Health Department. These organizations have representatives on the advisory board and have assisted in identifying first generation trainers. The state ETC is also working with key persons on a grant received to establish a Native American Resource Center to determine how the two programs can collaborate.

There is close collaboration between the AHEC program at the medical school and the ETC program. There are four AHECs, one in each quadrant of the state. The director of each AHEC sits on the advisory board. The established AHEC network has benefited the ETC in the dissemination of its programs.

The Chairperson of the Department of Neuroscience is heading up the NIMH effort in the state. A coordinator will be hired for this grant at 20 percent FTE. Until that person is hired, the Program Coordinator of the ETC is filling that position. The Program Coordinator of the ETC grant sees her position with respect to the NIMH grant as keeping NIMH people informed of ETC activities, sharing useful information and advising on some of the obstacles and problems that may arise.

C. Program Activities

1. Training of Trainers

In October 1989 the North Dakota ETC held their second generation training conference. Approximately ten individuals attended from each of the target disciplines, about 70 individuals total. The first generation trainers assisted in identifying second generation trainers.

Second generation trainers are expected to do three to five trainings before the end of the grant period. As of March 1990, approximately 15 of the 70 second generation trainers had conducted trainings.

2. Outreach Training

Other trainings that the ETC has sponsored include an AIDS Day for Medical Students in year 01 of the grant and an AIDS/Substance Abuse Day for Medical Students in year 02 of the grant. Patients with AIDS are used at these AIDS days and are generally the only contact medical students have with the disease.

Teleconferencing has been used extensively as a management tool and as an education vehicle. This mode fits well with the rural geography and the climate of the state, which makes intrastate travel difficult. As stated previously, teleconferencing has been used to facilitate board meetings.

3. Initiatives to Impact Professional School Curricula

There is no formal strategy for impacting health profession school curricula. This is seen as a long and slow process by the ETC, requiring time and persistence in convincing faculty and curricula developers that it is necessary. Because the medical community is relatively small in North Dakota, the approach for impacting curricula will be less formal; i.e., communicating with and convincing one's peers of the need for the change.

D. Regional Relationship

NDAETC staff are impressed with the job that the regional staff is doing and think that the regional contribution to the project is invaluable. The train-the-trainer method has proven an effective method for getting information disseminated, especially in North Dakota where it is difficult to reach the rural areas of the state. The NDAETC complimented the region on the development of the mini-sabbatical program. All except two of the first generation trainers attended the **mini-sabbatical,** and it is seen as a crucial component of giving clinical staff hands on experience with AIDS patients.

SOUTH DAKOTA AIDS ETC

A. Program Overview and Structure

The South Dakota AIDS ETC has been operational since April 1988. The South Dakota AIDS ETC (SDAETC) is administratively and programmatically decentralized. The task of coordinating AIDS education and training programs is delegated to the three Area Health Education Centers (AHEC), located in Pierre, Sioux Falls and Yankton. Although these three AHECs do not geographically cover the whole state, they do provide services on a statewide basis.

Two Co-Directors, one from the University of South Dakota (USD) campus in Sioux Falls and one from the USD campus in Yankton, provide guidance on the project's educational and administrative efforts. Recently a Project Coordinator was hired. This position was recommended by the regional ETC staff during their visit to SDAETC in order to enhance the site's educational activities. The Co-Directors and the Project Coordinator meet regularly with the AHEC directors to discuss current and future activities of the South Dakota AIDS ETC.

B. Program Activities

The stated goal of the South Dakota AIDS ETC was to provide interdisciplinary educational programs that would increase the level of knowledge and expertise for health professionals in the treatment and prevention of HIV. Specific objectives included training state-level faculty to use the regional AIDS curriculum, identifying local health professionals through whom the information would be disseminated to the community, establishing a communication network within the state and among the states of the Mountain-Plain AIDS ETC, and developing a plan for maintaining the South Dakota AIDS ETC when federal funds are ended. The mechanism for achieving the goals has been primarily through the two-tiered train-the-trainer model being used throughout the region.

1. Needs Assessment

During year 01 of the project, a formal needs/demands assessment targeted towards physicians, dentists, nurses, emergency medical technicians and social workers was conducted statewide. The response indicated interest across the disciplines in attending the train-the-trainer workshops.

2. Training of Trainers

Six first generation faculty were trained at the first generation training conference held in Denver, including one of the Co-Directors and the Project Coordinator. The first generation faculty consists of two physicians, two nurses, a dentist, and an emergency medical technician.

Second generation conferences were planned for the summer and fall of 1989. Despite promotional activities, including mailed announcements of the

workshops to professional groups, advertisements in the area newspapers, and a notice in the regional newsletter, the summer session had to be cancelled due to lack of interest. However three late summer and fall workshops held in Sioux Fall, Rapid City and Pickstown were well attended.

The trainers were selected based on their geographic distribution and their willingness to be AIDS educators. The SDAETC has had difficulty recruiting physicians for the second generation train-the-trainer workshops. As of March 1990, only one physician had attended a workshop. Future plans to address this physician recruitment problem include offering training programs for physicians in their clinical practices, utilizing professional meetings, and enhancing promotional activities.

Future planned activities of the SDAETC site include targeting the Native American reservations. In the spring 1990, a two-day train-the-trainer workshop is planned for representatives from each of the reservations including nurses, community health representatives and AIDS coordinators. Trainers for this workshop will be mainly first and second generation faculty. The SDAETC plans to feature a story on the training experiences at the reservations in the regional newsletter, AIDS Newslink. Additionally, SDAETC's future plans include using the already well-established statewide teleconferencing network to conduct AIDS training for health care professionals.

A telephone survey is planned to track second generation trainer activities, receive feedback on the train-the-trainer workshops, determine the need for trainer updates, and encourage trainers to conduct more training sessions.

3. Outreach Training

Other educational activities held in 1989 included programs that varied in length from one hour to a full day. Presenters included first and second generation faculty. On one occasion a clinical AIDS expert from Kansas was recruited as a presenter. Continuing education credits are available for educational programs that last longer than two hours through various educational institutions in the state.

C. Regional Relationship

The SDAETC considers the regional input to have been very helpful. The regional office is considered readily available to serve as a resource; also the quarterly regional meetings are thought to be valuable as sources of inspiration and to share experiences within the region. The regional curriculum is being used for training activities in South Dakota.

UTAH AIDS ETC

A. Program Overview and Structure

The Utah ETC operates under the auspices of the Department of Family and Preventive Medicine of the University of Utah School of Medicine.

F. Marion Bishop, Ph.D., M.S.P.H., Professor and Chairman of the Department of Family and Preventive Medicine serves as the Project Director of the Utah ETC, allocating 10 percent time to the project. Neal A. Whitman, Ed.D., who devotes 20% time, serves as the ETC's Educational Coordinator, responsible for the day-to-day coordination of the ETC program. All first generation trainers are part of the state ETC staff.

The Utah ETC follows a highly centralized model with all training activities emanating from the state ETC office. Eight staff trainers conduct the bulk of the ETC offerings. They include: Larry G. Reimer, M.D. (infectious disease); Lawrence J. Lutz, M.D., M.P.H. (family medicine); R. Moser, Jr., M.D., M.P.H. (preventive medicine); E.G. Hartigan, R.N., Ed.D. (nursing); Marilyn H. Ford, R.N., Ed. (nursing/patient education); David Spendlove, Ph.D. (Social Work); J.A. Aldous, D.D.S. (dentistry); and J.B. Lazar, M.D., M.P.H. (public health education).

B. Program Activities

The ETC has identified as its greatest barrier to program implementation the residual attitude of complacency in its providers, a situation they believe is shared by other low incidence states. In the ETC's opinion, providers do not feel that AIDS is their problem, in spite of the growing problem, since the infectious disease specialists in Utah can adequately serve the current state case load (100 living patients). Dentists are content to refer patients to the University Hospital clinic.

In the first two years of the program, the ETC's program efforts have been directed at the eastern portion of the state known as the Wasatch Front.

1. Needs Assessment

The Utah AIDS ETC has made use of the results of a Department of Family Medicine-sponsored survey of Utah physicians conducted by two medical students. In this survey, information was received from nearly 200 Utah physicians.

2. Training of Trainers

Seven first generation trainers were trained in the fall of 1988. First generation trainers officially provide 10 percent time to the ETC program. Because these trainers are the state AIDS experts, it is somewhat difficult to identify which activities can be attributed to the ETC and which are carried out as part of their other responsibilities. However, all teaching done by these trainers is based on the MPRAETC curriculum, in which the state ETC has a strong sense of ownership, and utilizes the MPRAETC evaluation form.

Therefore, all of their extramural professional educational activities (outreach training) are considered, directly or indirectly, as part of the ETC program.

The train-the-trainers course for second generation trainers has been the only direct training activity wholly organized and implemented by the Utah ETC staff. Second generation trainers were identified via several mechanisms: first generation trainers' referral of their colleagues; recruitment through professional societies; recruitment from among attendees of ETC presentations; and nomination by deans of professional schools around the state. Those interested in becoming trainers attended the October 1989 train-the-trainer workshop, which highlighted the nutritional management of AIDS patients. Of the 50 that attended, 27 signed a contract to become trainers--the vast proportion of those signing contracts were among those tapped by their deans. About half of the second generation trainers are academically-based; the other half being recruited from among practicing providers.

3. Outreach Training

The program strategy of the Utah ETC is to piggy-back its programs onto events of other organizations whose membership includes the **ETC's** target groups under the rationale that this approach is more efficient and that their presentations are more likely to reach providers who would not ordinarily attend an AIDS-only program. Four annual association activities were initially targeted--Utah Family Practice Refresher Course, Rocky Mountain Occupational and Environmental Health Course, Rocky Mountain Infection Control Association annual meeting, and the Health Education Association of Utah annual meting--but this strategy has been expanded to include a number of other organizations.

An example of the **ETC's** implementation of this piggyback strategy was their participation in the annual Family Practice Refresher Course held in February 1990. The Utah ETC staff was part of the planning committee for this conference. Three slots on the program were devoted to AIDS issues: the one-hour plenary session, **"AIDS** Public Policy," was attended by all conference participants; the one hour and forty-five minute elective session, "AIDS Diagnosis and Management," was offered twice during the conference; and "AIDS in the Workplace, **"** an elective one hour and forty-five minute session was offered once. American Medical Association (AMA) Category 1 **CMEs** and American Academy of Family Physicians (AAFP) Recognition Credit were offered.

4. Initiatives to Impact Professional School Curriculum

The **ETC's** strategy for impacting professional school curriculum in the state revolves around dissemination of the regional ETC curriculum, in the spirit of collegiality. The Utah ETC has provided copies of the curriculum, for their information, to the University of Utah Schools of Nursing, Pharmacy and Social Work, as well as schools of nursing outside the University of Utah sys tern.

5. Other Activities

The ETC worked hard to implement an AIDS hotline for health care providers, but the formal activity has proved to be a less effective strategy than the informal networks that have developed through its other training activities. The ETC set up the hotline system as part of an existing hotline at the University Hospital. The hotline operator for the University Hospital system was trained to screen calls, with first generation trainers available to respond to questions related to HIV infection. A brochure has been prepared describing the hotline service and the hotline has been aggressively marketed at Utah ETC training activities. A tracking form has been developed to monitor hotline activity. In spite of these efforts, the hotline has been poorly utilized, providers preferring instead to contact the speakers they have encountered during their training when they have a question.

Another important aspect of the Utah program, multidisciplinary visits, is scheduled for implementation in the third program year.

C. Sustainability

The Utah ETC has concerns for sustainability of its efforts beyond the Project period. Currently, the state funds only 12 percent of the total Medical School budget, and it is not anticipated that AIDS education will be considered a priority within that limited budget.

A. Background

Wyoming is a very low incidence area with only 32 AIDS cases as of July 1990. This presents an obstacle to ETC activities in that there is no perceived need on the part of health care providers. Unfortunately, to date, the concern of providers has been more on how to avoid the disease rather than on how to care for infected individuals.

B. Program Overview and Structure

The Wyoming AIDS ETC (WAETC) operates under the auspices of the University of Wyoming Family Practice Program.

The staff of the Wyoming ETC are Dr. Mary Jewell, Dr. David Calhoun and Ms. Char Schnabel. Dr. Jewell, the Project Director, was originally on the project in a 25 percent capacity. This was increased to 30 percent when the NIMH grant was awarded to the region.

Dr. David Calhoun is the AIDS Education Coordinator of WAETC and one of only two infectious disease specialists in the state. Dr. Calhoun contributes 15 percent of his time to the project.

Ms. Char Schnabel, B.S.W., M.S., joined the ETC team as the Project Coordinator in January 1989, six months after the initiation of the project. She originally served the project in a 50 percent capacity and increased this commitment to 75 percent time when the NIMH grant was awarded. It was not until the Program Coordinator was hired that the program got off of the ground in Wyoming. The WAETC staff see this coordination function as essential; and if they had it to do all over again, the Program Coordinator would have been brought on to the project in the beginning.

The strategic direction of the state ETC is decided by the ETC staff and an advisory board comprised of the first generation trainers. The advisory committee meets on a bi-monthly basis.

C. Program Activities

1. Training of Trainers

The first generation trainees were selected during the proposal writing period. The WAETC first generation trainers include physician's assistants, nurses, emergency medical technicians, representatives in the public health field, a physician, and a social worker. The majority has been very active with the ETC project. However, one lesson learned by the WAETC is that first generation trainers must be carefully chosen. Some of the trainers have not been as active as the ETC would like them to be.

To identify second generation trainers, the advisory board did an informal needs assessment by talking with their peers and colleagues. In

September of 1989, the Wyoming ETC held its second generation train-the-trainers conference in Casper, Wyoming over a three-day period. The training counted as 15 hours of continuing education units. Approximately 47 persons attended from all target professions, of which over half of the participants were nurses. The trainees were well dispersed geographically. The participants paid for their travel and the state ETC paid for the hotel room and 90 percent of boarding expenses. Each participant was also provided with a copy of the regional curriculum. The Wyoming ETC called on expertise from within and without the region to conduct some of the sessions.

All second generation trainers signed a contract to conduct two trainings within the next year. As of September 1989, 22 of the trainers have given 54 presentations. The state ETC staff are trying to think of ways to encourage the rest of the second generation trainers to conduct trainings. Second generation trainers are not reimbursed for their presentations.

In the spring of 1991, the state ETC is planning a conference for all of its second generation trainers. This conference will consist of an update on clinical information and educational techniques as well as a mental health training session in coordination with the staff of the NIMH grant.

2. Outreach Training

The WAETC collaborates closely with the State Public Health Department and has conducted many trainings for health care professionals serving in the public health sector. WAETC is also producing a clinical newsletter in collaboration with the Public Health Department to inform and update all primary care physicians in Wyoming and to let physicians know of AIDS resources within the state.

The WAETC staff also attempts to have a presence at the annual professional meetings for all disciplines. The purposes of this activity are to increase the recognition statewide of the ETC program, recruit second generation trainings and to conduct AIDS education programs in front of a captive audience.

In year 03 of the grant, the Project Director and the Project Coordinator will travel around the state visiting actual trainings and meeting with the second generation trainers. The purpose of these visits will be to solicit feedback from the second generation trainers and to assist in monitoring the quality of the trainings being given.

3. Initiatives to Impact Professional School Curriculum

Two professors at the nursing school requested and received the curriculum for incorporation into their classes. A meeting with the faculty from nine nursing schools is also planned to discuss incorporation of AIDS information into nursing school curricula.

D. Regional Relationship

The WAETC staff are impressed with the regional effort. There is mutual support, with the regional staff supporting efforts in Wyoming as well as

WAETC initiatives feeding back to the region. The WAETC staff indicated that the regional staff seek input and advice from all of the states before moving forward with plans. This process is invaluable for instilling a sense of commitment to the ETC program and has worked well in the Mountain-Plains region.

One of the major benefits to the State of Wyoming from participation in the ETC program has been the opportunity for a few health professionals to become expert resources on the care of HIV/AIDS patients. Without the first generation training sessions in Denver, the mini-sabbatical program, the logistical and financial support, and the access to experts currently involved in the epidemic, this opportunity may not have presented itself. Having even just a few experts in the state allows those providers who see an occasional patient with HIV/AIDS to have someone to turn to for professional guidance.

New England AIDS Education and Training Center

Case Study

NEW ENGLAND AIDS EDUCATION AND TRAINING CRNTRR

CASE STUDY

I. PROGRAM OVERVIEW

The New England AIDS Education and Training Center (NEAETC) was established in April 1988. Originally, the NEAETC served Massachusetts, Rhode Island, Maine, New Hampshire and Vermont. Connecticut was officially added to NEAETC's region in the spring of 1989.

NEAETC is headquartered at the University of Massachusetts Medical School campus in Worcester, Massachusetts. In Massachusetts, regional AHECs provide local structure for program implementation. In Rhode Island, NEAETC activities are coordinated through the Brown AIDS Program, while in Connecticut, Yale University and the University of Connecticut Health Center are the primary collaborating institutions. In the first two years of the grant, the Maine Consortium for Health Professions Education, the major NEAETC subcontractor, served both as a funding conduit and a coordinator of activities in the three more rural northern states. Through a number of other subcontracts, the expertise and resources of a wide variety of organizations and individuals have been mobilized throughout the region, including the Beth Israel Hospital, Boston Health and Hospitals Corporation, the University of Vermont Medical School, and Dartmouth Medical School/Mary Hitchcock Hospital.

The focus of NEAETC has been more on the provision of training than on the creation of an organizational structure. At the central level, the ETC staff function both in an administrative capacity and in a direct training capacity regionwide. The subcontractors provide training in their respective areas of expertise to target audiences primarily in their geographical catchment areas.

NEAETC's offerings have been aimed primarily at expanding access to care and improving clinical practice. The NEAETC program targets a broad spectrum of health care professions, in particular those serving minority populations, in a number of health care settings including hospitals, health centers and private practice. The NEAETC strikes a balance between a primary care and subspecialty focus. NEAETC education and training activities include faculty development/train-the-trainer courses, special focus workshops, and conferences. A number of clinical training opportunities are ongoing in the three more urban states. The ETC also addresses expansion of AIDS content in professional school curricula.

The NEAETC's formal goal and objectives are included as Appendix I.

II. PROGRAM HISTORY

A. Regional HIV Epidemiology

The epidemiology of the AIDS epidemic varies across the region. Geographically, the greater Boston area of Massachusetts has the highest incidence of reported AIDS cases with several medium-sized Massachusetts cities (Worcester, Springfield, Fall River, New Bedford, Lowell and Lawrence) reporting a rapidly growing number of AIDS cases. An increasing proportion of new cases is seen in the IV drug abusing population. Cases in the rural and small town areas of Massachusetts are predicted to grow in the future.

In Connecticut, AIDS cases are concentrated in New Haven and Hartford, although the impact is being felt in the smaller cities and towns throughout the state. The percentage of AIDS cases in Connecticut related to IV drug use is high as is the percentage of female AIDS cases in the state.

The city of Providence, in Rhode Island, has a rapidly growing number of AIDS cases. As in Connecticut, there is a high concentration of IV drug-related cases.

The largely rural northern tier (Maine, New Hampshire and Vermont) is currently a low-incidence area. However, three cities, Burlington, Vermont, Manchester, New Hampshire, and Portland, Maine have rapidly growing numbers of AIDS cases.

B. Organizational Background

The ETC grant is lodged in the Office of the Chancellor of the University of Massachusetts Medical Center (UMMC) and flows into the AHEC program for administration. The UMMC, consisting of a 369-bed tertiary care hospital, a medical school with 440 full-time faculty, a doctoral program in medical sciences, and a graduate school of nursing, as well as the only family residency program in the state vests NEAETC with a credible institutional base from which to operate as well as built in access to a large target audience. UMMC created an HIV Clinical Center in 1987. This clinic has served as the institutional base for UMMC's increased involvement in patient care, research, teaching, and educational outreach related to the problem of AIDS. The Division of Infectious Diseases serves as the focus of UMMC HIV research, as well as an outreach education program targeting college students and allied health professionals.

The Massachusetts Statewide Area Health Center Program, established at UMMC in 1978, is a partnership effort among UMMC, the Boston University School of Medicine, and the six regional Area Health Educational Centers. Most of the two and four year colleges and universities in the state have participated in the AHEC in either a governing, planning, or program development capacity. The AHEC connection has provided NEAETC with experience in implementing continuing education programs, a primary care focus, a long history of collaboration with local communities, and the administrative and management systems established by the AHEC program over the years.

C. BTC Origin and Development

The development of the NEAETC was coordinated through the Massachusetts Statewide AHEC program, under the leadership of its director, Mick Huppert, From its inception, the ETC program in New England was envisioned as a collaborative effort; not an easy task in the New England region, Massachusetts in particular, with its plethora of independent and competitive medical and academic institutions. The AHEC, with its institutional capability in continuing education but little previous direct involvement in AIDS work, saw itself as ideally positioned as a neutral party to facilitate the collaborative effort in a highly turf sensitive arena. The AHEC assembled a large planning committee and undertook a lengthy planning process in the development of the NEAETC.

The strategy to overcome the turf barrier was to choose key people at key institutions to serve key roles in the ETC project. In Massachusetts, Dr. Harvey Makadon's commitment to the project established linkages with the Beth Israel Hospital and Harvard University; Dr. Lynn Eckhert facilitated the NEAETC-UMMS clinical connection; and Dr. Howard Libman tied NEAETC in with Boston City Hospital and Boston University Medical School. In Rhode Island, Dr. Kenneth Mayer of Memorial Hospital, affiliated with Brown University, was identified as the lead person in that state. These four have been instrumental in developing programs within their organizations and overseeing the subcontracts with each of their institutions.

Again using historical AHEC connections, locally based providers and institutions with experience in the provision of services to AIDS patients, the conduct of research, and/or the implementation of programs for health providers were brought into the planning process. Such associations included the AIDS Action Committee, the Massachusetts Hospital Association, the Fenway Community Health Center, and the Massachusetts Department of Health, among others.

The northern tier of the region, Maine, Vermont, and New Hampshire, developed in a different manner. These three states were grouped together because of their similar geography and similar AIDS epidemiology. The Maine Consortium for Health Professions Education was designated the lead agency for the ETC program in these three states. The Maine Consortium, in turn, identified the University of Vermont Medical School, Dartmouth Medical School in New Hampshire, and the New England College of Osteopathic Medicine in Maine as key institutions for ETC activities around professional school curriculum. Additionally, the College of Osteopathic Medicine was seen as an important vehicle in the planning and implementation of AIDS education and training programs for osteopathic physicians, an important source of primary care particularly in Maine.

After receipt of the grant, many of the relationships established during the planning process were formalized as subcontracts, and the committee evolved into the regional New England AIDS ETC Advisory Board. A separate advisory committee, comprised of the three subcontractor organizations, the Maine Consortium, and representatives from the Offices on AIDS in each of the states was established for the northern tier.

The subcontractors each developed their own programs, but worked in close collaboration with NEAETC staff who provided a broader perspective as well as technical expertise in the development of educational programs. The role of the University of Vermont and Dartmouth Medical School expanded, making these institutions the lead education and training centers in their respective states, rather than concentrating only on internal curriculum development efforts. The state of Connecticut was brought into the NEAETC program in May 1989 when supplemental funds became available. The program development process was similar to that of Massachusetts and Rhode Island, in that key people in key institutions were identified to play lead roles. The individuals were presented with a variety of NEAETC programmatic alternatives and given the option to develop those which fit their organizational capabilities and their local needs.

In year 03 of the grant, the Maine Consortium will play a less prominent role in NEAETC. NEAETC will subcontract directly with the three professional schools in the northern tier, thus eliminating an administrative layer. The northern advisory committee, however, will continue as is.

III. PROGRAM STRUCTURE

A. Organizational Roles and Relationships

The structure of the NEAETC is somewhat difficult to define. This may be due, in part, to the fact that there has been more emphasis placed on the provision of training than organization building. Structurally, the NEAETC program is a conglomerate consisting of health providers, hospitals, medical schools, health centers, governmental bodies, and community agencies.

At the core of the NEAETC is the central ETC office, which is staffed through three mechanisms: time is donated through the AHEC; funding directly through the ETC grant; and time obtained through a subcontract with the institution at which the individual is employed. There are upwards of fifteen subcontracts with organizations participating in NEAETC activities on an ongoing basis; subcontracts with numerous individuals to provide specific training; and grants to organizations to provide seed money for small projects. The ongoing subcontractor organizations are listed in Appendix II.

The central ETC office serves three major functions: administration; direct training; and facilitation and coordination. Administrative functions include administration of the grant itself as well as the numerous subcontracts, and monitoring and evaluating the program. The central ETC staff are responsible for organizing a significant portion of the training provided by NEAETC and several staff members, primarily one of the Co-Principal Investigators, the Project Director and the Health Educator often serve as trainers. Perhaps the most difficult function served by the central office staff is that of facilitator--coordinating, nurturing the subcontracts, and collaborating with the subcontractors in an advisory capacity on program design and program planning issues--no small feat given the sheer number of subcontractors. Further coordinating functions include producing the newsletter, and collecting and disseminating AIDS-related resources. The NEAETC is administered from its Worcester office; a satellite office at the

Beth Israel Hospital in Boston serves as a base of operation for the staff when working with subcontractors in the Boston area.

In Massachusetts, Rhode Island, and Connecticut, the scope of work of the ongoing subcontracts usually revolves around specific training activities limited to a specific agency. In the northern tier, the Maine Consortium for Health Professions Education is the primary subcontractor, administratively responsible for the three-state subregion and programmatically responsible for education and training activities in Maine. The Consortium delegates programmatic responsibility for Vermont and New Hampshire via subcontracts with the University of Vermont Medical School and Dartmouth Medical School respectively. The scopes of work of these latter subcontracts include a state coordination function and responsibility for training activities statewide. Descriptions of the activities of selected subcontractors are included in Appendix III.

B. **Staffing**

The NEAETC staff consists of a Principal Investigator, three Co-Principal Investigators, a Project Director, a Project Administrator, a Health Educator, and a Program Coordinator.

Michael Huppert, M.P.H., Principal Investigator, has been the Director of the Massachusetts Statewide AHEC Program since its inception. In addition, Mr. Huppert is on the faculty of the University of Massachusetts Medical Center, teaching community medicine and practice management for medical students and residents in the Department of Family and Community Medicine. As Principal Investigator, he is responsible for the overall management of the grant and the liaison with HRSA. Mr. **Huppert's** 25 percent time is donated to the ETC project.

Harvey Makadon, M.D., serves as one of **NEAETC's** three Co-Principal Investigators, but functionally acts as the **ETC's** medical coordinator responsible for planning and curriculum development for central programs and serving as the chief liaison between the ETC and the medical community. Dr. Makadon is also responsible for coordinating subcontract activities with the Beth Israel Hospital in Boston where he is the Director of Ambulatory Care. He devotes 20 percent time to his activities with NEAETC.

N. Lynn Eckhert, M.D., **Dr.P.H.,** is a second Co-Principal Investigator. Dr. Eckhert is the Chairperson of the Department of Family and Community Medicine at the University of Massachusetts. Dr. Eckhert is responsible for planning and integrating HIV infection issues into the undergraduate curriculum at University of Massachusetts Medical School (UMMS), working with colleagues in other medical schools in New England, assisting in planning train-the-trainer programs for undergraduate preceptors and residency faculty and for performing a liaison function with physician specialty societies. She has provided about 10 percent time to the ETC project in the first two years, but will be out of the country on sabbatical in the third year.

Howard Libman, M.D. is the third Co-Principal Investigator. Dr. **Libman's** role in the NEAETC focuses on the development of specific training materials.

In addition, as Assistant Professor of Medicine at Boston University School of Medicine and Assistant Director of the AIDS Program at Boston City Hospital, he acts as the liaison for ETC activities with those institutions, particularly medical school curriculum and residency training programs. Dr. Libman commits 10 percent time ETC activities.

Donna Gallagher, R.N., C., M.S., A.N.P. Ms. Gallagher works full-time on the ETC project as the Program Director, responsible for the day-to-day programmatic activities of the project both in terms of program content and systems maintenance. Prior to taking this position, she worked as a Nurse Practitioner and Team Manager in the AIDS and Oncology unit at the Harvard Community Health Plan and has extensive experience, both clinical and educational, in the care of HIV-positive persons. This prior experience has had carry over into her ETC role, particularly in relationships with subcontractors, providing technical assistance in developing training programs and serving an informal quality control function, as well as enabling her to serve as a trainer.

Jack Starmer, M.Ed., M.Th. joined the ETC in October 1989 as its full-time Health Educator. Mr. Starmer's previous experience involved developing health education programs for independent schools in the New England region and training school health providers, faculty, and administrators to lead programs in human sexuality and relationships. As Health Educator, he is involved in program development and implementation, and serves as a resource person available to the subcontractors.

Kathryn Gray-Quinn is the full-time Program.Coordinator, responsible for the day-to-day administrative activities of the project including logistical support for all direct and co-sponsored training events. This position was created in year 02 of the Project.

Alan Chuman, M.P.H., serves as the Program Administrator. Mr. Chuman is responsible for ETC administrative activities, fiscal affairs, reporting and evaluation, as well as managing the subcontracts. Mr. Chuman, who is not supported at all through the ETC grant but devotes 40 percent time to ETC activities, fulfills this role of part of his AHEC responsibilities.

In Rhode Island, Ken Mayer, M.D., Director of the Brown University Program on AIDS, serves as the ETC Coordinator. For the northern tier, there are four key people. Ham Robbins, R.N. serves as the Program Coordinator for the subcontract with the Maine Consortium for Health Professions Education; Chris Grace, M.D., a Family Practice practitioner, and Bill Wadland, M.D., an Infectious Disease practitioner serve as Co-Program Coordinators for the subcontract with the University of Vermont; and-Ford von Reyn, M.D., Infectious Disease, serves as the Program Coordinator for the Dartmouth subcontract.

C. Approaches to Collaboration, Integration and Regionalization

1. NEAETC Approach to Collaboration

NEAETC has a strong tradition of collaboration. The Massachusetts Statewide AHEC Program, the ETC's parent organization, set the standard for

NEAETC with its more than ten year history of collaborative operation. In developing the grant proposal to HRSA, the AHEC program spent a great deal of time establishing linkages with health care leaders, key AIDS provider agencies, research institutions, and community organizations in the original five-state area. This tradition has been carried on in the implementation of the NEAETC program, serving as the basis of the relationship between the NEAETC staff and its subcontractors.

In addition to the interpersonal aspect of collaboration, the ETC has pursued various approaches to financial collaboration, i.e. co-sponsorship. The "mini-grant" approach is the primary mechanism the ETC has used to co-sponsor training events. Another collaborative funding approach used has been to sponsor the expansion of training programs initiated under other sponsorship; the expansion of the Massachusetts Hospital Association and Dr. Makadon's "AIDS for Primary Caregivers" curricula are examples. Piggybacking onto the agendas of other organizations' conferences, but in a such a way that the ETC is deeply involved in the planning process, is yet another of NEAETC's mechanisms for collaboration and cost-sharing.

There is a high concentration of other federally-funded AIDS projects in the New England region: HRSA Services Demonstration Projects, Pediatric AIDS Services Demonstrations, and HIV Services Planning Grants; NIMH grants; two ATEUs; and NIDA-funded activities. Because of the ETC's collaborative bent, but also because of the small size of the region and the many hats worn by the AIDS players in the region, the NEAETC has worked collaboratively with most of the other federally-funded AIDS projects in the region--of course, some more closely than others. Collaboration has taken many forms. In some cases, ETC subcontractors are also holders of other grants, as is the case with the Fenway Community Health Center which is the Metropolitan Area HIV Service (MAHS) demonstration grantee. The ETC co-sponsors activities with these other grant-holders and frequently uses staff of these other projects as faculty in their training programs. The collaborative relationship between the NEAETC and the NIMH grantees is multifaceted: representatives of the projects sit on each other's advisory boards; the projects often make faculty available to the other's training events; and the grantees have co-sponsored several major conferences.

2. NEAETC Approach to Integration

NEAETC's approach to integration is exemplified in the relationship between the NEAETC program and the AHEC program. At the central level, there is an integration of AHEC and NEAETC project staff. The Principal Investigator and the Program Administrator are full-time AHEC staff whose time is donated to the ETC program. At the operational level, the *six* regional AHECs in Massachusetts are an important vehicle for implementing NEAETC's training programs.

3. NEAETC Approach to Regionalization

NEAETC's approach to regionalization is hard to conceptualize. Program activities are carried out in the six-state New England Region where NEAETC serves as a stimulus, both financial and through technical assistance, to existing AIDS resources to provide more and better training. Although there

are instances of regionalization, such as the New England-Wide Pediatric AIDS Conference, Faculty Development Programs on AIDS for Primary Care Providers, and faculty development programs on AIDS and substance abuse, the NEAETC seems to lack a regional strategy. There is no strategic plan for enhancing state capabilities or intra-state coordination, for diffusing AIDS training resources from resource rich areas to resource poor areas, or for sharing resources among participating agencies. After the site visit, NEAETC informed JSI that they had recently established a Clinical Directors Advisory Committee comprised of physicians and nurses from all six states. This committee appears to be a promising vehicle for improving the "regionalization" of clinical training.

In the northern three states, there is more of a regional structure than in the rest of the region, with the Maine Consortium designated as playing a coordinating role for the region and where a half-time Program Coordinator was assigned for specifically this purpose. In the third year of the grant, the three lead organizations will be dealing directly with the NEAETC central office, and it will be interesting to see whether this sense of region will still hold.

D. Organizational Qualities

The New England region has a high concentration of organizations and institutions that are leaders in the provision of care of HIV/AIDS patients, in HIV/AIDS research, and in HIV/AIDS-related education. The NEAETC staff has done an excellent job of harnessing this expertise to meet its program goals despite the history of professional competition that could have prevented such collaboration and cooperation. Consequen t-ly, the subcontractors to the ETC are all highly credible institutions on the cutting edge with respect to the AIDS epidemic. NEAETC is to be commended in having been able to maintain a strong primary care focus, even in programs implemented through the high-powered medical institutions that characterize the region.

The cultivation of collaborative relationships has resulted in the provision of a large volume of high quality training in the region, and has minimized the competition over target trainees. However, there seems to have been missed opportunities and the NEAETC's goal of building a regionwide "network" of collaborative relationships has not yet been entirely fulfilled. While there has been a great deal of collaboration, the collaboration tends to be bilateral, i.e. between the central office and an individual subcontractor. Although there is a wealth of expertise available, sharing across state lines or even across organization lines in the same state has been limited. A number of subcontractors indicated that more opportunities to exchange ideas would be welcomed. Further, in terms of actual program implementation, subcontractors tend to follow more of an organizational or institutional agenda, or one of limited geographic reach. While in the beginning, it would not have been politic for the ETC to suggest that subcontractors take on wider responsibility, the NEAETC has established its credibility and developed the trusting relationships to now be proactive in this regard. For the most part, NEAETC funds have been used to further the activities of institutions already active in AIDS. Mini-grants have provided opportunity for some new players but the ETC has not been strategic in inducing the participation of

organizations that have constituencies that should be but are not currently involved in AIDS work. Although institutional programs have been strengthened with resources and technical assistance from NEAETC, these strengths have not necessarily flowed back **into'** the program to be exploited on a regional level.

The **ETC's** strategy of minimal structure has succeeded well in the short term, However, if the past is any predictor of the future, the nature of the epidemic and therefore the training needs can be expected to continue to change rapidly. It will be critical that there be some sustainable mechanism--either a strong organization or an integrated regional system or both--in place that will not only monitor the needs but also mobilize the resources on an ongoing basis. As mentioned previously, the Clinical Directors Advisory Committee appears to be a positive step in this direction. **NEAETC's** real challenge for the future is to develop a strategy and an organizing framework for implementing that strategy which assures that the responsive, quality training that has been the **ETC's** trademark continues long into the future.

IV. EDUCATION AND TRAINING PROGRAM

A. Needs Assessment Activities

No formal needs assessments have been done as part of the NEAETC program. However, all of the subcontractors have been active in the AIDS arena for some time--providing care, doing research, and/or carrying out education related to HIV/AIDS prior to becoming involved in the ETC program. Based on the assumption that thisexperience has yielded a good understanding of the training needs in the field, a conscious decision was made to place resources into training rather than additional data gathering.

B. Training Activities

1. Target Trainees

The **ETC's** two-pronged trainee target are broadly defined to include those **"who** are active in the care of AIDS patients" as well as "the larger number of health and social service professionals who have little experience with AIDS and HIV infection." Specifically, the target trainees are identified as health care providers who have faculty and/or in-service responsibility for the education of residents, students and colleagues in medical centers, hospitals and health professions schools throughout the region or health care providers who are currently active in providing care for HIV-positive patients. Physicians, dentists, nurse practitioners, physician assistants, nurses and allied health professionals (physical and occupational therapists, dental hygienists, medical technologists, medical assistants) who fall into the above categories are all targeted.

2. Training Activities, Objectives and Methods

Training activities are organized and/or conducted at two levels--the NEAETC central level and the subcontractor level. At each of these levels, the training is either provided directly or as a co-sponsored event. The

former is generally the mechanism of choice of the subcontractors while the latter is the predominant mechanism employed at the central level.

A range of educational and training approaches used, including the didactic method, small group discussions, role playing, and video vignettes are designed to elicit discussion and interactive broadcasts. An interesting approach used in some student education by NEAETC is the "standardized patient" methodology--a technique for teaching and evaluating interviewing and diagnostic skills by using trained non-physician "actors" to simulate a patient encounter.

The NEAETC categorizes its training activities as follows:

- **Faculty Development and Train-the-Trainer Programs:** targeted toward health care providers who have faculty and/or inservice responsibility for the education of residents, students, and colleagues in medical centers, hospitals, and health professions schools throughout the region;

- **Intensive "Secondary" Training (Mini-Residencies):** programs focusing on the clinical management of AIDS patients;

- ***Primary" or "Basic" AIDS Training:** targeted toward a wide range of health professionals and offered through a workshop or conference format;

- **Curriculum Initiatives for Resident and Health Professions Students in Training.**

In addition, the NEAETC undertakes several special focus initiatives, the implementation of which cross-cuts these categories:

- **Community-Based Initiatives:** seed money to fund new or expanded curricula development, trainings, and development of resources and materials;

- **Substance Abuse:** programs implemented and planned as a result of supplemental funding received half way through year **02** of the grant;

- **Programs that Impact Minorities:** programs that train providers who serve large numbers of minority patients, particularly community health center personnel.

The programs of selected subcontractors are described in more detail in Appendix III. Following is a brief description of some of the education and training activities that have taken place under each of the above categories.

o Faculty Development and Train-the-Trainer Programs

"AIDS for Primary Caregivers" - Two and a half day programs targeted toward faculty with responsibility for teaching medical students and/or residents. This program, which has gained national recognition, has been offered twice and is based on the Society of General Internal Medicine (SGIM) curriculum developed under the direction of Dr. Harvey Makadon, Co-Principal Investigator to the NEAETC, with funding from the American Foundation for AIDS Research (this curriculum is outlined in the next section). Dr. Makadon implemented the second offering of this program. This is an annual offering of the ETC. In year 01, this program had 19 participants, including 17 MDs and 5 RNs. In year 02, there were also 19 participants, 11 of whom were MDs and 5 of whom were RNs.

The Massachusetts Hospital Association (MHA) subcontracts to the ETC to conduct train-the-trainer programs in community hospitals. The program goal is to prepare trainers to teach hospital staff, including dietary staff, pharmacists, social service staff, medical records personnel, maintenance staff, as well as boards of trustees how to better carry out their roles vis a vis AIDS patients. Those trained are generally RNs. Prior to ETC funding, the MHA had developed an "AIDS 101" manual for participants in the program. The ETC funding has allowed the MHA to offer this training in more hospitals as well as providing for the development of an "AIDS 201" manual, focusing on patient care issues.

Four local train-the-trainer workshops have been offered around the state of Massachusetts including ones in Lawrence, New Bedford and Berkshire County. The workshops assisted in the development of local speakers bureaus and in-house trainers for community agencies. The majority of those trained were nurses and allied health professionals.

Some faculty development activities have been initiated at participating universities. At UMass Medical School, a one-day workshop was held for family physicians who serve as preceptors for third year medical students in collaboration with the Department of Family Medicine. At Dartmouth, faculty development efforts have taken the form of "'grand rounds."

o Mini-Residencies

Seven mini-residency programs are currently being offered under the NEAETC through five subcontracts:

- Brown University - The Brown University AIDS Program has a mini-residency component that targets physicians.
- University of Massachusetts Medical Center - targets physicians.
- Beth Israel Hospital - has two mini-residencies, one for physicians and one for nurses.
- Yale - has two mini-residencies, one for physicians and one for nurses.

- University of Connecticut Health Center – targets primary care providers – physicians, physicians assistants, and nurse practitioners.

Each of these mini-residencies is described in Appendix III.

o Primary or Basic AIDS Training

Primary or basic AIDS training programs are targeted for physicians, dentists, nurses, and allied health professionals. The programs vary in length, in approach, and in content. They have been anywhere from one hour long to two days long with a total attendance range from 10 to 400 participants. In year 01, there were 80 such programs held. Of these 80 programs, 29 were six or more hours long with an average attendance of 87 participants per session. The remaining 51 programs of shorter duration had an average attendance of 52 persons.

The programs are geared to local needs and are frequently designed in response to a request. In Massachusetts, it is usually the six AHECs that offer this type of training; in Rhode Island, the ETC co-sponsors programs with the Department of Health and the Brown University Program on AIDS; in Connecticut, the University of Connecticut Health Center, the Northwest Connecticut AIDS Project, and Yale University subcontractors will be offering this type of training; and in the northern tier, the Maine Consortium is responsible.

Some examples of this type of training being offered are listed below:

- The Northwest Connecticut AIDS Project sponsors a series of workshops for nurses who work in the four hospitals serving Litchfield County. The workshops are two hours in length and are offered every other month. Topics include: Legal and Ethical Issues; Women and AIDS; Pediatric AIDS; IV Drug Users; and Community Resources.

- A one-day program was held in January 1990 by the Yale University subcontractor. The approach was an "AIDS 101" targeted toward a multidisciplinary audience. Sixty people attended, the majority being registered nurses and social workers.

  The Yale subcontractor also offered a series of four programs on substance abuse, neuro-psych, ethical issues, and women and children's issues. Approximately 15 professionals attended each session, including a few physicians.

- Several grand rounds, half day, and full day workshops were offered by the Massachusetts' AHECs covering all regions of the state.

- Grand rounds were conducted at Dartmouth and the Maine Medical Center as well.

The ETC co-sponsored with the Boston College School of Social Work an international conference entitled "AIDS '89: The Social Work Response." Four hundred social workers attended from New England alone.

The ETC, through its Maine Consortium contract, took over the sponsorship of an annual two-day program entitled "Living with AIDS" that was previously offered by the Maine Consortium. Participants from all health professions attended this program.

The Maine Consortium conducted five 7-hour events across the State of Maine entitled "AIDS Education: Impact on Service." The target population included home health agencies, mental health services, long-term care staff and nursing home staff.

A ten-session AIDS symposium was offered by the University of Vermont Medical School. The participants included residents, attending physicians, medical students, nurses, and other health professionals. Attendance has ranged from 35 to 65 people at any one session.

- The Boston AIDS Consortium Mental Health Task Force presented a two-day conference entitled "Creating AIDS Care Partnerships: The Clinical and Community Response for Mental Health Professionals." The program was designed to provide mental health professionals with a forum to discuss the impact of HIV infection on their professional practices. CEUs were granted for MDs, RNs, SWs, NCCs, and CCMHCs. This program was sponsored by several organizations, including the NEAETC.

The NEAETC facilitated a two-day conference on pediatric AIDS for HHS Region I.

The New England School of Osteopathic Medicine works through the Maine Osteopathic Association and the New England Osteopathic Assembly. Participating in the professional meetings of these two organizations was deemed the most efficient way of reaching osteopaths in the region. Several programs from one to three hours have been conducted at the Maine Osteopathic Association meetings. A three hour AIDS Symposium was conducted for the New England Osteopathic Assembly in Newport, Rhode Island. This was three hours in duration and focused on clinical updates and sexual history taking in primary care practice. Osteopathic physicians from throughout the region participated in this program.

A day-long course for dental health professionals was developed under a subcontract with Tufts University Dental School and was

marketed with the assistance of the regional AHECs in Massachusetts. The course was given several times in central, northern and southeastern Massachusetts. It was not as well received as anticipated and has been discontinued in favor of a more consultative approach in conjunction with local dental initiatives.

o Curriculum Initiatives for Resident and Health Care Professions Student Education

In Massachusetts, resident and student education has consisted, for the most part, .of symposia devoted to AIDS. For example, an AIDS Awareness Day was held in Boston for students from all four Massachusetts medical schools. Over 200 students attended a two-day symposium held for the second year class of the University of Massachusetts Medical School. A lecture series for medicine residents at UMass Medical School, attended by thirty residents, was held in November 1989.

In Rhode Island, a one-day symposium for students at Brown University was conducted with over 100 students in attendance. A series of three two-hour evening sessions for residents at Brown-affiliated teaching hospitals was attended by fifteen residents, and an ongoing biweekly lecture series is now offered to the house staff and others at Rhode Island Hospital.

The three subcontractors to the Maine Consortium, Dartmouth Medical School in New Hampshire, the University of Vermont Medical School, and the New England College of Osteopathic Medicine, were all given the charge of developing medical school curricula and integrating curricula into undergraduate and graduate medical school education. The successes in this area include:

A clinical symposia course was designed at Dartmouth for first year students. One unit of this course was on AIDS. The unit uses "standardized patients" for medical students to interview. Participation in the unit is limited; only 8-10 students at a time attend a class to facilitate participation and discussion. Eight faculty preceptors facilitate the discussion. These faculty were trained for their preceptor role. In addition, AIDS content has been incorporated into the fourth year course "Health, Society and Physicians."

The University of Vermont has expanded AIDS content in both undergraduate and resident training. First year students now receive a special series of four two-hour sessions on AIDS. A sexual history taking class was initiated as part of a human sexuality course. AIDS content has been added to a first, second and third year epidemiology courses. A series of ten, one-hour sessions on various aspects of HIV/AIDS has been included in the residency program. In addition, residents are being trained in counseling and sexual history taking using video feedback. For this class, actors from the drama school were paid a small sum to participate as persons with AIDS.

The New England School of Osteopathic Medicine has conducted a thorough analysis of the AIDS content in its curriculum. Several programs have been conducted for medical, physical therapy, occupational therapy, and nursing

students of one to two and a half hours duration. An additional six hours on AIDS has been added to courses throughout the curriculum.

Additionally, students and residents are able to attend the faculty development and primary AIDS programs offered throughout the NEAETC program.

o Community-Based Initiatives

Community-based initiatives are implemented through NEAETC's "mini-grant" program. Grant money is intended to provide seed money to individuals or institutions for curricula development, special training programs, and resource and material development. This pool of money has allowed the ETC to respond in a flexible manner to new training ideas, to assist community agencies with local programming, and for meeting needs not contemplated at the time of the original proposal preparation. The funding helps to foster and reward initiative and can make the difference in whether a new idea is pursued or lies dormant. Most of the projects under the community-based initiative are cost-shared with the sponsoring organization in that several organizations have already contributed a great deal to a particular project and this money allows them to bring the project to fruition. The average size of the grant is between $1000 and $3000. This unique approach has been well received and well used by several organizations. A list of community-based initiatives awarded in year 02 of the grant is included as Appendix IV.

o Substance Abuse Programs

Half way through year 02 of the grant, the NEAETC received supplemental funding to provide additional training for health care providers on substance abuse and HIV/AIDS. For the most part, the activities under this funding will be added on to the existing programs. A faculty development program was designed on AIDS and Substance Abuse. The content of the program will emphasize the clinical aspects of substance abuse and the skills necessary to be an effective clinician and teacher in this area.

The Massachusetts Hospitals Association's train-the-trainer program for community hospitals has been expanded to include a substance abuse component.

Also, under this initiative, a series of six teleconferences on Alcohol, Drug Abuse and AIDS will be offered for physicians, nurses, and social workers. This series will be broadcast using the HealthNET network operated by the Boston University AHEC program. HealthNET has negotiated with the AIDS Satellite Network of the Physicians' Association for AIDS Care (PAAC) to include the substance abuse series as part of the regular network broadcasts. HealthNET has negotiated an agreement to have its sites, most importantly community health centers, receive these broadcasts free of charge. The content of these teleconferences is discussed in the next section.

Additionally, several regional workshops are planned and will be offered through the regional AHECs, the Rhode Island Department of Health and Brown affiliated hospitals, the Maine Consortium for Health Professions Education, and other community agencies with experience and interest in substance abuse and AIDS.

3. Curricula and Haterials Developed or Used

Subcontractors tend to develop programs for replication, thus requiring some sort of formal curriculum. On the other hand, underlying the NEAETC's direct training and its co-sponsored activities is the often-articulated philosophy that "prepackaged trainings don't work" and that trainings must be individualized. Therefore, formal curricula are largely absent at the central level. Where formal curricula are used, NEAETC has generally utilized or built upon existing curricula and materials.

One program that was centrally developed is the "Substance Abuse and AIDS Program; A Faculty Development Program for Primary Care Providers." Faculty from Yale, Harvard, and Brown, as well as Project Trust at Boston City Hospital were involved in the development of this three-day program. The program is guided by a set of training objectives, an agenda, pre/post test, and a collection of review articles.

The annual regional faculty development program, "AIDS for Primary Caregivers," is based on the Society of General Internal Medicine (SGIM) "primary" AIDS curriculum developed under a grant from the American Foundation for AIDS Research. The components of the curriculum are:

- Medical Issues
- Epidemiology of HIV infection
- Transmission of the HIV virus
- Infection control
- Screening and Diagnostic Tests
- Overcoming reluctance
- Patient counseling
- Taking a sexual history
- Ethical concerns
- Cultural sensitivity
- IV Drug abuse
- Referral and community linkages
- Use of multidisciplinary teams
- Management of patients outside the hospital

The Massachusetts Hospital Association uses a number of formal curricula in its training programs. Its initial train-the-trainers series, "AIDS 101," is guided by two curricula. The first, "AIDS: An Educational Reference Manual," was developed jointly by MHA and the Massachusetts Department of Public Health prior to ETC affiliation. This curriculum includes both teaching methods as well as AIDS content. Under ETC funding, a supplemental curriculum on substance abuse was developed and includes sections on addictive disease, classification, effects and treatments, the HIV-substance abuse connection, and intervention strategies.

Through a subcontract with the Somerville Portuguese American League, a multidisciplinary training manual was developed for the Portuguese-speaking health care community. The manual can be used either as an instructional guide or as a self-study manual. It includes instructional guidance material (a self-test with an answer key, general learning objectives, and profession-specific expectations) as well as substantive sections on dispelling myths,

background information (causative agent, epidemiology, transmission, symptoms), diagnostic tests, treatment, condom use as well as profession-specific precautions against contamination (physicians,particularly internists, surgeons and pathologists, nurses, laboratory technicians, social workers, acupuncturists, dentists, housekeeping personnel, ambulance personnel, funeral homes employees, workers in animal research labs and teachers).

Several important reference manuals have also been produced as part of the NEAETC program. The first, "Clinical Manual for Care of the Adult Patient with HIV Infection," by Drs. Howard Libman and Robert Witzburg is intended as support for any ETC training. It is an expansion and update of a collection of review articles, mainly written by Boston City physicians, originally developed as a clinical guide for the Boston City Hospital AIDS program. The second, developed under the MHA subcontract is a practical reference on HIV/AIDS patient care particularly relevant to hospital-based personnel. Written by local AIDS experts, "HIV/AIDS Patient Care: A Collection of Works for Hospital Personnel," covers 17 topics. "AIDS Mini-Residency Program Readings: 1989-90," a collection of journal articles has been assembled to support the Beth Israel nurse mini-residency program. In addition, the Central Massachusetts AHEC compiled the proceedings of the HHS Region I pediatric AIDS conference.

The NEAETC has produced several video training materials as well. Through its subcontract with Boston City Hospital, NEAETC is in the final production stage of a video to support culturally-sensitive AIDS care for the Haitian community which relies heavily on BCH for its care. The video, which provides caregivers with background on the Haitian culture in general as well as cultural responses to AIDS, is due for completion in the fall of 1990. Videotapes and video vignettes have been developed by the Medical Humanities Division at UMMC and the Rhode Island Hospital as teaching aids in the respective institutions.

Eleven hour-long interactive teleconferences on AIDS and related subjects targeting the New England community health center network, were produced for broadcast distribution to the HealthNET sites in Year 01. For wider coverage following the initial broadcasts, videotapes of these teleconferences were distributed through cable networks in the greater Boston area with concurrent notification to the health centers to make them aware of these broadcasts. An additional six teleconferences on substance abuse are in production, financed through supplemental grant funds.

4. **Outputs**

In terms of participant numbers, the NEAETC reached 7606 persons in year 01 of the grant. 5202 of these persons participated in programs categorized as primary or basic AIDS education and 1269 fall under the category of student/resident training. The estimated numbers for year 02 (based on nine months worth of data) are 12,978. 10,100 of these participants were reached through primary or basic AIDS programs (including the substance abuse teleconferences) and 1350 were reached through student/resident education programs. Year 01 includes the original five states; year 02 includes the

State of Connecticut, which joined the NEAETC program half way through the year.

C. Efforts to Reach Minorities

One of NEAETC's strategies for reaching health professionals serving minority communities builds on the network of community health centers which serve as points of entry for many disadvantaged minorities seeking health care services.

- The Massachusetts League provides training on AIDS to the Boards of Directors of the health centers.

- The FCHC provides on-site, in-service training for health center provider staff. This includes AIDS training and consultations as well as a series of AIDS research updates.

- The Boston University.AHEC HealthNET is an interactive TV network focusing on health topics and producing education programs for health workers. The HealthNET serves 45 participating institutions in Massachusetts and New Hampshire through weekly education programs. Forty community health centers are subscribers (program started in 1984). In year 01 of the grant, the AHEC HealthNET produced six hour-long interactive broadcasts on AIDS, as well as five other related broadcasts on substance abuse and on hepatitis. This initiative was heavily subsidized through a grant from Smith, Kline, and French as well as ETC funding. A series of substance abuse teleconferences produced by HeathNET and broadcast via the AIDS Satellite Network of the Physicians' Association for AIDS Care is currently underway. Community health centers will receive these broadcasts free of charge.

- The Maine Consortium in conjunction with the Maine Office of AIDS designed a clinical update and legal/ethical issues program targeted for the boards of directors at community health centers. A similar program is being designed to target physicians at community health centers.

The NEAETC has also collaborated with the following individuals and groups to implement programs for providers serving minority communities:

- Somerville Portuguese American League produced a training manual for Portuguese-speaking health care providers;

- The Worcester Latino AIDS Network developed a training manual in Spanish and conducted workshops for Latino health and social service providers in the Worcester area;

- The Rhode Island Department of Health, via its Minority AIDS Task Force, has offered a major conference on minority issues in each of the first two years of the ETC program. In addition, it has presented "brown bag" symposia on minority issues targeting community health care providers:

. Dr. Michael Meyers, a minority private practice physician in Boston, serves as a consultant to the NEAETC to develop curricula on issues of particular concern to minority populations and to serve as NEAETC's liaison on minority issues with key staff of a number of health centers in the Boston area.

D. Training Issues and Successes

A highlight of the NEAETC program is its emphasis on training aimed at improving skills and producing changes in clinical practice. The program is replete with examples of such efforts, however, most notable is the wide variety of clinical training opportunities made available at a number of sites around the region under the NEAETC auspices. Known as mini-residency programs, these intensive clinical experiences assist providers, who are otherwise capable of providing care and who want to provide care, of getting over the fear or uncomfortable feeling of treating patients with HIV/AIDS. While most providers in the higher incidence New England states have ample opportunities to avail themselves of basic AIDS education, this "advanced" training is certainly filling a training gap. Although the clinical trainings are open to providers throughout the region, mini-residencies have been less accessible and less widely marketed to providers in lower incidence states. NEAETC is challenged to develop strategies to get providers from the northern tier states to participate in the mini-residency programs.

NEAETC's ability to provide training to a broad spectrum of professional disciplines practicing in a variety of health care settings should also be noted among its successes. There is one notable exception however. Training of dental health professionals has not fulfilled its potential. Early efforts to market a dental program in various locations around Massachusetts met with minimal success. The current consultative strategy is reactive rather than proactive, a continuing void in a region where dental care for AIDS patients is extremely limited.

In its subcontracting, the NEAETC's approach has generally been to hook up with organizations or institutions already active and known in the areas of AIDS research, AIDS care, or AIDS education. Given the number of AIDS "players" in the region, this no doubt has enabled the ETC to capitalize on this wealth of expertise available throughout the region and has been helpful in avoiding duplication. At the same time, it has been somewhat limiting. Subcontractors have tended to focus on their traditional geographic, institutional and/or professional constituencies. While training to date has reached a broad spectrum of health care providers, it remains to a large extent a shotgun approach. A future challenge for the central office staff will be to develop a strategic plan for comprehensive training coverage in the region.

NEAETC community initiatives or mini-grants, while similar to co-sponsorship undertaken by other ETCs, add a strategic catalytic dimension. Monies awarded under this initiative have been used for seed money for good ideas that may not have otherwise been developed, for completing projects that

had been started but have run out of money, and for responding to training and education activities that were not envisioned at the time of grant application or subcontract negotiations.

The NEAETC has followed through on its strategic approach to serving minority populations. By targeting providers and staff at community health centers, the NEAETC extends its training to organizations that serve as points of entry for large numbers of minorities seeking health care. NEAETC also targets training of health care providers serving two minority populations not targeted by other ETCs--Portuguese-speaking and Haitian communities, the latter being a particularly high risk group. Excellent training materials have been developed to improve AIDS care to these groups.

The strong bias of the NEAETC central staff against "prepackaged" programs might well have led to missed opportunities and loss of economies of scale. This may be particularly true in the low-incidence areas of the region where educational offerings are appropriately introductory in nature and among constituencies whose AIDS-related tasks are well-defined. Fortunately, as the program has developed, a balance has been struck between structured programs and customized events, with the subcontractors tending toward prepackaged programs for constituencies they know well and the NEAETC staff designing customized offerings for more specialized or sophisticated audiences.

V. PROGRAM ADMINISTRATION

A. Administrative Systems

1. Management Control Mechanisms

The systems for subcontract management were already in place with the AHEC program, thus, facilitating the process of bringing the ETC on board. Subcontracts are negotiated and drawn up by the Principal Investigator. The Grants Management Office approves the subcontract and an account is established. Bills go through the Grants Management Office, although close track of subcontractor accounts are kept in the ETC office. Reconciliation of expense reports are done monthly. The staff time for fiscal management of the grant is donated to the ETC. The two staff who are responsible for the management are both full-time AHEC employees.

2. Management Information Systems

Data are collected for each training event and are kept in a spreadsheet database. Reports can be generated in a variety of formats, and are generally run for inclusion in year-end reports and continuation applications. These reports include a complete listing of all ETC sponsored programs, location, target population, and number of participants. Thus, the database is used more for reporting purposes rather than ongoing management.

3. Coordination

At the central level, the Program Director and the Health Educator serve an informal coordinating function in the course of their day-to-day

activities. In the first two years of the project, the Maine Consortium for Health Professions Education was formally charged with the responsibility of coordinating activities in the northern tier, a responsibility that has been phased out for the third year.

Subcontractor meetings are held quarterly to discuss program direction as well as management and administrative issues. All subcontractors are required to submit a six-month progress report and an annual report.

Advisory boards also serve a coordination function. In addition to the six-state New England AIDS ETC Advisory Board, consisting of the major subcontractors and key strategists and collaborators, the northern tier has its own advisory committee, comprised of the three subcontractor organizations, the Maine Consortium, and representatives from the Offices on AIDS in each of the states.

4. Marketing the ETC

A New England AIDS ETC logo has been developed. Stationery with the logo is used mostly by the central office staff. Subcontractor organizations use their own logos but always mention the ETC in any brochures, handouts, or materials developed that are related to ETC activities.

There is no formal strategy to market the ETC as an entity, although the central office maintains a comprehensive mailing list. Efforts to market the ETC include:

- Development of a brochure describing the NEAETC program with a detachable section for requesting further information or for requesting addition to the mailing list.

- Production of a newsletter. To date, one newsletter has been produced. The newsletter included comments from the Director, an article on a new staff member, a calendar of events, a review of audiovisual materials, and an annotated listing of resources.

Marketing of individual ETC offerings has been very successful. Attendance at programs has exceeded original projections. Some programs, such as the faculty development programs, have been oversubscribed and have waiting lists.

B. Systems for Managing Training Events/Programs

1. Trainee Recruitment/Selection

In general, the sponsoring organization is responsible for trainee recruitment. This is usually accomplished through brochures advertising the particular program. Registration is generally open to all within the targeted group. In the case of mini-residencies, where only a few can attend at a time, recruitment is more select. For the most part, trainees self select into programs.

2. Output/Outcome Reports

A program report is completed for every training sponsored by the ETC. This is a two-page form and includes the following data fields: program title; program location; type of program; length of program; teaching approach; registration fee; CEUs; evaluation method; and practice setting. A different form is used for reporting resident and student trainings. These forms are forwarded to the NEAETC for inclusion in the database.

C. Training Facilities

The ETC works together with its many subcontractors and co-sponsoring organizations to identify training sites and facilities. Where available and appropriate, university auditoria and classrooms are used. Often, commercial conference space is rented. The mini-residency programs are offered on-site at collaborating hospitals.

D. Cost Sharing

Cost-sharing occurs at both the administrative and programmatic level. UMMC and the Massachusetts Statewide AHEC program provide considerable support in the form of office space, utility costs, phone costs, subcontract administrative costs, supply and equipment costs, and, particularly, in fully underwriting the salary expense of the Principle Investigator and the Project Administrator.

With NEAETC's approach of collaborating with existing programs, costs for programs are decreased because trained staff are already in place, program development is sometimes minimal, and institutional support is provided. In short, ETC programs are incorporated into the existing structure.

E. CEUs

CEUs are offered for many of the ETC's programs. Continuing education departments of the collaborating medical schools have facilitated the process of making continuing education credit available for training programs offered by the respective university.

F. Library/Information Services

The NEAETC maintains an AIDS resource library. This library consists of materials from sponsored trainings, curricula and materials from other ETCs, relevant newsletters, and videos. The videos of AIDS Satellite Network broadcasts of the Physicians Association for AIDS Care are also contained in the resource library. Listings of available materials are included in the NEAETC newsletter.

ETC staff have been working with the Boston AIDS Consortium on development of the Provider Information Network (PIN), a computerized

compendium of AIDS health care and social service providers for persons with AIDS. PIN information will be available by phone for use by all health care providers. The information gathering is complete for the **Boston area.** Currently, the AIDS Consortium is fund raising for the computer equipment. The ETC is working to expand the PIN to the rest of Massachusetts with a small grant from the Department of Public Health. Eventually, the ETC plans to expand the system to the rest of New England.

The Central Massachusetts AHEC produced an AIDS information and services directory for the Central Massachusetts region. The directory was distributed free of charge to providers and persons with HIV infection. This project was partially funded by the ETC.

G. Sustainability

The **NEAETC's** plan for sustainability follows the strategy that has made the Massachusetts Statewide AHEC Program self-sustaining after the withdrawal of federal support. Over the, past six years, the Statewide AHEC has been very successful in replacing the decreasing level of federal funding with state, local and private **sources of funding. Plans call for the ETC to follow the** same strategy of keeping legislative and public officials informed of the effort and the benefits to their constituents; development of programming that involves and serves the mutual interest of the medical center and community facilities and providers; and implementing programs (such as the various faculty development, training-of-trainers and student curriculum projects) which have long-term impacts without need of ongoing funding.

VI. SUMMARY AND FUTURE PLANS

The New England AIDS ETC has emerged as a confederation of subcontractors working collaboratively with the central NEAETC staff to deliver training meant to significantly impact the AIDS-related health care practices in the region.

The New England AIDS ETC can take credit for many training successes, especially their clinical mini-residencies, their community-based initiatives program, and their efforts with community health centers. The NEAETC has taken two different approaches to developing its programs. In Massachusetts and Connecticut, the approach has been to identify key individuals and key organizations already involved in AIDS research, AIDS education, or AIDS patient care and hook up to their programs. In this manner, the NEAETC is able to enhance and support existing, successful programs. In the northern tier states and, to some extent, in Rhode Island, the approach has been to identify a major subcontractor who will take the responsibility of coordinating activities for the entire state.

The program in Massachusetts and Connecticut consists of a multitude of subcontractors and collaborating agencies. The NEAETC has done a very good job of getting all of these various organizations and institutions to commit to the ETC program, as politics and "turf wars" have often been barriers in the past. The challenges to the NEAETC program are to develop a mechanism for

feeding this wealth of expertise back into a regional program, especially enhancing the sharing of materials, successful programs, and individual or institutional expertise across subcontracting organizations and across the states in the region.

In the future, the structure and programmatic approaches are expected to remain essentially the same. For the most part, the current subcontractors will continue with their participation and their programs, although the roles of a few--notably the Maine Consortium for Health Professions Education--will be modified. There will be few modifications in the faculty development programs, the train-the-trainer programs, the minority outreach programs, the primary AIDS programs, or the mini-residencies. The community-based initiatives will serve the same needs as in the past. The budget includes the funding of 10 to 12 community-based initiatives in Connecticut to target agencies or areas of the state that have not been fully included in programs to date. The plans for the substance abuse supplemental funding monies are in the initial implementation phase. These activities will be in full swing in year 03 of the grant.

One new initiative worthy of note is in the area of professional school curriculum. A task force of Harvard School of Medicine faculty have taken on the task of developing a model curriculum for all four years of medical school. The initial planning has begun with Dr. Harvey Makadon, Co-Principal Investigator of the NEAETC, leading this initiative.

One area to watch in the future is that of sustainability. One of its strengths in the short term may turn out to be a weakness in the longer term. With its loose structure and collaborative approach, the NEAETC gives the appearance of operating more like a short term project than an on going concern. HRSA funding has been the glue that has held this conglomerate together. Sustainability of the ETC entity in the absence of these funds is questionable. Sustainability of individual programs may fare better. The seed money provided by project funding has strengthened the programs of NEAETC subcontractors which are becoming institutionalized. Plans for sustaining broader programmatic efforts call for the NEAETC to follow a strategy similar to that followed by the Massachusetts Statewide AHEC Program which has been successful in the past six years with replacing the decreasing level of federal funding with state, local and private sources of funding. However, in the absence of an ETC entity, the responsibility for program continuation will fall back onto the AHEC whose mandate is limited to Massachusetts rather than the region as a whole. Even in Massachusetts, past fund-raising successes are not guaranteed to continue into the future given the current state fiscal crisis.

APPENDIX1

Goals and Objectives of NEAETC

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Goal:

Improve the ability of health care providers to appropriately diagnose, treat and care for AIDS patients in their own communities, and serve as effective patient educators to help prevent the transmission of HIV infection.

Objectives:

1. Establish a mechanism for collaboration on education initiatives among academic institutions, hospitals, health care professionals, health centers, and public and private agencies concerned with the provision of services to AIDS patients and with the education of health professionals and health professions students.

2. Provide for faculty development and train-the-trainer programs. These programs will be targeted for physicians, dentists, physician assistants, nurse practitioners, nurses and allied health professionals who have faculty and/or in-service responsibility for the education of residents, students and colleagues in medical centers, hospitals and health professions schools throughout the region, and will enable participants to implement the curriculum on HIV infection to be developed by the ETC.

3. Provide training on the prevention, diagnosis and treatment of HIV infection to practicing health professionals throughout the New England area, focusing on the education of primary care providers. Training will focus on all issues related to effective patient management, including counseling of patients on risk reduction, cultural sensitivity, ethics, availability of community resources, and dealing with one's own fears and biases, as well as up-to-date information on research and clinical aspects of HIV infection.

4. Provide for development of curriculum and training opportunities for medical students and residents, and other health professions students, emphasizing skills such as history taking and patient communication.

5. Provide for special focus on training needs of health professionals who serve large numbers of minority patients.

6. Provide for coordination of ETC activities with existing AIDS hotlines, clearinghouses, Treatment Evaluation Units, Clinical Studies Groups, and tertiary care institutions to assure ongoing availability of information and consultation for health professionals.

7. Provide plan for continuation beyond project period.

APPENDIX II

List of NEAETC Subcontractor Organizations

List of NEAETC Subcontractor Organizations

- Beth Israel Hospital
- Boston Trustees of Health and Hospitals (Boston City Hospital)
- Maine Consortium for Health Professions Education
  - .University of Vermont Medical School (Direct subcontract in Year 03)
  - .Dartmouth Medical School (Direct subcontract in Year 03)
- 5 Regional AHECs (Berkshire AHEC, Boston AHEC, Merrimack Valley AHEC, Southeastern Massachusetts AHEC, Central Massachusetts AHEC)
- Massachusetts Hospital Association
- Brown University AIDS Program
- Rhode Island Department of Health
- Yale-New Haven Hospital (Yale University Schools of Medicine and Nursing) (Years 02 and 03)
- University of Connecticut Health Center/Mount Sinai Hospital Outpatient Department (Years 02 and 03)
- Hartford Hospital (Years 02 and 03)
- Fenway Community Health Center
- Massachusetts League of Community Health Centers
- Tufts University School of Dental Medicine (Years 01 and 02)
- AIDS Action Committee
- Boston University School of Medicine (AHEC HealthNET)

APPENDIX III

Description of NEAETC Subcontractors' Programs

THE NORTHERN TIER

A. Background

The northern tier consists of the states of Maine, Vermont, and New Hampshire. These three states were grouped together because of their similar geography and similar AIDS epidemiology; i.e., large rural and small town areas where the number of reported AIDS cases is small, but where increased cases are projected in the future.

B. Structure and Staffing

The contract to direct and coordinate education and training programs for these three states was given to the Maine Consortium for Health Professions Education. Seven months after the start of the subcontract a Program Coordinator was hired for the northern tier. This position was 50 percent sponsored by the Maine Office on AIDS and 50 percent sponsored by the ETC grant .

The Maine Consortium, in turn, funded two subcontracts with the purpose of developing medical school curricula and integrating this curricula into undergraduate and graduate medical school education. These two subcontracts were established with the University of Vermont Medical School and Dartmouth Medical School in New Hampshire. A third subcontract was established with the New England College of Osteopathic Medicine. The purpose of this subcontract was twofold: to impact on osteopathic medical school curricula; and to plan and implement AIDS education and training programs for osteopathic physicians throughout the New England region.

During year 01 of the grant, a Northern New England Advisory Committee comprised of members from the three subcontractor organizations and representatives from the Offices on AIDS in each of the three states was formed . The goals for the committee were to give the northern ETC program its own identity and to set goals and priorities for AIDS education activities in the tri-state area. A Maine Training Committee, comprised of members who are training and program oriented, was also created to guide AIDS education and training programs for the State of Maine. Additionally, the New England College of Osteopathic Medicine established an AIDS advisory group and the University of Vermont Medical School established an AIDS planning group.

In year 03 of the grant, subcontracts will be drawn up directly between the NEAETC central office and Dartmouth, the University of Vermont, and the Maine Consortium. This will increase the efficiency of managing the grant by cutting out an administrative layer. The New England College of Osteopathic Medicine will continue to subcontract with the Maine Consortium.

C. Program Activities

1. Dartmouth Medical School

In years 01 and 02 of the grant, Dartmouth focused on faculty development and the integration of HIV/AIDS material into undergraduate and resident

medical training at their respective institutions. Faculty development was in the format of grand rounds at Dartmouth. The grand rounds include physicians as well as residents and medical students.

A clinical symposia course was designed at Dartmouth for first year students. One unit of this course was on AIDS. The unit uses "standardized patients" for medical students to interview. Participation in the unit is limited; only 8-10 students at a time attend a class to facilitate participation and discussion. Eight faculty preceptors facilitate the discussion. These faculty were trained for their preceptor role.

Dr. Ford von Reyn, the Program Coordinator at Dartmouth, conducts monthly seminars on AIDS, These sessions are taped and made available to anyone who makes a request. Generally, five to ten primary care physicians attend these sessions. The majority of trainees for Dartmouth's programs have been physicians and nurses.

2. University of Vermont Medical School

The University of Vermont has focused on undergraduate and resident training. A sexual history taking class was initiated as part of a human sexuality course, and the epidemiology of AIDS was added to an epidemiology course. Residents were trained in counseling and sexual history taking using video feedback. For this class, actors from the drama school were paid a small sum to participate as persons with AIDS. The thrust of the undergraduate family practice curriculum at the University of Vermont is toward training of rural physicians.

A ten session AIDS symposium was offered by the University of Vermont Medical School. The participants included residents, attending physicians, medical students, nurses, and other health professionals. Attendance has ranged from 35 to 65 people at any one session.

3. The Maine Consortium for Health Professions Education

In Maine during year 01, the focus was on faculty development as well as primary health provider training. Two grand rounds were presented at the Maine Medical Center concentrating on pediatric AIDS and AIDS from an infectious disease perspective. The ETC took over the sponsorship of an annual two-day program entitled "Living with AIDS" that was previously offered by the Maine Consortium. Participants from all health professions attend this program. The Maine Consortium, with their ETC contract, conducted five programs throughout the State of Maine entitled "AIDS Education: Impact on Service.' Each program lasted seven hours. The target population included home health agencies, mental health services, long-term care staff and nursing home staff.

The Program Coordinator, working with the Maine Office of AIDS, designed a clinical update and legal/ethical issues program targeting the boards of directors at community health centers. A similar program is being designed to target physicians at community health centers.

4. New England School of Osteopathic Medicine

The New England School of Osteopathic Medicine works through the Maine Osteopathic Association and the New England Osteopathic Assembly. Participating in the professional meetings of these two organizations was deemed the most efficient way of reaching osteopaths in the region. Several programs from one to three hours have been conducted at the Maine Osteopathic Association meetings. A three hour AIDS Symposium was conducted for the New England Osteopathic Assembly in Newport, Rhode Island. This was three hours in duration and focused on clinical updates and sexual history taking in primary care practice. Osteopathic physicians from throughout the region participated in this program. The School of Osteopathic Medicine has also done staff training in two of Maine's osteopathic hospitals.

The New England School of Osteopathic Medicine has also conducted a thorough analysis of the AIDS content in its curriculum. Several programs have been conducted for medical, physical therapy, occupational therapy, and nursing students of one to two and a half hours duration.

D. Regional Relationship

Although, administratively, the subcontractors will be dealing directly with the NEAETC central office in the future, all agree that there is value in a subregional Northern tier concept. In particular, the subcontractors feel they will continue to benefit from sharing program ideas during the advisory board meetings.

With regard to the ETC, however, subcontractors feel that they have not been involved in the strategic decision-making process at the regional level. This is especially true with respect to budgeting decisions; funding priorities have not been communicated to the subcontractors.

BETH ISRAEL HOSPITAL

Under the umbrella of the Beth Israel (BI) Hospital subcontract, Dr. Harvey Makadon, a general internist, provides a primary care focus for both physicians and nurses for the regional program. The major activities for physicians conducted under this subcontract include the development and implementation of a primary care train-the-trainer's module on medical interviewing around AIDS issues, convening of an AIDS Provider Group, development of a casebook for use in medical curriculum and provision of ad hoc training sessions, as well as serving as the catalyst for the development of other AIDS training products.

The AIDS Provider Group consists of 50 to 60 physicians in the Boston area, mainly primary care providers, who meet monthly at Beth Israel Hospital to talk about special AIDS issues and cases.

The ETC-sponsored casebook development is part of a larger effort under the aegis of the Office of Educational Development at Harvard. New Pathway, as this effort is known, is a project to develop integrated curricula around a specific medical problem, in this case, AIDS. Following the development of the core curriculum by Harvard, and educational materials and the casebook under ETC auspices, the Macy Foundation will fund the implementation of the new curriculum including a faculty development course.

As a catalyst, Dr. Makadon put together a group of experts to develop a curriculum on AIDS and drug abuse, building upon the primary care module.

Clinical Training for Physicians

At the BI, clinical training for physicians takes the form of case consultation, under the direction of Dr. Makadon and Dr. Calvin Cohen. The program offers a weekly half-hour session during which time consultation is provided on a multidisciplinary basis for physicians who want to discuss specific case management questions. The program serves a network of ten primary care physicians, thirty residents, and ten medical students. A typical session is attended by 2-4 providers, including practicing physicians and medical residents. Consultation is available from the Homecare and the Social Services departments as well.

Nurse Mini-Residency

The Beth Israel hospital also serves as the site for a nurses' mini-residency program. In December 1987, Dr. Harvey Makadon approached Susan Burns, Director of Community Services and Home Care at Beth Israel Hospital to develop a training program that contained both didactic and practical activities. Susan Burns worked on program content with Eileen Hodgman, who is a program developer.

Their target audience for this program is staff nurses from community hospitals and home health agencies. They were not going to train nurse practitioners or licensed practical nurses. The mailing lists of the

Massachusetts Nursing Association, hospital listings, and employees of the VNA were used to market the program.

The didactic part of the program had already been developed and implemented as part of a course entitled "Center for the Advancement of Nursing Practice," also conducted at the BI. Initially, a four-day practical was planned; however in subsequent cycles, a two-day practical emerged as the optimum balance between depth of experience and the time nurses could get away from work.

The didactic segment of the program has evolved from an AIDS 101 type of presentation at the beginning of the course to a more mature level, as there had been a striking increase in basic knowledge of AIDS over the first two years.

The practical segment was designed to show the nurse the whole spectrum of the illness from inpatient, to ambulatory, to home care. The practical is run in five groups of four nurses with a "core faculty advisory group" that is responsible for the nurses for the two days. This advisory group is comprised of clinical nurses and social workers from BI.

During the first part of day one, the nurses are divided into three inpatient units to accompany the core faculty advisory group on nursing rounds. For part two of the first day, each nurse hooks up with a primary care nurse taking care of an AIDS patient and follows that nurse for the rest of the day. At the end of day one, the nurse visits the clinical trial nurse. The day culminates with an interview of an AIDS patient by one of the core faculty,

Day two focuses on community resources and home care. The nurse visits a patient in the home in the morning and visits the STD Clinic in the afternoon, where pre- and post-testing are viewed in great depth.

Nurses from the six state regional area have taken the course. The course is free for nurses from BI but is $75 for others. Ms. Burns did not feel that this fee was too high for the applicants. Although not advertised, there are "scholarships" for nurses who are unable to attend for financial reasons. These monies are used for tuition, housing and transportation. The program is run five times a year. Many more people take the didactic course (120) then can be accommodated in the practical.

The ETC role in this mini-residency program is primarily as a funding agency; however, Ms. Burns pointed out the collaborative and consultative role that the ETC has played numerous times. Help was received from the ETC in the development stage and on an as needed basis for program maintenance.

DNIVRRSITY OF MASSACHUSETTS MEDICAL CENTER
MINI-RESIDENCY PROGRAM

The mini-residency at the University of Massachusetts Medical Center is under the direction of Dr. Patrick Fairchild, Medical Director of the HIV Clinic at UMMC, and Dr. Neil Blacklow, Director of the Division of Infectious Diseases. The idea for the mini-residency was originated by the Project Director of the NEAETC who approached Dr. Fairchild with the idea at the time the grant proposal was being written.

The target audience is practicing family physicians, general internists, fellows in infectious diseases, residents in medicine, nurse practitioners and staff nurses from the VNA. It has been difficult to create a didactic course to meet the needs of all of these providers. The course takes a middle of the road approach so that everyone can understand the material. The articles that are germane to the course are collected in a binder and sent to the participants before the course.

The mini-residency consists of both a didactic segment and a practical segment. There have been four mini-residency programs offered as of March 1990. Fifteen to twenty people complete each didactic session. Two or three of these participants go on to complete the clinical portion;

The didactic segment is one day long. At first, the didactic session was heavily weighted to the basic science aspects of HIV infection but has evolved into a more **"how to"** approach. The didactic portion consists of presentation on serotesting, epidemiology, pediatric AIDS, clinical manifestations, antiviral therapy, vaccine development, prevention of transmission, psychiatric concerns, special consideration of the IV drug abuser, and AIDS Clinical Trials Groups.

The clinical segment consists of a half day in the HIV Clinic observing and taking part in the team management of HIV infected clients. Participants are paired either with a fellow, a nurse practitioner or Dr. Fairchild. For that day, the clinic is “stacked” with the more **"interesting"** patients. Emphasis is placed on history-taking, physical findings, and symptoms related to HIV disease as well as diagnostic and therapeutic decision-making. Indications and mechanisms for patient enrollment and eligibility into **NIH**-sponsored protocols are discussed.

The participant stipend is $20; and, although not advertised, there are scholarships for people unable to pay the stipend or for housing and travel expenses.

YALE-NEW HAVEN HOSPITAL

A. Background

The Yale-New Haven Hospital subcontract has been very slow in becoming operational. Connecticut did not become a part of the ETC until Year 02 of the project. In addition, because of initial problems funding delays, the Yale site did not appoint an ETC person until August 1989. Unfortunately, this person left the job in October and Mary Mellors, R.N., took the position of Coordinator. Ms. Mellors donates her time to the ETC.

Under the leadership of the central office staff, the Yale site planned to develop similar programs to the other sub-contractors in the region; i.e., the nurse mini-residency at Beth Israel Hospital, the primary care mini-residency at UMMC, and other education and training programs being offered in the region. Unfortunately, in the fall of 1989, there was a major structural change in Yale's AIDS program, so that relationships with the physician providers never developed and the primary care residency has not occurred.

B. Education and Training Programs

1. Faculty Development Program: AIDS and Substance Abuse

As part of the Yale-New Haven Hospital subcontract, a program entitled "Substance Abuse and AIDS: A Faculty Development Program for Primary Care Providers" was developed. This three-day program is guided by a set of training objectives, an agenda, pre/post test and a collection of review articles. The program, held in March 1990, was open to physician and nurse faculty from the entire New England region.

2. Nurse Mini-Residency

The nurse mini-residency became operational in January 1990. It is marketed to the southwest corner of Connecticut, including New Haven and Bridgeport, where most of the cases in the state are concentrated (other than in Hartford, which is another sub-contractor). It targets nurses in community hospitals, skilled nursing facilities, inpatient hospices, visiting nurse or community health agencies or other settings caring or anticipating caring for patients with AIDS-related illnesses. In all, the program will accommodate 10 nurses. Thus far, one session has been held that three staff nurses from southwest Connecticut attended.

There is no formal didactic component associated with the residency, however, it will be marketed in conjunction with a Primary AIDS Training Conference. All participants who have not had didactic training are recommended to take an educational program at another time supported by the Yale site.

The structure of the nurse mini-residency is a two-day program of observation of patients in a 29-bed general medicine unit with a high proportion of AIDS patients. The program is conducted under the supervision of the head nurse. Structured observation includes:

- assessment, diagnosis, intervention, and evaluation of the patient with AIDS-related health problems;

- implementation of intradisciplinary use of "substance abuse guidelines" in the care of the AIDS patient;

. participation in multidisciplinary team rounds;

. participation in patient care rounds for discharge planning;

. participation in patient activity groups;

- consultation with clinical nurse specialist (AIDS, psychiatric liaison) concerning the development of a patient care plan;

. participation in staff support group led by psychiatric liaison nursing to role play situations in the care of AIDS patients with IV drug abuse or difficult behaviors;

- an optional rotation to the outpatient AIDS Clinic to gain experience in the outpatient management of AIDS-related health problems.

3. Miscellaneous Events

Other educational and training programs offered by the Yale subcontractor include :

o A one-day program held in January 1990. The approach was an "AIDS 101" targeted toward a multidisciplinary audience. Sixty people attended, the majority being registered nurses and social workers.

o A series of four programs were held on substance abuse, neuro-psych, ethical issues, and women and children's issues. Approximately 15 professionals attended each session, including a few physicians.

C. Regional Relationship

The relationship between the Yale site and the central office is a loose one. A representative from Yale always attends the quarterly ETC subcontractor meeting. The Yale subcontractor, however, relies more heavily on the central office for management and administrative purposes rather than for program development assistance.

BOSTON HEALTH AND HOSPITALS CORPORATION

Through a subcontract with the Boston Health and Hospitals Corporation, coordinated by Dr. Howard Libman at Boston City Hospital (BCH), the ETC has funded the development of three discreet training products. The subcontract provides salary support for the coordinator and discreet amounts for each of the products.

The first product, "Clinical Manual for Care of the Adult Patient with HIV Infection," by Drs. Howard Libman and Robert Witzburg was published early in 1990, and is intended as support for any ETC training. It is an expansion and update of a collection of review articles originally developed as a clinical guide for the Boston City Hospital AIDS program.

The second product is a video to support culturally sensitive AIDS care for the Haitian community which relies heavily on BCH for its care. The video, which provides caregivers with background on the Haitian culture in general as well as cultural responses to AIDS, is due for completion in the fall of 1990.

The third product, a self-instructional set of 20 to 30 slides for community health center staff, is in the planning stage.

MASSACHUSETTS HOSPITAL ASSOCIATION

The focus of the Massachusetts Hospital Association (MHA) subcontract is on the training of hospital-based trainers. Activities are coordinated by Denise Basaillon. Building on a previously developed AIDS policy manual for hospital CEOs, the subcontractor is responsible for first developing and implementing general AIDS training (AIDS 101). This program has recently added a substance abuse module. Responding to a need for additional training, AIDS 201 addresses more practical applications.

The manual for the AIDS 101 train-the-trainers program, "AIDS: An Educational Reference Manual" was developed jointly with the Massachusetts Department of Public Health. The two-part manual includes sections both on educational issues (adult education, teaching strategies, learning objectives, and resources) and AIDS information (clinical aspects), as well as psychosocial issues confronted by the caregiver. Training began in the fall of 1989. Approximately 80 hospitals apply each year for training; 25 are accepted based on interest, need and geographic location. The staff of five hospitals are trained in a cluster, on-site at one of the participating institutions. Usually four to five staff members attend from each hospital representing different areas such as infection control, staff development, and social services. The AIDS Action Committee assists in the implementation of this program by coordinating PWA speakers. Approximately 125 individuals have participated in this program as of March 1990.

The didactic session on substance abuse includes presentations on: addictive disease, classification, effects and treatments; the HIV-substance abuse connection; and intervention and strategies. It has been conducted for three of the initial training clusters and will be conducted as a supplementary training until all of the initial group has been trained. The session has been and will continue to be conducted as a second round of training for trainers trained in the first five AIDS 101 programs and will subsequently be added as third day of the AIDS 101 curriculum.

AIDS 201, which is fully funded by NEAETC, consists of a series of didactic patient care conferences, the first of which was held in February 1990. This one-day conference, held at the MHA office, addresses transcultural issues in providing AIDS care, clinical features of HIV and new treatment strategies, HIV-infected IV drug users, and linkages to out of hospital care.

As part of its subcontract, MHA has published a practical reference on HIV/AIDS patient care particularly relevant to hospital-based personnel. "HIV/AIDS Patient Care: A Collection of Works for Hospital Personnel," covering 17 topics and written by local AIDS experts, was published in the fall of 1989.

In addition, the MHA is undertaking a special project to hook up hospitals to on-line AIDS information services including CDC, clinical trials, and the Provider Information Network (PIN) of the Boston AIDS Consortium.

MOUNT SINAI HOSPITAL OUTPATIENT SERVICES

UNIVERSITY OF CONNECTICUT MEDICAL CENTER

The Mount Sinai Hospital Outpatient Service (University of Connecticut Health Center) in Hartford, Connecticut, became a subcontractor of the New England AIDS ETC in the second year of the grant when Connecticut was transferred from the NYU ETC's catchment area to that of NEAETC as part of a supplemental grant. The subcontract provides for a small budget for training materials, a nominal amount of the physician-coordinator's time (Dr. Harry Katz-Pollak), and 20 percent time for a nurse (Marie Hebert-Begley), who spends the remainder of her time in clinical practice. The budget includes assistance to the University of Connecticut Department of Continuing Education to support the ETC training effort.

The program of the University of Connecticut Medical Center focuses on primary care providers--physicians, physician assistants and nurse practitioners--in northeastern and north central Connecticut.

The program is strategically targeted and designed for maximum behavioral change. The program targets cities and towns in which the epidemic is in its early phases. The underlying premise of the program is that primary care givers in these areas are aware that if they have not yet seen an AIDS patient, it is only a matter of time before they will. The program is designed to prepare these caregivers for this first encounter which, if it goes smoothly, should encourage them to see treating AIDS patients as a more routine part of their practice. The program is viewed as a pilot, and the subcontractor expects to learn from the experience of the first year and to adapt the design accordingly.

The training program consists of a two-phase design: a one-day didactic session for community-based providers followed by an optional half-day mini-residency.

The didactic session, "AIDS/HIV Infection: Management in the Primary Care Setting," focuses on the "bread and butter" issues of providing AIDS care in a private practice setting. It is presented by a team consisting of the physician-coordinator, the program's nurse-clinician and a social worker from the state health department. The physician presents the biology and epidemiology of HIV infection, HIV antibody testing, clinical manifestations, and management. As part of the strategic design, these presentations concentrate on information with practical application to the primary care giver, rather than the scientific details. The nurse-clinician discusses pre- and post-test counseling and other relevant psychosocial issues, while the social worker describes the medical/legal aspects of AIDS including Connecticut's AIDS confidentiality and testing law. The program closes with a series of case discussions. A set of 400 clinical and didactic slides has been developed to support these sessions. Algorithms of "what to do in case..." have been made into both slide and handout format. The didactic sessions are considered a prelude to and a means of actively marketing the mini-residencies. In the first year, didactic sessions were held in six locations, primarily community hospitals. 430 persons attended, of which 130 were physicians.

The University of Connecticut Department of Continuing Education provides considerable support and advice to the program. It takes responsibility for logistics including site arrangement, marketing, registration, and CME accreditation. Offering CMEs and skillful marketing are considered to have been the two critical success factors in achieving high physician response. The marketing approach deserves special note. A special brochure was designed for the series. It not only carried the name of the Office of Continuing Education of the University of Connecticut, but prominently announced that the program was presented in cooperation with the six local institutions. It gives the positive and non-threatening message that primary caregivers are not expected to become AIDS experts and that they can count on the support of those who are:

> The course is designed to teach health professionals the basic skills and knowledge that will enable them to deliver initial counseling, medical evaluation and treatment to HIV infected persons. The course will also provide guidelines for the ongoing care of people with AIDS/HIV infection, in consultation with specialists.

The brochure also notes in several places that interested participants should register early because a "brisk" response is expected, a strategy which tends to stimulate demand.

On advice from the Department of Continuing Education, a nominal fee of $20, which covers course materials, lunch and breaks, is charged to engender a sense of value for the program. Supplemental funding for this series was obtained from Burroughs-Wellcome Company and LyphoMed Company.

The mini-residency experience is offered at an ambulatory care facility, (the Bergdorf Health Center, one of the Mount Sinai Hospital outpatient sites) and the facility where the physician-coordinator has a large portion of his clinical practice. The health center is located in a disadvantaged section of Hartford with an AIDS patient population made up primarily of IV drug users and their spouses. The mini-residency is integrated with the health center's regularly scheduled AIDS clinic. During the mini-residency, the clinical staff of the health center doubles as the training staff. The clinic staff have been prepared for their roles as trainers by the physician-coordinator and the nurse clinician.

The design of each clinical experience is carefully orchestrated by the physician-coordinator. Patients in the current clinical practice are identified for their teaching value and are scheduled for the day of the mini-residency. They are sequenced to build from initial identification through various complications. An attempt is made to ensure that at each clinical experience there will be at least one patient in each of the following categories: asymptomatic HIV+; asymptomatic but with a low T-cell count; co-infection with syphilis; co-infection with tuberculosis; CNS problems; and AZT management problems. To ensure that this schedule is followed, the patients are contacted personally by the physician-coordinator or the nurse clinician. In a population of IV drug abusers, it is difficult enough to have patients

keep medical appointments, but to be able to implement such as ambitious training design, the staff must be highly commended for their efforts.

During the half-day experience, participants observe various health center staff as they interact with the patient. They are encouraged to ask questions of the patients as they observe the medical consultation and they are offered the opportunity, but not required, to physically examine the patient.

A mini-residency experience is scheduled every 6-7 weeks. Because of space limitations and the potential to be intrusive, this clinical experience is limited to one practitioner at a time. Marketing begins with the program brochure described above:

> A practical follow-up training session will be arranged for a limited number of attendees who wish to review personally clinical cases of AIDS/HIV infection, being treated at a major ambulatory care facility. This mini-residency will offer you the opportunity for direct discussions with infected persons about their personal experience with AIDS.

At the close of the didactic session, participants interested in participating in the mini-residency are asked to fill out an enrollment form. It is stressed that enrollees be providers actively involved in patient care, an emphasis being placed on primary care physicians. Of the 430 participants in the six didactic sessions, 30 have expressed interest in participating in the mini-residency.

A month before the scheduled experience, the enrollment forms are reviewed and providers are phoned until one can attend. By the end of April, 1990 four participants had been scheduled. Much to the frustration of the staff, two of these had to cancel too late to reschedule a replacement. Consideration is now being given to scheduling two participants at a time. Of the two providers that have been trained, one was a private practice physician and the other was a nurse practitioner from the corrections department providing care in penal institutions around the state.

BROWN UNIVERSITY AIDS PROGRAM (BRUNAP)

The major subcontractor in Rhode Island is the Brown University AIDS Program, which includes three hospitals affiliated with the Brown University Medical School. The overall subcontract is administered and coordinated through the Memorial Hospital under the direction of Dr. Ken Mayer; Rhode Island Hospital and Miriam Hospital serve as the clinical training sites. The clinical experiences are coordinated by Dr. Alvan Fisher and Dr. Chuck Carpenter respectively.

While the subcontractor is involved in collaborative efforts with most of the other AIDS training resources in the state and is often in a leadership role, it does not see its role as either determining the strategic direction of AIDS training in the state or as the coordinator of AIDS training efforts statewide. The subcontractor is supported by an advisory committee which serves a review and comment function.

The subcontractor's training strategy is to involve the primary care departments together with the resources of the infectious disease departments in training primary caregivers. The subcontractor primarily targets physicians to supplement the state health department's focus on nurses' training. The subcontractor's primary responsibilities include holding an annual physician's conference, carrying out a primary provider education program, and serving as the focal point for mini-grant activities in Rhode Island, as well as collaborating with other agencies in a variety of AIDS training efforts.

The first annual physicians conference was held in May 1989. This one-day conference included sessions on current practice and patient management issues, discussions by local and national AIDS care role models on how to integrate AIDS care into one's practice, and presentations of networking and referral sources in the Rhode Island area, as well as local non-medical community resources that can be called upon to support patient care. The second conference is scheduled for September 1990.

The training design of the Primary Provider AIDS Education Program includes two sequential didactic sessions followed by an optional clinical experience at one of the two locations. The format of the clinical experience differs between the two sites.

The didactic sessions are scheduled in the evening for the convenience of the providers. The curriculum content for the didactic component is an evolving one. Originally, the agenda that was originally piloted included legal issues, psychosocial issues, and a list of resources in addition to clinical management. It was found that providers were really only interested in the clinical management aspects of the program. The agenda has been modified to a large extent in response to the providers' interest, with a heavy emphasis on the practical rather than academic aspects of patient management, such as counseling and testing of at-risk patients, monitoring the asymptomatic patient, prophylactic therapies in early HIV infection, treatment of opportunistic infections, and case management of early and advanced HIV infection. In spite of its lack of popularity among the participants, the psychosocial content was considered to be too relevant to be dropped. In the

first year, the agenda is covered over two sessions spaced one week apart. A three-session program was piloted for a short time, but the original two-session model was reinstated. Integrative clinical case discussions follow the didactic portion of each session. Five short written cases, with follow-up questions have been prepared for this purpose.

The Primary Provider AIDS Education Program is marketed via a letter of invitation from the director and the coordinator of the Brown University AIDS Program to "All Interested Medical Colleagues." Prospective participants are solicited through mailing lists obtained from the Rhode Island Medical Association, a targeted mailing list of the American Medical Association, and a mailing list from the Rhode Island Family Practice Association. The letter, which is sent out approximately one month before the first session, indicates that five credit hours in Category 1 CMEs is available free of charge. The program is also advertised in the Rhode Island Medical Journal. As of the spring of 1990, the didactic program was attended by 78 physicians, 15 residents, 20 dentists, 7 nurse practitioners, 4 physicians assistants and 1 other health care worker.

At the end of the didactic component, providers are asked to sign up for the clinical component. Approximately half of the attendees participate in the clinical component. The clinical experience takes place at either the Tuesday afternoon immunology clinic at Meriam Hospital or the Wednesday morning AIDS/HIV clinic at Rhode Island Hospital. One physician is scheduled per session. Participants have the opportunity to observe approximately 10 patients. The Meriam Hospital experience focuses on case management within the context of solo practice while the Rhode Island Hospital experience offers a more institutionally-based focus including formal case conferencing.

As of June 1990, approximately 30 of the physicians who attended the didactic sessions also participated in the clinical experience; others are scheduled to complete the mini-residency in the coming months.

Under a mini-grant, a pediatrics mini-residency program was presented in March 1990. It paralleled the regular mini-residency program with two didactic sessions and a half-day practicum at the Pediatric HIV clinic at Rhode Island Hospital. The didactic portion was attended by 64 health care providers including physicians, nurse practitioners and nurses, the majority of whom provide care in non-hospital settings. A second mini-grant supported a one-day program on substance abuse, given by Alan Whartenburg at the Alcohol and Addiction Project at Rogers Williams Hospital. The program, targeted to primary care providers caring for substance abusers, was attended by 100 people. It focused first on care issues for the substance abuser both in the inpatient and outpatient setting, including the behavioral aspects of patient management, and progressed to the role of the primary care provider in relation to AIDS and substance abuse, wrapping up with issues of HIV management. 'Two other mini-grant activities in the state included events for Brown medical students (a day-long seminar for students which included 4 diverse panels, and an AIDS Awareness Day).

Future plans include co-sponsoring a dental program with the state health department and the dental society.

New York - Caribe AIDS/SIDA Education and Training Center

Case Study

NEW YORK-CARIBE AIDS/SIDA EDUCATION AND TRAINING CENTER

CASE STUDY

I. Overview of Program

The AIDS Education and Training Center (ETC) funded by the Health Resources and Services Administration (HRSA) at New York University (NYU) provides a comprehensive training program for health professionals in New York City; Long Island; New Jersey; Puerto Rico and the U.S. Virgin Islands. Connecticut was initially included in the program but was transferred to the New England ETC located at the University of Massachusetts, Area Health Education Center (AHEC). Also, upper New York state and the mid-Hudson Valley region has been transferred to the ETC based at the University of Pittsburgh. Finally, the State of New Jersey came under the domain of the ETC funded at the University of Medicine and Dentistry of New Jersey, although NYU-initiated programs for New Jersey which were already in place will continue until June 1991.

This redefinition of the NYU-ETC service area which occurred at stages during the first two years of funding allowed the program to concentrate on the high need areas of metropolitan New York, Long Island, and Puerto Rico. Reshaping of the ETC's region as the program was just getting underway also presented a significant obstacle to program planning and development efforts. Nevertheless, the ETC staff have developed and implemented six strong components in their education and training program including programs for physicians and other primary care givers; programs for dentists and dental hygienists; workshops and other educational offerings for other professional disciplines; a Train-the-Trainer Summer Institute; a Faculty Institute; and an AIDS Warmline for health professionals.

A. Cooperating Groups and Agencies

The ETC is formally based in the Division of Nursing of the NYU School of Education, Health, Nursing and Arts Professions, although the ETC receives input from other Departments in the School, as well as from the Schools of Social Work, Medicine and Dentistry. Prior to ETC funding, the Division of Nursing was also funded by the National Institute of Mental Health to provide training on mental health and neuropsychiatric issues of AIDS to health professionals in New York City. The ETC and the NIMH training projects share staff, space and materials. An Educational Programs Committee (EPC) comprised of NYU faculty from a cross-section of health professions assists in curriculum development and has been able to expand the existing modules developed under the contract with the National Institute of Mental Health (NIMH).

The ETC's organization emphasizes collaboration with professional organizations through the Council of Professional Health Related Organizations (CoPHRO) and the various State Nurses Associations. The (CoPHRO) is composed of practicing health professional organizations in each of the targeted states. The CoPHRO was initially created to support programs, recruit members of their discipline to attend offerings, advise on faculty selection, detect unmet educational needs, assist in acquiring

space for workshops and contribute to the-process of program evaluation. The redefinition of the geographic area by WSA has necessitated redefining the membership of this council. As a consequence, the role of the **CoPHRO** in the program has been in flux.

The ETC subcontracts with the Nurses Associations of New York and New Jersey for state coordinators to plan and coordinate workshops. There was also a subcontract with the Connecticut Nurses Association before the region was redefined.

During year 01 of the program, a subcontract with the University of Puerto Rico (UPR) Medical Sciences Campus was developed. This subcontract establishes the Puerto Rico Center for AIDS Education (PRCAE) and assures the delivery of AIDS education throughout the 6 health regions of Puerto Rico. In the third year of the project, a subcontractual relationship was also established with SUNY-Stony Brook, previously an NIMH AIDS training project site, to coordinate and expand training efforts of the ETC on Long Island.

B. Program Goals and Objectives

The ETC program goal is to establish a regional educational and training center on AIDS for a variety of health care professionals in a multi-state region. The objectives of the program as initially identified in the proposal are:

1. To prepare primary care givers and other health care givers in the region for the treatment and prevention of AIDS.

2. To prepare selected health care professionals to serve as instructors in disseminating information about the treatment and prevention of AIDS to other health care professionals in their institution and/or community through a specifically designed trainer curriculum.

3. To serve as a support system for health care professionals in the region and as the focal point for information and assistance in resolving questions about AIDS.

4. To provide faculty who teach undergraduate and graduate students in the health professions with information about the treatment and prevention of AIDS which will assist them in incorporating the content modules developed in the ETC into their respective curricula.

5. To sensitize health care professionals to the stigma that society imposes on minorities by training these practitioners to be aware of and serve the needs of the minority communities.

6. To implement a plan for evaluating the effectiveness of the ETC in increasing trainee knowledge, to improve attitudes and measure the efficiency of the operation.

Supplemental grants received for the third year of the program also helped to shape two additional, focused program objectives. The first was a grant to develop and implement intensified training addressing substance abuse issues. The second supplemental grant was for education and training efforts for the Community and Migrant Health Centers in Puerto Rico.

II. Program History

A. Origin and Major Developmental Milestones

One of the two most significant aspects of the development of the ETC at NYU was the pre-existence of the AIDS Training program funded by the National Institute of Mental Health (NIMH). The ETC staff considers this situation to have been "fortuitous" as the ETC training program was able to build and expand on the NYU Mental Health Project in terms of both scope of trainings and geographic outreach. The two programs draw on the same established pool of trainers familiar with the projects' training modules. The ETC and NIMH projects also share offices and meeting rooms for cost effective measures and enhanced communication and coordination of resources.

The relationships established by the NYU Mental Health AIDS Project also support the AIDS ETC Program. These relationships are with groups in the public and private sectors of the health care system, gay and ethnic minorities who are currently providing care or are administratively responsible for care to AIDS/HIV populations, and members of the AIDS Service Delivery Consortium for the New York City AIDS Services Demonstration Program. Trainers for the NYU ETC course offerings are selected from these experienced community groups which helps to establish program credibility. The trainers are familiarized with the training curriculum, given guidelines and learning objectives from the ETC management team, and have access to all the information and training resources of the ETC. The link to the NIMH AIDS Training Program was further strengthened in the third year by the relationship established between the ETC and SUNY-Stony Brook for training on Long Island.

The second major factor affecting development of the NYU ETC has been the shifting definition of the ETC's region reassigning Connecticut, upstate New York and the mid-Hudson Valley region, and, eventually, New Jersey. Although the ETC staff have proven to be adaptable, this situation has been the source of some frustration, because it has interfered with the ability of staff to plan and target their programs. It has likewise resulted in a certain amount of wasted energy toward coalition building. This geographic arrangement has also created some bewilderment among target groups in New York. For example, health care workers requesting inservice on AIDS in Westchester County frequently call the NYU ETC only to be directed to the Pittsburgh ETC, a region to which they do not readily identify for training activities.

Several other issues that have impacted the ETC's development are also notable. The ETC, as well as the NIMH project, has not had to contend with a controlling institutional bureaucracy that often characterizes other academic based training and research grants. NYU has clearly allowed the programs to have autonomy in program design and implementation and the Division of Nursing has been supportive in providing free office and training space.

Finally, the original NYU proposal speaks openly about the competition for ETC funding in New York and the resulting difficulty the University had in coalition building. However, the ETC did meet and secure the support of

several agencies prior to funding and has successfully continued its efforts since the program was begun.

B. Institutional Background

The New York University is composed of fourteen schools, colleges and divisions at six major centers in Manhattan with additional campus programs throughout the state. The academic units that are part of the ETC program are: the School of Medicine and Post-Graduate Medicine, the College of Dentistry, School of Social Work, School of Education, Health, Nursing and Arts Professions (SEHNAP), Center for Continuing Education in Nursing, the Sex Information and Education Council of the U.S. and the Center for Career Advancement. Each of these units has a history of sponsoring some AIDS educational interventions since 1986.

The NYU School of Medicine receives funding from the NIH to be an AIDS Treatment Evaluation Unit (ATEU). This unit evaluates the safety and therapeutic efficacy of antiviral agents. Fred Valentine, MD, the Principal Investigator of this Project also serves as a resource to the AIDS ETC. The NYU College of Dentistry has operated an AIDS Education, Prevention and Patient Treatment Center since May 1986. Since December of 1986 there has also been special dental treatment facilities for AIDS patients at the Bellevue Medical Center staffed by residents of the NYU College of Dentistry.

Other AIDS activities of NYU are found in the Division of Nursing. As discussed, the NIMH has funded a three year Mental Health Project. The division has also offered AIDS forums as early as 1982 for the University and Greenwich Village community. Faculty from SEHNAP developed a brochure on **"How** to Talk to Your Children About **AIDS"** and have been consultants to local media about AIDS and AIDS education issues. The Recreation and Leisure Studies Department from this same school has developed a series of courses related to gay issues including AIDS, stress, and recreation and leisure for people with illnesses.

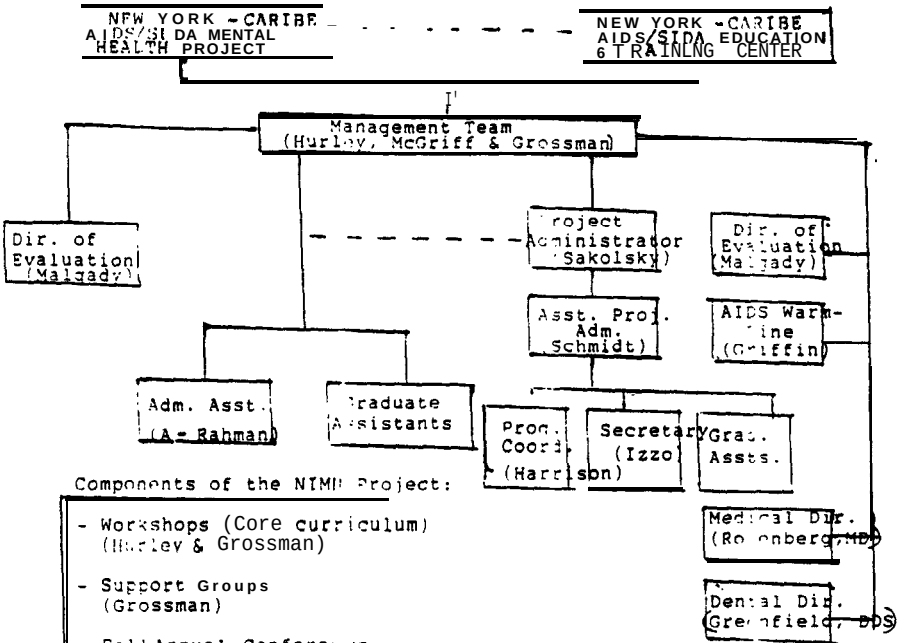
The long range plans for NYU include continued collaboration with the School of Medicine, NYU Medical Center, and the College of Dentistry and the School of Social Work. The organization of the New York-Caribe ETC and its interrelationship to the NIMH AIDS project is shown on the chart on the next page.

III. Program Structure

A. Geographic Target Area

The targeted geographic areas serviced by this ETC originally contained all of New York State which ranks first in the nation in AIDS cases. In New York City, AIDS is now the leading cause of death among men ages 25-44 and women ages 25-29. While gay men still comprise the majority of AIDS cases in any risk behavior group, the disproportionate representation of minorities among AIDS cases continues to grow. Currently, 28 percent of AIDS cases are among Black males and 23 percent are Hispanic males. An even more disproportionate number of women are minorities (51 percent Black, 32 percent Hispanic and 16 percent White).

ORGANIZATIONAL RELATIONSHIPS AND PROGRAM COMPONENTS OF THE NIHH AND HRSA FUNDED AIDS PROJECTS



Components of the NIMH Project:

- Workshops (Core curriculum) (Hurley & Grossman)
- Support Groups (Grossman)
- Fall Annual Conference (Grossman)
- Program Development Committee (PDC) (Hurley & Grossman)
- Seminars for Physicians (McGriff, Lipkin, M.D.)
- Seminars for Dentists (McGriff & Greenfield, D.D.S)

Components of the RTC:

- Discipline Specific Workshops (Hurley & McGriff)
- Substance Abuse & HIV workshop (Naegle)
- AIDS WarmLine (Griffin)
- Task Force on Minorities (Clark)
- Videotapes for Discipline Specific Modules (Grossman)
- Videotapes for Primary Care Givers (McGowan)
- Videotapes for Dentists (McGowan)
- Train the Trainer Institute (Griffin)
- Faculty Institute (Bonaparte)
- Council of Professional & Health Related Organizations (CPHRO) (McGriff & Grossman)
- Educational Programs Committee (EPC) (Grossman)

KEY
- Direct Responsibility
- Consultative Relationships

Subcontracts with the

- University of Puerto Rico, Medical Sciences Campus in San Juan (D. Gely)
- State University at Stony Brook (R. Walton)
- New York State Nurses Assoc. (M. Orr)
- New Jersey State Nurses Assoc. (E. Flemming)
- Telesource, Inc. (McGowan)
- Community Health Care Assoc, of New York State, Inc. (Labiner)

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Since 1983, the proportion of IV drug cases has risen from 19 percent to 34 percent. The combined pediatric cases of New York City and the State of New Jersey are 50 percent of the pediatric cases in the country. While the increase in each borough of NYC is similar, the statistics for the boroughs of Brooklyn, Bronx, Queens and Staten Island are slightly higher than Manhattan. The AIDS cases of Manhattan are predominantly gay white males. The other boroughs have an AIDS population primarily of minority IV drug users. **The New York City Health Department estimates that up to 230,000 people in New York City are infected with HIV and that the number of people with AIDS in the state will rise to 60,000 by the end of 1993.**

New Jersey ranks fifth in the nation in numbers of AIDS cases. The largest percentage are IV drug users, their sex partners and children. Racially, 49 percent of the AIDS cases are among Blacks, 13 percent are Hispanic and 38 percent are White. Thus, a large majority are from Black and Hispanic communities of New Jersey even though they do not make up a majority of the overall population.

The cumulative number of AIDS cases reported in Puerto Rico to date is over 4,000 and the annual incidence rate is higher than any other U.S. state or territory except' **the** District of Columbia. The Virgin Islands, which also has a very high incidence rate, is also included in this ETC region.

B. **Collaborating Programs**

The organization of the ETC, including its relationship to the NIMH AIDS Training Project, was described in the previous section. State Nurses Associations in New York, New Jersey and Connecticut (until its transfer) serve as subcontractors to provide State Coordinators and implement workshops for the training of nurses, social workers, physical and recreational therapists, rehabilitative and bereavement counselors and nutritionists. The Nurses Associations are given a free rein in terms of the location and target group for trainings, but are specifically required to hold a certain number of trainings. Each of the Associations is provided with and oriented to the centrally developed training modules and materials. Each also follows the philosophy of drawing on a small pool of tested trainers.

A subcontract was established with the University of Puerto Rico on May 1, 1988, the first operational year of the NYU ETC. This contractual agreement with the University of Puerto Rico established the Puerto Rico Center for AIDS Education (PRCAE) as a subsidiary of the NYU ETC. The PRCAB **provides AIDS** education for a variety of health professionals in Puerto Rico. The management team of the NYU ETC has and will continue to visit the PRCAE site twice a year. There will be six two-day workshops delivered by the project in Puerto Rico during the 02 and 03 years of the project. Some of the 22 potential AIDS trainers identified by the PRCAB attended the Train-the-Trainer Institute provided during the 01 and 02 years of the NYU project. The evaluations and **pre/post** tests designed by the NYU ETC have been modified by the PRCAE and translated into Spanish for use in the PRCAE course offerings.

The Educational Programs Committee (EPC) has been established to develop and organize curriculum content and plan teaching strategies for

the health professionals in the ETC region. This energetic committee is composed of fourteen faculty members from NYU, each representing a specific health care discipline: medicine, nursing, dentistry, psychology, social work, occupational, physical and recreational therapy, bereavement, rehabilitation counseling and nutrition. Under the direction of the ETC staff and assisted by practicing clinicians from various disciplines serving people with AIDS, the EPC has developed discipline-specific and interdisciplinary case management curricula.

Initially, the faculty were to contribute 5 percent of their time to the curriculum development but it is evident that much more time has been spent in this phase of program development. The EPC faculty representing Therapeutic Recreation, Nursing, Nutrition, Social Work, Occupational Therapy and Physical Therapy have consulted on videotape productions for the modules that are discipline specific. The ETC has also drawn on AIDS training and caregiving experts from Bellevue Hospital to develop the train-the-trainer curriculum and to assure the consistency and currency of HIV information provided by ETC programs.

The Council of Professional and Health Related Organizations **(CoPHRO),** representing a broad range of practicing professionals and health care organizations in the target states, was initially created to provide regional input in all phases of program development and evaluation. As a formal body, this advisory council has not played as active of a role in program development of the NYU ETC as originally envisioned, because membership was not consistent due to the shifting regional definition. The **CoPHRO** met once during the first year and again in July 1990. During the interim, members were contacted informally for reactions and input to ETC programs. Individual council members have been supportive and collaborative with the ETC management team on an ad hoc basis.

There were other major collaborative efforts underway at the time the proposal was submitted. The NYU AIDS Mental Health Project and the NYU AIDS ETC intended to work with New York Hospital Association under a grant from the W.K. Kellog Foundation to develop a curriculum on AIDS mental health issues for hospital **CEO's.** However, this grant had expired by the time the ETC was funded. The NYU ETC has collaborated with the NYC Health and Hospitals to develop curriculum for training all city hospital personnel. There will be co-sponsored offerings regarding substance abuse, HIV testing and counseling, minorities, women's issues and pediatric AIDS.

The Robert Wood Johnson Foundation AIDS Grant funds the AIDS Health Service Program for Newark and Jersey City under the direction of the New Jersey Department of Health. A resource person from this program serves on the Council of Professional and Health Related Organizations. Other collaborative efforts include cosponsoring programs with the Gay Men's Health Crisis and Sloane Kettering Hospital. The NYU ETC cosponsored a multi-regional conference for PHS physicians in DHHS Regions I, II **&** III with the **ETC's** in Massachusetts and Maryland. As mentioned, the ETC established an important subcontract for training in Long Island with **SUNY-**Stonybrook, previously a NIMH AIDS training contractor.

Initially, there was a subcontract with the New York Minority Task Force on AIDS to provide consultants for workshop faculty, curriculum development and minority issues. Due to reorganization within the Minority

Task Force there is no longer a formal contract with the ETC. Consultations on minority issues are provided by individuals from the Minority Task Force, faculty of NYU and the Hispanic AIDS Task Force composed of Hispanic leaders and convened by the ETC management team.

C. Accessibility of Training Sites

In order to make training events accessible to large numbers of health professionals across the region, video teleconferencing was to be a major emphasis of the NYU ETC. In the first year of the project there were three videoconferences. However, the ETC staff determined that this was not an appropriate training strategy after the region was significantly reduced in size. Perhaps more significantly, the staff was also not satisfied with the quality of training and training event management afforded through this medium.

A series of open workshop offerings are held on the NYU campus in the Spring and Fall. Currently, many ETC course offerings are held on site in hospitals and agencies that either request trainings or are targeted/recruited by the ETC and its subcontractors because of the population that the organization serves. The Summer Train-the-Trainer Institute is held on the NYU campus where classrooms and housing are offered to program participants. A clinical experience is offered to participants in the Institute through arrangements with the Bellevue Hospital clinics as well as area agencies according to the interests specified by individual participants. The subcontract with UPR is intended to assure that training is accessible throughout Puerto Rico.

D. Staffing

Dr. Erline McGriff - Project Director. As the head of the "management team", responsible to the Dean of the School of Education, Health, Nursing and Arts Professions, Dr. McGriff provides direction for the planning and implementation of the project; approves appointment and assignment of project staff; administers the budget; provides for a systematic and ongoing record keeping system; and supports the evaluation methods of the project. Dr. McGriff is also the Associate Director of the NIMH project. A Professor in the Division of Nursing, she spends about 50 percent of her time on the ETC project and about a 35 percent on the NIMH project.

Dr. Patricia Hurley - Associate Project Director. Dr. Hurley collaborates with the project director in carrying out the duties and responsibilities related to the implementation of the ETC specifically as they relate to the NYU AIDS Mental Health Project. Dr. Hurley also assumes administrative responsibility for the Train-the-Trainer Institutes and the Faculty Institute held in the third year in collaboration with the School's Center for Career Advancement. Also a Professor in the Division of Nursing, Dr. Hurley spends about 30 percent time on the ETC project and 60 percent of her time as Project Director of the NIMH Training Project.

Dr. Arnold Grossman - Assistant Project Director. Dr. Grossman collaborates with the Associate Project Director and Project Director in planning and implementing the goals-and objectives of the project; and assumes major responsibility as chairperson of the Educational Programs

Committee for the basic core curriculum and the components of the curriculum that are discipline specific. Dr. Grossman is a Professor in the Department of Recreation, Leisure, Physical Education and Sport. He devotes 35 percent of his time to the project and replaces Deborah Labovitz who originally was Assistant Project Director and chair of the EPC. Dr. Grossman was recruited to this position based on successful collaboration with Drs. McGriff and Hurley on the NIMH Project, where he spends about 20 percent time.

Dr. Robert Malgady - Director of Evaluation. Dr. Malgady analyses and interprets data from evaluation instruments that measure the effectiveness of the ETC in increasing knowledge and improving attitudes of trainees. He assumes responsibility for coordinating and reviewing the evaluation efforts of the UPR site. Dr. Malgady has also replaced the individual that originally served as the NIMH evaluator in order to achieve continuity of evaluation between the two programs. Dr. Malgady is a Professor in the Department of Mathematics, Science and Statistics Education. He devotes 10 percent of his time to the ETC project and 10 percent time to the NIMH project.

Mr. Bill Sakolsky - Project Administrator. Mr. Sakolsky assists the members of the management team with the day to day operation and implementation of the project and responds to calls from other units within the project. He takes the lead in marketing the program, staffing the offerings and arranging for facilities. He performs informal needs assessments prior to individual training events and attends a majority of the course offerings to assure coordination and quality control. Mr. Sakolsky has experience as a caregiver to people with AIDS and experience with office/business management and continuing education.

Mr. Fred Schmidt - Assistant Project Administrator. Mr. Schmidt is responsible for the business management of the office including setting up and maintaining an appropriate record keeping and fiscal control system. He also provides direction for the administrative assistant funded under NIMH and for graduate students.

In addition to the members of the management team, the ETC staff resources include Joan Hoexter, RN, Professor Emeritus of the School of Nursing who provides consultation on curriculum development and Tom Adamski, RN, an experienced caregiver who provides consultation for consistency and currency of HIV information. Conrad Rosenberg, MD is the ETC Medical Director. Dr. Rosenberg has assumed primary responsibility for development of trainings targeted to primary care physicians including directing development of three videotapes. Harriet Goldman, DDS is the ETC Dental Director. She has assumed primary responsibility for development of trainings targeted to dentists, including directing development of two videotapes. The UPR site director is Professor Daisy Gely and the Project Director of the AIDS Project at SUNY, Stony Brook is Dr. Rose Walton.

There are currently fourteen members of the Educational Programs Committee (EPC). These members work under the direction of the Assistant Project Director who chairs the EPC:

NAME	DISCIPLINE
Vivian Clarke	Health Education
Sharron Dal ton	Nutrition
Nancy Esibill (first two years)	Rehabilitation Counseling
Harriet Goldman	Dentistry
Joanne Griffin	Nursing
Diane Grodney	Social Work
Arnold Grossman (chair)	Social Work/Recreational Counseling
Claudette Lefebvre	Recreation Therapy
Carla **Mariano**	Nursing
Paula **McCreedy**	Occupational Therapy
Eileen Nathanson (first two years)	Physical Therapy
Doris **Berryman**	Recreation Therapy
Mary Cuff Plante	Nursing
Conrad Rosenberg	Medicine
Joan Hoexter	Nursing

The faculty for this committee are all licensed or certified in a health related profession; hold graduate degrees with successful experience in the practice of their discipline; and have some experience with teaching students or individual/group counseling related to HIV. These faculty members assist with the design, revision and evaluation of the basic core curriculum of the ETC.

In addition, some members were assigned to a specific function related to the implementation of the project: Clarke expanded the IV Drug Abuse Module with special consideration to minorities; Goldman and Rosenberg with two attorneys (Wheatley and Barr) developed a module on legal/ethical issues; Grossman organized the mental health content into modules to include difficult psychosocial issues confronting health care providers; **Mariano** developed an interdisciplinary case management module; Grodney and Griffin designed curriculum for train-the-trainer institutes in year 01 and 02; Griffin is the lead trainer for the train-the-trainer institute; Hurley, **McGriff** and Grossman designed the curriculum for the Faculty Institute in year 03. In the third year of the program, two EPC based Task Forces were formed; one to address minority issues under the direction of Vivian Clarke and a second to address substance abuse issues under the direction of Dr. Madeline Nagle.

Finally, eight part-time graduate students funded through both the HRSA and **NIMH** grants assist in the staffing of the AIDS Warm Line, staffing workshops and work with the project evaluator.

B. Organizational Qualities

The **NYU** BTC has assembled a strong and committed core staff and created an active Educational Program Committee to develop curriculum and consult on videotape production. This academic committee has networked with practicing clinicians in their specific disciplines who are actively involved in the care of people with AIDS/HIV. The ETC Management team has also collaborated with the existing AIDS network of providers/agencies. This collaboration has increased the pool of experienced trainers and provided credibility to a developing program.

A definite strength of the ETC program is the collaboration and co-development with the NIMH AIDS Mental Health Project at NYU. The ETC training program has been able to build and expand on the NIMH Project, coordinate resources and course offerings, and cultivate external relationships and linkages that benefit both programs.

The ETC has remained flexible in organizational and training program development by design and from necessity. The regional redefinition by HRSA basically undercut the structure and activities of the CoPHRO. The management team has nevertheless maintained an active relationship with specific individuals of the board and the program has benefited from this relationship. Except for New Jersey and Long Island, the shifting region also undercut the initial strategy of involving nurse associations to disseminate the centrally developed training modules outside of New York city.

The subcontract established with the University of Puerto Rico Health Sciences Campus is clearly an asset to the ETC organization. This campus is the primary educational institution for a majority of the health professionals who serve in Puerto Rico, The relationship between the UPR site and the central NYU ETC site appears to be mutually beneficial.

Finally, the NYU AIDS ETC has been able to manifest the best aspects of an academic institution without accruing the associated liabilities; a credit to both the ETC and NYU. The energetic, involved EPC committee and the supportive, but autonomous environment in which the ETC program exists at NYU are two apparent examples.

IV. Training Program

A. Needs Assessment Procedures

The NYU ETC proposal as submitted to the Health Resources and Services Administration did not include specific plans for conducting a needs assessment in the region. The central ETC staff have relied on "key informant" input from the CoPHRO members and other AIDS practitioners/ agencies for identification of health professional training needs in the region. In addition, the ETC subcontractors are responsible for assessing needs and targeting trainings in their respective areas. Needs assessments for planning individual programs targeted to specific agencies are conducted on an informal, but consistent basis.

For the Faculty Institute held in the third year of the project, a comprehensive survey was developed and administered to faculty of health professional schools throughout the region. The survey assessed the current place, content and future plans for HIV/AIDS in curricula. The results, not yet available, will be used for planning the outline and content of the Institute.

The PRAEC identifies the needs of health professionals relating to AIDS/HIV through liaisons with the Secretariats throughout the island's health divisions.

B. Training **Strategies**

To meet the objectives of the AIDS ETC there are seven overall program components. These are **programs for physicians and other primary care givers; programs for dentists and dental hygienists; workshops and other educational offerings for other professional disciplines; a Train-the-Trainer Summer Institute; a Faculty Institute; special, ad hoc programs; and an AIDS Warmline for health professionals. All components are discussed in this section on training strategies, except for the Warmline which is discussed in Section V.**

Trainers for the NYU ETC course offerings are selected from the public and private sectors of the health care system, gay and ethnic minorities who are currently providing care or administratively responsible for care to AIDS/HIV populations, and members of the **AIDS** Service Delivery Consortium for the New York City **AIDS** Services Demonstration Program. The trainers are familiarized with the training curriculum and given guidelines and learning objectives from the ETC management team.

1. Specific Training Strategies and Methods.

a. **Programs for Physicians and Primary Caregivers. The program for primary care givers targeted physicians, physician's assistants and nurse practitioners for skill building in care and management of people with AIDS. The initial strategy for reaching this group employed the use of** an **interactive videoconferencing lecture series. The program content included epidemiology, immunology, medical aspects of AIDS, diagnostic assays, vaccines and treatment, safety protocols and prevention, multidisciplinary case management, mental health issues'and neuropsychiatric complications.**

The-interactive videoconferencing method was chosen to accommodate physicians' crowded schedules. State coordinators were responsible for networking and encouraging attendance. Two interactive videoconferences were held for primary care givers on April 6, 1988 and May 18, 1988. Hospital Satellite Network calculated from their viewership survey that a national audience of about 13,500 physicians and other primary caregivers were reached through 91 downlink sites. However, the ETC staff was dissatisfied with the documentation of program participants provided by the production company and with the capacity for quality control and evaluation that this medium allowed. Further, it was not practical to continue the interactive conference strategy since 75 percent of the site links were outside **of the** ETC region after it was redrawn. Thus, interactive teleconferencing as initially proposed by the ETC was discontinued after three conferences including one held for dentists.

The new ETC strategy for bringing AIDS information to large numbers of physicians is production and distribution of videotapes of panels of HIV experts. The ETC, with the Medical Director, Dr. Rosenberg, taking the lead, is currently working with Telesource, a production company, to develop three videotapes for physicians. One tape will address epidemiology, risk assessment and sexual history taking; the second tape will address issues of patient management; and the third tape will address specialist issues **(OB/GYN/Pediatrics).** These tapes will be mass produced and distributed through the NYU **School of Medicine, the New York Academy of Medicine,** the New York County Medical Society, the Nassau-Suffolk County

Medical Society and the Academy of Medicine for New Jersey. The tapes will also be translated and dubbed for use in Puerto Rico. The ETC also intends to include a content evaluation along with each tape that can be returned for CME credit to encourage viewing.

The ETC originally planned to offer primary care givers who attended the teleconferences a clinical opportunity under a preceptor at the NYU Medical Center. The objective of this one day clinical experience in an acute setting was to familiarize participants with the environment; precautions necessary when dealing with the HIV patient; and to expose the participants to treatment modalities used for opportunistic infections. However, it was determined not to offer the clinical experience through this component of the program, apparently because the audiences were too large to logistically allow implementation.

The ETC has also started to offer workshops and conferences targeting primary care physicians, both ETC generated and upon request. One program held in the spring of 1990 was a three-day "faculty development" course for about 40 physicians. An important effort just getting underway is a series of six offerings for physicians in Community Health Centers in New York City under subcontract to the Community Health Center Association of New York State (CHCANYS).

b. Programs for Dentists and Dental Hygienists. Development of the second ETC program component paralleled that of the physician program, The second interactive videoconference sponsored by the ETC was targeted to dentists and focused on three issues: general information about HIV; identification of oral lesions associated with HIV; and appropriate infection control precautions. A one day clinical experience at the Dental Clinic for AIDS Patients in Bellevue Hospital was to be offered to participants who attended the videoconference. The objectives of this experience were to learn appropriate infection control; recognize lesions; and reduce anxiety in providing care to AIDS patients. Because the audience was so large the clinical experience was again not offered to conference participants.

As with physicians, the ETC is now developing a videotape in conjunction with Telesource to be distributed to dentists. The video content is being directed by Dr. Goldman of the EPC and will focus on operatory cleaning procedures and oral diagnosis of HIV related opportunistic infections.

c. Program for Other Health Care Professionals. The third training component provides programs for nurses, social workers, psychologists, occupational, physical, and recreational therapists, nutritionists, bereavement and rehabilitation counselors and health educators. The ETC offers workshops which incorporate core curriculum modules developed by the NIMH training project and expanded by the ETC. In addition to these modules, the ETC has developed specific curriculum for each of the targeted professionals. This has been a major area of activity of the ETC and the primary focus of the EPC.

Videotape productions developed by EPC members for Therapeutic Recreation, Therapists, Nutritionists, Nurses, Social Workers, Occupational and Physical Therapists are part of the discipline specific modules. The

concept for the videos originated with the management team in response to a perceived need to support the capability of trainers to meet the diverse training requirements of a multidisciplinary audience. It was thought that at any given training event, individual trainers could train using the core curriculum followed by splitting into small, discipline-specific groups using the videos to support training. These videos are being/have been produced at the NYU Center for Media Services.

The implementation of these modules is flexible and can occur in different formats from two day workshops to a course implemented over a period of five weeks. A series of four two-day workshops co-sponsored with the NIMB project are held on the NYU campus each spring and fall. The ETC also holds workshops on site at an institution co-sponsoring or requesting training.

There was initially a clinical component for counselors, recreational therapists, nutritionists, social workers, psychologists and health educators. Community-based AIDS organizations such as the Gay Mens Health Crisis, PWA Coalition, Minority Task Force on AIDS and the Institute for the Protection of Lesbian and Gay Youth were to offer this face to face experience for the workshop participants; The one-day clinical experience for nurses, occupational and physical therapists was also to take place at various medical centers throughout the region. As for physicians, it has proven logistically difficult to offer this clinical component to workshop participants in the first two years of the project..

d. Train-the-Trainer Institute. The fourth program of the ETC is the Train the Trainer Institute. Participants in this program were to be selected from Upstate New York, and the rural areas of New Jersey and Connecticut for the first year. This plan changed with the geographic redefinition. Planned for only the first two years of the project, a Faculty Institute was held in place of the Train the Trainer Institute in the third year of the project. At one point the ETC management team considered also having a train-the-trainer institute in the third year due to high demand, however this proved to be logistically unfeasible.

State coordinators and Council resource persons assist in recruitment. Participants are selected primarily because they are responsible for staff training in their own setting. The participants of this week long institute are required to provide a letter from their sponsoring institution expressly stating that they accept and will be responsible for the applicant's commitment to train at least fifty other individuals at the sponsoring institution. The Training Institute focuses on: barriers to teaching and learning about HIV; HIV infections; the impact of AIDS on PWAs, health care workers and targeted populations; and HIV instruction program with objectives, lesson plans and evaluation.

The program is five days in length with two days covering the core curriculum and two days covering education and training principles and techniques. The training institute includes a clinical experience on the fourth day of the program. The fifth day is devoted to integrating the clinical experience with previous learning and setting future objectives.

e. Faculty Institute. The Faculty Institute is the fifth component of the NYU ETC program and was offered for the first time in the third year of the grant. About 40 faculty from graduate and undergraduate colleges and universities in the region attended a two day institute which focused on barriers to teaching and learning about AIDS; effective strategies for teaching about AIDS; and developing objectives, lesson plans and clinical experiences for their specific discipline. The Faculty Institute was offered through the Center for Career Advancement at NYU.

f. Other Special Programs. In addition to these primary program components, the ETC initiates or responds to a number of specific activities. On separate occasions, the assistance of the ETC was requested to plan and hold two workshops, one for podiatrists and one for pharmacists, on HIV issues. Both requests were catalyzed by mandatory CEU requirements legislated by the state of Florida in which many New York state practitioners hold joint licenses.

The ETC sponsored a Train-the-Trainer Institute for NYU Medical Students on two consecutive Saturdays early in the second year. Supporting the initiative of the American Medical Student Association (AMSA), the objective of the Institute was to train medical students in public health education skills focusing on HIV and adolescents.

In Puerto Rico, a training program for AIDS Support Facilitators is being offered in the second and third year of the grant. This program prepares selected health care providers to develop an HIV/AIDS Support System Network for other health care professionals. The goal of the network is to increase health professionals' competencies in improving the quality of care of persons with AIDS by assisting them with the stresses of care of people with HIV infection and in preventing burnout.

On World AIDS Day, December 1, 1988, the NYU ETC sponsored a program to recognize the efforts of agencies in the region that have contributed to improving the quality of life of PWAs. This highly appreciated program was also instrumental in developing contacts and coordination within the region's caregiving community. The ETC has continued this activity each year on World AIDS Day.

The ETC is providing a series of trainings on AIDS issues to case workers employed by the NYC Human Resources Administration at the request of that agency.

2. Curricula and Materials Developed/Used

The core curriculum, including the mental health aspects of AIDS, that had been developed for the NYU-NIMH AIDS training project are included for each target audience in the AIDS ETC. The core curriculum includes modules for HIV Infection and AIDS - An Introduction; Pathophysiology of HIV and HIV-Related Diagnoses; HIV Antibody Testing and Counseling; Infection Control and Health Teaching for Persons with HIV Infection; Psychosocial Issues for Health Care Providers; Psychosocial Issues of Subgroups of the Population; Neurological and Neuropsychiatric Manifestations; Concepts of Death and Dying Related to Working; and Stress and Coping. Advanced modules have also been developed covering HIV Counseling and Testing; Neurological and Neuropsychiatric Manifestations Associated with HIV

Infection; and Management Strategies for Health Care Providers in Confronting Difficult Psychosocial Issues.

The ETC has expanded on this core curriculum by adding special modules covering Substance Abuse; Minority Issues; Interdisciplinary Case Management; Legal/Ethical Issues; and Long Term Planning. In addition, the ETC has developed the curricula for each of the discipline-specific modules. Each of the **NIMH/ETC** modules include purposes, specific instructional objectives, content, teaching methods and materials, and bibliographies.

As mentioned, the EPC has been actively involved in curriculum development for their respective disciplines. The EPC faculty reviewed the existing core curriculum and then worked individually to develop the discipline specific modules. Each faculty member working on a module was required by the ETC management team to contact a practicing clinician in their field to provide formative input and content review. When it was determined that videos would be a valuable training tool for the discipline specific modules, EPC members took the lead in scripting and directing the videos based on their respective modules. Videotapes have been completed for therapeutic recreation, nutrition, nursing and social work; occupational therapy and physical therapy are in production.

All EPC activities in curriculum development have been conducted under the direction of Dr. Grossman. Be provides technical assistance and maintains the committee's momentum. However, the management team believes that the flexibility allowed the EPC in the curriculum development and, in particular, the video production process resulting in different and creative approaches on each module.

The three videos for physicians are being developed in a like manner under the direction of Dr. Rosenberg and produced under subcontract to Telesource. Dr. Rosenberg established training objectives with input from practicing clinicians and ETC staff. From there, the videos were scripted and filming of physician and patient interviews began at Bellevue. Approximately eight hours of taping were edited down on the basis of both content and technical quality to comprise the first two of three tapes, each about thirty minutes long. The first tape covers epidemiology, history taking and basic clinical care. The second tape covers the role of the primary caregiver as the medical and psychosocial case manager. A third tape targeting **OB/GYN** and pediatricians, as well as a recap of case management, is in the planning phase.

Participants in the Train-the-Trainer Institute receive a training manual that contains each of the core, core advanced and discipline specific modules. The training curricula and exercises prepared by Dr. Griffin of the EPC for the second part of the Institute covering principles and techniques for AIDS training and education have not yet been documented by the ETC.

Persons from Puerto Rico who attended the first train-the-trainer program formed the core of a curriculum development committee and adapt the content from NYU's program to make it relevant and culturally sensitive to meet the needs of the people in Puerto Rico.

3. Evaluation

The program evaluation design for the first three training strategies is based on pre and post testing of trainees to assess change in the affective domain, as well as participant satisfaction. The ETC uses a variation of the instrument prepared for the NIMH project which was developed from available instrumentation in the field and by adapting standardized scales to be AIDS specific in content. During the third year, the attitude scale was further refined and examined through factor analysis and work-setting specific scales were developed. The ETC has been working toward inclusion of components to assess behavioral characteristics, as well as attitudinal, in instruments for trainee evaluation.

Content examinations related to specific modules were developed by the evaluator in consultation with the fourteen members of the Educational Programs Committee, but it has been difficult to keep the content tests current with the modules and the content tests proved not to be very useful for evaluation.

In the case of instrumentation for the Puerto Rican component, all scales *were* translated into Spanish. To ensure comparability with the English version, the "back translation" method was employed.' In this method two specialists translate from English to Spanish, independently and then reconcile any discrepancies; two additional specialists independently translate back to English. The process is repeated until a suitable English-Spanish match is achieved.

The evaluation of the Train-the-Trainer Institute is descriptive, focusing on documenting the number of regional trainees reached by each trainer and what specific training objectives were achieved. The cost efficiency and cost effectiveness of specific program components were not formally assessed in the first few years of the program, primarily because the ETC staff did not sense that this was a HRSA priority. An overall assessment of the program's cost efficiency was performed in the third year and estimated costs per trainee at approximately $125 or about $21 per contact hour.

4. outputs

In the first year of the grant three workshops were held in New York, two in New Jersey and two in Connecticut by the ETC subcontractors. Twelve workshops were cosponsored by the NYU AIDS Mental Health project in New York City. Thirty five trainers from New York, New Jersey, Connecticut, Puerto Rico and the Virgin Islands attended the first year train-the-trainer institute. These trainers were then expected to train a minimum of 1750 health professionals. About 16,150 physicians, dentists and other health professionals reportedly received the teleconferences. The ETC management team also responded to a number of individual requests from agencies and institutions. As the reputation of the ETC grew in the region the requests for these types of interventions increased.

During the second year of the project over 3000 health care workers were trained in a variety of 35 workshops throughout the region. The average number of contact hours for ETC course offerings was 8 1/4 hours.

The ETC also co-sponsored six half-day programs for specific agencies. The majority of course offerings were held on-site in local hospitals and health care agencies. Over 500 health care professionals were educated on AIDS through the programs sponsored under contract with the University of Puerto Rico and 170 health professionals participated in programs held in the Virgin Islands. About 40 trainers were registered for the second Train- the-Trainer Institute in the second year. The Faculty Institute was held in the 03 year of the program with 40 health professional educators from schools around the region in attendance.

After the third year of the program, the ETC estimates that over 25,000 health professionals have attended events sponsored or cosponsored by the ETC, not including those projected to have viewed satellite broadcasts.

C. Bfforts to Reach Minorities

Due to the location of the ETC in the greater metropolitan New York area there are a great number of health care professionals who care for minority patients. State Coordinators are instructed to plan health care professional programs in communities where there are large minority populations. This approach has been effective with the NIMH Mental Health AIDS Project. A training module in IV drug abuse and modules concerning the special needs/issues of groups in minority communities have been developed. Finally, there is minority representation on the Education Program Committee and the CoPHRO.

Efforts to reach minority practitioners and address minority concerns are also demonstrated in course offerings and workshop participant recruitment. The ETC sponsored a train-the-trainer two-day program for first and second year medical students to improve communication skills and overcome cultural barriers when talking to adolescents on the lower East side of NYC, a large Hispanic neighborhood. Participants for the Train-the-Trainer Institute were selected from the Hispanic Counseling Center, Covenant House, Gouverneur Hospital and other agencies and institutions from high incidence and minority areas. During the second year of the project approximately 22 percent of the workshop participants were Black, approximately 4 percent were Hispanic and approximately 10 percent were Asian. In course offerings in the Virgin Islands the audience was 75 percent Black, 11 percent White and 4 percent Hispanic. In Puerto Rico, of course, the participants are mostly Puerto Rican.

D. Center of Excellence

The NYU ETC formally proposed a Center of Excellence for HIV and Substance Abuse to be developed in the third year of the grant. Although HRSA has determined not to pursue the Center of Excellence concept, the ETC management staff will continue to focus efforts on this serious problem for the NYU ETC region.

B. Training Issues and Successes

The NYU ETC has established a credible and visible program through the implementation of an academically designed curriculum that is discipline specific; a training institute that has created trainers throughout the region; a series of videotape productions that will be mailed extensively throughout the region; and an AIDS Warmline for the support and peer counseling of health care workers. These strategies are effective in establishing a regional AIDS education center in a constantly changing region. There is a strong management team which draws on the strength of the NIMH training project and actively develops and markets the ETC programs in the broad AIDS caring network.

Through subcontracts with the University of Puerto Rico Medical Sciences Campus, the New York State Nurses Association, and the New Jersey State Nurses Association the AIDS ETC is able to reach a large number of health professionals and create a larger pool of experienced trainers to implement the educational interventions of the ETC. The relationship of these subcontractors with the NYU ETC has been positive. The modules and evaluation instruments are shared with each organization, including Spanish translations, and some trainers are prepared at the Train the Trainer Institute at NYU. This process allows for program continuity. The one difficulty identified by the PRAEC program staff was in the hiring of a part time health educator due to low salary. This problem has been resolved and the position has now been filled.

The dedication of the Education Programs Committee composed of NYU faculty clearly exceeds their initial commitment. Using academic faculty in curriculum development is a shift from the NIMH model for curriculum development which used a program development committee composed of clinicians to provide input to the staff. The ETC management team believes that the increased academic involvement significantly lengthened the development process, particularly with respect to videotape production, but also significantly enhanced the quality of curricula and training material products.

The ETC staff also felt that the EPC members involved in the development and implementation of the Train-the-Trainer Institute were directly responsible for much of its success. In particular, the staff recognized Dr. Griffin for innovative training techniques and exercises for training of trainers. An interest in documenting this in a train-the-trainer module was expressed, but available time for this was limited. At the time of the site visit, the possibility of taping this aspect of the Institute for future documentation was a suggestion under consideration.

The ETC staff are much more pleased with the strategy to use videotapes to reach physicians and dentists as opposed to the interactive teleconferences. Although these tapes will be widely distributed, there is some concern that the tapes alone will not be a useful training mechanism. The staff considered developing a companion guide, but felt that this was not flexible enough. The staff now hopes to be able to offer a discussion leader to large groups, such as medical associations, that plan a showing of the videos and to train volunteers to be discussion leaders for smaller group viewings. However, specific plans have not been formulated.

V. Program Administration

A. Systems for Managing Training Programs

1. Marketing

The ETC staff feel that it has taken the first few years of the program before word really got out about the ETC and its goals and activities. They are now confident, based on the number of requests for on-site training programs and applications for the Train-the-Trainer Institute, that the program has become fairly visible in the community. To formally market the ETC's programs offered on-site to institutions in the New York area, a media packet was sent to each hospital and health professional school. Call backs were made to the major magnet hospitals caring for AIDS patients. Bulk mailings are done on flyers for the open workshop series held at NYU, one of the programs most visible activities.

The ETC does not keep an extensive mailing list in house, because it is not cost effective. Instead the Program Administrator has developed a "decision makers" list for direct mailings of ETC offerings and activities and incorporates ETC information into the larger mailings of other groups, such as professional associations. The ETC recently put all STD clinics, drug rehabilitation centers and community health centers on their mailing list to improve marketing to providers to high risk and minority groups. The ETC staff had originally intended to segment the market more than they have for targeting programs, but found that it has been effective to follow the in-roads and contacts that the program already has through staff, EPC members and other ETC associated people and programs.

2. Trainee Recruitment/Selection

Rather than recruiting or selecting trainees, the ETC often responds to calls to do programs on site for institution/agency staff. The only prerequisite in this instance is that the requesting organization must be able to assemble a minimum number of people, about 35 or 40, before the ETC considers it cost effective to conduct a program. The Program Administrator does an informal assessment to determine the perceived training needs of the audience and their previous AIDS training experiences. The Program Administrator also actively "recruits" institutions and agencies that serve high incidence/high risk communities.

The NYU ETC does selectively accept applicants for its summer Train-the Trainer Institutes. Applicants must be health care professionals and are almost always responsible for inservice training in their home institution. Applicants must supply the ETC with a letter of intent and a letter of support from their supervisor indicating that the applicant will train at least 50 individuals at the home institution. The ETC Program Administrator does some recruiting of train-the-trainer candidates from organizations serving high incidence populations. The subcontractors also refer individuals from their areas, including Puerto Rico and the Virgin Islands. Overall, recruitment efforts are limited since the number of applicants has been about double the 40 person Institute limit in the first two years.

3. Output/Outcome Reports

The NYU Center for Continuing Education in Nursing contributed a personal computer to the project which is used for the project data base and evaluation data. For each training event, data are maintained on number of trainees by profession and race, number of contact hours, training satisfaction and pre/post attitude responses. The Program Administrator also reviews participant comments on the evaluation forms and provides feedback to the trainers.

Participants in the first Train-the-Trainer Institute were required to provide the ETC with formal documentation of having trained at least 50 health care professionals before they receive ETC certification. Participants in subsequent Train-the-Trainer Institutes are also requested to provide evaluation results, as well as documentation. There are reports on Warmline activity every six months which break down calls by question, profession worksite, and geographic categories. The State/Site Coordinators submit quarterly reports to the Project Director. on program activity.

4. Subcontractors

The site coordinators of the Puerto Rico AIDS Education Center and the State Nurses Associations of New York and New Jersey are responsible for planning and marketing their own training events. These coordinators also apply for continuing education credit, select the training sites, develop and mail promotional brochures and coordinate registration at the workshops.

B. Training Facilities

Many trainings are held on site at the institution co-sponsoring or requesting training. The NYU AIDS ETC has access to the facilities of the NYU including auditoriums, classrooms, libraries and the Loeb Student Center where most of the open workshops are held. The New York Medical Center also has three teaching centers in close proximity: Bellevue Hospital, University Hospital and Veterans Administration Medical Center. The administrative offices of the AIDS ETC are located with the NYU AIDS Mental Health Project which are located at the Center for Continuing Education in Nursing.

C. Cos t-sharing

NYU has provided office space, training facilities and housing for the summer Institute to the ETC. It can also be assumed that sharing of space, programs and materials with the NYU AIDS Mental Health Project also results in overall cost savings.

There is a minimum fee structure for current course offerings. The ETC requests $75 from Train-the-Trainer participants to defray the cost of meals and for a training manual and materials provided for use at the home institution. The open workshop series held on the NYU campus are

subsidized by a $40 charge per participant. Group and student rates are also offered.

The ETC has pursued other grants and funding sources, including concept papers presented to the New York AIDS Institute and to NYC Health and Hospitals, as well as applications to the NIMH and CDC, but these efforts have not yet yielded additional funding. As mentioned previously, the ETC has received supplemental funding from HRSA to address substance abuse and HIV, and to sponsor programs targeting Community and Migrant Health Centers in Puerto Rico.

D. CEU's

In general, the ETC has not gotten prior approval for Continuing Education Credit for all disciplines. CEU's have been provided for nurses and recreational therapists since the first year of the project and for dentists since the second year of the project. The physicians who view the videotapes and complete the evaluation will receive CME's. The ETC is also working towards being able to offer CME's on a regular basis in the future. The ETC staff noted that obtaining prior approval is a difficult process and is made-more problematic by the constant revision of the ETC's curriculum. The ETC does provide each trainee with a letter of attendance so that they may pursue CEU's in their discipline. In many instances, co-sponsoring of trainings by the ETC in the second year of project has also obviated the problem.

B. Information Services

AIDS Warmline. The seventh program component of the NYU AIDS ETC is an AIDS Warmline to provide AIDS information, referral and consultative support to health care professionals in the region. The AIDS Warmline is staffed by graduate assistants who use the Sex Information and Education Council of the U.S. based within SEHNAP and other local hotlines as a resource, as well as Dr. Fred Valentine of the NYU AIDS Treatment Evaluation Unit. All calls are answered within twenty four hours. The majority of the calls are primarily from health educators and nurses and also social workers, physicians and counselors. The callers are generally seeking information on AIDS research, educational inquiries, counseling and legal issues. Additionally, the ETC has developed a professional peer counseling network of over 40 health care professionals who have volunteered to participate as peer counselors. These counselors are from the geographic target area and from various health professions.

The ETC's Warmline has not been used as extensively as the staff had anticipated, although activity had increased somewhat by the middle of the program's second year. This component of the program had not been identified by the staff as an initial priority area for development and it was thought that the Warmline would benefit from a more explicit definition of purpose and function and increased marketing based on such definition.

VI. ETC Future Plans

The New York-Caribe ETC will continue to provide trainings following their seven component format and will continue to update and modify their training curricula through the efforts of the Educational Programs Committee. The staff would like to document the participatory exercises currently used for training of trainers and develop others. The ETC staff are also planning to develop an advanced training module on long term care issues.

In order to follow up on the first level of information dissemination to the medical and dental community through videotapes, the ETC staff hope to involve physicians and dentists more directly in the educational processes of the ETC. As mentioned, the ETC hopes to provide discussion facilitators in companion with video viewings. The ETC's medical and dental directors also plan to increase the number of workshops or clinical update conferences targeting physicians and dentists in the future.

Finally, the staff would like to enhance their evaluation mechanisms for measuring program outcomes. The ETC had originally hoped to assess behavioral changes, but this has proven difficult in practice. There may be the possibility of having a graduate student to do telephone follow-up of trainees or agency directors to assess behavioral/practice outcomes in the future. The ETC would also like to evaluate the effectiveness of training provided by Train the Trainer participants and to follow-up on the effects of the Faculty Institute on changes in health professional school curricula.

VII. Summary

Building on the foundation of the NYU AIDS Mental Health Project, the NYU AIDS ETC has established a credible and viable regional program through collaboration with existing AIDS networks and an active Education Program Committee who create and consult on curriculum for the various health professions. Despite a constantly changing geographic region, the management team has been able to provide education to health professionals in high incidence areas and address cultural and minority issues through use of a defined pool of experienced trainers and by targeting workshop participants from high incidence areas that serve minorities.

Although some of the actual ETC training throughout its region is subcontracted, the ETC maintains program continuity by a uniform, centralized process of curriculum and materials development and evaluation. As with other ETC's, the ETC faces challenges in effectively reaching physicians and in improving outcome evaluation of their activities.

The structured and participatory process for curriculum development by the ETC is clearly a strength of the project. The positive energy of both the ETC staff and EPC members experienced during the site visit is also notable.

WAMI AIDS Education and Training Center

Case Study

CASE STUDY

WAMI AIDS EDUCATION AND TRAINING CENTER

I. Program Overview

The WAMI AIDS Education and Training Center is developing and implementing a regional program for training primary care practitioners, allied health care personnel, and health professional students in the states of Washington, Alaska, Montana, Idaho (WAMI) and Oregon. The sheer size of this region and the resultant physical and professional isolation experienced by many primary health care, providers in the region are situations that the WAMI AIDS ETC is attempting to address through their program. The program components include a train-the-trainer program, a series of clinical updates held around the region, integration of AIDS curricula in health professional schools, and other special courses and activities according to training needs identified in the region. Trainees are to include faculty of health professions schools; primary care practitioners including health aides in the Alaska bush and individuals serving Native American populations; allied health personnel such as medical technicians and dental hygienists; adolescent and substance abuse counselors; and students of the various health professions.

A. Cooperating Groups and Agencies

The program is being integrated into the extensive WAMI Medical Education and WAMI AHEC network with AIDS ETC coordinators being placed with the AHEC headquarters in five locations throughout the region. In Oregon, the ETC efforts are being independently coordinated by the Oregon Health Sciences University.

The program uses existing resources and facilities of six AIDS related programs in Seattle-King County. In particular, the program has direct connections with the regional STD Training Program based in Seattle and the NIMH AIDS Training project operated by the University of Washington Schools of Social Work and Nursing. In the near future, these training programs will be physically located with AIDS and STD clinical and research programs in one facility. The facility, which may be the first of its kind, will be called the University of Washington School of Medicine Center for AIDS and **STD's.**

B. Program Goals and Objectives

The program's major goals are both outcome and impact oriented and are stated as follows: 1) increase the number of primary care practitioners in the Northwest and Alaska who are willing and able to diagnose, manage and refer HIV infections and related conditions; 2) develop and support capabilities in "resource cities" (smaller, but important medical communities in the region besides Seattle and Portland) by training multidisciplinary teams of health care personnel to diagnose, manage and counsel AIDS patients and their support systems and to serve as the local area source of consultation and training to health personnel in outlying communities; and, 3) institute AIDS curricula for medical, dental,physician assistant and nursing students and medical residents at the University of Washington and Oregon Health Sciences University, **and for** students in nursing schools, schools of

social work, clinical psychology, naturopathy and chiropractics around the region.

The specific objectives for achieving these goals establish organizational and programmatic targets. These objectives, adapted from the original proposal, are shown below. The full descriptions are attached as Appendix I.

1. Develop a regional AIDS Education and Training Center Program conducted through the WAMI Area Health Education Center Program and co-located with other AIDS prevention and management programs to promote cooperation, collaboration and creativity.

2. Develop the capabilities of "resource cities", which are strategically located cities in Washington, Alaska, Montana, Idaho and Oregon, for the multidisciplinary care and management of HIV/AIDS by training a nucleus of health professionals from each targeted community in AIDS diagnosis, therapy, care, management, resource recognition, and teaching techniques.

3. Provide support in each "resource city" to provide training to their geographically related health care communities.

4. Establish component state-wide AIDS education advisory committee and maintain collaboration with other programs that participate in AIDS control and educational efforts in Seattle-King County and across the WAMI states and Oregon.

5. Develop educational techniques and materials as needed, including developing materials for an AIDS-specific train-the-trainer program and working with other HRSA AIDS ETC's to identify and share existing resource materials.

6. Work with health professional schools in the region, and University of Washington health professional schools in particular, to integrate an AIDS curriculum into course work.

7. Evaluate the impact of the program.

Following on these overall objectives established at the beginning of the program, the ETC staff developed seventeen related and specific objectives for the second year of the grant to focus on identified strengths of the project and to concentrate on areas of need or improvement. These are also contained in Appendix I.

With respect to the second objective, the original proposal projected the establishment of 20 "Centers of Competence". However, implementation of this concept was delayed, except in Oregon, by high training demands placed on the ETC in Washington state and by organizational development issues. During the third year of the project, the ETC began proceeding with the development of a modified version of the Centers of Competence idea -- now termed "resource cities". Eleven communities throughout the

region which are expected to see between 5 and 50 persons with HIV/AIDS in the next few years were identified and reviewed for their readiness to provide a continuum of HIV care. The ETC intends to focus its training efforts toward supporting the development of local service 'delivery systems in these communities along a "continuum of **care"** model.

II. Program History

A. Origin and Developmental Milestones

1. WAMI States

The initial conception of the WAMI AIDS ETC recognized that a number of resources for AIDS education programs and AIDS care services already existed in the Seattle-King County area. Many of these were associated with the University of Washington and the Seattle-King County Department of Public Health. Further, the Seattle STD Training Program funded by the Centers for Disease Control, was already serving the region, but its dedication to AIDS education was limited due to its mission to provide training in all **STD's.**

It was also recognized that numerous continuing medical education programs and journal articles related to AIDS were already available, but that this did not necessarily translate into changes in provider attitude and practice. It was thought that community-based, practical, convenient and informal training programs, delivered by influential local physicians and/or providers would provide the best mechanism for a truly effective education and training program.

Therefore, it was felt that a dedicated AIDS Education and Training Center, affiliated with the University of Washington's regionalized medical education program in Washington, Alaska, Montana and Idaho (WAMI) and with the WAMI Area Health Education Centers (AHEC) would provide the most appropriate structure for the program. This would provide the basis for the "centers of competence/resource cities" concept and would be the best vehicle to make accessible Seattle's STD and AIDS resources to regional primary care practitioners and allied health professionals for training and consultation in their own communities.

The program was placed under the Associate Dean for Regional Affairs who is also the regional director of the AHEC program. In consideration of the expansive region to be covered, the correspondingly high travel costs, and the size of the initial grant (about **$400K),** the decision was made to keep the core project staff small, supplemented by training faculty on a consulting basis from throughout the region as required. A conscious decision was also made to hire most of the staff from outside the University to bring in new and fresh expertise.

The original plan for achieving regional program development and outreach was to place AIDS health education coordinators in each of the four AHEC sites outside of Seattle (Spokane, Bozeman, Boise and Fairbanks).

This was delayed into the second year, because the relatively new AHEC sites were not prepared to quickly assimilate ETC initiatives. By the middle of the second year, half-time coordinators had been placed in each of the AHEC sites in the hopes that this would help the ETC to more effectively move its program out into the region.

The existing infrastructure of the STD program was of assistance in establishing the ETC regionally. However, the public health system focus of the STD training program is a different network than the AHEC's were apparently accustomed; also contributing to the slower than anticipated assimilation of the AHEC structure into the ETC.

By the third year of the UAMI ETC program, the AHEC's had still not been satisfactorily involved in the ETC effort and effective regionalization of ETC activities and programs continued to be problematic. During this year, a new Director joined the ETC bringing a renewed commitment to decentralizing large parts of the ETC program. Initially, dropping the AHEC's out of the ETC structure was considered, because of their disappointing level of involvement. Instead, the central ETC site decided to develop explicit scopes of work for each of the AHECs following directly on the findings of the third year needs assessments of the eleven resource cities. The AHEC's in Alaska, Montana and Idaho have now developed and begun acting on individualized plans for impacting the HIV care system locally through training and support. The central site has also been reorganized into two program components - Regional Activities and Centralized Activities - to more clearly emphasize the different functions through this structure.

Another major external influence that affected the regional development of the ETC was the passage of "Omnibus AIDS Legislation" by the Washington Legislature in early 1988. One provision of this legislation established requirements for AIDS education for a wide range of health professionals as a condition of licensure. The practical effects of this legislation were twofold. The first was generation of tremendous and immediate demand for AIDS training in the state. The second was the entry into the AIDS training 'market' of numerous and variously qualified groups competing to offer training. The net effect for the ETC was that much of their energy and resources were directed towards quickly establishing a training program in Washington and responding to many requests for training around Seattle and the rest of the state. Meanwhile, this further contributed to a slowing of the program's regionalization in Alaska, Montana and Idaho.

2. Oregon

An exception to the relatively slow pace of regionalization encountered by the UAMI ETC has been the independent development of the site based at the Oregon Health Sciences University. In Oregon, the ETC program was filling a significant gap in that little AIDS training for health professionals beyond "AIDS 101" was occurring prior to the infusion of HRSA funds. The program's development was further facilitated by an informal partnership with the Oregon Health Division and its network of

health departments. The partnership has the Health Division concentrating primarily on public education and the ETC on professional education.

The relatively low AIDS prevalence in Oregon and the associated fact that the number of players in the AIDS field was small presented both opportunities and challenges to the ETC development. The opportunities arose from the fact that the key individuals of the Oregon ETC site were already or quickly became highly visible as the state's AIDS experts. They are each highly involved in AIDS-related committees and community based organizations, further facilitating cooperation and non-duplication of activities within the AIDS training and service network. Through their intense efforts, they were able to channel this opportunity into extensive training and clinical program activity. Conversely, the fact that there were so few resources in the state led to great demand on the energy and resources of the staff and reinforced the need to implement the original ETC strategy of developing locally based expertise.

B. Institutional Background

1. University of Washington, School of Medicine

The School of Medicine is a component of the University of Washington's Health Sciences Center in Seattle, which comprises the Schools of Dentistry, Medicine, Nursing, Pharmacy, Public Health and Community Medicine, and Social Work. The combined faculties teach 3,000 undergraduate and graduate students enrolled in the six schools. An additional 650 resident physicians are completing their postgraduate training at the University.

The University of Washington is internationally recognized for expertise in research and training in the field of sexually transmitted disease. As the only medical school in the region, the institution has traditionally provided education and service in the states of Alaska, Montana, and Idaho. The programs described next are examples of this tradition.

a. WAMI Program of Regionalized Medical Education

The WAMI Program began in 1971 with funding from the Commonwealth Foundation and later by the federal Bureau of Health Manpower. Through this program, up to 60 medical students from Washington, Montana and Idaho take their first year at Washington State University (Pullman), Montana State University (Bozeman) and the University of Idaho (Moscow). As many as 15 start their medical education at the University of Alaska, Fairbanks.

In their third and fourth years, all of the school's students may take six-week clerkships in disciplines required for graduation and elective clerkships with physicians in 16 communities throughout the four states. Twenty-one percent of the school's clinical training takes place away from Seattle. The majority of this training is provided by clinical faculty members who are office-based private practitioners.

b. WAMI Area Health Education Centers

In 1985, the School of Medicine received a three-year grant from the Public Health Service to establish a network of five area health education centers in the WAMI states. The grant, conducted in cooperation with the other schools of the Health Sciences Center, addresses the continuing problems of a shortage of primary care personnel and a maldistribution of health providers in the region. The multidisciplinary program focuses on rural parts of the region, building upon the network of clinical training established in the WAMI Program.

The centers are being established sequentially. The Montana AHEC, affiliated with Montana State University, has its headquarters in Bozeman and serves the entire state. The Eastern Washington AHEC in Spokane is affiliated with Washington State University and serves the area of Washington east of the Cascade Mountains. The Idaho AHEC, which just started up in 1988, is based in Boise and will cover all of Idaho. Also recently initiated are an AHEC based in Seattle to serve Western Washington and Southeast Alaska and another with headquarters in Fairbanks to serve rural Alaska. The latter emphasizes working with Alaska Bush hospital staffs and their health providers who are Alaska Natives working as community health aides or as MEDEX practitioners. Each of the AHEC sites are free-standing, non-profit organizations with local boards and associated with a University.

2. Oregon Health Sciences University

The WAMI ETC has subcontracted with the Oregon Health Sciences University, Division of Infectious Diseases to develop and implement ETC programs in that state. The University includes schools for Medicine, Dentistry and Nursing. Within the medical school, the Division of Infectious Diseases runs a comprehensive AIDS outpatient clinic, support group and case management program from the university hospital. The clinic follows many of the AIDS patients in the Portland area and from around the state. The Division also provides consultative back-up to AIDS care providers around the state and sponsors a six-week rotation on the ID service for medical residents focusing on the inpatient and outpatient management of HIV infection.

3. Collaborating Agencies

Primary collaborating organizations for the AIDS ETC include the School of Medicine's Seattle STD Training Program (CDC), the Seattle-King County Health Department's AIDS and Demonstration Prevention Project (CDC), the University of Washington School of Social Work's AIDS Project (NIMH), the School of Medicine's AIDS Treatment and Evaluation Unit (NIH), the Seattle-King County's AIDS Clinic (Robert Wood Johnson Foundation and Harborview Medical Center), and each of the WAMI states' Health Education/Risk Reduction Programs (CDC).

The activities of each of these programs and their relationship to the ETC is described in more detail in the next section.

III. Program Structure

A. Geographic Target Area

The five states of Washington, Alaska, Montana, Idaho and Oregon covered by the WAMI-0 AIDS ETC encompass 28 percent of the total area of the United States. This predominantly rural region is noted for its rugged terrain and diverse geographical characteristics.

Approximately 50 percent of the region's 9.25 million residents live in metropolitan areas surrounding Seattle and the Puget Sound, Spokane in Eastern Washington, Anchorage in Alaska, Boise in Idaho, Billings in Montana, and Portland in Oregon. The other half are sparsely distributed throughout the region. Hispanics and Native Americans, the two largest ethnic minority groups, each form about 3 percent of the population in the region. Urban areas have also attracted a large number of recent immigrants from Asian countries.

The occurrence of AIDS cases in the Northwest and Alaska has paralleled that in the United States as a whole; both in that most AIDS cases are concentrated in urban areas and among specific population groups. About 75 percent of the region's more than 2,000 cumulative AIDS cases by 1989 had been reported from the Seattle or Portland metropolitan areas. As in the remainder of the country, the most rapid rate of increase is now occurring in smaller cities and in rural areas.

B. Collaborating Programs

The AIDS Education and Training Center Program is administered by the University of Washington School of Medicine's regional program (WAMI) and its component Area Health Education Centers Program (AHEC). Through this arrangement, the AIDS ETC has access to the region's medical students, physicians-in-training and medical professionals. The AIDS ETC is also allied with the University of Washington School of Medicine's Division of Continuing Medical Education, Primary collaborating organizations for the AIDS ETC are described individually starting on the next page.

1. Seattle STD Training Program and Clinic

Seattle's STD Prevention Training Program is one of 10 regional centers funded by the Centers for Disease Control to teach and update skills needed to diagnose, treat, and prevent sexually transmitted diseases. This program has been developed and administered cooperatively by the School of Medicine and the Seattle-King County Public Health Department. The STD Program is located at Harborview Medical Center, a county facility and the medical school's largest teaching hospital.

The staff and faculty of the Seattle STD Training Program consult and share resources with the School of Social Work's NIMH-funded AIDS Project and the health department's AIDS Prevention and Demonstration Project. Through its nine years of operation, the program has established a regional

as well as national reputation, The program annually reaches 400-500 medical and allied health professionals through its system of eight core courses, medical school curriculum and clinical updates.

Since the beginning of the AIDS epidemic, the Seattle program has expanded its curriculum so that one-fifth of its didactic material is for AIDS professional education, but is limited by its obligation to the teaching of the other major sexually transmitted syndromes. Thus, the program is offering its experience and resources in collaboration with the AIDS ETC in order to extend the AIDS training efforts and capabilities in the region.

2. AIDS Prevention and Demonstration Project (APP)

The AIDS Prevention Project is funded by the Centers for Disease Control and administered by the Seattle-King County Department of Public Health. The primary mission of this project is to test five AIDS control strategies, including education, one-to-one counseling with antibody testing, extended counselling and contact tracing. The project's primary service area is Seattle-King County. The program has been in operation since 1985.

The AIDS ETC is working closely with the staff of the AIDS Prevention Project (APP). Ann Downer, MPH, who is now the Director of the ETC, was previously the Director of Education for the APP. In that capacity, she consulted on curriculum development and training to the AIDS ETC. She contributed her train-the-trainer curriculum to be refined and utilized by the AIDS ETC. This curriculum has also been made available to the other HRSA ETC's throughout the country.

A close working relationship with the APP also provides access to its medical and epidemiological expertise, and its medical database. The AIDS ETC has benefited the APP by providing access to collaborative regional networks, and to faculty, staff and technical support.

3. National Institute of Mental Health (NIMH) AIDS Project

This AIDS Project is funded by the NIMH through the Schools of Social Work and Nursing, but staff are co-located with the ETC. Program planning and resources are closely intertwined between the two programs. The primary mission of this project is to develop and deliver training modules on the psychosocial aspects of AIDS for primary care practitioners and allied health care professionals. The project's service area was primarily Washington State, but this has recently been extended through the ETC sub-contracts with the WAMI state AHEC's.

Dr. Lewayne Gilchrest, principal investigator of the AIDS Project, was being funded partially by the AIDS ETC to develop and implement the evaluation component. Ms. Heather Andersen, coordinator of the NIMH AIDS project, is also one of two program coordinators and a trainer for the ETC.

In addition to supplying the internal evaluation structure, the AIDS ETC has access to NIMH psychosocial and neuropsychiatric modules for use in its curricula and has access to the use of the project's database on psychosocial aspects of AIDS.

4. AIDS Treatment Evaluation Unit (ATEU)

The AIDS Treatment Evaluation Unit is funded by the NIH to design and perform clinical studies regarding the treatment of AIDS. Seattle's ATEU is administered by the School of Medicine and located at Harborview Medical Center. In addition to the expertise of its staff and the strength of its clinical research, the Seattle ATEU is in frequent communication with primary care physicians in the community. As a collaborating entity of the AIDS ETC, the ATEU provides expert consultation and access to updates in the latest research.

5. AIDS Outpatient Clinic

The AIDS Outpatient Clinic is supported.through county, Harborview Medical Center and Robert Wood Johnson Foundation funds. The clinic operates five mornings a week and is currently located at Harborview Medical Center, adjacent to the STD clinic. Physicians who staff the AIDS clinic share the WAMI-sponsored MEDCON beeper for AIDS calls. The ETC had originally planned to offer clinical training to community based providers through this facility, but this has proven logistically difficult. However, the education and clinical programs will soon be joined together in the same facility enabling the staff of the AIDS clinic to provide clinical training for selected AIDS ETC participants.

6. State Health Education/Risk Reduction Programs (HE/RR)

The Health Education/Risk Reduction Programs of Washington, Alaska, Montana, Idaho and Oregon are components of their state departments of social and health services and most frequently an expansion of STD programs. The HE/RR programs are funded by the CDC.

The HE/RR programs are responsible for setting up and monitoring HIV testing and counseling sites throughout the state. Working closely with state AIDS epidemiologists, the HE/RR directors provide excellent access to epidemiological data. They also sponsor public and community education efforts, which provide access to community sponsors and interest groups. The AHEC AIDS coordinators and the Oregon site coordinator are or will be working closely with the state HE/RR directors to assure interchange of data and activities between state, university and community activities.

C. Accessibility of Training Sites

The ETC's main training facility is located at the ETC office in Seattle and many of the trainings to date have taken place there or on-campus. This has been an adequate arrangement to date, since the demand for training and, consequently, much of the ETC's activities have been centered in the metropolitan Seattle-Tacoma area.

The ETC staff acknowledge that the major problems confronting health professional education and health care of any kind in the Northwest and Alaska include geographic barriers to communication and health care delivery; geographic maldistribution of resources along with inadequate access to health care by underserved populations; lack of continuing education and other forms of support for primary care providers to underserved populations, and; cultural and social barriers within the various subgroups of Native Alaskans, American Indians and migrant workers throughout the region.

The WAMI AIDS ETC is attempting to meet these challenges in the area of AIDS training and education by building upon the WAMI Regionalized Medical Education Program and the WAMI Area Health Education Center Program. The AHEC AIDS coordinators are responsible for becoming acquainted with AIDS resources in.their area and for working with local health care agencies and professional organizations to use the resources of the ETC to effectively meet local needs. Many of the ETC trainings are co-sponsored and offered locally to improve recruitment of and ease of access for health professional trainees. Perhaps. the most significant effort of the WAMI AIDS ETC to make the program accessible to trainees throughout the region has been an emphasis on training of trainers. This component of the program has clearly been successful in inducing a multiplicative effect on information dissemination to health professionals. In the future, the concept of developing capabilities in the eleven resource cities that are focal points of the medical network throughout the region will also significantly improve accessibility of training and consultative support.

In Oregon, a majority of trainings are also in the major Metropolitan area, Portland, but trainings to date are proportionately more often taken out of Portland into local communities. This is partly by strategic design for fostering local capability and partly by the need to "piggy-back" on other training projects to stretch the available resources.

D. Staffing

1. Project Staff

The WAMI AIDS ETC has both a core staff based at the University of Washington School of Medicine and regional staff assigned to each of the WAMI statewide Area Health Education Centers. The positions and roles of the WAMI AIDS ETC staff are described below.

David W. Johnson, MD - Project Director. Dr. Johnson is director of the Area Health Education Center Program in the University of Washington School of Medicine and is deputy director of the University's Washington, Alaska, Montana, and Idaho (WAMI) Regional Programs. He is responsible for the overall leadership and management of the ETC and for the integration of the AIDS education and training efforts into the work programs of the five WAMI AHEC sites. Dr. Johnson has spent much of his ETC-related time on maintaining inter- and intra-University relationships and in developing the organizational infrastucture, including taking the lead in development of the Center for AIDS and STD's. He is also responsible for evaluating progress and monitoring expenditures and for serving as the contact person for the University of Oregon Health Sciences University.

Ann Downer, MPH - Deputy Project Director. Formerly the director of the AIDS Prevention Project, Ms. Downer has now joined the AIDS ETC full time to direct general operations. Her responsibilities include supervision of ETC staff, faculty and consultant recruitment and evaluation, planning and scheduling of multi-component and multidisciplinary programs, course organization and planning, curriculum development and training. She was preceded in this position by Ms. Susan Kaetz.

Lynn Chapman, M.Ed. - Program Coordinator. Ms. Chapman is responsible for coordinating the central activities of the ETC and participates in many of the ETC trainings, including having primary responsibility for all aspects of the Train-the-Trainer component of the ETC program. In this capacity, she has taken the lead on train-the-trainer curriculum development and implementation, trainee selection, evaluation, and follow-up . She also serves in the role as AHEC AIDS Coordinator for the Western Washington area. Ms. Chapman is full-time on the project.

Heather Andersen, RN, MN - Program Coordinator. Ms. Andersen is responsible for coordinating the regional activities of the ETC. She is responsible for ETC training programs in Eastern Washington, Alaska, Idaho and Montana, including facilitating activities of the central site and its AHEC satellites intended to develop and support the resource cities. Ms. Andersen is also the coordinator of the NIMH funded AIDS training project. She is the lead person in the ETC structure for developing and conducting trainings on the psychosocial issues of AIDS.

Lucia Mejier - Training Specialist. Ms. Mejier is a full-time trainer on the project focusing on IVDU issues. Ms. Mejier has developed an innovative and comprehensive curriculum on IVDU counseling and risk-reduction. A highly skilled trainer, Ms. Mejier currently works full-time for the ETC project.

Bernadette LaLonde, PhD - Program Evaluator. Dr. LaLonde is responsible for developing course evaluation methods and for the design, conduct and reporting of evaluation efforts. Dr. LaLonde is a research assistant in the University of Washington Schools of Social Work and Nursing. She is currently assisting the ETC program to develop an evaluation plan for assessing program impact in the "resource cities".

Dr. LaLonde works closely with Dr. Lewayne Gilchrest, the principal investigator on the NIMH AIDS training project. Dr. LaLonde replaces Dr. Lynn Mandel as the Program Evaluator.

The central ETC staff also includes two full-time administrative assistants. The first was hired at the beginning of the project and the second was hired in the middle of the first year.

AHEC/AIDS Coordinators. Each of the four AHEC sites outside of Seattle have been funded by the central ETC site to hire part-time AIDS coordinators. In the first year of the grant, the AHEC sites were not prepared to assimilate ETC related activities and much of this funding was returned. Half-time AIDS health education coordinators were hired in the second year for the Eastern Washington, Idaho and Alaska AHEC's.

In the third year, the increased emphasis on decentralization brought by the new ETC project director resulted in a substantial change in the roles of the AHECs, particularly in Alaska and Idaho. In Idaho, there are now three half-time coordinators; one for each "resource city" in the state. Their role will be to facilitate and encourage development of an HIV caregiving network. In Alaska, the AHEC has further subcontracted with the local community based AIDS organizations to be the agent for the ETC's efforts to develop local capability. Each of the AHEC coordinators report to the AIDS ETC program director for functional direction and work with the AHEC directors to establish a special AIDS Education Advisory Committee in each state or "resource city" and help to develop AIDS interest groups in their states.

2. Subcontractor Staff

Mark Loveless, M.D. - Site Director. Dr. Loveless is an Assistant Professor of Medicine at the Oregon Health Sciences University in the Division of Infectious Diseases. Dr. Loveless is directly involved in all aspects of the ETC program at the Oregon site including participating in trainings for health professional practitioners and students, responding to "Physician's AIDS Hotline" questions and consultative requests, and supervision of the clinical residency. He is acknowledged as one of, if not the leading AIDS expert in the state.

James Simons, R.N.C. - Program Administrator. Mr. Simons is Instructor of AIDS Education in the Division of Infectious Diseases at OHSU and is funded full-time by the ETC to be the Oregon site administrator. Mr. Simons has primary responsibility for all program planning, curriculum development, materials development, training implementation and evaluation. He is the primary contact for inter-site communications and reporting. Mr. Simons also supervises the AIDS outpatient clinic and teaches in the OHSU Schools of-Medicine and Nursing, as well as at the Portland State School of Social Work.

3. Consultants

Whenever possible, the WAMI AIDS ETC brings in expert consultant trainers to assist with curriculum development and training in specific areas. A recent example is the use of Ms. Jane Crigler, "Health Care Services Consultant," to conduct the needs assessment or "evaluation of readiness" of eleven cities around the region.

4. Changes from Proposed Staff

A Nurse Practitioner, responsible for development of curriculum and training for nurses, nurse practitioners, and MEDEX personnel, was to be added to the ETC staff. The nurse practitioner was also to participate in AIDS out-patient clinical care in Seattle. Similarly, a Social Worker was to be hired to act as a case manager to help reduce the demands placed on clinic staff by rotating ETC trainees, and to serve as a trainer in case management and other social services to AIDS patients. However, these positions have not been filled yet as the clinical component at the central site of the WAMI ETC will not be in place until the Center for AIDS and **STD's** is completed.

E. Integration with Other Programs

The description of the collaborating agencies in this project demonstrates that there are significant areas of integration between the WAMI ETC and the other AIDS programs in the Seattle area and with the AHEC program. Another concrete example of integration is the sharing of office and training space.

A shortage of space at the University Medical School necessitated that office space for the central training site be rented off-campus. As in many academic settings, priority is given to programs with research grants that contribute higher ratios of indirect costs to the University. For the first six months of the **ETC's** existence, the office space was located in the basement of a building on-campus. In seeking more appropriate space, the ETC made a concerted effort to co-locate the office with other AIDS training programs to facilitate both coordination of the programs and cost-effectiveness. This was seen as an important and unique opportunity for the different projects to share resources and work together toward common goals.

At the time of the site visit, the ETC was co-located with the NIMH AIDS Training Project and the STD Training Program on one floor of a building near the campus'. The rent for this space comes entirely out of ETC funds and, in return, the ETC is able to make NIMH and STD program training resources and materials available beyond the Seattle-King County area.

Soon the ETC will become even more integrated with other AIDS related programs when the Center for AIDS and **STD's** is formed. The Center will combine in one building a center for AIDS research, an AIDS clinic, a viral

disease clinic, an STD clinic and all of the NIMH, CDC and HRSA funded AIDS and STD training programs. The Center will be placed under the office of the Chairman of the UW Department of Medicine and will have linkages to both the University Hospital and to the Harborview Medical Center (county funded) and Department of Public Health.

The initiative for this Center came from the ETC effort to counter the physical space problem and separation from the University, but enlisting the interest and support of enough collaborating programs was required before the University would act on the idea. This process has taken almost three years. The Center will allow incorporation of a clinical component in the ETC program that was not previously feasible. It is also expected that the Center concept will help to attract more physicians to ETC offerings and to promote greater involvement of UW faculty in ETC programs.

F. Organizational Qualities

Clearly, major assets of the WAMI AIDS ETC are the project staff in both Seattle and Portland. Although it is not unusual to find similarly energetic and dedicated individuals working in the AIDS field, the WAMI-0 staff is further distinguished by a complementary and synergistic combination of individuals. An extension of this complementarity, and an additional strength of the program, is the extensive integration and cooperation of AIDS-related programs in the Seattle area which will surely be enhanced by the new Center for AIDS and STD's.

A potential strength of the program that has yet to be realized is use of the WAMI and AHEC networks to address the problems of bringing trainings to such a vast region. For a number of reasons already outlined, this aspect of the program has lagged behind. Important adjustments for the future will be the central ETC site's intent to be more specific on expected AHEC tasks and 'deliverables'; and the central sites restructuring into central and regional components. The new project director, Ms. Downer, clearly has a strong commitment to developing an effective regional program that will direct the resources of the ETC as closely as possible to local communities that are in need. Another challenge may be for the WAMI AIDS ETC to maintain an identity distinct from the Center for AIDS and STD's; not to be dominated by the Seattle-King County medical community hierarchy that has the potential to restrict the ETC's capability for becoming a truly regional resource.

IV. Training Program

A. Needs Assessment Procedures

Some training needs assessments had already been conducted prior to the inception of the ETC. This includes a survey of 1,000 Washington State physicians carried out by the Seattle-King County Department of Public Health's AIDS Prevention Project and the Seattle Sexually Transmitted Disease Training Program in conjunction with the Washington State AIDS Program. The survey found that a majority of respondents were dissatisfied

with the relevancy and applicability to their own practices of the AIDS material presented by continuing medical education programs. A similar survey conducted in Oregon also found that "AIDS 101" was fairly well disseminated, but a need existed among physicians for more specific clinical information and opportunities to increase or become more comfortable with expertise in AIDS care.

Between January and May 1990, the ETC conducted an evaluation of the readiness of eleven cities (resource cities) in Alaska, Idaho, Montana and Eastern Washington to serve persons with AIDS. Meetings of professional and volunteer representatives of public and private service agencies were facilitated and held in the communities of Omak and Tri Cities in Washington; Billings, Great Falls and Missoula in Montana; Boise, Moscow and Pocatello in Idaho; Fairbanks, Anchorage, and Juneau in Alaska. With the assistance of a health services consultant, the meetings were designed to assess community service capabilities, current issues and corresponding training needs; and to establish local contacts for ongoing ETC work. The findings of the analysis are being used to target ETC training resources and activities for the next few years and to develop scopes of work for the AHEC subcontracts.

The ETC also coordinated with the state AIDS programs to perform statewide needs assessments specifically of primary care physicians. The Oregon State Health Division, in conjunction with the Oregon Medical Association have already completed this assessment. Alaska is conducting an assessment based on Oregon's model. Washington state physicians were being surveyed by the Department of Licensure at the time of the visit. In addition to each of these assessments, the ETC and the Department of Family Medicine at the University of Washington are co-funding a medical student research project to perform a needs assessment of primary care physicians in the Northwest region.

Curriculum needs assessments have been conducted or are in the process of being conducted for the University of Washington Medex Program (survey of the students), Schools of Social Work, Medicine, Nursing, and Public Health, as well as the region's 4-year nursing schools.

The WAMI ETC joined with the NIMH project to sponsor a series of "retreats" to get key informant input into the program planning process. On one retreat, trainers and other representatives of minority communities were invited to discuss mechanisms for coordinating program offerings with minority communities and for improving the cultural sensitivity of trainings. A second retreat sought input from area physicians on the needs of practitioners and strategies for increasing physician participation in trainings.

Finally, the Training Coordinator conducts a survey of individual needs of students for each train-the-trainer program several weeks prior to the course. The information gathered through a mailed survey is used to adapt the course and manual content as necessary to fit the overall needs of each group.

B. Training Strategies

To accomplish its overall goals and objectives, the AIDS ETC is developing, implementing and evaluating activities, including train-the-trainer programs, clinical updates, and curriculum for health professional students in the University. of Washington system, the Oregon Health Sciences University and other regional health professional schools. The ETC also develops materials that are needed to fill gaps, such as development of a series of instructional videotapes partly in response to the training demand created by the Omnibus AIDS Legislation.

The project is also starting toward development of a regional network of 11 resource cities in Washington, Alaska, Montana, Idaho and Oregon. Professionals in each community are being trained in AIDS through programs offered on-site in regional cities and in Seattle to selected groups. It is expected that the trainees are then available to provide further training locally and/or to serve as an important local resource for clinical care and consultation. To date, this strategy has been applied in an organized, targeted manner by the Oregon site only, although there are now clearly defined plans for the WAMI region as well.

The actual training program has been an evolving process drawing on staff strengths, lessons learned and somewhat shaped by external influences. The project is implementing four basic strategies and consequent training methods as outlined on the next page in order to achieve its goal of increasing the number of primary care practitioners in the region willing and able to care for people with HIV infection. A fifth strategy originally termed "AIDS Intensive Training" has not been implemented. The AIDS intensive programs were to be three days in length for a multi-disciplinary team and were to include a clinical practicum. However, the concept was essentially 'sabotaged' when health professionals throughout the state rushed to satisfy the training requirements of the Omnibus legislation. The ETC now has developed preliminary plans for offering a clinical training program as soon as the relocation to the Center for AIDS and STD's is complete.

1. Specific Training Strategies and Methods

AIDS Intensive + Instructor Training (Train-the-Trainer) Programs: Due to the geographic vastness of the region, it was determined that effective train-the-trainer programs are essential to a successful project outcome. The train-the-trainer programs are designed for health professionals who are already or are interested in becoming AIDS trainers.

The program was originally designed as a four day course with the fourth day focusing on teaching methods. Based on feedback and evaluation the course has been extended to five 8-hour days of instruction with health education concepts and AIDS-specific teaching techniques integrated throughout the week. Each participant receives an extensive resource manual with chapters included for epidemiology and infection control, psychosocial issues, sexuality, testing and counseling, patient management, drugs and HIV, special populations, and legal and ethical issues. In

addition, sections are included on training guidelines and training resources.

Upon completion of the course, participants were asked to teach at least one 3-hour session on AIDS to other health care providers. In the third year, the ETC began having trainees sign a 'contract' to train at least 12 hours per year and to include participant evaluations as part of their trainings. By the middle of third year of the program, the WAMI ETC had trained about 500 trainers around the region through its train-the-trainer activities. About 300 of these individuals are considered currently active trainers. The ETC staff feel that they may have sufficiently exhausted this strategy and intend to significantly decrease emphasis on training of more trainers in the future.

Clinical Updates: Clinical updates are made available to groups of providers throughout the five state area upon request and in cooperation with co-sponsoring organizations. These updates are delivered by a multidisciplinary team of experts in AIDS-related fields from the collaborating institutions and programs. Annual one to two-day clinical updates were also planned as reinforcement to graduates of the train-the-trainer program. However, budgetary constraints have not allowed implementation of this "institute" so far.

AIDS clinical updates are also delivered through the University of Washington's Division of Continuing Medical Education and through organized state and/or regional annual meetings of health professions associations. In 1988189, the Division of Continuing Medical Education was offering six courses for primary care physicians around the state of Washington. The ETC managed these trainings including planning the agenda, recruiting speakers, paying honoraria and marketing the program.

The curriculum of the updates is flexible to cover the unique training and logistical needs of each training site. Information covered includes medical aspects relating to epidemiology, means of transmission, infection control, sexual and substance use history taking, clinical manifestations, early signs and symptoms including for psychological/neuropsychiatric disorders, antibody testing and counseling, and primary patient care and management. The psychosocial aspects of AIDS are also covered including reactions to terminal illness and threat of death, patients' loss of social support, the process of stigmatization, homophobia and its effects on the care of patients and their families, legal and ethical issues, staff impact and burnout, and the special problems of racial and ethnic minority group members with AIDS or at high risk of AIDS.

Integration of Curriculum in Professional Education: In an effort to impact health profession education with respect to AIDS content, curricula has or is being developed for Oregon Health Sciences University, the School of Social Work at Portland State, and the University of Washington Schools of Medicine, Social Work, Nursing, Dentistry, Public Health and Community Medicine, and the MEDEX Program. Under a grant from the Association of Public Health Schools, the ETC staff, specifically Ann Downer, prepared

the curriculum for an AIDS concentration in the Extended MPH Degree program of the University of Washington.

The medical school AIDS curriculum will be established as an elective clerkship for third- and fourth-year students and residents, much as an elective in sexually transmitted diseases through the Seattle STD Training Program now stands. Medical Students and residents will also receive AIDS training during their clerkships and rotations at WAMI regional sites. The AIDS curriculum will be developed by the project's staff consultants and collaborating medical school faculty.

In collaboration with the NIMH project, specifically Dr. Gilchrest in the School of Social Work and Ms. Andersen in the School of Nursing, the ETC is providing technical assistance toward establishing cross-listed interdisciplinary AIDS courses in the curriculum of each school. In addition, the Nurse Practitioner Program of the Division of Community Health Care Systems has agreed to provide access through instructional courses to its students. This curriculum will be developed in liaison with project staff and collaborating faculty from the School of Nursing.

Special Courses and Activities: A faculty development course was offered to medical staff and faculty from the Oregon Health Sciences University, from the University of Washington, and major affiliated teaching hospitals around the region. The three day course, held in Portland, was intended as a vehicle to identify and train key individuals that would serve as the key experts and foundation for the 'center of competence' in their respective areas. AIDS experts from around the country were brought in as trainers and a curriculum developed for AMFAR was used. Although the course was successful and was originally planned as a periodic activity, the ETC staff is re-thinking the benefit of this activity relative to the cost of the course and difficulty of recruiting physicians to multi-day courses.

A major effort in 1988 was the production of a videotape series in conjunction with the Novela Health Foundation, the Department of Licensing, the Washington Community College System, and the State AIDS office. The state decided to disseminate a core program through the Community College system in response to the health professional licensing requirements established by the Omnibus Legislation. The Novela Health Foundation was contracted to produce the video training program and the ETC was in turn commissioned to provide technical assistance in design and development of the videos. Six videotapes were produced covering epidemiology and etiology, clinical manifestations, psychosocial aspects of care, testing and counseling, transmission and infection control, and legal and ethical issues. Each video is intended to be presented by a qualified facilitator and each segment includes facilitator's instructions with learning objectives, summary points and discussion questions.

A special curriculum was developed and a series of courses have been provided to substance abuse counselors in Washington for the state Bureau of Alcoholism and Substance Abuse. All substance abuse counselors in the state were to be trained with this curriculum by the summer of 1989,

following which the ETC was planning to extend the same training to counselors in each state of the region beginning with Oregon.

A modified version of training of trainers was also conducted focusing on substance abuse issues. Three day courses focusing on substance abuse have been held for institution based health professionals who are responsible for inservice education or are managers of clinical services. The course also includes segments on effecting organizational development and behavior with specific ideas for changing or improving intake procedures to be more attuned to substance abuse. Trainees were asked to both hold trainings in their home institutions and to implement appropriate systemic or procedural changes. Trainees are currently being followed-up by the ETC staff to assess factors contributing to organizational successes and barriers.

2. Curricula and Materials Developed/Used

In addition to curriculum development for the clinical updates and the health professional schools, the AIDS ETC works closely with the AIDS Prevention Project and NIMH-funded AIDS Project to develop training materials to facilitate and supplement each program's training efforts. Through collaboration with the AIDS Prevention Project, the AIDS ETC was able to utilize the train-the-trainer curriculum created by Ann Downer. The AIDS Teaching Skills Curriculum was also disseminated to each of the ETC's throughout the country. The curriculum includes sections on adult learning theory, creating a climate for learning, curriculum design and planning, choosing and using instructional methods, preparing and using visual aids, recognizing and responding to resistance, and training and facilitation skills.

As indicated above, each participant in the AIDS Intensive + Instructor Training receives an extensive AIDS resource manual with training guidelines, information, articles and a bibliography. In the future, the ETC Program Coordinator is considering changing the manual to provide the actual training modules and to incorporate more of the NIMH developed psychosocial training modules. The curriculum used for each instructor training course is adapted to meet the needs indicated by each group.

For the faculty development course held in Portland, the ETC used the curriculum developed for AMFAR by Dr. Harvey Makadon from Beth Israel Hospital in Boston and also brought Dr. Makadon out to lead the course. Although the course was beneficial, the ETC staff is confident that enough expertise exists within the region to accomplish similar efforts in the future.

The ETC's Training Specialist on substance abuse issues, Lucia Mejier, developed the curriculum for substance abuse and other counselors. The curriculum is comprised of 14 lesson plans, including innovative modules on "strategic risk intervention" and "risk intervention skills". Ms. Mejier is also working with the NIMW project to develop an instructor training

curriculum on "cultural relevancy" which focuses on the development of culturally sensitive/aware trainings.

In conjunction with the **Novela** Health Foundation, the ETC produced a video on the Care of a **Latino** Patient, based on the care of a real patient. Another video produced in conjunction with the **Novela** Health Foundation was on HIV Counseling: Avoiding The Pitfalls. Each of these products are to be used as part of a training program and include a facilitator's guide.

3. Target Trainees

The WAMI ETC had originally intended to target its programs in two phases. The first phase was to concentrate on faculty, other primary care providers, and students in the WAMI network and communities with relatively large populations at high risk. The second phase was to expand trainings to include communities with lower incidence of AIDS and was to target providers in allied health care settings. The AHEC coordinators were to assist the ETC in targeting communities and specific trainees. This plan was somewhat diverted by the Washington state legislation which led to the WAMI programs being more reactive than originally intended and was also delayed by the slow start up of the AHEC sites.

For the train-the-trainer courses, the ETC has been able to target health care providers and educators in health departments, community and migrant health centers and other health care facilities seeing people at risk for HIV infection. The program has also been targeting communities along the north/south Interstate 5 corridor where AIDS cases and high risk populations are concentrated. The program achieves institutional and geographic targeting through a trainee application and prioritizing process. The program coordinator maintains a map of the region displaying where past participants have come from and highlighting areas on which to concentrate future efforts. Capitalizing on the strength of their training specialist, the ETC has also targeted substance abuse and other counselors.

The ETC site in Oregon has targeted specific communities that are area medical centers and that have a person or persons that can be trained to serve as the area AIDS expert. These persons are either self or community identified through the site's needs assessment process. Trainings have been held in three such communities ('centers of competence') and two more have been targeted for future trainings.

4. Evaluation

An integral part of the program's first phase of development was to be the creation of a definition of competence for AIDS practitioners. Successful participants of the AIDS ETC train-the-trainer program were to have met these criteria and model these standards. The standards of practice/criteria for competence were also to be used in the establishment of the centers of competence.

This idea of developing standards of competence has, not surprisingly, proven problematic in implementation and has not received great attention

to date, either by the WAMI ETC or anyone else. Achieving consensus on appropriate standards and devising a method of measurement are clearly not simple tasks. Recognizing that it is an important area, the ETC still intends to address the issue and will be working with others at the University of Washington School of Medicine, including Ms. Susan Kaetz, the former Director of the ETC, to develop clinical competency criteria.

Training activities of the participants in the train-the-trainer programs are tracked by a follow-up form and participants are "rewarded" for training by receiving journal updates. Most ETC trainings are evaluated using participant evaluations, pre/post tests of knowledge and attitudes, and in some cases follow-up evaluations. The Oregon site currently evaluates the impact of their programs on targeted communities through informal feedback by the community based organization network. The general evaluation plan of the ETC is described more fully in a separate document.

5. outputs

The WAMI AIDS ETC distinguishes five levels of ETC involvement in trainings. Level I is when the ETC staff are the primary planners and providers of the training. Level'11 is when ETC staff have major planning input, but not necessarily program delivery or when staff present as part of another organization's program. Level III is when the ETC provides financial support only and Level IV is space only. Level V is secondary training provided by graduates of the ETC's instructor training. Almost all of the trainings have co-sponsors; most frequently the STD program, the state Bureau of Alcohol and Substance Abuse, or the Office of CME.

The WAMI AIDS ETC provided training to 1,885 health professionals in its first year through 24 training course offerings. Four of these trainings were train-the-trainer courses that trained 78 instructors that went on to train an additional 924 health professionals (Level V). In the first three quarters of the second year, the ETC had been directly involved in about 75 trainings for over 5700 trainees. About 400 trainees were trained through 23 Level I ETC offerings. Most trainees, about 3,300, were participants in Level II offerings. Another 5,900 trainees were indirectly trained through Level V activities reported in the first three quarters of the second year. In addition, the Oregon site reported having trained about 1800 health professionals and students in the first year and another 2,500 in the first half of the second year. The WAMI AIDS ETC had projected that by the end of the three grant period more than 7,900 health care workers would be reached through the project's activities. This figure has already been exceeded.

Other outputs include the three video training products and the three training curriculum manuals, all of which already have been or can be made available nationally.

C. Efforts to Reach Hinorities

Already an important part of the AHEC mission is to address the problem of the lack of minority health professionals in the region. The WAMI AIDS ETC is attempting to meet this challenge in the area of AIDS training and education by building upon the WAMI Regionalized Medical Education Program and the WAMI Area Health Education Center Program. The AHEC/AIDS Coordinators are or will be responsible for working with the AHEC directors to establish a special AIDS Education Advisory Committee in each state and will help to develop AIDS interest groups including the minority populations in their states.

In addition to the inclusion of culture and minority sensitive material in the core curriculum, there are a number of specific examples of ETC projects aimed at addressing minority issues in their training program. Specific ETC activities have included co-sponsoring a training with the Migrant Farmworker's Council in Yakima, WA for a multidisciplinary group of health care professionals; work with the People of Color Against AIDS Network (POCAAN) to develop and deliver trainings for minority health professionals; a training for the Indian Health Service in Montana; production of the video on Care of a Latino Patient in conjunction with the Novela Health Foundation; and the current effort to develop a curriculum on Cultural Relevancy with the NIMH project.

D. Training Issues and Successes

The WAMI AIDS ETC has developed strong training curricula, course offerings, and training materials. This is again a tribute to the impressive staff and the close collaboration and cross-fertilization between AIDS training projects. The curriculum for substance abuse counselors is a notable example of an innovative training curriculum developed through the ETC, as is the videotape series developed with the Novela Health Foundation. The ETC has also directly or indirectly trained large numbers of health care professionals, particularly in Washington and Oregon, in large part through the success of the Instructor training program. It is obvious that the ETC expended a great deal of energy to be responsive to the immediate training needs of health professionals in Washington created by the legislation.

The main issue facing the ETC is the dislocation of the training strategies from the objective of regionalizing the program and establishing local centers of expertise. Although the focus on train-the-trainers has clearly been an effective training strategy for disseminating information to large numbers throughout the region, the ETC expects to be able to offer more intensive, focused trainings to communities outside the Seattle area with its new decentralized structure and individualized state training plans. The ETC staff is also excited about the opportunity presented through the Center for AIDS and STD's to initiate a clinical training program.

V. Program Administration

A. Systems for Managing Training Events

1. Marketing

Initial marketing of the ETC included a news release prepared and sent to newspapers and television stations around the region announcing the program. Two brochures describing the program were also prepared and distributed throughout the region by general mailings and distribution at association meetings. A panel exhibit was prepared for use at conferences and an article featuring the ETC was printed in the School of Medicine's lay-oriented publication, Medicine Northwest.

The ETC is developing its own mailing list database for promotion of its offerings. Courses and video products are also advertised through the regionwide AHEC newsletter and the Washington State AIDS Office's newsletter and the Washington Medical and Hospital Associations. The Oregon site similarly promotes its course offerings.

Many of the offerings are announced through the ETC's co-sponsoring organizations. For example, the clinical updates on AIDS for physicians are advertised through University's Division of Continuing Medical Education's system of course announcements.

One of the Oregon sites major activities is a "Physician's AIDS Hotline", The Hotline was successfully marketed by distributing a printed Rolodex card through the Oregon Medical Association's journal.

2. Trainee Recruitment/Selection

Trainer participants in the train-the-trainer program are selected through a formal application process. To date, the program has received more applications than there are spots available allowing the program to be selectively target its trainings. Health care providers and educators in health departments, community and migrant health centers and other health care facilities seeing people at risk for HIV infection receive priority. In Oregon, the site recruits specific individuals from targeted communities that have been identified as key community resources through the sites training needs survey process.

3. Output/Outcome Reports

Output reports are provided from an automated database maintained by the ETC evaluator. Data is summarized according to type of course, training site, major co-sponsors and professional discipline. Data reported by train-the-trainer graduates on ETC provided tracking forms are also tabulated and included in this report. The central site receives similarly organized quarterly activity reports from the Oregon site.

The evaluator also provides outcome summaries for each course which include speaker evaluations and pre/post test results. Follow up outcomes

are also assessed and reported for some trainings. A report of training costs which details expenses, in-kind contributions, revenues and cost per trainee are prepared for major training offerings

These output and outcome reports are used to modify and improve training procedures, and to provide detail on the actual process of training.

B. Training Facilities

Facilities for training are shared with collaborating programs. Currently, the AIDS Prevention and Demonstration Project, the Seattle Sexually Transmitted Disease Training Program, and the National Institute of Mental Health's AIDS Project each share conference facilities with the AIDS ETC. Rooms are also available through the University of Washington School of Medicine. On-site training facilities are available through the AHEC's university affiliations (Washington State University in Spokane; Montana State University in Bozeman; the University of Alaska in Fairbanks). Training facilities in Oregon are available through affiliation with the Oregon Health Sciences University.

Many trainings are or will be held in local communities., The ETC works with the AHEC's, health departments, professional societies and other co-sponsoring organizations to identify training sites and facilities.

C. Cost Sharing

By close collaboration with the five major AIDS-related programs in the Seattle area as well as the Seattle STD Training Program, the WAMI AIDS ETC has achieved significant cost efficiency by sharing space and equipment. Additionally, most trainings are being co-sponsored with one or several other health organizations such as state health departments, professional associations or other major AIDS-related programs. This also translates into significant cost sharing/cost effectiveness in training activities within the region. In-kind contributions to the ETC have included salaries and honoraria, training materials, space and equipment, and promotional materials.

Most Level I ETC courses are offered free of charge. The five day Instructor training course requires a participant fee of $50 to cover the cost of materials and refreshments. The ETC has also made its videos available for purchase approximately at cost.

The ETC has also looked to supplement their program by obtaining other sources of funding. For example, the ETC staff submitted a grant to the Association of Schools of Public Health to prepare an extended degree program. This will be a major ETC product developed completely without HRSA funds.

The Oregon site is very active in seeking alternative funding, often out of necessity. For several of the larger course offerings, the Oregon site was able to secure underwriting from corporations such as

Burroughs-Wellcome and LyphoMed. The staff have also formed a charitable AIDS Research and Education Foundation to help defray the cost of training and clinical programs. The site uses undergraduate assistants to assist with database management and other program management activities. At the time of the visit, the site was investigating the possibility of obtaining CDC funds via the state Public Health Division to support the Hotline.

D. CEU's

In general, the legislated licensing requirements in Washington has encouraged professional associations to approve CEU's for ETC trainings. The video update series has been approved for CEU's by 26 professional associations. Through its NIMH linkage to the School of Nursing the ETC is able to offer Nursing CEU's on all course offerings. Through other co-sponsorings, such as with the UW Office of Continuing Medical Education which can offer CME's, the ETC is able to offer continuing education credits to a variety of professions.

E. Library/Information Services

A resource lending library of written and visual materials has been created at the central office to assist trainers. In addition, the ETC computer system is linked to the Health Sciences Library system. Through this connection, the ETC has arranged to be automatically sent recent articles with certain key word identifiers. The Program Coordinator sends the bibliography to all of the Train-the-Trainer graduates. Each trainer can choose up to five articles to be sent to them in support of their continuing education and training activities.

The Washington site is establishing a speakers bureau database to support the activities of their train-the-trainer graduates, as well as other organizations looking for speakers. Each site also acts as a resource of information and technical assistance to providers and AIDS service organizations on an ad hoc basis.

F. Other Services

MEDCON Telephone Consultation Service - Clinical faculty members and other physicians in the region can already gain access to the specialty resources in Seattle by telephone. MEDCON is a 24-hour service that offers toll-free telephone consultation in all fields of medicine to physicians in the WAMI states and Oregon through specially trained operators and 250 faculty members in the University of Washington's Schools of Medicine and Dentistry. MEDCON provides access to AIDS consultation for health professionals through the AIDS ETC. Calls coming in to MEDCON of an HIV-related nature are referred to the ETC for response. The ETC increased attention to this element of the program in the third year of the program by including it directly in the budget and by establishing formal procedures for receiving and responding to calls.

As mentioned, the Oregon site of the ETC has also developed an "AIDS Provider Hotline" to serve as an educational resource for health

professionals. This has been a very successful activity as they receive an average of one call per day, many from previous trainees with questions or requests for consultation. The site administrator formally tracks each call according to requestor, location, request and response. Each request is classified by category including infection control, testing, education resources, medical referral, legal/ethics, research, and specific diagnosis/treatment. In addition to providing a service to the provider community, this information is maintained on a database that feeds directly into the sites program planning process by providing information on AIDS knowledge, issues and activity around the state.

VI. ETC Future Plans

The ETC's future plans are partially predicated on the recognition that the program needs to move more aggressively out of the Seattle area to other population centers. The ETC will be actively pursuing the implementation of state training plans and development of resource cities. It is anticipated that the AHEC coordinators will be of direct assistance in identification of needs and coordination of the activities toward this objective. The increased emphasis on decentralization of the WAMI program comes in part through the philosophy of the new director and also through gradually reached awareness of both local needs and important local resources on the part of the central office training staff while conducting trainings throughout the region during the second year.

As mentioned, the ETC intends to begin a clinical training program once the Center for AIDS and STD's is in place. WHile currently in the formative stages, it is thought that the program may include three or four separate tracks -- Biomedical, Psychiatric, Dental, and perhaps a track for "Continuum of Care" training. The program would have preceptors for individualized instruction and would incorporate rotations through appropriate agencies.

The ETC would also like to improve on its minority targeted trainings. The ETC has already moved in this direction with the development of culturally relevant curriculum, videotapes and train-the-trainer courses for minority health professionals. The ETC hopes to work more with the Indian Health Service and Community and Migrant Health Centers. The Oregon site is intending to increase and solidify the clinical aspects of their training program. The site administrator would also like to develop a technical assistance service to communities for development of AIDS care networks, although no specific plans have been made. The assistance would cover the range of administration, education and clinical assistance activities.

Finally, the ETC is interested in going beyond evaluation of outputs to developing more substantive impact evaluation, such as measuring changes in professional practice, but is struggling with developing useful methods and assessment tools, as are other ETC's.

VII. Summary

The ETC has made significant progress toward their primary mission of establishing an AIDS ETC in the Northwest region. The ETC has assembled a strong and committed staff and has developed comprehensive and specific training curricula, courses and materials. The formation of the Center for AIDS and STD's is an important and exciting development. The Center will foster even greater inter-program collaboration, already a strength of the program, and provide the ETC with access to facilities for clinical training. The ETC may, however, have to be careful not lose its identity as an independent program within the strong Seattle-King County and UW medical community.

As has been discussed in this document, the Washington state legislation mandating training 'threw the ETC program a curve', particularly as it came early in the ETC's development. This diversion of the central ETC's attention and energies, in combination with the tendency of the outlying AHEC's to co-opt the time of the site AIDS coordinators, and the prohibitive travel costs encountered in the region, have retarded regional training program development. An additional problem perceived by the ETC is that they had looked for more guidance from HRSA regarding program expectations and, in particular, more contact with the work of other ETC's, but felt that this was not forthcoming.

In spite of these obstacles, the ETC has directly or indirectly trained large numbers of health care professionals. However, it has been difficult to assess, other than anecdotally, progress towards the first goal of increasing the number of practitioners willing and able to manage patients with HIV infection. The ETC has developed a strong plan for evaluating program outputs and knowledge and attitude outcomes, as will be discussed in a separate document, but a method for evaluating program impact on the first goal above or the second goal of establishing centers of competence/resource cities has remained elusive.

By virtue of the positions of ETC staff or collaborators within the University structure, the ETC has made strong progress toward the third goal of instituting AIDS curricula in schools of health professions. This may in the long run be the most important area of achievement for impacting AIDS care practice.

Appendix I

Program Goals and Objectives

The program's goals are to: 1) increase the number of primary care practitioners in the Northwest and Alaska who are willing and able to diagnose, manage and refer HIV infections and related conditions; 2) create "centers of competence" in major medical communities in the region by training multidisciplinary teams of health care personnel to diagnose, manage and counsel AIDS patients and their support systems and to serve as the local area source of consultation and training to health personnel in outlying communities; and, 3) institute AIDS curricula for medical, dental, physician assistant and nursing students and medical residents at the University of Washington and Oregon Health Sciences University, and for students in nursing schools, schools of social work, clinical psychology, naturopathy and chiropractics around the region.

The specific objectives intended to address the achievement of these goals are:

1. Develop a regional AIDS Education and Training Center Program conducted through the WAMI Area Health Education Center Program.

   Purpose: To increase the numbers of primary care practitioners capable of handling the medical and psychosocial aspects of HIV infection in the Northwest and Alaska.

   a. Establish and equip a central training site in Seattle in proximity to existing AIDS clinical services.

   b. Locate the WAMI AIDS Education and Training Center with other AIDS prevention and management activities to promote cooperation, collaboration and creativity.

   c. Hire AIDS Center staff and an AIDS educational coordinator to be located at each of the WAMI AHEC sites.

2. Develop multidisciplinary centers of competence (COC) for the care and management of AIDS in strategically located cities in Washington, Alaska, Montana, Idaho and Oregon.

   Purpose: COCs within each state can better and more cost effectively address the many barriers to training and health care, and also provide a system of continuing education and support for practitioners in underserved areas.

   Potential locations of the centers of competence include: Bellingham and Tacoma in western Washington; Spokane, Wenatchee and Yakima, in eastern Washington; Anchorage and Fairbanks, in central Alaska and Ketchikan in Southeast Alaska; Great Falls, Missoula, and Billings in

Montana; Boise, and Pocatello in Idaho; Portland and Eugene in western Oregon and Bend in eastern Oregon.

a. Identify and survey key community leaders, health providers, and care givers in major population centers in the WAMI states and Oregon to determine community-specific training needs.

b. Develop centers of competence by training a nucleus of health professionals from each targeted community in AIDS diagnosis, therapy, care, management, resource recognition, and teaching techniques. A definition of competence and/or standards for practice will be established and modified by the COCs.

c. Give encouragement and technical support for the above health professionals to provide inservice training for their colleagues and staff.

3. Provide support for each center of competence to provide training to their geographically related health care communities.

Purpose: To "bring the training home" to hard to reach populations as well as develop a cadre of well-trained professionals who can train others, thereby initiating the multiplier effect throughout the region.

a. Identify and recruit key community resources responsible for dissemination of information regarding AIDS and attitudes including and especially representatives from minority communities such as health aides in the Alaska bush.

b. Provide intensive training for the above in teaching techniques, values clarification, didactic presentations, and AIDS medical and psychosocial aspects.

c. Provide on-site supervision, direction, technical assistance, and updates for local trainers.

4. Establish component state-wide AIDS education advisory committee and maintain collaboration with other programs that participate in AIDS control and educational efforts in Seattle-King County and across the WAMI states and Oregon.

a. Establish an advisory group consisting of representatives from the network of AIDS organizations in each state, including CDC Health Education/Risk Reduction counselors, local and state health departments, volunteer organizations, and health professions associations.

b. Collaborate with funded organizations to potentiate development and implementation of AIDS training activities.

5. Develop educational techniques and materials during years 02 and 03.

Purpose: To facilitate effective and efficient training of medical and allied professionals, caregivers, and support services.

a. Work with other HRSA AIDS ETCs to identify and share existing resource materials.

b. Identify gaps in training techniques and materials and develop appropriate responses.

c. Develop materials needed for AIDS-specific train-the-trainer program, local training needs of centers of competence and other specific target audiences.

d. Define a specific train-the-trainer program to be made available to other HRSA AIDS ETCs.

6. Work with University of Washington health professional schools to integrate an AIDS curriculum into course work, including the Schools of Medicine, Dentistry, Nursing, Social Work, and the School of Public Health and Community Medicine's MEDEX Program for physician's assistants. Integrate AIDS course work into the curriculum of other health professional schools in the five states.

   Purpose: To assure that all health professional schools in the five-state region have appropriate and adequate information for student education.

   a. Provide continual technical assistance, consultation and staff support when requested.

7. Evaluate the impact of the program.

   a. Create criteria for competence/standards of practice for the care and prevention of AIDS, ARC and HIV infections,

   b. Develop and implement evaluation of the train-the-trainer program to be used by the AIDS ETC.

   c. Develop and implement quantitative measurements to evaluate the effectiveness of training provided by the centers of competence.

   d. Develop and implement quantitative measurements to evaluate clinical updates (on-site and in Seattle).

   e. Research response to AIDS training in urban and rural communities of the Northwest and Alaska.

Following on the first years experience, the WAMI AIDS ETC established the following specific objectives or tasks to provide the plan for the second year's activities.

1. Complete hiring and training of AHEC coordinators in four AHECs.

2. Provide technical assistance to existing AHEC AIDS Advisory Boards (Idaho, Alaska, Montana).

3. Develop pre- and post-course measurements to determine impact on individual participants and use these measurements in the development of criteria of competence.

4. Continue to assist communities in the development of centers of competence.

   a. continue to train trainers in the designated communities.

   b. sponsor at least one forum on community coalition - building in AIDS services and prevention.

   c. provide technical assistance and training to existing AIDS task forces .

5. Develop train-the-trainer model for minority professionals.

   a. offer and evaluate closely two train-the-trainer courses for minority professionals.

   b. develop and test culturally and ethnically relevant curriculum and materials.

   c. develop tracking device for trainers to evaluate their impact.

   d. offer ongoing technical assistance to trainers.

6. Offer an instructor training to all ETC trainers, instructors and lecturers.

7. Develop prevention and treatment curriculum for at-risk populations (substance users, women, children, adolescents) and develop common agendas for institutions that work with those populations (example: create mutual curriculum for health care professionals and substance abuse professionals stressing health care principles for substance abuse professionals and substance abuse principles for health care professionals).

8. Provide training and technical assistance to Bureaus of Alcohol and Substance Abuse in each state.

9. Develop additional train-the-trainer curriculum as needed.

10. Provide support for and technical assistance to cross-listed interdisciplinary courses for the Schools of Nursing, Public Health and Community Medicine, Social Work, and Medicine.

11. Develop a technical assistance manual.

12. Plan, implement and evaluate at least four in-house instructor trainings.

13. Plan, implement and evaluate at least four major AIDS trainings outside of our facility for health care providers who see clients at high risk for AIDS.

14. Develop a qualified speakers bureau.

15. Assist health facilities in setting up AIDS training for their staff.

    a. Arrange for speakers and educational materials.

    b. Monitor entire training process by using technical assistance manual.

16. Market and promote our program.

    a. Develop mailing lists and distribute.

    b. Speak at conferences.

    c. Advertise in health professional journals and newsletters.

17. Work with evaluator to develop data collection forms for our trainers in the field.

Western AIDS Education and Training Center

Case Study

WESTERN AIDS EDUCATION AND TRAINING CENTER

CASE STUDY

I. OVERVIEW OF THE PROGRAM

In September 1987, the University of California at Davis (UCD) School of Medicine, in association with the California Area Health Education Center (AHEC) established an AIDS Education and Training Center (ETC) which has subsequently become known as the Western AIDS ETC. This ETC encompasses California (except for the Los Angeles area), Arizona, Nevada, and Hawaii. The Western AIDS ETC is part of the AIDS Education Center (AEC), a division established within the California AHEC system to respond specifically to the growing AIDS epidemic by educating primary care providers. The regional ETC office, based in Fresno, coordinates and oversees the functions of numerous Area AIDS Education and Training Centers (AA ETCs) which were phased into operation over the three-year project period. Each AA ETC has its own faculty and is responsible for implementing five levels of AIDS training in the geographic area where it is located. This decentralized regional model was chosen in order to be responsive to local community needs and relationships, to encourage local community involvement, and to establish foundations for self-sustained training activities.

A. Cooperating Groups and Agencies

The Western AIDS ETC links together a number of universities and schools throughout the region and has been built on existing structures for health professional education. In California, Nevada and Arizona, the AHEC system provides the structure for the ETC. In Hawaii, the University of Hawaii School of Medicine is the site of an AA ETC. National Institute of Mental Health (NIMH) AIDS Training Projects have also contributed significantly to the programmatic structure in Arizona and Hawaii. The ETC has also established a Program Steering Committee (PSC) involving many public and private AIDS interest groups, as well as representatives of participating universities in the ETC.

B. Program Goals and Objectives

The broad goal of the Western AIDS ETC is a statement of intended impact on improving access to AIDS/HIV care:

> Improve access to high quality health care for patients at risk for or infected with HIV using educational and informational interventions.

Each year, the specific focus of the goal has shifted slightly to reflect the changing nature of the AIDS environment. In the third year, for example, the goal has focused on increasing the number of providers willing and able to treat HIV+ individuals.

The six objectives which support the ETC's goal are more process than outcome oriented. They relate to organizational or programmatic issues:

1. To develop the network of AA ETCs for providing education and training.

2. To establish the provision of five levels of training to a specific number of health professionals.

3. To provide materials to support the AA ETC training activities.

4. To establish the ETC as a resource center for health professionals throughout the region.

5. To establish the AA ETCs with teaching hospital affiliations to encourage integration of AIDS curricula and sustainability of training activities.

6. To provide minority specific and culturally relevant programs.

II. PROGRAM HISTORY

A. Origin and Developmental Milestones

1. Development of the ETC

The California AHEC and, specifically, the AIDS Education Center within the AHEC took the lead in forming the regional coalition of institutions participating in the ETC. In Arizona and Nevada, the respective statewide AHECs were invited to participate in the ETC to maintain the formative strategy of building on existing AHEC networks. No AHEC exists in Hawaii, but the University of Hawaii School of Medicine was thought to fit well,with the AHEC philosophy of community-based, primary care programs. The University was thus invited to participate in order to approximate the region defined by DHHS Region IX. The ETC became known as the UC-Davis AIDS ETC.

At the outset of the program, the regional ETC staff focused on developing the AA ETC projects, conducting the faculty development program, promoting the ETC programs and acquiring the educational materials. Initially, up to 24 AA ETCs were planned for phase-in over the course of the project. The sites were each to be funded at about $40,000 per year for a two-year period, after which they were expected to be essentially self-sufficient. However, it quickly became apparent that budget restrictions and other practical considerations required revision of this strategy to the funding of fewer AA ETCs, 14 or 15 over the course of the project, for longer periods of time to foster complete development and institutionalization.

In the first year, AA ETCs were established in California and Arizona. In year two, additional sites in California, as well as one in Hawaii, were added. AA ETCs in Nevada were funded for the first time in the 03 year of

the project. However, even in the absence of AA ETC funding, health professional faculty from Nevada received ETC training materials at the Faculty Development course offered in the second year of the project, enabling the ETC to have informal impact in the state earlier than anticipated.

In California, the local AHECs, which shared the ETC mission of providing continuing education to primary care providers, served as the focal point of the development and implementation of the ETC's program. In Arizona, a subcontract was awarded to the University of Arizona; funding was passed through the AHEC and on to the AIDS Education Projects. In Hawaii , the ETC subcontracted with the University of Hawaii. In the latter two cases, the ETC program was piggybacked onto the NIMH programs that were already operational. For example, at the Arizona AIDS Education Projects, the NIMH team consisted of five faculty with training in medicine, clinical psychology, psychiatric nursing, health education and dentistry. The ETC subcontract supplemented this team by providing funds for a program coordinator and a portion of the extramural facility housing the projects.

In the third year of the project, several organizational changes took place. First, the ETC changed its name from the UC-Davis AIDS ETC to the more appropriate Western AIDS ETC. Second, the regional configuration was finally completed; through a subcontract with the University of Nevada, two sites in Nevada were added. Third, the structure of the Arizona AA ETC changed slightly. As of the beginning of the third year, the relationship between the ETC and the AIDS Education Projects became more direct, bypassing the AHEC. Finally, in the third year of the grant, the Western AIDS ETC, through the California AHEC System, was awarded an NIMH grant to train health care providers in the mental health aspects of AIDS, which will ultimately enable each of the AA ETCs to add a mental health professional to its training team.

2. Developmental Issues

By attaching the ETC to existing structures already providing professional education, the ETC bypassed many developmental stages. For example, administrative and communication systems were, to a large degree, already in place for use by the ETC. The AHEC and NIMH projects also have established ties with medical, nursing and dental school faculties, professional societies, hospitals, and health departments. Through these contacts and other community affiliations, the ETC developed a decentralized program to fulfill its mission and goals for offering accessible and community-focused AIDS education and training to its health professional constituencies. This allowed the organization to quickly establish its first 5 AA ETCs and begin significant training in the first program year.

In Arizona, the ETC was fortunate to have drawn in members of the AIDS Education Projects team who had already been involved professionally and personally in the AIDS field. For example, Dr. Kay Bauman, the site Director, had been highly visible throughout the state both as an AIDS caregiver and educator. Dr. James Allender, a clinical psychologist and AIDS caregiver, was also major asset in the development of community

networks for the Arizona AA ETC because of his activities as a Board member on the Tucson AIDS Project (TAP). Similarly, the Projects' program coordinator, Mr. Marcos Rodriguez, had been very active in the community through TAP and the Tucson Minority Consortium on AIDS.

A major developmental challenge that faced the Western AIDS ETC initially was the establishment of relationships beyond the AHEC network. In California, because of the high incidence of AIDS, there had already been extensive AIDS training activity in both the public and private sectors. UCD was, by its own admission, a "latecomer" to AIDS education and needed to work to establish the credibility of the ETC. A major portion of the Project Director's time early in the project was devoted to meeting with many agencies and organizations for the explicit purpose of networking. One of the functions of the PSC was also to solidify linkages outside the AHEC system.

Though the ETC regional office relates to the UCD campus, it is actually located in Fresno. This distance and off-site location has provided the ETC with the dual advantages of being somewhat removed from the bureaucracy of the University of California system, but also being able to invoke the UCD name to establish program credibility. One major problem, in part due to this physical separation, has been the processing of contracts at the UCD campus.

The University base of the AHEC was switched from UCSF to UCD in 1988 creating a period of adjustment due to significant procedural differences between the two campuses. In the first two years of the ETC, significant delays were experienced in the subcontracting and billing processes leading to subcontractor frustration. The AHEC and ETC have an effective liaison officer on the UCD campus responsible for coordinating contracting and payment; however, the physical separation and the inevitable procedural errors resulting from the new relationship slowed the process. Fortunately, programs were able to get started in the absence of payment because of the placement of the AA ETCs in a larger infrastructure that was able to support efforts.

As the program has developed, new roles for the regional office have also surfaced. The first was to serve as a resource center for both the educational and clinical needs of health professionals. Secondly, a need for filling in training gaps was identified. The regional office directly sponsors training beyond that conducted by the AA ETCs, such as train-the-trainer programs and clinical training for providers not served by an AA ETC.

B. Institutional Background

The California Statewide AHEC program organized eight medical schools into a cooperative relationship with the major state health agencies and with a network of 18 local AHECs. A state-funded system of 12 AHECs is expected to remain after all the AHECs have completed their federal funding phase.

The California AHEC program has been successful in establishing many health professional training opportunities throughout California. These include: clerkships; new primary care residency training programs; expansion of residency programs into underserved areas; dental residency programs; geriatric dentistry curriculum components; miniresidency programs for pharmacists; health education and nutrition components for medical residency programs; new degree granting nursing programs; networks of hospitals and clinics providing continuing education to staffs of small rural hospitals and clinics; minority recruitment programs; post-baccalaureate programs; a Hispanic medical education and training program; a group of consortia of biomedical libraries linking hospitals, academic institutions and public libraries throughout northern and central California.

Specific AIDS training experience of the universities and medical centers affiliated with the ETC is also extensive. All the University of California Medical Schools have incorporated AIDS material into their curricula and virtually all the teaching hospitals affiliated with the ETC have initiated in-service AIDS training programs. UCLA, UCSF, the University of Hawaii and the University of Arizona are recipients of NIMH AIDS Training contracts and have been providing training on the psychosocial aspects of AIDS.

The Arizona and Nevada projects have structures similar to the California AHEC. The Nevada AHEC, initiated in 1987, is based in Reno and has an initial rural target area in Elko. Arizona's AHEC project has been in existence since 1984. It functions from the Rural Health Office and the Department of Family Medicine at the University of Arizona and covers the entire state. The University of Hawaii has no AHEC program, but has similar goals and activities in administering programs aimed at underserved populations and establishing educational programs for primary care providers.

III. PROGRAM STRUCTURE

A. Geographic Target Area

Since the first group of AIDS patients were identified at UCLA in 1981, California has had a high proportion of the AIDS cases. With approximately 12 percent of the U.S. population, the four states in the Western ETC region have about 21 percent of the AIDS cases reported nationally. In California, the AIDS epidemic is highly concentrated among homosexual and bisexual men. However, the California State Department of Health Services Office of AIDS has reported a rapid increase in the numbers of IV drug users, women, children and minorities.

As the AIDS epidemic spreads, the responsibility for the care of HIV infected patients is moving from the university health sciences centers to community hospitals and clinics and from tertiary care specialists to primary health care providers. The Department of Health Services Office of AIDS estimates that by 1991, 30.8 percent of California's cases will be reported in areas of the state outside of the Los Angeles and San Francisco

SMSAs. The spread of the epidemic in California and the rest of the region is radiating outward from the two large urban areas.

B. Collaborating Programs

The AIDS educational programs of the Western AIDS ETC are carried out by community based subcontractors, the area AIDS Education and Training Centers (AA ETCs). In general, the regional ETC office seeks to establish AA ETC sites based on:

- local need for additional AIDS education programs for health professionals;
- the presence of a teaching hospital partner for the AA ETC;
- the presence of an agency, generally an AHEC office, which is prepared to carry out the educational programs of the AA ETC with modest administrative support;
- the willingness of the staff and faculty to enter into a subcontract for the delivery of a prescribed number of educational programs and to operate within a specified budget.

For the first year of the project, subcontractors were established in five communities. The AA ETCs and their respective sponsoring agencies are as follows:

San Jose AA ETC	San Jose Medical Center Health Education and Training Center
Tucson AA ETC	University of Arizona at Tucson Department of Family and Community Medicine
San Diego AA ETC	University of California at San Diego Department of Internal Medicine
Sacramento AA ETC	University of California at Davis Department of Family Practice
Fresno AA ETC	San Joaquin Valley Health Consortium Valley Medical Center

In the second year, sites were established in the following five communities:

East Bay (Oakland) AA ETC	Highland-Alameda Hospital
Central Coast (Salinas) AA ETC	Natividad Medical Center

Northern San Joaquin (Modesto) AA ETC	North San Joaquin AHEC
Honolulu Area AA ETC	University of Hawaii, Manoa
Contra Costa (Martinez) AA ETC	Contra Costa County Health Dept.

By the third year, AA ETCs had been established in each of the four states in the region. Year-three sites included:

Las Vegas AA ETC	University Medical Center of Southern Nevada
North Coast (Santa Rosa) AA ETC	Community Hospital of Sonoma County
Phoenix AA ETC	Phoenix Baptist Hospital University Medical Center
Reno AA ETC	Washoe Medical Center and Veterans Administration Hospital
San Francisco AA ETC AA ETC	San Francisco General Hospital

To streamline administration, in 1990 and beyond, several of the AA ETCs will be consolidated--Northern San Joaquin Area AIDS ETC will be placed under the Sacramento AA ETC and the East Bay Area AA ETC will be responsible for the adjacent Contra Costa County area--resulting in 13 ongoing AA ETCs.

Each AA ETC has a director who is responsible for the overall conduct of the AIDS education programs in the AA ETC's community. The AA ETC Director is also responsible for the development of a working relationship with a teaching hospital formalized by a written agreement and subject to the approval by the ETC regional coordinator. The faculty of each AA ETC is selected from established AIDS service teams at teaching hospitals. The faculty are expected to be centers for excellence for AIDS-related services in their communities.

The ETC is guided by a Program Steering Committee (PSC) involving many public and private AIDS interest groups, as well as representatives of participating universities in the ETC. The charge of the PSC was originally to provide an advisory role into educational issues, but this has since been expanded beyond educational issues to include a review of project strategy, funding priorities and planning decisions. The PSC has been meeting on a semi-annual basis. Currently, the 16-member PSC includes 13 representatives from the California health care community, as well as one each from Arizona, Nevada and Hawaii.

C. Staffing

1. Western ETC Staff

Hibbard Williams, M.D., Dean of the UCD School of Medicine serves as principal investigator, with Malcom Watts, **M.D.,** project director of the California Area Health Education Center system, serving as co-principal investigator. The time of both these men is donated to the project.

Day to day administration and management of the project is carried out by the California AHEC system based in Fresno. Initially, Charles Gessert, MD, the director of the **AHEC's** AIDS Education Center (AEC) and a major force behind the conceptualization and establishment of the ETC, served as the **ETC's** Project Director as well, assisted by Barbara Marquez, MPH. During the second year of the project, Dr. Gessert and Ms. Marquez left the project and the **ETC's** management was restructured. Currently, the management team consists of Clark Jones, who serves as the Project Director, Roger Larson, M.D. is the Medical Director, and Michael Reyes, M.D., is the Associate Medical Director. Lynette Jordan, an information specialist, is the Director of the ETC Resource Center, while Maria Canfield, M.S., serves as the ETC Evaluator.

UC-Davis has provided for the general oversight of the project with support services from the medical school dean's office, the office of the vice chancellor for business and finance, the office of research, the department of family practice, and other offices. Liaison with offices on the UCD campus is managed by Roberta Wallace, MA, project liaison administrator for the project.

2. Subcontractors

Each AA ETC is staffed by a site director and faculty. The faculty of each AA ETC is composed of at least one physician, one nurse and one dentist. In the spring of 1990, there were a total of seventy faculty members. These faculty are recruited from the AA ETC-affiliated teaching hospital based on their experience with and commitment to AIDS. Faculty members are trained through the **ETC's** Faculty Development Institute and in turn become key trainers for the AA **ETC's** target area.

Key staff at the subcontractor level include:

San Jose Medical Center	Esparanza Garcia-Walter
University of Arizona	Kay Bauman, M.D., Gloria Valenzuela, and Sarah Kraner, M.S.
UC-San Diego	Chris Matthews, M.D., and Susan Benson, M.S.
UC-Davis	Jane Fox-Garcia
San Joaquin Valley Health Consortium	Kathy Pomaville

Highland-Alameda Hospital	Kathleen Clanon, M.D.
Central Coast AHEC	Robert T. Phillips and Dianne Shaheen
University of Hawaii	Jane Waldron, Ph.D.
University of Nevada	Nancy Rody, M.D.
Community Hospital of Sonoma County	Marshall Kubota, M.D. and Tina Faux
San Francisco General Hospital	Ronald Goldschmidt, M.D. and Claire Rappapor t

3. Other Contractors

Contractual relationships were established with several individuals and institutions throughout the region to provide educational support for the AA ETC faculty teams. The ETC contracted with:

- Charles Lewis, M.D., Sc.D., at the University of California at Los Angeles for faculty training and educational materials;
- the University of California at San Diego for faculty development for physicians and nurses;
- the University of California at San Francisco School of Dentistry for dental faculty development; and
- the California Nurses Association for faculty development.

D. Organizational Qualities

The Western AIDS ETC has developed an educational program based on the existing AHEC structure and on the programs developed by the NIMH AIDS training projects of UCLA, Arizona and Hawaii. This structure allowed for rapid development of the AA ETCs, particularly those established in the first year.

The AA ETCs were planned, developed and operate with the goal of creating an ongoing AIDS education/service resource for their communities. This has been accomplished by building on the existing system of decentralized health professions education, utilizing the existing faculties of affiliated teaching hospitals, and centralizing curriculum development, faculty training and material distribution. Though the processing of contracts through the University of California system has been cumbersome, it has not constrained the initiation of training by the AA ETCs; training efforts of the AA ETCs were supported by the affiliated hospital or University while funds were being processed.

The five levels of training strategy to accomplish the goals of the AIDS ETC, which are described in the next section, have provided structure to the decentralized model of training interventions. The decentralized structure is meant to enable the AA ETCs to be responsive to the training needs of their communities while providing centralized resource support. However, decentralization has, at the same time, thwarted efforts by the regional ETC staff to institute a common, core curriculum.

The concept of building on the extensive AHEC network and pre-existing relationships for organizational development and program implementation has worked well in California. The degree to which the AHEC structure played a facilitative role in the development of the Arizona program is less clear. In Hawaii, the NIMH training project provided the foundation for the AA ETC. The outcome of the AHEC based development strategy in Nevada is not yet apparent.

IV. TRAINING PROGRAM

The Western AIDS ETC conducts the majority of its AIDS related training through the AA ETCs as described. Each AA ETC develops a scope of work as part of their funding request describing their intended training program for the next year based on four levels of training established by the regional office. In order to get the program underway in the first year of the ETC, the Scopes of Work were developed centrally. Based on input from the Program Steering Committee and from the AA ETCs, the regional ETC has since established the policy that, in the first year, AA ETCs are held to a Scope of Work that includes all four levels of training and that, in subsequent years, are allowed to develop and present their own Scope of Work.

Additional funds are made available on an essentially competitive basis for special initiatives. For example, the Arizona site was able to delineate a broader scope of work in the second year with somewhat different priorities, although still adhering to the basic idea of providing four levels of training. The site also proposed and received additional funding to develop training programs targeting the issues of Native Americans and rural communities.

A. Needs Assessment Procedures

The ETC did not conduct an initial, centralized needs assessment of health professional training needs. However, a number of targeted needs/demand assessments have been conducted. Prior to conducting its first faculty development program, the ETC did a needs assessment survey of AA ETC faculty. This survey provided input into the planning process and identified interest in clinical training and exposure to integrated AIDS health care service systems. The Fresno, Sacramento and North San Joaquin sites did training demands assessments in their local areas. The Tucson site conducts informal needs assessments as part of the planning process prior to any community based trainings. Further, the Association of California Health Centers, in conjunction with both the UCD and USC ETCs,

conducted a survey to gauge interest in AIDS-related educational programs for the staffs of primary care health centers.

In addition to these specific mechanisms, the Western ETC relies on a key informant process through its Program Steering Committee to provide general information on training needs and issues. Similarly, the Arizona site has its own advisory board through the NIMH project that provides direction on training needs in the area.

B. Training Strategies

1. Specific Training Strategies and Hethods

There are five levels of training provided by the Western ETC:

Level One - Training for Faculty Development. During each year of the project, the regional ETC staff arranges for training opportunities for AA ETC faculty teams at major AIDS centers. The AA ETC faculty teams participate in a week of intensive clinical and didactic training. The faculty are also brought together for an annual three-day retreat.

The intent of the Level One training is to develop familiarity with an integrated AIDS health care service system; expertise in a wide range of AIDS education materials for health professionals; the ability to improve and expand the care of AIDS patients within the faculty members' local communities; and the ability to teach the major principles of prevention: risk assessment, sex history taking and behavior modification.

The site for the health sciences center/medical school-based faculty team training experience is chosen on the basis of availability of health sciences center faculty to devote appropriate blocks of time to working with the AA ETC faculty teams; availability of intensive exposure to inpatient and outpatient AIDS services; presence of a well-articulated set of protocols; and community involvement in the service system.

The first faculty development training was held in February 1988 at the UCSD Owen Clinic, a HRSA AIDS Demonstration project. A complementary experience was held for dental faculty in April 1988 at the UCSF School of Dentistry.

In the second year of the project, a five-day program for dental faculty was held October 31-November 4, 1988 at the UCSF School of Dentistry. This program was attended by the dental faculty of the second generation and unfunded AA ETCs. A total of 11 dentists attended, including two from the Hawaii Department of Dental Public Health. The clinical training program for the physicians and nurses was again held at the Owen Clinic November 14-18, 1988. This program included a combination of didactic, small group and experiential sessions at the Owen Clinic and at various community-based AIDS service organizations.

In addition to these training experiences, faculty teams have had the opportunity to share ideas and foster ongoing professional relationships

with their counterparts at annual faculty retreats. The first retreat was held in January 1989 at the Asilomar Conference Center in Pacific Grove, California. The retreat emphasized training concepts, skills and techniques, and psychosocial issues and drew upon individuals from several AA ETCs, including three from Arizona, to serve as conference faculty. The retreat was attended by more than fifty AA ETC faculty.

Three major faculty development events were held in the first half of the third year. The first was November 8-10, 1989, when thirty people gathered in San Diego for a three-day AIDS update for physicians and nurses and other interested faculty. The major portion of the program was put together by the San Diego AA ETC at the Owen Clinic through a subcontract. Staff from the regional office of the Western AIDS ETC provided technical assistance, training materials and spoke during the program.

The second major faculty development program took place at Asilomar Conference Center, January 30-February 2, 1990. This faculty seminar, which was open to all faculty from the AA ETCs, was entitled "AIDS and Mental Health." Over seventy people attended the seminar which emphasized the mental health issues associated with HIV infection. The program was sponsored by the Western AIDS ETC with the assistance of the AIDS Professional Education Program (APEP) at UC San Francisco which organized the agenda and arranged for speakers, while the ETC was in charge of the list of invitees and overall meeting arrangements. A wide range of mental health issues was offered in both plenary sessions and in small group workshops.

On March 2-3, 1990, the dental faculty from the AA ETCs met at the UC Davis Medical Center for the dental faculty refresher course. This faculty development program was co-sponsored with the Sacramento AA ETC through a subcontract. Fourteen dentists attended this two-day course. The first day dealt with issues related to learning resources, teaching techniques, and dealing with difficult audiences; while the second day addressed clinical issues of HIV and dentistry.

Level Two - Training for Primary Care Residents. Family practice residents are the primary audience for this level of training. A substantial number of medical students on clerkships participate in level two experiences. Each AA ETC assures through written agreement with the teaching hospitals and the statewide AHEC office that the training will be integrated into the primary care residency programs at the affiliated teaching hospitals. Residents are introduced to AIDS-related competencies such as risk assessment, counseling, screening, testing, early diagnosis of all AIDS conditions, care of symptomatic HIV infected patients, and the organization of health services for AIDS patients.

Initially there was to be implementation of common ETC-disseminated modules in the residency programs of the teaching hospitals of the AA ETCs. This did not prove to be practicable. Each AA ETC now determines its own residency training model, most conducting traditional AIDS seminars for family practice residents.

Three of the first generation AA ETCs have established AIDS rotations for primary care residents. The faculty of the Tucson AA ETC hold a conference one day each month for Family Practice residents and provide in-service sessions for nurses in the Department of Family Practice. In addition, Dr. Kay Bauman offers a one-month AIDS elective working with her through independent study and by participating in the Immunodeficiency Clinic of the University Medical Center. At Santa Rosa, "Grand Rounds" devoted to AIDS/HIV infection are held at least once per month run mostly by the faculty member. There is also an HIV "Hot Line" for the residents to get answers to questions from this faculty member. There are also innumerable "hallway consults" with the residents about clinical problems. At Fresno, there is a two-hour session each month. Dr. Michael Reyes, the physician faculty member, does one hour and an outside consultant does the other hour. Topics include: Early Intervention and Assessment; Pneumocystis pneumonia; Evaluation of Altered Mental Status in HIV Infection; Dermatological Manifestations of HIV Infection.

Level Three - Training for Health Care Workers in the AA ETC-Affiliated Teaching Hospitals. Hospital-based physicians, nurses and social workers are trained on different AIDS issues such as sexual history-taking, risk reduction counseling, psychosocial concerns and clinical management. These sessions are generally organized as a short series of two to three-hour formats and are attended by small groups of hospital workers.

Level Four - Training for Health Professionals in the Community. The AA ETCs focus these workshops on developing skills of the primary health care provider and target community hospitals, public clinics and professional societies. Some of these skills are in risk assessment, counseling, early screening, testing and diagnosis, and case management.

Level Five Training - Community Impact Workshops. The purpose of this level of training is to provide a forum for community education and bring together a range-of community leaders, policy makers-and care providers. The objectives are to improve awareness of the AIDS epidemic's impact on the local community, improve awareness of the local AIDS health services system, and improve awareness of the need for the development of local AIDS related services, educational programs and prevention programs. The eleven AA ETCs either sponsor or co-sponsor these educational interventions.

The expected activities in each of these areas are outlined by the sites in their scopes of work agreed upon at the beginning of each year. AA ETC directors with their faculty teams are responsible for planning arrangements for levels two, three, four and five of the training program. The directors are responsible for the identification of the need for consultants from outside of the AA ETC community and for securing these speakers.

In addition to the training levels described above, the regional ETC office coordinates programs to supplement the efforts of the AA ETCs. Six AIDS training programs were conducted by the regional ETC in the first two years of the project including an ongoing noontime case management conference, a breakout workshop at the national conference of

migrant/community health centers and a three day HIV antibody counselor training program.

An innovative outreach training program, which cross-cuts several levels of training, was begun in the third project year. Faculty teams, consisting of a physician and nurse or a dentist and nurse, visit private practice providers in their offices during non-patient hours. The medical or dental faculty member trains the provider while the nurse trains the rest of the staff. Issues addressed can be customized according to the needs of the practice. Piloted by the Associated Medical Director and a nurse practitioner from the Fresno AA ETC, the outreach training is being conducted by a number of the AA ETCs. Providers willing to participate in the outreach training were originally identified through a survey sponsored by the local medical society; the training is continuing via word-of-mouth publicity.

2. Curricula and Materials Developed/Used

Since its inception, the Western AIDS ETC has operated under the premise that many excellent AIDS education and training materials already exist. Rather than duplicate efforts in curriculum development, the ETC's strategy was to disseminate these existing materials. It was anticipated that each AA ETC would adapt the materials to their own situation and training needs.

The series of training modules developed by the UCLA NIMH AIDS training project were chosen to serve as the core curricula to be utilized by the AA ETCs. There are eight modules each of which includes a Trainer's Guide, a Learner's Guide, Videos, and evaluation instruments. Reportedly, however, the modules are used only sporadically.

Through subcontract with several individuals, the Western ETC developed three modules/slide series on "AIDS 101", "AIDS in the Latino Community", and a dental curriculum including oral manifestations of HIV infection and infection control which were distributed to the AA ETCs.

Several AA ETCs also have developed their own curricula and modules with other resources available to them. For example, the AIDS Education Projects team of the University of Arizona (Tucson AA ETC) has developed and specifically documented a curriculum consisting of 19 lessons ranging from "Introduction and Overview" to " How to Approach an AIDS Patient in Your Practice" to "AIDS: Personal Experiences".

As part of the ETC's resource center function, the regional information specialist obtains and screens educational materials from around the country, and then publicizes those found to be useful.

3. **Outputs**

Approximately 9,600 health care professionals were initially projected to be trained over the three-year project period. This target was revised upward based on the first year's experience.

	Year 01	Year 02	Year 03
Level One--Faculty Development			
Faculty	20	?	114
Level Two--Clinical Training			
Primary Care Residents	373	852	274
Level Three--Hospital-Based Professionals			
Physicians	329	541	374
Nurses	907	1,054	678
Others	1,064	973	337
Level Four--Community-Based Professionals			
Physicians	532	1,648	578
Nurses	(see Others)	1,258	1,394
Dentists	(see Others)	834	674
Dental Auxs .	(see Others)	1,187	
Mental Health Providers	(see Others)	189	
EMTs	(see Others)	307	
Allied Health	(see Others)	820	1,225
Others	1,018		
Level Five			
Community Leaders	6,000	5,643	1,585
TOTAL	10,500	15,306	7,233

C. Efforts to Reach Minorities

The AA ETCs have planned and are already conducting outreach and training programs to reach minority health professionals and other health professionals serving largely minority clientele. The San Diego AA ETC offers a mini-residency at the Owen Clinic for physicians of the local community health centers in San Diego. Rural hospitals and clinics in the agricultural-based valley of California are the focus of the Fresno AA ETC. The San Jose AA ETC outreaches and networks with minority health professionals in inner city health centers. The regional Resource Center also has a curriculum available to faculty on AIDS in the Latino Community. The Arizona AA ETC is very active in providing programs specifically for health care workers in the Native American and Latino communities and collaborates closely with organizations such as the Tucson Minority Consortium on AIDS and Proyecto SIDA.

D. Training Issues and Successes

The AA ETCs through their scopes of work are implementing programs according to five levels of training as defined by the Western AIDS ETC. This regional model allows for a local response to training needs, identification of local trainers to implement the course offerings, and local marketing of programs, while still maintaining the sense of a coordinated, regional training program. The regional ETC also participates in training efforts by sponsoring or co-sponsoring workshops/conferences throughout the region.

The faculty development program designed by the Western AIDS ETC provides a common direction to the faculty of the AA ETCs. This program and the faculty retreat provide for faculty support and sharing. This type of formative development allows the ETC to get feedback from the field and implement new curricula which can be modified by the individual AA ETCs.

The ETC has designed a program around existing structures with continuing institutional interest in and responsibility for medical education. Each subcontract requires that programs be planned with continuation in mind and annual reports record progress towards this goal. Although the ETC has relaxed the concept of AA ETC self-sufficiency within two years, the perception remains that funding levels are not guaranteed from year to year. This seems to have the effect of producing both anxiety and eagerness to actualize high levels of training activity at the AA ETC level.

Special emphasis has been given to integrating the AIDS content into residency programs, programs of hospital in-service training programs, dental society teaching programs and the established education delivery systems. The community awareness workshops will help to generate governmental and consumer support for the long range effort.

V. PROGRAM ADHINISTRATION

A. Systems for Managing Training Programs

1. Central Management Activities

The project is administered by a network of subgrants. These contractual instruments include specific scopes of work for each subcontractor, name the reports and documents to be delivered and specify the budget for that portion of the work of the ETC.

The AA ETCs' activities are monitored by the regional ETC staff in a number or ways. The AA ETC directors were initially responsible for compiling semiannual reports, and quarterly meetings with ETC staff were planned to assure that the development of each AA ETC remains on schedule. The latter schedule was modified due to budget constraints. There are frequent informal telephone contacts between the AA ETCs and the ETC, as well as formal quarterly telephone reporting. The telephone reporting system for monitoring and collection of data, which was introduced in the third grant year, covers: identifying information; scope of work review; report on programs conducted, and calendar of future events. The information is collected during a telephone conversation with the subcontractors; data collection is facilitated using a telephone reporting worksheet. Once the data is collected, it is entered into a database and a summary report is produced. The summary reports are distributed to the subcontractors to confirm the accuracy of the data.

Further, regional ETC staff conduct annual sites visits. In the first two years, the ETC Project Director visited each of the sites except Hawaii , most annually, meeting with the AA ETC director and principal faculty. The first round of site visits was used to provide program planning assistance to the AA ETCs, and the written agreements between the AA ETCs and their teaching hospital were reviewed to assure the adequacy of training programs. In the third year, all sites were visited by at least one member, usually two, of the regional ETC's management team. A formal site visit protocol has been developed to structure data collection.

The AA ETC Management Notebook documents the annual subcontracting process, as well as reporting and evaluation requirements.

2. Marketing

Marketing is seen as an important function of the regional ETC office. In the first year of the project, the project director spent a significant portion of his time networking with other AIDS training or service providers. The regional office has also initiated a quarterly newsletter, The AEC Bulletin, with a calendar of upcoming events. The first issue of The AEC Bulletin was distributed to 225 people throughout the region.

The ETC has developed a formal range of Networking/Promotion efforts. The Resource Center has established working relationships with several AIDS agencies and clearinghouses. Visibility of the ETC has also been promoted

through a series of meetings, conferences and presentations to organizations throughout the ETC region.

The Western AIDS ETC has also marketed itself by conducting or co-sponsoring a series of surveys and needs assessments in cooperation with the Associated California Health Centers, the PHS Region IX Office in San Francisco, and the California Medical Association.

3. Output/Outcome Reports

The regional office of the ETC has developed a uniform "sign-in" sheet for use at all AA ETC trainings. This uniform sheet was to assure consistent information on trainees collected throughout the program, although this data has not been tabulated beyond overall numbers of trainees. The sign-in sheet was revised in the third project year to begin to prepare for uniform data set being recommended for ETCs nationwide.

The local sites have been providing quarterly reports to the regional office, though consistency was only achieved in the third year. Year-end progress reports with activities, outputs and some outcomes are consistently provided by each AA ETC.

B. Training Facilities

The Western ETC is providing accessible training sites throughout the 4-state region by using the extensive AHEC network. Training is provided primarily through these AA ETCs at their local affiliated teaching hospitals. In addition, the ETC is using the facilities at major AIDS treatment centers such as UCSD for its faculty development training.

The ETC has also recognized the need to provide training to providers not located in an AA ETC area. The staff of the regional ETC office conduct training programs to supplement the capabilities of the AA ETCs including subsidizing selected individuals to attend the APEX training program at San Francisco General.

C. Cost Sharing

Cost-sharing is an issue that receives major attention at the Western ETC. The program had originally intended to fund each AA ETC for a two-year period, after which the programs were to be absorbed by the teaching hospitals. The actual feasibility of this plan has subsequently been called into question, however it continues to shape the attitude and activities of the ETC sites.

Each AA ETC provides assurance that all of its supported personnel (staff and faculty) are significantly cost-shared by other community programs and/or the affiliated teaching hospital. The AA ETC's financial support for level five training, the community mobilization workshops, is limited to the contribution of staff time, the time of the AA ETC faculty

team, and some support for consultant speakers. Remaining budget items are covered by local community co-sponsors.

In addition to extensive cost-sharing requirements in all its subcontracts, the ETC is actively pursuing funding from state, local, foundation and federal sources. The ETC has obtained California state funding for some of its AA ETCs, totaling $90,000, and two of them have obtained supplemental grants on their own.

D. CEUs

The regional ETC office reported that of 88 programs offered by AA ETCs in the first year, 46 programs did not offer CEUs and 42 offered CEUs . The AA ETCs are responsible for obtaining CEU/CME approval, although this is not required by the ETC.

E. Library and Information Services

A major function of the ETC regional office is information collection and dissemination through the Western AIDS ETC Resource Center which was established at the Fresno headquarters in September 1988. The Resource Center is staffed by an information specialist who is available to respond to questions or requests for information from throughout the region. The Resource Center is organized into four components: the AIDS Training Activities Calendar; the educational materials database; the clinical training programs database; and an on-site library, including a videotape lending library of more than 50 AIDS training tapes. A quarterly newsletter on training activities is published. In addition, the information specialist reviews and distributes educational materials.

In the third project year, the development of the AIDS Clinical Information Network was begun. The Clinical Information Network, which will include up-to-date clinical protocols, a warmline, and other types of technical information to provide support providers in the treatment of HIV+ individuals. Information will be available to providers via a variety of media including telephone, fax and online computer access.

VI. SUMMARY

The Western AIDS ETC credits the fact that it was established by piggybacking on an existing structures that were already providing education and training to primary care providers, together with the fact that, for its training materials, it primarily utilized existing training materials that were developed by such organizations as the NIMH AIDS training program for its rapid start-up.

Over the three years of the ETC's existence, 15 AA ETCs have been developed and based at a teaching affiliated hospital. 13 of these sites are on-going entities. Each has been responsible for AIDS education

programs within a given catchment area. The staff and faculty of the AA ETCs have been significantly cost-shared with their teaching hospitals.

The network of AA ETCs provides for rapid dissemination of information; a mechanism for linking clinicians for participation in clinical research; a large network of decentralized AIDS training for health care providers and a mechanism for replicating integrated inpatient, outpatient, hospice and home care for AIDS patients.

210 LINCOLN STREET
BOSTON, MASSACHUSETTS 02111

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AIDS Regional Education and Training. Centers Evaluation

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JSI

JOHN SNOW, INC.

Final Evaluation Overview

AIDS REGIONAL EDUCATION AND TRAINING CENTERS' EVALUATION

HRSA Contract # 240-88-0070

December 30, 1990

JOMN SNOW, INC.

AIDS EDUCATION AND TRAINING CENTERS

FINAL EVALUATION OVERVIEW

I. INTRODUCTION

The following report is an overview of the evaluation activities planned and conducted by the eleven AIDS Education and Training Centers funded by the Health Resources and Services Administration (HRSA) in the first and second funding rounds (September 1987 and April 1988): the AIDS Education and Training Center for Southern California (AETC-SC); the Delta Region AIDS Education and Training Center (Delta ETC); the East Central AIDS Education and Training Center (ECAETC); the Emory AIDS Training Network (EATN); the Mid-Atlantic AIDS Regional Education and Training Center (MAARETC); the Midwest AIDS Education and Training Center (MATEC); the Mountain-Plains AIDS Education and Training Center (MPAETC); the New England AIDS Education and Training Center (NEAETC); New York-Caribe AIDS/SIDA Education and Training Center (NY-Caribe); WAMI-0 AIDS Education and Training Center (WAMI-0); and the Western AIDS Education and Training Center (Western ETC). The report was prepared after reviewing the ETCs' evaluation documents and instruments, and discussing evaluation issues with ETC staff during the site visits and follow-up telephone calls. The report reflects the status of evaluation at the eleven sites in Summer 1990.

II. SUMMARY OF FINDINGS

A. Relationship Between Project Structure and Evaluation

Among the four first generation ETCs, direction and control of evaluation activities closely parallels program structure. Three of these four ETCs are decentralized in both their program structure and evaluation activities. While some have developed or adapted evaluation tools centrally, they have been disseminated as models; sites are free to use them or not, or to modify them as they see fit. Virtually no standard evaluation methodology or approaches are being used ETC-wide. At the more centralized of these four ETCs (NY-Caribe) evaluation is also centralized. A uniform evaluation instrument is used throughout and standardized data for evaluation is available for central analysis.

Among the seven second generation ETCs, project structure is not necessarily a predictor of the degree to which evaluation activities are centralized or decentralized. In the ETC where sites are most independent--the AETC of Southern California--evaluation activities are most independent as well. Among four of the five remaining ETCs which are relatively decentralized programmatically (Delta, MATEC, MAARETC and New England), as well as EATN which combines a high degree of centrally-directed programming with a number of independently functioning subcontractors, basic evaluation procedures are standardized with some degree of coordination from the ETC headquarters. In all of these cases, there has been and continues to be a trend toward more uniform procedures and more ETC headquarters involvement.

The last of the seven ETCs, Mountain-Plains where there is a high degree of autonomy in the implementation of training activities, uniform evaluation procedures were developed collaboratively and are being coordinated centrally.

B. Administration of the Evaluation Process

1. Evaluation Coordinators

With the exception of AETC of Southern California, all of the ETCs have a designated evaluation person at the regional level. At Delta, EATN, ECAETC, MATEC, MPAETC, NY-Caribe, and WAMI-0, this person serves exclusively in an evaluation capacity, devoting 10-25 percent time to the ETC; the evaluator at the Western ETC devotes 50 percent time. At the New England ETC, evaluation is one of the responsibilities of the .40 FTE Project Administrator while, at MAARETC, the full time Education Coordinator also supplies the regional evaluation input.

Evaluation expertise at the program implementation site level is varied not only across the ETCs but within ETCs as well. At several of the ETCs, there have been formal plans to enhance evaluation expertise or increase time commitment of individuals to evaluation across all sites, but this has yet to occur. For the most part, commitment to evaluation at the site level beyond basic data collection has been directly related to the personal interests of individual site staff.

2. Evaluation Reports

Throughout the ETC network, evaluation reports are produced at a number of levels: evaluation reports of individual events; evaluation reports on a series of events; evaluation reports on selected issues across dissimilar events; and overview evaluation reports, both ETC-wide and for individual sites, for a given time period.

In most cases, reports are prepared at the site level, if at all, and are made available to the regional ETC. At others--EATN, MPAETC, New England and NY-Caribe--some or all of the evaluation reports are prepared at the regional level and returned to the implementation sites.

Two important issues have arisen with regard to evaluation reports: timeliness and usefulness. The timeliness of reports, which is as important as the information the report conveys, has been an issue for most of the ETCs. Several of the ETCs have expressed concern over this issue and are making an effort to improve turnaround time. Approaches to speeding up turnaround have included the use of mark sense coding for optical scanning/data entry (MPAETC and WAMI-0) and requiring that reports be submitted with request for reimbursement (Delta). In the case of at least one ETC site, the desire to publish before releasing preliminary data has interfered with the timely dissemination of useful evaluation information.

In part, the utility of evaluation reports lies in their ability to serve a documentation/accountability function. In that regard, the ETCs have performed well. On the other hand, evaluation reports should also serve a guidance function. For the most part, evaluation reports, whether prepared at the site level or at the regional ETC level, have consisted of simple

aggregation of data with little or no narrative discussion; interpretation being left up to the person reviewing the data. Several exceptions are noted. The New England ETC attaches a cover letter to the aggregated data it returns to its subcontractors which includes some interpretation of the data and recommendations. The Northern Illinois site of MATEC, which does a considerable amount of specialized training for other organizations such as the Chicago Health Department and the U.S. Public Health Service, prepares substantial evaluation reports for the recipient agency in which evaluation data collected in a variety of ways are integrated and interpreted, and formal recommendations made. A comprehensive evaluation report was prepared for the Western ETC's faculty development training which included a review of the literature and a description of the methodology as well as the results from participant feedback about the program and outcome evaluation (pre/post knowledge and attitude tests), a discussion of the findings, and suggestions and recommendations. In cases where evaluative research has been undertaken as a special project under the auspices of the ETC, substantive reports should be forthcoming.

C. Approaches to Project Evaluation

1. Project Monitoring

Within the context of this evaluation review, monitoring refers to the process by which progress toward the ETC's formal goals and objectives is tracked and reported, and goals and objectives are modified if necessary. For the most part, ETC goal statements have been directed at the activities the organizations intended to undertake, rather than the outcomes these activities were intended to produce; project monitoring has had a "process" evaluation focus with regard to institutional and program development.

While most of the ETCs continue to structure their progress reports to HRSA to coincide with their initial goal statements, emphasis on project monitoring as an evaluation activity has diminished as the ETCs have become increasingly involved in evaluation activities that speak to the quality of the programs they provide. ECAETC continues to place heavy emphasis on monitoring as an evaluation activity.

2. Evaluation of Outputs

Evaluation of outputs, within the context of this evaluation review, refers to the collection and analysis of data about the education and training events offered by the ETC as well as data about the participants who attend these events. Analysis may include the degree to which training targets are met and potential trainee "markets" are penetrated.

While the ETCs universally collect and report data on training events and participants, the way in which data are collected and aggregated, the variables identified, and the reporting formats widely differ among ETCs. In some cases, uniformity of data collection within an ETC was not achieved until a year or more into the project period. In other cases, the data collected was modified two or three times in the initial two-year period.

All of the ETCs, with the exception of the New England ETC, maintain or are in the process of developing an automated uniform database of training

events and participants. dBASE is most often used. The nine databases that are currently operational are maintained at the regional level. 'The MAARETC database, based on the database created by its Maryland site, is currently being expanded to all sites. NEAETC stores its event and participant data in paper files at the regional level.

All of the ETCs collect and store descriptive data about each of the education and training events provided under their auspices. However, there is little comparability across ETCs. The variables common to most of the ETCs include only: an identifying title; date(s) held; some form of location descriptor; number of hours; and a count or estimate of total participants. The character of the databases differ as well. Delta and ECAETC's databases detail various aspects of the educational structure, process and/or content of the events; MATEC has a similar but less intense focus. Southern California, MAARETC and WAMI-0's databases tend to broadly characterize events according to their educational approaches, while EATN, MPAETC, New England and the Western ETC keep basic management-type data which essentially allows them only to identify events and distinguish between them.

At the regional level, the ETCs' participant databases generally fall into one of two categories: individual participant data or aggregate participant data. Southern California and New England receive participant data from the site level only in aggregate form, while Delta, EATN, MATEC and Mountain-Plains have access to individual participant data as well as aggregate data. MAARETC has been getting aggregate data from its sites, but with its transition to a uniform database may now be in a position to get individual data. ECAETC offers both options; at a minimum, sites report aggregate data, but may submit data on individual participants for aggregation by the regional office.

Two 'important concerns with regard to participant data are whether the relevant variables are captured and whether the data are complete. Overlying these concerns is the issue of comparability of data across ETCs. HRSA has expressed particular interest in knowing the degree to which primary care practitioners, particularly physicians, are being reached by ETC programs and the degree to which training programs are reaching minorities. Delta, ECAETC, EATN, MATEC, and Mountain-Plains have occupation and work-setting data on individual participants and can easily identify the number of primary care providers reached. New England receives aggregate data by profession and work setting. MAARETC, NY-Caribe, Southern California, WAMI-0 and the Western ETC currently do not have ready access to data identifying the number of primary care providers served. With regard to minority reach, Delta, ECAETC, EATN, MATEC, MPAETC and NY-Caribe collect trainee ethnicity for individual trainees, while Southern California, MAARETC, WAMI-0 and the Western ETC are or will be collecting aggregate data or estimates. New England makes gross estimates of minority participants. Further, Delta, ECAETC, EATN, MPAETC and NY-Caribe collect data on ethnicity/minority status of participants' practices, either in terms of proportion of each ethnic group or the predominate minority. MATEC obtains aggregate data on number of participants with various proportions of minority patients.

The way data are collected strongly influences the completeness of the information, the ability to do cross-tabulations and the inferences that can be drawn from the results of the analyses. Data which are collected at registration are far 'more likely to be complete than data collected post-

training particularly that collected as part of the evaluation process. The individual data collected by four of the ETCs is collected post-training; these ETCs also have aggregate data. To the extent that the aggregate data is registration data, completeness of the more detailed individual data can be estimated. Only a few of the ETCs have actually attempted to make estimates of completeness of data.

The number and complexity of output reports run the gamut of simple to complex, and few to many. For the most part, these reports tend to be simple documentation of events and participant characteristics. Several of the ETCs routinely generate reports on variables of special interest to HRSA. MATEC's "Minority Case Load Report" provides data on participants by ethnicity as well as minority caseload by site and ETC-wide. MATEC's "Training Productivity" report provides data on the number of primary care providers trained by site. EATN prepares pie charts detailing the work-setting and occupation of its participants.

A few of the ETCs have begun to look at outputs in a more evaluative light. The most common evaluative use of output data is a comparison of actual number of participants to the number targeted, either by type of event or by profession. MATEC has done a comprehensive analysis of changes in trainee/training patterns (Yr 01 to Yr 02). Some ETCs have begun the process of assembling output data in a way that it can be used to judge impact. EATN has begun to map participants by broad zip code in preparation to analyzing the degree of market penetration it has achieved in various geographic areas within each state.

3. **Analysis of Program Costs**

In this review, cost analysis is a generic term referring to any one of a number of ways of relating costs to program. Cost accounting refers to the compilation of costs for various cost centers, cost centers generally being various categories of training. Cost efficiency refers to input/output analysis--cost per event or cost per trainee--either overall or by type of training. Cost/benefit refers to an analysis which relates cost to outcome, while cost/effectiveness compares the cost of one type of intervention to another in achieving the same or similar outcomes.

Only four of the ETCs have done any cost analyses to date. EATN and New England have cost efficiency calculations for some of their programs using direct cost methods. EATN has calculated a "cost per trainee" for several types of events such as conferences and customized trainings; New England has calculated "cost per training day" for its faculty development workshops and for conferences. Both use these figures more for management than for evaluative purposes.

MATEC and NY-Caribe have done more extensive analysis. Using full cost methods, they have calculated "average cost per participant" and "average cost per contact hour." NY-Caribe has done a summary analysis for the three-year project period by site as well as the program as a whole. MATEC's analysis is by site for Years 01 and 02, as well as changes in these cost figures from Year 01 to Year 02.

It is generally agreed that cost analysis focusing on cost/benefit or cost/effectiveness is not feasible for a number of reasons: difficulty in

identifying, classifying, categorizing and determining the cost of the program inputs that would serve as the basis of the analysis; difficulty in identifying and quantifying the program outcomes (effects and benefits); and, finally, establishing the linkages between the two.

D. Formative Evaluation of Training Products

In this evaluation review, formative evaluation of training products refers to the process by which training products--curricula, audiovisual materials and other items which are intended to have specific effects on trainees' knowledge, attitude, skills or behaviors--are assessed during their developmental stage to determine whether instructional objectives are being met. The results of the assessment are incorporated into modifications of the product before its final release. Formative evaluation is a collection of assessments from various perspectives including verification of the accuracy and appropriateness of the information, assessment of the sensitivity of the presentation, pretesting of visuals, and testing of the preliminary product for acceptability, effectiveness and unintended effects.

For the most part, formative evaluation of training products has been limited to "expert review" of content for accuracy and appropriateness, and occasionally feedback from users about whether they liked the product or found it useful.

Several sites report having formal protocols for formative review of curricula or products in development--Delta Region ETC, the Kentucky site of ECAETC and the Morehouse site of EATN for curricula, Southern California and the Michigan site of ECAETC for materials--but as yet, there have been no reports forthcoming which document the conduct of these reviews, their findings or the way the findings were used to improve the final product.

There have been no reported formative evaluations of audiovisual materials developed, particularly on videos, which have required significant investment of ETC resources. As a result, while these products might have been well-received by the intended audience, there is currently no documentation of their educational value.

The only notable example of formative evaluation of an ETC product comes from the Ohio State site of ECAETC in which a field test was conducted as part of the development of its computer-assisted learning package. Approximately twenty physicians tested the package on their own computers under conditions similar to the intended user environment. The computer program itself allowed respondents to document difficulties or questions as they were encountered; these annotations were printed out and returned to the ETC. Upon completing the field test, the field test subjects responded to a questionnaire about the respondent's interest in the material, the importance, practical value, and adequacy of coverage of the content, self-reported improvement in knowledge, the quality, ease of use and value of the computer-assisted format.

The Western ETC has planned an elaborate evaluation of its forthcoming mental health curriculum module including a pilot-test and more summative evaluations of effectiveness in general use.

E. Approaches to Evaluation of Education and Training Programs

1. Standardization of Evaluation ETC-Wide

Initially, most of the ETCs reported resistance on the part of their sites to standardized evaluation. Over the two year period, a trend toward more acceptance of uniform procedures has been noted as relationships between ETC headquarters and their sites have matured and trust built. Particular success in implementing standardized procedures has been achieved where the procedures were developed collaboratively. On the other hand, the Delta ETC has developed a comprehensive "Manual of Operation for Evaluation" centrally which has been disseminated to all of the sites, yet there has been little evidence of its use.

Collection and reporting of output data, as described above, has been the major target of standardization. Nine of the ETCs have standardized event and participant data collection ETC-wide; Southern California and MAABETC are currently in the process of doing so.

The next most common targets of ETC-wide standardization is formative and/or process evaluation of individual education and training interventions. The specific approaches to formative evaluation of events is described in Section II.E.2 below. Delta, ECAETC, EATN, MAABETC, Mountain-Plains and NY-Caribe have designated forms for use ETC-wide which solicit feedback from participants about various aspects of the training.

NY-Caribe has developed and validated a pre and post-training attitude scale which is used routinely in conjunction with all of its training programs. Mountain-Plains has attempted to standardize procedures for assessing training effectiveness in enhancing knowledge, attitudes, belief and intended behavior (KABB) by developing a "pool" of KABB questions to be drawn upon by sites opting to do pre/post-training testing. Partially in response to requests for a standardized instrument, the Western ETC, through its San Francisco site, has developed and validated an attitude scale; it has been distributed in preliminary form to be used at the option of the sites.

EATN, New England and WAMI-0 each use relatively standardized procedures for doing follow-up on participants of selected intensive events to begin to gauge impact on practice.

2. Approaches to Formative Evaluation of Training Events

Formative evaluation of training events, for the purposes of this evaluation review, refers to the assessment of various aspects of the content, structure and/or process of the event with an eye toward incorporating the findings into the improvement of future events. Much of what the ETCs have called "process" evaluation is included. In the strictest sense, preliminary evaluations of effectiveness which feed into future programs are also formative, but are considered separately.

The most commonly applied approach to formative evaluation of training events is the post-training ratings of various aspects of the event by the participants themselves using a written questionnaire. The focus ranges from global assessment of the entire program to detailed ratings of presenters, sessions and teaching methods. Sessions and topics tend to be rated on

usefulness, practicality and relevance; presenters on clarity of presentation, educational skills and knowledge. These process-oriented evaluations provide documentation of the event and the way in which it was received, they are of limited value as formative evaluation because, while they may diagnose problem areas, they provide little specific direction for program improvement.

Open-ended questions which solicit post-training participant feedback provide more extensive data. "What did you like best?" "What did you like least?" and "What would you change?" are frequently asked open-ended questions. Delta ETC uses a variant on this approach, routinely asking participants to comment on "things I would change," "things I would keep," and "I would like to tell the presenter or program organizer . .." The Florida site of EATN uses an "extended evaluation" for its more intensive programs, asking participants for substantive comments on each presenter and session, an approach which has yielded rich formative data.

As a supplement to its participant feedback, EATN routinely obtains feedback from its trainers. Its "Trainer's Evaluation" form asks for the trainer's own assessment of, among other things, what went well with the session and how well the trainees and workshop objectives had been matched. On its "Training Report Form," WAMI-0 asks "which techniques worked best?" "which techniques did not work well?" and "what kind of problems (if any) did you encounter in your training?"

Several other approaches to formative evaluation are in use in selected instances. Exit interviews are routinely held for obtaining formative data from participants in clinical experiences organized by Mountain-Plains and EATN . In a number of instances, three to six month follow-ups are done, either by mailed questionnaire or telephone interview, in which respondents are asked to comment, in retrospect, about aspects of the training that have proven most useful. The Delta ETC uses a particularly innovative approach to formative evaluation in which PWAs who have been part of a panel are asked to comment on the overall program from the perspective of the trainees' potential clients.

For the most part, utilization of formative data for program improvement has been informal. The Maryland site of MAARETC, for example, takes a more formal and strategic approach. Intensive courses are subjected to detailed formative evaluation at the outset and the results fed back into course improvement. Ultimately a maintenance level of formative evaluation is built into ongoing courses. "One-shot" presentations are subjected to broad formative questions to ensure that the course planners continue to tune into the needs of the providers and provider agencies they serve; detailed evaluation with an eye toward improving specific components of the training in such courses is deemed unnecessary.

3. Approaches to Evaluation of Program Outcomes

The degree to which ETCs are evaluating program outcomes varies widely not only across ETCs but among the sites of a given ETC. However, interest in conducting evaluation of outcomes has been piqued even among ETCs where little or no outcome evaluation has here-to-fore been conducted. A variety of approaches to evaluating program outcomes has been noted. The examples below are illustrative and are not intended to be an exhaustive catalogue of outcome evaluation activities.

a. Evaluation of Effectiveness

For purposes of this evaluation review, the evaluation of effectiveness refers to the assessment of the degree to which a training intervention has met its instructional objectives relative to increasing knowledge, changing attitudes, enhancing skills and stimulating the "intention to act." While not identical, effectiveness roughly coincides with "immediate impact." (Immediate impact may measure outcomes that are not necessarily related to instructional objectives.)

Pre/post-training testing is the primary method used for assessing effectiveness of training in increasing knowledge, utilizing primarily multiple choice and true/false questions. This approach has been used only sporadically among ETC sites and, where used, its use has appropriately been limited to longer programs. The value of measuring the ability of participants to memorize random and isolated facts has been called into question by some ETC evaluatqrs.

Pre/post-training testing is also commonly used to measure changes in attitudes, beliefs and opinions felt to have relevance to AIDS caregiving. These changes are generally measured by presenting opinion statements and asking participants to rate the degree to which they agree or disagree with these statements. The NY-Caribe ETC appears to be the only site which has done significant validation of the attitude scales it uses.

Attitude assessment being done by the ETCs is beginning to move from assessments of more general attitudes such as homophobia, which are less susceptible to change via a limited training intervention, to more focused ones such as assessments of perception of personal risk, which are more likely to change in response to training. WAMI-0, in conjunction with its Substance Abuse Counselor Course, has developed a six-item scale to measure personal reaction to situations which some might consider personally risky. The scale is prefaced as follows:

> Sometimes what we know and how we feel are very different. Please read the following statements and circle the number that most closely corresponds with what you know about risk. Then circle the number that most closely describes your feelings.

The San Francisco site of the Western ETC is in the final stages of validating an attitude assessment instrument which includes scales measuring situation-based perception of risk, fear of contagion, emotions towards AIDS patients, and professional resistance.

The degree to which ETCs and their sites have borrowed pre/post-training questions or entire tests from one another, or have expressed interest in doing so, is a matter of concern. There have been a number of instances where such tests have been adopted, whole-cloth, without any consideration of whether they relate to the teaching objectives or content of the adoptive program. As a counter-example, the Mountain-Plains has made an effort to key items in its pool of KABB questions to specific units in its standard curriculum. Thus, when its sites select individual units for a particular training event, they can select only the appropriate test questions to accompany them.

Different approaches based on self-assessments have been used by ETCs. One of these approaches, the "self-efficacy" approach, calls on participants to directly assess the degree to which the training has contributed to a particular change--typically level of knowledge or degree of comfort with a particular situation or ability to perform a particular task. Effectiveness of MAARETC's Home Health Care training is assessed via an item that states: "As a result of this program, I think I'll feel more comfortable with HIV patients,' asking respondents to select "a lot more comfortable," "somewhat more comfortable," and "not more comfortable." WAMI-0 uses open-ended questions to assess the effectiveness of its more intensive programs. The evaluation questionnaire used in conjunction with its train-the-trainers program asks participants to "name one skill that you have acquired or improved as a result of attending this workshop?" while that used in conjunction with its substance abuse counselor training asks participants to "write one fact or idea from the training that you learned, and that seems important to you."

Other well-focused examples of the self-efficacy approach to determining the effectiveness of training change come from several of the Southern California sites. From the University of Southern California site:

As a result of this program, do you feel that you:

- know the current issues pertaining to HIV infection in the Latino Community?
- know what issues to cover when counseling HIV infected persons? when conducting an initial HIV evaluation?
- can conduct comfortably an initial HIV evaluation?
- can integrate sexual history taking and risk identification into one's own practice?

Paraphrasing a test item from UCLA:

On a scale of l-5, how much did attendance at the conference influence:

- your willingness to screen and care for patients with HIV infection?
- your decision whether or not to take sexual histories on patients you're seeing for the first time?

Another self-assessment method asks participants to self-report competencies prior to training and then again at the end of training. EATN uses this approach in the assessment of its train-the-trainers program. Participants are asked to report their confidence in their level of knowledge and skill with regard to various tasks, both clinical and teaching. EATN's South Florida site uses this same approach to gauge the effectiveness of its clinical training in increasing participants' comfort level in providing care to clients who are engaged in nine specific risk behaviors.

A third approach using self-assessment is done post-training only but asks participants to make retrospective assessments of the competence levels prior to training as well as at the end of training. This approach was borrowed from the one developed by the AIDS Task Force of the Society of General Internal Medicine for its "AIDS & the Primary Care Provider" curriculum, and has been used by New England for its faculty development workshop and by the Maryland site of MAAEETC in the evaluation of its HIV Counselor training.

Those ETCs that have addressed the effectiveness of training in stimulating participants to consider behavior change have done so from two perspectives. The first looks at behavioral intention--what will they do differently. The second looks at the effectiveness of the training in reducing specific barriers to action.

In assessing training effectiveness in stimulating behavioral intention, the central issue is the phrasing of the question "what will you do differently as a result of this training?" Subtle differences in the phraseology result in significantly different answers. Abstractly-worded questions seemed to have resulted in answers which are too diffuse or conversely, too detailed, to be of value. More concretely worded questions, pointing to categories of behavior and/or time limited changes, have produced far richer responses. For instance, for EATN's train-the-trainers workshop, behavioral intent is obtained from a question on the post-training questionnaire which asks: "what three things are you likely to do differently when you return to **your worksite?"**

While open-ended questions may provide richer responses, the difficulty of analysis in trying to link responses to specific course objectives is increased. More direct questions provide a tighter link between specific behavioral objectives. A question used by AETC-SC's UCLA site is illustrative:

> How likely is it that you will regularly take sexual histories on patients you're seeing for the first time?"

An interesting approach to evaluating training effectiveness in reducing barriers to **care is used by both the** UCLA **and SC site of the** Southern California ETC and in the evaluation of the MAAEETC Dental Program. Using a pre/post-training self-reporting procedure, participants are asked the extent to which specific issues serve as a barrier or deterrent for them in treating AIDS patients. The issues listed are specific to the training audience and relate to training activities aimed at diminishing these barriers. UCLA asks that each item be rated; MAAHETC asks that the two most significant concerns be identified from a larger list.

The MAAEETC Dental program uses an interesting time series design to assess effectiveness in a variety of areas. Self-reports of perceptions (the degree to which participants perceive that they are already treating infected individuals, the degree of risk they perceive that they encounter when treating HIV+ healthy individuals), readiness to act (opinion on appropriateness of treating HIV+ individuals in private practice), and intended behavior (plans to be immunized for hepatitis-B) are collected immediately pre-training and again post-training to assess immediate effectiveness. Longer term effectiveness is assessed by comparing pre-

training and follow-up responses to show either the persistence of changes measured directly after training, or the development of even more favorable view after analyzing what was learned in training or reassessing attitudes back in the context of their practice. Variables analyzed in the assessment of longer term effectiveness include perceptions of the degree to which they are already treating HIV+ patients, the appropriateness of treating HIV+ healthy patients in settings like their own, and the risks they face in treating HIV+ healthy patients, as well as attitudes which impede providers from becoming more involved in the care of HIV infected patients.

b. Evaluation of Impact

Evaluation of impact, for purposes of this evaluation review, refers to the extent to which participation in ETC training has led to changes in on-the-job behavior or has actually precipitated actions or events that would not have otherwise occurred. This is actually an assessment of mid-term impact. The true measure of impact is improvement in outcomes, both physical and psychological, of people with HIV/AIDS. However, this is not only extraordinarily difficult to measure, but it would be virtually impossible to attribute any such change to a given intervention or even to the collective interventions of an ETC given the volume of potential confounding variables in the environment.

Impact on on-the-job behavior is measurable only after a participant has had an opportunity to return to work and apply newly acquired knowledge. Therefore, one would expect some lag time before impact evaluations would be undertaken. At this time, only EATN, MAARETC, New England, the Western ETC, WAMI-0 and the UCLA site of Southern California have actually begun implementation of impact studies.

Almost all of the impact evaluations have involved follow-up studies of one sort or another. Data for most of the follow ups have been collected from the participant; in one study, data was collected from patients of the participants. Time frames have generally been between three and six months post-training. Respondents have been followed up variously via telephone interviews and using mailed questionnaires, and, for the most part, follow-up studies are administered by the ETC headquarters.

EATN follows up on specific planned actions that participants reported at the end of training. In telephone interviews, participants are reminded of their planned actions and asked the extent to which these plans have been carried out.

4-6 -months after its train-the-trainers program, WAMI-0 conducts a telephone follow-up of participants, asking, among other things, the number of trainings conducted since attending the program, the types of groups of individuals the trainings targeted, the topics covered and the approximate number of people trained. Train-the-trainers programs that have focused on substance abuse issues have included a day on facilitating organizational change, particularly regarding changing intake and history-taking procedures. Participants are followed up to assess successes and barriers to effecting change in the trainees' home institutions.

MAARETC measures the impact of its Dental Training program by comparing pre-test responses with follow-up responses to measure actual changes in

behavior: immunization for hepatitis-B, HIV screening procedures in place and infection control procedures being utilized. Evaluation of the train-the-trainers component of the Dental Training program further seeks to document impact by asking respondents to report the number of trainings, specifically in infection control, they have conducted since completing the course, as well as to report the number of individuals attending these events.

The Virginia site of MAAHETC is conducting an impact assessment of its "AIDS in Adult Institutions." Mailed questionnaires ask participants "What have you done with the information you learned from the AIDS Training Program?" Explicit response choices are given with room for additional comments:

- Disseminated info about HIV/AIDS to other staff
  Provided training programs for other staff
- Served as the HIV/AIDS resource person in my institution
  Learned to protect myself from infection
  Informed others how to protect themselves
  Provided counseling to HIV-infected individuals
  Determined my role in meeting the educational needs of clients during incarceration
  Determined my role in meeting the educational needs of clients upon release into the community
  Identified community resources and local AIDS service organizations

The New England ETC conducts follow-up evaluations to assess the impact of the faculty development programs and the mini-residencies. Questionnaires are mailed to participants from the NEAETC headquarters with a cover letter signed by the trainer. A month later, blind reminders with a second copy of the questionnaire is sent to all participants to give those who have not yet responded a second chance to do so. As a result, the response rate has been very high. Impact is measured in terms of:

- identification of specific things that participants do differently as a result of having taken the course; and

- identification of new educational programs on HIV infection/AIDS that the participants have developed, coordinated or served as an instructor which can in some way be attributed to participation in the NEAETC course.

In a special study, the UCLA site of Southern California conducted phone interviews with 1,500 patients of nurses and doctors who had participated in the sexual history training. Patients were asked if the provider asked 12 different types of questions including "are you sexually active or not, " "number of sexual partners you have" and "your sexual practices". They were also asked if they were offended when questions were asked about their sexual health. At the end, one question specifically asked: "Overall, do you feel that the provider has enough information about you to provide you with the best possible care?"

Mountain-Plains is in the planning stage-of its follow-up evaluation. Evaluation of impact will be conducted on the first generation train-the-trainers program, second generation train-the-trainers activities, and "outreach" training conducted by both first and second generation trainers. As originally envisioned, all participants were to be surveyed three months after training to ascertain the degree to which they have utilized information from MPAETC courses. It is anticipated that a sample of participants who received training will be followed up. The follow-up will rely primarily on mailed questionnaires but telephone interviews may be incorporated into the design.

Several unique approaches to impact evaluation have been noted. The MAARETC headquarters has taken another approach examining the impact its statewide sites have or have not had on their participants by comparing data from statewide needs assessment conducted by other agencies with like items on post-training evaluations. Items such as the percentage of providers reporting "comfort in dealing with HIV infected people" are examined. While the approach is relatively qualitative, MAARETC hopes to introduce some quantification into the study.

The Western ETC has piloted an approach to impact evaluation involving chart reviews of patients of residents that have participated in one of its clinical training programs. The chart reviews focus on the degree to which participants routinely do risk assessment and risk reduction counseling. A form was used for abstracting the information documented in the patient charts.

Recently, the Western ETC has begun a study of the impact of its training in increasing the number of physicians willing to see HIV+ patients. Using a "key informant" approach, a number of the ETC sites have identified, by name, the physicians and dentists in their communities who treat AIDS patients. This list, which the ETC reports has been surprisingly easy to compile, serves as a baseline for the assessment of impact. Repeat rounds will document any increase. New names on the list can be compared with training rosters to determine whether or not new entries to AIDS practice have previously been ETC training participants.

4. Unique and Interesting Techniques and Methodologies

In reviewing the evaluation methodologies of the eleven ETCs, several unique and interesting evaluation techniques and methodologies were noted. Several are highlighted below.

A number of the ETCs have made use of the "standardized patient" technique in the training and evaluation of individual trainees, particularly in professional school settings. Both the Northern and Southern Illinois sites of MATEC are involved in developing AIDS-related Standardized Patient Encounters for training medical students and residents. The evaluation component involves video monitoring of the doctor-patient encounter for later viewing and analysis and a follow-up session between doctor and patient where the patient offers a critique of the encounter. The University of Massachusetts and Brown University sites of the New England ETC have used this methodology with medical students and internal medicine residents to train them to educate and gather data from patients, and to evaluate their performance in doing so. Each student spends 15 minutes with one standardized

patient. The student is asked to obtain a focused and relevant history, perform a relevant physical exam, develop a differential diagnosis, communicate their impressions and provide patient counseling. The students are then given written feedback on their performance. The USC site of Southern California is also in the process of developing a package for teaching and assessing clinical skills using standardized patients. The cases have been developed and used in two training situations. Accompanying the cases is an evaluation form for the conduct of the interview. This evaluation form contains behavioral statements that will be rated by an observer in order to evaluate the trainee's conduct of an interview with the patient. The form includes items for introduction of self, for manner of obtaining information, for feelings and attitudes revealed, for the content of the interview, and for additional comments and suggestions.

The Alabama site of EATN has purchased a technology called the "Q-Sys t em," consisting of a portable computer with 32 response pads, much like those used on TV game shows. A set of questions and multiple choice answers are programmed into the computer to correspond with the content flow of the presentation. During the course of the presentation, the presenter triggers the computer to flash the appropriate question and answer choices on a large monitor for the trainees to see. Those seated at the response pad stations key in their answer. The responses are immediately tabulated by the computer and presented on the monitor. This immediate feedback enables the presenter to ascertain whether his/her points are being grasped before moving on to a new area. In addition, the responses are automatically stored in the computer for subsequent use in evaluation studies. The technology was found to be very engaging, keeping the trainees alert and lightening up the session. It may also turn out to be a motivational tool in that it enables trainees to position their own comprehension and attitudes, anonymously, among their peers.

The Maryland site of MAAHETC utilizes a methodology for evaluating the effectiveness of its HIV Counseling training program in improving counseling skills of the participants, particularly their ability to respond quickly and appropriately to statements of clients that potentially have significant consequences. The technique makes use of a paper and pencil test administered before and after training. The test presents statements that might be typically made by clients in a pretest or posttest counseling situation. Participants are asked to write down the first thing they would say to the client following each of the statements. The responses are scored as follows: Detracts (-1); Neutral (0); Somewhat Facilitative (+1); Very Facilitative (+2). The specific statements on the pre-training questionnaire and on the post-questionnaire are not the same, but the situations they represent are-- pre-test counseling session, post-test counseling with negative result, post-test counseling session with positive result.

MPAETC tested a methodology, introduced by the Utah site, called the "educational grid" to assess the degree to which trainers effectively communicated their main points. Speakers were asked to list the main points they would try to make during their presentation on their Presenter Form, The Participants' Evaluation form contained a corresponding item, the Educational Intervention Grid, asking participants to list the main points that the speaker made. The speaker's lists and the participant's lists were compared and an average calculated which represented the speaker's success in conveying his or her main points.

The evaluation of MAARETC's Dental Program, both the train-the-trainers component and the training for practicing professionals, is notable for its elegant, yet simple design. The evaluation makes use of a time series design including a pretest, a posttest and a 3-6 month follow-up. Variables relate directly to the training objectives; questionnaire items measure these variables in subtle ways. The appropriate insertion of variables on the three instruments tap several dimensions of effectiveness and impact.

F. Evaluation of Other Project Activities

Although the ETCs have been involved in a number of project activities other than education and training events--initiatives to infuse AIDS content into professional school curricula, hotlines, information dissemination, for example--there has been little evaluation of such activities reported.

Several of the ETCs have conducted baseline surveys of the status of AIDS content in professional school curricula, most notably the extensive survey conducted by NY-Caribe in preparation for its curriculum development-oriented faculty development workshop. Evaluation of hotlines and information dissemination activities has been primarily output-oriented.

G. Status of Evaluation Activities

Collection of output data is done universally and routinely for ETC education and training events nationwide. Process/formative evaluation is carried out on the vast majority of these events. Beyond this basic level of evaluation, the degree to which the ETCs have undertaken evaluation varies from ETC to ETC, and from site to site and program to program within individual ETCs. Interest in and actual implementation of outcome evaluation has been increasing. Some of the ETCs have begun to establish a threshold, typically events of four hours to one-day in length, for conducting some outcome evaluation.

1. Evaluation of Train-the-Trainers Efforts

The level of train-the-trainers activities varies widely across ETCs:

- MATEC, through its sites, has been intensely involved in train-the-trainers activities, having conducted more than 50 varied train-the-trainers events in the first two years.
- Train-the-trainers was a major focus of the WAMI-0 program in the first thirty months of the program. Approximately 500 trainers have been trained through these programs; it is estimated that 300 are currently active trainers.
- NY-Caribe held a five-day summer train-the-trainers institute in each of its first two years and an abbreviated version the third year. Also in the third year, it did a faculty development course for

professional school faculty focusing on curriculum development around AIDS issues.

- The Western ETC has held two five-day faculty development workshops, one for its medical faculty and one for its dental faculty. In the second year, a second five-day dental program and a faculty retreat emphasizing training skills and psychosocial issues were held. In the third year, a 3-day clinical update for faculty, a dental refresher course, and a mental health faculty seminar were held.

- Mountain-Plains has conducted one regional master trainers program, while each of its state sites has conducted at least one in-state program.

- The NEAETC conducts annual regional faculty development workshops for medical school faculty; one of its contractors, the Massachusetts Hospital Association, has conducted five programs for institution-based trainers annually.

- Delta ETC conducted two-day TOT workshops based on the ETC curriculum in Louisiana, Mississippi and Arkansas, as well as a two-day dental train-the-trainers.

- MAAHETC has begun implementing a two-tiered dental train-the-trainers program through its five state sites.

- The Virginia site of MAAHETC has held five week-long train-the-trainers sessions.

- The West Virginia focuses its train-the-trainers activities on medical students. Students interested in doing training are given a three-hour training-of-trainers session, focusing on educational methods and techniques.

- EATN conducted a one-week regional nurse TOT program; an agency-specific train-the-trainers program has been conducted by its South Carolina site.

- The USC site of Southern California conducted an Instructors Training Program for family practice faculty.

- The Kentucky site of ECAETC held a train-the-trainers course to orient staff to its dental curriculum.

For the most part, evaluation of these train-the-trainers activities were subjected to basic formative evaluation. Several outcome-oriented evaluations were noted.

In addition to a strong formative evaluation component, the evaluation of the New England ETC's annual faculty development program has included an effectiveness component in the form of self-reporting of retrospective pre-training and post-training knowledge or skills proficiency on 13 AIDS-related

areas, along with an impact component in which subsequent trainings conducted have been identified through mailed follow-up questionnaires.

WAMI-0 has developed an extensive set of evaluation instruments for use in conjunction with its train-the-trainers program including: a workshop needs/demand planning survey; a community assessment sheet; a pre-training questionnaire which ask participants to rate their own level of confidence in the knowledge base and teaching ability in a long list of AIDS-related topics; a training plan; a training plan which provides a baseline for impact evaluation; a course evaluation form which collects process-oriented formative evaluation data; a participant evaluation questionnaire which collects data from individuals subsequently trained by train-the-trainers participants assessing the training performance of the latter; a training report form which collects -output data; and a telephone follow-up form which is used to structure the follow-up survey.

EATN used a modification of the WAMI ETC's approach to evaluate its nurse train-the-trainers program including: individual daily session evaluations; pre/post-training self-reported knowledge and skills, including the knowledge and skills to be able to conduct a variety of education and training programs; a post-training action plan; a six-month informal phone follow-up by the headquarters staff to determine impact in terms of plan completion (follow-up did not include obtaining impact-oriented information on trainings conducted); a trainer's evaluation of the course; and an analysis of costs.

MAAEETC dental train-the-trainers program is being evaluated using the same time series design (pre/post/follow-up) and instrumentation that is used to evaluate its "Dental Care Professionals" course with two impact-oriented questions added to the follow-up: the number of AIDS infection control courses presented by TOT participants, and the number of individuals who attended these courses. The follow-up study is now underway and data are coming in but have not yet been analyzed.

In a comprehensive evaluation of its 1990 faculty development seminar focusing on mental health issues, the Western ETC included pre/post-training testing of knowledge, attitudes and risk perceptions. Attitudes and risk perception were measured by means of 6-point Likert-type scales while knowledge was measured via multiple choice questions. Baseline ratings and change scores were examined as a function of participants' gender, race occupational status, and geographical location, as well as their previous clinical and personal contact with HIV-AIDS patients. Pre-training findings showed a positive skew in the attitudes and perceptions of risk among participants in this faculty development program. Probably because of this high baseline, overall increases in positivity were not statistically significant. One item, perception of risk from accidental needlesticks, showed a significant change in the desired direction, indicating that the program had been successful in reducing this concern.

2. Evaluation of Clinical Training Opportunities

Across the national ETC-network, a variety of training events have been offered that were "clinical" in nature. For the purposes of this review, "clinical" opportunities are those in which participants have the opportunity to learn and/or practice caregiving skills by interacting with HIV-infected individuals and/or others in an actual caregiving setting. Skills-oriented

workshops are not considered clinical training opportunities for purposes of this review. Clinical experiences have been offered primarily to medical practitioners, but have also been organized for other professions, and have varied in the length and intensity of the exposure.

Seven of the eleven ETCs offer some type of clinical training opportunity. Evaluation of these clinical trainings have been almost exclusively formative in nature--participant feedback on the content, structure and/or process of the event. A few exceptions have been noted.

In addition to extensive formative evaluation, the South Florida site of EATN evaluates the effectiveness of its mental health clinical experience via pre/post-training testing. Changes in knowledge, opinions, as well as changes in personal level of discomfort in working with individuals with various characteristics including clients with HIV/AIDS, those engaged in high risk behaviors, as well as those with non-AIDS-related conditions are routinely measured.

The "AIDS Clinical Training Program" for physicians, offered by the USC site of the Southern California ETC, utilizes a post-training questionnaire to evaluate the experience. In addition to the formative components of the evaluation, effectiveness of the experience has been evaluated using the self-efficacy approach. Participants are asked to "rate the impact this clinical experience has had" on their knowledge and understanding; professional habits and attitudes; technical skills; clinical skills (such as Hx, Px, Dx); and management skills. Further, they are asked: "As a result of this experience, do you feel you are able to diagnose and treat HIV positive patients, AIDS patients?"

The New England ETC offers a variety of clinical training experiences. Broad evaluation, including evaluation of effectiveness and of impact, are being conducted on three of them. These clinical experiences include both a didactic and a hands-on component. The Brown University and University of Massachusetts' mini-residencies for physicians are evaluated for effectiveness by measuring pre/post-training changes in self-reported confidence in undertaking six AIDS-related primary care tasks: answering patient questions; screening/history-taking; practicing infection control; counseling HIV+ patients; providing primary care management; and utilizing appropriate community resources and referral networks. The Beth Israel Nurses' mini-residency is evaluated using a post-training questionnaire that taps three dimensions of effectiveness: effectiveness of the experience in conveying specific nursing task-related information (gathered via open-ended questions); effectiveness in promoting insights ("As a result of this mini-residency, I discovered . . . . I realized...") ; and effectiveness in stimulating participant's intention to change the way they provide nursing care to people with AIDS. Both the physicians' clinical training and the nurses' clinical training have been evaluated for impact via a six-month follow-up questionnaire which asked participants to identify specific things that they are doing differently as a result of having taken the course.

The Western ETC pilot-tested a chart review methodology for assessing the impact of its clinical training for family practice residents to see whether they were incorporating risk assessment and risk reduction counseling into their day-to-day practice. The charts of 50 patients aged 12-50 who were seen for routine care in a family planning outpatient setting were sampled. The

charts were reviewed for evidence of sexual history-taking; evidence of STD history-taking; evidence of substance abuse history-taking and evidence of risk reduction counseling (including counseling on condom use, other specific risk reduction strategies, and/or distribution of patient education materials). In order to link outcomes to the training, institutional influences on risk assessment and risk reduction counseling were controlled by documenting the extent to which the institution had policies regarding documentation or whether the record forms included such questions.

3. Program Evaluation

For purposes of this evaluation review, program evaluation refers to the analysis of multiple events with similar objectives, content, structures and/or processes to determine collective outcomes. Throughout the ETC national network, there are a number of programs which involve a more or less uniform approach to a given offering over time or in various geographic locations. While, in many cases, identical or similar instruments, often including questions on behavioral intent, have been used to evaluate the individual events, there has been little analysis that would allow generalization across the program. The Northern Illinois site of MATEC is an exception where aggregate analyses of two programs have been conducted. The first was on a series of twenty-five sessions held for personnel of the Chicago Department of Health's neighborhood clinics. In response to the question "what will you do differently?" respondents overwhelmingly indicated that they would use universal precautions, indicating a highly successful program. The second analysis examined a series of eight l-2 day programs put on for the Bureau of Mental Health's local mental health centers. The response to the same question yielded very non-specific and diffuse answers. "Try to be more sensitive" and "nothing different" were predominate answers, indicating a much less effective program with regard to stimulating specific action.

Three of the ETCs have done aggregate analysis of several unrelated events. NY-Caribe routinely does pre/post-training attitude testing. Early in the project, it did an interesting aggregate analysis. Sites at which most of the attendees were academically-oriented showed high positivity on the pretest; these trainees showed modest gains in positivity and expressed only moderate satisfaction with the training. Trainees at sites in the front line of health care with significant chance of contact with PWAs (predominantly those in city settings) showed only moderate positivity on pretest; they, too, showed modest gains in positivity and were only moderately satisfied with the ETC training. Trainees at more remote sites with less chance of contact with PWAs began training with low positivity toward people with AIDS but showed significant increase in positivity on posttest; these trainees expressed high satisfaction with the ETC training.

The Mountain-Plains ETC has been doing aggregate analysis of training effectiveness based on pre/post-training responses on knowledge, attitude, belief and behavior items from disparate trainings held in three states. The common factor of events included in the analysis was that each of the events were one day or longer (i.e. expected to produce some change). The aggregate analysis of nine offerings indicates that participants feel that, as a result of training, they have sufficient knowledge to protect themselves from HIV infection. Because of lack of common content, structure or process,

conclusions speak only to the effects that AIDS training, in general, can have.

EATN is in the process of completing an aggregate analysis of training impact . Participants of three one or two-day conferences held in the winter of 1989-90 were followed up by telephone 12-13 weeks after training. In this follow-up they were asked, with regard to the things that they reportedly planned to do differently at the completion of training, what progress had been made. If no action had been taken, they were asked to explain. In the analysis, variables constituting constraints to implementation will be divided between factors within the control of the participant and those outside the control of the participant. Data from more than 80 participants have been collected and analysis is underway.

H. Outside Influences on ETC Evaluation Activities

The nature and/or extent of the evaluation activities of the ETCs have, to some degree, been influenced by outside factors.

1. Subcontractors

On one hand, pressure from subcontractors has imposed constraints on the ETCs' ability to implement their evaluation plans. Subcontractors were primarily concerned with delivering programs and tended to resist evaluation as simply an added administrative burden. Further, as roles and relationships were being defined between the ETCs and their subcontractors, the subject of evaluation sometimes piqued concern over regional control versus subcontractor autonomy. In the interest of building and preserving relationships with subcontractors, ETCs have tended to "give" on issues of evaluation in such instances of potential discord.

On the other hand, subcontractors have made significant contributions to regional evaluation activities. In a number of instances, innovative evaluation methodologies developed by one of the subcontractors were adopted regionwide. Subcontractors active in evaluation have served as models, stimulating other subcontractors to do more. In one case, the database developed by one of the subcontractors has served as the basis for a uniform database used by all of the subcontractors.

2. Continuing Education Credits

Certifying ETC events for continuing education credit tends to have a positive influence on evaluation: training providers and trainees know that evaluation is required and are more tolerant of evaluation conducted in this context. However, where credentialing organizations have control over the evaluation approach, there is potential for lack of uniformity of approach--one for programs for which continuing education credit is sought and another for the rest of the ETC programs.

3. Collaborating Organizations

Many ETC programs are presented in collaboration with other organizations, with the ETC as a co-sponsoring partner or with an ETC representative as a presenter in a larger program. Many of these

collaborating organizations are well-established and have long-standing management systems in place, including evaluation systems. In such collaborative situations, there is potential for competition over whose evaluation methodology will apply. All of the ETCs have reported experiencing this at one time or another. Some, like the North Carolina site of EATN, take a strong position, requiring EATN evaluation as a condition of their participation.

Since the field of AIDS players is relatively small and ETC staff often wear multiple hats, it is often difficult to determine the extent to which a given presentation should be considered an ETC event. The UTAH site of the Mountain-Plains ETC cites the use of the ETC evaluation tool as criteria as to whether to count the training as an MPAETC event.

4. HRSA

HRSA has always considered evaluation an integral part of the ETC program. Evaluation plans were included in each of the ETC's proposals; acceptance of these evaluation plans was implicit in HRSA's project award. During the first two project years, the ETCs looked toward HRSA for guidance as to where to place their evaluation emphasis. Only a few directives were forthcoming, such as the need to document minority participation. Beyond this, HRSA has provided little guidance in terms of the specific direction evaluation should take or level of effort ETCs should devote to evaluation activities. Some of the ETCs have taken the position that, until they are told otherwise, they will continue in the direction and at the level they deem appropriate. In other cases, perceived *lack* of guidance from HRSA has resulted in some degree of inertia with regard to evaluation activities, particularly in cases where the ETC has experienced pressure from its subcontractors to do less.

III. CONCLUSIONS

From the review of the evaluation activities planned and being carried out by the eleven ETCs, it is clear that the ETCs want to do meaningful evaluation. However, implementation of evaluation has not proven as straightforward as originally anticipated. In the first three years of the program, ETCs have experienced many competing pressures for their resources. Priority has been given to building intraorganizational relationships, establishing credibility in the marketplace, and providing needed and quality programs.

Over the three-year period, there has been positive movement in the evaluation sector: an overall increase in the level of evaluation activity; increased willingness on the part of trainers and subcontractors to collect evaluation data; development of more standardized approaches; and movement from basic program documentation and formative event evaluation toward evaluation of trainee outcome. However, there is further need to capitalize on the existing momentum and convert good intentions into action.

The need to define the national ETC program in terms of its outputs is as pressing as ever. A great deal of attention has been focused, by HRSA and the ETCs, on collecting and reporting output data, yet there is still little uniformity in the data. Although the ETC committee on data has made progress

in defining common data needs, the final draft of a national program and service record format has only recently been completed and no definitive action has yet been taken. As time goes on, the ETCs are becoming more invested in their own data systems, making future changes more difficult. Further, longitudinal comparability of individual ETC's data is becoming more and more compromised as decision-making about uniform requirements continues to be delayed.

The vast preponderance of evaluation activities to date has been process-oriented, the majority simply documenting participants' reactions to events, sessions and/or presenters. Only a few instances were noted in which formative evaluations were structured in such a way as to make a significant contribution in terms of adjustments in the content, structure or process of ETC programs. In only one instance was there evidence of a strategic plan to move from formative to summative evaluation,

A fair amount of outcome evaluation is in process or planned for the immediate future. Several instances of well-thought out evaluation designs were observed; however, there were many more instances in which there was little linkage between course curriculum and the outcomes measured. Several studies of the impact of various trainings on on-the-job behavior and/or implementation of planned actions are underway, and some preliminary findings are beginning to emerge. Results range from encouraging to disappointing. On the encouraging side, outcome evaluations conducted in relation to AIDS 101-type events suggest that the most often reported change was in participants' reported level of comfort in working with HIV/AIDS patients (interpersonal) and a better understanding of how to protect themselves from infection. This suggests that the most important effect of basic AIDS training is to stimulate a state of "openness to engage in the caregiving process" and perhaps "readiness to learn what to do." Findings of more task/skills-oriented training relate to the specific learning objectives of the individual event. For example, evaluation of a series of counseling courses noted an intention to be more sensitive to clients' confidentiality. In many evaluations which ask the question "what will you do differently?" the predominant answer has been "nothing" but these findings may be more an artifact of faulty instrumentation than of lack of impact. Truly disappointing, however, is the fact that only a very few of the potentially high impact, and often high cost, programs--training-of-trainers and, particularly, clinical training--incorporate a solid evaluation of effectiveness and impact.

Finally, there have been a number of interesting and innovative evaluation techniques developed and enlightening evaluations conducted around the ETC network. Unfortunately, on one hand, there has not been as free-flowing an exchange of evaluation methodologies and potentially helpful results either inter-ETC or intra-ETC, as there could have been, while on the other hand, a good deal of the exchange that has taken place has resulted in inappropriate and inapplicable "borrowing" of instrumentation.

IV. RECOMMENDATIONS

In order to ensure that the following recommendations are practical, most have been drawn directly from the collective evaluation experience of the eleven ETCs themselves:

1. Evaluation should be more centrally controlled even, and perhaps particularly, at ETCs that are highly decentralized and autonomous, to ensure comparability and completeness of data. Promotion of standardized approaches to evaluation and evaluation designs, and coordination of evaluation activities is an appropriate function of the project's evaluation coordinator. Compliance with the ETC's evaluation program should be a condition of participation in the overall program. The ETC should monitor this compliance on an ongoing basis and provide technical assistance to sites that are having difficulty. Centralized data analysis is a way of simultaneously maintaining control and taking some burden off of the sites.

2. All ETCs should designate a person at the regional level to take responsibility for evaluation activities. That person should have a strong grounding in practical approaches to evaluation. At least .20 FTE should be allocated to evaluation activities. In cases where that individual has other program responsibilities, the .20 FTEs should be "protected time" for evaluation.

3. Collaboration, both intra-ETC and inter-ETC, on evaluation approaches and methodologies should be strongly encouraged. An evaluation committee should be established at each ETC with representation from each subcontractor/site with the ETC evaluation coordinator convening the committee and taking an active role in promoting such collaboration between meetings. Annual meetings of ETC evaluation coordinators should be sponsored by HRSA.

4. While a data committee comprised of representatives from several of the ETCs has been actively working to develop data recommendations, HRSA should ultimately define the set of standard data requirements for documenting all ETC education and training offerings in order to be able to characterize its program nationally in terms of federal priorities. (Precedents for federally-mandated reporting already exist within HRSA, for example, BHCDA's BCRR).

5. Databases of individual participant and event data, rather than aggregate data, should be maintained at the regional ETC level to allow for more in-depth analyses.

   Since the number of participants filling out evaluations is always less than the total number of participants, it would be useful to get a comparison of demographics of registrants versus those participating in evaluation in order to be able to generalize from the results of the evaluation.

   It may be useful to track trainer characteristics, particularly staff, versus affiliated versus per diem in order to correlate with trainee assessments or outcomes to see if one approach is better than another.

6. HRSA should specify minimum evaluation requirements. The following may be considered for discussion purposes:

a. All Offerings

Participant feedback should be routinely solicited at all offerings provided under the auspices of the ETC programs. Questions should be designed to identify specific areas where improvement could be made, not simply a documentation of how well the program or its components were received.

The effects of the offerings should be evaluated in a way that both anticipated and unanticipated outcomes are captured. Use of the adult learning theory model of self-assessment may be helpful in this regard. Some examples of ways to capture this data include open-ended questions phrased as follows:

- "As a result of having attended this workshop, I know . . . I feel . . . I believe . . . I can (do) . . ."
- "I leave this conference with the following new or additional knowledge . . . . . skills . .../ I leave this conference with the following changed views, beliefs . . . "

b. Offerings on Which Substantial ETC Resources Have Been Expended

Tests of random bits of knowledge are of little practical benefit. Evaluation of effectiveness of an event in communicating specific facts should be limited to instances where specific bits of factual knowledge are critical to the activities participants are being trained to carry out.

All offerings, except for conferences and other primarily informational sessions, on which substantial ETC resources have been expended should be evaluated in terms of the degree to which the training has stimulated a state of "openness to engage in the caregiving process" and "readiness to learn what to do." Offerings in this category include:

- offerings of four hours or more;
- offerings replicated more than once (i.e. substantially the same content, format and presenters);
- offerings for which a formal ETC curriculum provides the structure;
- in-service training customized for a specific organization; and,
- didactic components of clinical offerings/practica.

In order to be a true test of the effectiveness of the offering, the specific attitudes, beliefs and behavioral intentions should be

directly related to the specific objectives of the offering. The approach to capturing this information--pre/post-testing, pre/post self-reporting, post-only self-reporting--should be selected according to the dimension to be measured. It is important that indiscriminate borrowing of questions and instruments be eliminated; adaptation is encouraged provided that borrowed items specifically relate to the course objectives.

c. Offerings Aimed at Changing On-the-Job Behavior (Regardless of Length or ETC Effort)

At a minimum, evaluation of any offering which is aimed at changing on-the-job behavior should include a post-training inquiry of "intention to act." The wording of these questions should be as specific as possible and should directly relate the course objectives and content. Allow for qualitative as well as quantitative differences. For example:

"In my practice, I intend to:

- Do a routine and comprehensive sexual history on all of my patients;
- Do a routine but selective sexual history on all of my patients;
- Do a comprehensive sexual history on patients I believe might be engaging in high risk behaviors;
- I do not feel it appropriate to do a sexual history given the nature of my practice;
- Other . . ."

d. Offerings on Which Significant ETC Resources Have Been Expended

All offerings on which significant ETC resources have been expended should be evaluated in terms of impact, in other words, the on-the-job behavior resulting from the training: implementation of new practices, changes in previous practice, new roles and tasks taken on, etc. Where planned action was captured post-training, the degree to which it was implemented along with barriers to implementation should be determined.

Offerings in this category include:

- offerings of twelve (12) hours or more;
- in-service training customized for a specific organization; and,
- clinical offerings/practica.

The assessment of on-the-job behavior may be done by collecting participants' self-reported behavior or client-reported behavior through mailed questionnaire, by telephone interview, by direct observation, or by chart review. On-the-job behavior of in-service training participants may be reported by the participants' institution/agency.

e. Train-the-Trainers Programs

Train-the-trainers (TOT) programs need better definition. It has been applied to AIDS training of university faculty, and institution-based trainers as well as preparing a cadre of ETC/subcontractor trainers. It is highly questionable whether some training, such as AIDS updates for faculty, should be considered TOT. TOT should imply not only some commitment to go on to do future AIDS training, but also to comply with training standards and reporting requirements set by the ETC.

The **ETCs** should control the quality of training being provided by trainers trained under its auspices, i.e. trainers should not being giving out misinformation or displaying biases. Therefore, individual participant assessment should be conducted as well as evaluation of the training program itself. **ETCs** should assess the knowledge base and sensitivity of all graduates of its **train-the-**trainers programs, even when these programs assume content expertise and focus only on training skills. This is best accomplished by observing trainers in action before certifying them as having **successfully** completed the program. In cases where participants are less content-sophisticated, pre/post-training testing may be appropriate.

HRSA is particularly interested in the impact of train-the-trainers programs in terms of the diffusion effect. If the definition of train-the-trainers assumes a close and ongoing association between the ETC and its train-the-trainers graduates, getting counts of second generation trainees should not be problematic. Counts can be obtained through periodic telephone or mail survey, or preferably via ongoing reporting.

f. Efforts to Impact Curriculum

At a minimum, an **ETC's** efforts to impact the curricula of professional schools should be evaluated in terms of process.

Where a significant amount of the **ETC's** effort will be invested in influencing curricula in its service area, more elaborate evaluation should be done. In such cases, an evaluation of impact should supplement the process evaluation. At a minimum, this requires a baseline survey of the status of HIV/AIDS prior to ETC efforts.

A variety of qualitative methods could be employed including focus group discussions, case studies, etc.

This minimum set of requirements should not be construed as the only evaluation to be performed. The **ETCs** may be conducting more extensive

and interesting studies and should, in no way, be dissuaded from doing so.

Even though progress has been made in gaining subcontractor participation in evaluation activities, it should be noted that the ETCs would probably welcome a directive from HRSA as a mandate from the funder would give them more leverage in achieving compliance, particularly in politically sensitive situations.

7. As programs mature, basic process evaluation of events should be de-emphasized, and intensive formative evaluation should give rise to a maintenance level of evaluation for quality control and management purposes.

8. ETCs should have an explicit plan for moving from formative to more summative evaluation. While some experimentation with instrumentation is functional, continued revision makes longitudinal comparability of evaluation data difficult.

9. All train-the-trainers programs should include a session on evaluation, including both an orientation to the ETC's evaluation methodologies and instruments, and a presentation of general concepts so that trainers can tailor evaluations to their particular programs.

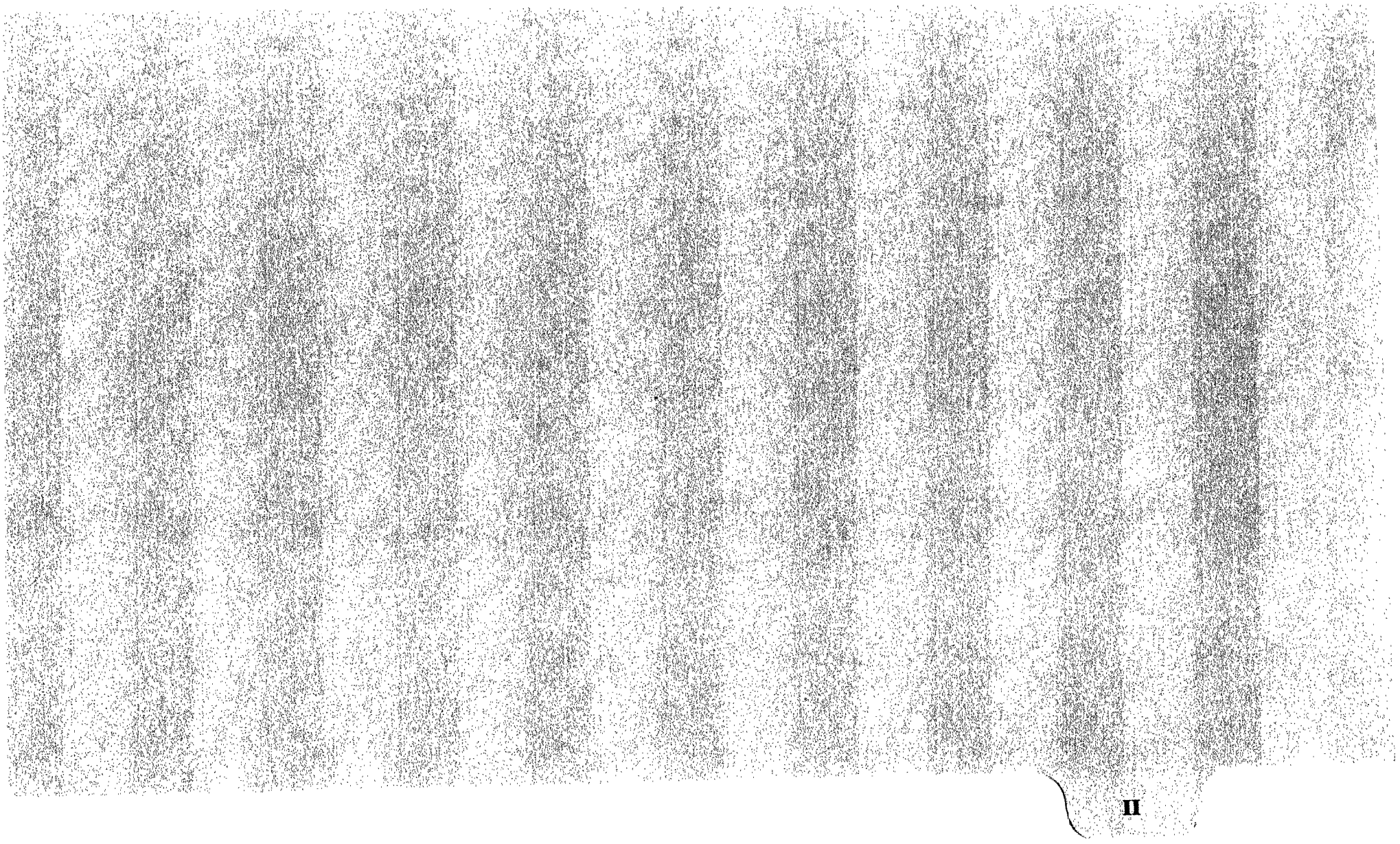
10. Many ETC products--curricula and media presentations--have been developed for wide distribution. A great deal of the ETCs' efforts and funds have been devoted to developing products. However, insufficient effort has gone into their evaluation. While most have been subjected to "expert reviews," none have had an extensive formative evaluation including an evaluation of both intended and unintended outcomes.

    It is recommended that HRSA call a moratorium on the development of products which may be duplicative of existing products until more extensive evaluation of current products has been performed. It is further recommended that HRSA require that all ETC products developed henceforth undergo more rigorous evaluation.

11. The ETCs should be encouraged to do cost efficiency analyses; however, analyses of cost/benefit and cost/effectiveness are probably neither appropriate nor feasible.

    HRSA should develop the methodology by which cost efficiency analysis is done, with particular attention paid to definition of the cost centers and the cost allocation method(s) (e.g. direct cost, full cost, etc.) to be used.

12. ETCs should be encouraged to prepare or have subcontractors prepare formal evaluation reports for all events which intend to influence attitudes or/and behavior. These reports should include interpretation, conclusions and recommendations. Reports should be made available to HRSA for review at site visits.



AIDS EDUCATION AND TRAINING CENTER FOR SOUTRRRN CALIFORNIA

EVALUATION REVIEW

I. OVERVIEW

The University of Southern California School of Medicine is the prime contractor for The AIDS Education and Training Center for Southern California (AETC-SC) which serves a five county area of Southern California through the collaborative efforts of the University of Southern California, the University of California at Irvine School of Medicine (UCI), the University of California at Los Angeles School of Medicine (UCLA), and the Drew University School of Medicine (Drew). Each site functions independently, focuses on areas of expertise, serves their unique institutional needs, and offers programs to practitioners within a specific catchment area.

The mission of this endeavor is to improve the care of HIV-infected patients in the Southern California area through the education and training of primary health care providers, to enable these providers to 'develop a better understanding of AIDS and HIV infection, and to prepare a proportion of these providers to train others. Education and training goals specify three levels of training to include didactic sessions, clinical experiences, and intensive clinical preceptorships for physicians, nurses, physician assistants, dentists, psychologists, social workers, emergency room staffs, students, and residents. The educational objectives and specific methods for each level of training are identified and specifically addressed in the case study report.

Each site reports separately regarding its activities and its progress in addressing goals and objectives. The evaluation plan calls for a process as well as an impact evaluation of programs. Sites do report using participant assessment forms for level one (didactic), two (brief clinical), and three (intensive clinical) programs but have not yet implemented a means of assessing the impact of a program or workshop. A region-wide plan to assess impact is currently under development.

II. THE ADMINISTRATION OF THE EVALUATION PROCESS

The evaluation process was, initially, to remain the responsibility of the individual sites. The sites varied in program and evaluation design with some sites focusing on process or formative evaluations and others emphasizing a more research oriented approach. During the spring of 1990 a plan was developed to coordinate an evaluation activity across sites.

A. The Evaluation Plan

1. The Evaluation as Proposed

The AIDS ETC for Southern California initially proposed two major components in the evaluation plan: program evaluation to determine the extent to which learning activities are appropriately and adequately provided at each of three levels of training and performance assessment to determine the extent

to which trainees have met educational objectives at designated criterion levels of performance. Each site was to be responsible for the design and implementation of evaluation instruments and for the regular reporting of evaluation results.

Program Evaluation: The proposal called for records to be maintained to document the number of learning programs, trainees, and courses; to track the objectives served in each of the courses; to document the methods and procedures used and the materials provided; to record the costs; and to document the trainees' general "acceptability" of the program. It was proposed that the quality of individual program components would be studied through post-program questionnaire and through direct observation of learning activities.

Assessment of Trainees' Achievement: Plans called for assessments to be conducted at each of the three levels of training:

- For Level 1, pre and post program data would be collected addressing knowledge (multiple choice question examinations).
- For Level 2, data would be collected "appropriate to the educational objectives of the learning program". Those training programs focused on knowledge acquisition would employ examinations, those focused on skills would employ observational techniques.
- For Level 3, participants would be observed at the conclusion of their training and over time. Rating scales would be designed to be used by faculty/staff. When appropriate, standardized patients may be used with observational rating scales. In addition, real patients may be trained in the use of observational rating scales.

Assessment of Student Learning Gains: Learner performance measures were to be developed for the educational objectives of each program. Decisions regarding overall assessment techniques were to be made by the Education Director in consultation with the training program personnel at each of the sites. Decisions concerning the assessment techniques would be based on program objectives and considerations of economy.

2. The Implementation of the Evaluation Plan

Overall, with the exception of the evaluative studies conducted by the UCLA site, evaluations have thus far been formative in nature. The sites are evaluating the learning activities at each of the three levels of trainings through participant assessments of program components. However, the AETC-SC is beginning to design means of assessing which trainees have met educational objectives at designated criterion levels of performance.

Needs assessments have varied by area. The different task forces have been utilized as a means of assessing the educational needs of targeted professional groups. In addition, the AETC is supporting (along with other California ETC programs) a survey of physicians throughout the state conducted

by the California Medical Society which will examine practice and attitudinal issues. This information will serve as baseline data to enable the AETC to measure impact. Project Staff have met with representatives from the AIDS dental clinic in West Los Angeles, the Los Angeles Commission on AIDS,, the Los Angeles County Medical Association, the Southern California Kaiser Permanente Medical Group to assess area needs. The Drew site is preparing a needs assessment targeted for minority practitioners.

A variety of demand or needs assessments are being conducted at different sites. UCI administers a needs survey before training programs and USC School of Medicine has been asked to conduct an assessment of faculty preparedness to supervise the care of HIV-infected patients as well as to offer instruction to students and residents, The Training Grant Continuation Application notes that a needs assessment was implemented in cooperation with the L.A. County OB/GYN Society in early 1989 and that questionnaires were sent to the Los Angeles Chapter of the California Society of Family Physicians, and to entering medical students at USC. The UCI site reports that AIDS learning needs of medical residents are assessed by a multiple choice examination and questions about AIDS related interests. Residents need more information about opportunistic infections and current treatments. Learning needs for nurses were assessed by a written survey of hospital and home care nurses. Over 100 respondents indicated that they needed more information about clinical treatments, nursing interventions, and symptom management.

B. Locus of Responsibility

Jerry Gates, Ph.D., Program Director, serves as the USC site director and as overall program director with responsibility for daily operation and management of the site including organization of the task forces and the development, implementation, and evaluation of the program activities.

1. Staff Responsibility

There is no individual responsible for evaluation at the project level.

The USC site reports that its site-specific evaluation is being emphasized during the second half of year two. Dr. Julie Nyquist is assisting with the design of evaluation activities and research studies and her time will be at 50% beginning in September 1990.

2. Subcontractors

The three subcontractors are the University of California at Los Angeles, the University of California at Irvine, and Drew University. Each of the subcontractors assesses training needs of the health professionals within the targeted area and is responsible for tailoring programs to meet those needs. Each of the subcontractors functions independently and is responsible for program planning, implementation, and evaluation.

Each primary training site has a site director to direct the training site and be responsible to the Steering Committee and the USC Program Director. Each of the site directors maintains responsibility for evaluation activities.

- Zemmar Lenoir, M.D., is the site director for ETC activities at Drew University and is assisted by Wilbert Jordan, M.D.

- Jeremiah Tilles, M.D., is the site director for ETC activities at UC Irvine and is assisted by Donald Forthall, M.D., the Clinical Education Coordinator, and by Shelia Fitzgibbons, R.N., the Training Specialist.

- Charles Lewis, M.D., Sc.D., is the site director for ETC activities at UCLA and is assisted by Mary Ann Lewis, R.N., D.P.H. and Maria Hayes-Bautista, R.N., M.P.H.

3. Advisory Responsibility

The Regional Steering Committee, comprised of nine members and chaired by the program director includes the principal investigators for the three subcontracting institutions and representatives from Nursing, Physician Assistant Program, Medical Education, Administration, and the USC AIDS Clinic. This committee determines region-wide policies regarding needs, priorities, program implementation, and evaluation. In addition, it is supposed to monitor the implementation of the scope of work and provide administrative and programmatic guidance and support to the subcontractors.

c. Coordination of Evaluation Activities

Each site is individually responsible for program development, implementation, and evaluation. Neither program nor evaluation activities are coordinated centrally. Each site sends in regular reports, summarizing activities, to the central site. UCLA collects data on all attendees at any in-depth training session and documents information on scope/topics, dates and any pre and post test results. This data is provided to the central offices at USC. UCI regularly submits program data forms. There is currently no indication, however, of how data will be coordinated centrally and analyzed or how findings will be reported over time.

D. Reporting of Findings

Each site individually prepares a summary report of activities and program results.

III. APPROACHES TO PROJECT EVALUATION

A. Monitoring

The AETC-SC has a central administrative, education and communication core unit at USC and each site has several individuals providing administrative support. The major format for inter-site communication is the monthly meetings of site directors.

There is no formal system established for the central site to monitor or evaluate programs or activities taking place at other sites. However, Dr. Lee and the previous project administrator did visit each of the sites during the first year of funding. Each visit focused on activities and staffing.

B. Output Evaluation

1. Data Collection

Each of the three subcontractor sites sends activity reports to the central site at USC. The Educational Activities Report (included in Appendix I) requires information for the following areas:

- Title of Presentation
- Location
- CE credits
- Presenter(s)
- Presentation date, length, location
- Presentation Objectives
- Target Audience
- Format
- Level
- Topics Covered

Two sites regularly fill in and submit these forms. The ETC plans to implement a revised Program and Services Record. This draft form is included in Appendix II.

2. Output Reports

The Southern California AIDS ETC has been able to report (September 1988) on the numbers of trainee participants, by professional group, for each of the three levels of trainings conducted. This progress report documents the development of curriculum, as well as activities for each of the three levels of training. Each site is requested to submit an educational activities report for each event and detail the title, location, length, objectives, and format of the presentation; the presenters; the target audience; and the topics covered. A new reporting form is currently in draft and will be used starting in June 1990.

Descriptive data is available for a majority of level 1 training which includes topics covered, length of program, presenters, and audience profiles. This information has not been grouped together for an overview of the area or for analysis purposes. During the first year, over 1,000 participants were trained (all sites) at level 1 training, 17 participants were trained (UCLA) at level 2 training, and 6 participants (USC and UCLA) were trained at level 3 training. During the second year, over 6,000 health care professionals participated in level 1 training over 1,000 health care professionals participated in level 2 training, and over 80 practitioners took part in level 3 training.

C. Cost Efficiency and Cost Effectiveness

No analysis of cost efficiency or cost effectiveness has been prepared as yet.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

Many AIDS curricula planning outlines, self-instructional programs, and videotaped simulated patient interviews had been developed prior to ETC funding. Twelve tapes and modules were developed by Dr. Lewis as part of the NIMH AIDS training project. Additional tapes are being developed with ETC funding, including a tape for use in training of Latino providers. The stated process for this development involves the following steps:

- Needs assessment conducted with key informants in focus groups
- Scripting, filming, and editing of video
- Formative review of video by the initial focus groups
- Revisions and development of accompanying guides and materials

V. APPROACBES TO EVALUATING EDUCATION AND TRAINING OFFERINGS

There has been no reported activity regarding evaluation of overall program outcome to date. Plans have been developed, in 1990, for an ETC-wide evaluation study, designed by Dr. Lewis and approved by all site directors. AETC-SC plans to apply standardized protocols to certain activities at all four sites. The plan calls for all evaluations studies undertaken at the individual sites to use the same instruments. One evaluation program will use a pre-tested approach to determining the impact of sexual history taking workshops on the behavior of physicians. A second will examine the quality of care provided to asymptomatic HIV positive patients. The third will use the critical incident methodology to assess the impact of training sessions for physician assistants and nurse practitioners.

A. Standardization of Evaluation ETC-Wide

There are no standardized forms presently in use to assess process or outcomes of training and education programs.

B. Approaches to the Formative Evaluation of Training Events

1. University of California Irvine Medical Center (UCI)

UCI reports consistent use of formative evaluation questions at all training and education sessions. The forms discussed here are included in Appendix III (Program Assessment: AETC Course Evaluation Forms and Pre- and Post-tests). The evaluation for "HIV Management Training Course" asked participants to rate various elements of the program on a 1 (poor) to 5 (excellent) scale. In addition, participants are asked to identify which events need improvement and to suggest means of improvement.

The Aids Presentation Evaluation assesses participant reaction to their educational experience by rating several categories: usefulness of material to present job activities, level of interest, level of information received, and for meeting expectations. In addition, participants are asked to specify what they initially hoped to obtain from the training experience that may not have been covered, to note the most and least useful part of the session, and to indicate future needs.

2. University of California Los Angeles (UCLA)

The UCLA site similarly asks participants to assess various elements of a workshop. For example, the evaluation form for "AIDS Workshop for the Primary Care **Provider"** asks participants to rate the days' event by indicating agreement or disagreement with a series of statements under the following general categories:

- Organization and Clarity
- Enthusiasm and Stimulation
- Instructor's Knowledge and Rapport
- Instructional / Group Skills
- Program Goals and Objectives

This instrument is included in Appendix IV.

The UCLA site offers training to facilitators to use trigger tapes developed as part of the NIMH funded contract. At the end of the training symposium, participants are asked to **assess** their experience and offer an indication of their own ability in facilitating small group discussion. A five-point rating scale is used with 1 rated as not effective and 5 as very effective. Participants are asked the following self assessment questions:

How effective was the training in helping you accomplish the following:

- Asking questions to clarify ideas?
- Drawing out the opinions of less involved group members?
- Remaining neutral?
- Dealing with challenges from the group?
- Preventing one person from dominating the group?
- Occasionally summarizing for the group the issues and areas that have been covered?

In addition, participants are asked to rate their level of comfort and indicate the strongest aspects of the training received. This instrument, "Facilitator Training Evaluation" is also included in Appendix IV.**

3. University of Southern California (USC)

The evaluation forms used with many of the USC programs asks participants to offer ratings on several program components. Participants indicate to what extent the program met expectations and met stated objectives. Ratings **(1=excellent, 4=poor)** are also offered for each of the

program sections and faculty. Two examples of evaluation forms "Latinas and AIDS - Program Evaluation" and "Meeting the Challenge of HIV Infection - Program Evaluation" are included in Appendix V.

In addition, both forms follow an adult education model and ask participants to indicate to what extent they now know certain information and can perform certain activities in their practice. These items reflect the workshop objectives. The rating scale is a four-point scale ranging from completely (1) to not at all (4). A specific example is offered in section C, below.

C. Approaches to Evaluating Training Outcomes

1. University of California Irvine Medical Center (UCI)

For some training activities, UCI uses an examination to assess level of knowledge about HIV. This multiple choice test focuses on transmission, prevention, precautions, use of various tests, as well as clinical manifestations, and other areas of medical knowledge. This. instrument , as previously noted, is included in Appendix III as part of the "Program Assessment" package referred to Section V.B.l. Also included is another pre test instrument in use at UCI which focuses on practitioner attitudes - most especially negative attitudes toward various people engaging in certain behaviors. For example, participants are asked to indicate their level of agreement (strongly disagree - strongly agree) with statements such as: "gays/bisexuals are getting what they deserve with AIDS" or "IV drug users are getting what they deserve with AIDS". In addition, participants are asked to answer other questions (with yes/no or true/false categories) related to their beliefs and practice such as:

- Can you distinguish the difference between adequate and inadequate coping?
- Denial of AIDS as a terminal disease should be looked upon as being psychologically adaptive.
- The US government should provide the means to quarantine people with AIDS and positive HIV antibody test.

For some training activities, UCI utilizes post tests of knowledge (multiple choice tests), clinical practice (true/false tests), issues (brief essay exams). One type of continuing education program for nurses includes an evaluation form that asks participants to view a videotaped scenario and fill out a form indicating the range of possible solutions, the benefits and costs of each solution, and personal values relative to each solution.

2. University of California Los Angeles (UCLA)

UCLA has queried practitioners about AIDS related experiences, practices and attitudes. The following questions have been included on forms used in 1984, 1986, and 1989 and can be used for comparison of change over time:

Practice Experience:

- Worked up a patient for AIDS or HIV Infection in 6 months previous to interview
- Caring for at least one patient with AIDs or AIDS-related complex

Sexual History Taking:

- Ask patients abut sexual orientation
- Ask patients about number of sexual partners
- Ask patients about sexual practices

Physicians' Attitudes:

- To what extent do you think the average physician is uncomfortable in discussing sexual matters with homosexual patients

The Practice and Attitude Questionnaire, currently being analyzed, has been used as a post test with doctors participating in a mandatory training program related to HIV/AIDS. The questions ask about current practice, the perceived effects of the conference attended, deterrents and incentives to treating AIDS patients, ratings for 29 knowledge and attitude statements, as well as a behavioral intention question related to taking sexual histories on patients seen for the first time. This instrument is included in Appendix VI. Examples of general assessment questions are:

- How did your attendance at the conference influence your willingness to screen and care for patients with HIV infection? (1= no influence at all, 5= considerable influence); and

- In retrospect, how do you feel about the policy of making attendance at this AIDS education program mandatory? (1= strongly disapprove, 5= strongly approve).

Examples of incentives or deterrents for treating AIDS patients are:

- Emotional issues faced by AIDS patients;
- Time required to treat these patients; and
- The necessity of discussing sexual practice.

Among the 29 knowledge and attitude questions are the following:

- I know how to convert sexual history answers to level of risk for HIV infection;
- Nothing can be done to help AIDS patients;
- It doesn't matter if I know the details of a patient's sexual history, because these behaviors can't be changed;

- HIV is not nearly as infectious as Hepatitis B; and
- Providers who care for a lot of persons with AIDS are often gay or bisexual.

The behavioral intention question focuses on sexual history taking:

- How likely is it that you will regularly take sexual histories on patients you're seeing for the first time?

Furthermore, participants are asked to indicate how influential the training was in influencing the decision to take sexual histories.

As an additional follow-up on this training, the UCLA site has conducted phone interviews with 1,500 patients of nurses and doctors who have participated in the sexual history training. The phone interview form and the preliminary results are also included in Appendix VI. Patients are asked if the provider asked 12 different types of questions including, "If you are sexually active or not", "The number of sexual partners you have" and "Your sexual practices". They are additionally asked if they were offended when questions were asked about their sexual health. At the end, one question specifically asked: "Overall, do you feel that the provider has enough information about you to provide you with the best possible care?"

3. University of Southern California (USC)

USC utilizes a self-assessment based on adult learning theory. Both the evaluation form for "Latinas and AIDS" and the form for "Meeting the Challenge of HIV Infection" ask participants to indicate level of knowledge and ability related to their practice. Both forms, referred to in Section V.B.3. above, are included in Appendix V. For example, participants in the "Latinas and AIDS" workshop were asked:

> As a result of participating in this program do you feel that you:
>
> a. know the current issues pertaining to HIV infection in the Latino Community?
>
> b. know what issues to cover: when counseling HIV infected persons?
>
> when conducting an initial HIV evaluation?
>
> c. can conduct comfortably an initial HIV evaluation?
>
> d. can integrate sexual history taking and risk identification into one's own practice?

USC utilizes a pre test questionnaire for several training programs. The questionnaire assesses attitudes, beliefs, and practice. With the implementation of a follow-up study, USC will be able to compare the two and offer a measure of change. For example, participants in the HIV Nurse Clinician Training Program are asked to fill in a pre-test to assess knowledge, attitudes and professional habits regarding HIV and AIDS currently held by health care workers. The questionnaire is included in Appendix VII. The first grouping of questions (l-35) asks participants to rate their level of agreement with items related to attitudes, beliefs, and practice. For example, some of the statements are:

- People with AIDS should be encouraged to continue working at their jobs for as long as they can;
  I would be embarrassed to have to explain proper condom use to a client or patient; and
  I feel prepared to counsel people who have recently learned that they are infected with the HIV virus.

The next group of questions ask-participants to rate **fifteen factors** indicating how each factor affects the desire/willingness to deal with HIV infected patients. On a one to five scale, 1 indicates a strong deterrent and 5 indicates a strong incentive. For example, three of the items are:

- Risk of acquiring HIV from needlesticks;
- Many HIV patients are young; and
- The need to take a complete sexual history.

The last six questions focus on factual information and are presented as a multiple choice quiz.

Similarly, a pre test for social workers asks participants to rate 11 attitude questions indicating level of agreement on a one to five scale and also includes the questions on deterrents / incentives and knowledge items. The instrument is included in Appendix VII.

The USC site is in the process of developing a package for teaching and assessing clinical skills using standardized patients. The cases have been developed and used in two training situations. Accompanying the cases is an evaluation form for the conduct of the interview. This evaluation form contains behavioral statements that will be rated by an observer in order to evaluate the trainee's conduct of an interview with the patient. The form, included in Appendix VII, includes items for introduction of self, for manner of obtaining information, for feelings and attitudes revealed, for the content of the interview, and for additional comments and suggestions. Thus far, the cases have not yet been used for evaluation purposes.

VI. EVALUATIONS CONDUCTED

Each of the four sites is involved in three levels of training which range from didactic presentations to clinical experiences and intensive preceptorships. Thus far, each site has maintained responsibility for the

design and evaluation of its own programs. The Drew site, because of late start-up, has not yet evaluated programs.

Overall, the staff feels that a majority of presenters are unwilling to use evaluation forms for short presentations. Since seventy-five percent of the level one programs are one hour in length, there is no data available for these presentations. The sites do utilize evaluation forms for level one programs of longer duration and for level two programs. There is no data available to document process or impact evaluation across the ETC.

The **UCI** site reports on both process and outcome evaluation. Program participants are queried at the completion of presentations and workshops and a feedback loop to program planners for needed re-design is reported. Evaluation of teaching process is achieved through participant assessments of the workshop. To date, **UCI** reports that they analyze the program strengths and weaknesses by evaluating teaching process and its impact on patient care providers and on the care of AIDS patients. To do this, they query practitioners' level of comfort caring for patients. **UCI** plans, in year three, to participate in the **ETC's** integrated outcome study.

The UCLA cite reports on both process and outcome evaluation. UCLA reported, in the first year of ETC activity, work with Kaiser-Permanente which provided an opportunity to conduct a test of the efficacy of the UCLA sexual history taking module on physicians' behaviors. Results will be published. Currently available information comparing survey results from 1984, l986, and 1989 does indicate a significant change in practice experience and sexual history taking among Los Angeles County physicians over time. While only 12% of Los Angeles practitioners asked patients about sexual practices in 1984, 18% did in 1989. More dramatically, while 23% asked patients about sexual orientation in 1984, 42% did in 1989. This finding is attached in Appendix VIII.

In addition, the UCLA site has been conducting interviews with 1,500 patients served by physicians and nurses who have participated in AIDS related training in order to assess the effects of asking sexual history. Results of this study will be published. Preliminary results indicate a 20% increase in the proportion of patients who felt that their doctor had enough information. The phone survey protocol and preliminary results, referred to in V.C.2. above, are attached in Appendix VI.

Furthermore, UCLA reports that in grant year two, UCLA evaluated the impact of the Chicano Studies Research Center's satellite teleconference (funded by CDC). This evaluation was based on a pre and post test assessment of knowledge and beliefs and will be published.

At present, USC reports that documentation is maintained for all training and educational activities and includes objectives, duration, target personnel, number of trainees, and teaching methods used. In addition, USC reports that trainees will complete pre and post program assessments for each activity. The post program assessments used to date are formative in nature and ask participants to rate or comment on the components of the workshop or training. Performance evaluation is being planned (see **"Objective** Structured Clinical Assessments" in Appendix VIII). By the end of year three, USC plans to have evaluation techniques developed for impact evaluation.

As an example of program summary data currently available, two program summaries are included in Appendix VIII. The evaluation for the "AIDS Project Los Angeles" is a process oriented evaluation. A majority of participants indicated that the program met the participants' learning needs and indicated that the program information will be useful for work. The individual presentation received ratings in the mid-range and above. At conference end, participants were asked to rate their willingness to treat HIV infected persons. The average rating was 3.8 on a rating scale of 1 (never) to 5 (always).

The "Dental Care and AIDS" evaluation included a process evaluation as well as a knowledge evaluation. Overall, the program was rated highly on the evaluation (4.6 out of a possible 5). Participants offered a high rating for i terns such as "met learning needs" (rating of 4.5) and "useful in work" (rating of 4.6). Well over half of the participants scored above 96% on the knowledge test, yielding a mean score of 88%.

A. Level 1 Training

Level 1 trainings consist of didactic presentations focused on increased awareness, understanding, and knowledge. The learning objectives are based on the educational needs of the professionals caring for people with HIV infection.

UCI reports the use of participant assessments of presentation or workshop components and has a variety of program assessment forms available for faculty use, including participant ratings and attitude questions, and knowledge items. For example, the nursing program Nursing Responsibilities in Caring for Patients with AIDS, included several levels of evaluation. Participants were asked to react to the presentations by rating usefulness, level of interest, level of information received, and degree to which the program met their expectation. In addition, participants were queried about the most and least useful parts of the session. For each of the individual workshops, participants were asked to rate the instructor. A nine-item true/false test is included in the program packet for pre and post test use. Summary results were not available at the time of the site visit.

USC similarly uses participant assessment forms for many of the level one and level two programs. The Latinas and AIDS program evaluation form (as discussed in Section V.B.3. above) asked participants to offer a self assessment on several program objectives as well as rate various elements of the program. Results were not available at the time of the site visit.

B. Level 2 Training

Level 2 trainings are brief clinical experiences in clinics, hospitals and community practices. Educational activities are designed to help participants utilize knowledge about HIV/AIDS in the clinical setting; to address personal concerns; and to apply a multidisciplinary approach to care. Other Level 2 programs are train-the-trainer programs.

In several instances, USC has conducted a pre-workshop survey of participants. For example, a program offered at the USC School of Medicine: Meeting the Challenge of HIV Infection for practicing family physicians and the program Dental Care and AIDS for practicing dentists queried participants, before training, about their current practice, including patient profiles and their own professional behavior. The program Review of Pediatric HIV/AIDS Infection, offered at the Fifth National Pediatric AIDS Conference and a program for Social Workers both utilized a pretest that included questions about attitudes and fears related to HIV/AIDS as well as multiple choice knowledge items. Use of these pre-test forms offers an opportunity for a follow-up and an analysis of change. Thus far, there has been no follow-up survey of these participants. These pre-test forms are all included in Appendix IX.

The Instructor Training Program at USC provides an example of a level two training of trainers. A program designed to prepare individuals to serve as instructors or trainers for other programs was offered to family practice faculty. Eight faculty members received training on pre and post HIV test counseling and risk assessment and then served as facilitators during the training of community based physicians in a day long workshop. There is no indication of how performance was judged.

C. Level 3 Training

Level 3 trainings consist of intensive clinical preceptorships involving the direct care of patients with HIV/AIDS. This experience is focused on enabling trainees to diagnose HIV related medical problems; to treat the complications of HIV infection in the ambulatory setting; and to become familiar with available materials for AIDS education.

The HIV Nurse Clinician Training Program offered at USC serves as an example of level three training. The program consists of readings and a needs assessment prior to training; an intensive week long program involving small group workshops, didactic sessions, skill development sessions; a rotation through six different clinical experiences at sites around Los Angeles (two per week for six weeks); the development of a plan to impact HIV care and education at the home institution; and a follow up needs assessment and report.

The course structure provides several opportunities for process and impact evaluation. Before the week long program, participants conduct a needs assessment in their home institution to better understand attitudes and knowledge among the nursing staff. Six months after the completion of the program, participants repeat the needs assessment procedure in their hospitals. The results of these assessments will be used to help measure impact .

This is a unique evaluation design. While the results of this second needs assessment will **not truly reflect the quality of the program or of the** nurse's activities, the process provides a valuable learning experience for the participants. However, follow-up interviews with participants will provide valuable data that could enable the evaluator to assess change in

practitioner attitudes or behaviors, The time period has not yet elapsed for the first group of trainees to complete this second assessment.

There are additional opportunities for assessment for this level three training. Structured discussions at the end of each day enable participants to offer feedback to course faculty. At the end of the program, each participant presents a case. While there is no standard format for evaluating this presentation, there is ample opportunity here to assess participant understanding. A sample of the program evaluation form in current use is included in Appendix X.

The AIDS Clinical Training Program for physicians offers continual opportunity for observation, correction, and evaluation as the trainee works closely with staff. Furthermore, the program concludes with a practitioner self assessment and course evaluation. A copy of the Evaluation and Participant Feedback form is also included in Appendix X. Participants were asked about their expectations, if their objectives were met and if they thought they could meet the stated learning objectives as well as comment on their ability to diagnose and treat HIV positive patients and AIDS patients. In addition, participants were asked to rate and comment on the various components of the clinical experience. The resultant data is not yet summarized for this program. A follow-up telephone interview focused on course evaluations and queried participants about current needs. USC is currently looking at the possible use of the standardized patient format to assess clinical skills.

VII. SUMMARY OF ISSUES AND CHALLENGES FOR THE FUTURE

While the independent functioning of each site enables each institution to determine its unique needs and utilize its own expertise, there is potential for duplication of effort across sites for the development and design of both programs and evaluations.

Although the ETC is decentralized with each of the sites operating quite independently, program development could gain from a commonly shared approach to evaluation. The utilization of uniform pre and post intervention measures and/or uniform measures on follow-up would enable the ETC to assess overall impact and progress in the region. The measures could incorporate behavioral intent and behavioral change. This effort would need support at the site director level.

To date there is no central site budget. However, a collaborative effort to assess project impact would be facilitated by an evaluator position. An evaluator, commonly supported by each of the sites, could be responsible for the design and analysis of a follow-up assessment of a sampling of participants from all sites in level 2 or level 3 training.

The 1990 Training Grant Continuation Application reports the intent to develop an ETC wide evaluation effort, using standardized protocols and identical instruments across sites. As the various sites move in the direction of collaboratively developed instruments, one relatively simple first step might be an agreement to query participants for first and second

level training about behavioral intent. A follow-up with a sampling of participants across sites could probe for behavioral change.

In many instances a good deal of valuable pre-training information is being collected. This information relates to attitudes, knowledge, and reported practice. Follow-up studies would allow sites to compare pre and post results for an analysis of change.

Several unique activities should be highlighted in a case study report and a qualitative evaluation review. The "Adopt an AIDS Patient" effort coordinated by Dr. Jordan at Drew University in his work with community churches could serve as a model of community and health center coordination in the care of HIV/AIDS affected individuals. The well designed preceptorship program is worthy of a focused case analysis and qualitative evaluation review. A follow-up study of participants in the preceptorship program would be very insightful and could offer valuable information to other ETCs.

APPENDIX I

Output Evaluation -- "Educational Activities Report"

AIDS EDUCATION and TRAININGCENTER
for SOUTHERN CALIFORNIA

EDUCATIONAL ACTIVITIES REPORT

TITLE OF PRESENTATION: _____

LOCATION: _____ **CE** credit provided?

PRESENTER **(s):** _____ Date: _____

_____ Length: _____ **(hours)**

_____ Location: _____

PRESENTATION OBJECTIVES **(s):** _____

_____

_____

TARGET AUDIENCE: _____

Participants	Community Based	In-house	Faculty
Number in practice	_____	_____	_____
Number in graduate/residency training	_____		
Number who are students	_____		

Others in attendance: _____ Number: _____

FORMAT:

Lecture
-Demonstration
__Group Discussion
__Role Play

Brief clinical experience
Case Conference
___ Other

LEVEL:

__Knowledge & understanding
Technical Skills
__Problem Identification

__Problem Solving & Management
Professional habits I? attitudes
Interpersonal & communication skills

TOPICS COVERED: (Indicate all that apply)

__Basic information
Fears and concerns of health care practitioners
__Update about AIDS
Prevention
Community resources
Treatment and care

Human sexuality
Psychological and Emotional Issues
Legal and Ethical Issues
Substance abuse and treatment
Other topics and issues _____

_____

Level 1 + 2
compliance with 2 sites - Inner
USC

APPENDIX II

Output Evaluation -- @aft "Program and Services Record"

-DRAFT-

AIDS Education and Training Center
PROGRAM 8 SERVICE RECORD

(1) Site [__] (USC, UCI, UCLA, Drew) (2) Date[_____]
yy mm dd

(3) Location [__] (LA, Orange, Riverside, San B., Ventura)

(4) Title [_____]
(25 letters maximum)

(5) Hours [___ 1

(6) Objectives [_____]
(20 letters maximum)

(7) Code [_] A = sole sponsorship
B = co-sponsorship

(8) Method [___]

A = Conference/Symposium	F = Teleconference
B = Lecture	G = Train-the-Trainer
C = Clinical	H = Workshop
D = Follow up	I = Other
E = Self instruction	

(9) No. of Participants [____]

(10) Minority Participants [_]

A = Caucasian (Non-Hispanic)	F = Puerto Rican
B = Black (Non-Hispanic)	G = Other Hispanic
C = Asian/Pacific Islander	H = Other
D = -Native American	I = Unknown
E = Mexican/American	

(11) No. Urban [_____]
No. Rural [_____ 1

(12) Discipline:

Physician	[_____1
Resident	[_____1
Nurse	[_____1
Dentist	[-----1
Dental Aux	I_____1
Allied Health	[_____1
Social Work/Mental Health	[_____]
PA/NP	[_____1
Other	[_____1

ETC PROGRAM AND SERVICE RECORD

Di · ·

The purpose of this reporting procedure is to document the nature and scope of activities sponsored or assisted by ETC and their regional sites per month. Each record should be completed for each documented activity. In each record listed, please attach an agenda and a list of faculty and/or contributions **if appropriate.**

Explanation of Categories:

1. Site - The two letter site designation should be entered here.

2. Date - The date (yy mm dd) of each activity.

3. Location- The county where the activity occurred.

4. Hours- This category defines "hours" in terms of the hours planned for an educational activity. Does not refer to the hours devoted to the activity by the learner. Document only whole and half hours.

5. Objective The specific measurable objectives which the documented activity meets should be identified by number (if applicable).

6. Sponsorship Code - This category specifies the nature of sponsorship in assistance provided by the ETC.

   A = Sole Sponsorship

   B = **Co-sponsorship (with one or more agencies or groups.** All co-sponsors should be listed on agenda attached for each activity).

7. Method - This category permits classification of educational methods used.

A = Conference/Symposium
B = Lecture
C = Practicum
D = Follow-up
E = Self-instruction
G = Teleconferences
H=Train-the-Trainer
I = Workshop
J = Other

8. Total Par - List total number of individuals participating in the educational activity.

9. Minority Participants -

A = Caucasian (Non-Hispanic)
B = Black (Non-Hispanic)
C = Asian/Pacific Islander
D = Native American
E = Mexican/American
F = Puerto Rican
G = Other Hispanic
H = Other
I = Unknown

10. Urban/Rural - Indicates the number of participants attending from rural an&or urban areas.

11. Site Staff- List names and affiliations of ETC personnel who participated in the delivery of the educational activity.

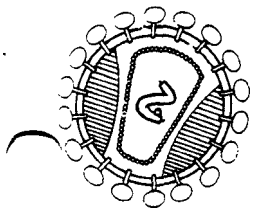
12. Discipline - List participants by discipline

Categories:
Physician
Resident
Nurse
Dentist
Dental Aux
Allied Health
Social Worker/Counselor
NP/PA
Other

APPENDIX III

Approaches to Formative Evaluation -- **UCI**

Program Assessment: **AETC** Course Evaluation Forms and Pre/Post-Tests



AIDS
EDUCATION AND
TRAINING
CENTER **FOR SOUTHERN CALIFORNIA**

University of California Irvine Medical Center
101 The City Drive South Rt. 81
Orange, CA 92668
714/937-7612

PROGRAM **ASSESSMENT**

AETC **COURSE EVALUATION FORMS**

AND PRE- AND POST- TESTS

HIV MANAGEMENT TRAINING COURSE

COURSE EVALUATION

Please circle appropriate number for each event.

Date: _____

	Excellent	Very Good	Satisfactory	Fair	Poor
Orientation	5	4	3	**2**	**1**
I.D. Clinic (UCIMC)	5	4	3	2	1
I.D. Clinic (LBVA)	5	4	**3**	2	**1**
Moral **&** Ethical **Seminar**	5	4	**3**	2	1
Psychology **&** Neurology **Seminar**	5	4	3	2	**1**
Case Management Conference	5	4	3	2	1
Journal Club	5	**4**	**3**	**2**	**1**

Which events needed improvement? _____

How? _____

Other comments: _____

AIDS Presentation Evaluation

Name of Speaker: _____ Date: _____

This questionnaire is designed to dssess your reaction to the presentation you have just attended. We are grateful for your assistance.

Put a check (✓) in the spaces along the line which best indicates your reaction to each of the following:

In terms of usefulness in your present job activities, the material presented will probably be:

Not at all useful ——— Useful on a dally basis

In terms of holding your Interest. the presentation was:

Not interesting at all ——— Exceptionally interesting

In terms of amount of information received, the material presented was:

Not informative at all ——— Exceptionally informative

In terms of meeting your expectations, to what extent did this session provide you wrth what you had hoped to get from thistraining experience:

Not at all ——— Met my expectations completely

If you indicated above that the session did not meet your expectations, what drd you initially hope to obtain from this training experience that was not covered?

_____

_____

_____

What do you consider to be the most useful part of the session?

_____

_____

What do you consider to be the least useful part of the session?

_____

_____

Do you want more training in thrs area? Yes_____ No_____

What specific subject areas would you like covered by this speaker or other speakers! in the future?

_____

_____

This examination is being given to assess your level of knowledge about HIV infection. Please fill in the date below and circle your current level of training. **Also,** please print your name at the top of this page.

Date_____/__/____ Level of Training: **R1** R2 R3 Other _____

Circle all correct **responses. There** may **be more** than **one correct answer** per **question.**

1. HIV may be transmitted by:

   a. Vaginal sexual contact
   b. Rectal sexual contact
   c. Orogenital sexual contact
   d. Kissing
   e. Sharing eating utensils
   f. Shaking hands
   g. Sharing needles
   h. Accidental needle sticks
   i. Breastfeeding
   j. Blood transfusions
   k. Childbirth

2. In order to protect to protect other people, and HIV-infected, asymptomatic person should be counselled to:

   a. Use condoms during sexual intercourse
   b. Abstain from activities that involve mucosal contact with blood, semen or vaginal secretions
   c. Avoid sharing of household utensils, such as eating utensils, towels and toothbrushes
   d. Avoid kissing
   e. Avoid jobs in the food service industry
   f. Avoid jobs that require doing lunch on frequent occasions

3. The approximate rate of seroconversion among health care workers who have received needlesticks or other significant exposures to HIV in the hospital or laboratory is:

   a. Less than 0.5%
   b. **Between** 0.5% and 1.0%
   c. **Between** 1.0% and 2.0%
   d. Greater than 2%

4. When examining a patient whose HIV status is not known, the following precautions **should** be taken:

   a. Gloves should always be worn
   b. Gloves should be worn only if contact with body fluids is likely to occur
   c. A gown should always be worn

d. A mask should be worn if splattering of body fluids is likely to occur
e. Protective eyewear should be worn if splattering of body fluids is likely to occur

5. HIV serology would usually be indicated in which of the following persons:

a. IV drug abusers
b. Male homosexuals
c. Female homosexuals
d. Sexual partners of IV drug abusers
e. Heterosexuals with multiple partners
f. Anyone presenting with a sexually transmitted disease
g. Family members of HIV+ persons who are not sexual contacts
h. All pregnant women
i. All immigrants from countries of high prevalence
j. All patients with tuberculosis
k. All patients with unexplainable febrile illnesses
1. All patients

6. HIV ELISA tests measure:

a. HIV antibody
b. HIV antigen

7. HIV Western Blot tests measure:

a. HIV antibody
b. HIV antigen

8. Which of the following are associated with primary HIV infection:

a. Cryptococcal meningitis
b. Pneumocystis carinii pneumonia
c. Aseptic meningitis
d. Mononucleosis-like syndrome
e. Rash
f. No symptoms

9. An asymptomatic HIV+ person, presenting as an outpatient, the following baseline laboratory examinations should always be ordered as part of the initial workup:

a. CBC with differential
b. Thyroid function studies
c. Serum electrolytes, BUN and creatinine
d. Liver function tests
e. VDRL

f. Epstein-Barr virus titers
g. Cytomegalovirus titers
h. Toxoplasma gondii titers
i. Pneumocystis carinii titers
j. ESR
k. Lymphocyte subsets

10. The following immunizations should be given to HIV infected, asymptomatic patients (if not previously immunized):

a. Influenza vaccine
b. Oral polio vaccine
c. Inactivated polio vaccine
d. Diphtheria vaccine
e. Tetanus vaccine
f. Pneumococcal vaccine
g. BCG

11. Therapy with AZT in HIV infected individuals should be based on:

a. Antibody titer
b. Antigen titer
c. Presence of positive HIV culture
d. T4 lymphocyte count
e. Presence of symptoms indicative of progression to ARC or AIDS

12. Common side.effects of AZT are:

a. Nausea
b. Headache
c. Neuropathy
d. Rash
e. Anemia
f. Leukopenia

13. During the first 6 months of AZT therapy, hemoglobin and white blood cell counts should be measured approximately every:

a. 2 to 3 weeks
b. month
c. 3 months

14. Asymptomatic HIV infected individuals with T4 cells $<200/mm^3$ who are taking AZT should be considered for primary prophylaxis against PCP with which of the following regimens:

a. Trimethoprim/sulfa
b. Inhaled pentamidine
c. AZT alone

15. Findings associated with the likelihood of progression of HIV infection to AIDS include:

a. T4 lymphocyte count **<200/mm^3**
b. Anemia
c. Elevated ESR
d. Oral candidiasis
e. Oral hairy leukoplakia
f. ITP
g. Loss of **p24** antibody
h. Appearance of **p24** antibody
i. Loss of **p24** antigen
j. Passage of time

16. The most common diagnosis indicative of AIDS in the U.S. is:

a. **Candida** esophagitis
b. Pneumocystis carinii pneumonia
c. Mycobacterium avium-intracellular infection
d. **Kaposi's** Sarcoma

17. The most common presenting symptoms in PCP include:

a. fever
b. cough
c. shortness of breath
d. sputum production

18. The most typical radiographical pattern in PCP is:

a. Consolidation of one or more lobes
b. **Pleural effusions**
c. Diffuse interstitial infiltrates
d. Cavitary lesions

19. A diagnosis of PCP can often be made:

a. On clinical grounds alone
b. By sputum gram stain
c. By special staining of sputum specimens
d. By bronchoalveolar lavage with special stains

20. First line treatment for PCP includes:

a. Respiratory Support
b. **Trimethoprim/sulfa**
c. Inhaled pentamidine
d. **IV pentamidine**

21. Cryptococcal meningitis in AIDS patients typically presents as:

a. An acute illness with headache and meningismus
b. A subacute illness with headache and few signs of meningeal irritation

22. The treatment of choice for cryptococcal meningitis in AIDS patients is:

a. Ketoconazole
b. Fluconazole
c. Amphotericin

23. After treatment of cryptococcal meningitis, patients should be:

a. Carefully followed without continued prophylaxis
b. given weekly amphotericin prophylaxis

24. AIDS patients with odynophagia or dysphagia should be evaluated for:

a. Herpes esophagitis
b. **Candida** esophagitis
c. CMV esophagitis
d. Hysteria

25. Appropriate therapy for **candida** esophagitis is:

a. Acyclovir
b. Ketoconazole
c. Amphotericin
d. **Trimethoprim/sulfa**

26. Which of the following are typical manifestations of mycobacterium avium intracellular infection in AIDS patients:

a. **"Wasting** syndrome"
b. Chronic diarrhea
c. Chronic fevers
d. Pulmonary infiltrates
e. Meningitis

27. The workup of diarrhea in AIDS patients should include consideration od the following organisms:

a. Cryptosporidium
b. Isospora **belli**
c. **CMV**
d. MAX
e. Pseudomonas aeruginosa
f. Salmonella
g. Streptococcus pneumoniae

28. In AIDS patients with severe diarrhea, the following would be appropriate empiric therapy, pending definitive diagnosis:

a. Metronidazole
b. **Trimethoprim/sulfa**
c. Lomotil
d. No therapy

29. Neoplasms associated with HIV infection include:

a. **Kaposi's** sarcoma
b. Bronchial carcinoma
c. Non-Hodgkin's lymphoma
d. Melanoma
e. Rectal carcinoma

1. Gays/Bisexuals are getting what they deserve with AIDS

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

2. Children are getting what they deserve with AIDS

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

3. I.V. drug users are getting what they deserve with AIDS

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

4. Hemophiliacs are getting what they deserve with AIDS

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

5. Women are getting what they deserve with AIDS

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

6. I could avoid AIDS by avoiding social contact with certain groups of people.

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

7. One could avoid AIDS by changing one's sexual behavior.

Strongly Disagree	Somewhat Disagree	Agree	Somewhat Agree	Strongly Agree
___	___	___	___	___

8. Have you ever taken a formal course on stress, crisis and coping?

_____ Yes

_____ No

14. Homosexuality is maladaptive behavior which could be corrected by psychological intervention.

_____True _____False

15. I could place myself and my family members at risk of contracting AIDS by caring for these patients on the hospital ward.

_____True _____False

16. The United States government should provide the means to quarantine people with AIDS and positive HIV antibody test-

_____True _____False

17. As a means of controlling the epidemic, people with AIDS should be prevented from holding jobs in the following areas:

a) those working in hospitals or in the medical field ___True ___Fa

b) those who have contact with the public ___True ___False

c) those working in the food industry or in restaurants ___True ___

I identify myself with the following:

Age Group: ___20 - 30 ___30 - 40 ___ > 40

Sex: _____Male _____Female

Marital Status: ___Never married ___Divorced ___Separated

___Living with opposite sex partner

Sexual Orientation: ___Heterosexual exclusively

___Homosexual exclusively

___Bisexual

Ethnic Identity: ___Asian ___Black ___Caucasian ___Hispanic ___(

AETC II
Post Test

AIDS and the Health Care Worker

1. "Fear of Contagion" refers to:

   A. AIDS patients fear of hospitalization
   B. Health Care Workers fear of becoming infected with the HIV virus
   c. Fear of polio

2. *Most* needlestick injuries could be prevented if:

   A. Nurses would recap needles quickly
   B. Nurses would stop recapping needles
   c. Physicians started giving injections

3. Three health care workers who have documented HIV seroconversion:

   A. Most likely acquired the infection through casual contact
   B. Had very unusual exposures to a large amount of blood for extended periods of time
   C. Had been giving personal care to home *care* patients

4. The occupation of health care workers at highest risk for an occupational exposure in the CDC study was:

   A. Physicians
   B. Nurses
   c. Occupational Therapists

5. The most important fact that has bee? learned about health care worker exposure to the HIV virus is:

   A. Most exposures could have been prevented
   B. Health care workers need to anticipate their possibility for exposure and use the appropriate precautions
   c. All of the above

Name: _____
Data: _____

AIDS TRAINING AND EDUCATION FOR NURSES
LEVEL 1

PRE-TEST **POST-TEST**

Directions: Please circle T if the statement is TRUE
F if the statement is FALSE
U if you are UNSURE

T F U	According to the Center8 for Disease Control (CDC), from 1983 to 1987 statistics on AIDS risk group8 have changed dramatically.	T F U
T F U	It is the nurses responsibility to discuss the HIV test results with the patient8 wife.	T F U
T F U	The nurse may be able to determine HIV risk status by doing a sexual history.	T F U
T F U	Diarrhea is uncommon in AIDS patients.	T F U
T F U	Pneumocystis Carinii Pneumonia (PCP) is one of the most common opportunistic infection8 found in patient8 with AIDS.	T F U
T F U	Behavioral change8 in patient8 with AIDS should be ignored by the nurse, because it usually indicate8 depression.	T F U
T F U	Neurological symptoms will not appear until late in a patient'8 diagnosis.	T F U
T F U	If a patient with AIDS ha8 a sudden onset of blurring vision it is fine to Wait 3-4 weeks for the patient to be 8een and evaluated by an opthamologist.	T F U
T F U	If a patient with AIDS is hospitalized and being evaluated for possible toxoplasmosis, the nursing care plan should include seizure precautions.	T F U

ETHICS: DECISION-MAKING FORM

Complete this form after each videotaped scenario to clarify the range of possible solutions, the benefits vs. costs of each solution, and your personal values relative to each solution.

ISSUE/PROBLEM: _____

SOLUTIONS			
BENEFITS			
COSTS			
VALUES			

SELECTION/ ACTION: Based on your assessment of the benefits vs. costs and your personal values, which solution would you pursue?

_____

EVALUATION: How did selection of the above solution make you feel? How do you think it will work in reality?

_____

Post Test Questions

1. **Identify four factors that distinguish AIDS from other life-threatening illnesses**
   1.
   2.
   3.
   4.

2. **Describe two** personal. **social. political. legal. or ethical implications of AIDS.**
   1
   2

3. **Describe two** relevant psychosocial **assessment criteria.**
   1.
   2.

4. **Discuss two skill bases essential for psychosocial intervention with the person with AIDS.**
   1.
   2

5. **Differentiate delirium from dementia.**

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF REGISTERED NURSING

1410 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-3350

For office use only
☐ Approved
☐ Rejected
By:.....
Provider #.00005.....

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

1. **PROVIDER:**

Name:			Phone:
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER NURSING EDUCATION/ RESEARCH DIVISION			(714) 634-5611
Address: Street and Number: 101 THE CITY DRIVE	**City:** ORANGE	**County:** ORANGE	**State:** CA / **Zip Code:** 92668

2. TITLE of COURSE:	Dates to be Given:	CE Contact Hours: (clock hours)
Moral and Ethical Dilemmas in AIDS	through fiscal year 1990	2

3. TYPE OF OFFERING: (Academic, Workshop, Institute, Conference, Inservice, Seminar, Lecture, Home Study, etc.)
Inservice/Workshop

4. PHYSICAL FACILITIES: (Classroom, equipment, learning resources, library, etc.)
Classroom

5. INSTRUCTORS: (Attach verification of instructor qualifications, CV)

Name:	Title:
Sheila Fitzgibbons, RN, PHN, MPA	Nurisng Instructor, AIDS Education and Training Center - UCI
	AIDS Clinical Research Coordinator

6. BRIEF DESCRIPTION OF COURSE:
In this workshop the learners will acquire an ethical perspective of AIDS. This workshop combines the videotape presentation of fictionalized scenarios that raise ethical problems about the care of patients with AIDS or HIV infection. This is followed by a discussion of possible solutions to each of the problems.

...

OBJECTIVES OF COURSE:

As a result of viewing and discussing the videotape on ethical dilemmas in AIDS, the learner will:

1. Be able to define the concept of informed consent
2. Be able to distinguish legal obligations from ethical responsibilities in the the area of confidentiality.
3. Be able to discuss the California BRN statement about a nurse's responsibility to treat patients with communicable diseases.

8. TEACHING METHOD(S):

Affective stimulation. Videotape. Group discussion

9. CONTENT (Outline Form):

I. Informed consent

II. Confidentiality, HIV, and the law.

III. Durable power of attorney for health care

IV. R.N.'s obligation to treat those infected with communicable diseases including HIV.

10. METHOD OF EVALUATION:

Completion of ethics decision making form. (See attached).

APPLICATION SUBMITTED BY: (Signature in full) ANN MARIE DONGLIS, RN, MSN, CNA	Title: DIRECTOR OF NURSING EDUCATION	Date:

PLEASE SEND TYPED-COMPLETED APPLICATION TO BONNIE KERR RN, BSN. RT. 86. AND YOUR EXTENSION NUMBER WERE YOU CAN BE REACHED.

ETHICS: DECISION-MAKING FORM

Complete this form after each videotaped scenario to clarify the range of possible solutions, the benefits vs. coats of each solution, and your personal values relative to each solution.

ISSUE/PROBLEM: _____

SOLUTIONS			
BENEFITS			
COSTS			
VALUES			

SELECTION/ ACT I ON **Based on your assessment of the benefits vs. costs and your personal values, which solution would you pura**

EVALU(N How did aelection of the above solution ma' **you feel? How do you think it will work in reality?**

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF REGISTERED NURSING
1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-3350

For office use only
☐ Approved
☐ Rejected
BY:.....
Provider #.00005.....

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

1. PROVIDER:

Name:			Phone:
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER NURSING EDUCATION/ RESEARCH DIVISION			(714) 634-5611
Address: Street and Number	**City:**	**County:**	**State:** / **Zip Code:**
101 THE CITY DRIVE	ORANGE	ORANGE	CA / 92668

2. TITLE OF COURSE:	Dates to be Given:	CE Contact Hours: (clock hours)
Clinical Treatments & Nursing Care for Patients with AIDS	through 1990	4

3. TYPE OF OFFERING: (Academic, Workshop, Institute, Conference, Inservice, Seminar, Lecture, Home Study, etc.)

Inservice

PHYSICAL FACILITIES: (Classroom, Equipment, Learning Resources, Library, etc.)

UC Irvine Medical Center - Classroom

5. INSTRUCTORS: (Attach verification of instructor qualifications, CV)

Name:	Title:
Sheila Fitzgibbons RN. PHN. MPA	AIDS Clinical Research Coordinator
	Nursing Instructor, AIDS Education and
	Training Program, UCI

6. BRIEF DESCRIPTION OF COURSE:

This workshop will cover Nursing Management for opportunistic infections and Kaposi's Sarcoma in AIDS. The other issues that will be addressed are: Epidemiological perspectives, and HIV Risk assessment.

Sheila Fitzgibbons, RN, MPA.
UC Irvine Medical Center

Nursing Responsibilites in Caring for Patients with AIDS

OBJECTIVES

1. The participant will be able to discuss the reasons why the nurse's role is important in the AIDS multidiciplinary approach.

2. The participant will be able to discuss three of the most common AIDS opportunistic infections and the signs. and symptoms patients may experience while hospitalized.

3. The participant will be able to discuss two nursing intervent ions related to symptom management in caring for a patient with severe oral candida (oral thrush).

I. AIDS as a Nursing Issue

A) Knowledge and Skills needed to care for patients with AIDS
B) AIDS and Primary Care Nursing
C) The nurse, the core to the AIDS multidiciplinary approach

II. Opportunistic Infection and Cancer in AIDS

A) Pneumocystis Carinii Pneumonia
B) Kaposi's Sarcoma
C) Mycobacterium Avium Intracellulare
D) Cryptococcus Meningitis
E) Toxoplasmosis
F) Herpes Simplex Virus
G) Cytomegalovirus
H) Primary Lymphoma
I) Cryptospor idiosis
J) Candidiasis

III Symptom Management / Nursing Invtervention Patients with AIDS

* Refer to Problems and Symptoms Associated with AIDS VNA-Handout

Handouts

1) AIDS Problem List and Suggested Nursing Care Plan

2) Sipes, Carolyn RN,BSN,MSN, "AIDS Update" Nursing Life Mar/Apr 1988

3) Table 6.1 VNA Home Care Hospice Manual 1987

Nan: _____
Date: _____

AIDS TRAINING AND EDUCATION FOR NURSES
LEVEL 1

PRE-TEST **POST-TEST**

Directions: Please circle T if the statement is TRUE
F if the statement is FALSE
U if you are UNSURE

T F U	According to the Centers for Disease Control (CDC), from 1983 to 1987 statistics on AIDS risk group8 have changed dramatically.	T F U
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T F U	If a patient with AIDS is hospitalized and being evaluate&for possible toxoplasmosis, the nursing care plan should include seizure precautions.	T F U

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF REGISTERED NURSING
1420 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-3350

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

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☐ Rejected
By:.....
Provider #.00005.....

1. PROVIDER:

Name:			Phone:
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER NURSING EDUCATION/ RESEARCH DIVISION			(714) 634-5611
Address: Street and Number	**City:**	**County:**	**State:** / **Zip Code:**
101 THE CITY DRIVE	ORANGE	ORANGE	CA / 92668

2. TITLE OF COURSE:	Dates to be Given:	CE Contact Hours: (clock hours)
AIDS: Issues for Nursing Education & Practice	through fiscal year 1990	4

3. TYPE OF OFFERING: (Academic, Workshop, Institute, Conference, Inservice, Seminar, Lecture, Home Study, etc.)

Workshop/Inservice

4. PHYSICAL FACILITIES: (Classroom, Equipment, Learning Resources, Library, etc.)

Classroom

5. INSTRUCTORS: (Attach verification of instructor qualifications, CV)

Name:	Title:
Sheila Fitzgibbons, RN, PHN, MPA	Nurisng Instructor, AIDS Education and Training
	AIDS Clinical Research Coordinator

6. BRIEF DESCRIPTION OF COURSE:

This vorkshop is designed to help learners identify and acknowledge their attitudes, feelings and values about educational and ethical issues related to nursing and AIDS. The learners will be Nursing Instructors and Nurse Educators.

OBJECTIVES OF COURSE:

After participating in this workshop the learner will be able to:

1. Identify the critical factors to be considered in the establishment of a policy regarding nursing students and their involvement in the care of patients with AIDS (PWA's).
2. Identify the institutional liabilities associated with a nurse presented with an HIV positive test result after being "exposed" and involved with care of PWA's.
3. Discuss affective issues related to care of PWA's including "burnout", emotional attachment/detachment, and value conflicts.

8. TEACHING METHOD(S):

Affective stimulation.
Videotape - group discussion

9. CONTENT (Outline Form):

I. Nursing school policy regarding students and the care of PWA's.

II. Barriers and fears that impede learning body substance precautions in Nursing Education.

III. Policy issues - HIV positive nurses.

IV. Affective issues in the nursing care of PWA's

a. value conflicts

b. burnout

c. emotional attachment/detachment

10. METHOD OF EVALUATION:

Post test

APPLICATION SUBMITTED BY: (Signature in full) ANN MARIE VONGLIS, RN, MSN, CNA	Title DIRE&R OF NURSING EDUCATION	Date:

PLEASE SEND TYPED-COMPLETED APPLICATION TO BONNIE KERR RN, BSN. RT. 86, AND YOUR EXTENSION NUMBER WHERE YOU CAN BE REACHED.

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF REGISTERED NURSING
1420 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-3350

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

For office use only
☐ Approved
☐ Rejected
By:.....
Provider #.00005.....

1. PROVIDER:

Name:			Phone:
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER NURSING EDUCATION/ RESEARCH DIVISION			(714) 634-5611
Address: Street and Number	**City:**	**County:**	**State:** / **Zip Code:**
101 THE CITY DRIVE	ORANGE	ORANGE	CA / 92668

2. TITLE OF COURSE:	Dates to be Given:	CE Contact Hours: (clock hours)
Psycho-social Aspects of AIDS for Nurse	through fiscal year 1990	2

3. TYPE OF OFFERING: (Academic, Workshop, Institute, Conference, Inservice, Seminar, Lecture Home Study, etc.)

Workshop/Inservice

4. PHYSICAL FACILITIES: Classroom, equipment, learning resources, library, etc.)

Classroom

5. INSTRUCTORS: (Attach verification of instructor qualifications, CV)

Name:	Title:
Sheila Fitzgibbons, RN, PHN, MPA	Nursing Instructor, AIDS Education and Training Center - UCI

6. BRIEF DESCRIPTION OF COURSE:

This workshop provides an overview of the psycho-social considerations in persons with AIDS. The workshop discusses the continuum of AIDS disability and the impact on the patient's life. A videotape is used to demonstrate an individual's personal account of how this illness has effect&d his life.

OBJECTIVES OF COURSE:

After participating In this workshbp the learner will be able to:

1. **Identify four factors that distinguish** AIDS from life-threatening illness.
2. Describe two relevant psycho-social assessment criteria.
3. Describe the difference between delirium **and dementia.**

8. TEACHING METHOD(S):

Lecture - videotape - group discussion

9. CONTENT (Outline Form):

I. Uniqueness of AIDS

II. Personal impact of AIDS

III. Personal account of a person with AIDS (videotape)

IV. Psycho-social data base/assessment

10. METHOD OF EVALUATION:

Post test - see **attached**

APPLICATION SUBMITTED BY: (Signature in full)	Title:	Date:
ANN MARIE DONGLIS, RN, MSN, CNA	DIRECTOR OF NURSING EDUCATION	

PLEASE SEND TYPED-COMPLETE3 APPLICATION TO BONNIE **KERR RN, BSN. RT. 86. AND YOUR EXTENSION NUMBER WHERE YOU CAN BE REACHED.**

Post Test Questions

1. Identify four factors that distinguish AIDS from other life-threatening illnesses.
   1.
   2.
   3.
   4.

2. Describe two personal, social, political, legal, or ethical implications of AIDS.
   1
   2.

3. Describe two relevant psychosocial assessment criteria.
   1.
   2.

4. Discuss two skill bases essential for psychosocial intervention with the person with AIDS.
   1.
   2.

5. Differentiate delirium from dementia.

STATE OF CALIFORNIA—BUSINESS, TRANSPORTATION AND HOUSING AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF REGISTERED NURSING
1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-3350

APPLICATION FOR CONTINUING EDUCATION COURSE APPROVAL

For office use only
☐ Approved
☐ Rejected
By:.....
Provider #. 00005.....

1. PROVIDER:

Name:			Phone:
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER NURSING EDUCATION/ RESEARCH DIVISION			(714) 634-5611
Address: Street and Number	**City:**	**County:**	**State:** / **Zip Code:**
101 THE CITY DRIVE	ORANGE	ORANGE	CA / 92668

2. TITLE Of COURSE.	Dates to be Given:	CE Contact Hours: (clock hours)
AIDS and the Health Care Worker	through fiscal year 1990	2

3. TYPE OF OFFERING: (Academic, Workshop, Institute, Conference, Inservice, Seminar, Lecture, Home Study, etc.)

Inservice/workship

4. PHYSICAL FACILITIES: (Classroom, Equipment, Learning Resources, Library, etc.)

Classroom

5. INSTRUCTORS: (Attach verification of instructor qualifications, CV)

Name:	Title:
Sheila Fitzgibbons, RN, PHN, MPA	Nursing Instructor, AIDS Education and Training Center - UCI
	AIDS Clinical Research Coordiantor

6. BRIEF DESCRIPTION OF COURSE:

This two hour workshop **discusses** body substance precautions for specific procedures related to care of the patient with AIDS in the hospital and home care setting. The workshop discusses **incidences** of HIV exposure in health care **workers**

154-441.CE4 (Revised 3/88

(Over)

7

OBJECTIVES OF COURSE:

See attached

8. TEACHING METHOD(S):

Video tape - group discussion
Slides - group discussion

9. CONTENT (Outline Form):

I. "Fear of Contagion" and its effect on health care workers caring for HIV infected patients.

II. Body substance precautions - video

III. HIV occupational exposure to HIV - U.S. and CDC data (slides).

IV. Prevention of HIV exposure in the health care setting.

10. METHOD OF EVALUATION:

Post test - see attached.

APPLICATION SUBMITTED BY: (Signature in full) ANN MARIE DONGLIS, RN, MSN, CNA	Title: DIRECTOR OF NURSING EDUCATION	Date:

PLEASE SEND TYPED-COMPLETED APPLICATION TO BONNIE KERR RN, BSN. RT. 86, AND YOUR EXTENSION NUMBER WHERE YOU CAN BE REACHED.

AETC II
Course Object ives

AIDS and The Health Care Worker

The participant will be able to describe appropriate infection control precautions when caring for the patient with AIDS or HIV infection

(2) The participant will be able to discuss the most common accidental exposure injuries and methods of prevention

(3) The part-icipant will be able to discuss "Fear of Contagion" and how this effects patient care

AETC II
Post Test

AIDS and the Health Care Worker

1. "Pear 'of Contagion" refers to:

   A. AIDS patients fear of hospitalization
   B. Health Care Workers fear of becominginfected with the HIV virus
   c. Fear of polio

2. Most needlestick injuries could be prevented if:

   A. Nurses would recap needles quickly
   B. Nurses would stop recapping needles
   c. Physicians started giving injections

3. Three health care workers who have documented HIV seroconversion:

   A. Most likely acquired the infection through casual contact
   B. Had very unusual exposures to a large amount of blood for extended periods of time
   c. Had been giving personal care to home care patients

4. The occupation of health care workers at highest risk for an occupational exposure in the CDC study was:

   A. Physicians
   B. Nurses
   c. Occupational Therapists

5. The most important fact that has been learned about health care worker exposure to the HIV virus is:

   A. Most exposures could have been prevented
   B. Health care workers need to anticipate their possibility for exposure and use the appropriate precautions
   c. All of the above

APPENDIX IV

Approaches to Formative Evaluation -- UCLA

1. Evaluation: AIDS Workshop for the Primary Care Provider
2. Facilitator Training Evaluation

AIDS EDUCATION and TRAINING CENTER
for
SOUTHERN CALIFORNIA

UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

EVALUATION

PRESENTATION TITLE: AIDS Workshop for the Primary Care Provider

DATE: Wed., 8-10-88 Thus., 8-11-88

INSTRUCTOR: Charles Lewis, M.D.

PLEASE CHECK APPROPRIATE CATEGORY: Physician Nurse Physician Assistant Dentist Behavioral Science other

DIRECTIONS: Please help us assess the effectiveness of this workshop by carefully rating the following. Check N/A if the behavior is not applicable or observed.

	Strongly Agree			Uncertain			Strongly Disagree	N/A
1. ORGANIZATION AND CLARITY								
a. Major points covered	1	2	3	4	5	6	7	( )
b. Communicated what was expected to be learned	1	2	3	4	5	6	7	( )
c. Presented in an organized manner	1	2	3	4	5	6	7	( )
d. Emphasized what was important	1	2	3	4	5	6	7	( )
2. ENTHUSIASM AND STIMULATION								
a. Stimulated interest in subject	1	2	3	4	5	6	7	( )
b. Was enthusiastic about the subject matter	1	2	3	4	5	6	7	( )
3. INSTRUCTOR'S KNOWLEDGE and RAPPORT								
a. Discussed points of view of other than his/her own	1	2	3	4	5	6	7	( )
d. Demonstrated breadth of knowledge	1	2	3	4	5	6	7	( )
e. Provided support and encouragement	1	2	3	4	5	6	7	( )
f. Encouraged a climate of mutual respect	1	2	3	4	5	6	7	( )
g. Demonstrated sensitivity to the needs of otherr	1	2	3	4	5	6	7	( )

4. INSTRUCTIONAL/GROUP SKILLS

a. **Encouraged** active participation in discussion 1 2 3 4 5 6 7 ( )

b. Utilized audio/visuals effectively 1 2 3 4 5 6 7 ( )

c. Gave positive reinforcement 1 2 3 4 5 6 7 ( )

e. Geared instruction to participants' level of readiness 1 2 3 4 5 6 7 ( )

e. Questioned to elicit underlying under standing 1 2 3 4 5 6 7 ( )

i. Demonstrated clinical procedures and **techniques** being taught 1 2 3 4 5 6 7 ( )

5. PROGRAM GOALS AND OBJECTIVES

a. Goals and **objectives** were appropriate for the participants 1 2 3 4 5 6 7 0

b. I obtained valuable information 1 2 3 4 5 6 7 ( )

c. I obtained valuable skills 1 2 3 4 5 6 7 ( )

d. My attitudes have been modified 1 2 3 4 5 6 7 ( )

6. Please indicate by a check in the appropriate range your opinion of the overall effectiveness of this program/ session.

1	2	3	4
OUTSTANDING (would recommend to others)	**GOOD** (would benefit fro8 suggestions below)	FAIR (needs to improve as indicated below)	POOR (should not pre **sen** t again)

ADDITIONAL COMMENTS:

etc
wider audience
publication

NIM + prod. materials
trigger lapes

Partic eval
trans of facilitator
to use trigger lapes

Facilitator Training Evaluation

w that 1 osium la over, we would like you to, once again ate the facilitator training session you • teneed. We believe that with the Infotmation you have gained from your, experiences facilitating, your opinions or suggestions may have changed.

---

1. How effective was the tnining in helping you accomplish the following:

a) Asking questions to clarify ideas?

Not effective 1 2 3 4 5 Very effective

b) Drawing out the opinions of less involved group members?

Not effective 1 2 3 4 5 Very effective

c) Remaining value neutral?

Not effective 1 2 3 4 5 Very effective

d) Dealing well with challenges from the group?

Not effective 1 2 3 4 5 Very effective

e) Preventing one person from dominating the group?

Not effective 1 2 3 4 5 Very efl ective

f) Occasionally summarizing for the group the issues and areas that have been covered?

Not effective 1 2 3 4 5 Very effective

2. After your experience at the conference, how comfortable do you feel facilitating small group discussions?

Not comfortable 1 2 3 4 5 Very comfortable

3. On average, how participative were the providers in your group(s)?

Not participative 1 2 3 4 5 Very participative

4. What wore the strongest aspects of the training you received?

_____

_____

_____

APPENDIX V

Approaches to Formative Evaluation -- USC

1. Program Evaluation: **Latinas** and AIDS
2. Program Evaluation: Meeting the Challenge of HIV Infection

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA
USC SCHOOL OF MEDICINE

LATINAS and AIDS

PROGRAM EVALUATION

DIRECTIONS: Please give us your opinion about this program. Your responses will be used in planning future experiences. Thank you.

	Completely			Not at all
1. Did this program meet your expectations?	1	2	3	4
2. Did this program meet its stated objectives?	1	2	3	4
3. As a result of participating in this program do you feel that you:				
a. know the current issues pertaining to HIV infection in the Latino Community	1	2	3	4
b. know what issues to cover when counseling HIV infected persons	1	2	3	4
conducting an initiil HIV evaluation	1	2	3	4
c. can conduct *comfortably* an initial HIV evaluation	1	2	3	4
d. can integrate sexual history taking and risk identification into one's own practice	1	2	3	4

4. Please rate each of the follow aspects of this program

	Excellent			Poor
a. Setting the record straight (Eunice Diaz)	1	2	3	4
b. Latinas in So. Ca. (Dr.. Hayes-Bautista)	1	2	3	4
c. HIV Health Services in So. Ca. (Dr. Lifshitz)	1	2	3	4
d. Latinas and Sexuality (Dr. Arguelles)	1	2	3	4
e. Latinas and Sexuality (Panel)	1	2	3	4
f. Culture, Spirituality and the Church (Panel)	1	2	3	4

Please provide additional comments:

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA USC SCHOOL OF MEDICINE

MEETING THE CHALLENGE OF HIV INFECTION

PROGRAM EVALUATION

DIRECTIONS: Please give us your opinion about this program. Your responses will be used in planning future experiences. Thank you.

	Completely			Not at all
1. Did this course meet your expectations?	1	2	**3**	4
2. Did this **course meet its stated objectives?**	**1**	2	**3**	4
3. As a result of participating in this course do you feel that you **:**				
a. know the current issues pertaining to HIV infection	1	2	**3**	**4**
b. know how to provide HIV test counseling	1	2	**3**	**4**
c. know what needs to be covered in conducting an initial HIV evaluation	1	2	**3**	**4**
d. can conduct comfortably an initial HIV evaluation	1	2	**3**	**4**
e. can comfortably provide pre HIV test counseling	1	2	**3**	**4**
f. can *comfortably provide* post HIV test counseling	1	2	**3**	**4**
g. can integrate sexual history taking and risk identification into one's own practice	1	2	**3**	**4**

4. Please rate each of the follow aspects of this course

	Excellent			Poor
a. HIV Infection Update (Dr. **Leedom)**	1	2	**3**	4
b. Persons with AIDS Panel Discussion	1	2	**3**	4
c. Risk ID and Sexual History Taking (Sm. groups)	1	2	**3**	4
d. Pre- Post-HIV Counseling (Sm. groups)	1	2	**3**	4
e. Review of skills **(Dr. Katsufrakis)**	**1**	2	**3**	4
f. Medical eval. of the HIV positive pt. (Dr. Rarick)	1	2	**3**	4

Please provide additional comments:

APPENDIX VI

Approaches to Outcome Evaluation -- UCLA

1. Practice and Attitude Questionnaire - Post Test
2. Phone Interview Form and Preliminary Results

UCLA Pract attitude factor analysis under ...

MD participants in training prog

1) Approximately, how many of the patients on your panel (caseload) do you suspect may be at risk for HIV? (please indicate an actual number. not a percentage) _____

2) Approximately. how many asymptomatic HIV+ patients have you seen? _____

3) Approximately, how many AIDS/ARC patients have you treated? _____

4) If you have cared for HIV+ patients: overall, how did you find working with these patients?

Much more difficult than you expected	1	2	3	4	5	Much less difficult than you expected

5) How willing are you to screen and care for patients with HIV infection?

Not at ail willing	1	2	3	4	5	Very willing

6) How did your attendance at the conference influence your willingness to screen and care for patients with HIV Infection?

No influence at all	1	2	3	4	5	Considerable influence

7) In retrospect, how do you feel about the policy of making attendance at this AIDS education program mandatory?

Strongly disapprove	1	2	3	4	5	Strongly approve

8) To what extent are the following issues incentives or deterrents for you to treat AIDS patients?

	Strong Deterrent				Strong Incentive
Emotional issues faced by AIDS patients	1	2	3	4	5
Time required to treat these patients	1	2	3	4	5
Potential exposure to HIV	1	2	3	4	5
Gay lifestyle of many AIDS patients	1	2	3	4	5
Treating rare infections	1	2	3	4	5
Prognosis of AIDS patients	1	2	3	4	5
The necessity of discussing sexual practices	1	2	3	4	5

The following statements reflect knowledge and attitudes about AIDS related issues. Please circle the number that best reflects how strongly you agree or disagree with the statement.

		Strongly Disagree				Strongly Agree
1)	Following universal precautions provides protection from occupational infection with HIV.	1	2	3	4	5
2)	I know how to convert sexual history answers to level of risk for HIV Infection.	1	2	3	4	5
3)	Many of my patients would be offended if I asked them questions about their sexual behaviors.	1	2	3	4	5
4)	I feel comfortable counseling patients about sex.	1	2	3	4	5
5)	Homosexuals with AIDS are just as deserving of sympathy as other patients.	1	2	3	4	5
6)	Nothing can be done to help AIDS patients.	1	2	3	4	5
7)	All patients admitted for trauma with active bleeding should be tested for antibodies to HIV.	1	2	3	4	5
8)	I hove some concerns about asking patients questions about their sexual behaviors.	1	2	3	4	5
9)	There is no reason for persons with AIDS to be seen separately (time or place) from other patients.	1	2	3	4	5
10)	There's nothing I personally can do to help an AIDS patient.	1	2	3	4	5
11)	I'm concerned about getting Infected with HIV from caring for persons with AIDS.	1	2	3	4	5
12)	It doesn't matter if I know the details of a patient's sexual history, because these behaviors can't be changed.	1	2	3	4	5
13)	Sexual health k an important port of a patient's general well being.	1	2	3	4	5
14)	Having AIDS patients in you office will not bother other patients.	1	2	3	4	5
15)	I know how to introduce sexual history questions into my history taking.	1	2	3	4	5
16)	Sex education Is not an effective way to prevent the spread of AIDS.	1	2	3	4	5
17)	I'm afraid of whot I might hear and have to deal with If I took a sex history on every patient.	1	2	3	4	5
18)	HIV is not nearly as infectious as Hepatitis B.	1	2	3	4	5

		Strongly Disagree				Strongly Agree
19)	The spread of HIV infection can be prevented.	1	2	3	4	5
20)	Having too many AIDS patients in your office or hospital makes it hard to recruit staff.	1	2	3	4	5
21)	Being exposed to HIV in the hospital environment is a real threat even to those who practice good infection control techniques.	1	2	3	4	5
22)	I feel uncomfortable discussing sexual practices with homosexual patients.	1	2	3	4	5
23)	Providers who care for a bt of persons with AIDS are often gay or bisexual.	1	2	3	4	5
24)	My commitment to screening for and providing care to HIV+/AIDS patients outweighs my concerns about interacting with this population.	1	2	3	4	5
25)	Homosexuals who contract AIDS are getting what they deserve.	1	2	3	4	5
26)	I am less emotionally prepared to deal with AIDS patients than cancer patients.	1	2	3	4	5
27)	My family k concerned about my being exposed to HIV at work.	1	2	3	4	5

28) How likely k it that you will regularly take sexual histories on patients you're seeing for the first time?

Not at all likely 1 2 3 4 5 Very likely

29) How did your attendance at me conference influence your decision whether or not to take sexual histories on patients you're seeing for the first time?

No Influence at all 1 2 3 4 5 Considerable influence

The next set of questions are about you. The answers will not be used to identify individuals but to help us classify answers.

1) What is your age? _____

2) Are you: _____male _____female

3) What is your specialty? _____

4) How long have you been practicing medicine?

Patient name:_____

Phone number:(day)_____(eve)_____

MD RNP MSW CRNA CNM PA

Hello. My name **is** _____. **I'm calling**
You **may** have received a letter **telling** you I was going to call. **I'd** like to ask you a few questions about a visit you had to (
We are interested in the **type** of information wc nave **about** our patients. No e will see your **answers,** and the questions will take about **five** minutes to answer. **Is** this a good time for me to ask you the questions?

My records say that you had an appointment:

in (department:) _____

on (date of appointment:) _____

Is that correct? Yes No

If no, Did you have **an** appointment? Yes No

If yes, correct infonnation above.

If no, terminate interview.

---

1) Was this your **first** visit to the (name of department) _____ department?

Yes **N o** DK

2) Was it the first time you saw that (type of provider)_____?

Yes No DK

3) We are interested in the discussion you had with your provider about your medical history. We don't need to know what your answers were, just **whether** or not your provider asked you certain questions. Please answer yes or no to the following **twelve** questions. Did **your** provider ask you about **your:**

Sleeping habits	Yes No	DK
Eatinghabits	Yes **No**	DK
Smoking habits	Yes No	**DK**
Use of medications	Yes No	DK
Use *of* alcohol	Yes **No**	DK
Use of recreational **drugs**	Yes No	**DK**
Use of seatbelts	Yes No	**DK**
Cholesterol **&** diet	Yes No	**DK**
Screening for colon/breast cancer	Yes **No**	DK
If you are *sexually* active or not	Yes No	**DK**
The number of sexual **partners you have**	Yes No	**DK**
Your sexual practices	Yes No	**DK**

a) *If no* to sex questions, Would you have been offended if the provider had asked you questions about your sexual health?

Yes No DK

b) *If yes to* sex questions, Were you offended when the provider asked you questions about your sexual health?

Yes No DK

4) **Overall,** do you **feel** that the provider has enough **information** about you to provide you with the best possible care?

Yes No DK

If no, What other type of information do you feel is important for providers to ask?

_____

_____

5) Was the provider you saw a man **or a woman?**

Man Woman DK

Finally, I have a **couple** of **questions about you.**

< 1 year 1-5 years **>** 5 years

7) My records say that your birthday is _____.

Is that correct?

Yes No DK

If no, When **is** your birthday? _____

That is all of the questions I have. Thank you for taking the time to help me.

Other comments:

Survey of pt. re. proc. who have been trained

Unpaid or practice

EVALUATION OF SHT

NURSES:DOCTORS = 200; PATIENTS = 1,500

EFFECTS OF ASKING SEXUAL HISTORY

QUESTION = a 20% increase in proportion of patients who felt doctor had enough information

		Before	After
Sexually Active	A	25	43
	B	17	17
No. of Partners	A	10	20
	B	5	6
Sexual Practices	A	10	20
	B	4	4

APPENDIX VII

Approaches to Outcome Evaluation -- USC

1. HIV Nurse Clinician Training Program - HIV Questionnaire
2. Social Workers HIV Questionnaire
3. Conduct of the Interview: Risk Assessment

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA
LAC/USC MEDICAL CENTER

HIV Nurse Clinician Training Program
HIV QUESTIONNAIRE INSTRUCTIONS

Introduction

The attached questionnaire is designed to identify the knowledge, attitudes, and professional habits regarding HIV and AIDS currently held by health care workers. By collecting data in many settings and over a period of time, we can measure changes resulting from educational programs, as distinguished from a general increase in knowledge about HIV. The information provided will also help us to improve the training program over time.

Purpose

The questionnaire will serve three primary purposes:

1. Evaluate the immediate impact of the HIV Nurse Clinician Training Program on the participants.
2. Identify the current knowledge and attitudes held by the co-workers of participants in order to evaluate the impact of future training activities designed by participants.
3. Identify whether or not the HIV Nurse Clinician Training Program has an impact beyond those who are participants in the program.

Instructions

1. Please complete the attached questionnaire upon receipt. This will help establish a baseline and will enable us to better evaluate the immediate impact of the training program. Please send the completed questionnaire to the AIDS Education and Training Center,USC School of Medicine,1975 Zonal Ave., KAM 200,Los Angeles, CA 90033, ATT: Susan Mowrey by 1-17-90. We are asking that you include your name so that we can match your pre-course responses with your post-course responses: however, your responses will held in the strictest of confidence and will not be shared with your instructors or with anyone else.

2. Please distribute this questionnaire throughout your facility, especially to those with whom you will be working during the coming year. You will need to do this prior to the beginning of the training course. Your co-workers should not identify themseives by name. Please collect, and mail the completed questionnaires when you send in your questionnaire.. We will compile and analyze the results for you.

AIDS EDUCATION AND TRAINING CENTER
FOR SOUTHERN CALIFORNIA
LAC/USC MEDICAL CENTER

HIV QUESTIONNAIRE

Hospital/Institutional Form

THIS QUESTIONNAIRE IS DESIGNED TO DETERMINE THE PREVAILING BELIEFS, ATTITUDES AND KNOWLEDGE HELD BY HEALTH CARE PROFESSIONALS ABOUT HIV AND ABOUT THOSE WHO ARE INFECTED.

All data will be treated in a confidential manner. Hospital: _____

Age: Sex: ____M - F

Ethnicity: White (not Hispanic) - Hispanic Black Asian Other

Educational Level: Please check the highest level attained

High School Diploma		
Graduate Diploma	Nursing	Other
AA-Degree	Nursing	Other
BA-Degree Baccalaureate	Nursing	Other
Masters Degree	Nursing	Other
Doctoral Degree	Nursing	Other

Field:

____RN
____LVN
Nursing Attendant
Allied Health (Specify)_____
Other Health Care Worker (Specify)_____

Work Setting: Please check your primary work setting.

Home Care	OB/GYN	Public Health
Intensive Care	Pediatrics	Surgical
Medical	Psychiatry	Other_____

Years of Nursing Experience_____

I have cared for or have supervised the care of number of patients with HIV infection.

PLEASE GIVE US YOUR OPINION REGARDING THE FOLLOWING STATEMENTS

Strongly Agree (SA)- Agree (A)= Neutral or no opinion (N) - Disagree (D)- Strongly Disagree (SD)

	Strongly Agree	A	N	D	Strongly Disagree
1. People with AIDS should be encouraged to continue working at their jobs for as long as they can	1	2	3	4	5
2. Homosexuals should be protected against discrimination just like any other minority group	1	2	3	4	5
3. I do not like working with homosexuals clients/patients	1	2	3	4	5
4. Most I.V. drug users have little regard for their own health	1	2	3	4	5
5. All patients should be tested for HIV antibodies	1	2	3	4	5
6. HIV results should be readily available on the chart of each patient	1	2	3	4	5
7. All health care professionals should routinely be tested for HIV antibody	1	2	3	4	5
6. Mandatory reporting of all persons who are HIV seropositive should become law	1	2	3	4	5
9. I would not mind working for someone who was openly gay or Lesbian	1	2	3	4	5
10. I.V. drug users are a difficult population to work with	1	2	3	4	5
1 1 . I.V. drug users are able to reduce their risk of becoming infected with HIV	1	2	3	4	5
12. Disclosure of HIV-antibody test results to the sexual/needle-sharing partners of HIV infected persons should be made legal	1	2	3	4	5
13. Information regarding HIV test results should not be any more confidential than other medical records	1	2	3	4	5
14. AIDS confidentiality laws often protect the patient with. AIDS while jeopardizing the health-care professional	1	2	3	4	5
15. I do not like working with I.V. drug users	1	2	3	4	5
16. I accept sex as a normal part of life, but I don't like to talk about it	1	2	3	4	5
17. It makes me uncomfortable it people use street language when describing sexual activities	1	2	3	4	5
16. Sexually explicit brochures and pictures make me uncomfortable	1	2	3	4	5
19. I would be embarrassed to have to explain proper condom use to a client or patient	1	2	3	4	5
20. Using sexually explicit videotapes to educate clients/patients about safe sex would make me uncomfortable	1	2	3	4	5
21. I would find it easy to talk about specific sexual practices when educating people about the risk of AIDS	1	2	3	4	5

	Strongly Agree	A	N	D	Strongly Disagree
22. I feel prepared to counsel people who have recently learned that they are infected with the HIV virus	1	2	3	4	5
23. I know how to counsel clients/patients about HIV-antibody testing	1	2	3	4	5
24. I am not sure how to handle the personal issue confronting families and friends of parsons with AIDS	1	2	3	4	5
25. I would feel comfortable providing information on AIDS to co-workers	1	2	3	4	5
26. When someone is diagnosed with AIDS they should be made DNR (do not resuscitate) automatically	1	2	3	4	5
27. I am concerned that working with HIV-infected individuals could endanger my health	1	2	3	4	5
28. Even with precaution, I consider that I am at increased risk of getting AIDS if I provide care of AIDS clients/patients	1	2	3	4	5
29. Standard infection-control procedures are adequate protection	1	2	3	4	5
30. I am confident that my job does not put me at increased risk of HIV infection	1	2	3	4	5
31. Newborns of HIV-infected mothers should not be placed in the nursery with newborns of non-infected mothers	1	2	3	4	5
32. I would feel comfortable using the same dishes and eating utensils as an HIV-infected person	1	2	3	4	5
33. I would feel comfortable doing CPR on a HIV infected person	1	2	3	4	5
34. I would feel comfortable hugging a HIV infected person	1	2	3	4	5
35. I would be more willing to deal with AIDS if :					
a. better treatments and more hope of a cure existed	1	2	3	4	5
b. there were less risk of catching it	1	2	3	4	5
c. there were good emotional support systems for the staff	1	2	3	4	5
d. there were an adequate number of support services	1	2	3	4	5
e. there were good didactic/teaching sessions	1	2	3	4	5
f. most patients were not gay	1	2	3	4	5
g. most patients were not I.V. drug users	1	2	3	4	5
h. (fill in the blank)_____					

PLEASE RATE EACH OF THE FOLLOWING FACTORS AS TO HOW IT AFFECTS YOUR DESIRE/WILLINGNESS TO DEAL WITH HIV INFECTED PATIENTS

Strong deterrent (SD)- Minor Deterrent (MD)- Not a Factor (NF)- Minor Incentive (MI) - Strong Incentive (SI)

	Strong Deterrent SD	MD	NF	MI	Strong Incentive SI
1. Risk of acquiring HIV from needlesticks	1	2	3	4	5
2 Risk of acquiring HIV from exposure to Mood of HIV infected patients	1	2	3	4	5
3. Risk of acquiring HIV from exposure to sputum/ other body secretions	1	2	3	4	5
4. Risk of acquiring HIV from being in the same vicinity as an AIDS patient	1	2	3	4	5
5. Risk of acquiring an HIV related infection (e.g., TB)	1	2	3	4	5

	Strong Deterrent SD	MD	NF	MI	Strong Incentive SI
6. Risk of exposing my family/loved ones to HIV or related infections	1	2	3	4	5
7. The need to adhere to the "universal infection precautions"	1	2	3	4	5
6. Emotional stress on me, as a health care professional	1	2	3	4	5
9. The prognosis of AIDS patients/working with patients who have fatal illness and their families	1	2	3	4	5
10. Emotional issues faced by patients with AIDS/HIV infection	1	2	3	4	5
11. Many HIV patients are young	1	2	3	4	5
12. Many HIV patients are gay	1	2	3	4	5
13. Many HIV patients are IV drug users	1	2	3	4	5
14. The unusual infections or pathology off en associated with HIV patients	1	2	3	4	5
15. The need to take a complete sexual history	1	2	3	4	5

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HIV/AIDS BY CHOOSING THE RESPONSE YOU FEEL IS CORRECT

1. More virus is present with a diagnosis of Clinical AIDS or ARC than with HIV positive but asymptomatic status.

   a) True b) False c) Don't Know

2. The risk of becoming infected with HIV from a single needle-stick accident from an HIV infected patient is

   a) less than 1% b) about 5% c) about 20% d) almost 100%.

3. The number of health care workers without other risk factors who have become HIV positive in the U.S. is

   a) 5 to 10 b) almost 100 c) around 200 d) close to 1,000

4. According to one extensive study, after living in the household for two years or longer with a known AIDS patient, taking no precautions other than avoidance of sexual contact,the risk of acquiring HIV is

   a) zero b) about l% c) about 5% d) about 25% e) about 50%

5. The average length of time from initial HIV exposure/infection to the onset of clinical disease is

   a) less than 2 yrs b) about 7 years c) more than 10 years d) not known

6. The average tife expectancy folbwing a clinical diagnosis of AIDS is

   a) about 1 month b) about 6 months c) 12-24 months d) greater then 3 years

Adapted from:

CSULB AIDS Research and Education Project
LAC/USC Medical Center and AIDS Education and Training Center for Southern California, HIV Questionnaire
LAC/USC Medical Center, Women's Hospital Attitudes Assessment Questionnaire

AETC: 6.14.69
1.01.90

[redacted]
FOR SOUTHERN
LAC/USC MEDICAL CENTER

HIV QUESTIONNAIRE

Trainee Form

THIS QUESTIONNAIRE IS DESIGNED TO DETERMINE THE PREVAILING BELIEFS, ATTITUDES AND KNOWLEDGE HELD BY HEALTH CARE PROFESSIONALS ABOUT HIV AND ABOUT THOSE WHO ARE INFECTED.

All data will be treated in a confidential manner. Name:_____

Age:_____ Sex: _____M _____F

Ethnicity: _____White (not Hispanic) _____Hispanic _____Black _____Asian _____Other

Educational Level: Please check the highest level attained

_____High School Diploma
_____Diploma Graduate _____Nursing _____Other
_____AA-Degree _____Nursing _____Other

_____Baccalaureate Degree _____Nursing _____Other
_____Masters Degree _____Nursing _____Other
_____Doctoral Degree _____Nursing _____Other

Field:

_____RN
_____LVN
_____Nursing Attendant
_____Allied Health (Specify)_____
_____Other Health Care Worker (Specify)_____

Work Setting: Please check your primary work setting

_____Home Care _____OB/GYN _____
_____Intensive Care _____Pediatrics _____
_____Medical _____Psychiatry _____

Years of Nursing Experience_____

I have cared for or have supervised the care of _____ number of

Strongly Agree ... Strongly Disagree

1. People with AIDS should be encouraged to continue working at their jobs for as long as they can	1	2	3	4	5
2. Homosexuals should be protected against discrimination just like any other minority group	1	2	3	4	5
3. I do not like working with homosexuals clients/patients	1	2	3	4	5
4. Most I.V. drug users have little regard for their own health	1	2	3	4	5
5. All patients should be tested for HIV antibodies	1	2	3	4	5
6. HIV results should be readily available on the chart of each patient	1	2	3	4	5
7. All health care professionals should routinely be tested for HIV antibody	1	2	3	4	5
8. Mandatory reporting of all persons who are HIV seropositive should become law	1	2	3	4	5
9. I would not mind working for someone who was openly gay or Lesbian	1	2	3	4	5
10. I.V. drug users are a difficult population to work with	1	2	3	4	5
11. I.V. drug users are able to reduce their risk of becoming infected with HIV	1	2	3	4	5
12. Disclosure of HIV-antibody test results to the sexual/needle-sharing partners of HIV infected persons should be made legal	1	2	3	4	5
13. Information regarding HIV test results should not be any more confidential than other medical records	1	2	3	4	5
14. AIDS confidentiality laws protect the patient with AIDS while jeopardizing the health care professional	1	2	3	4	5
15. I do not like working with [illegible]	1	2	3	4	5
16. I accept sex as a normal [illegible] don't like to talk [illegible]	1	2	3	4	5
17. It makes me [illegible] language wh[illegible]	1	2	3	4	5
18. Sexually expli[illegible] me uncomfortable	1	2	3	4	5
19. I would be embarra[illegible] proper condom use to a client or pati[illegible]	1	2	3	4	5
20. Using sexually explicit [illegible] clients/patients about safe sex [illegible]	1	2	3	4	5
21. I would find it easy to talk about [illegible] sexual practices when educating people about the risk of AIDS	1	2	3	4	5

[illegible] about HIV-[illegible]

24. I am not sure how to handle the personal issue confronting families and friends of persons with AIDS [illegible]

25. I would feel comfortable providing information on AIDS to co-workers 1 2 3 4 5

26. When someone is diagnosed with AIDS they should be made DNR (do not resuscitate) automatically 1 2 3 4 5

27. I am concerned that working with HIV-infected individuals could endanger my health 1 2 3 4 5

28. Even with precaution, I consider that I am at increased risk of getting AIDS if I provide care of AIDS clients/patients 1 2 3 4 5

29. Standard infection-control procedures are adequate protection 1 2 3 4 5

30. I am confident that my job does not put me at increased risk of HIV infection [illegible] 4 5

31. Newborns of HIV-infected mothers should not be placed in the nursery with newborns of non-infected mothers [illegible] 4 5

32. I would feel comfortable using the same dishes and eating utensils as an HIV-infected person [illegible] 4 5

33. I would feel comfortable doing CPR on a HIV infected person [illegible] 4 5

34. I would feel comfortable hugging a HIV infected person [illegible] 4 5

35. I would be more willing to deal with AIDS if:
   a. better treatments and more hope of a cure existed [illegible] 4 5
   b. there were less risk of catching it [illegible] 4 5
   c. there were good emotional support systems for the [illegible] 4 5
   d. there were an adequate number of support services [illegible] 5
   e. there were good didactic/teaching sessions [illegible] 4 5
   f. most patients were not gay [illegible] 4 5
   g. most patients were not I.V. drug users [illegible] 4 5
   h. (fill in the blank) _____

PLEASE RATE EACH OF THE FOLLOWING FACTORS AS TO HOW IT AFFECTS YOUR DESIRE/WILLINGNESS TO DEAL WITH HIV INFECTED PATIENTS

Strong deterrent (MD) - Minor Deterrent (MD) - Not a Factor (MD) - Minor Incentive (MI) - Strong Incentive (SI)

					Strong Incentive
				MI	SI
1. Risk of acquiring HIV [illegible]				[illegible]	5
2. Risk of acquiring HIV [illegible]				[illegible]	5
3. Risk of acquiring HIV [illegible] other [illegible]				[illegible]	5
4. Risk of acquiring HIV from being in the same vicinity as an AIDS patient	[illegible]	[illegible]	3	4	5
5. Risk of acquiring an HIV related infection (e.g., TB)	[illegible]	2	3	4	5

9. The prognosis of AIDS patients/working with patients who have fatal illness and their families	1	2	3	4	5
10. Emotional issues faced by patients with AIDS/HIV infection	1	2	3	4	5
11. Many HIV patients are young	1	2	3	4	5
12. Many HIV patients are gay	1	2	3	4	5
13. Many HIV patients are IV drug users	1	2	3	4	5
14. The unusual infections or pathology often associated with HIV patients	1	2	3	4	5
15. The need to take a complete sexual history	1	2	3	4	5

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HIV/AIDS BY CHOOSING THE RESPONSE YOU FEEL IS CORRECT

1. More virus is present with a diagnosis of Clinical AIDS or ARC than with HIV positive but asymptomatic status.

   a) True b) False c) Don't Know

2. The risk of becoming infected with HIV from a single needle-stick accident from an HIV infected patient is

   a) less than 1% b) about 5% c) about 20% d) almost 100%

3. The number of health care workers with [illegible] risk factors who have become HIV positive in the U.S. is

   a) 5 to 10 b) almost 100 c) [illegible] d) close to 1,000

4. According to one extensive [illegible] household for two years or longer with a known AIDS patient, taking no precau[illegible] of [illegible] the risk of acquiring HIV is

   a) zero b) about 1% c) [illegible] d) [illegible] e) about 50%

5. The average length of time from [illegible] infection to the [illegible] of clinical disease is

   a) less than 2 yrs b) [illegible] 10 years d) not known

6. The average life [illegible] diagnosis of AIDS is

   a) about 1 month b) about [illegible] 24 months d) greater than 3 years

Adapted from:

CSULB AIDS Research and Edu[illegible]
LAC/USC Medical Center and AIDS [illegible] and Training Center for Southern California, HIV Questionnaire
LAC/USC Medical Center, Women's [illegible] Attitudes Assessment Questionnaire

AETC: 8.14.89
1.01.90

AIDS EDUCATION AND TRAINING CENTER . FOR SOUTHERN CALIFORNIA

Social Workers HIV QUESTIONNAIRE

THIS QUESTIONNAIRE IS DESIGNED TO DETERMINE THE PREVAILING BELIEFS, ATTITUDES AND KNOWLEDGE HELD BY HEALTH CARE PROFESSIONALS ABOUT HIV AND ABOUT THOSE WHO ARE INFECTED.

Highest earned degree: _____

My specialty is: _____ Male_____ Female

During the past five years, the number of clients that I have cared for or supervised care of who are HIV positive;

the number who have AIDS_____?

PLEASE **GIVE US YOUR OPINIONS REGARDING THE FOLLOWING STATEMENTS**

Strongfy Agree (SA)- Agree (A)- Neutral or no opinion (N) - Disagree (D)- Strongly Disagree (SD)

	SA	A	N	D	SD
1. Every patient should be tested for HIV	1	2	3	4	5
2. HIV results should be readily available on the chart of each patient	1	2	3	4	5
3. The in-hospital continuing education program available to me is adequate in teaching me to deal with HIV infection	1	2	3	4	5
4. There is currently adequate support for people with HIV needle accidents or exposure	1	2	3	4	5
5. The risk of a Health Care Worker acquiring HIV increases significantly as he/she deals with more HIV infected patients	1	2	3	4	5
6. People with AIDS have little hope of ever leading a productive life	1	2	3	4	5
7. When someone is diagnosed with AIDS they should be made DNR (DC NOT RESUSCITATE) automatically	1	2	3	4	5
8. Most people with AIDS belong in hospices	1	2	3	4	5

	SA	A	N	D	SD
9. I would be more willing to work with AIDS if...					
there were less risk of catching it	1	2	3	4	5
there were good emotional support systems for the staff	1	2	3	4	5
there were an adequate number of social workers		2	3	4	5
there were good didactic/teaching sessions	1	2	3	4	5
most patients were not gay	1	2	3	4	5
most patients were not IV drug users	1	2	3	4	5
(fill in the blank)_____					
10. I would be more willing to deal with AIDS if better treatments existed and if more hope of cure existed	1	2	3	4	5
11. I usually attempt to educate HIV infected patients about how to reduce the risk to others	1	2	3	4	5

PLEASE RATE EACH OF THE FOLLOWING FACTORS AS TO HOW **IT AFFECTS YOUR DESIRE/WILLINGNESS TO DEAL WITH HIV INFECTED PATIENTS**

Strong deterrent (SD)- Minor Deterrent (MD)- Not a Factor (NF)- Minor Incentive (MI) - Major Incentive (SI)

	SD	MD	NF	MI	SI
1. Many HIV patients are IV drug users	1	2	3	4	5
2. Risk of acquiring HIV from exposure to Mood of HIV infected patients	1	2	3	4	5
3. Risk of acquiring HIV from exposure to sputum/ other body secretions	1	2	3	4	5
4. Risk of acquiring HIV from being in the same vicinii as an AIDS patient	1	2	3	4	5
5. Risk of acquiring an HIV related infection (e.g., TB)	1	2	3	4	5
6. Risk of exposing my family/loved ones to HIV or related infections	1	2	3	4	5
7. The need to adhere to the "universal infection precautions"	1	2	3	4	5
8. Many HIV patients are gay	1	2	3	4	5
9. Emotional stress on me, as a health care professional	1	2	3	4	5
10. Greater time required to be spent on the ill HIV infected patient	1	2	3	4	5
11. Taking care of seriously ill patients	1	2	3	4	5
12. The prognosis of AIDS patients/working with patients who have a fatal illness	1	2	3	4	5

	SA	A	N	D	SD
13. Emotional issues faced by patients with AIDS/HIV infection	1	2	3	4	5
14 Many HIV patients are young	1	2	3	4	5
15. HIV patients often have concerned family members or friends and dealing with them requires additional time/effort	1	2	3	4	5
16. The unusual infections or pathology often associated with HIV patients	1	2	3	4	5
17. The need to take a complete sexual history	1	2	3	4	5
16. Effectively treating HIV related problems requires a broad base of knowledge about the psychosical of the disease	1	2	3	4	5

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HIV/AIDS BY CHOOSING THE REPONSEYOU FEEL IS CORRECT

1. More virus is present with a diagnosis of Clinical AIDS or ARC than with HIV positive but asymptomatic status.

a) True b) Fake c) Don't Know

2. The risk of becoming infected with HIV from a single needle-stick accident from an HIV infected patient is

a) less than 1% b) about 5% c) about 26% d) aimost l00%.

3. The number of health care workers without other risk factors who have become HIV positive in the U.S. is

a) 5 to 10 b) almost100 c) around260 d) close to l,000

4 According to one extensive study ,after living in the household for two years or longer with a known AIDS patient, taking no precautions other than avoidance of sexual contact,the risk of acquiring HIV is

a) zero b) about l% c) about 5% d) about 25% e) about 50%

5. The average length of time from initiil HIV exposure/infection to the onset of clinical disease is

a) less than 2 yrs. b) about 7 years c) more than 10 years d) not known

6. AZT extends survival time of the average patient with clinical AIDS by an average of

a) not at all b) about 6 months c) 12-24 months d) more than 3 years e)cures the disease

7. AZT improves the qualii of iife of patients with AIDS

a) True b) False c) Don't know

8. The average life expectancy folbwing a clinical diagnosis of AIDS is

a) about 1 month b) about 6 months c) 12-24 months d) greater then 3 years

Please list all of topks and issues you would like to learn more about.

Please list all of the skills you would like to acquire and/or Improve.

Thank you for completing this questionnaire.

AETC
3/30/90

AIDS Education and Training Center
for
Southern California

CONDUCT OF THE INTERVIEW
Risk Assessment

Trainee:_____ **Evaluator:**_____

This form contains behavioral statements selected for evaluating the trainee's conduct of an interview with a patient, and the feelings and attitudes that were revealed during the interview. For each of the statements listed below, please indicate the extent to which the trainee met the following criteria: outstanding, satisfactory, minimally satisfactory, and unsatisfactory.

KEY Please circle the appropriate number following each statement.

Outstanding - 4 Satisfactory - 3 Minimally Satisfactory - 2
Unsatisfactory - 1 Unable to judge or N/A - 0

INTRODUCTION OF SELF

1. Greeted the patient, introduced self and explained role. **4 3 2 1 0**

2. Demonstrated consideration for the patient's comfort. **4 3 2 1 0**

3. Asked the patient how he/she felt. 4 3 2 1 0

MANNER OF OBTAINING INFORMATION

1. Used language that was clearly understandable to the patient. 4 3 2 1 0

2. Allowed the patient ample time to talk. 4 3 2 1 0

3. Asked an appropriate number of cbsed-ended questions. 4 3 2 1 0

4. Asked an appropriate number of open-ended questions. 4 3 2 1 0

5. Used appropriate facilitation methods
(Please evaluate as many as possible).

a.	silence	4 3 2 1 0
b.	confrontation	4 3 2 1 0
c.	non-verbal cues provided by the patient	4 3 2 1 0
d	verbal cues provided by the patient	4 3 2 1 0
e.	approval/support	4 3 2 1 0
f.	empathy	4 3 2 1 0
g.	reflection of feelings	4 3 2 1 0

6. Used what the patient said to maintain continuity. 4 3 2 1 0

7. Provided time during the interview for the patient to ask questions. 4 3 2 1 0

8. Answered the patient's questions appropriately. 4 3 2 1 0

9. Ended the interview after an appropriate length of time. 4 3 2 1 0

FEELINGS AND ATTITUDES REVEALED

1. Expressed recognition of the patient's signs of discomfort and/or fatigue. 4 3 2 1 0

2. Inquired as to patient's concern an&or fears. 4 3 2 1 0

3. Expressed approval and/or support to the patient's statements. 4 3 2 1 0

4. Provided verbal and non-verbal assurance to the patient. 4 3 2 1 0

5. Demonstrated concern and interest by paying attention to what the patient was saying (e.g., by means of eye contact; nodding of head; verbally). 4 3 2 1 0

6. Responded appropriately to the patient in emotional distress (e.g., comforted the crying patient). 4 3 2 1 0

7. Demonstrated recognition when the patient said one thing but meant another (e.g., made further inquiries into the area in question). 4 3 2 1 0

8. Demonstrated a respect for the patient and his/her attitudes, beliefs, and feelings. 4 3 2 1 0

CONTENT OF INTERVIEW

The following questions were asked.

1. Sexually active? 4 3 2 1 0
2. Sex with men, women, or both? 4 3 2 1 0
3. Number of partners? 4 3 2 1 0
4. Frequency of sex (with each partners)? 4 3 2 1 0
5. Types of sex practices (with each partner)? 4 3 2 1 0
6. Use of condoms and or other form of protection? 4 3 2 1 0
7. History of STD? 4 3 2 1 0
8. History of IV drug use? 4 3 2 1 0
9. Fear of HIV infection? 4 3 2 1 0

COMMENTS AND SUGGESTIONS

Please comment on any other aspects not included in the list above, but that affected the conduct of the interview. Please include both positive and negative factors.

APPENDIX VIII

Evaluations Conducted -- UCLA

1. Table 1 Response Rates and Characteristics of Respondents and Table 2: AIDS Related Experiences and Practices
2. Objective Structure Clinical Assessments
3. AIDS Project Los Angeles: Program Summary
4. Program Summary: Dental Care and AIDS

Result - Needs assessment
Survey of MD - Practice

Table 1: **Response** Rates and Characteristics of **Respondents**

	1984 (635)[1]	1986 (279)[2]	1989 (463)[1]
Response Rates	63.1%	60.0%[3]	77.0%
Specialty :			
General Internal Medicine	42.4%	44.1%	47.7%
General practice	26.3	17.2	17.3
Family practice	31.3	38.7	35.0
Solo Practice:	50.4	54.5	51.2
Foreign Medical Graduate?	17.3	19.9	21.4
Female:	6.8	9.0	19.7

[1] Los Angeles County.
[2] Los Angeles SMSA.
[3] Response rate represents that for the entire state of California (N= 1000).
[4] Does not include graduates of Canadian or Western European medical schools.

Co-spon. effort

Table 2: AIDS-Related Experiences and Practices

	1984 (635)[1]	1986 (279)[2]	1989 (463)[1]
Practice Experience[3]			
Worked up a patient for AIDS or HIV Infection in 6 months previous to interview	27.1%	43.0%	73.8%
Caring for at least one patient with AIDS or AIDS-related complex	<1.0	6.1	39.5
Sexual History Taking[3,4]			
Ask patients about sexual orientation	23.0	20.1	42.3
Ask patients about number of sexual partners	9.9	9.0	29.8
Ask patients about sexual practices	12.1	16.5	18.4
Physicians' Attitudes			
To what extent do you think the average physician is uncomfortable in discussing sexual matters with homosexual patients?			
Considerable	34.9	28.5	33.3
Moderate	41.2	43.7	38.6
Small to None	23.9	27.7	28.1

1 Los Angeles County.

2 Los Angeles SMSA.

3 See text for question wording.

4 Percentages are based on the total number of physicians surveyed.

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA

UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

OBJECTIVE STRUCTURED CLINICAL ASSESSMENTS

Purpose:

To develop objective structured clinical assessments (OSCA) which can be used in a variety of educational settings to evaluate the clinical competence of those who are or will be caring for people with the HIV infection. These OSCA's will be designed so that each can be used to provide feedback to learners regarding their progress while in training and as a summative evaluation instrument. Medical students and physicians will be targeted.

Product: An AIDS OSCA which can be used as a whole and with individual modules which can be used as part of existing OSCA's such as those now being used at several medical schools. Each module would contain the following: 1. a description of the module, 2. set of objectives, 3. listing of skills and/or behaviors which are to be measured, 4. assessment instrument(s), 5. instructions on how to operate the module, 6. instructions on how to train the real or standardize patient., and instructions on how to train the physician evaluator. In addition, the OSCA will contain an comprehensive set of instructions indicating how to set up an OSCA, include video taped examples of selected modules, and data from the USC site pilot tests.

Clinical areas to be assessed

1. History taking skills
   a. sexual
   b. risk identification
   c. identification of early stages of HIV infection
   d. identification of selected manifestations (such as psych. and pulmonary)

2. Physical examination skills
   a. identification of early stages of HIV infection
   b. identification of selected manifestations (such as psych. and pulmonary)

3. Universal precautions

4. Counseling skills
   a. sexual
   b. testing
   c. behavior change

5. Ethical and legal issues

6. Selected management skills

AIDS PROJECT LOS ANGELES

PROGRAM SUMMARY
AMERICAN RED CROSS
MARCH 10, 1989

Circle the number that best represents your opinion:

	Not at all 1	2	3	4	Very Much 5		
1. The program met my learning needs.	1.)	2.)	3.) 7	4.) 17	5.) 13	NA.)	AVG. 4.1
2. The program information will be useful in my work.	1.)	2.)	3.9 6	4.) 13	5.) 18	NA.)	AVG. 4.3

Comments:
-1 learned that AIDS is not easily transferred

3. The presentations were clear, thorough, and interesting.

a.) Medical Overview (D. Dassey)	1.)	2.) 3	3.) 7	4.) 12	5.) 17	NA.) 1 AVG. 4.3
b.) PWA Panel (S. Jue)	1.)	2.) 1	3.) 2	4.) 6	5.) 26	NA.) 2 AVG. 4.6
c.) Clinical Sx. and Tx. (J. Foremaker)	1.)	2.) 1	3.) 8	4.) 14	5.) 8	NA.) 6 AVG. 3.9
d.) Infection Control (J. Foremaker)	1.)	2.) 2	3.) 11	4.) 14	5.) 5	NA.) 5 AVG. 3.7
e.) Case Study	1.)	2.) 4	3.) 13	4.) 4	5.) 3	NA.) 13 AVG. 3.3
f.) Legal Issues (M. Kadzielski)	1.)	2.)	3.) 3	4.) 7	5.) 7	NA.) 20 AVG. 4.2

Comments:
-Medical overview deserves a more in depth look
-1 understand the topics well

4. I would recommend this program to my colleagues.

1.) ___ 2.) 3.) 3 4.) 15 5.) 20 NA.) ___ AVG. 4.4

Comments:
-Everything was interesting to me
-Well paced, well presented
-Highly recommended

5. My overall rating of this program:

1.) ___ 2.) 3.) 3 4.) 19 5.) 14 NA.) 1 AVG. 4.3

Comments:
-Yes, but I was expecting more
-Educational
-Well organized
-Enjoyed it a lot
Very good will be a great help in every day practice

6. What information was most useful to you?

Comments:
-Clinical & infection control
-PWA panel
-Infection control
-The whole day
-Sterilization methods
-How to better treat patients with HIV
-Statistics
-Precaution & protection
-The PWA panel .
-All was interesting
-Practical matters symptoms, treatment, and infection control
-Infection control
-Medical overview/PWA panel
-Treatment protocols for oral lesions
-handouts of up-to-date pertinent literature
-Infection control, legal side of treating the AIDS patient
-Epidemiology section & PWA panel
-PWA Panel
-PWA panel
-Medical overview useful in placing disease in context
-Medical overview
-All info. was useful
-Signs and symptoms - Legal aspects
-Prevention measures and how HIV positive patients can be handled properly - no discrimination
-Clinical Sx. & Tx., Infection Control
-Entire program PWA panel
-Specific measures to institute in practice
-Infection control, Clinical Symptoms
-The clinical symptoms & treatment
-Video presentation oral manifestation

7. Which part was least useful?

Comments:
-Case study & Legal issues
-Break
-Statistics
-Coffee breaks and case studies
-PWA panel and case 'studies
-PWA panel
-Case Studies
-Infection control issues
-group case study
-Case Study
-Infection control
-Case S-tudy
-Case study
-Case study
-Case studies
-The PWA panel
-Make the case study section a full group effort
-None *every* aspect was useful

8. How do you think today's program could be improved to better meet your needs?

a. content (information, materials, etc.)

Comments:
-More spedific info. on Tx. of lesions
-More videos
-Even more specifics on drugs dosages & specific products
-Fine as is
-Satisfactory
-Well done
-Improve AV materials
-*More* current findings
-More structured PWA panel

b. format (time, place, agenda, etc.)

Comments:
-c & d rather slow
-Start earlier, end earlier
-Satisfactory
-Add additional 5 minutes to AM and PM break
-Better speakers, more slides
-Better seating arrangements to view slides
-Location very good

I would be willing to treat HIV infected persons

NEVER 1: 0 2: 1 3: 9 4: 11 5: 6 NA: *10* AVG. 3.3

PROGRAM SUMMARY

TITLE: DENTAL CARE AND AIDS

DATE: FRIDAY, NOVEMBER 3, **1989**
8:00 A.M. - 4:00 P.M.

LOCATION: ST. JOHN'S HOSPITAL AND MEDICAL CENTER
1328 22ND STREET
SANTA MONCIA, CA 90404

****

attended: 100
program evaluations received: 85
knowledge evaluations received: 75

Knowledge Evaluations:

n=75

35	scored	**24/24** = 100%
10	scored	**23/24** = -96%
4	scored	**22/24** = 92%
5	scored	**21/24** = 88%
2	scored	**20/24** = 83%
2	scored	**19/24** = 79%
17	scored ≤	**18/24** = 75%

mean score **= 21/24** = 88%

56/75 (75%) participants scored **>** 80%
19/75 (25%) participants scored **<** 80%

Program Evaluations:

See attached.

Comments:

St. John's proved to be an ideal location for this 8-hour program. Attendance was well above anticipated numbers, and the facility itself was suited for a large training. Audio-visual equipment in the conference room was state of the art, and added to the ease and professionalism of the presentations.

The learners were made up of dentists, registered dental hygenists, and dental assistants.

Overall, the program was rated very high on the evaluation (4.6/5.0). Most felt the program met their learning needs **(4.5/5.0),** that it would be useful in their work **(4.6/5.0), and** that they would recommend this program to their colleagues **(4.7/5.0).**

AIDS PROJECT LOS ANGELES
DENTAL CARE AND AIDS

NOVEMBER 3, 1989

PROGRAM SUMMARY

:cle the number that best represents your opinion:

	Not at all	Very Much
The program met my learning needs.		

1. _____
2. _____
3. 7
4. 30
5. 48
NA. _____
AVG. 4.5

Comments:
- -Well organized, well presented.
- -Very informative with useful information.
- -It was very educational.
- -1 really did like the program.
- -Very wide ranging on topics, very good.
- -Many new approaches.
- -Definitely! This really opened my eyes to AIDS and that I do have fears, that are not as frightening now.
- -1 very much appreciated and learned things here I did not know.
- -It was a lot information.
- -Very good presentation.
- -Well prepared and comprehensive.
- -More emphasis on "real dental issues" and medical updates what we "should know", names of new drugs/ new protocols etc.
- -Best program on AIDS I've been to.
- -This is the best, most complete presentation I've been to I learned alot.
- -Adds to my line up of truths, should up a line up of myths,
- -Re enforced what I already knew plus learning something a little "new".
- -Very informative.
- -Excellent pacing, printed info., and speakers.
- -Very informative and helpful - greater insight humonistacally.
- -More legal aspects would be helpful.
- -Previous lectures have covered much of the material.

-1 learned more of the facts. It made things much more clear to me.
-Professionally done, very sensitive to all issues excellently executed.

2. The program information will be useful in my work.

1.	
2.	
3.	6
4.	20
5.	58
NA.	1
AVG.	4.6

Comments:
-1 didn't really learn anything new of a lecutural nature.
-Especially since most of my co-workers are here and now we can work together to improve infection control in the office.
-Because I will alway's remember how I would want to be treated if I had it.
-1 think all dental personel should be required to attend this lecture.
-Immediately Thanks!
-Less fear of HIV+.
-Yes, I hope & will share what I learned today with my offices.
-The presentations will help me to explain better.
-1 will talk about all the precautions that are recommended to my co-workers.
-Excellent.
-More emphasis for "Infection Control" could be given in my experience this is the area where dentists will try to "save" costs and it is not fair to their employees nor patients.
-The information was very applicable.
-Information learned here directly impacts my position as a dental hygienist.
-Can share new knowledge and my present beliefs with confidence.
-It's always best to keep up with current info. & new or improved techniques regarding the HIV virus the care of patients & personnel.
-Great instructions for infection control in the office.
-For other staff as well as patient education.

3. The presentations were clear, thorough, and interesting.

Dassey	Anselmo	Formaker	Jue
1.	1.	1.	1.
2. 2	2. 3	2. 2	2.
3. 12	3.	3. 14	3. 13
4. 22	4. 17	4. 23	4. 18
5. 47	5. 45	5. 44	5. 49
NA. 2	NA. 7	NA. 2	NA. 5
AVG. 4.4	AVG. 4.3	AVG. 4.3	AVG. 4.5

PWA's	Dealing with our Fears	Kadzielski
1.	1.	1.
2.	2. 1	2. 2
3. 10	3. 6	3. 10
4. 14	4. 14	4. 18
5. 56	5. 58	5. 32
NA. 5	NA. 6	NA. 23
AVG. 4.6	AVG. 4.6	AVG. 4.3

Comments:

- It was especially impacted by the psychosocial issues & the experiences of the 2 PWA's.
- The entire program was put together very well.
- 1 like how the psychosocial issues were presented.
- Everything was very informative & presented professionally. I wish more of the general public would attend seminars like this!
- Good.
- Dr. Formaker needs to stop saying "uh" otherwise good. Good use of audio-visual material.
- Thanks to James & Shawn for speaking so candidly about their experiences to us. I hope we will remember we're treating people with a disease, not just treating a disease.
- Lecturer drove me crazy, kept saying "um".
- Infection control should have been more specific and less broad.
- We hope you do this program every six months.
- Not enough time on legal.
- the medical terminology was over my head.
- Atty was excellent, M.D. was excellent.
- The PWA-panel was a very eye-opening testamonial.
- 1s it possible to include a female on the PWA panel?? Possibly IVDU's?? This would be interesting.
- All modules were excellent. I am very happy I attended. It has been one of the most interesting CE programs I have ever attended.
- Overall, absolutely outstanding.

4. I would recommend this program to my colleagues.

1.	
2.	
3.	4
4.	17
5.	64
NA.	
AVG.	4.7

Comments:

-Very organized - running on time.
-I'd like to rent your health care worker AIDS/Fear tape to show to my dental office staff.
-I hope to see this kind course every year or every six months.
-I don't know their level of knowledge.
-All dentist's should-be exposed to a program like this one!
-Knowledge reduces fear.
-Yes.
-Very much.
-1 will try to make the videos I saw here available to my fellow office partners.
-1 think everyone could benefit from the info. 'presented.
-All people.
-Offer program at the So. Calif Dental Mtg. in Anaheim in May.
-Interesting & informative start to finish (the day didn't drag like it usually does for an all day course).
-Yes, I will pass out flyers and talk about this program at all of my lectures.
-How can we reserve the video on Fears?? Excellent
-Especially to local dental communities and dental schools prior to any prejudiced feeling & mis-info. to take root.
-Excellent!
-1 think anyone/everyone should see this program.
-1 enjoyed the update of knowledge on AIDS & the well organized format. P.S. The food was very good.
-Everyone should take this seminar it was great!
-Absolutely.

5. My overall rating of this program.

1.	
2.	
3.	3
4.	28
5.	52
NA.	2
AVG.	4.6

Comments:
- -So agreeable/upbeat/factual/and organized.
- -Excellent.
- -Great info. - great presentation by great quality speakers!
- -Very organized, informative, and interesting.
- -1 like the fact that all aspects of AIDS were discussed.
- -Excellent! Every worker should be forced to sit thru a symposium like this.
- -Printed info. very excellent - program was well presented, food was good!
- -Very informative.
- -Some parts seemed a bit repetitious.
- -Very organized.
- -This was a very useful and informative presentation.
- -Very good.
- -1 feel it's very good. A bit long maybe should have it in 2 sessions.
- -Covered all the basics.
- -Very helpful.
- -Was interesting.
- -Great!
- -Top notch.
- -Was very good but felt a little preached at.
- -Very well organized.

6. What information was most useful to you?

Comments:
- -All
- -Everything was presented well.
- -Treating the individual diseases.
- -We know how to protect ourselves by now. We need to know to help PWA's.
- -Legal issues.
- -Film on oral manifestations.
- -Useful to have written info. to go with the lecture.
- -Specifics about just how transmissable this disease is & precautions to be taken.
- -Dealing with my fears thru your video.
- -Oral Manifestations & Infection control.
- -Dealing with fears.

-Sterilization - psychosocial.
-All of the workshop was useful to me. The sterilization and the infection control was most useful.
-Oral manifestations.
-Psychosocial/videos.
-Morning session.
-Infection control, psychosocial.
-The lesions and their control was the most practical & referent.
-All useful.
-Personal feelings of PWA's and legal aspects.
-Especially enjoyed panel with PWA's helped to make it real.
-Infection control, oral manifestations, and overcoming fears.
-Oral manifestations, infec. control, and PWA panel.
-Clinical manifestations - PWA panel.
-Everything was very important.
-Medical overview, epidemiology, oral-manifestations, legal, and ethical issues.
-The large # of HIV+ people in the future.
-Reiteration that HIV is not contracted dentally at all.
-The fear issue will be good to explore with my staff. All of the other info. was well balanced & equally useful.
-PWA panel and dealing with fears.
-All of it was useful.
-The technicalities reinforced & clarified what I had read but the panel helped, me to understand how they feel our PWA's are not as willing to talk & now-f see why.
-Oral manifestations.
-Oral diagnosis of HIV patients.
-All was great - very thorough.
-Legal and medical overview.
-Oral manifestations.
-Helped confirm things that are already being done in office & show areas that need work.
-What the PWA's had to say.
-Barrier, fear tape, and legal.
-Review of medical overview, epidemiology, and infection control.
-Review of medical overview, epidemiology, and infection control.
-The information from the PWA panel.
-All.
-Oral manifestations followed by informative pres.
-Infection control.
-Handling fears of HIV infected patients, general medical info. about the virus, oral manifestations, and PWA panel.
-Infection control.

-With proper precautions, no particular danger to dental care givers.
-The program was well designed and covered more relevant topics than any other lecture I've attended. The speakers were all very knowledgeable on their appropriate field.
-When the two PWA's talked about their problems, I felt so sorry for them.
-Everything.
-Oral manifestations.
-All.
-Oral manifestations and HIV infection.
-The beginning discussion given by Dr. Dassey, and the video on dealing with fears.
-About dealing with PWA's and fear.
-Infection control and psychosocial issues.
-Infection control.
-Medical & Legal.
-Infection control.
-Infection control, oral manifestations, and legal ramifications.
-All of it.
-Infection control protocol, Tx protocol for AIDS symptoms, and photo's of oral manifestations.
-The PWA panel and the fears video.
-PWA panel.
-Working through our fears - this info. is applicable in every aspect of my professional & social life.
-Oral manifestations, infec. control, psychosocial, and PWA panel. These are incredibly inspirational patients!
-The medical overview & oral manifestations modules were excellent and gave me a broad understanding of oral complications assoc. with HIV+ patients.
-Oral manifestation info./slides.
-"Fears Video" and listening to the PWA's.
-Oral manifestations & infection control.
-Update on latest info. since the last AIDS seminar I attended new statistics & medical update with current state of disease.

7. Which part was least useful?

Comments:
-D & E.
-PWA panel.
-Legal issues.
-Sterilization.
-Psychosocial issues.
-Legal aspects, due to not having to carry my own malpractice or any legal incounter.
-Probably the legal aspects for me personally.
-Generally a good program.
-Psychosocial issues.
-Medical overview.
-Dealing with our fears.
-Social.
-Interview with PWA's - buy ot was a compassionate reminder that : kara are human beings

-Psychosocial and legal.
-The graphs-and stats.
-Infection control.
-Medical overview & epidemiology - this provided a good review for me just the same.
-Legal details - doesn't apply as directly to me but I liked having all materials to read thru.
-Legal issues & infec. control not applicable to my needs since I'm not a dentist but I'm sure it was extremely useful for the dental professionals.
-All great.
-Epidemiology.
-Medical overview.
-All was useful.
-All was useful.
-Legal issues.
-Legal aspects - let me clarify - very lengthy and in depth not necessarily applicable to dental.
-Non of info. was not useful we needed all of it.
-Office infection control - we do all of these things.
-All useful.
-Legal.
-Infection control - too broad and not too much new info.
-Working through fears.
-Legal implications.
-Listening to PWA's.
-Everything had something useful - it was a productive day.
-PWA panel, followed by legal aspects.
-legal aspects.
-Psychosocial issues film.
-Infection control.
-Fears.
-Oral manifestations. .
-Psychosocial.
-Very begging first 'hour.
-Epid.
-Legal issues.
-1 feel that the part on infection control was repatative, I had alot of this while at USC
-dental school. Still continue to practice good infection control.

8. How do you think today's program could be improved to better meet your needs?

a. content (information, materials, etc.)

Comments:
- -Excellent.
- -Felt a bit preached to but the facts were informative.
- -Content was good but need to lighten up.
- -It was very good.
- -More legal aspects.
- -1 am recent gradd. from UCLA - (although HIV+ individuals are seen there this was the best program that I've seen.
- -15 min. only for legal aspects - and basically to answer main questions 1) discrimination 2) health guestionaire re: HIV+. Also new medical updates . very important to keep us up to date.
- -None, was great.
- -The PWA's and Sally were especially good.
- -Excellent program.
- -It was excellent!.
- -It seemed a little long for the information presented.
- -Keep the film on anger, anxiety, and fear. It was done well & the message came acorss loud and clear.
- -Go to lunch sooner.
- -Info. packet is great.
- -Info. packet excellent.
- -Speakers all could have been given more time. Would like to know more on legal ramifications for treating patients and disclosure of HIV test info.
- -More ont Tx of AIDS.
- -Include info. on source of referral for med & dent. therapy, social aid and emotional support.
- -Perhaps to many handouts.
- -Info. and materials were good.
- -Educational materials to have in our reception rooms to better educate everyone.
- -It was great!
- -Add a woman & an IVDU to the PWA panel and if you are targeting dental professionals obtain a couple of your PWA's who have personally had a bad experiences with dentist's.
- -Cut last part by 1/2 hour legal views over done!

b. format (time, place, agenda, etc.)

Comments:

- -Excellent!
- -Make it shorter.
- -Try to stay on scheduled. Enjoued the course but would have enjoyed it more if there weren't **quite** so many **"um's"** from a particular speaker. It drove me crazy.
- -Time needs to be more organized. To follow to schedule, due to fact that eight hours is a long time.
- -Good.
- -All good - even lunch.
- -Good.
- -Very organized.
- -Excellent!
- - None - was great.
- -Thanks!
- -Good location with great A/V capabilities.

APPENDIX IX

Evaluations Conducted -- Level 2 Training

Pre-Intervention Assessment Examples:

1. Meeting the Challenge of HIV Infection
2. Dental Care and AIDS
3. Review of Pediatric HIV/AIDS Infection

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA USC SCHOOL OF MEDICINE

MEETING THE CHALLENGE OF HIV INFECTION

We need your help in identifying whether or not HIV infection and AIDS is becoming a major issue facing Family physicians today. These results may be used in planning future educational programs. Thank you for your cooperation.

1. Male ___ Female ___ 2. Year completed medical school _____ 3. Years in current practice ____

4. Practice specialty _____ 5. Full time ___ part time ___ Retired _ Resident _

6. Practice location: Inner city ___ Urban ___ Suburban ___ Rural ___

7. Please estimate the percentage of the patients in your practice who are:
White (not Hispanic) ___ Hispanic ___ Black ___ Asian ___ Other ___

13. Do you routinely obtain a comprehensive patient sexual history?

	Men	Women
All regardless of age?	Yes ___ No ___	Yes ___ No ___
Under the age of 21?	Yes ___ No ___	Yes ___ No ___
Between the ages of 21 and 35?	Yes ___ No ___	Yes ___ No ___
Over the age of 35?	Yes ___ No ___	Yes ___ No ___
Who have had an STD infection?	Yes ___ No ___	Yes ___ No ___
With a current STD infection?	Yes ___ No ___	Yes ___ No ___

9. Do you routinely provide STD (including AIDS) risk reduction counseling for patients?

	men	Women
All regardless of age?	Yes ___ No ___	Yes ___ No ___
Under the age of 21?	Yes ___ No ___	Yes ___ No ___
Between the ages of 21 and 35?	Yes ___ No ___	Yes ___ No ___
Over the age of 35?	Yes ___ No ___	Yes ___ No ___
Who have had an STD infection?	Yes ___ No ___	Yes ___ No ___
With a current STD infection?	Yes ___ No ___	Yes ___ No ___

10. Estimate the percentage of your patients who are at risk for AIDS due to:
Sexual activity ____ IV Drug abuse ____ Other drug abuse ____ Alcohol abuse ____

11. How many patients have asked you:	men	Women
about their own risk for exposure to the HIV virus?	-	-
about safe sex practices?	-	-
to be tested for exposure to the HIV virus?	-	-

12. About how many patients have:	men	Women
you referred for HIV testing?	-	-
tested positive for the HIV virus?	-	-
been diagnosed with AIDS?	____	____

13. Do you manage or refer patients who are HIV infected but who are asymptomatic?
Manage ___ Refer ___

14. Do you manage or refer patients who have active AIDS? Manage ___ Refer ___

15. Are you using the CDC universal precautions for: All patients? ___ Patients at risk? ___ Not using? _

AIDS Education and Training Center for Southern California

DENTAL CARE AND AIDS
PRE-WORKSHOP SURVEY

We would appreciate your completing this survey; your responses will help us in planning future educational programs and services. Thank you.

Participant Background

1. Male_____ Female_____ Year complete dental school_____Ethic Background: White(not Hispanic)_____ Hispanic_____Black_____Asian_____Other_____

Practice Background

2. Practice specialty: General_____Oral Surgery_____Orthodontics_____Periodontics_____Other___

3. Practice location: Inner city_____Urban_____Suburban_____

4. Please estimate the percentage of the patients in your practice who are: White(not Hispanic)_____Hispanic_____ Black_____Asian_____Other_____

5. Estimate the number of your patients who:

Are in high risks groups _____
Are HIV positive _____
Have AIDS _____

6. Do you employ the universal precautions in your practice? Yes_____No_____

Dental Attitudes Regarding AIDS:

7. Please mark what you believe to be the prevailing attitudes in the dental profession regarding AIDS:

_____There is widespread fear of contacting the AIDS virus from patients with AIDS
_____It is easy to tell whether or not a person has AIDS
_____Dentists are generally willing to provide care to patients with AIDS, after receiving training
_____People who have AIDS have brought it on themselves through sexual or drug use practices

8. Please indicate what you believe to be reasons among dentists for not treating patients with AIDS: include:

_____Fear of losing other patients
_____Lack of knowledge about oral manifestations of AIDS and managing AIDS patients
_____Lack of knowledge about proper sterilization procedures
_____Unwillingness to change practice habits
_____Fear of contacting AIDS
_____Preference not to treat gay patients

9. Please indicate your estimation of the likehood of dentists contacting HIV through exposure to HIV positive patients:

_____Unsure
_____Not concerned; perceive no real threat to dentists
_____Little risk with proper management
_____Somewhat concerned; some risk involved
_____Very concerned; hesitant to treat HIV positive patients
_____Extremely concerned; will not treat HIV-infected patients at this time

Personal Objectives for this Course

1. Please indicate what you hope to gain from this training course.

2. How will this course be useful to you?

Thank you for your help.

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALCFORNIA

Review of Pediatric HIV/AIDS Infection

Fifth National Pediatric AIDS Conference

THIS QUESTIONNAIRE IS DESIGNED TO DETERMINE THE PREVAILING BELIEFS, ATTITUDES AND KNOWLEDGE HELD BY HEALTH CARE PROFESSIONALS ABOUT HIV AND ABOUT THOSE WHO ARE INFECTED.

Age: Sex: ____M ____F Years of Experience_____

Ethnicity: White (not Hispanic) ____Hispanic____Black Asian Other

Field:

Physician Speciality_____
Nurse Speciality_____
Social Worker Speciality_____
Psychologist/Mental Health Worker Speciality_____
Other Health Care Worker (Specify)_____
(Specify)_____

Work Setting: Please check your primary work setting.

Private Practice Public Health Hospital Based
Home Health Care University Based Other_____

I have cared for or have supervised the care of number of children with HIV infection.

PLEASE **GIVE US YOUR OPINION REGARDING THE FOLLOWING STATEMENTS**

Strongly Agree (SA)- Agree (A)- Neutral or no opinion (N) - Disagree (D)- Strongly Disagree (SD)

	SA	A	N	D	SD
1. Children with AIDS should be encouraged to continue attending school	1	2	3	4	5
2. Newborns of HIV-infected mothers should be placed in the nursery with newborns of non-infected mothers	1	2	3	4	5
3. I am concerned that working with HIV-infected individuals could endanger my health	1	2	3	4	5
4. Even with precautions, I consider that I am at increased risk of getting AIDS if I provide care for AIDS clients/patients	1	2	3	4	5

5. I would feel comfortable doing CPR on a HIV infected person	1	2	3	4	5
6. I would feel comfortable hugging a HIV infected person	1	2	3	4	5
7. I feel prepared to counsel families who have recently learned that family member is infected with the HIV virus	1	2	3	4	5
8. I know how to counsel patients families about HIV-antibody testing	1	2	3	4	5
9. I am not sure how to handle the personal issues confronting families and friends of persons with AIDS	1	2	3	4	5
10. AIDS confiintiality laws often protect the patient while jeopardizing the health-care professional	1	2	3	4	5
11. Most I.V. drug users have little regard for their own health	1	2	3	4	5
12. All patients should be tested for HIV antibodies	1	2	3	4	5
13. All health care professionals should be routinely tested for HIV antibody	1	2	3	4	5

PLEASE RATE EACH OF THE FOLLOWING FACTORS AS TO HOW IT AFFECTS YOUR DESIRE/WILLINGNESS TO DEAL WITH HIV INFECTED PATIENTS

Strong deterrent (SD)- Minor Deterrent (MD)- Not a Factor (NF)

	SD	MD	NF
1. Risk of acquiring HIV from needlesticks	1	2	3
2. Risk of acquiring HIV from exposure to blood of HIV infected patients	1	2	3
3. Risk of acquiring HIV from exposure to sputum/ other body secretions	1	2	3
4. Risk of acquiring HIV from being in the same vicinity as AIDS patients	1	2	3
5. Risk of acquiring an HIV related infection (e.g., TB)	1	2	3
6. Risk of exposing my family/loved ones to HIV or related infections	1	2	3
7. The need to adhere to the "universal infection precautions'	1	2	3
8. Emotional stress on me, as a health care professional	1	2	3
9. The prognosis of AIDS patients/working with children who have fatal illness and their families	1	2	3
10. The unusual infections or pathobgy often associated with HIV infected children	1	2	3

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HIV/AIDS BY CHOOSING THE RESPONSE YOU FEEL IS CORRECT

1. More virus is present with a diagnosis of Clinical AIDS or ARC than with HIV positive but asymptomatic status.

a) True b) False c) Don't Know

2. The risk of becoming infected with HIV from a single needle-stick accident from an HIV infected patient is

a) less than 1% b) about 5% c) about 20% d) almost 100%.

3. The number of health care workers without other risk factors who have become HIV positive in the U.S. is

a) 5 to 10 b) almost100 c) around200 d) close to 1,000

4. According to the current literature, after living in the household for two years or bnger with a known AIDS patient, taking no precautions other than avoidance of sexual contact,the risk of acquiring HIV is

a) zero b) about l% c) about 5% d) about 25% e) about 50%

5. The average life expectancy folbwing a clinical diagnosis of AIDS is

a) about 1 month b) about 6 months c) 12-24 months d) greater then 3 years

APPENDIX X

Evaluations Conducted --Level 3 Training

1. Sample Course Evaluation: HIV Nurse Clinician Training Program
2. AIDS Clinical Training Program: Evaluation and Participant Feedback

HIV NURSE CLINICIAN TRAINING PROGRAM

Course Evaluation

We want to thank you in advance for helping us to refine this training program. Your verbal feedback has helped greatly. We would like your final thoughts now that the week is over.

1. Preparation Packet:

Articles: **Were they helpful/not helpful?** Please be specific, what would you add? **delete? modify?**

They were helpful (with the inclusion of the pre-test which forced me to read them) to prepare myself better for the class

Assignments:: **How did they help/not help you prepare for the workshop? What would you add? delete? modify?**

The survey helped me do an informal needs assessment of my unit.

The papers (to write) I didn't find particularly helpful except again I was able to identify relavent material & read it ahead of time.

2. Course **Objectives:**

How did we meet/not meet your personal objectives?

felt that I broadened & deepened my knowledge base and also learned about resources to draw on in the future, and also gained information to network.

How did we meet/not meet the course objectives?

Opened up questions, particularly in the area of cross-cultural issues & ethics that will be of great value, and overall felt the course objectives were definitely met above & beyond my expectations.

3. **Course Content:**

How did the content meet/not meet your personal and the course objectives? What would you add? delete? modify?

found the Consulting component of unexpected value. I can't think of any content that could be added - I did find it particularly

4. Speakers:

Please evaluate each speaker. How did his/her presentation help/not help your personal/course objectives.

Betty Mancuso: Excellent - I felt it especially valuable that Betty works in the system & has an understanding of some of the issues we struggle with.

Zoe-Anne Fitzhugh: Excellent - clear with her material & her own issues - & really strong sense of group process.

Bonnie Heikes: Excellent & thorough & v. helpful handout.

Anne Diaz: Excellent - a great role model of patient advocate

Danny Jenkins: Excellent - This is the 3rd time I've heard Danny & learn more each time. Really appreciated role plays.

Family Panel: Paul, Michael, HelenClare Wonderful - all of them I learned so much.

"Expert" Panel: Josue, Bill, Pam, Julie, Anne Excellent -

5. Teaching Strategies:

How did the teaching strategies help/not help you meet your personal/course objectives?

Lectures: Above & beyond my expectations in all these categories. I felt right I really absorbed the information using the different strategies.

Case studies:

Clinical (Thursday):

In class cases:

Role plays:

Overall, how was the workshop? would you recommend it to others? Thank you, Zoey and Betty.

Wonderful! Yes! Yes! Yes!

AIDS EDUCATION AND TRAINING CENTER FOR SOUTHERN CALIFORNIA

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE

AIDS Clinical Training Program

Evaluation and Participant Feedback

1. What were your initial expectations and did they change during the experience?

2. Overall, how well were your own objectives met?

3. Overall, were you able to meet the stated learning objectives?

4. On a one to ten scale rate the impact this clinical experience had on you regarding the following dimensions.

   a Knowledge and understanding
   b. Professional habits and attitudes
   c. Technical skills
   d Clinical skills (such as Hx, Px, Dx)
   e. Management skills

6. As a result of this experience, do you feel you are able to diagnose and treat HIV positive patients, AIDS patients?

7. What are the strengths and weaknesses of this clinical experience?

8. Was there sufficient "hands on" experience?

9. Asses the observational opportunities and experiences.

10. Was the frequency and quality of feedback you received adequate?

11. What is your assessment of the handouts, readings and didactic materials?

12. What are your suggestions for improving this clinical experience?

DELTA RBGION AIDS EDUCATION AND TRAINING CBNTBR

BVALUATION REVIEW

I. OVERVIEW

The Delta Region AIDS ETC (DRA ETC), with administrative offices situated at the Louisiana State University Medical School in New Orleans, represents a cooperative effort among Louisiana State University, Tulane University School of Public Health and Tropical Medicine, the University of Mississippi School of Medicine, The University of Arkansas School of Medicine, and other professional organizations.

The two project goals are to improve services to patients with AIDS by providing education and training to primary care providers including primary care physicians, nurses, social workers, dental workers, and emergency service personnel and to prevent transmission of AIDS by teaching primary care providers safe medical practices and encouraging them to teach prevention to their patients. The first eighteen months of the program were focused on the establishment of an administrative structure and a resource center, the development and implementation of an extensive needs assessment, curricula development, and training of ETC faculty. Subsequently, training activities have increased in communities around the region through the efforts of discipline-specific program committees of the ETC and in the health professional schools through the efforts of the university-based faculty.

To date, evaluation of education and training programs is formative in nature. However, the DRA ETC has developed an impressive and thorough protocol for evaluation processes and strategies which has been distributed to faculty. In addition, curriculum developed by the ETC includes evaluation suggestions and questions for instrumentation which would enable facilitators to measure the effectiveness of training.

II. THE ADMINISTRATION OF THE RVALUATION PROCESS

A. The Evaluation Plan

A clearly defined evaluation plan is included in the project description. In March 1989 a Manual of Operation for Evaluation was completed to delineate the theoretical framework guiding the evaluation and describe the processes by which the ETC's evaluation component is to operate. This manual has been distributed to the various sites to serve as a guide for program planners.

1. The Evaluation as Proposed

The DRA ETC proposed a four staged evaluation process which includes a training needs assessment, an input evaluation, a process evaluation, and an impact evaluation. Each of these is described in the Manual of Operation for Evaluation, which offers details about the various components of a multi-dimensional approach to determine whether the project goals and objectives have been met; to determine if they were met in an effective, efficacious, and cost-effective manner; and to assess whether participants* knowledge, attitudes, and behaviors are leading to improved health care services.

First, a training needs assessment targeting specific health care professionals was to be conducted to document current proficiency. This needs assessment is to serve as baseline data of knowledge, attitudes, and practice.

Input evaluation was to focus on and document human, material, and financial resources. Data was to be collected on the number, type, and unique characteristics of programs and financial resources.

Process evaluation was to assess and monitor the training process of each educational program to determine what occurred and to assess the quality of the services provided. Subjective evaluation instruments were to be included in all ETC programs and would query participants/users on opinions about and reactions to various activities. The proposal specifies that data will be collected on a continuing basis and that compilation and analysis will be made on a monthly and quarterly basis to regional and State staff and technical trainers.

Impact evaluation was proposed in a two staged process. A pre/post-training instrument was to be administered for each educational activity to assess the immediate impact (effectiveness) of course content and training on knowledge acquisition as well as on preliminary changes in attitudes and skills. The second stage consists of a modified time series evaluation design to assess post-training impact.

Overall, the Manual of Operation for Evaluation is an impressive and thorough document which establishes the objectives, protocols, and strategies for an-evaluation plan. The appendices include various instruments for faculty development workshop evaluation, for participant evaluations (process oriented), for the faculty field report, for the project status report, and for materials review (appraisal checklist).

2. The Implementation of the Evaluation Plan

Needed attention to organizational development has somewhat slowed the programmatic development with the Delta Region AIDS ETC. With little pre-existing activity to build on, the DRAETC has begun the process of developing AIDS/HIV-related training programs for health professionals in the area. The first step in the process was a needs assessment. Information gleaned from the survey offers baseline data for future analysis.

The evaluation component is, to date, formative in nature. The Manual of Operation for Evaluation remains a guide for use and it may serve as a

planning and teaching guide for program developers. There is no indication, to date, of use of the pre/post measurement suggestions contained within the manual. The plans for impact evaluations are not being implemented because of time and financial constraints.

However, the overall philosophic commitment to evaluation was introduced early on. A teaching skills session, combined with the executive committee meeting (July 1988) offered staff a review of potential training materials and a presentation on evaluation.

B. Locus of Responsibility

The administrative center of The Delta Region AIDS ETC has been established at the Charity Hospital at New Orleans and is administered by the LSU Medical School. The overall administration of the program is considered a joint venture between the two major institutions in New Orleans, LSU Medical School and Tulane University. The project director is from LSU and the associate director from Tulane. The administrative staff is currently housed within the Louisiana State University site and the program and evaluation staff located at Tulane University, a walking distance away: .

1. Staff Responsibility

A reorganization of the staff and redefinition of staff responsibilities has recently taken place. The case study report outlines the changes and specific staff responsibilities.

Michael Pejsach, Ed.D., the Evaluation Director for the Delta Region AIDS ETC, is based at the Tulane School of Public Health and Tropical Medicine and is responsible for the development of the Evaluation Manual.

Faculty are responsible for the evaluation component of their workshops.

2. Advisory Responsibility

Profession-specific volunteer Program Committees have been formed in medicine, nursing, social work, dental health, and infection control/allied health. These committees, each with a specified budget, take the lead in the development of curriculum and programs. An Executive Committee is responsible for overall ETC development and policy and is comprised of the Project Directors, State Directors, Program Directors, the Evaluation Director, and the full time ETC staff.

3. Subcontractors

The Program Committees for medicine, nursing, social work, dental and infection control and allied health were initially established as advisory groups but have evolved in such a way that they are responsible, with a **specific budget, for developing, implementing, and evaluating programs in** specialty areas. Program development activities include goal setting, timetables, curricula development, faculty/facility development, and evaluating the needs, performance, responses, outcome of the programs with the education and evaluation directors. The ETC Program Directors are:

- Gay Lynn Bond, MSW, Program Director for Social Work
- Joel1 Bowab, MT (ASCP) CIC, Program Director for Infection Control
- George Risi, MD, Program Director for Medicine
- Penelope Dralle, PhD, Program Director for Mental Health
- Elizabeth Humphrey, RN, EdD, Program Director for Nursing
- John Ritchie, DDS, MEd, was the Program Director for Dentistry but is leaving the area.

C. Coordination of Evaluation Activities

Faculty for the various workshops are responsible for the implementation of any evaluation component beyond the required forms for program reporting. The overall summative evaluations remain the responsibility of Dr. Pejsach.

D. Reporting of Findings

Findings from the key informant interviews and for the Health Professionals Needs Assessments are documented in a report prepared by Ann Fitzgerald (former Education Director of the Delta Region AIDS ETC) to the Executive Committee and the Program Planning Committees, December 1988. The Evaluation Summary Report for Year 02 (April-October 1989) is part of the Delta Region AIDS ETC Report and offers a detailed summary of findings from the process evaluations, field reports, and 6 month examination of objectives.

III. APPROACHES TO PROJECT EVALUATION

A. Monitoring

The administrative staff, while providing support for program activities at the request of the various committees, collects and processes data pertaining to the various events and offerings. The current staff re-structuring, and the particular position of Ms. Foxworth to provide consistent support to the training activities of the ETC faculty will enable the central office to more closely monitor overall project activities. The roles and functions of the various components of the ETC are currently being reviewed.

The ETC has developed a data collection/management protocol. The protocol stipulates that the ETC coordinator assumes responsibility for the distribution of appropriate instruments and for periodic reporting forms for all events. Faculty assumes responsibility for introducing the evaluation component, for the distribution of forms to participants, the collection of completed forms, and the submission to the central office of the Faculty Field Report and the participant evaluations.

All faculty for professional training programs submit a letter of agreement detailing the date and site of the proposed program, the title of the workshop, and the scope of work to be performed. The agreement also stipulates that payment is made upon the completion of the work and submission of reports as established by the program planning committee; this includes the

participant evaluation forms. In addition, faculty should complete a Faculty Field Report which details the following information: date, title, site, and length of the event; time spent in preparation; type of event; learning objectives and learning strategies; equipment used; evaluation methodology used; participant professional groups; problems encountered; and strategies found to be successful. A copy of this form is included in Appendix I.

All data must be returned to the ETC Coordinator who is responsible for overseeing the development of a Project Status Report. This form is returned to the Evaluation Director. The protocol further stipulates that the Evaluation Director has responsibility for coordinating the outside appraisal of ETC developed materials, for coding and computer entry of data, for data analysis, and the generation of statistical reports and compilation of qualitative data (within specified time periods after receipt of materials).

The Training Grant Continuation Application reports on project activities and serves as a summary indication of activities taking place prior to and during the start up phases. Networking activities include communication links with professional schools and associations for the Tulane LSU AIDS Clinical Trials Unit, the AIDS Services Demonstration Project **(HRSA/RWJ),** the Area Health Education Centers (HRSA), various professional schools and associations, health care facilities, Louisiana Legislature AIDS Task Force, and a variety of community groups in New Orleans and Arkansas.

Executive Committee meeting minutes serve as a document of reported events and always include program director reports. A checklist format with the minutes highlights action needed and action taken.

B. **Output Evaluation**

Records of program activities are kept centrally. All program facilitators must submit a brief program description in order to have expenses processed. This requirement enables the central office of the ETC to monitor program activities. To date, program development activities detailed in the case study and updates include specific curriculum, faculty development workshops, the establishment of a resource library, the development of a monthly newsletter and utilization of an existing bulletin board system, and the development of a communication and resource center.

The Process Evaluation Summary Report prepared in October 1989 offers a comparison between the first year data (reported in the Evaluation Data Summary Report February through April 1989) and the data reported in the first six months of Year 02. The Year 01 data included eleven ETC events and was based on 255 participant evaluations. The Year 02 data is based on 9 ETC events and on 230 participant evaluations. On the average, these events comprised two hours of training time. Generally, findings were similar for both years. One may observe somewhat higher rating in Year 02 for the educational/technical and organizational aspects of the learning experience. Reasons for attending the program differed in Year 02 and show evidence of a stronger professional interest in the topic.

For Year 02, the general format for the events includes lectures supplemented by slides and/or handouts. Participants were primarily female,

had been working for over ten years, and reported spending less than five hours on HIV related activities. Participants ranked the events they attended and gave the ETC events an overall average of 8.2 on a rating scale of 1 to 9, offering an average ranking of 8.0 for faculty and 7.8 for various aspects of the sessions. The summary data sheets (pages 11-15 of the report) are included in Appendix II.

C. **Cost** Efficiency and Cost Effectiveness

There is, as yet, no analysis of cost efficiency or cost effectiveness.

IV. FORMATIVE RVALUATION OF PRODUCTS **DEVELOPED**

Discipline specific curricula have been developed for medicine, dentistry, and social work. **Curriculum** for nursing is being completed. The development of the multidisciplinary curriculum and the profession specific curricula followed these specific steps:

- development of the basic technical elements by individuals with training and expertise in the area;
- editorial review;
- review by educators for clarity and correct grammar; and
- evaluation and feedback from target training groups.

The Data Collection/Management Protocol stipulates that the Evaluation Director is responsible for coordinating the outside appraisal of ETC developed materials.

V. APPROACHES TO EVALUATING EDUCATION AND TRAINING **OFFERINGS**

Evaluation instruments are reported as under development, with various instruments having been tested in faculty development workshops. The Evaluation Summary Reports for Year 02 (April-October 1989) offer a description of the evaluation 6-month report by objective, a summary of field reports, a process evaluation summary report, and an impact evaluation summary report . All programs utilize a standard process evaluation format.

A. **Standardization of Evaluation ETC-Wide**

The ETC reports that a standard Participant Evaluation form is used for all programs. This form, a formative evaluation instrument for evaluating the process and structure of DRA **ETC's** training offerings, asks participants to provide information in the following areas:

1. Reason for attending session.

2. Opinions regarding the adequacy of program components:

   - ratings of education level of technical information;
   - ratings of usefulness of information for work;
   - adequacy of content for stated goals and objectives;
   - adequacy of materials, aids, and time allowed;
   - likelihood of attending another session; and
   - overall opinion of session.

3. Assessment of presenters.

4. Assessment of various program components as factors for attending another session.

5. General thoughts and suggestions for change.

6. Demographics.

Regular use of the process evaluation instruments, for all programs and across sites, permits comparisons among sessions and, in summary form, between the start up Year 01 and Year 02. An overview of findings was noted above. A copy of the Participant Evaluation form is included in Appendix III.

B. Approaches to the Formative Evaluation of Training Events

As noted above, the Participant Evaluation form queries participants on basic demographics, their work setting and training, and work time spent on AIDS related services; their reason for attending the program/session; their perceptions of the educational /technical and organizational aspects of the session, and their ranking of presenters' organization, apparent knowledge, and delivery. This information has been used by the regional headquarters to prepare yearly summary reports.

In addition, the ETC has utilized a unique formative evaluation approach. People With AIDS who serve as panel members for training events have occasionally been asked to attend the entire training event and offer critiques and feedback to faculty at the conclusion of the day. Additional discussion of this technique may be found in Section V.D. below.

C. **Approaches to Evaluating Training Outcomes**

The centrally controlled overall impact evaluation, originally scheduled to begin on or about December 1, 1989 has not been implemented and no progress report is as yet available. At the time of the site visit it had been determined that a time series evaluation design, as the approach to evaluating training outcomes, would be too costly and too time consuming. A follow-up survey of program participants is under consideration.

Material is available, in the evaluation manual and in the various curricula, to serve as guides for the development of training outcome evaluation instruments. This material has been distributed to faculty; however, there has been no specific training, beyond the initial introduction, attending to the development of evaluations. The use of any instruments beyond the required reporting forms are at the discretion of faculty.

The available material, when used, could yield insight into the effectiveness of training. For example, the Multidiscipline Curriculum which contains a variety of modules with specific objectives and exercises also includes review questions, specific scenarios, or role play assessments with observer instructions. The questions, whether they focus on specific information or relate to scenarios or role play, are well suited for post session assessment of learners and can offer an insightful evaluation of training objectives and participant skills. In addition, the curriculum contains a separate evaluation section. This evaluation section lists each objective with specific evaluation questions. Some examples are:

1. From the Section: Modes of Transmission
Question related to Objective A.3: "From the list below circle three bodily fluids which contain the virus but do not result in transmission.'

2. From the Section: Epidemiology
Question related to Objective C.l: "Define retrovirus."

3. From the Section: Clinical Care
Question related to Objective D.8: "List the areas to assess when conducting an HIV specific mental health assessment."

4. From the Section: Multidisciplinary Team Skills
Question related to Objective B.3: "Identify supports and barriers. to a multidisciplinary team approach in your health care setting."

5. From the Section: Client Perspective
Question related to Objective D.3: "Identify at least three major losses experienced by people who are HIV positive and symptomatic."

D. Unique and Interesting Evaluation Techniques

The Delta Region AIDS ETC reports a unique formative evaluation approach. When appropriate, faculty for education and training events include people with AIDS. In addition to offering their specific training component, these individuals have bee-n asked to sit in on the entire program and offer comments and ratings to the faculty at the end. Their observations may focus on program content as well as program processes. This inclusion of an evaluation component that reflects the perspective of the person being served by health care professionals can offer valuable insight to program presenters and planners. There is no written report documenting the process, the nature of the comments, or the nature of the changes made as a result. A recommendation to develop such a report is included in the final section. This unique formative evaluation approach may be advantageously used for a variety of programs.

VI. EVALUATIONS CONDUCTED

As noted above, a needs assessment was conducted and may provide base line data for future evaluation efforts. In addition, various curricula include very specific evaluation instruments for assessment of knowledge, attitude, and behavior change. To date, however, evaluation instruments in use are formative in nature. Use of these forms is required; faculty collect completed questionnaires and submit them to the ETC coordinator. There is no reported use of pre and post-training measures for analysis of change. Delta Region AIDS ETC has not yet attempted to assess impact.

A. Needs Assessment

Findings from the needs assessment survey, conducted among a sampling of health professionals in a tri-state area, were reported in a Summary Document dated December 1988. Highlights from this report follow:

Sampling: A sample of over 3,000 health professionals was randomly selected from the State licensing boards of Arkansas, Louisiana, and Mississippi, a total population of 81,402 health care professionals. A total of 842 surveys were completed: 249 from Arkansas, 335 from Louisiana, and 244 from Mississippi (with an additional 14 in "other" category).

Demographics: Survey respondents are predominately white, female, between the ages of 39 and 45, and in practice for 12-16 years. Respondents include 154 dentists, 203 dental hygienists, 78 infection control practitioners, 139 nurses, 112 physicians, and 151 social workers.

Content Areas: The content areas of most interest are modes of transmission, prevention of transmission, risk groups, information and skills specific to professional group.

Attitudes: Dentists and registered dental hygienists rated themselves as "not comfortable" working with the HIV-infected, while physicians, registered nurses, and social workers rated themselves in the medium range for comfort; infection control practitioners rated themselves in the high range for comfort. A majority of respondents agree that a professional's personal opinions about AIDS/HIV would affect quality of service.

Learning Methods and Settings: Continuing education is reported as the techniques currently in use to increase knowledge about HIV. All professional groups reported that they would probably use informational workshops and self study programs but would probably not use programs that required face to face contact with HIV/AIDS individuals.

In addition to the mailed survey, a telephone interview was conducted among 15 key informants to assess the information and skills these HIV experts think that their peers should acquire. One-half to one full hour telephone interviews were conducted among a cross-section of health professionals represented by program planning committees. This survey was conducted in Fall 1988, and findings reported to the executive committee of the Delta Region

AIDS ETC in a summary report dated December 1988. Highlights from this report are summarized below:

Target Population: "Key informants were defined as people involved in HIV activities or working in a position where HIV education is important, outside of the New Orleans Metropolitan area.

Treatment/Skills Issues: Key informants emphasized the need to address all aspects of care for the HIV infected; the importance of familiarity with the Social Security and insurance systems, networking, and referral; familiarity with psychosocial dynamics of diagnosis, patient management, and fear. Attitudes were highlighted as "key" and necessary special skills were identified as "compassion" not clinical competence.

Barriers to Treatment: Key informants stressed the need for care workers to acquire knowledge and skills related to HIV infection in order to remove the barriers of fear and better serve clients.

B. Train-the-Trainers

Faculty Development workshops were designed to ensure a group of trained trainers throughout the region to implement the various ETC curricula. Workshops have been held in New Orleans, Jackson, Little Rock, and Shreveport.

The questionnaire used for the evaluation of faculty development workshop gathers information about the participants (profession, specialty area, years in practice, degree, ethnicity, ethnic populations served, time in various settings, and time spent working with HIV related issues). Participants are asked to rate various aspects of the workshop including course content, presentation style, organization, and administration for usefulness or helpfulness. A variety of questions attend to technical content, educational methodology, faculty development skills, and faculty performance. A copy of the Faculty Development Workshop evaluation form is included in Appendix IV.

The evaluations for the faculty development workshops have been process oriented. Feedback from several of these workshops have enabled programs planners to redesign program updates. Original assumptions were that faculty were knowledgeable about HIV/AIDS but needed adult education skills. Participant assessments indicated a stronger need for AIDS related information. Programs offering updates to faculty are designed to offer this needed information.

C. AIDS Clinical Skills Workshops

Clinical Skills Workshops offered multidisciplinary and profession-specific conferences. The first series began in November 1988 in collaboration with the Metropolitan New Orleans Infectious Diseases Group to increase baseline knowledge, skills, and attitudes relevant to understanding the HIV-infected patients. The program consisted of two-hour meetings held monthly. Evaluation was conducted but final results are not currently available.

D. Profession-Specific Training Workshops

Profession-specific course modules have been developed for presentations to physicians, dentists, nurses, infection control professionals, allied health personnel, social workers, public health workers, and mental health workers. Each professional group needs a basic course (AIDS 101) and a more advanced knowledge and skill training.

The instrument used was the standard Participant Evaluation form described in Section V.A., asking for ratings of various program components. Participants rate the educational level of the technical information, the degree to which this information is useful to their work, the adequacy of the content in meeting goals and objectives, the adequacy of the print and media aids, as well as the adequacy of the time allotment, setting, and faculty. The Summary Report includes data from these workshops. Individual reports are not available.

E. Co-Sponsored Programs

The Delta Region AIDS ETC provides resources and logistic support to other organizations wishing to sponsor programs. Cosponsorship requirements include the use of evaluation tools designed by the ETC evaluator. These forms are the standard Participant Evaluation form used for the profession-specific courses. Data from these events are included in the summary reports.

VII. SUMMARY OF ISSUES AND CHALLENGES FOR THE FUTURE

The Delta Region AIDS ETC has devoted a good deal of needed attention to organizational development and restructuring and to the development of HIV/AIDS related educational and training effort geared toward health care professionals new to the area. Quite appropriately, early evaluation efforts have been formative in nature. Participants offer assessments of the educational experience which can, in turn, be used in the redesign of presentations and workshops. The ETC could document the use of these process evaluations and the existing feedback loops.

The DRA ETC has utilized an innovative formative evaluation mechanism which should be written as a case study. In several workshops people infected by HIV have, in addition to serving on a panel, been asked to observe workshop offerings and present comments to faculty at the end. This presents a valuable opportunity for program developers to gain insight into patient and client needs and incorporate their perspectives in professional trainings.

The ETC had developed, early on, a substantial document which offered a philosophic commitment to evaluation and guidelines for implementation. This evaluation manual was distributed to all sites. However, there is no indication, to date, of how this manual is used. It would be helpful to query the various faculty and site directors regarding this manual and their needs related to program evaluation efforts. Faculty may find it easier to use a predesigned instrument than to develop their own. It may be that a relatively simple and uniform questionnaire for pre and post program measures

of knowledge, attitudes and/or behavioral intent could uniformly be used across all full day programs.

The use of evaluation instruments and the value of evaluation results must often be demonstrated to faculty, who sometimes view evaluations as unimportant or too time consuming. If all faculty development (train-the-trainer) programs were evaluated with rigor and results communicated to participants, compliance with evaluation implementation could be modeled and perhaps substantially improved.

The requirement for submitting workshop data sheets with payment requests increases the likelihood of compliance. Data currently collected by faculty could be expanded to include measures of behavioral intent and/or participant self assessments of skills and knowledge.

With the development of a file of trainees, the ETC is now in a position to initiate a regionwide follow-up of a sampling of professionals who attended in-depth workshops. This follow-up can focus on reported change in professional activities. A relatively short and simple mailing or phone interview would not be as time consuming or costly as the proposed time series study. Valuable insight into program effects could still be obtained.

APPENDIX I

Project Honitoring -- Faculty Field Report

DELTA REGION AIDS ETC
Faculty Field Report

Please fill this out at the conclusion of your presentation. It should be returned within 14 days to the ETC Office

Name: _____ - - - -Your ETC affiliation: _____ - - -
Date of EVENT: /- / -/

Site of EVENT: (town/city) _____ (state) _____

Title/Topic of Event: _____

Length of Event _____ (hours/minutes)

Estimate time spent in preparation: _____ (hours/minutes)

How would you describe the event (i.e. presentation, complete program, session in a program) _____

Learning objectives covered: (be specific)

1 _____

2 _____

3 _____

Learning strategies used: (match to the objective(s) covered)

1 _____

2 _____

3 _____

Equipment (i.e. slide projector), materials (i.e., handouts, pamphlets) used: (match to above)

	item	quantity or length time used
1		
2		
3		

Evaluation methodology used:

For participants: _____ (i.e. skills, knowledge, attitude tests)

For session/presentation: _____ (i.e. Standard ETC Provider *Evaluation*)

What profession(s) (check) and indicate the number in the space provided:

❑ Physicians	_____	❑ LPN Nurses	_____
❑ Dentists	_____	❑ Reg. Dental Hyg.	_____
❑ Infection Con.	_____	❑ Social Workers	_____
❑ RN Nurses	_____	❑ Other (specify)	_____

Problems, if any, encountered:

_____

_____

Strategies you found particularly successful:

_____

_____

_____

APPENDIX II

Process Evaluation Summary Report-- Year 01 and 02 Comparisons

For Each Of The Selected Questions & Variables Listed Below, The Number To The Right Side Of It Represents The Varlables' Mean or Percentage Score Based on 230 respondents.

PART I : Program Information

Q2. What was your main reason for attending this program or session: **#=percent** checking.

Year 1		Year 2	
professional interest	**=59.6%**	professional interest	**=71.3%**
share information	**=4.1%**	share information	**=1.3%**
assigned to attend	**=32.2%**	assigned to attend	**=20.4%**
reputation of speaker	**=0.0%**	reputation of speaker	**=0.4%**
other	**=3.3%**	other	**=1.3%**

PART II: Educational/technical and organizational aspects.

	MEAN SCORE YEAR1	**YEAR 2**
Q3. How educational was the technical information presented in this program?	7.85	7.86
Q4. How useful/practical for your work is the information presented in this program?	7.84	7.96
Q5. How adequate was the content for the stated goals and objectives?	7.94	**7.97**
Q6. How adequate were the audiovisuals used in this session?	7.64	7.92
Q7. How adequate were the handout materials in this session?	7.86	8.13
Q8. Was there adequate time for the **program or session?**	7.67	8.05
Q9. How likely is it that you would attend another session presented in this setting or environment?	7.80	**8.16**
Q10. How likely is it that you would attend another session presented by this faculty?	7.98	8.16
Q 11. Overall, my opinion of this session(s) was:	8.06	8.16

PART III: Below are three areas of provider performance. Each presenter was ranked on **Degree** of Organization, Apparent **Knowledge** of Subject Matter, and Delivery Skills. Presenters were assessed on a 1 to 9 scale **1=poor, 9=excellent, #=MEAN** SCORE

The Mean Scores Reported Here are Composite means **BasedOn** All ETC Faculty having presented

	YEAR 1	**YEAR2**
V 12. Presenter's organization:	**=8.15**	8.19
V13. Presenter's apparent knowledge	**=8.49**	**8.53**
V 14. Presenter's delivery:	**=8.02**	8.03

The following tables are a comparison between the first and second year variables.

Part IV: Items which respondents believe are important factors to attending another session.

YEAR 1

Variable	% Considering It Important	% Less Important	N.A.	Checked only
V15.Faculty	'67.5%	1.6%	20.4%	**5.4%**
V 16.Setting-Accessibility	64.7%	0.8%	33.6%	4.1%
V17.Setting-Environment	**56.8%**	**2.9%**	33.6%	3.3%
V18.Content meets need	80.5%	0.0%	12.0%	6.2%
V19.Program Time-Amount	63.7%	2.5%	25.8%	2.5%
V20.Program Time of day	58.1%	2.5%	32.6%	2.5%
V2 1 .Each Session-length	57.1%	4.2%	31.2%	**2.0%**

• note: percents in body of table represent the percentages of those responding who scored each variable along a 9 point likert scale:values of 6-9=important; values of 1-4=less important.

YEAR 2

Variable	% Considering It Important	% Less Important	N.A.	Checked only
V15.Faculty	• 67.8%	**0.9%**	19.6%	**2.6%**
V 16. Setting-Accessibility	**66.5%**	1.3%	18.7%	2.2%
V17.Setting-Environment	57.0%	3.0%	26.5%	1 . 7 %
V18.Content meets need	81.7%	0.4%	16.5%	2.2%
V19.Program Time-Amount	**67.0%**	3.0%	**16.5%**	2.2%
V20.Program Time of day	60.9%	**0.9%**	23.5%	**1.7%**
V2 1 .Each Session-length	58.7%	**1.7%**	25.2%	1.3%

• note: percents in body of table represent the percentages of those responding who scored each variable along a 9 point likert scale:values of 6-9=important; values of 1-4=less Important.

Part V: Personal objective:

Q24. What was your personal objective in attending this offering?

YEAR 1: **97.9%= "To learn more about AIDS & treatment/care issues"**
0.0%= 'To teach other Health Care professional"

YEAR 2: 77.4%= "To learn more about AIDS & treatment/care issues"
2.6%= "To teach other Health Care professional"
19.8%= Did not respond

Q25. Was personal objective(s) met?

YEAR 1: **95.4%=Responded Yes**
4.6%=Responded No

YEAR 2: 87.4%=Responded Yes
2.2%=Responded No
8.3%=Missing

Part VI: Participant demographics, populations served & work setting:

Q30. What is your profession and number identifying themselves as such:

	Year 1	Year2		Year 1	Year2
Dentist:	N=27	N= 0	Nurse (RN):	N=51	N=86
Dental Hygienist:	N=50	N=50	Physician:	N=25	N=10
Infection Control:	N= 13	N=16	Social Worker:	N=37	N= 4
Other:	N=26	N=24	Nurse (LPN):	N= 6	N=22
Missing:	N=20	N= 3			

Q3 1. Professional specialties and the number identifying themselves as such:

	Year 1	Year2		Year1	Year2
Infection control:	N=20	N=27	Pharmacy:	N= 1	N=0
Administration:	N=5	N=6	Geriatrics:	N=4	N=1
EducaUon/counsel:	N= 1	N=9	Mental health:	N=5	N=4
Welfare services:	N=1	N=O	Home/hospice:	N=27	N = Q
Pastoral care:	N=2	N=0	Dentistry:	N=9	N=3
In-patient care:	N=15	N=0	Mat/child care:	N=7	N=7
Substance abuse:	N=7	N=3	Non-medical other:	N=7	N=1
Family Medicine:	N=0	N=3	Public Health:	N=0	N=l
Medical Other:	N=0	N=56			
Missing:	N=62	N=41	Not Applicable:	N=82	N=59

Q32. Years have been in practice: **Year 1: Mean=12.28 YEARS**
Year 2: Mean=11.60 YEARS

Q33. Listing of respondents' highest professional degree:

	Year 1	Year 2		Year 1	Year 2
DDS:	N=13	N - O	MPH/MSW/MSN/MS:	N-47	N=21
RN:	N=4	N=15	BSN/BSW/BS/BA:	N-SO	N=44
Ph.D.:	N=3	N=0	M.ED/MASTERS:	N=0	N=7
MD:	N=3	N=11	DIPLOMA:	N=33	N=54
LPN:	N=6	N=6			
Not Applicable:	N=82	N=20	Missing:	N=62	N=52

Q34. Respondents' reported sex: Year 1: Male =25.9% Female=74.1%
Year 2: Male =a. 1% Female=87.0%

Q37. Respondents' mean age: Year 1= 33.8 years
Year 2= 34.2 years

Q35. Respondents' reported ethnicity: number and percentage of total respondents:

Year 1		Year 2	
V. Asian/Pacific Islander:	N=5 (2.2%)	V. Asian/Pacific Islander:	N=2 (0.9%)
V. Hispanic/Latino:	N=4 (1.7)	V. Hispanic/Latino:	N=5 (2.2%)
V. White/Caucasian:	N=193 (84.3%)	V. White/Caucasian:	N=189 (82.2%)
V. Black American:	N=26 (11.35%)	V. Black American:	N= 17 (7.4%)
V. Native American:	N=1 (0.4%)	V. Native American:	N=1 (0.4%)

Q36. Which ethnic group(s) arc your patient/client population and percentage sewed?

YEAR1

Percentages . * Group*	(≤) 10	20	30	40	50	60	70	80	90	100	NA	Checked only
V.Asia/Pacific	8.9%*	-	-	-	-	-	-	-	-	0.7	a.6	
V.Hispanic/Latino	17.9	-	0.7	-	-	-	-	-	-	0.7	67.6	13.1
V.Black American	4.1	3.4	6.2	6.8	10.3	1.4	4.8	27	-	0.7	31.7	27.6
V.Native American	2 7	0.7	-	-	-	-	-	0.7	-	0.7	86.9	8.3
V.White/Caucasian	2 7	3.4	2.1	27	124	4.8	4.1	2.1	27	27	26.9	31.0

● *,note: percentages are coded kss then or equal to: hence 10%=0. 1 to 10.0%
*note: numbers in body of table-percent of those responding who Indicated they served that specific ethnic group and the corresponding client population percentage.

YEAR2

Percentages ** Group*	(≤) 10	20	30	40	50	60	70	80	90	100	NA	Checke only
V.Asian/Pacific Islder	8.3%*	-	0.4	-	-	-	-	-	-	0.4	68.7	6.5
V.Hispanic/Latino	17.8	2.2	--	-	-	-	-	-	-	0.4	47.4	16.1
V.Black American	3.0	2.6	9.1	6.5	8.7	26	26	26	1.7	0.4	14.8	29.1
V.Native American	3.9	0.9	0.4	-	-	0.4	-	-	-	0.4	66.1	11.7
V.White/Caucasian	1.7	22	3.9	3.0	10.4	57	5.2	6.1	0.9	1.3	9.1	34.4

**note: percentages are coded kss then or equal to: hence 10%=0.1 to 10.096
*note: numbers in body of table=percent of those responding who indicated they served that specific ethnic group and the corresponding client population percentage.

38. Estimate of percentage time spent in each of the following settings:

YEAR1

setting ● 96thncspent	≤25%	≤50%	≤75%	≤99%	10096	N.A.	checked Only
V.Private Practice:	4.1%'	2.7%	0.9%	1.8%	2.3%	80.2%	-
V. Private Hospital:	2.7%	1.4%	0.5%'	0.5%	11.9%	83.1%	-
V.Public Hospital:	2.7%	0.5%	-	2.3%	7.3%	86.7%	0.5%
V.CommityAgency:	5.9%	3.6%	2.3%	3.6%	10.5%	73.0%	0.9%
V.Academic Setting:	4.1%	3.2%	1.4%	2.7%	3.2%	85.4%	-

**note: percentages are coded less then or equal to: hence 25%=0.1 to 25.0%
*note: numbers in body of table=percent of those responding who indicated they spent Ume in that specific practice setting and the corresponding amount of Ume.

YEAR2

Setting ● %tbnespent	125%	450%	≤75%	≤99%	100%	NA	checked only
V.Private Practice:	4.4%*	1.3%'	0.9%	1.7%	3.5%	76.1%	0.4%
V. Private Hospital:	3.9%	3.5%	1.3%	3.9%	14.4%	59.6%	1.3%
V.Public Hospital:	3.0%	4.8%	1.3%	4.8%	12.6%	58.7%	2.6%
V.CommityAgency:	7.0%	0.4%	1.3%	1.3%	2.6%	74.8%	0.4%
V.Academic Setting:	5.6%	3.5%	1.3%	0.9%	1.7%	74.4%	0.4%

**note: percentages arc codcd less then or equal to: hence 25%=0.1 to 25.096
*note: numbers in body of table=percent of those responding who indicated they spent time in that specific practice setting and the corresponding amount of time.

Q40. Estimate of number of hours/month respondents who reported spent working with HIV-related issues

YEAR1

hours/month:	0	≤5	≤10	≤15	≤20	≤25	≤30	≤35	≤40	≤80	≤120	≤160
percent of respondents	25.4	25.4	17.2	3.3	9.8	2.4	2.4	0.8	5.0	4.1	1.6	2.4
number of respondents	31	31	21	4	12	3	3	1	6	5	2	3

NOTE: of total number (N=255), 52.2% percent (N=133) left this variable blank.

YEAR2

hours/month:	0	≤5	≤10	≤15	≤20	≤25	≤35	≤40	≤80	≤120	≤160
percent d respondents	10.9	22.2	8.7	1.7	0.9	0.9	1.7	1.3	1.7	1.3	3.5
number of respondents	25	51	20	4	2	2	4	3	4	3	8

NOTE: of total number (N=230), 44.8% percent (N=103) left this variable blank.

APPENDIX III

Standardized Evaluation Instruments -- Participant Evaluation Form

DELTA REGION AIDS ETC
Participant Evaluation

In order to make our programs as useful as possible to you, **as** well **as** others, please give **us** your feedback. This **information will be held in strictest** confidence.

PART I: PROGRAM INFORMATION

1. What was the name of the **session** or presentation? Date:
2. **What was your main reason for attending this program or session? Please check one.**
   - ☐ professional interest
   - ☐ share information
   - ☐ other---_-_
   - ☐ assigned **or sent to** attend
   - ☐ reputation of presenter

PART II: **Please** circle the **number that comes closest to your opinion. 1=Poor, 9=Excellent**

3. How **educational was the technical information presented in this program?**	1	2	3	4	5	6	7	8	9	NA
4. **How useful /practical for your work is the information presented in this program ?**	1	2	3	4	5	6	7	8	9	NA
5. **How adequate was the content for the stated goals and objectives?**	1	2	3	4	5	6	7	8	9	NA
6. **How adequate were the audio-visuals** used **in this session?**	1	2	3	4	5	6	7	8	9	NA
7. **How adequate were the handout materials in this session?**	1	2	3	4	5	6	7	8	9	NA
8. **Was there adequate time for the program or session?**	1	2	3	4	5	6	7	8	9	**NA**
9. **How likely is it** that you would attend another session presented in this setting or environment?	1	2	3	4	5	6	7	8	9	**NA**
10. How likely is it that you would attend another session presented by this faculty?	1	2	3	4	5	6	7	8	9	NA'
11. Overall, my opinion of this session(s) was:	1	2	3	4	5	6	7	8	9	NA

PART III: Below are three areas **of provider** performance. **Assess** each presenter by entering a number (**1** to **9**) next to each item **under the presenter's** name. **1=Poor. 9=Excellent**

Presenter's Name:						
12. Presenter's Organization:						
13. Presenter's apparent knowledge of the subject material						
14. Presenter's **delivery:**						

PART **IV: For** the question below, **please** check **all** that apply, grade and comment.

15. Which **of the items** below do you **believe** are the most important factors to attending another session.

CHECK		GRADE	Comments
16. ☐	**Faculty**	----------	----------
17. ☐	**setting - Accessibility**	----------	----------
18. ☐	**Setting -Environment**	----------	----------
19. ☐	**Content Level -Meets Need(s)**	----------	----------
20. ☐	**Program Time - Amount**	----------	----------
21. ☐	**Program Time of Day**	----------	----------
22. ☐	Each **Session-Length**	----------	----------
23. ☐	**Other**	----------	----------
24. ☐	**Other**	----------	----------

additional questions on **reverse** side

Part V: For the questions below, please share some of your thoughts with us.

25. What was your personal objective in attending **this offering?**

26. Was your personal objective **(s)** met? ☐ Yes ☐ No

27. Things I would change:

28. Things I would keep:

29. I would like to tell the presenter or program organizer:

Part VI: Other important information that would help us:

30. What is your profession ? (check one)

☐ Dentist
☐ Dental Hygienist
☐ Infection Control Practitioner
☐ Medical Technologist
☐ Nurse
☐ **Nurse** (LPN)
☐ Physician
☐ Social Worker
☐ Other (please specify) _____

31. What is your specialty area? (if applicable) _____
32. How many years have you been in practice ? _____
33. Please list your highest professional degree: _____
34. Are you:

☐ Male ☐ Female

35. Do you consider yourself :

☐ Asian/Pacific Islander
☐ **Hispanic/Latino**
☐ **White Caucasian**
☐ **Other**
☐ **Black American**
☐ **Native American**

36. Which ethnic group(s) in your patient /client population do you serve (CHECK ALL THAT APPLY AND, IF **POSSIBLE,** INDICATE PERCENTAGES):

Ethnic Group	Percentage
☐ **Asian/Pacific** Islander	_____
☐ **Hiispanic/Latino**	_____
☐ **Black American**	_____
☐ **Native America**n	_____
☐ **White Caucasian**	_____
☐ **Other**	_____

37. Your Age _____

38. Please estimate what percentage of your time is spent in each of the following settings:

Private Practice	_____
Private Hospital	_____
Public Hospital	_____
Community/Health Agency	_____
Academic Stting	_____
Other (please **specify)**	_____

39. Your Of&e/Agency ZIP CODE : _____

40. Please estimate the number of hours per month you spend working with HIV related issues _____

THANK YOU

APPENDIX IV

Evaluations Conducted -- Faculty Development Vorkshop Evaluation Form

DELTA REGIONALDS ETC
Faculty Development Workshop Evaluation

This questionnaire is designed **to get your opinion on various aspects of** the workshop, **including** course content, **presentation** style. organization and admtnstration. This tnformation will help us assess how useful the workshop was for you.

Please CIRCLE the number that most closely matches your **opinion** for the following components:

PART I- Technical **Content.**

	Less useful than expected							More useful than expected	NA
1. The technical level of the content was:	1	2	3	4	5	6	7	8 9	**NA**
2. I anticipate the practical value of the content **in terms** of application to be:	1	2	3	4	5	6	7	8 ' 9	NA
3 Overall, the technical content was:	1	2	3	4	5	6	7	8 9	NA

[PART **II-** Educational Methodology

	Less **useful** than expected							More useful than expected	NA
4. The clarity of the training/educational objectives of the workshop was:	1	2	3	4	5	6	7	8 9	NA
5. The quality of group discussions:	1	2	3	4	5	6	7	8 9	NA
6. The quality of the activities was:	1	2	3	4	5	6	7	8 9	NA
7. The usefullness of the workshop **objectives** was:	1	2	3	4	5	8	7	8 9	NA
8. The quality of feedback received on my pro-**gress** throughout the training workshop was:	1	2	3	4	5	6	7	8 9	NA

[PART **III-** Faculty Development Skills

	Not **Very** Helpful							**Very** Helpful	NA
9. In regard to enhancing your functioning as an AIDS **ETC** faculty member, the workshop was:	1	2	3	4	5	6	7	8 9	NA
10. In improving your training and **delivery skills,** the workshop was:	1	2	3	4	5	6	7	8 9	NA
11. In improving your curriculum design and modification sktlls?	1	2	3	4	5	6	7	8 9	NA
12. In enhancing your effectiveness as an AIDS educator for your colleagues and patients the workshop was:	1	2	**3**	4	5	6	7	8 9	NA

13.List the major strengths of this training workshop **in** terms of what was helpful to you:

14. List the main weaknesses of this training workshop in terms of what was LESS helpful to your learning:

Part IV: Organization and Administration (check one box for each question)

Do you consider that the administrative arrangements were adequate with respect to:

15. **Accomodations**	cl Yes	❑ **No**
16. Eating arrangements	❑ Yes	❑ No
17. working space	❑ Yes	❑ **No**
18. Briefing on workshop purpose	❑ Yes	❑ **No**
Was there enough Ume for:		
19. Presentations of materials	❑ Yes	❑ No
20. Discussion of **materials**	❑ Yes	❑ **No**
2 **1**. Group work/task sessions	❑ Yes	❑ **No**

Please circle the ● pproprlatc **number**	**Too Much**				Just **right**			Too **Little**	**NA**
22 Overall, the workload was:	1	2	3	4	5	6	7 ' 8	9	NA
23. The number of participants **in** the workshop was:	1	2	3	4	5	6	7 0	9	NA

Please circle the ● ppqriste **number** | Too Much | Just right | Too Little | NA

24. The number of **facilitators** was: 1 2 3 4 5 6 7 8 9 NA

25. To what extent do you feel that you were involved in the **structure** of the training workshop program?

26. Dld the training workshop reflect the importance of **multidisciplinary** team approach to AIDS **Education**

Part V: Faculty Performance:

Below are five areas of faculty performance. Assess each member by entering a number next to each item under the faculties name. 1= poor, **9=** excellent.

Faculty's Name: 1_____ **2**_____ 3_____ 4 - - - - - - - 5_____

27. Presented in an organized and coherent manner

28. **Availability**

29. Clarity of explanations

30. Mastery of Technical Area

31. **Easy** to Approach for help/information

Part VI: Other very important information:

32. What is your profession?

- ❑ Dentist
- ❑ Dental Hygienist
- ❑ Infection Control Practitioner
- ❑ Medical Technologist
- ❑ Nurse.
- ❑ Physician
- ❑ Social Worker
- ❑ Other_____

What is your specialty area? _____

33. How many years have you been in-practice?_____

34. Please **list** your highest degree: _____

35. Are you: ❑**Male** ❑**Female**

36. Do you consider yourself:

- ❑ Asian/Pacific Islander
- ❑ **Hispanic/Latino**
- ❑ White/Caucasian
- ❑ Black American
- 0 **Native** American
- ❑ Other_____

37. Which ethnic **group(s)** in your patient/client population do you serve (CHECK ALL THAT APPLY AND, IF POSSIBLE, INDICATE PERCENTAGES):

Ethnic group	Percentage
0 **Asian/Pacific** Islander	_____
❑ **Hispanic/Latino**	_____
❑ White/Caucasian	_____
❑ Black American	_____
❑ Native American	_____
0 Other (please specify_____)	_____

38. Your Age_____

39. Please estimate what percentage of your **time is** spent in each of the following settings:

	% time allotted
Private Practice	_____
Private Hospital	_____
Public Hospital	_____
Community/Health Agency	_____
Academic Setting	_____
Other (please specify_____)	_____

40. What is the ZIP Code *of your* practice _ _ _ _ _

41. Please estimate the number of hours **per month you spend working with** HIV **related issues** _____

IV

EMORY AIDS BDUCATION AND TRAINING CENTER

EVALUATION RBVIBW

I. OVBRVIBW

The Emory ETC, known as the Emory AIDS Training Network (EATN), is centered at the Emory University School of Medicine. Morehouse School of Medicine's Area Health Education Center in Atlanta and the University of South Florida Mental Health Institute in Tampa were involved as primary subcontractors at the outset. The University of South Carolina School of Public Health, the University of Alabama at Birmingham, and the North Carolina Primary Care Association came on as subcontractors during the first year. At the end of Year 02, the ETC served a five-state region including North Carolina, South Carolina, Florida, Georgia, and Alabama. In year 03, Dade and Monroe Counties, in the tip of Florida, and the four medical schools in the state were funded as a separate ETC, and withdrew from EATN's catchment area.

The EATN's program includes education and training activities at five levels: Train-the-Trainers (Level I); information and skill-building in specialized subject areas (Level II); broad informational updates (Level III); short presentations, generally part of a larger offering (Level IV); and, self-study materials (Level V).

In addition to doing extensive output analysis, the EATN conducts broad formative evaluation of the process, structure and content of its education and training events. Evaluation of effectiveness of high intensity events, such as the Nurses Train-the-Trainers course, has been conducted. Studies of the impact of selected trainings on on-the-job behavior are underway.

II. ADMINISTRATION OF THE EVALUATION PROCESS

A. The Evaluation Plan

1. The Bvaluation as Proposed

Emory's initial grant proposal shows evidence of considerable effort to make evaluation an integral part of its program. Evaluation is first discussed as part of Emory ETC's goals and objectives statement. The ETC's evaluation strategy and methodologies are further described in its evaluation plan. The ETC proposed to evaluate the effectiveness of its training and education programs and materials using formative, impact, process and outcome evaluation measures. Cost-effectiveness analysis was also to be carried out.

Formative Evaluation. In the development of its training programming, curricula and materials, the ETC proposed involving members of its target training audience in the formative evaluation process. The forums for this aspect of the formative evaluation were to be ETC Advisory Committees, Leadership Roundtables as well as focus groups.

The materials and curricula were to be further assessed in the formative stage via controlled audience testing and evaluations. Small groups of local providers were to be randomly assigned to pilot sessions with the proposed curricula, or used as control groups. Analysis of the results was to be conducted by Emory MPH Program students.

Process Evaluation. All intensive, single-subject conferences, multi-subject regional conferences, workshops and preservice/inservice education programs conducted by the ETC or its subcontractors were to be subjected to what EATN terms "process" evaluation.

This evaluation, which can be considered part of the formative evaluation of training events, was to consist of an analysis of the number of participants who begin and complete each session, the proportion of the desired target groups exposed, and the level of satisfaction or interest among the participants.

With the assistance of the project's evaluation consultant, the ETC was to develop evaluation tools/methodologies for collecting process data. The data collection was to be implemented by the EATN and subcontractor training staff, with analysis performed by the EATN headquarters staff.

Process evaluation was to be the primary mechanism for evaluating Level IV courses.

Individual Trainee Assessment. The Emory ETC was to evaluate each of its summer training intern's (i.e. train-the-trainers participants) initial performance by use of written examinations of didactic material covered during the training term. The interns' ability to plan training activities was to be assessed from workplans they would be assigned to write as part of their coursework. On-the-job performance was later to be assessed by the ETC staff by observing the intern as s/he conducted a training event in his or her home state.

Evaluation of Training Outcomes. (Note: the ETC refers to these activities as impact evaluation). All intensive, single-subject conferences, multi-subject regional conferences, workshops and preservice/inservice education programs conducted by the ETC or its subcontractors were to be assessed in terms of their outcomes.

Plans called for the assessment of the impact of the training event on attitudes, knowledge and behavioral intentions through pre-training testing and post-training testing. Further, a sample of participants were to receive follow-up testing three months after the event to see if any additional changes had occurred or if earlier changes had been sustained. Pretests were to contain background questions including socio-demographic items.

With the assistance of the project's evaluation consultant, the ETC was to develop evaluation tools/methodologies for collecting data. Pre, post and follow-up data were to be matched by means of a coding scheme so that changes in individual respondents can be detected, along with aggregate and group changes. The data collection was to be implemented by the ETC

and subcontractor training staff, with analysis performed by the ETC staff.

The ETC expected to be able to conduct the full range of outcome evaluation activities on trainings at Levels I, II and III, the principal focus being on Levels II and III.

The impact of Level I training, involving relatively few health providers in a concentrated program requiring the mastery of certain skills and knowledge, was to receive additional evaluative attention. Specific competencies related to the intensive training was to be assessed through examination and outcome evaluation of their performance after returning to their community through trainer observation of trainee activities.

Level IV training offerings were to be subjected to minimal assessment of effectiveness based on posttest only.

Cost Efficiency and Cost Effectiveness. With the assistance of the project's evaluation consultant, the ETC was to develop methods for assessing cost effectiveness. The cost effectiveness of programs presented by graduates of the summer intern program was to be assessed, but it was not clear from the proposal whether cost effectiveness analysis would be done on a event by event basis for all other training events or for some aggregate of these.

In its evaluation plan, the Emory ETC proposed a three-step evaluation process:

Step I: Consisting of formative evaluation of curricula relying heavily of focus groups drawing on health providers in the Emory/Atlanta community.

Step II: Consisting of controlled testing of the curricula using small groups of local health providers randomly assigned to pilot sessions with the proposed curriculum or as control groups where there is no training exposure. The pilot sessions and their evaluation were to be carried out with the assistance of Emory MPH Program students.

Step III: Consisting of program evaluation in the field in terms of both process and outcome.

2. Implementation of the Plan

The EATN Clinical Advisory Committee has been involved in reviewing clinical teaching materials and formulating training plans and content prior to implementation. Special groups have also been convened for this purpose, but formal focus group research has not been undertaken, nor has the EATN used controlled testing of materials. Formative evaluation of training events--process evaluation in EATN parlance--is being carried out routinely. Outcome evaluation has been very limited.

B. Locus of Responsibility

1. **Staff**

Formal job descriptions detail the role each member of the EATN staff was to take in the evaluation process. As the program has developed, the evaluation tasks have been redistributed. Currently:

Kathleen R. Miner, Ph. D., M.P.H., the Project Director, is responsible for the overall direction of all evaluation activities, devoting 15% of her time to research and evaluation. She was involved in the development of the overall evaluation plan and is responsible for making policy and program decisions suggested by evaluation results.

Richard Levinson, Ph.D., **EATN's** primary evaluation consultant, has primary responsibility for evaluation design and analysis. The position of evaluation consultant is an "intermediate" one. Dr. Levinson, who provides 20% time to the project, acts in the capacity of a staff evaluator but does not participate in the program's daily functioning. He is paid in part by the project and in part by Emory in his faculty role as associate professor in Emory University School of Medicine's Department of Community Health. He is also Acting Branch Chief for Research and Evaluation, at the U.S. Center for Health Promotion and Education, CDC.

Sandra Huckaby, the Deputy Director for Administration, is responsible for overseeing output evaluation and monitoring evaluation activities of the subcontractors. Felicia J. Guest, the Deputy Director for Training, is responsible for evaluation of Emory-based events and for reviewing the evaluation data from all EATN events.

All members of the key training staff take part in implementing the evaluation activities of the ETC.

2. **Subcontractors**

At Morehouse, all staff are scheduled to devote a significant proportion of their time on the project to evaluation and research activities (Co-Investigator-10% time; Medical Director-30% time; AHEC Coordinator-20%; Physician-30% time; Program Administrator-20%). The staff of the University of South Florida contractor have a lesser role in research and evaluation but it is nonetheless significant (Project Director-15% time; Training Coordinator-10% time; Physician-lo% time).

Evaluation activities of these subcontractors are directed at evaluation of their respective sections of the ETC and include development of an evaluation plan, collecting evaluation data, preparing statistical summaries, reports and graphics, analyzing the results from reports and evaluations, and recommending to the ETC personnel changes in curricula and procedures based on the results of these evaluations.

3. **Consultants**

Initially, Nancy Thompson, M.P.H., was to provide staff assistance in the selection and interpretation of the appropriate statistical measures in the

analysis of ETC data. Instead, she serves as a per diem statistical consultant, primarily supervising students involved in various EATN statistical and evaluation activities.

C. Coordination of Evaluation Activities

The evaluation consultant oversees all evaluation activities, in collaboration with senior Emory staff. He proposes special studies and discusses findings with the staff.

Quarterly meetings of EATN subcontractors provide a forum for approving proposed evaluation methodology, and for discussion of evaluation of events and their effectiveness.

D. Reporting of Findings

Collection of evaluation data is part of the program implementation responsibility of the subcontractors and the Emory-based training staff. Evaluation forms are forwarded to EATN headquarters where the data are aggregated for both participant demographic variables and training event process/structure/content variables. Reports containing these aggregated data are returned to the implementing site.

For purposes of reporting to **HRSA,** EATN prepares ETC-wide statistical summaries as well as summaries of participants served by each implementing site and training activities by state.

Special evaluative research projects are undertaken, from time to time, with the assistance of Emory graduate students. These activities are supervised by the Evaluation Consultant and reports issued at their conclusion.

III. APPROACHES TO **PROJECT** EVALUATION

A. Project **Monitoring**

The Emory **ETC's** initial proposal presents a detailed statement of goals and measurable objectives, specifying times for completion. In addition, the ETC has prepared a detailed **workplan** for each of the three years of the project, further specifying tasks and timeframes in more detail. These documents provide an excellent baseline against which the ETC monitors the project's progress. Progress is reviewed periodically by the staff. The goals and objectives statement serves as the format for the **ETC's** progress reports.

Day-to-day monitoring of subcontractor and project activities is the responsibility of the Deputy Director for Administration.

B. Output Evaluation

1. Data Collection

Output data primarily comes from two different sources: "Data for Training Log" form; and the "How Did We Do?" form. The data on the "Data for Training Log" form includes data on all those attending a given offering; total attendance counts are supported by an attendance roster which is appended. The "How Did We Do?" form provides demographic information about participants but is limited to those completing this post-training evaluation questionnaire, some 40-60% of the total of those in attendance.

The "Data for Training Log" form, included in Appendix I, is completed by the trainer or the training coordinator at the end of the training event. Data include:

- event title
- city and state in which event was held;
  beginning date;
  job category(s) of intended audience;
  sponsor (network sponsors coded; others written out);
  hours of contact time (rounded to half hour);
- CEUs (if yes, number offered);
  were "How Did We Do?" forms completed?; and
  total attendance.

Demographic data collected via the "How Did We Do?" form, which is discussed in Section V.A.l, include:

- professional designation (29 professional designations are coded);
- work setting (15 settings plus "student in training" are coded);
- participant's ethnic group (5 ethnic groups are coded);
- zip code at participant's workplace;
- number of HIV+ persons cared for in previous six-month period; and
- largest ethnic group among participant's client population (5 ethnic groups are coded).

2. Training Database

A central training database, maintained at the EATN headquarters, is used to store and organize data on all training activities and participants ETC-wide. The database, utilizing d-Base IV, is extremely flexible, enabling the ETC to produce a variety of statistical and management reports.

3. Analysis of Outputs

EATN does extensive output analysis, including generation of training logs, training summaries, registration summaries, graphic profiles of participants, and geographic analysis.

Training Logs. A chronological listing of training events; by state, is generated. These logs include events sponsored by all subcontractors as well as Emory-based staff. In Year 01, the logs included event title, type of training (level), number of contact hours, intended audience, and number of participants. In Year 02, the log was expanded to include the city in which the event was held, the sponsoring subcontractor/Emory, whether CEUs were offered and number if available, number of participants completing registrations, number completing evaluations, and number of incomplete registrations. Annual activity of each state is summarized at the end of each report and includes total number of events; total number of official registrants; total incomplete registrations; total attendees (official plus incomplete); and total hours of training. A sample log is included in Appendix II for illustrative purposes.

The EATN reports that, in the first year of the project, it reached over 7,000 health professionals in 73 separate training offerings. In Year 02, an additional 12,114 health care workers attended 253 training events.

Training Summary. EATN produces an annual Training Summary which lists the number of trainees by state. This report is a complete count of participants obtained from the "Data for Training Log" form, and includes registrants who did not complete a formal EATN registration form.

The largest number of individuals attending EATN events was from Florida, with 3,111 and 4,336 participants in Years 01 and 02 respectively. The second highest participant count came from Georgia in Year 01 (2,533), but was slightly outpaced by South Carolina in Year 02 (2,617 versus 2,526). North Carolina registered the fewest participants each year (50 and 610).

A copy of the Year 01 and Year 02 Training Summary are included in Appendix II.

Registration Summary. The Registration Summary, which is produced annually, provides EATN-wide summary data on participants by state and by demographic variable. Both actual number of participants in each category and the percentage of the total are given. However, the data includes only participants who have completed formal EATN forms, in Year 01 representing approximately 44% of the participants present and in Year 02 representing approximately 62% of the participants present, the percentages are probably more meaningful.

The Year 02 Registration Summary indicates that approximately 21% of the registrants were physicians and an additional 21% were nurses--a shift from 34% nurses and 10% physicians from the previous year. Administrators represented a substantial proportion--15% in Year 01 and 11% in Year 02. Social workers and, more recently, dentists are among the professional categories most frequently attending training. More than half of the respondents were Caucasian; the largest minority category being Black Americans. However, a large proportion did not respond. Overall, providers were most frequently from hospitals and private practice settings; in Year 01, a substantial proportion worked in health departments; in Year 02, over 10% were students in training. Caucasians accounted for the largest ethnic group the patient population served; Black Americans comprised the largest minority group, with a large and growing proportion of non-response. Previous

experience with care to HIV+ individuals was relatively constant over the two year period; 30-40% of the participants had never cared for an HIV-infected person, with about 27% reporting having worked with l-10; however, a large proportion did not know or did not answer.

Annual registration summaries are also prepared for each of the subcontractors as well as the for participants attending Emory-sponsored events. Differences in the profiles are striking.

'A copy of the Year 02 EATN-wide Registration Summary as well as the individual site summaries are included as Appendix II.

Graphic Profiles. In addition to the tabular format in which the Registration Summary data is cast, the EATN-wide data for each variable are presented in graphic format as well. These graphs, in pie chart format, provide for a readily understood profile of the participant population. Samples of these graphs are included in Appendix II.

Geographic Analysis. Using the first three digits of the respondents' zip codes, EATN does a geographic analysis of participant origin. These data are presented in the form of thematic maps, as illustrated in Appendix II. While heavy concentrations of participants are seen in particular areas of each state, the maps show wide geographic distribution of trainees in each state.

The geographic analyses are a preliminary step to a study of market penetration in which participant data by profession would be used as the numerator and total number of active professionals by profession would be used as the denominator. To date, EATN has had difficulty obtaining accurate denominator data.

c. Cost Efficiency and Cost Effectiveness

As part of its initial grant proposal, the ETC did a cost analysis of projected costs. The description of the Emory ETC's approach to cost accounting along with the caveats contained in its proposal would suggest that this ETC has a firm grasp on cost accounting methodology and understands well the concept of cost-effectiveness analysis.

Three cost per training figures were projected:

- cost for actual training sessions only. The cost per trainee would be expected to increase with the intensity of the training effort.
- costs for actual training sessions plus allocated costs attributable to needs assessment and evaluation activities. These costs were allocated on a simple per-trainee basis rather than weighted allocation.

- costs for actual training sessions plus allocated needs assessment and evaluation costs plus allocated administrative costs. The administrative costs were allocated on a simple per-trainee basis rather than a weighted allocation.

In describing its methodology for determining cost effectiveness, appropriately no attempt was to be made to compare outcomes across levels of training.

As implementation of the program proceeded, EATN began to look at its costs. Early on, it was determined that direct costs, i.e. those costs that could be directly attributable to a training event (as described in the first cost analysis methodology above) were the most meaningful and valid numbers that could be calculated. Thus, the latter two approaches to cost analysis have not been pursued.

Cost analysis is being carried out more as a management function than an evaluative function. Typical "cost per trainee" figures have been determined for various types of training. On average, large conferences cost $35 per participant while customized trainings run in the neighborhood of $100 per participant. When a new training event is proposed and a budget prepared, the projected cost per trainee is compared with historical cost per trainee of like programs to determine the financial feasibility. Emory's methodology for determining cost per trainee is illustrated in Appendix III in its cost analysis for major conferences held in Year 02.

In consulting a health economist in the design of an approach to conduct a cost/benefit analysis, it was determined that no good measure of "benefits" could be found. Therefore, EATN will not pursue this aspect of their cost analysis.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

In its first two years of operation, the EATN has developed a number of products. Expert review is carried out on products with medical/clinical content. State-level boards in South Carolina and Alabama, and existing advisory groups in Georgia, Florida and North Carolina serve as the forum for these expert reviews. The focus group research and controlled testing of products that was initially planned has not been implemented.

A. Formative Evaluation of Mailed Resource Materials

"Key Contacts," a resource manual developed by EATN, contains a loose insert by which recipients can request updates, and provides for **users' comments on the manual.**

A Feedback Form is attached to some of the materials distributed, such as slide sets. There has been very little response, to date, to these efforts to obtain user feedback.

B. Formative Evaluation of Training Materials

In the first year of the project, materials evaluation was included in general training evaluation, with specific questions on applicability and relevance of the material. Currently, the formative evaluation of training events includes one question on the adequacy and helpfulness of the materials used in the offering.

C. Formative Evaluation of Curricula

Formative evaluation was to be an integral part of the curriculum development process undertaken by Morehouse School of Medicine. The Nursing, Social Work and Medical Curricula were to be pilot tested. The formative evaluation was to be undertaken using questionnaires to query faculty and students about appropriateness of teaching materials, ease of adaptation of the module format, adequacy of content, and applicability to practice.

In the development of the Nursing Curriculum, a number of instructors from the Morehouse nursing program contributed draft material which was subsequently integrated into a preliminary curriculum by the Morehouse staff with the assistance of the EATN. This preliminary curriculum was then returned to its authors and others for an "expert review." The curriculum is currently undergoing its pilot testing, in which these nursing instructors are using it in their classes. Feedback from these instructors and students is being gathered as described above and a report will be forthcoming.

V. APPROACHES TO EVALUATING INDIVIDUAL EDUCATION AND TRAINING INTERVENTIONS

A. Standardization of Evaluation ETC-Wide

EATN's evaluation strategy is two-pronged. For short programs, an "after only" form is used to determine how well the program and the trainers were received by participants and whether needs and objectives were met. For longer programs, several-day sessions, "before-after" measures are obtained, and follow-up studies are considered.

1. "How Did We Do?"

EATN developed a standardized form, entitled "How Did We Do?," for conducting formative evaluation of its education and training events. EATN refers to this as their "process evaluation." The original tool primarily collected formative evaluation data about the process, content and structure of the event, but also began to look at effectiveness through an "intention to behave" question.

The variables collected for formative evaluation include:

- usefulness and practicality of the content;
- adequacy of time to cover the material;
- helpfulness and adequacy of the teaching materials;

- adequacy of response to participants' questions; and
- degree to which teaching was tailored to the skill level of the participants.

Each instructor was to be listed with suggestions for how the individual could "do a better job next time." Suggestions on how the workshop in general could be improved were also solicited. To begin to assess the effectiveness of the workshop in stimulating changes in behavior, a question on behavioral intent was included: "What will you do differently at work as a result of this workshop?" The primary effect that the workshop had on participants was identified by asking participants to "write down one fact or idea from the workshop that you learned and that seems important to you." This original form was pilot-tested. The original form and the results of that pilot are included as Appendix IV. The forms have been distributed network-wide for use at all EATN training events.

At the request of the subcontractors, the "How Did We Do?" form was abbreviated, retaining only the six process, structure and content variables, along with questions relating to whether marketing materials gave them appropriate expectations for the workshop. The demographic data required for output analysis, as described in Section III.B., was added to the form. The current version of the "How Did We Do?," which collects both formative data and data for output analysis on a single sheet of paper, is included in Appendix V.

Also included on the current "How Did We Do?" form is a question on behavioral intent, discussed in Section V.B.2. below. These data are not routinely quantified; staff periodically examine the responses.

Data are analyzed at Emory to assure uniformity. All evaluation forms are reviewed by the Deputy Director for Training as well as by relevant training staff and appropriate action is taken if necessary.

2. Standardized Follov-up Methodology for Evaluating Impact

Follow-up studies are conducted on a number of EATN events that have enough substance to expect behavior change.

Toward the end of the workshop, the follow-up procedure is explained. Participants who agree to participate in the follow-up are asked to complete the "What Will You Do Differently as a Result of this Workshop?" form, which asks participants to write one or two sentences about what they "plan to do differently" in their work setting as a result of the training, being as specific as possible. The form also solicits contact information.

The timing of the follow-up depends on the nature of the event, typically 12-13 weeks for conferences. Follow-ups are done by telephone interviews. All attempted contacts are carefully logged. The interviewer repeats a standard introduction and then either conducts the interview or schedules the interview for a more convenient time.

The interview begins by reading the participant's response of intended action from the "What Will You Do Differently?" form. The respondent is asked

whether they remember having written that and, then, whether s/he has taken any action to implement the planned action. Responses as to actions taken or reasons for not taking action are recorded in depth, and respondents are asked to summarize the degree to which they consider their plans to have been implemented as well-as the prospects-for actually completing the plan. Information on several independent variables is solicited such as:

- status of the respondent (staff vs. volunteer);
- need for securing permission to put the plan into action;
- number of people who have been involved in implementing the plan;
- is the activity time limited or ongoing; and
- need for additional knowledge or skill required to implement the plan.

A copy of the tools used in the follow-up evaluation are included in Appendix VI.

Responses will be aggregated for all events rather than analyzing them by training, with an eye to analyzing the impact of training in general on specific professional groups. Qualitative analysis will aim first at examining which specific intentions fall out--implementation of some will depend only on the participant's follow-through while implementation of others will require institutional change.

B. Approaches to Formative Evaluation of Training Events

EATN considers needs/demands assessments an integral part of the formative evaluation of its training offerings. Needs/demands assessments have been undertaken in a variety of formal and informal ways; data from these assessments may serve as a baseline for determining whether participant objectives are met.

The "How Did We Do?" form is a major source of formative evaluation data. Because of the broad nature of the questions on this instrument, the data gathered are of rather limited value for making substantive changes. The Extended Evaluation form (see Section VI.C.2), used by USF in the formative evaluation of its clinical tutorial, provides much richer data for course improvement.

Formative evaluation of the Grady tutorial is carried out through exit interviews by the nurse coordinator and through a follow-up telephone call made approximately three to four months following the tutorial at the time when the next tutorial is being organized.

For Emory-based training events, formative evaluation data from the consultant trainer's perspective is also gathered. The Trainer's Evaluation form is used for this purpose. Using this form, the consultant trainer assesses:

- what parts of the training worked and didn't work, recommendations for improvement;
- the degree to which the training objectives were met; behavior changes that could be expected to result from the training;
- the appropriateness of the trainees to the session;
- the support provided by EATN, both in preparating and during the workshop; and
- adequacy of the facility.

The Trainer's Evaluation form is included as Appendix VII.

C. Approaches to Evaluating Training Outcomes

1. Bvaluation of Program **Effectiveness**

Within the Emory AIDS Training Network, a number of approaches have been used to evaluate the effectiveness of training in stimulating change. These include :

- pre/post-training testing;
- pre/post-training self-reporting;
- post-training self-reporting; and
- post-training action plan.

Pre/Post-Training Testing. Pre/post-training testing is being used by the University of South Florida to evaluate the effectiveness of its mental health clinical tutorial in increasing participants' knowledge about HIV. Participants are presented with 20 statements, primarily having to do with modes of transmission and antibody testing, which they are asked to rate as true or false.

Pre/Post-Training Self-Reporting. Effectiveness of training in increasing knowledge and skill levels is evaluated by asking participants to report their confidence in their level of knowledge and skill with regard to various tasks. This approach is primarily used in the evaluation of EATN's train-the-trainers programs; tasks that are queried include both clinical tasks about which participants will ultimately be teaching as well as teaching and training tasks.

The University of South Florida uses the pre/post-training self-reporting approach to gauge the effectiveness of its clinical tutorial in improving comfort levels with clients engaging in nine specific risk behaviors.

Post-Training Self-Reporting. Effectiveness of training in stimulating behavioral intentions is evaluated by asking the question "as a result of this training, what will you do differently?" EATN gathers this data routinely via the "What Will You Do Differently?" form, described in

Section V.A.2. above, and used routinely for EATN-sponsored events. For special training events, a variant may be used. For instance, for the train-the-trainers workshop, behavioral intent is obtained from a question on the post-training questionnaire which asks: "what three things are you likely to do differently when you return to your worksite?"

Post-Training Action Plan. The post-training action plan is the primary mechanism used to evaluate the effectiveness of the train-the-trainers program. It is used firstly as a "test" to determine whether the trainees can adequately plan a training program, and secondly as a measure of behavioral intention of the future trainings they intend to conduct. This latter also serves as a baseline for follow-up studies which seek to identify the actual level of training activity.

2. Evaluation of Program Impact

The telephone interview follow-up methodology described in Section V.A.2. is the primary mechanism for determining the impact EATN trainings have had on on-the-job behavior.

D. Unique and Interesting Techniques Used

1. The "Q-System"

The University of Alabama (UAB) site has developed a data gathering and entry procedure that allows for -an ongoing evaluative process. It is known as the "Q-system," a computer-assisted system for on-site learner testing and evaluation of lecture and materials. Using the system, lecturers create instant analysis of pre-test results and provide learner feedback.

"Q System" consists of a portable computer with 32 response pads, much like those used on TV game shows. A set of questions and multiple choice answers are programmed into the computer to correspond with the content flow of the presentation. During the course of the presentation, the presenter triggers the computer to flash the appropriate question and answer choices on a large monitor for the trainees to see. Those seated at the response pad stations key in their answer. The responses are immediately tabulated by the computer and presented on the monitor. This immediate feedback enables the presenter to ascertain whether his/her points are being grasped before moving on to a new area. In addition, the responses are automatically stored in the computer for subsequent use in evaluation studies. The subcontractor pilot tested the "Q System" at a resident research conference and found the technology to be very engaging, keeping the trainees alert and lightening up the session. The technology may be particularly motivating for the laggards in the group as it enables trainees to position their own comprehension and attitudes, anonymously, among their peers.

2. Methodology to Evaluate Impact of Perception of Personal Risk

Providers' fears are considered to be a significant barrier to care. With the assistance of an M.P.H. student, the EATN is piloting a methodology for assessing the degree to which training impacts on the fears of its

participants. Using a pre/post-training design, participants will be surveyed to identify the presence of such fears, the relationship of fear to the degree of contact, and differences in fears between professions. A questionnaire has been drafted and has undergone a pilot test at a day-long conference in the spring of 1990. The questionnaire and results of the pilot test will be available shortly.

VI. EVALUATION CONDUCTED

Every training event conducted by EATN agencies is subject to evaluation of some kind. At a minimum, output data and formative data on the process, structure and content of the event have been carried out. Most of the events conducted in the first year average 3.5 contact hours, and therefore were not subject to the evaluation of effectiveness. In Year 02, pre/post-training assessments were begun to evaluate the effectiveness of workshops greater than 6 contact hours in duration, particularly train-the-trainers activities. Follow-up studies have been initiated on selected events to evaluate impact.

A. Formative Evaluation of All Training Events

Formative evaluation is conducted for every event according to the methodology described in V.B above. Data on each event are aggregated at EATN headquarters and returned to the subcontractor. Evaluation Reports provide annual summaries of responses for the EATN as a whole, as well as training events conducted by Emory and each subcontractor. Evaluations uniformly demonstrate high scores for training events; the lowest rating by attendees is for adequacy of time to cover the training topic. The EATN Evaluation Report of Year 02 is included in Appendix VIII for illustrative purposes.

B. Evaluation of Train-the-Trainers Program

The methodology for evaluating EATN's training-of-trainers programs was adapted from that developed by the WAMI ETC. It includes a pre/post-training self-reporting, development of an action plan, and follow-up.

1. Nurse Train-the-Trainers Program

A one-week Nurse Train-the-Trainers event, targeted at nursing professionals who are in positions to effect changes in nursing curriculum, was held in September 1989. It was attended by 12 nursing school instructors from schools in Georgia, South Carolina and Alabama.

The evaluation design and tools were adapted from the WAMI ETC material, and include individual daily session evaluations; pre/post-training self-reported knowledge and skills; a post-training action plan; a six-month follow-up to determine impact; a trainer's evaluation of the course: and an analysis of costs.

Each day, an evaluation form was distributed to assess participant satisfaction. Results from the daily evaluations indicate that the

participants found the content "useful and practical" (4.54 out of 5.0). All trainers completed evaluations of the training experience from their perspective, and these were reviewed and kept in the event file at Emory.

A pre- and post-test on confidence levels of the participants' knowledge and skill related to AIDS-care and teaching/training tasks was administered. Of the eighteen scaled AIDS-care questions (1=quite confident to 7=not at all confident), all of the matched pre/post tests showed significant movement toward the "quite confident" end of the scale.

As part of the workshop, participants completed action plans outlining HIV/AIDS teaching and curriculum development activities they planned to pursue upon returning to their respective institutions. While these plans served as a test of effectiveness of the workshop in stimulating participants' intentions to act, they also served as a baseline for subsequent follow-up to determine whether plans had been put into action. This telephone follow-up evaluation was undertaken 4-5 months after the workshop. A member of the EATN headquarters staff called each of the participants to assess progress toward completing the tasks outlined in the individual workplans. Rather than relying on a formal interview schedule, the individual doing the follow-up informally reviewed the plan with the participant, and then asked about what had actually been accomplished and what parts of the workshop had been most useful in facilitating implementation of the plan.

Direct cost, in terms of cost per trainee, was calculated. The program was found to be very expensive. Full costs, which would have included allocated overhead, will not be calculated.

A copy of the demographic portion of the pre-training instrument, the post-training instrument and the Action Plan form are included as Appendix IX.

2. Evaluation of the PALSS Train-the-Trainers Program

The South Carolina site is working cooperatively with Palmetto AIDS Life Support Services (PALSS) in the design and implementation of a train-the-trainers program for health care team members throughout the state. The three-prong effort includes an annual conference on AIDS, eight train-the-trainers workshops for outreach workers, and a team leader training seminar.

Train-the-trainer events for the community-based outreach workers are evaluated through use of the standard EATN "How Did We Do?" form. The train-the-trainer program for PALSS team leaders includes a pre- and post-training test and follow-up, in a format similar to the nurse train-the-trainers program.

These workshops have recently been held and the results of the evaluations are forthcoming.

C. Evaluation of Clinical Training

1. Grady Hemorial Hospital Tutorial

The clinical tutorial at Grady Memorial Hospital in Atlanta is targeted at physicians and clinical nurses, primarily from the public health system. The tutorial, which is two days long, contains a didactic component and a precepted clinical observation. Each session accommodates four participants.

Formative evaluation of the Grady tutorial is accomplished in two ways. At the end of the two-day tutorial, the nurse coordinator holds an informal "exit interview" with participants to obtain feedback about the experience. Three to four months after the tutorial, generally just before the next round is to be conducted, the nurse coordinator makes a follow-up phone call to participants to determine, in retrospect, what they remember most about the experience and what aspects have proven most useful. This follow-up process has been formalized somewhat,in Year 03 with the institution of a written interview schedule, a copy of which is included in Appendix X.

2. USP HIV Clinical Tutorial

The University of South Florida offers a "clinical tutorial" to provide mental health professionals with the skills necessary to become HIV/AIDS treatment resources within their own agencies or institutions. The tutorial is three days in length and includes observation and/or participation in HIV-related mental health assessment and intervention. The tutorial can accommodate four to six participants at a time.

The evaluation strategy is two-pronged: formative evaluation of the tutorial design; and, the effectiveness of the tutorial in changing knowledge, opinions, and discomfort.

Formative evaluation utilizes two data collection instruments: the EATN "How Did We Do?" form and USF's Extended Evaluation form. The latter is used to evaluate each session and each presenter of the workshop, as well as to evaluate specific elements of program design. Each session is listed and participants are instructed to "comment on the content and format of each session, and on the presentation style, organization and clarity of each presenter" and to make suggestions for ways to improve each session." Constructive feedback for presenters is also solicited. The tutorial's structure and process is assessed by open-ended solicitation of comments on the pacing of workshop sessions, lunches and breaks, facilities, and the three-day format. Participants are asked to assess the brochure and the reference materials. Verbal feedback supplements this written format during a program evaluation session at the end of the three days.

To assess the effectiveness of the tutorial in measuring changes in knowledge and attitudes, an objective scale is administered to participants prior to the workshop and again at the very end of the three-day program. This instrument is a modified version of one that was administered to community mental health staff throughout Florida. The instrument includes 20 true/false knowledge items; 13 opinion statements to which respondents are asked to agree or disagree; 6 items measuring perception of risk of on-the-job infection with respect to specific kinds of client contact; and 9 items

measuring discomfort with clients with various characteristics. Demographic data about the participant are also collected. Supplemental information on the effectiveness of the tutorial with regard to knowledge can be obtained from the item on the original "How Did We Do?" form which instructs participants to write down one fact or idea from the workshop that seems important.

Effectiveness of the tutorial in stimulating participant's intention to act can be measured using information gathered from the "What Will You Do Differently?" question on the "How Did We Do?" form.

A great deal of useful formative data about the structure, process and content of the tutorial was obtained from.the extended evaluation; that data gathered using the "How Did We Do?" form was comparatively insignificant. The results of the tutorial held in Tampa in February-March 1990, indicated that the observation sessions, particularly at the immunodeficiency clinic and at the support group session at Tampa AIDS Network, were perceived by all four participants as the most valuable components. Participants felt that more time was needed to cover most subjects and the suggestion was made that the opportunity to interact with PWAs via the panel discussion be provided at the end. The nature of the feedback on the sessions also strongly suggest that participants experience significant benefits from the workshop. While data from the objective scale are currently under analysis, preliminary results suggest positive effects from participation.

The instruments used in the evaluation of USF's clinical tutorials, as well as the aggregated data from a selected offering is included in Appendix XI.

Long-term evaluation is planned for all participants in the Tutorial. An advanced workshop will be conducted during the second year of operation of the program. This advanced workshop will be offered only to graduates of the original workshops, and the attendees will participate in intensive program evaluation and data collection regarding attitudinal and behavioral changes made subsequent to their original-participation.

D. Evaluation of Program Impact

Follow-up studies were conducted on selected conferences that approached AIDS from a fresh perspective using the standardized EATN methodology. Conferences selected for follow-up include:

- Full-day conference sponsored by the Emory-based training staff in Tampa for mental health and social work case managers;
- A one-day conference on "Women and AIDS," held in Jekyll Island, GA;
- A two-day conference on sexuality issues around AIDS, co-sponsored with SIECUS.

Follow-ups were scheduled 12-13 weeks after the event. All participants who agreed to be contacted were followed up by telephone by an EATN volunteer or student interviewer calling from the headquarters under the direction of the EATN evaluation consultant. As of April 1990, telephone surveys of training participants were completed for over 60 individuals; the last group were ready for follow-up in May. A total of 80-100 responses are expected for the analysis.

B. Evaluation of State-Mandated Training in Florida

In the spring of 1988, the Florida legislature mandated three hours of HIV/AIDS training for all licensed individuals. The Center for AIDS Education for Health Care Providers (CAEHCP) at USF has fulfilled this role for health care providers by providing a course entitled "HIV Update for Health Care Providers." The update program is for physicians, dentists, dental hygienists, psychologists, school psychologists, mental health counselors, marriage counselors, family therapists, social workers, nurses and nursing home administrators. The program has been approved to meet the requirements set forth by the applicable licensing board. The HIV Update Program consists of the following components:

- Epidemiology
- Clinical Manifestations and Treatment of AIDS
- HIV in the Workplace
- Legal Issues
- Cultural Considerations in Prevention, Treatment and Counseling
- Neuropsychological and Mental Health Issues

The program, which is undertaken by CAEHCP staff, is evaluated using the regional "How Did We Do" form. Data for each offering is aggregated at EATN headquarters and returned to the CAEHCP.

The results of the Update given in January 1989 in Clearwater, Florida is illustrative. Nearly 125 participants completed the evaluation. Respondents strongly agreed that the content was useful and practical, and that instructors were knowledgeable and skilled. They rated the time coverage, teaching aids, and responsiveness of instructors quite highly as well. Ratings of two of the instructors were highly variable, from excellent to boring; two other speakers were generally rated highly by all. The volume of statistics and highly technical language was criticized as was the poor quality of the slides used. Legal issues, particularly about confidentiality, and HIV testing were the modal factual areas cited by respondents as key information gained in the offering. A number of the participants made suggestions for improving the workshop structure--increasing the length and adding a break were often cited. In responding to the question about what they will do differently as a result of the workshop, the more frequent participant responses included:

- be more protective of patients' rights to confidentiality;

- implement universal precautions, particularly the use of gloves;
- reduce or limit HIV testing; and
- nothing different.

The aggregated data from this event is included in Appendix XII.

VII. SUMMARY AND CHALLENGES FOR THE FUTURE

The Emory AIDS Training Network initially proposed an ambitious and comprehensive evaluation plan. As the program has unfolded, many aspects of the plan have been implemented; some have been found to be unworkable or inappropriate; yet others have not yet received sufficient attention.

One of EATN's strongest areas of evaluation is its collection and analysis of output data. Its training/participant database provides ready access to output data for management as well as statistical purposes. Report formats, such as graphic analysis and thematic mapping, make data more readily understandable. The database might be made yet more useful by the addition of fields which encode such things as event format and teaching methods used.

EATN has focused heavily on the formative evaluation of the structure, process and content of its training events. Its standardized approach based on its "How Did We Do?" form is applied regionwide, an instrument which has been utilized by other ETCs as well. This form is attractive in its simplicity; however, the data that it collects may not be sufficient to suggest appropriate adjustments to some of its program efforts. The "How Did We Do?" form may be considered, more appropriately, a tool for evaluating "one-shot" events, and for maintenance-level formative evaluation and monitoring of subcontractors. The University of South Florida contractor has gone to a more extensive formative evaluation tool for its ongoing Mental Health HIV Clinical Tutorial.

While EATN generates a number of interesting and potentially useful output reports and reports of the formative evaluation of individual and aggregate events, these reports are simply presentations of aggregate data with little interpretation of what the data mean or of implications the data have for programming. Expansion of reports to include data interpretation would be particularly useful in cases where EATN is processing data for its subcontractors.

The EATN has made a good start at evaluating some of its program outcomes. It has designed a standardized follow-up methodology for evaluating the impact of its programs and its efforts to date to implement this methodology have shown that it is quite workable. While follow-up is also conducted in conjunction with the Grady clinical tutorial, the questions asked make it more of a formative process evaluation than an evaluation of impact. This is truly a missed opportunity in light of the potentially high impact of this intervention as well as its high cost.

Evaluation of effectiveness of **EATN's** offerings aimed at enhancing knowledge and attitudes, and in stimulating "intention to behave" have been somewhat spotty. Several of the more resource-intensive offerings have been subjected to such evaluation, notably the Nurse Train-the-Trainers program. There has been less attention paid to evaluating either the effectiveness or the impact of **EATN's** "customized" trainings provided in response to specific agency requests, many of which would be expected to yield significant payoff. There is the paradox, of course, that while the need for evaluation of such programs is pressing, the cost of evaluation is high. EATN would be challenged to become more involved in outcome-oriented evaluation of these offerings in the future.

EATN has a strong commitment to solid evaluation. The EATN has itself raised many of the issues noted above, but feels constrained by what is perceived as a lack of resources to produce well-designed studies.

APPENDIX1

Output Evaluation -- "Data for Training Log" Form

DATA **FOR** TRAINING **LOG**

Complete after the training event:

1. Event Title: Exact name. Should be consistent with any printed **flyer** or agenda. If event is a workshop in a larger event, list workshop first.

_____

2. **City and State** _____

3. **Beginning Date** _____

4. **Intended Audience:** List job categories of all attendees, e.g. physicians, nurses, **EMTs**

_____

_____

5. **Sponsor:** Use EU, USF, MSM, SC, NC for network members. Spell out any others. **Circle the** key sponsor if there are more than one.

_____

_____

6. **Hours Duration:** Use exact number for in-session time. No units smaller than half hours, e.g. "2.5 hours."

_____

7. CEU: Answer either "No" or exact number of hours awarded. Do not use just "yes."

_____

a. **Were EATN data forms completed?** (If yes, please attach)

9. What was the **total attendance,** regardless of forms? _____

10. Are **other** registration lists or other evaluation data available? ____ **no** ___ **yes**

_____

Explain

11. **Trainer** _____

12. **Event Code:** Will be assigned by Carol. - - - -

1/90

APPENDIX II

Output Evaluation -- EATN Output Reports

1. Training Logs
2. Training Summaries
3. Registration Summaries
4. Graphic Profiles
5. Geographic Analysis

ALABAMA
YEAR TWO TRAINING CALENDA
EMORY AIDS TRAINING NETWOI
April I, 1989 to Present

03/27/90

EVENT TITLE	CITY	DATE	INTENDED AUDIENCE	SPONSOR	HOURS DURATION	CEUs	NUMBER OF REGISTRATIONS COMPLETED	NUMBER OF EVALUATIONS COMPLETED	INCOMPLETE REGISTRATIONS	EVENTCODE
Providing Supportive Services	Mobile	04/06/89	Family physicians	EU	12	12	12	12		1084
Tallapooma DHR AIDS Update	Dadeville	04/10/89	Rental health providers	EU	b	No	34	34		1086
Perinrtal Perspective	Huntsville	05/11/89	Nurser	EU	1	No			100	
Understanding/Caring for PYA	Opelika	05/27/89	Social workers, came ● anagers, nurses	EU	3	No	33	27		1125
Women and AIDS	Tuscaloosa	05/31/89	Preservice NPs	EU	1	No			58	
AIDS Update on Counseling YAAO	Tuscaloosa	06/06/89	Mental health providers	EU	2	No	21	19		1134
AIDS -An Update	Huntsville	06/09/89	Physicians serving Community Health Centers	MSM	7	Yom	13	8		1182
AIDS Update	Eutaw	06/16/89	Physicians serving Community Health Centers	MSM	7	Yam	5	4		1183
AIDS in Obstetrics/Brookwood	Birmingham	06/20/89	MDs, RNs	UAB	1	1	23			1174
AIDS Update	Cullman	06120109	MDs, RNs, Pharmacy	UAB	2	1	24			1163
AIDS ● -d Minorities	Montgomery	06/28/89	State health council ● emberm	EU	2	No			SO	
HIV-Update	Roanoke	09/06/89	MDs, Dentists, Dental ● msistantm	UAB	2	No	28			1181
Psychosocial Issues/AIDS	Montgomery	09/07/89	Social workers, nurses, health educator8	MSM	1	No			20	
AIDS 101 Update	Greenville	09/12/89	Social workers, nurses, health ● ducatorm, mental health (State of Alabama)	EU	1	No			150	
AIDS & Tuberculosis	Birmingham	09/12/89	JCPHD MDs	UAB	1	Ves			b	
AIDS Treatment	Birmingham	09/22/89	JCPHD MDs, RNs	UAB	2	Yes			15	
ENT Manifestations of HIV	Birmingham	10/02/89	MDs	UAB	1	Yes			22	
Third Alabama AIDS Symposium	Montgomery	10/04/89	HIV counselors, partner notifiers, health educators, outreach workers	EU/UAB	18	18			bb4	
Opportunistic Infections	Montgomery	10/05/89	RNs, MDs, PHRs, MSWs	UAB	1	Yes			100	
AIDS: Trtmt of Clinical Infect	Huntsville	11/07/89	MD's	UAB	2	Yes	12		3	1223

ALABAMA
YEAR TWO TRAINING CALENDAR
EMORY AIDS TRAINING NETWORK
April 1, 1989 to Present

03/27/90

EVENT TITLE	CITY	DATE	INTENDED AUDIENCE	SPONSOR	HOURS DURATION	CEUs	NUMBER OF REGISTRATIONS COMPLETED	NUMBER OF EVALUATIONS COMPLETED	INCOMPLETE REGISTRATIONS	EVENTCODE
AIDS Related Opportunistic Inf	Tuscaloosa	11/14/89	MDs	UAB	2	No	15			1242
AIDS Update	Eutaw	11/21/89	Nurses, N. Alabama Health Servicer	EU/UAB	2	No	31	19		1188
AIDS: Treatment of O.I.'s	Birmingham	12/11/89	MD's	UAB	1	No			1	
AIDS: Review of New Treatments	Birmingham	12/18/89	MPH's, MD's, MSW's, and STD personnel	UAB	1	No			50	
AIDS In Children/AL Headstart	Mobile	01110190	Headstart herlth consultants, nurses, ● delnistretors, health ● ducrtors	EU	6	No	lb	I6	20	1261
AL Family Practice Assoc	Birmingham	01114190	Family Practioners--MD's	UAB	1	NO	25			1267
Multi-issue AIDS Training	Decatur	02103190	MD's, RN's	UAB	5	No	50		1	1269
AIDS - New Therapies	Birmingham	02/05/90	RN's, MSW's, PHR's, Public health staff	UAB	1	No			75	
HIV Update, Therapies	Birmingham	02/11/90	Pharmacists	UAB	1	No	64		11	1285
Nhrt's New with HIV end AIDS	Tuscumbia	02123190	Nurses, social workers	EU	5	4.25	53			1291
TB end AIDS	Birmingham	03/01/90	MD's, RN's, PHR's, RT's	UAB	2	No	89	90	11	1286
Mobile AIDS Updrte	Mobile	03/01/90	nom	UAB	4	No			120	
AIDS Update/Hlthcare Providers	Monroeville	03/22/90	Internists, family prrctitioners, Infectious diseases specielists	EU	5	3.65				
Lethal Connection:HIV & Abuse	Decatur	03/23/90	Internists, family prrctitioners, infectious diseases	EU	5					

Tote1 official registrations: 548 Total incomplete registrations: 1,477 Grand total: 2,025

Total number of events: 34 Total hours of training: 109.5 *Units denote awardto highest ranking profession

Emory AIDS Training Network

Year One Total Participants by State
April 1, 1988 - March 31, 1989

Alabama	664
Florida	3,111
Georgia	2,533
North Carolina	50
South Carolina	758

Includes registrants who did not complete formal Emory registration form.

EATN Training Summary
April 1, 1989 - March 21, 1990

State	Number of Trainees
Alabama	2,025
Florida	4,336
Georgia	2,526
North Carolina	610
South Carolina	2,617
TOTAL	12,114

REGISTRATION SUMMARY
Emory AIDS Training Network
April 1, 1989 to Present
03/28/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data. These trainees are approximately 62% of the total of 12,114 trainees,

By State

	Total To Date	Percentage of Total
Alabama	542	7.25%
Florida	2,998	40.00%
Georgia	1,496	20.00%
North Carolina	374	5.00%
South Carolina	1,998	26.71%
Other States	72	0.96%
Total:	7,480	

by Professional Category

	Total To Date	Percentage of Total
M.D.	1,578	21.10%
Qsteopath	19	0.25%
Physician's Assistant	64	0.66%
Nurse Practitioner	I34	1.79%
Nurse	1,592	21.26%
Lab Personnel, Radiology	70	1.04%
Emergency Medical Tech.	44	0.59%
Dentist	630	8.42%
Dental Assistant	154	2.06%
Social Worker	515	6.09%
Health Educator	221	2.95%
Psychologist	125	1.67%
Mental Health Worker	177	2.37%
Chaplain	30	0.40%
Nutritionist	65	0.67%
Pharmacist	92	1.23%
STD Worker	28	0.37%
Occupational Therapist	32	0.43%
Clinical Support Staff	134	1.79%
Clerical Support Staff	148	1.90%
Outreach Worker	64	0.86%
Other Professions	214	2.86%
Administrator	846	11.31%
Anesthestist, Respiratory Tech	52	0.70%
Volunteer	2s	0.33%
Health Insurance Provider	0	0.00%
Optoaetrist	98	1.31%
tledical Records Specialist	3	0.04%
Professional Code in Error	1	0.01%
No Answer Given	317	4.24%
Total :	7,480	

REGISTRATION SUMMARY
Emory AIDS Training Network
April 1, 1989 to Present
03/28/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data. These trainees are approximately 62% of the total of 12,114 trainees.

By Work Setting

	Total To Date	Percentage of Total
Health Department	678	9.06%
Community Health Center	203	3.78%
Office, Private Practice	1,157	15.47%
Hospital	1,081	14.45%
Home Health Agency	151	2.02%
Community-based Organization	317	4.24%
Prepaid Plan, HMO	20	0.27%
Nursing Home/Personal Care	81	1.08%
Student in Training	837	11.19%
Mental Health Center	344	4.60%
Hospice	20	0.27%
Migrant Health Center	10	0.13%
Governmental Admin Office	183	2.45%
Other	1,051	14.05%
Medical Center, University	138	1.84%
No Answer	1,095	14.64%
Erroneous Answer	34	0.45%
Total:	7,480	

By Number of HIV-infected Persons Served in Last 6 Months

	Total To Date	Percentage of Total
None	2,213	29.59%
1-10 Persons	1,963	24.24%
More than 10 Persons	577	7.71%
Do Not Know	810	10.83%
Other	0	0.00%
No Answer	1,914	25.59%
Erroneous Answer	3	0.04%
Total:	7,480	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	10	0.13%
Black American	1,480	19.79%
Hispanic/Latino	210	2.81%
Native American	113	1.51%
White/Caucasian	2,947	39.40%
Other	242	3.24%
No Answer	2,476	33.10%
Erroneous Answer	2	0.03%
Total :	7,480	

REGISTRATION SUMMARY
Emory AIDS Training Network
April 1, 1989 to Present
03/28/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data. These trainees are approximately 62% of the 'total of 12,114 trainees.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	106	1.42%
Black American	760	10.16%
Hispanic/Latino	184	2.461
Native American	83	1.11%
White/Caucasian	3,958	52.911
Other	91	1.22%
No Answer	2,298	30.72%
Erroneous Answer	0	0.00%
Total:	7,480	

REGISTRATION SUMMARY

Emory-Sponsored Events
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who **completed** registration forms to provide demographic data.

By State

	Total To Date	Percentage of Total
Al abara	183	7.96%
Florida	316	13.75%
Georgia	1,370	59.62%
North Carolina	77	3.35%
South Carolina	327	14.231
Other States	25	1.09%
Total :	2,298	

By Professional Category

	Total To Date	Percentage of Total
M.D.	324	14.10%
Osteopath	3	0.13%
Physician's Assistant	48	2.09%
Nurse Practitioner	85	3.70%
Nurse	537	23.37%
Lab Personnel, Radiology	17	0.74%
Emergency **Medical** Tech.	39	1.70%
Dentist	29	1.26%
Dental Assistant	40	1.74%
Social Worker	168	7.31%
Health Educator	159	6.92%
Psychologist	17	0.74%
Mental Health Worker	13	0.57%
Chaplain	8	0.35%
Nutritionist	58	2.52%
Pharmacist	4	0.17%
STD Worker	21	0.91%
Occupational Therapist	27	1.17%
Clinical Support Staff	26	1.13%
Clerical Support Staff	39	3.70%
Outreach Worker	29	1.26%
Other Professions	79	3.44%
Adeinistrator	369	16.06%
Anesthestist, Respiratory Tech	0	0.00%
Volunteer	24	1.04%
Health Insurance Provider	0	0.00%
Optometrist	98	-- 4.26%
tledical Records Specialist	0	0.00%
Professional Code in Error	1	0.04%
No Answer Given	*36*	1.57%
Total:	2,298	

REGISTRATION SUMMARY

Eaory-Sponsored Events
Eaory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Work Setting

	Total To Date	Percentage of Total
Health Department	420	18.28%
Community Health Center	130	5.66%
Office, Private Practice	144	6.27%
Hospital	292	12.71%
Home Health Agency	91	3.96%
Comeunity-Based Organization	178	7.75%
Prepaid Plan, HHO	5	0.22%
Nursing Home/Personal Care	11	0.48%
Student in Training	254	11.05%
Mental Health Center	40	1.74%
Hospice	4	0.17%
Migrant Health Center	1	0.04%
Governmental Admin Office	87	3.79%
Other	322	14.01%
Medical Center, University	94	4.09%
No Answer	198	8.62%
Erroneous Answer	27	1.17%
Total:	2,298	

By Number of HIV-infected Persons Served in Last 6 Honths

	Total To Date	Percentage of Total
None	690	30.03%
1-10 Persons	691	30.07%
Hore than 10 Persons	278	12.10%
Do Not Know	305	13.27%
Other	0	0.00%
No Answer	334	14.53%
Erroneous Answer	0	0.00%
Total:	2,298	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	4	0.17%
Black American	638	27.76%
Hispanic/Latino	118	5.13%
Native American	33	1.44%
White/Caucasian	902	39.25%
Other	76	3.31%
No Answer	526	22.89%
Erroneous Answer	1	0.04%
Total:	2,298	

REGISTRATION SUMMARY

Emory-Sponsored Events
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	20	0.87%
Black American	314	13.66%
Hispanic/Latino	66	2.87%
Native American	32	1.39%
White/Caucasian	1,318	57.35%
Other	40	1.74%
No Answer	505	21.98%
Erroneous Answer	3	0.13%
Total:	2,298	

REGISTRATION SUMMARY

Morehouse AHEC/AIDS Education and Training **Center**
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data,

By State

	Total To Date	Percentage of Total
Alabama	18	12.16%
Florida	0	0.00%
Georgia	100	67.57%
North Carolina	0	0.00%
South Carolina	0	0.00%
Other States	30	20.27%
Total :	148	

By Professional Category

	Total To Date	Percentage of Total
M.D.	32	21.62%
Osteopath	1	0.68%
Physician's Assistant	3	2.03%
Nurse Practitioner	10	6.76X
Nurse	29	19.59%
Lab Personnel, Radiology	2	1.35%
Emergency Medical Tech.	2	1.35%
Dentist	5	3.38%
Dental Assistant	3	2.03%
Social Worker	6	4.05%
Health Educator	10	6.76%
Psychologist	1	0.68%
Mental Health Worker	4	2.70%
Chaplain	1	0.68%
Nutritionist	3	2.03%
Pharmacist	0	0.00%
STD Worker	1	0.68%
Occupational Therapist	0	0.00%
Clinical Support Staff	1	0.68%
Clerical Support Staff	6	4.05%
Outreach Worker	2	1.35%
Other Professions	10	6.76%
Administrator	13	8.78%
Anesthestist, Respiratory Tech	0	0.00%
Volunteer	0	0.00%
Health Insurance Provider	0	0.00%
Optometrist	0	0.00%
Medical Records Specialist	3	2.03%
Professional Code in Error	0	0.00%
No Answer Given	0	0.00%
Total :	148	

REGISTRATION SUMMARY

Motehouse AHEC/AIDS Education and Training Center
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Work Setting

	Total To Date	Percentage of Total
Health Department	10	6.76%
Cornunity Health Center	60	40.54%
Office, Private Practice	3	2.03%
Hospital	10	6.76%
Home Health Agency	0	0.00%
Community-based Organization	6	4.05%
Prepaid Plan, HMO	0	0.00%
Nursing Hose/Personal Care	0	0.00%
Student in Training	3	2.03%
Mental Health Center	3	2.03%
Hospice	0	0.00%
tligrant Health Center	0	0.00%
Governmental Adrin Office	5	3,38%
Other	34	22.972
Medical Center, University	13	8.78%
No Answer	1	0.68%
Erroneous Answer	0	0.00%
Total:	148	

By Number of HIV-infected Persons Served in Last *b* Months

	Total To Date	Percentage of Total
None	*36*	24.32%
l-10 Persons	32	21.62%
More than 10 Persons	*26*	17.37%
Do Not Know	10	6.76%
Other	0	0.00%
No Answer	43	29.05%
Erroneous Answer	1	0.68%
Total:	148	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	0	0.00%
Black American	58	39.19%
Hispanic/Latino	0	0.00%
Native American	2	1.35%
White/Caucasian	32	21.62%
Other	3	2.03%
No Answer	53	35.81%
Erroneous Answer	0	0.00%
Total:	148	

REGISTRATION SUMMARY

Morehouse AHEC/AIDS Education and Training Center
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	0	0.00%
Black American	45	30.41%
Hispanic/Latino	2	1.35%
Native American	1	0.68%
White/Caucasian	51	34.46%
Other	3	2.03%
No Answer	46	51.08%
Erroneous Answer	0	0.00%
Total:	148	

North Carolina AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data,

By State

	Total To Date	Percentage of Total
Al abaea	0	0.00%
Florida	0	0.00%
Georgia	0	il. 00%
North Carolina	83	100.00%
South Carolina	0	0.00%
Other States	0	0.00%
Total:	83	

By Professional Category

	Total To Date	Percentage of Total
M.D.	1	1.20%
Osteopath	0	0.00%
Physician's Assistant	1	1.20%
Nurse Practitioner	0	0.00%
Nurse	19	22.89%
Lab Personnel , Radiology	2	2.41%
Emergency Medical Tech.	0	0.00%
Dentist	0	0.00%
Dental Assistant	0	0.00%
Social Worker	1	1.20%
Health Educator	0	0.00%
Psychologist	0	0.00%
Mental Health Worker	0	0.00%
Chap1 ain	0	0.00%
Nutritionist	0	0.00%
Pharmacist	1	1.20%
STD Worker	0	0.00%
Occupational Therapist	0	0.00%
Clinical Support Staff	0	0.00%
Clerical Support Staff	1	1.20%
Outreach Worker	0	0.00%
Other Professions	0	0.00%
Administrator	6	7.23%
Anesthesti st, Respiratory Tech	0	0.00%
Volunteer	0	0.00%
Health Insurance Provider	0	0.00%
Optoaetrist	0	0.00%
Medical Records Specialist	0	0.00%
Prof essianal Code in Error	0	0.00%
No Answer Given	51	61.45%
Total:	83	

REGISTRATION **SUMMARY**

North Carolina AIDS Training Network
Emory AIDS Training Netnotk
April 1, 1969 to Present
03/21/90

Includes trainees with at least one contact hour with trainer nho completed registration forms to provide **demographic** data,

By Work Setting

	Total To Date	Percentage of Total
Health Departaent	22	26.51%
Community Health Center	0	0.00%
Office, Private Practice	2	2.41%
Hospital	18	21.69%
Home Health Agency	19	22.89%
Community-Eased **Organization**	0	0.60%
Prepaid Plan, HMO	0	0.00%
Nursing Howe/Personal Care	2	2.412
Student in Training	0	0.00%
Rental Health Center	1	1.20%
Hospice	0	0.00%
Migrant Health Center	0	0.00%
Governmental **Admin** Office	12	14.46X
Other	4	4.82%
Medical Center, University	2	'2.411:
No **Answer**	1	1.20%
Erroneous Ansner	0	0.00%
Total:	83	

By Number of HIV-infected Persons Served in Last **6 Months**

	Total To Date	Percentage of Total
None	24	28.92%
1-10 Persons	6	7.23%
tlore than 10 Persons	0	0.00%
Do Not Knon	3	3.61%
Other	0	0.00%
No **Answer**	50	60.24%
Erroneous **Answer**	0	0.00%
Total:	83	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percent age of Total
Asian/Pacific Islander	6	0.00%
Black American	1	1.20%
Hispanic/Latino	6	0.00%
Native American	0	0.06%
White/Caucasian	31	37.35%
Other	0	6.00%
No Answer	51	61.45%
Erroneous **Answer**	0	0.00%
Total: 81	83	

REGISTRATION SUMMARY

North Carolina AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	0	0.00%
Black American	0	0.00%
Hispanic/Latino	0	0.00%
Native American	1	1.20%
White/Caucasian	31	37.35%
Other	0	0.00%
No Answer	51	61.45%
Erroneous Answer	0	0.00%
Total:	83	

REGISTRATION SUMMARY

Alabama AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By State

	Total To Date	Percentage of Total
Alabama	320	91.17%
Florida	1	0.28%
Georgia	25	7.12%
North Carolina	0	0.00%
South Carolina	0	0.00%
Other States	5	1.42%
Total:	351	

By Professional Category

	Total To Date	Percentage of Total
M.D.	135	38.46%
Osteopath	2	0.57%
Physician's Assistant	4	1.14%
Nurse Practitioner	3	0.85%
Nurse	90	25.64%
Lab Personnel, Radiology	1	0.28%
Emergency Medical Tech.	0	0.00%
Dentist	5	1.42%
Dental Assistant	8	2.28%
Social Worker	2	0.57%
Health Educator	4	1.14%
Psychologist	0	0.00%
Mental Health Worker	1	0.28%
Chaplain	0	0.00%
Nutritionist	0	0.00%
Pharmacist	60	17.09%
STD Worker	0	0.00%
Occupational Therapist	0	0.00%
Clinical Support Staff	0	0.00%
Clerical Support Staff	2	0.57%
Outreach Worker	0	0.00%
Other Professions	2	0.57%
Administrator	17	4.84%
Anesthestist, Respiratory Tech	14	3.99%
Volunteer	0	0.00%
Health Insurance Provider	0	0.00%
Optometrist	0	0.00%
Medical Records Specialist	0	0.00%
Professional Code in Error	0	0.00%
No Answer Given	1	0.28%
Total:	351	

REGISTRATION SUMMARY

Alabama AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Work Setting

	Total To Date	Percentage of Total
Health Department	5	1.42%
Community Health Center	6	1.71%
Office, Private Practice	123	35.04%
Hospital	130	37.04%
Home Health Agency	3	0.85%
Community-Based Organization	12	3.42%
Prepaid Plan, HMO	0	0.00%
Nursing Home/Personal Care	0	0.00%
Student in Training	6	1.71%
Mental Health Center	2	0.57%
Hospice	0	0.00%
Migrant Health Center	0	0.00%
Governmental Admin Office	1	0.28%
Other	40	11.40%
Medical Center, University	14	3.99%
No Answer	9	2.56%
Erroneous Answer	0	0.00%
Total:	351	

By Number of HIV-infected Persons Served in Last 6 Months

	Total To Date	Percentage of Total
None	145	41.31%
1-10 Persons	149	42.45%
More than 10 Persons	5	1.42%
Do Not Know	40	11.40%
Other	0	0.00%
No Answer	12	3.42%
Erroneous Answer	0	0.00%
Total:	351	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	1	0.28%
Black American	52	14.81%
Hispanic/Latino	0	0.00%
Native American	13	3.70%
White/Caucasian	238	67.81%
Other	12	3.42%
No Answer	34	9.69%
Erroneous Answer	1	0.28%
Total: 84	351	

REGISTRATION SUMMARY

Alabama AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	9	2.56%
Black American	19	5.41%
Hispanic/Latino	2	0.57%
Native American	7	1.99%
White/Caucasian	268	76.35%
Other	2	0.57%
No Answer	43	12.25%
Erroneous Answer	1	0.28%
Total:	351	

REGISTRATION SUMMARY

South Carolina AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By State

	Total To Date	Percentage of Total
Alabama	0	0.00%
Florida	0	0.00%
Georgia	0	0.00%
North Carolina	21	1.24%
South Carolina	1,671	98.76%
Other States	0	0.00%
Total:	1,692	

By Professional Category

	Total To Date	Percentage of Total
M.D.	41	2.42%
Osteopath	0	0.00%
Physician's Assistant	0	0.00%
Nurse Practitioner	16	0.95%
Nurse	623	36.82%
Lab Personnel, Radiology	50	2.96%
Emergency Medical Tech.	2	0.12%
Dentist	27	1.60%
Dental Assistant	85	5.02%
Social Worker	188	11.11%
Health Educator	27	1.60%
Psychologist	14	0.83%
Mental Health Worker	46	2.72%
Chaplain	19	1.12%
Nutritionist	3	0.18%
Pharmacist	22	1.30%
STD Worker	6	0.35%
Occupational Therapist	1	0.06%
Clinical Support Staff	96	5.67%
Clerical Support Staff	77	4.55%
Outreach Worker	22	1.30%
Other Professions	36	2.13%
Administrator	229	13.53%
Anesthestist, Respiratory Tech	37	2.19%
Volunteer	0	0.00%
Health Insurance Provider	0	0.00%
Optometrist	0	0.00%
Medical Records Specialist	0	0.00%
Professional Code in Error	0	0.00%
No Answer Given	25	1.48%
Total:	1,692	

REGISTRATION SUMMARY

South Carolina AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Work Setting

	Total To Date	Percentage of Total
Health Department	48	2.84%
Community Health Center	34	2.01%
Office, Private Practice	74	4.37%
Hospital	332	19.62%
Home Health Agency	26	1.54%
Community-Based Organization	53	3.13%
Prepaid Plan, HMO	0	0.00%
Nursing Home/Personal Care	26	1.54%
Student in Training	555	32.80%
Mental Health Center	148	8.75%
Hospice	2	0.12%
Migrant Health Center	5	0.30%
Governmental Admin Office	27	1.60%
Other	331	19.56%
Medical Center, University	1	0.06%
No Answer	29	1.71%
Erroneous Answer	1	0.06%
Total:	1,692	

By Number of HIV-infected Persons Served in Last 6 Months

	Total To Date	Percentage of Total
None	657	38.83%
1-10 Persons	575	33.98%
More than 10 Persons	104	6.15%
Do Not Know	269	15.90%
Other	0	0.00%
No Answer	86	5.08%
Erroneous Answer	1	0.06%
Total:	1,692	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	1	0.06%
Black American	563	33.27%
Hispanic/Latino	14	0.83%
Native American	25	1.48%
White/Caucasian	676	39.95%
Other	100	5.91%
No Answer	312	18.44%
Erroneous Answer	1	0.06%
Total:	1,692	

REGISTRATION SUMMARY

South Carolina AIDS Training Network
Emory AIDS Training Network
April 1, 1989 to Present
03/23/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	12	0.71%
Black American	299	17.67%
Hispanic/Latino	11	0.65%
Native American	17	1.00%
White/Caucasian	1,133	66.96%
Other	22	1.30%
No Answer	197	11.64%
Erroneous Answer	1	0.06%
Total:	1,692	

REGISTRATION SUMMARY

USF Center for AIDS Education for Health Care Providers
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By State

	Total To Date	Percentage of Total
Alabama	0	0.00%
Florida	2,630	99.47%
Georgia	1	0.04%
North Carolina	1	0.04%
South Carolina	0	0.00%
Other States	12	0.45%
Total:	2,644	

By Professional Category

	Total To Date	Percentage of Total
M.D.	996	37.67%
Osteopath	13	0.49%
Physician's Assistant	7	0.26%
Nurse Practitioner	20	0.76%
Nurse	283	10.70%
Lab Personnel, Radiology	6	0.23%
Emergency Medical Tech.	0	0.00%
Dentist	563	21.29%
Dental Assistant	18	0.68%
Social Worker	150	5.67%
Health Educator	20	0.76%
Psychologist	93	3.52%
Mental Health Worker	113	4.27%
Chaplain	2	0.08%
Nutritionist	0	0.00%
Pharmacist	5	0.19%
STD Worker	0	0.00%
Occupational Therapist	4	0.15%
Clinical Support Staff	8	0.30%
Clerical Support Staff	23	0.87%
Outreach Worker	11	0.42%
Other Professions	87	3.29%
Administrator	209	7.90%
Anesthestist, Respiratory Tech	1	0.04%
Volunteer	1	0.04%
Health Insurance Provider	0	0.00%
Optometrist	0	0.00%
Medical Records Specialist	0	0.00%
Professional Code in Error	0	0.00%
No Answer Given	11	0.42%
Total:	2,644	

REGISTRATION SUMMARY

USF Center for AIDS Education for Health Care Providers
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Work Setting

	Total To Date	Percentage of Total
Health Department	23	0.87%
Community Health Center	36	1.36%
Office, Private Practice	760	28.74%
Hospital	293	11.08%
Home Health Agency	12	0.45%
Community-Based Organization	57	2.16%
Prepaid Plan, HMO	15	0.57%
Nursing Home/Personal Care	42	1.59%
Student in Training	19	0.72%
Mental Health Center	149	5.64%
Hospice	14	0.53%
Migrant Health Center	4	0.15%
Governmental Admin Office	33	1.25%
Other	315	11.91%
Medical Center, University	11	0.42%
No Answer	855	32.34%
Erroneous Answer	6	0.23%
Total:	2,644	

By Number of HIV-infected Persons Served in Last 6 Months

	Total To Date	Percentage of Total
None	647	24.47%
1-10 Persons	508	19.21%
More than 10 Persons	164	6.20%
Do Not Know	178	6.73%
Other	0	0.00%
No Answer	1,147	43.38%
Erroneous Answer	0	0.00%
Total:	2,644	

By Largest Ethnic Group in Patient/client Population

	Total To Date	Percentage of Total
Asian/Pacific Islander	4	0.15%
Black American	147	5.56%
Hispanic/Latino	78	2.95%
Native American	40	1.51%
White/Caucasian	1,066	40.32%
Other	51	1.93%
No Answer	1,258	47.58%
Erroneous Answer	0	0.00%
Total:	2,644	

REGISTRATION SUMMARY

USF Center for AIDS Education for Health Care Providers
Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

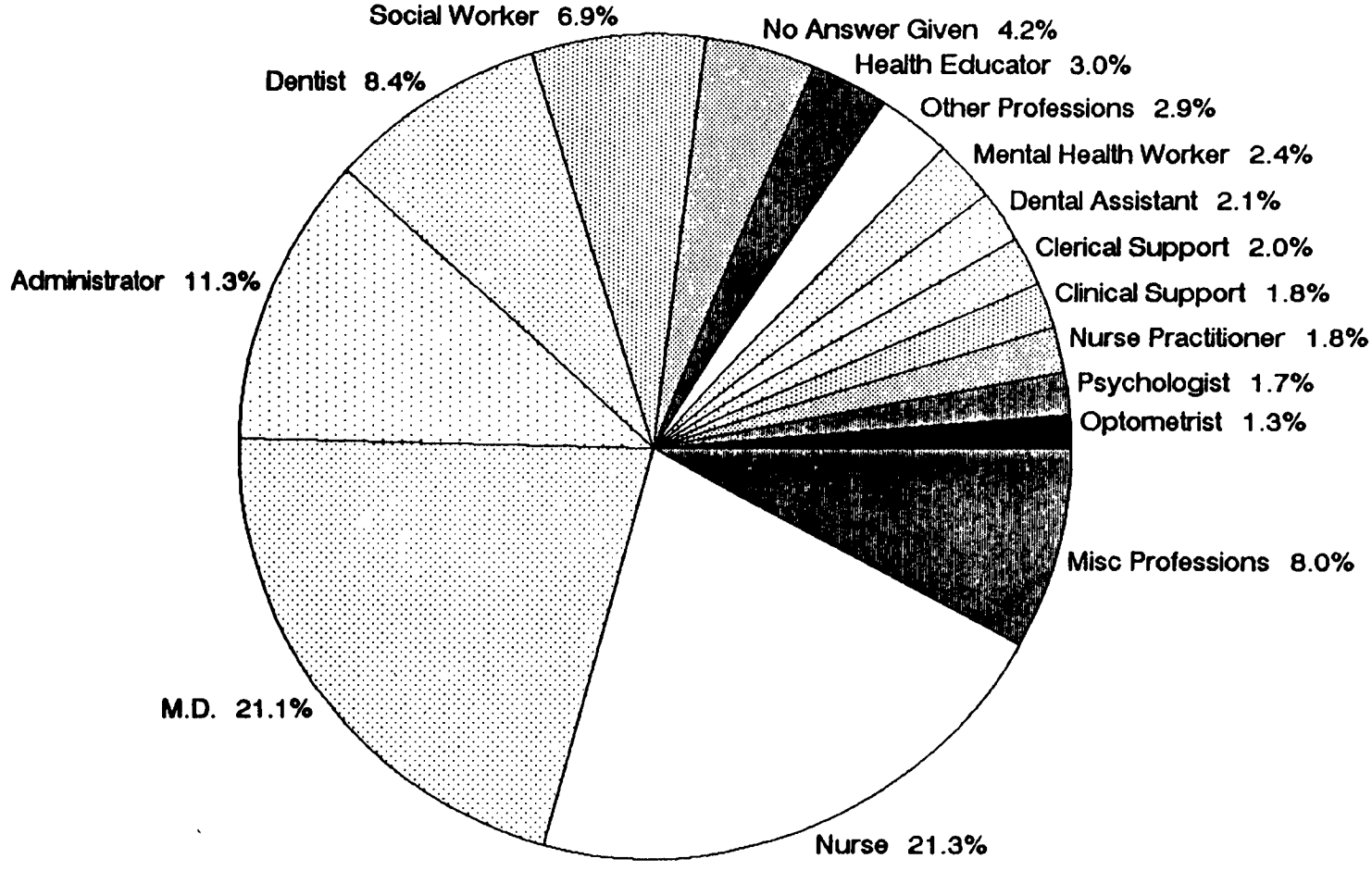
Includes trainees with at least one contact hour with trainer who completed registration forms to provide demographic data.

By Ethnic Group of Trainee

	Total To Date	Percentage of Total
Asian/Pacific Islander	64	2.42%
Black American	66	2.50%
Hispanic/Latino	102	3.86%
Native American	25	0.95%
White/Caucasian	1,149	43.46%
Other	17	0.64%
No Answer	1,220	46.14%
Erroneous Answer	1	0.04%
Total:	2,644	

EATN Registration by Professional Category

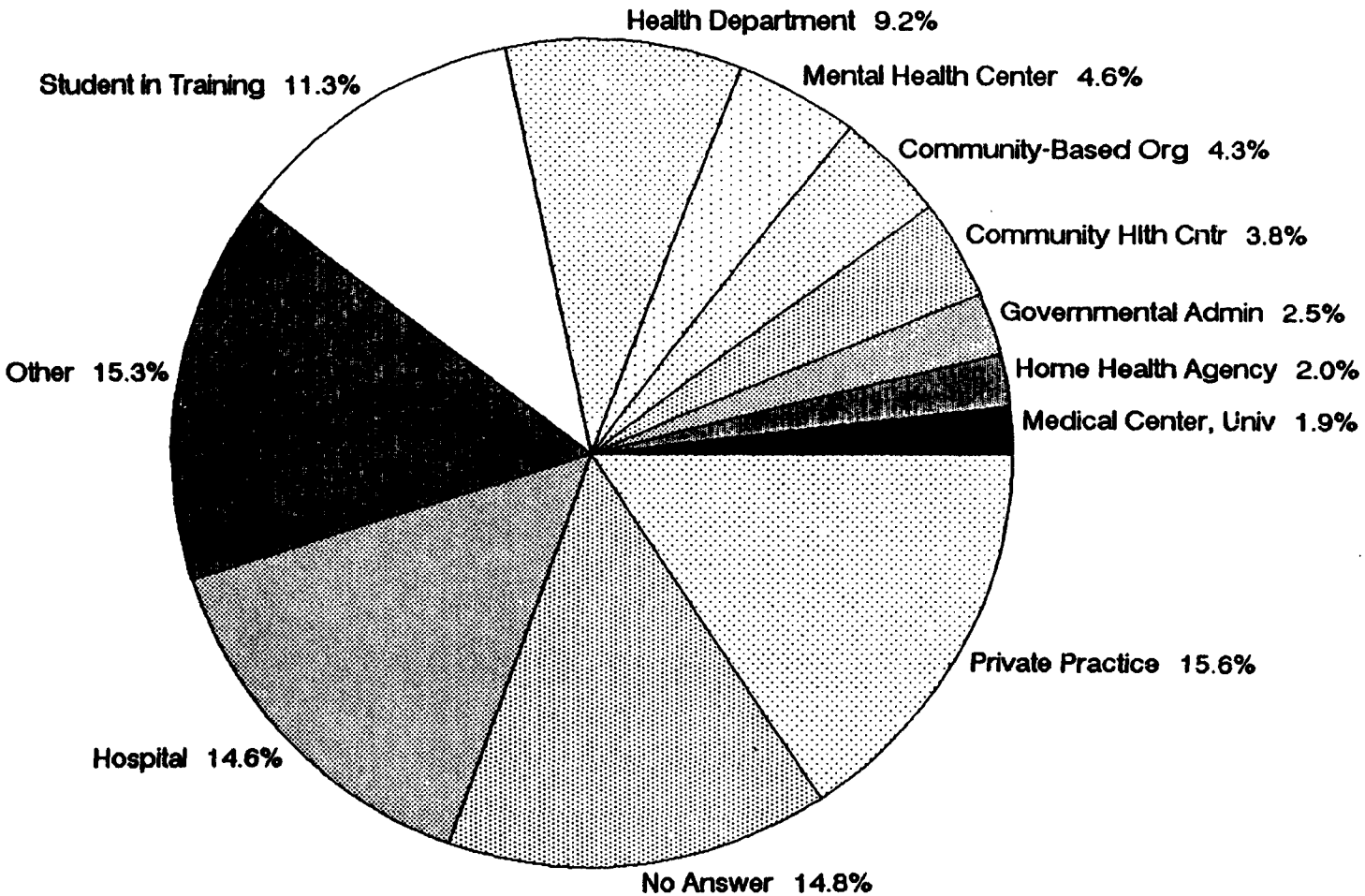
April 1, 1989 - March 21, 1990



N = 7480; Smallest groups combined under "Miscellaneous Professions".

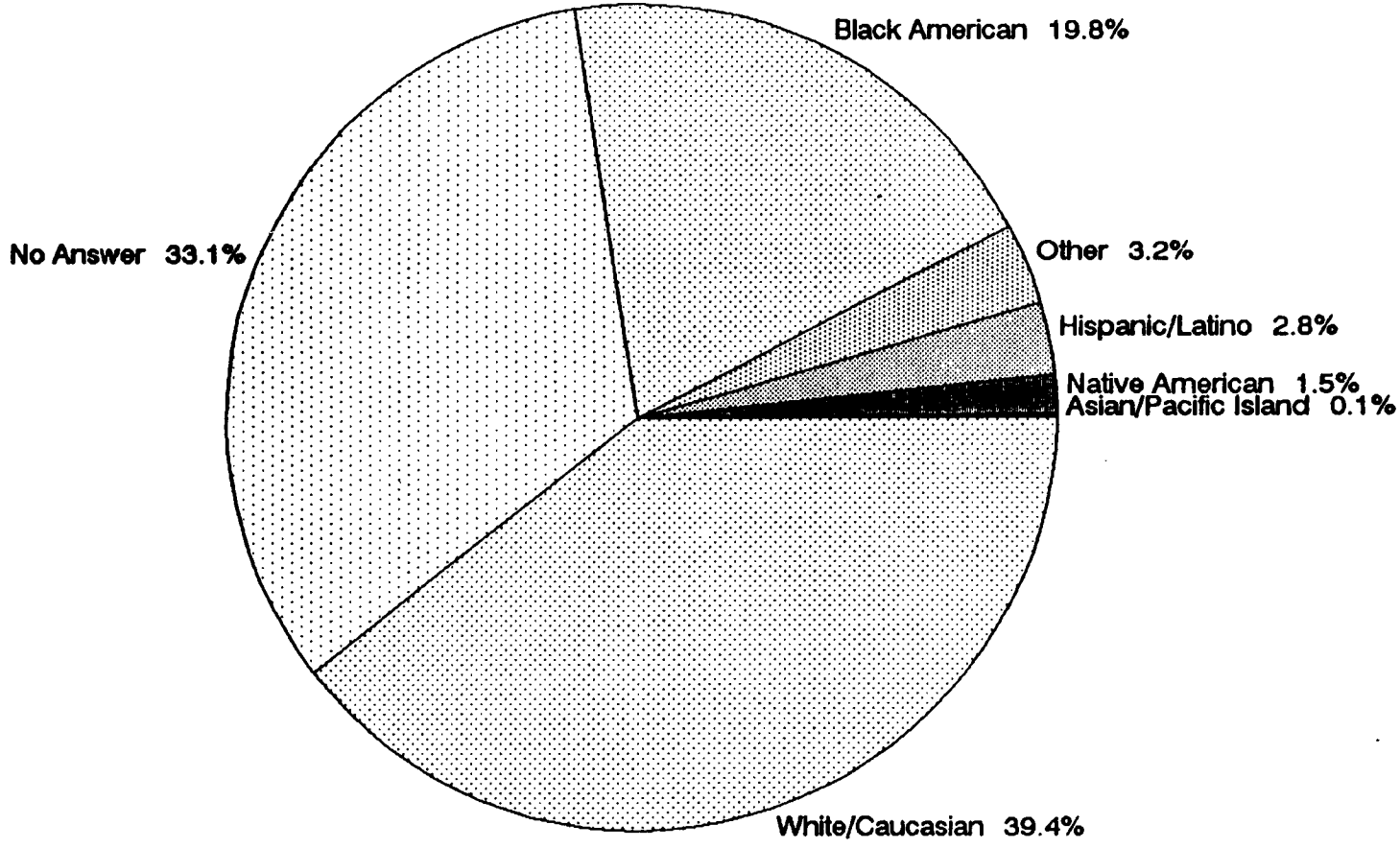
EATN Registration by Work Setting

April 1, 1989 - March 21, 1990



N = 7480; 4 smallest settings have been combined with "Other".

EATN Registration by Largest Ethnic Group in
Patient/client Population
April 1, 1989 - March 21, 1990

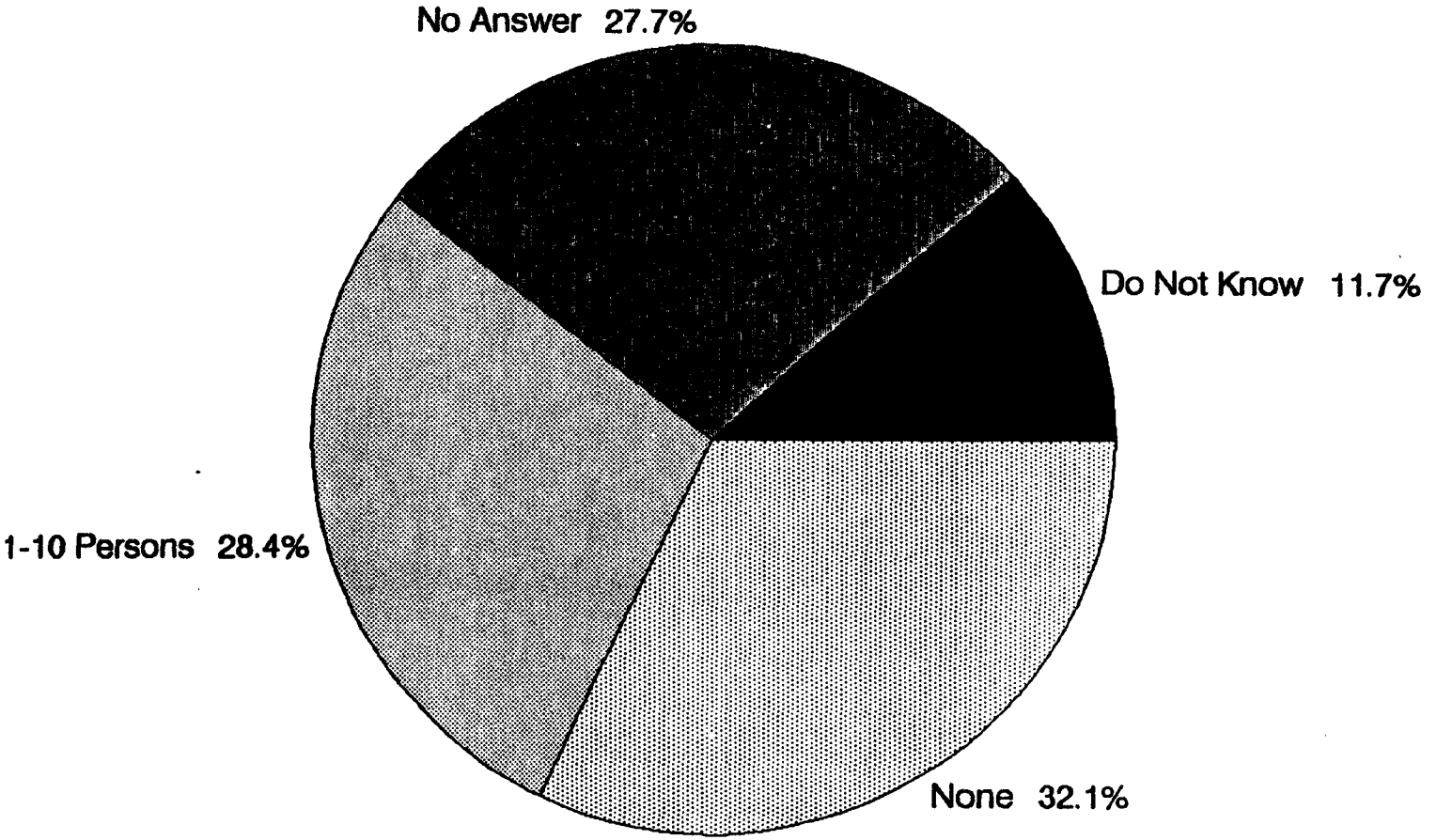


N = 7480; 2 erroneous answers omitted.

EATN Registration by Number of HIV-infected

Persons Served in Last 6 Months

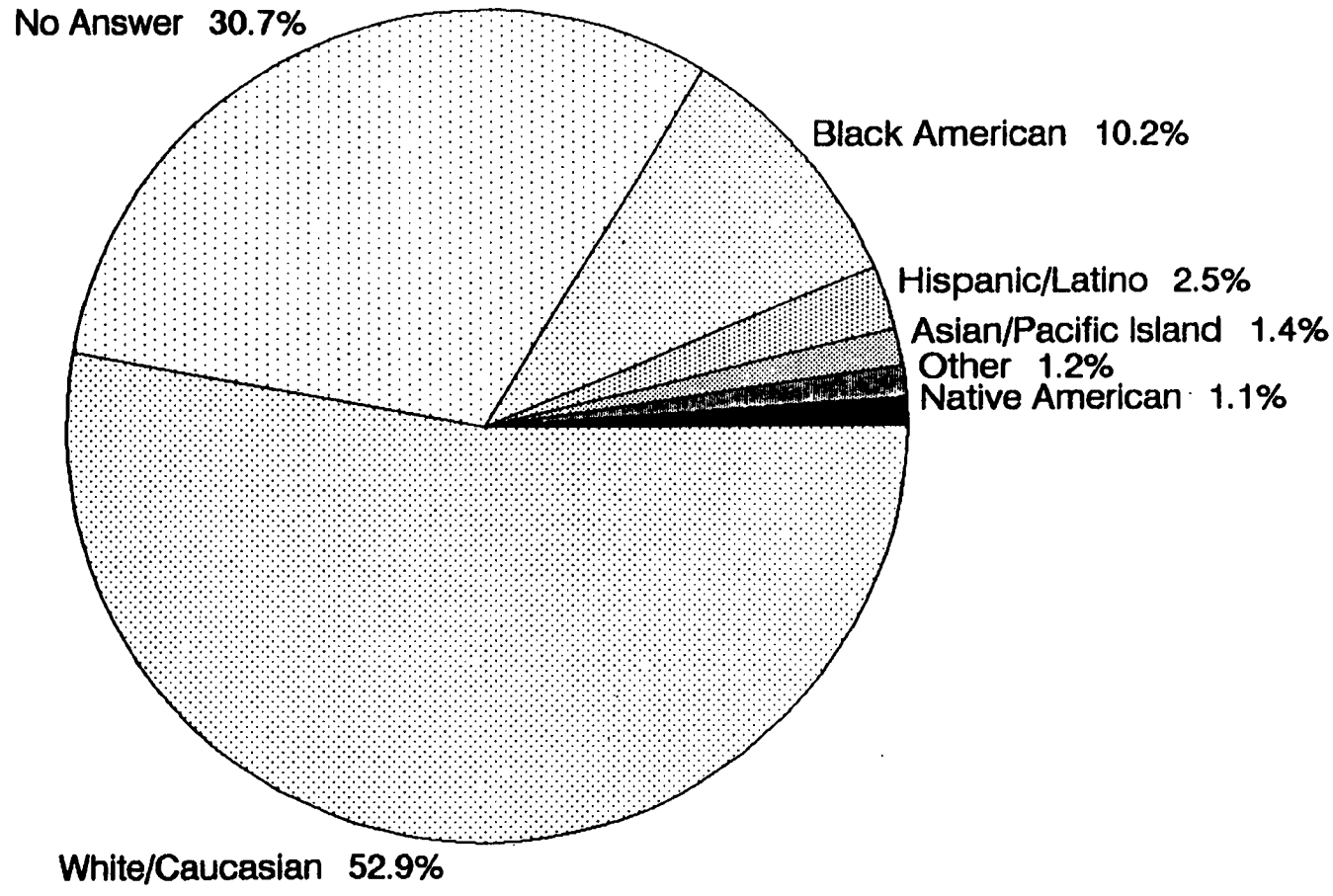
April 1, 1989 - March 21, 1990



N = 7480; 3 erroneous answers omitted.

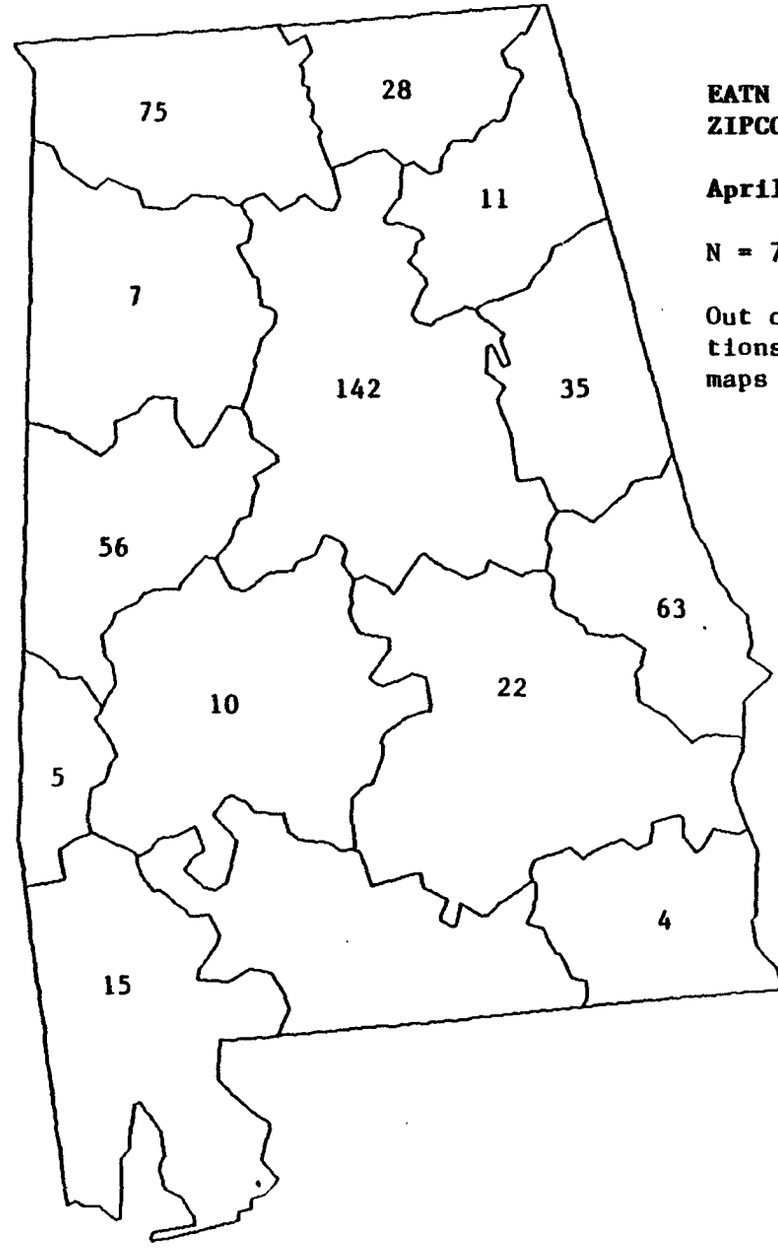
EATN Registration by Ethnic Group of Trainee

April 1, 1989 - March 21, 1990



N = 7480.

ALABAMA

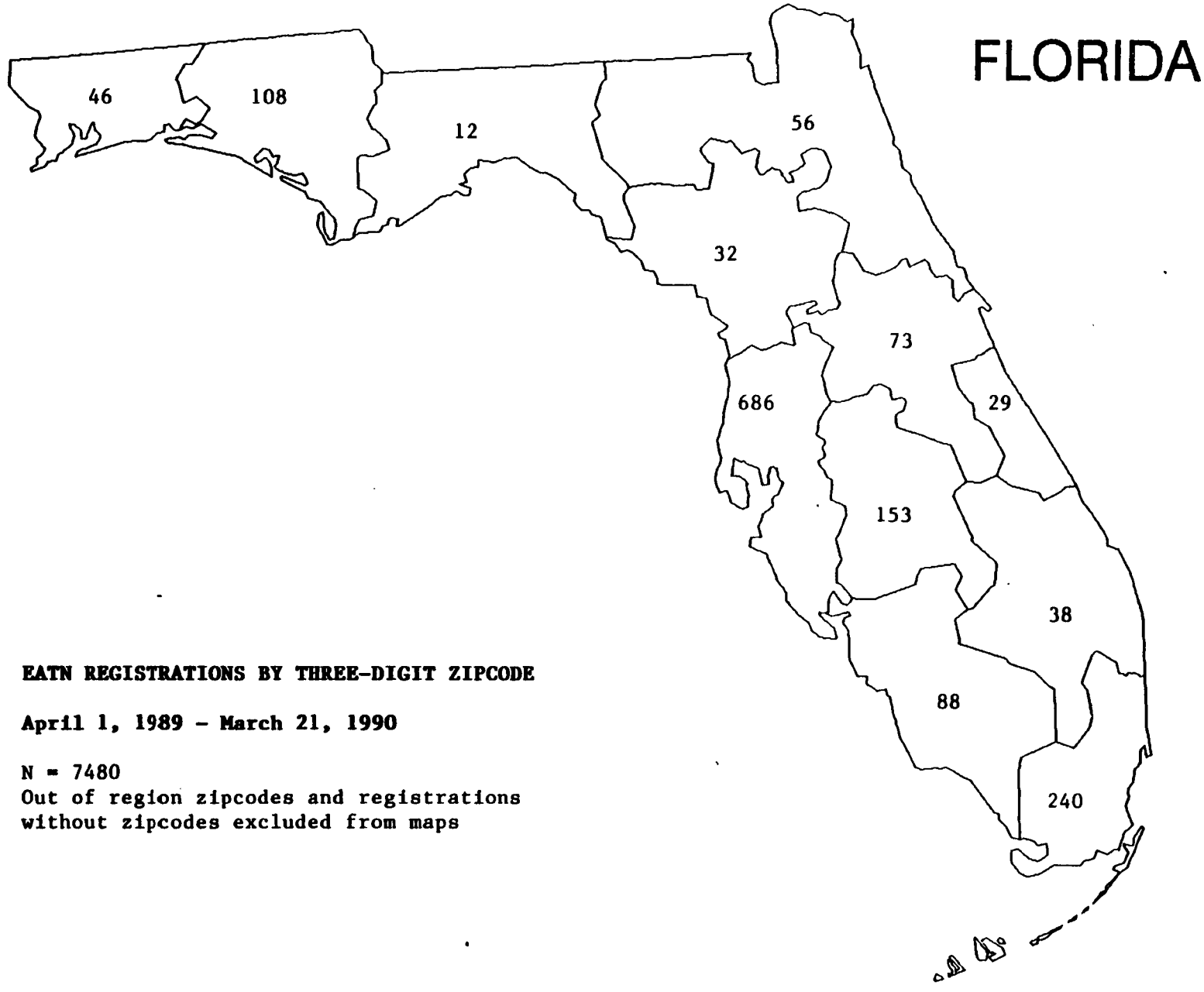


EATN REGISTRATIONS BY THREE-DIGIT ZIPCODE

April 1, 1989 - March 21, 1990

N = 7480

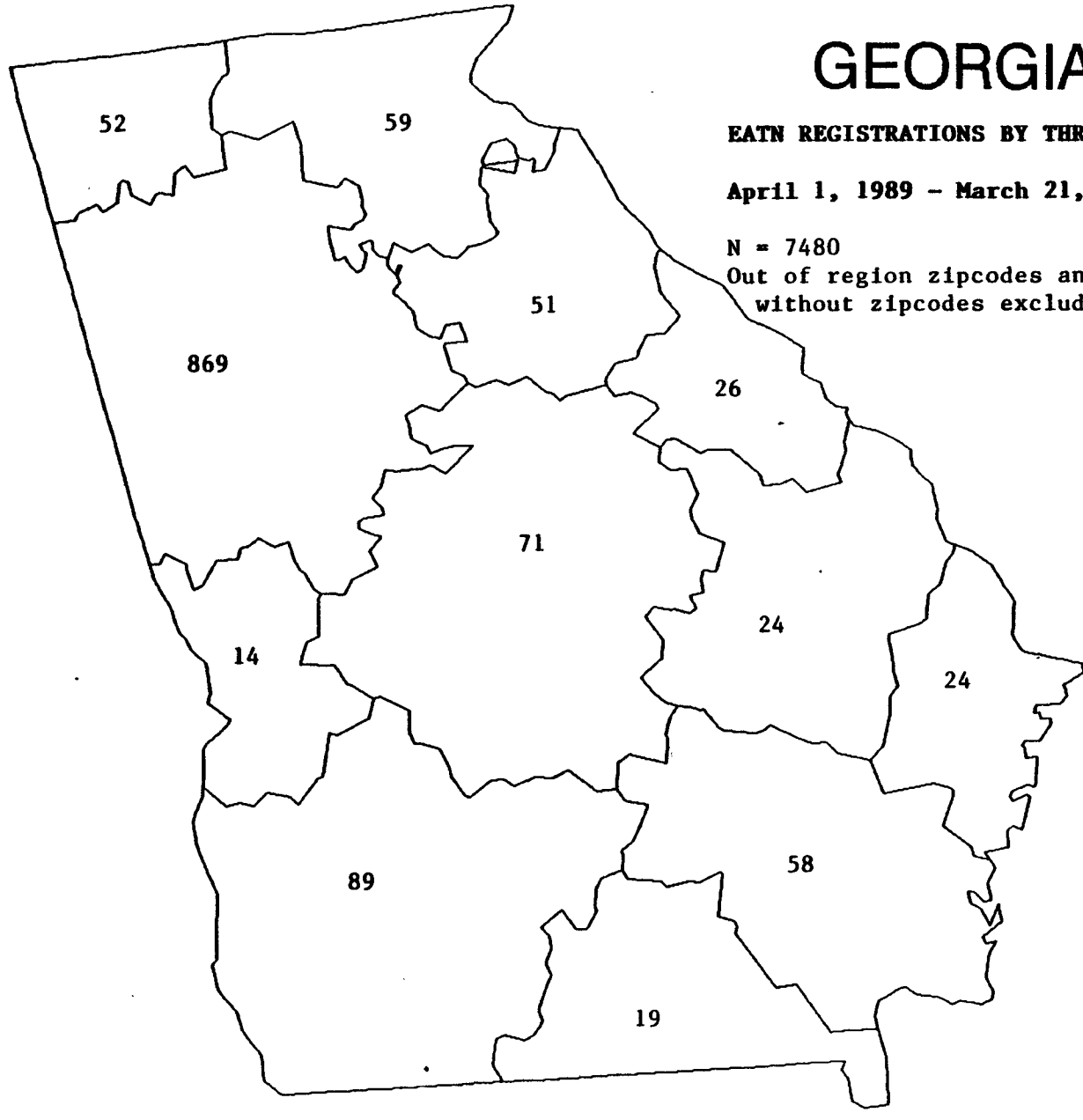
Out of region zipcodes and registrations without zipcodes excluded from maps



EATN REGISTRATIONS BY THREE-DIGIT ZIPCODE

April 1, 1989 - March 21, 1990

N = 7480
Out of region zipcodes and registrations
without zipcodes excluded from maps



GEORGIA

EATN REGISTRATIONS BY THREE-DIGIT ZIPCODE

April 1, 1989 - March 21, 1990

N = 7480
Out of region zipcodes and registrations without zipcodes excluded from maps

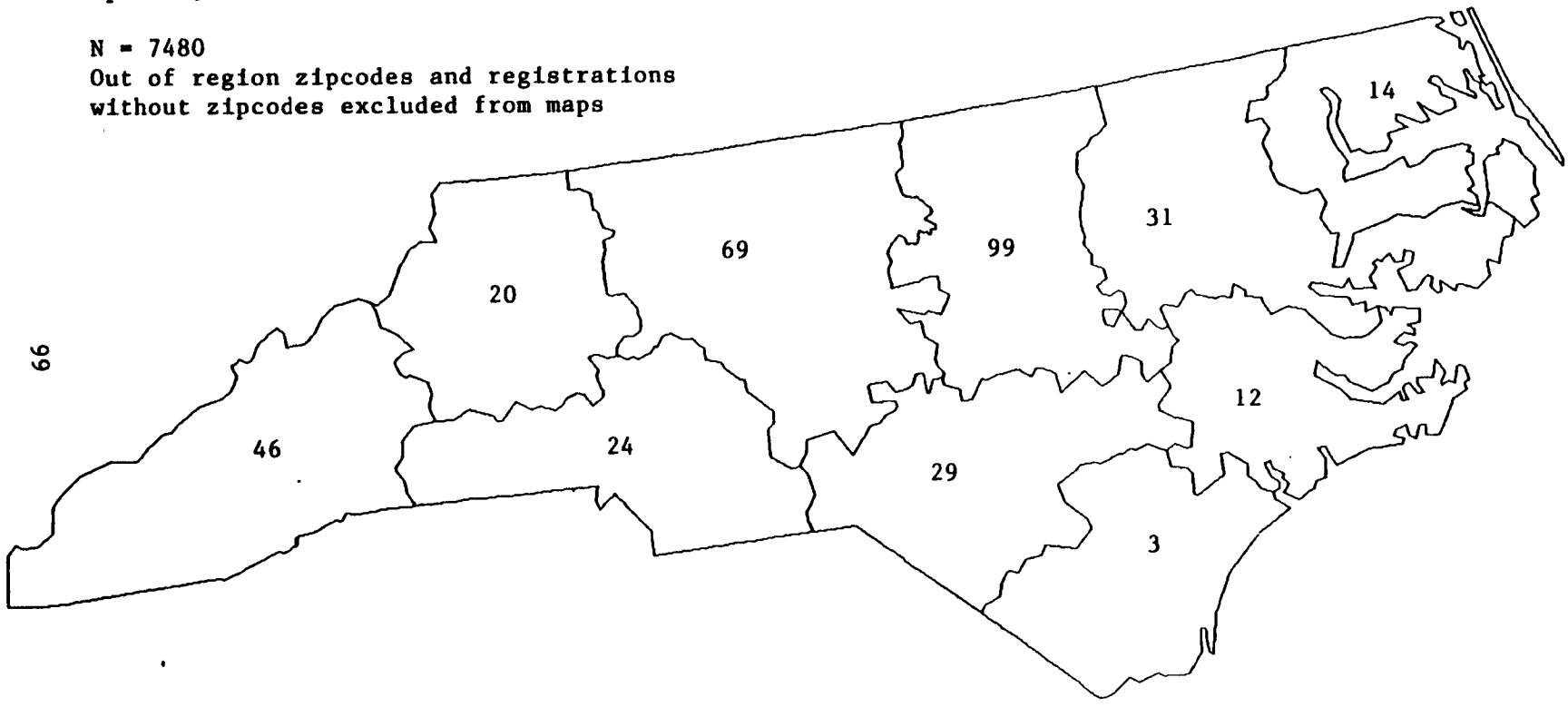
97

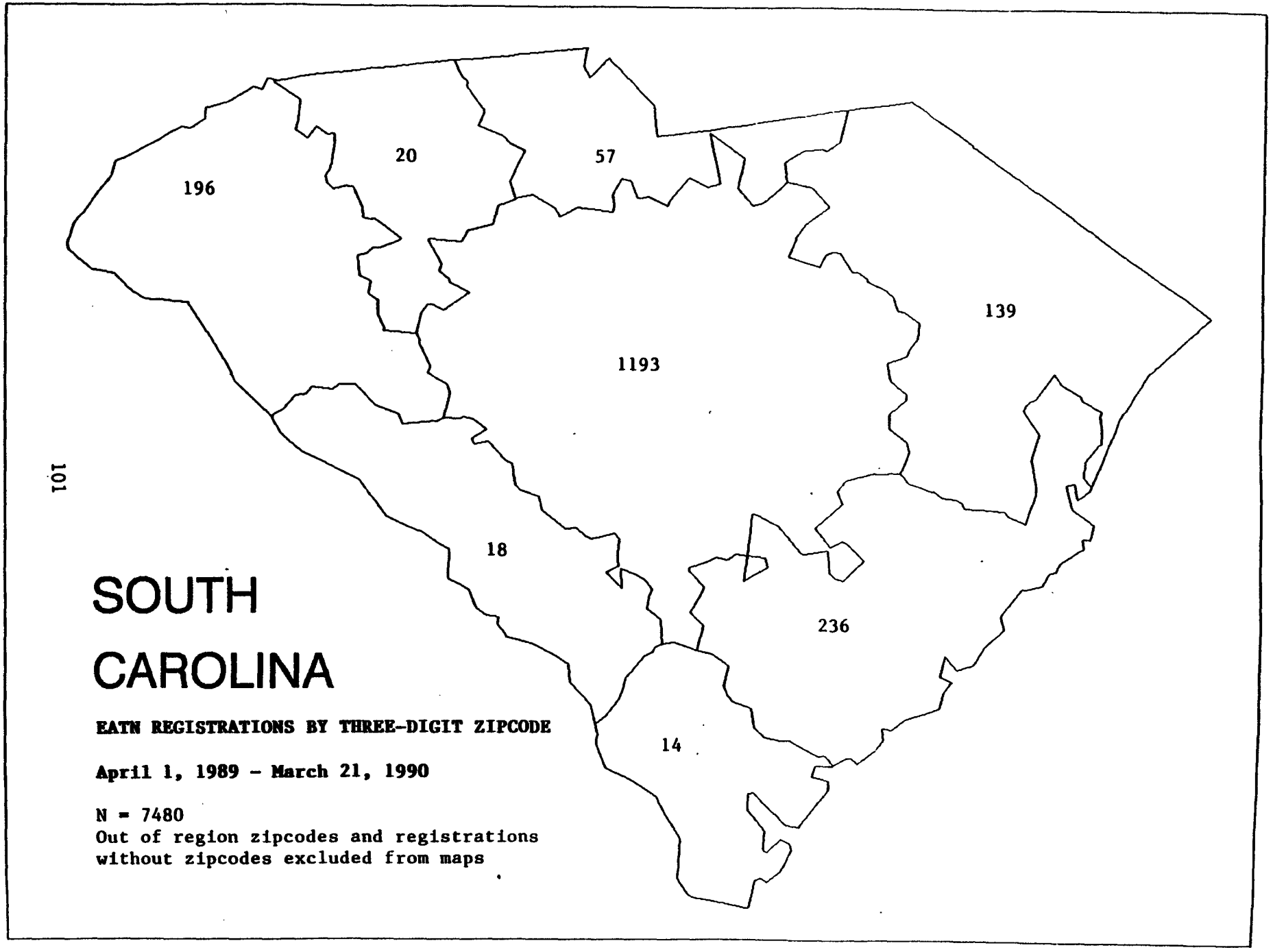
NORTH CAROLINA

EATN REGISTRATIONS BY THREE-DIGIT ZIPCODE

April 1, 1989 - March 21, 1990

N = 7480
Out of region zipcodes and registrations
without zipcodes excluded from maps





SOUTH CAROLINA

EATN REGISTRATIONS BY THREE-DIGIT ZIPCODE

April 1, 1989 - March 21, 1990

N = 7480
Out of region zipcodes and registrations without zipcodes excluded from maps

APPENDIX III

Cost Analysis -- Conference Cost Worksheet

Spring 1989 - Emory Major Conferences
Conference Cost Worksheet
Emory AIDS Training Network

Conference	Space	Food*	Staff Travel	Consultants	Copying**	CEU Expense	AV Equip Misc.	Total Expense	Registration Income	Net cost	Number of Participants	Cost per Participant	On-Site Registrants	No Shows
Learning to Care														
Atlanta 3/3	500.00	382.54		2617.07	400.50	100.00	133.00	4133.11	1370	$2,763.11	77	$35.88	39	5
Children with AIDS														
Atlanta 3/10	300.00	341.06		2245.52	363.00	82.50	150.00	3482.08	290	$3,192.08	50	$63.84	23	4
Women & AIDS														
Mobile 3/31	482.50	367.43	1934.25	2031.58	163.80	132.50		5112.06	1320	$3,792.06	115	$32.97	21	9
Children with AIDS														
Miami 4/7	200.00	346.88	2583.79	2123.06	370.80	52.50		5677.03	530	$5,147.05	55	[illegible]	10	9
Learning to Care														
Tampa 5/5	500.00	375.28	1519.39	2095.26	370.59	40.00	104.80	3004.52	745	$4,259.52	72	$59.16	31	4
Women & AIDS														
Myrtle Beach 5/19	0.00	409.40	2288.88	1112.69	163.80	52.50	76.25	4103.51	1880	$2,223.52	[illegible]	[illegible]	32	12

* Non-grant funds
**Estimated

6/27/89

2 of 4

APPENDIX IV

Standardized Evaluation Approaches -- Pilot Test on "How Did We Do?" Form

HOW DID WE DO? G&&-

Workshop Title _____ City and State _____

Date _____ Instructor(s) _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. Was the content **useful and practical?**	1	2	3	4	5
2. Was there **enough time** to cover all the material?	1	2	3	4	5
3. Were the handouts and other teaching aids **helpful and adequate?**	1	2	3	4	5
4. Did you receive **satisfactory answers** to your questions?	1	2	3	4	5
5. Did the instructor seem **aware of** your particular skill level, and teach accordingly?	1	2	3	4	5
6. Did the instructor seem to have **adequate knowledge and skill** to teach this workshop!	1	2	3	4	5

7. Did you read **a workshop announcement before you** came to the workshop today? c I **YES** ❑ NO

   If yes, did it give you a good idea of what the workshop would cover? c I **YES** c I NO

8. Please write down **one fact or idea** from the workshop that you learned, and that seems important to you:

9. What will you **do differently at work** as a result of this workshop?

10. Please **evaluate** your instructor. If there were two or more instructors, be sure to mention each by name. How can the instructor do a better job next time?

Instructor #1

Instructor #2

Instructor #3

11. **In your opinion,** how could this workshop be improved?

12. What are your **future AIDS training needs?**

MANY THANKS!

EMORY AIDS TRAINING NETWORK
735 Gatewood Rd, Atlanta 30322
(404) 727.2929

ATTACHMENT 7
SAMPLE TRAINING EVALUATION COMMENTS

When asked about an important fact or idea learned from this training, participants responded . . .

"There are major differences in HIV infection in children and adults." (1-31-89)

"Women are slow in perceiving their risk." (2-3-89)

"Use a member of the client population to reach other members of the client population." (10-6-33)

"How to deal with anger and fear." . (1-27-89)

"Build a program one realistic step at a time." (2-4-89)

When asked what they will do differently on the job as a result of the training, participants responded that they would . . .

"Do active listening - I'll be more aware and change a few of the things I do at work." (2-4-89)

"Be more patient with others and accepting of our differences." (2-4-89)

"Be consistent with procedures being used with dealing with contagion." (1-31-89)

"Talk to patients more strongly about using condoms." (1-27-89)

"Bring teaching down to learner's level" (2-4-89)

"Give people with AIDS more love and understanding." (1-31-89)

"Improve my post-test counseling." (9-20-88)

"Provide more realistic information." (7-29-88)

"Pre- and post-test counsel more thoroughly, and with greater confidence." (7-29-88)

"Diligently use universal protection; try to preserve hope if I have to counsel." (8-22-88)

Attachment 6

Evaluation Report

N= 885 responses*

	Strongly Disagree [1]	Disagree [2]	Not Sure [3]	Agree [4]	Strongly Agree [5]
1. Content realistic and practical	5 (0.6%)	9 (1.0%)	24 (2.3%)	211 (24.3%)	619 (71.3
2. Enough the to cover material	50 (5.8%)	78 (9.1%)	121 (14.1%)	273 (31.8%)	337 (39.2
3. Helpful, adequate handouts & teaching aids	7 (0.8%)	8 (0.9%)	64 (7.5%)	249 (29.1%)	327 (61.5
4. Questions satisfactorally answered	5 (0.63)	4 (0.50)	42 (5.0%)	245 (29.0%)	549 (6i.C
5. Trainer aware of participant skill level	11 (1.3%)	12 (1.42)	64 (7.51)	217 (25.4%)	549 (64.4
6. Trainer knowledgeable and adequately skilled	8 (0.9%)	5 (0.62)	15 (1.7%)	129 (15.02)	701 (81.7

*Final evaluation forms were not available Network-wide until 12/1/88. These data represent all events for Which completed evaluation forms were submitted.

Emory AIDS Training Network
February 1989

EMORY AIDS TRAINING NETWORK
EVALUATION REPORT
April 1, 1989 - September 30, 1989

QUESTION	PARTICIPANTS WI-IO ANSWERED" NO						
	-1-	-2-	-3-	-4-	-5-	ANSWER	AVE
	No.	No.	No.	No.	No.		
	%	%	%	%	%		
Realistic and Practical	67	73	109	1743	1588	23	4.3
	1.9	2.0	3.0	48.7	44.4	0.6	
Enough Time	96	408	390	1735	915	59	3.8
	2.7	11.5	11.0	49.0	25.8	1.6	
Helpful and Adequate	88	141	320	1862	1107	85	4.1
	2.5	4.0	9.1	52.9	51.5	2.4	
Satisfactory Answers	83	76	261	1737	1238	208	4.2
	2.4	2.2	7.7	51.2	36.5	5.8	
Trainer Aware	91	131	347	1576	1366	92	4.1
	2.6	3.7	9.9	44.9	38.9	2.6	
Trainer Skill	51	26	97	1252	2066	111	4.5
	1.3	0.7	2.8	35.9	59.2	3.1	
Read Workshop Announcement**	2166				1365	72	2.5
	61.3				58.7	2,0	
If Yes, Was it Adequate+*	1920				250	1433	1.5
	88.5				11.5	39.8	

* 1 = Strongly disagree
2 = Disagree
3 = Not sure
4 = Agree
5 = Strongly agree

** 1 = Yes
5 = No

TOTAL NUMBER OF RECORDS = 3603

APPENDIX V

Standardized Evaluation Approaches -- Current Version of "How Did We Do?" Form

HOW DID WE DO?

Today's Date _____ City & State _____ Workshop/Conference Title _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your instructors do a better Job. Some of this information is required by our federal funding agency. Please don't sign your name.

Circle one number for each statement:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
The content was useful and practical.	1	2	3	4	5
There was enough time to cover all the material.	1	2	3	4	5
Handouts and other teaching aids were helpful and adequate.	1	2	3	4	5
I received satisfactory answers to my questions.	1	2	3	4	5
The instructors seemed aware of my particular skill level, and taught accordingly.	1	2	3	4	j
The Instructors seemed to have adequate knowledge and skill to teach this workshop.	1	2	3	4	j

Did you read a training brochure or memo before you came? c I YES c I NO

If yes. did it give you a good Idea of what the training would cover? c I YES c I NO

[ ][ ][ ][ ][ ] ZIP code at' your office

Your professional designation. Students, mark planned designation (circle one only).

1 MD_____ specialty
2 Osteopath
3 Physician's Assistant
4 Nurse Practitioner
5 Nurse. RN. LPN
6 Lab Personnel. Radiology
7 Emergency Medical Tech
8 Dentist
9 Dental Assistant, Hygienist
10 Social Worker
11 Health Educator
12 Psychologist
13 Mental Health Counselor
14 Chaplain
15 Nutritionist, Dietitian
16 Pharmacist, Pharmacy Tech
17 STD Worker
18 Occupational Therapist
19 Nurse's Aide. Surgery Tech
20 Clerical Staff. Secretary
21 Outreach Worker
22 Administrator
24 Anesthetist, Respiratory Tech
25 Volunteer
26 Health Insurance Provider
27 Optometrist
28 Medical Records Specialist
29 Substance Abuse Professional
23 Other_____ specify

Your work setting (Mark the category that most closely describes your setting) (circle one only).

9 Student In training
1 Health deportment
2 Community health center
3 Office. private practice
4 Hospital
16 Drug/alcohol program
5 Home health agency
6 Community-based organization
7 Prepaid plan. HMO
8 Nursing home or personal care home
10 Mental health center
11 Hospice
12 Migrant health center
13 Governmental administrative office
15 Medical center. university
14 Other_____ specify

In the last six months, how many HIV-Infected persons have you provided services for in your work setting? (Circle one only):

1 None
2 1-10 persons
3 More than 10 persons
4 Don't Know

Largest ethnic group in your patient/client population. (Circle one only):

1 Asian/Pacific Islander
2 African American
3 Hispanic/Latino
4 Native American
5 White/Caucasian
6 Other_____ specify

Your personal ethnic group. (Optional. Monitoring only. Circle one only):

1 Asian/Pacific Wander
2 African American
3 Hispanic/Latino
4 Native American
5 White/Caucasian
6 Other_____ specify

1/90 EMORY AIDS TRAINING NETWORK

APPENDIX VI

Standardized Evaluation Approaches -- Tools for Follow-Up Study

WHAT WILL YOU DO DIFFERENTLY AS A RESULT OF THIS WORKSHOP?

1. Please write one or two sentences on what you **plan to do differently** in your work setting as a result of this training. Be as **specific as you** can.

_____

_____

_____

2. Does The Emory AIDS Training Network have your permission to **call you** in **6-12** weeks to follow up on this workshop in a **S-minute conversation?**

☐ **Yes**
☐ **No**

If yes, please complete this section:

Name: _____

Office phone: (___) _____
area code **number** ext.

Best time to reach you: _____

_____

3. Separate this form. **Turn in the top copy before you leave the workshop.** Keep the bottom copy for your records.

Thanks!

IMPACT EVALUATION

PARTICIPANT'S NAME: _____

NUMBER CALLED	1ST TRY DATE	2ND TRY DATE	3RD TRY DATE	4TH TRY DATE	OUTCOME
1.					
2.					
3.					
4.					
5.					
7.					
8.					

I'm Lenora Johnson, with the Emory AIDS Training Network in Atlanta. You attended a conference we sponsored on May 5th in Tampa. It was at the Hyatt Regency, and was called "Learning to Care." The conference dealt with support services for HIV-infected persons.

At that time you completed a brief questionnaire for us, stating what you planned to do differently as a result of the workshop. May I take 5 minutes to ask yo a few **followup** questions about your plans?

- ❑ No, not willing
- ❑ Yes, need to reschedule. (log above)
- ❑ Yes, now. Continue

When you were asked what you planned to do differently as a result of the workshop, you wrote: ***(Read Response Word For Word.)***

1. Do your remember writing this response? ❑ , ***yes*** ❑ no

2. Have you taken any action to put that plan into action? ❑ yes ❑ no

If **yes**, please describe what you have done.

If **no**, please state the reason(s) for not putting your plan into action.

3. As of today, do you consider you plan:
   - ❑ not begun at all
   - ❑ partially completed
   - ❑ totally completed
   - ❑ changed direction or g o a l

4. Do you expect to complete your plan, if you haven't do so already? If yes, when?

   - ❑ do not expect to complete plan
   - ❑ yes, will complete plan within three months
   - ❑ yes, will complete plan in more than three months

5. Do you think this type of telephone followup is helpful to you as a reminder?
   ❑ yes ❑ no

6. Your agency: _____
   Your position: _____
   Your main job tasks: _____
   _____

(All remaining questions are for persons who have partially or totally completed their plan.)

7. Was implementing your plan
   - ❑ part of your job?
   - ❑ a volunteer activity?

8. Did you have to secure special permission to put your plan into action?
   ❑ yes ❑ no

9. How many other people have been involved in putting you plan into action?
   - _____ none
   - _____ 1-5
   - _____ 6 or more

10. Is your activity

time limited? How long or how often?_____

_____ ongoing

11. Can you think of any added knowledge or skill that would help you implement your plan?

Thank you for your time.

APPENDIX VII

Approaches to Formative Evaluation -- "Trainer's Evaluation" Form

TRAINER'S EVALUATION FORM

Evaluation is an aaaantial part of our training management system. We ask that each consultant evaluate her/his training event and rka recommendations. Plaua fill out this form and return it along with the other completed paperwork as specified in your contract within one week after your workshop.

YOUR NAME: _____

TRAINING TOPIC: _____

LOCATION: _____ DATE(s): _____

CONTENT

1. Did you receive the advance information you needed to prapara and design the session adaquatcly?
YES ____ NO ____ Please offer suggestions for improving our planning process.

_____

_____

_____

2. Were EATN's training objactivas rt? YES ____ N D - - If any were not met, please explain:

_____

_____

_____

3. Please describe those parts of the training that worked well.

_____

_____

_____

4. Please describe those parts of the training that did not work well.

_____

_____

_____

(over)

EVALUATION BY TRAINER/Z

PARTICIPANTS

1. **Were** the participants appropriate for the session? YES ____ NO ____ **Comments:**

2. **What** changes in **participant work** behavior **would** you predict as a result of this training7

GENERAL EVALUATION

1. Who was your Local coordinator? Did you get **adequate** help from a Local coordinator at the training site? **Were AV's** and other local issues handled appropriately?

2. **Would** you **recommend** using the same facility again? YES ____ NO ____ Any modifications? YES _____ NO _____ **Comments:**

3. Please **note any additional recommendations** to **improve** the session.

4. Please note **any additonal** training needs that you identified.

5. Other **comments:**

APPENDIX VIII

Evaluations Conducted -- Summary Formative Evaluation of Year 01 Events

EVALUATION REPORT

Emory AIDS Training Network

April 1, 1988 to March 31, 1989

QUESTION	PARTICIPANTS WHO ANSWERED' NO						
	-1-	-2-	-3-	-4-	-5-	ANSWER	AVE
	No.	No,	No.	No.	No.		
	%	%	%	%	%		
Realistic and Practical	36	44	91	1456	1563	38	4.4
	1.1	1.4	2.9	45.6	49.0	1.2	
Enough Time	104	402	418	1485	753	66	3.8
	3.3	12.7	13.2	47.0	23.8	2.0	
Helpful and Adequate	56	127	319	1499	1100	127	4.1
	1.8	4.1	10.3	48.3	35.s	3.9	
Satisfactory Answers	61	75	232	1425	1168	267	4.2
	2.1	2.5	7.8	48.1	39.4	8.3	
Trainer Aware	59	97	333	1322	1310	107	4.2
	1.9	3.1	10.7	42.4	42.0	3.3	
Trainer Skill	40	17	51	989	2033	90	4.6
	1.3	0.5	1.6	31.6	65.0	3.0	
Read Workshop Announcement**	2375				787	66	2.0
	75.1				24.9	2.0	
If Yes, Was it Adequate**	2125				159	943	1.3
	93.0				7.0	29.2	

* 1 = Strongly disagree
2 = Disagree
3 = Not sure
4 = Agree
5 = Strongly agree

** 1 = Yes
5 = No

TOTAL NUMBER OF RECORDS = 3228

EVALUATION REPORT

Emory AIDS Training Network
April 1, 1989 to Present
03/21/90

QUESTION	PARTICIPANTS WHO ANSWERED' NO						
	-1-	-2-	-3-	-4-	-5-	ANSWER	AVE
	No.	No.	No.	No.	No.		
	%	%	%	%	%		
Realistic and Practical	88	88	135	2489	2308	34	4.3
	1.7	1.7	2.6	48.7	45.2	0.7	
Enough Tine	123	541	583	2525	1288	82	3.9
	2.4	10.7	11.5	49.9	25.5	1.6	
Helpful and Adequate	116	180	441	2638	1584	183	4.1
	2.3	3.6	8.9	53.2	31.9	3.6	
Satisfactory Answers	100	93	346	2538	1756	315	4.2
	2.1	1.9	7.2	52.6	36.3	6.1	
Trainer Aware	112	165	461	2291	1961	152	4.2
	2.2	3.3	9.2	45.9	39.3	3.0	
Trainer Skill	67	34	123	1790	2959	167	4.5
	1.3	0.7	2.5	36.0	59.5	3.2	
Read Workshop Announcement**	2935				2084	123	2.7
	58.5				41.5	2.4	
If Yes, Was it Adequate**	2600				376	2165	1.5
	87.4				12.6	42.1	

- 1 = Strongly disagree
  2 = Disagree
  3 = Not sure
  4 = Agree
  5 = Strongly agree

** 1 = Yes
  5 = No

TOTAL NUMBER OF RECORDS = 5142

APPENDIX IX

Evaluations Conducted

Instruments for Evaluating Nurse Train-the-Trainers

Train-the-Trainer
Emory AIDS Training Network
Emory University School of Medicine
Atlanta, Georgia 30322

Your ID_____

Pretest

1. Geographical location - G A _____NC _____SC
_____FL _____AL _____Other

2. Community: _____Urban Suburban _____Rural

3. Professional position (please specify type of nurse) _____

3a. If other than a nurse, please specify profession _____

4. Your highest degree _____

5. How many years of post-degree professional practice experience do you have? _____

6. What percent of your time is allotted for the following:

a. direct patient care _____
b. administration and policy making _____
c. supervision of clinical staff _____
d. community education _____
e. pre-service preparation _____
f. training _____
g. other _____

Train-the-Trainer
Emory AIDS Training Network
Emory University School of Medicine
Atlanta, Georgia 30322

Your ID_____

Post Test

1. Geographical location _____GA _____NC - S C
_____FL _____AL Other

For each of the following questions please circle the response which best represents your confidence level in: 1.) Your **knowledge** about the subject area, and 2.) your **skill** in teaching others about the subject area.

definitions:

PWA: Person with AIDS

HIV: Human imunodefeciency virus or HIV infection (the disease process)

AIDS: the end stage of HIV infection characterized by a variety of opportunistic infections.

1. How confident are you that you have the knowledge **and** skills to provide referral sources for someone who is HIV positive and in need of financial and social assistance?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to access referral sources:

quite confident						not at all confident
1	2	3	4	5	6	7

2. In general, how confident are you with your ability to reach people about AIDS as it relates to working with IV Drug users?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to work with IV drug users:

quite confident						not at all confident
1	2	**3**	4	5	6	7

3. How confident ***are you*** with your knowledge and ability to teach about the commonly used test for HIV antibody and the Western Blot?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in presenting appropriate information:

quite confident						not at all confident
1	2	3	4	5	6	7

4. How comfortable are you with your ability to teach about the transmission of the HIV virus?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about transmission:

quite confident						not at all confident
1	2	3	4	5	6	7

5. How confident are you with your ability to teach people how to identify the early symptoms of HIV infection?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to identify early symptoms of HIV:

quite confident						not at all confident
1	2	3	4	5	6	7

6. How confident are you that you have sufficient knowledge to teach effectively the issues regarding a person's psychological reaction to testing positive for the HIV antibody?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others the issues regarding a person's psychological reaction to testing positive for the HIV antibody:

quite confident						not at all confident
1	2	3	4	5	6	7

7. How confident are you that you have Sufficient skills and knowledge to teach what the experience of living with an AIDS diagnosis is like?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others what the experience of living with an AIDS diagnosis is like:

quite confident						not at all confident
1	2	3	4	5	6	7

a. How confident are you that you have sufficient skills and knowledge to teach about the stress of providing care for a person with AIDS (for family, caregivers and professionals)?

Knowledse of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about the stress of providing care for a person with AIDS (for family, caregivers and professionals):

quite confident						not at all confident
1	2	3	4	5	6	7

9. How confident are you that you have sufficient skills and knowledge to teach about loss and grief issues for the caregivers or persons with AIDS (for family, caregivers and professionals)?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about loss and grief issues for the caregivers of persons with AIDS (for family, caregivers and professionals):

quite confident						not at all confident
1	2	3	4	5	6	7

10. How confident are you that you have sufficient knowledge and skill identify HIV health care issues particular to Communities of color:

Knowledae of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to identify HIV health care issues particular to communities of color:

quite confident						not at all confident
1	2	3	4	5	6	7

11. How confident are you that you have sufficient knowledge and skill to identify the special problems related to care of AIDS patients in special populations?

Knowledse of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to deal with the special problems related to care of AIDS patients in special populations:

quite confident						not at all confident
1	2	3	4	5	6	7

12. How confident are you with your knowledge and skill in teaching professionals how to take a sexual history?

Knowledae of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to take a sexual history:

quite confident						not at all
1	2	3	4	5	6	7

13. **How** confident are you that you have **sufficient** knowledge to teach ways to effectively deal with deteriorating mental status/dementia due to HIV related infections?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to deal with deteriorating mental status/dementia due to HIV related infections:

quite confident						not at all confident
1	2	3	4	5	6	7

14. How confident are you with your ability to teach people the epidemiology of HIV infection and AIDS from the global and state perspective?

Knowledae of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in presenting appropriate information

quite confident						not at all confident
1	2	3	4	5	6	7

15. How confident are you that you have the knowledge to teach ways to identify common opportunistic infections of AIDS patients and the appropriate treatment?

Rnowledue of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill teaching others how to identify and treat common opportunistic infections of **PWA's:**

quite confident						not at all confident
1	2	3	4	5	6	**7**

16. How confident are you that you have the knowledge and skills to teach the healthy immune system and its functioning after HIV infection?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others the symptoms of a HIV compromised immune system:

quite confident						not at all confident
1	2	3	4	5	6	7

17. How confident are you that you have sufficient knowledge to provide community or pre-service education regarding the care of someone with HIV infection?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in providing community or pre-service education regarding care of someone with HIV infection:

quite confident						not at all confident
1	2	3	4	5	6	7

18. How confident are you with your ability to tailor your presentation to meet the needs of diverse audiences?

quite confident						not at all confident
1	2	3	4	5	6	7

19. How confident are you that you have sufficient knowledge to (1) plan/organize, **and** (2) deliver the following types of training formats:

		PLAN/ORGANIZE very confident				not at all confident	DELIVER very confident				not at all confident
a.	two hour lecture	1	2	3	4	5	1	2	3	4	5
b.	four hour(half day)	1	2	3	4	5	1	2	3	4	5
c.	one day workshop	1	2	3	4	5	1	2	3	4	5
d.	two day workshop	1	2	3	4	5	1	2	3	4	5
e.	in-service update	1	2	3	4	5	1	2	3	4	5

f. For nursing faculty:

How confident are you that you have sufficient knowledge to (I) plan/develop, and (2) implement AIDS education in nursing curricula?

quite confident						not at all confident
1	2	3	4	5	6	7

20. Please rate your comfort level in dealing with the following training related issues.

	very confident						not at all confident
a) targeting messages	1	2	3	4	5	6	7
b) large.audiences (+50)	1	2	3	4	5	6	7
c) responding to questions	1	2	3	4	5	6	7
d) adjusting presentation to sponsoring agency's time limits	1	2	3	4	5	6	7
e) using print and other teaching aids	1	2	3	4	5	6	7

21. To what extent do you believe that each of the following can transmit the HIV infection?

		Definitely Can	Probably Can	Probably Cannot	Definitely Cannot
a.	needlestick with an infected needle	4	3	2	1
b.	mouth-to-mouth CPR	4	3	2	1
c.	sharing coffee cups	4	3	2	1
d.	shaking hands	4	3	2	1
e.	touching equipment	4	3	2	1
f.	being in the same room	4	3	2	1
g.	cleaning blood-free vomitus	4	3	2	1
h.	toilet seats	4	3	2	1
i.	bedsheets	4	3	2	1
j.	assisting at autopsy	4	3	2	1
k.	emptying bedpans	4	3	2	1
1.	being sneezed or coughed on	4	3	2	1
m.	donating blood (risk to donor)	4	3	2	1

22. What three (3) things are you likely to do differently when you return to your worksite? Please list.

a.) _____

_____

b.) _____

_____

c.) _____

_____

Thank you very much.
9/15/89 EATN

adapted from: WAMI-ETC
PRETEST2.DOC

ACTION PLAN

Emory AIDS Training Network
Emory University
Atlanta, Georgia

Name: _____

1. Where will you implement AIDS education?

2. How do you intend to incorporate AIDS education in your nursing program?

3. Approximately how many people will attend each training **or** education program?

4. How many hours each day will be devoted to AIDS education?

5. Briefly, describe your students.

6. If you identified any education/training **barriers(e.g.** cultural, language, educational level, community resistance) on the community assessment that you completed in preparation for this course, what are your plans for overcoming these barriers?

7. Identify specific people who can help plan or conduct the educational programs.

8. If you identified any gaps in educational resources when you completed the community needs assessment form, how do you plan to fill those gaps?

9. Do you intend to reach other populations besides your nursing students? Who are they and how will you reach them?

10. How do you plan to evaluate the educational programs? What will you use as the criteria?

11. Do you anticipate any problems in planning, implementing or evaluating your AIDS education program?

12. If you anticipate problems, how do you plan to address them?

13. Choose three ideas, exercises' or training methods that you have learned in this training and explain how you would incorporate them into one of your own AIDS educational programs.

14. Diagram a tentative timeline for planning and implementing AIDS education in your nursing curricula or workplace. Start by selecting a program or series of programs you plan to conduct in your school and then set a target date. Work backwards when filling in your timeline, starting with the target date. Include when you gather the resources, market and conduct the training, Consider how long you will need to promote the program, line up speakers, etc.

Program Title_____ Target Date_____

Action	Sept.	Oct	Nov.	De

APPENDIX X

Evaluations Conducted

Interview Schedule for Retrospective Formative Evaluation
of Grady Memorial Clinical Tutorial

Follow-up Clinical Tutorial Evaluation.

Name:_____ **Date of Tutorial:**_____

Profession:_____

Type of Work **Setting:**_____

New **that you are** _____ **months** out from the clinical **tutorial:**

a.) **What are** the things you **recall?**

b.) What did you learn that **you haven't** used?

c) **What** have you **needed** that you **didn't** get?

d.) Do you **feel** you need a refresher?

e.) How many HIV infected patients do you see a month?

Before tutorial:

Today:

f.) what transmission categories do most of your patients come from?

g.) What is the single most helpful thinq you learned?

h.) Following are a list of five topics covered in the tutorial. Please rate each item as it relates to you today.

	1=most helpful 5=least helpful			
1.) New patient evaluation and work-up	1	2	3	4 5
2.) Evaluation and follow-up of patients discharged from the hospital	1	2	3	4 5
3.) Evaluation and continued plan of care for patients on AZT and other HIV related medications	1	2	3	4 5
4.) Didactic session on Clinical Manifestations of HIV Disease	1	2	3	4 5
5.) Didactic session on Diagnosis and Management of Opportunistic Infections	1	2	3	4

APPENDIX XI

Evaluations Conducted

Evaluation of University of South Florida's Mental Health Clinical Tutorial

HIV CLINICAL TUTORIAL WORKSHOP
EXTENDED EVALUATION FORM

Please answer all questions thoughtfully. Your honest and specific feedback will help us make these workshops increasingly valuable training experiences. We high/y ***recommend that you record*** your thoughts and ***comments*** throughout ***the course of the workshop. A*** moment or two at the end of each session will ensure thorough and accurate notation of important reactions and comments.

Ratinas of Sessions and Instructors:

(Space is given for ratings of each session and for ratings of each instructor/presenter. Please comment on the content and format of each session, and on the presentation style, organization and clarity of each presenter. Suggestions for ways to improve **each** session and constructive feedback for presenters are most welcome.)

Wednesday:

10:45 AM -- **Mental Health Overview (Michael D.** Knox, Ph.D.)

12:15 **PM -- Medical, Psychiatric and Historical Issues (Charles F.** Clark, M.D.)

1:45 PM -- *Panel Discussion*

3:30 **PM -- Neuropsychological Assessment** (Timothy **Boaz,** Ph.D.)

Thursday:

8:15 AM/10:00 AM -- ***Patient Assessment at the Immunodeficiency Clin&***

8:15 AM/10:00 **A M** -- Videotapes and Discussion

1:00 PM -- HIV/AIDS Medical **Update** (Robert P. Nelson, M.D.)

2:15 PM -- Suicide **Risk** Assessment (John C. Ward, **Jr., Ph.D.)**

3:15 **PM -- Depression and Cognitive Therapy (Michael G. Dow, Ph.D.)**

7:00 PM -- *Support Groups of* **the** *Tamoa AIDS Network*

Friday:

8:30 AM -- *Network Meetina for Health Care Providers*

9:30 AM -- *Psychoeducational AIDS Module*

11:00 **AM -- Prevention and Client Training Issues (Martha F. Anker, Ph.D.)**

1:00 PM -- **Issues of Chronic and Terminal Illness (Jeremy S. Gaies, Psy.D.)**

2:00 PM -- Ethical Issues (Frank Chessa, M. A.)

Ratings of Workshop Format: (Please comment of the following features)

Pacing of Workshop Sessions _____

Lunches and Breaks _____

Facilities _____

Three-Day Format _____

R ' of Workshop Materials:

Brochure _____

Information Binders _____

Please use the following space to comment on any other aspects of the tutorial program, as well as to summarize your thoughts and feelings about your experience in the workshop:

Thank you for helping us make the HIV Clinical Tutorial Workshop Program as clinically valuable and interesting a program as possible!

pre/post test for clinical tutorial
also doing long-term follow-up in year 03
-not yet designed - to be completed at research division

I.D. # _____

AIDS/HIV KNOWLEDGE SCALE

(Note: HIV stands for Human Immunodeficiency Virus, which is the virus that causes AIDS.)

	True	False
1. A person can be infected with HIV and not have the disease AIDS.	1	2
2. There are no documented cases of HIV positive individuals committing suicide shortly after being told of their infection.	1	2
3. When donated blood is screened for HIV antibodies, there is still a small chance that a person could be infected with HIV by receiving a blood transfusion.	1	2
4. Neuropsychological difficulties may be one of the first problems to develop as a result of HIV infection.	1	2
5. Having sex with an HIV infected person is the most common way of acquiring HIV.	1	2
6. Some HIV infected individuals may be admitted to a mental health facility because of neuropsychiatric symptoms of HIV infection.	1	2
7. It is impossible to get AIDS from sexual intercourse if you use condoms carefully.	1	2
a. Tt is theoretically possible for a woman to acquire HIV infection by giving oral sex to an HIV infected man.	1	2
9. If a nurse is accidentally stuck by a needle used on an HIV infected person, she will almost surely **become infected with** HIV.	1	2
10. A person can be infected with HIV for several months before he/she tests positive on an antibody test.	1	2
11. Sometimes a child born of an HIV infected mother may change from positive to negative on the HIV antibodies test.	1	2
12. If an HIV positive client states that he/she will be sexually active with a specific person and refuses to notify the partner of the infection, and condoms will not be used, the mental health professional may have a legal obligation to notify the partner of the risk.	1	2
13. Some people will test positive for HIV on the screening test (ELISA) even if they are not infected with HIV.	1	2

	True	False
14. The HIV antibody tests indicate whether an individual has AIDS.	1	2
15. As long as you and all of your sexual partners are exclusively heterosexual, having many sexual partners does not increase your risk of HIV infection.	1	2
16. Some symptoms of HIV infection may include (but are not limited to): forgetfulness, poor concentration, psychomotor retardation, apathy, and social withdrawal.	1	2
17. Studies have shown that there have been no major changes in sexual behaviors among gay males since the AIDS epidemic became well known.	1	2
18. Mental health professionals should consider the possibility of AIDS related neuropsychological or psychiatric symptoms if a patient has a history of high risk behavior.	1	2
19. All persons who are infected with HIV will develop AIDS within the first five years after exposure.	1	2
20. Most people who have been infected with HIV show symptoms of serious illness within 6 months.	1	2

AIDS/HIV OPINION SCALE

Below are statements regarding HIV infection and AIDS.
Please indicate whether you agree or disagree with the statement.

	AGREE	DISAGREE
21. if I had a choice, I would prefer to avoid working with an HIV infected person.	1	2
22. I think medical professionals and paraprofessionals working in a general medical facility should not be required to work with HIV positive patients.	1	2
23. I think mental health professionals and paraprofessionals working in a mental health facility should not be required to work with HIV positive patients.	1	2
24. I think substance abuse professionals and paraprofessionals working in a substance abuse facility should not be required to work with HIV positive patients.	1	2
25. I would be afraid of acquiring AIDS if I worked on a unit with HIV positive patients.	1	2
26. I think that all mental health inpatients should be tested for HIV antibodies.	1	2
27. I think that all substance abuse inpatients should be tested for HIV antibodies.	1	2
28. I think that all mental health outpatients should be tested for HIV antibodies.	1	2
29. I think that all substance abuse outpatients should be tested for HIV antibodies.	1	2
30. I think that all staff at my facility should be tested for HIV.	1	2
31. I think mental health and substance abuse inpatients who are HIV positive should only be treated on specialized units for HIV positive patients.	1	2
32. I would try to avoid working with patients who are HIV positive.	1	2
33. I do not believe that an HIV positive individual should be admitted to my program.	1	2

If you were involved in one of the following situations with an HIV infected client, what are the chances that you could acquire the HIV infection?

1 VERY LIKELY
2 SOMEWHAT LIKELY
3 POSSIBLE, BUT UNLIKELY
4 PRACTICALLY IMPOSSIBLE
5 IMPOSSIBLE

	VERY LIKELY				IMPOSSIBLE
34. Patient sneezing or coughing on me	1	2	3	4	5
35. Mouth to mouth CPR on a patient	1	2	3	4	5
36. Being bitten by a patient	1	2	3	4	5
37. Being spit on by a patient	1	2	3	4	5
38. Being stuck by a needle which was used on a patient	1	2	3	4	5
39. Directly touching patient's blood when applying pressure to stop bleeding	1	2	3	4	5

REASON FOR DISCOMFORT SCALE

Below is a partial description of individuals who could be admitted to your program. Based solely on this information, please circle the number that indicates the level of personal discomfort you would have in working with each type of client.

	NO DISCOMFORT						MUCH DISCOMFORT
40. Has major depressive disorder	0	1	2	3	4	5	6
41. Is homosexual	0	1	2	3	4	5	6
42. Is an IV drug user	0	1	2	3	4	5	6
43. Has AIDS	0	1	2	3	4	5	6
44. Has hepatitis B	0	1	2	3	4	5	6
45. Is a homosexual who is HIV positive (infected with HIV)	0	1	2	3	4	5	6
46. Is terminally ill	0	1	2	3	4	5	6
47. Is HIV positive (infected with HIV)	0	1	2	3	4	5	6
48. Is a child molester	0	1	2	3	4	5	6

RESPONDENT DATA SHEET

1. Age: - - - -

2. Sex:
___ Male
___ Female

3. Ethnic Group:
___ Asian-American
___ Black
___ Hispanic
___ Native American
___ White
___ Other

4. Marital Status:
___ Single, never married
___ Married
___ Cohabitant
___ Separated/divorced/widowed

5. Education:
___ Some college
___ College degree
___ Graduate studies
___ Master's degree
___ Doctor of Medicine (M.D., D.O., etc.)
___ Doctorate (Ph.D., Psy.D., Ed.D., etc.)

6. Occupation:
___ Nurse
___ Counselor
___ Social Worker
___ Psychiatrist
___ Psychologist
___ Mental Health Administrator
___ Other

HOW DID WE DO?

Workshop Title: HIV Clinical Tutorial Workshop
Date: **2/28-3/2/90** City and State: Tampa, Florida

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please **don't** sign your name.

1. Was the content useful and practical?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	0	0	0	4

Average: 5.00 Total Number of Respondents: 4

2. Was there enough time to cover all the material?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	1	0	3	0

Average: 3.50 Total Number of Respondents: 4

3. Were the handouts and other teaching aids helpful and adequate?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	1	0	0	3

Average: 4.25 Total Number of Respondents: 4

4. Did you receive satisfactory answers to your questions?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	0	0	0	4

Average: 5.00 Total Number of Respondents: 4

5. Did the instructor seem aware of your particular skill level, and teach accordingly?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	0	0	1	3

Average: 4.75 Total Number of Respondents: 4

6. Did the instructor seem to have adequate knowledge and skill to teach this workshop?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	0	0	0	3

Average: 5.00 Total Number of Respondents: 3

7. Did you read a workshop announcement before you came to the workshop today?

	Yes	No
Number:	4	0

Total Number of Respondents: 4

If yes, did it give you a good idea of what the workshop would cover?

	Yes	No
Number:	4	0

Total Number of Respondents: 4

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

COMMENTS: Early identification of HIV infected persons is desirable both in terms of their health and welfare or larger society./HIV positive-AIDS is treatable to improve quality of life./HIV infection can be a very long term illness because of advances in medical profession./Anonymous testing should be encouraged but not required.

9. What will you do differently at work as a result of this workshop?

COMMENTS: Require cognitive assessment or AIDS patients and develop social support groups for AIDS victims in prisons./I will support and encourage AIDS-HIV counseling and networking in our community./Training of staff will be better and in depth./Not being so confrontive about denial of fatality as it serves an important function to help quality of life.

10. Please evaluate your instructor. If there were two or more instructors, be sure to mention each by name. How can the instructor do a better job next time?

Comments: All of the instructors were quite good, but I think some were a little better than others because of their visual aids and-or distribution of hand-outs covering the lectures./ Jeremy Gaies was a good facilitator and presenter. He kept the group on time, on task without being aggressive. John Grannan was available during the sessions and for the community support group which was very helpful. Robert Nelson was excellent in his ability to communicate and demonstrate knowledge, warmth and empathy to us and the patients./Dr. Gaies did an excellent job by keeping the workshop a whole. All instructors were very knowledgeable in their fields and presented their research well. It could be hard to single one of them out./All instructors were exceptional speakers who gave useful practical information (except John Ward Jr. Ph.D., but this could partially be due to me having extensive training in this area).

11. In your opinion, how could this workshop be improved?

COMMENTS: Developing handouts for‘each lecture. Including discussion of specific cases in which medical and mental health care is provided simultaneously./Expanded-more time, probably a week to be able to more fully share the ideas and experiences since it is intense./With a full workshop that would give the latest development in AIDS research and training./Have AIDS-HIV and panel be on last day. Extend workshop to 4 or 5 days.

12. What are your future AIDS training needs?

COMMENTS: Specific mental health intervention, including psychotropics that may be useful for the AIDS-HIV patients./Updates in all areas as new information becomes available./Positive updates./Updates on recent changes in all aspects (medical, social, cultural) etc.

HIV CLINICAL TUTORIAL WORKSHOP
EXTENDED EVALUATION FORM

Please answer all questions thoughtfully. Your honest and specific feedback will help us make these workshops increasingly valuable training experiences. We highly recommend that you record your thoughts and comments throughout the course of the workshop. A moment or two at the end of each session will ensure thorough and accurate notation of important reactions and comments.

Ratings of Sessions and Instructors:
(Space is given for ratings of each session and for ratings of each instructor/presenter. Please comment on the content and format of each session, and on the presentation style, organization and clarity of each presenter. Suggestions for ways to improve each session and constructive feedback for presenters are most welcome.)

Wednesday:
10:45 AM -- Mental Health Overview (Michael D. Knox, Ph.D.)

Good historical overview, I needed statistical information-would benefit from current available resources to be included./Slides could be more up to date. Presentation should be a bit longer since it sets the stage for all follow-up questions./Informative but not as up to date as I would hope it could be (with the slides)./Good overview; would be helpful if hand-outs of the presentation were provided, given the rapid pace of the presentation.

12:15 PM -- Medical, Psychiatric and Historical Issues (Charles F. Clark, M.D.)

Was very interesting and gave some things to think about. Prior to discussion, did not think of practical reasons to consider HIV testing to be requirement. However, still think society problems hold much weight. Would have liked to hear more pros and cons to required testing./Very interesting and thought provoking presentation. Well presented, clearly stated and touching on many aspects and concerns./Interesting and informative, but unrealistic in proposing religious groups will provide AIDS patients assistance (particularly if they are unrepentent victims). Cultural historical perspectives very interesting./ Excellent presentation, including time left over for discussion.

1:45 PM -- Panel Discussion

Very informative, but would have preferred to have them last day after more information was obtained./Found the discussion very stimulating and informative. Appreciated the opportunity to speak with AIDS patients and hear their sides. Was surprised at some of their attitudes./Excellent - very helpful to be able to

interact with AIDS people, both formally and informally./ Excellent.

3:30 PM -- Neuropsychological Assessment (Timothy Boaz, Ph.D.)

Speaker appeared to have good base of knowledge. I felt rushed during the presentation as time was running out--would have liked lengthy discussion in this area./Found the subject quite interesting, but felt that this area will have little application to the Mental Health Centers I work with. Wish I had more staff and-or money to do in-depth neurological assessments./Less interesting - probably not useful material as presented for my needs./Fair, needs more explicit and comprehensive information./

Thursday:
8:15 AM/10:00 AM -- Patient Assessment at the Immunodeficiency Clinic

Fascinating - brought up some legal, ethical and medical concerns I would not have thought of./Would not have missed it for anything. Allowed us to listen to the concerns of AIDS patients and the upbeat attitudes of Dr. Nelson./Excellent--Not long enough. Really enjoyed watching the process behind the scenes and with patients who are in earlier stages of information.(SIC)/ Excellent: very helpful to observe the interaction between patient and physician.

8:15 AM/10:00 AM -- Videotapes and Discussion

Very informative especially "buffer zone"./The Buffer Zone was very relevant and I will hope to use it in AIDS education of my staff. Found first video tape too salesman-like./Second film better than first. I would like a copy for our Mental Health Center./Fair; not very helpful or interesting.

1:00 PM -- HIV/AIDS Medical Update (Robert P. Nelson, M.D.)

Not really enough time for questions - would have liked handouts on this discussion of medical processes./Very clear explanation and medical update./Appreciated the follow-up from this morning's clinic visit./Good speaker-presenter. Clear and informative-personable. I would have liked more time with him. His description of "Star War AIDS" was very descriptive. Very good; informative; would be good if he could discuss a particular case in which he referred for mental health services or wished he could have.

2:15 PM -- Suicide Risk Assessment (John C. Ward, Jr., Ph.D.)

Since I have had lots of training in this area, I did not find topic useful. Also speaker was not a good presenter./Although this area is an important part and an integral part of the workshop, for me it was an "old hat" having to do suicide

assessments in emergency services./Monotone voice was a problem for my attention-hypnotic./A little too general, but fairly good.

3:15 PM -- Depression and Cognitive Therapy (Michael G. Dow, Ph.D.)

Excellent, helpful information. Enjoyed receiving handouts as they will be useful in my therapy with all depressed clients./The same as above applies to this part of the workshop./Good interaction and handouts. There wasn't as much time for dialogue as I would have liked. I think this portion could be expanded./Good.

7:00 PM -- Support Groups of the Tampa AIDS Network

It was refreshing to see supportive family members and to hear how disease has affected them in caring for their friends./Parents and friends group gave me many ideas but also made me realize what an uphill battle it will be in our area./I felt intrusive for being there the whole time. Even though I was willing to participate, I felt it stole something from their intimacy. I would have been more comfortable if it was a voluntary group at the university./Excellent to hear,from the victims, what is helpful about the group.

Friday: 8:30 AM --Network Meeting for Health Care Providers

Very enjoyable. It was nice to see a well organized group that exchange information on available resources./Astonishing amount of cooperation and resources, but I guess this is the difference between urban and rural areas./Impressive--so many people and agency participation./Fair.

9:30 AM -- Psychoeducational AIDS Module

Good to see group in action./Well presented AIDS education course. Participation of center excellent. Also shows need for continuing education of presenters because of advances in AIDS research./Excellent-staff and patients were so well informed, comfortable. Gave me hope in starting a group in my agency./Excellent opportunity to see first hand the teaching of a very important skill to mentally disordered patients.

11:00 AM -- Prevention and Client Training Issues (Martha F. Anker, Ph.D.)

It was helpful that she provided historical background and shared the stumbling blocks they encountered in forming group--excellent speaker./Good discussion about possible pitfalls and their solutions./Good./Good resource information and animated presenter made asking guestions easier.

1:00 PM -- Issues of Chronic and Terminal Illness (Jeremy S. Gaies, **Psy.D.)**

Very helpful, useful information./Very stimulating and quite thorough discussion of various topics concerning AIDS and terminal **issues./Very** good--showed the importance of good all around care to extend and provide quality **life./Good** overview of relevant issues; could be improved through use of actual case example and the care given on the care needs of these cases.

2:00 PM -- Ethical Issues (Frank **Chessa,** M.A.)

Good debating material. He was very patient with us as we were very verbal and he did not get much time to present material./Enjoyed looking at AIDS related issues and dilemmas through the eyes of the philosopher.' Found this session somewhat short but very **stimulating./Excellent,** not nearly enough time--Definitely should be longer./Good overview **of** relevant issues although, much of it I did not fully understand, particularly distinotion between systems of ethics.

Ratings of Workshop Format
(Please comment on the following features)

Pacing of Workshop Sessions

Felt needed more time with almost all **speakers./Well** done and in good **progression./Quickly** paced time flow./Good.

Lunches and Breaks

Good./Sufficient time, enjoyed informal **discussions./Adequate./A** few more breaks would probably facilitate better attention and retention of information.

Facilities

Good./Excellent./Comfortable./Excellent.

Three-Day Format

Should be lengthier. However, this may be impractical from a marketing **perspective./Area** to be covered is so large that more days could be used, but it would be difficult to get away from work./Too brief for so much--very **intensive./Excellent;** cannot cover all of the good material and information in less time.

Ratings of Workshop Materials

Brochure

Should have been more specific about length of day./Very good and **useful./Well** done--good variations in type and style for ease in scanning or reading./Excellent.

Information Binders

Excellent./Very good./Quality--I'm glad I can take them to my agency to start our **library./Excellent.**

Please use the following space to comment on any other aspects of the tutorial program, as well as to summarize your thoughts and feelings about your experience in the workshop:

Enjoyed. Extremely useful material. Pleased with **experiencial** components as it gave a lot more information than speakers could **have./Some** of the information was outdated and might not have given an accurate picture. Questions about this, however, were answered expertly. I also understand that updates are planned in the near future. Since I will be responsible for AIDS training in our clinics, I was pleasantly surprised how much more material I have now at hand to present to my **staff./I** appreciate the quality of the staff and availablility of material from this workshop. I am the third member of our agency to attend and chose to do so not only to increase my professional knowledge, but because the experience was described as professionally expansive. I found this to be true. I feel I received a needed boost in my professional life from the **experiencial** stimulation and interaction with others outside my **field./In** summary, the workshop exceeded my expectations, and I am coming away from it with some practical information that I can easily apply in my work setting. The inclusion of visitors to the medical clinics and the active support group was excellent and quite beneficial in helping me to bridge the gap between therapy and practice, between the abstract and the real. I would not hesitate to recommend this training to colleagues and co-workers.

APPENDIX XII

Evaluations Conducted

Bvaluation of University of South Florida's State-Mandated HIV Update

HOW DID WE DO?

WORKSHOP EVALUATION SUMMARY?

Workshop Title: **HIV Update For Health Care Providers**
City **& State: Clearwater, Fl** Date: **1-11-89**

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question.

1. Was the content useful and practical?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	**1**	**5**	**7**	**77**	**33**

Average: 4.11 **Total Number of Respondents: 123**

2. **Was** there enough time to cover all the material?

	Strongly Disagree				Strongly Agree
	1	'2	3	4	5
Number:	2	12	13	68	26

Average: 3.86 **Total Number of Respondents: 121**

3. Were the handouts and other teaching aids helpful and adequate?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	1	4	22	75	18

Average: 3.88 Total Number of Respondents: 120

4. Did you receive satisfactory answers to your questions?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	5	6	16	55	17

Average: 3.74 **Total** Number of Respondents: 99

5. Did the instructor seem aware of your particular skill level, and teach accordingly?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	**1**	**9**	**25**	**56**	**27**

Average: 3.84 **Total Number of Respondents: 118**

6. Did the instructor seem to have adequate knowledge and skill to teach this workshop?

	Strongly Disagree				Strongly Agree
	1	2	3	4	5
Number:	0	2	2	63	51

Average: 4.38 Total Number of Respondents: 118

7. Did you read a workshop announcement before **you** came to the workshop today?

Yes	No
107	20

If yes, did it give you a good idea of what the workshop would cover?

Yes	No
105	5

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

Higher incidence of HIV virus in family donated blood than general population donated blood./ Regarding various syndromes AIDS can mimic./ The definitive test is of antibodies the body produces to the sporadic virus. Cells with CD4 lined receptors are susceptible to HIV./ Statistics related to the number of persons with AIDS in racial-ethnic groups./ Recent laws in confidentiality. Disclosure laws./ Cocaine users are very prone to AIDS - even more so than heroin addicts./ Legal implications as to disclosure of person testing positive to HIV./ The racial statistics of incidence of HIV were informative./ There are recent advances offering hope for effective treatment of AIDS./ Increased AIDS in heterosexuals. AIDS can be present as a mental disease./ Transmission of disease./ AZT criteria./ Read CDC guidelines./ Diversity of rates, incidence & prevalence between male and female./ Specific legislation regarding confidentiality./ Seborrhea-Psoriasis association./ 50% of infants born to HIV positive mothers are HIV positive./ I now have a decreased fear of working with HIV carrying patients./ Blood from family-friends more a risk of HIV than from the general population./ Universal precautions./ Legality and responsibility of HCW./ The cultural aspects presented by D. Goldsmith./ Importance of health care law as it relates to AIDS./ Higher sipsis with in children, lent virus./ Statistics and legal aspects./ Legal implications of confidentiality./ Legal issues./ knew most of the information already./ The specific lab test CD-4 and its use in determining more specifics on AIDS./ The concept of CD-4 cells & how they relate to the severity of the disease./ Blood from related family members has a higher rate of HIV infection vs non-related blood./ God is female./ Easier to get Hepatitis. HIV is a neurologic disease./ I wasn't aware of the laws completely, concerning confidentiality./ Information on exposure and contractions./ Heterosexual incidence./ Aspects of confidentiality./ More to learn./ Certain aspects of law regarding confidentiality exceptions./ Nothing new./ HIV virus more prevalent in minority groups./ Since the cure of AIDS is not known it is very important to teach the population the ways of transmission, thus preventing the spread./ Law-confidentiality./ Only 50% transmission of HIV to fetus./ High increase in babies in Florida testing positive for HIV./ Legal- informed consent law explained more clearly. Also requirement for reporting AIDS vs HIV to HRS./ Became aware of latest definitions & statistics, particularly in reference to Florida./ Medical law./ Updated information./ virus dies quickly./ Indicators of poor outcome- early primary and secondary signs./ The state legislature has no business dictating to health workers how to do their jobs./ The legalities regarding release of HIV testing information./ There are no firm statistics on how many positive HIV's will turn into full blown AIDS or the time span. Chances are greater of getting HBV from blood spill or stick than HIV./ HIV test is confidential./ Increased education works on decreasing spread./ Legal issues./ HIV patients have a large amount of skin infections./ The legal aspects- current standing./ Laws on

confidentiality./ Confidentiality awareness, safety precautions and increased awareness of the signs and symptoms of AIDS./ Transfusion statistics./ Legal aspects./ All./ The law protects the AIDS patient and not the health care worker./ informed consent rules./ Need to use increased dosage of . . . ie antidepressants./ Florida statute regarding informed consent for drawing HIV blood test./ The legal aspect of lecture./ Do not do AIDS testing in my lab because of legal consequences./ HIV testing./ Minorities affected more./ The complexity of HIV testing laws./ 1-800-HIV-STIK./ HIV structural, antiferemia & antibody relationship./ Increased prevalence of HIV in this geographical area of Florida (6192 cases). Legal aspects were very interesting./ Immunity to liability for not disclosing AIDS information to spouse./ How to cap (re-cap) a needle./ Legal issues surrounding informed consent./ The many & varied clinical manifestations./ Hepatitis B is much more contagious than HIV./ Double check & report before informing patients./ Blood began to be treated in blood banks for HIV beginning March '85./ Information is social slant instead of health care slant./ HIV negative should not be reported to insurance companies./ High risk of bisexire behavior in black males./ Clinical manifestations of AIDS./ 50% of HIV infected mothers give birth to HIV positive babies (I thought 100%)./ HIV test reporting & dissemination of results./ Increase risk of blood donations from family members vs. general public./ The law is an ass. AIDS-HIV is communicable./ 6-8 week latency period prior to sepsconversion./ There are no typical symptoms. The entire population should be HIV tested./ Specifics of informed consent & confidentiality./ Legal issues./ Issues ie confidentiality-disclosure./ Hospital prophloxis./ Law implications./

9. What will you do differently at work as a result of this workshop?

Nothing/ Will be more aware of patient confidentiality rights. More aware of seeping skin lesions in the home care setting./ Be more aware of the various manifestations of AIDS./ Think about the possibility of HIV more./ Not working with PNA's/ Nothing./ I will be very protective of patient confidentiality concerning HIV./ Focus on legal aspects and provide accurate statistics to co-workers./ More testing- more aware of different presenting symptoms./ when & when not to use universal precautions./ Reinforce importance of confidentiality./ Nothing./ Be more specific with informed consent./ Wear gloves more often when handling blood./ Testing protocol./ Legal issue as to notification of patient & spouse. Disclosure to others. (who to & who not to.)/ Be aware of necessary precautions in handling blood./ Use gloves when handling blood specimens./ Do more teaching of SAFE SEX./ Pay more attention to the law./ Aggressive inservice regarding prevention & confidentiality./ Be more aware./ Ask residents regarding history of blood transfusion./ Nothing./ Be more cautious around blood & body fluids./ Nothing in particular./ Wash & were gloves./ I am already very comfortable with my method of caring for potential & known HIV + patients./ More preventive measures./ Be very careful when drawing blood &

disposing needles./ NA/ Keep a low profile./ Not recap needles./ Nothing new./ Better infection control./ Retest all positives before giving out results./ Nothing really since already have had this information especially related to Universal precautions./ Probably nothing./ Nothing./ Nothing different./ Be more aware./ Phlebotomy precautions, gloves./ Read more: be more alert./ Nothing./ Secure HIV information./ Stress confidentiality of files to clerk staff./ Glove for all patients & caution on disposal in biohazard covered trash cans./ Nothing of any note. /Council the clerical staff who copy records for insurance companies./ Recheck all positives HIV to rule out false positives./ Wear gloves in or circulating. Treat everyone as infectious./ Enforce the universal barrier precautions. Make more information available to staff patients./ More testing for HIV./ Use more caution to protect the HIV patient from infections and protect myself from blood or body fluids from HIV patients./ Emphasize confidentiality./ Nothing./ Increase safety precautions to improve precautions (SIC)./ Decrease transfusions./ Provide education to all patients./ Observe all staff to be sure they are following all sterilization methods./ Not order HIV testing./ Use infectious disease personnel more effectively./ Contact attorney if positive HIV test is obtained./ Treat sharps more carefully./ Watch legal complications./ Probably not test for HIV until the legislature makes it possible to treat patients rather than the paperwork./ Insure we use 1-800-HIV-STIK for our folks./ Not much, perhaps able to do better counseling./ Needles won't be recapped or will recap with proper method./ Nothing./ Never order HIV tests- refer to USF (I'm not kidding.)/ Continue to be cautious: probably not order HIV testing, but refer these patients when indicated: too many requirements for informed consent and counseling./ Be aware of the many manifestations./ Take greater precautions./ Nothing./ Retired./ Study the law as it applies to testing for HIV, etc./ Use condoms./ More caution with techniques for sharps with health care provides./ Nothing./ Withhold Fasi's political comments./ Reinforce present policies./ Increase caution in handling of body fluid specimens./ Nursing procedures to be updated and supervised./ Nothing./ Be careful of informed consent and confidentiality./ I think this workshop has been excellent./ Be aware of legal issues./ Continue careful record keeping, review law within office./ Nothing./ Nothing./ Nothing./

10. Please evaluate your instructor(s). If there were two or more instructors, be sure to mention each by name. How can the instructor do a better job?

(Nelson) extremely information detailed. Information well organized./ Need pointer; listing statistics especially appropriate for physicians (M.D.'s); some slides not readable from some distance, pictures more interesting./ Excessive detail, monotonous voice didn't sound interested./ Too many statistics and slides_/ Knowledgeable and understandable_/ Excellent./ Excellent./ Fair./ Excellent, very knowledgeable./ Adequate, organized, good slides./ Very good./ Many new points./ Good./ Good./ All were very knowledgeable & concise./ Excellent./ Good./ Knowledgeable and had good presentation./ Very good./ A little

too dependent on slides & didn't always seem sure of topic./ speak louder./ Excellent./ Excellent./ Good but too rushed./ Well informed./ Okay./ Poor speaker./ Okay./ Very good slides of rashes & etc./ Good slides, good presentations./ Fair./ Good./ Very enlightening concerning biochemical & clinical information./ Good./ Excellent, but more time needed for further discussion./ Very dry. The information was valuable but presentation was dull./ Excellent./ Knowledgeable, good information./ Very Good./ Very good./ Spoke too rapidly./ Fair./ Great./ Use less data per slide./ Excellent./ Epidemiology if HIV- many charts and graphs./ No Q & A sessions./ Good./ Good overview of the scope of the epidemic./ Good./ Okay./ Excellent speaker, relevant, easy to listen to and understand./ Excellent./ Very Good./ Never got to the point, rambled./ Redundant./ He is knowledgeable but put us to sleep./

(Fasi) dynamic and refreshingly controversial./Good voice presentation; interesting; shared his own views; He did a very good job./ Very good- dynamic informative- thought provoking./ I felt that he made some comments that were unnecessary and uncalled for directed at gay persons ie Rock Hudson, etc./ Excellent speaker./ Excellent presentation of legal responsibilities of Medical Community./ Extremely interesting & practical. /Excellent./ Very good./ Good./ Fantastic, brought up lots of questions which should prove interesting in the future./ Get rid of./ Excellent; factual, & clear./ Very good./ Excellent coverage./ Good./ Legal issues very interesting & informative./ Very good. Presented good factual information./ Very knowledgeable and concise./ Not enough information is available to the average worker in other departments of Health Dept. except those associated mostly with AIDS or STDS./ Excellent and was prepared in his particular field. / Good./ Excellent more real life situations./ Good./ Good./ Knowledgeable and gave good presentations./ Very good./ Well versed in the law./ Excellent./ Excellent./ Excellent./ Good but was too rushed./ Well informed./ Okay./ Okay./ Very good issues, need to plan more time for cases and Q & A./ Informative & interesting speaker./ Good./ Very good don't fire him./ Very good & practical./ Excellent./ Good. Hand out on legal aspects./ Good concise information./ Good./ Excellent, wish he could have talked longer./ Excellent./ Informative./ 5./ Interesting speaker. / Very good./ Legal issues very well done. Shame to loose this instructor to Wisconsin./ Legal issues of HIV, good information./ Good talk, need more./ Okay./ Withhold practical views, etc. ie comments regarding DPR./ Excellent./ Very Good./ Adequate./ Some good facts./ Good presentation./

(Russell) very clear. well organized. Good presentation./Good, interesting, weak enunciation & grammar, talks too rapidly./ Good presentation of control in health care setting./ Knowledgeable./ Excellent./ Good./ Very good./ Okay./ Good clear & concise./ Good points. / Good./ Informative./ Very knowledgeable and concise./ Very good speaker./ Great./ Good./ Knowledgeable & gave a good presentation./ Very Good./ Good presentation./ Excellent./

Fair./ Good but too rushed./ Treatment & counseling in minority groups./ Okay./Good down to earth information./ Very good./ Very good. Practical but short and sweet./ Excellent./ Good./ Offered many practical nursing solutions. Interesting speaker./ Excellent./ 5/ Interesting speaker./ Very Good./ Excellent./ Great./ Excellent./ Very good./ Occupational rules, infections control, okay for nurses, not for doctors./ Good./ Okay./ Excellent speaker. Answered most questions./ Excellent./

(Brandenburg) Rather dull statistics./ Very good factual information./ Fair./ Very good./

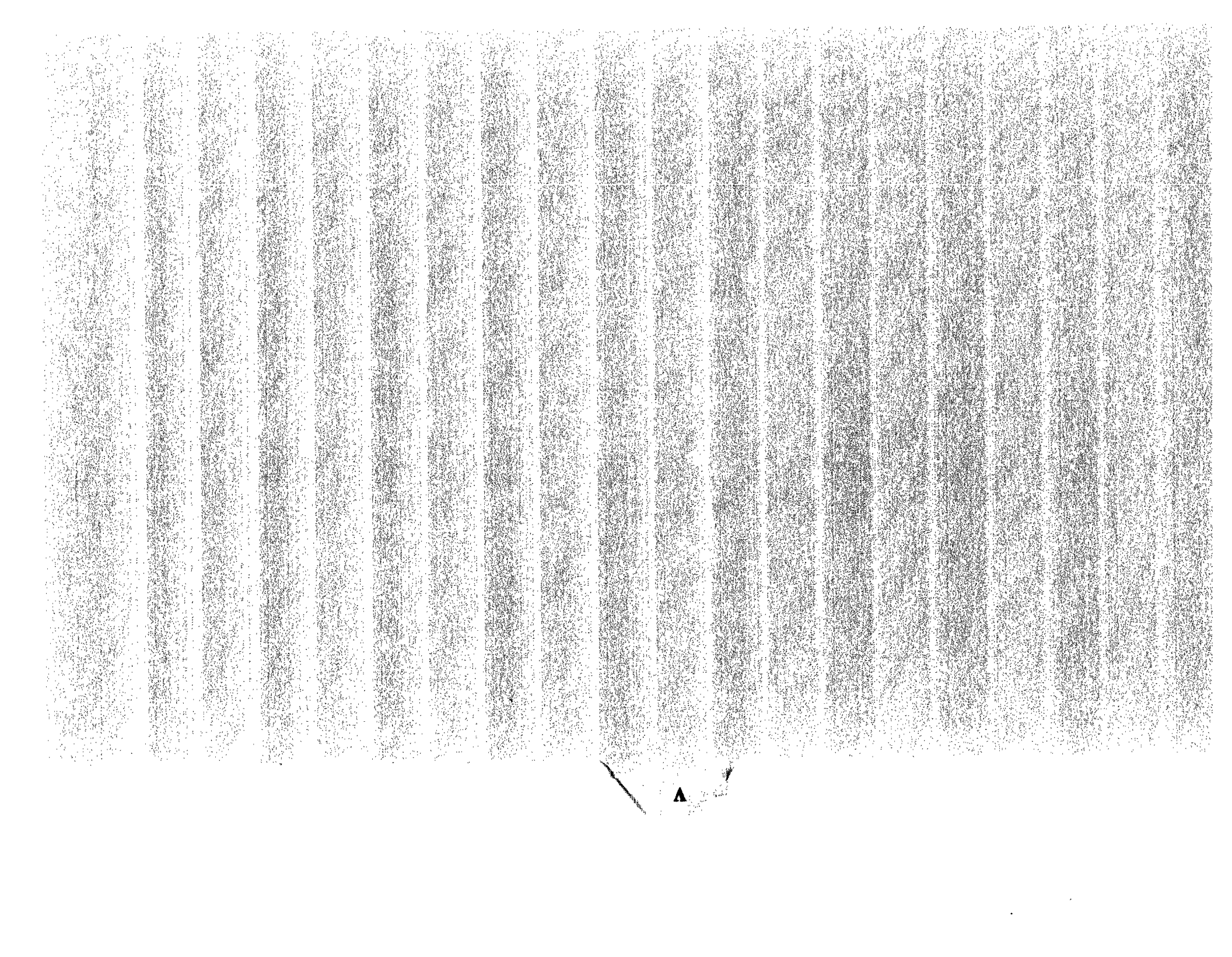
11. In your opinion, how could this workshop be improved? Fine/ More lights on during visual, the slides were all not clear, personality were good, less stats more personalities./More focus on psychological factors./ Written agenda so we can refer to./ Have more dynamic presenters like the lawyer who do more than read statistics. Keep the pictures of skin infections in the presentations. Clearer focus on slides./ Acknowledging the varied background of those present- (Defining terms, moderating details) The first speaker should define the major terms./ Too medically oriented. What about other health care professionals and their needs?/ Have a break./ Medical translation to layman's terms./ Better slides and pictures./ Expand to an all day presentation to cover material more thoroughly./ I think 3 hours without a break is-too long./ Delete repetition of pathophysiology of AIDS,(Virus, antibodies, etc.). Short scheduled break./ More information on counseling patients & contacts./ Decrease verbatim statistical quotes./ An update in use of "crack" and increase of HIV + persons due to use of "crack" for sex or sex for "crack". A break for programs that are 3 hours long. Provide an opportunity to ask questions./ Make overheads larger- unable to read from back of room./ Pretty good as is./ Make it longer. Please get speakers whose information does not conflict./ Just right./ Osteopath's also have specialities as do the M.D.'s/ I would've liked to have been able to see the speakers./ NA/ Make it a bit longer- then you could ask questions after each speaker as well as discussion groups./ less sarcasm more scientific information./ Workshop is excellent./ The room was too cold. Eliminate the 2nd and last speaker./ Three hours without a break is ridiculous./ To increase time from three hours to possibly four hours./ Would like less statistics & more on practical information for practicing community health providers./ Less medical terminology, less slides, more questions & answers per speaker./ Longer discussion on clinical presentation & treatment & update information./ If the state requires health workers to attend these sessions, then they should fund the workshops./ It was an excellent presentation. Three hours was long enough to present information without putting people to sleep./ More on the "law"./ More intervention oriented, psychological aspects of AIDS, Social implications./ We need a small break./ Do not need repeat of epidemiological data./ Provide one intermission half way through to allow for all the material to be available without

interruption./ Could not be./ Have question & answer session at end./ Extend the time./ Well done./ To have more speakers who are experts in the field of AIDS./ Yes./ More condensed./ Possibly could not be./ Allow more time on certain subjects especially on client handling & laws./ Have a mid workshop break. At least stand up, or else tableside urinals./ No improvement needed./ Have slides that could be read from our seats. Have a list of instructors & topics in the hand out. Organization of meeting was poor./ Illuminate speakers for lip readers. Program with name & subject of speaker./ Gear it more to specific needs of health care workers./ Need a break. Also a question & answer period./ Keep the lights on. Less slides. Much less emphasis on statistics. Speaking without reading notes./ Have more question & answer time. Have instructors "hang around"./ At least one 10 minute break./ More positive answers used if there are none, so indicate./ Fine as is./ More question time./ Less statistical analysis./ More information about AIDS as a disease and a social problem./

12. What are your future AIDS training needs?
For Florida renewal of license./ BASIC- Basic lay people training seminars for employees with high school education and less./ Unknown./ More about psychosocial impact on patients and their families, friends, etc./ More in depth study of legal aspects./ Review of direct patient care updates./ What are the clinical implications & issues to address for psychotherapist./ Continue update./ None- until additional information is provided for my knowledge./ Mental health issues, bereavement anticipatory grief, death & dying./ Safe sex./ Counseling skills, more legal issues./ Treatment modalities./ None until new information received such as new treatment, vaccine./ Updates. Nursing care for AIDS patients. Public Education for transmission and prevention of AIDS./ More clinical orientation./ Continued updates of the disease & the legality involved with this disease./ Case studies with specific local resources./ Caring.for children with AIDS./ Update on immunology, changes (if any) in care of the AIDS person./ None at this time./ As needed for relicensure and as date and information becomes updated, changes in practice noted./ Simple information for patient education, booklet, etc./ Continued updates./ Periodic updates, just like this one./ Continue with new facts as they arise./ Any new information available./ Updates as new information is made available./ Employer liability./ Any new information./ To be updated on any changes, new treatments, breakthroughs./ More on legal issues./ Continued updates. More information on medications. S&S of side effects./ All new information./ Probably none at this time./ AIDS related to clinical practice, issues related to counseling with AIDS patients./ Continued update lectures./ Somehow briefly summarize all the research data and to conclude the talk./ Updates as new information is found through research./ More information on universal precautions & specific guidelines for prevention. Diagnostic work & observation of HIV + infants./ Apparently nothing as the state legislatures seem to know best and will tell me./ Changes in law, treatment, etc./

Additional legal information. Psychological needs of AIDS patient (relationship to family & community)./ None except more awareness given by newsletter./ Updates as information changes or increases./ Psychosocial needs of the AIDS victim./ Continual legal updates./ More courses or seminars in AIDS./ Continual updating./ Depends on what requirements are for recertification and relicensure./ Continual updates./ Cure./ Update./ Economics and clinical issues./ Updates annually./ Done through reading./ More of the same./ How to finance family's move to an island somewhere safe./ None./ Emotional issues./ Some information about public health services overall for referral & treatment.

MANY THANKS!



EAST CENTRAL REGION AIDS EDUCATION AND TRAINING CENTER (ECAETC)

EVALUATION REVIEW

I. OVERVIEW

The East Central Region AIDS Education and Training Center (ECAETC) is coordinated at regional headquarters at Ohio State University and serves a four state region of Michigan, Ohio, Kentucky, and Tennessee through the collaborative efforts of the Cincinnati Board of Health in conjunction with the University of Cincinnati, Meharry Medical College, Ohio State University, the University of Kentucky, and the University of Michigan. The five specific goals address organizational functions, materials development, education and training, information collection and dissemination, and curriculum infusion.

The program strategy of ECAETC is fivefold:

- to focus on the education and training of primary health care providers on prevention and treatment of AIDS,
- to offer guidance in the development of a multidisciplinary approach to the management of HIV-related conditions,
- to provide training to selected individuals to train others,
- to provide updates of new and timely information about HIV/AIDS to primary and secondary health care providers,
- to establish a support system for area health professionals through hotlines, clearinghouses, referral activities, and the development of learning resources.

Evaluation activities include project monitoring, goal attainment, formative evaluation of materials, and participant assessment of presentations and trainings.

II. ADMINISTRATION OF THE EVALUATION PROCESS

A. The Evaluation Plan

The evaluation of the East Central AIDS Education and Training Center (ECAETC) was designed to provide information concerning the scope and effectiveness of the Center's education and training efforts. ECAETC conducts evaluation activities on three levels: project evaluation; evaluation of individual education and training interventions; and formative evaluation of training materials. Project evaluation focuses on issues of organizational development, and the breadth and scope of dissemination of its programs; goal attainment is measured in terms of task accomplishment and outputs. Evaluation of specific education and training interventions focuses on the responsiveness of the intervention to the needs of the attendees as well as the attendees' assessment of the quality of the presentation. Formative evaluation of training materials is based on "expert reviews" of content, and user reaction and feedback.

1. The Plan as Proposed

According to **ECAETC's** initial grant proposal, the project was to be evaluated in terms of the scope and effectiveness of its education and training efforts. The methods used to evaluate these efforts were to include:

(1) trainee assessment (exams, attitude scales, and self-report checklists);

(2) educational materials assessment (formative evaluation by experts, trainers, and trainees of seminars, computer-assisted instruction, Ohio Medical Education Network (OMEN) programs, and videotaped instruction segments);

(3) annual reports of numbers and types of trainees served (and trainers trained);

(4) annual estimates of' training costs per trainees;

(5) annual surveys of learners' professional associations and organizations to determine needed adjustments or additions to the **ECAETC's** cadre of AIDS educational offerings; and

(6) observations of trainees and trainers during and after their participation in the educational programs. These observations were intended as quality control measures to ensure a match between educational objectives and performances.

Evaluation instruments were to be designed in such a way as to permit comparisons among groups of trainees and educational strategies. Where appropriate, evaluation data would be analyzed to compare the relative effectiveness of various instruments as data are readily available, such as in OMEN. Arrangements would be made to include such information in the **ECAETC's** annual evaluation reports.

The initial evaluation plan called for a phase-in of evaluation activities during the three years of the grant:

Year-One Evaluation Plan

For Year-One, the plan included monitoring program development, development of evaluation instruments, needs assessments, evaluation of educational materials, and collection and analysis of evaluation data on trainees trained in the first year.

Year-Two Evaluation Plan

For Year-Two, there was to be an increase in all evaluation activities, especially evaluation of trainees and evaluation of the various instructional strategies and media used. Monitoring of **ECAETC's** progress in meeting its program goals, was to continue in the

form of tallies of numbers of trainees, costs per trainee, and observation of training activities.

Year-Three Evaluation Plan

Year-Three evaluation ac-tivity was scheduled to parallel those of Year-Two.

2. Implementation of the Plan

ECAETC's evaluation as actually carried has varied somewhat from the original plan. To a large extent, this is as one would expect since the environment one encounters in implementing a program is rarely identical to that predicted in the planning process.

A review of **ECAETC's** evaluation measured against its plan 18 months into the program revealed the following:

(1) Instrument Development (to be completed during the first nine months of the project)

-- monitoring instruments have been developed and are in place

-- a model participant feedback form has been developed
-- no instruments have been developed centrally to measure changes in knowledge, attitude, intention to practice

(2) Trainee Assessments (data collection, analysis and reporting was to have been carried out in the last quarter of the first year, and then on an annual basis)

-- the central data base is now established for the entry and analysis of trainee assessments

(3) Assessment of Educational Materials (data collection, analysis and reporting was to have been carried out in the last quarter of the first year, and then on an annual basis)

-- assessment of educational materials has been carried out as planned. Of particular note was the pilot test done for the **CAI** module for physicians

(4) Annual Report of Number of Trainees Served and Costs per Trainee (data collection, analysis and reporting was to have been carried out in the last quarter of the first year, and then on an annual basis)

reporting of number of trainees served has been carried out as planned

no reporting of cost per trainee, beyond gross figures, is available for this review

(5) **Annual** Needs Assessments of "Client" Organizations' Needs (annual surveys to be conducted)

-- these needs assessments were carried out during the first year using **"key** informant" rather than survey methodology

(6) Observation of Trainees During and After Training (data collection, analysis and reporting was to have been carried out in the last quarter of the first year, and periodically thereafter)

-- no observation was reported during this period

(7) Overall Center Program Evaluation (ongoing monitoring to be carried out with reporting annually)

-- monitoring and reporting carried out as planned

To some extent, the variance between planned and actual with regard to development of instruments to assess trainees, the conduct of these outcome assessments and observation of trainees in action might be explained by the fact that the development of standardized multi-disciplinary core and discipline-specific curriculum has just been or is still being completed, and therefore evaluation of their outcomes could not be expected to be in place. However, at the site visit, the Project Director indicated that, given the limited funds of the project, efforts would be directed at providing training rather than evaluating outcomes. It is not clear, at this time, whether ECAETC plans to drop outcome-oriented evaluation entirely.

B. Locus of Responsibility

1. Staff

The locus of responsibility for evaluation at the project level is lodged with the Evaluation Coordinator. By design, the Evaluation Coordinator for the ECARTC Project serves two roles: 1) internal support of all project personnel regarding evaluation, and 2) external evaluation of the project as much as is feasible given that he is a project staff member himself.

Neil Smith, M.S. is the Evaluation Coordinator. Mr. Smith who holds a degree in Business and Management Organization with a specific focus on performance evaluation, joined the project in the spring of 1990. Initially, James **Pearsol,** M.Ed. served as the Project Evaluation Coordinator. Toward the end of the first year of the project, Mr. **Pearsol** took on the responsibility of **ECAETC's** Center Director as well as the Director of the Ohio State University site. He was replaced as Evaluation Coordinator in the second year of the project by Robert **Aron, M.A., a graduate research associate and Ph.D. candidate** in training and development, who had served as coordinator for the **OSU** site in the first year of the project.

In addition, several of the sites have assigned individuals to conduct local evaluation efforts as is noted below.

2. **Advisory**

Built into the structure of ECAETC is the Criteria/Assessment Advisory Committee, consisting of representatives from city and state health departments, Sexually Transmitted Diseases (STD) centers, Area Health Education Centers (AHECs), organizations providing services to individuals displaying risk behavior vis a vis AIDS, at-risk individuals and minorities.

In addition to taking an active role in identifying specific behavioral objectives to be targeted by ECAETC's training interventions, this committee has been assigned responsibility for conducting various aspects of ECAETC's evaluation. The majority of the seven meetings initially scheduled for this Committee were to focus on evaluation, devoting one meeting each year to formative evaluation and one to summative evaluation. In the first year, the formative evaluation was to focus on activities concerned with existing and prototypic materials, while summative evaluation was to monitor the progress of the project as of the end of the year. While this Committee has reviewed media and curricular materials both individually and as a group, it is not clear whether this can be functionally considered a formal evaluative role.

3. **Sub-Contractors**

All of the sites are engaged in evaluation activities and, with two exceptions, the site directors hold responsibility for the design and implementation of program evaluation. Judith Presley in Tennessee, Judy Stephenson in Kentucky, and Ronn Rucker in Cincinnati are specifically responsible for evaluation activities at their site.

4. Evaluation Consultants

Early in the project, the ETC engaged the services of a team from Cornell University to do an audit of its evaluation activities. The audit of ECAETC's Year-One evaluation activities has been completed. The plan and materials for the audit is included in Appendix I.

ECAETC originally planned to have additional audits conducted. However, ECAETC was not entirely satisfied with the first audit and, given the fact that HRSA had subsequently let an evaluation contract, ECAETC has dropped this plan.

C. Coordination of Evaluation Activities

The individual sites are responsible for the evaluation of their programs. The master data base at central headquarters is available and sites can send in their evaluation forms which can be entered and summarized for them. Responsibility for analyzing the data and for generating reports, however, remains with the site. The evaluation coordinator attends all site director meetings and evaluation is a topic on the regular agenda.

D. Reporting of Findings

Currently reports are generated by site and the central headquarters generates annual reports. Neil Smith, the Evaluation Coordinator, plans to institute a quarterly reporting format. Performance evaluation forms for the OMEN and teleconferences are regularly entered and summaries generated. During late summer 1990, a data base was set up so that sites *can* submit program specific evaluation forms and then send in data to the central headquarters. Central headquarters is capable of generating basic summary statistics with breakdowns for any specific variables and can produce mailing labels as well. Examples of Database outputs are included in Appendix II. Page three of Appendix II illustrates a cumulative summary from program and service records. When sites do submit data to central headquarters for processing, the sites remain responsible for the analysis of the evaluation results and for the specific reports.

III. APPROACHES TO PROJECT EVALUATION

ECAETC's project evaluation is managerial in emphasis. Using this approach, ECAETC monitors and documents whether it accomplished what it set out to do in terms of structure, process and outputs. Thus, the main thrust of its project evaluation is essentially that of a management audit. In their own words, "evaluation is part of the methods and procedures to control the operations, to determine resource allocations, to keep the project on track, and to alter or eliminate steps or procedures that do not contribute to the attainment of the project goals and objectives."

The basis for the managerial approach the systematic specification of goals and objectives in a cascading hierarchy, from general to more specific and measurable, reminiscent of Management by Objectives (MBO). This goal and objectives specification was done as part of its initial planning process. At that time goals and objectives were formulated on three levels: Project Goals; Major Project Objectives **(MPOs)** and Specific Measurable Objectives **(SMOs).** The management audit documents the achievement of the goals and objectives.

While the accomplishment of many of the **SMOs** is documented through simple observation, as indicated above, ECAETC has gone to great lengths to develop elaborate monitoring systems to document performance with regard to several of the objectives, many of which are worthy of highlighting.

(1) Co-Sponsorship of Educational Programs

ECAETC tracks co-sponsorship of educational programs at its various sites using the Application to Co-Sponsor Educational Programs form. According to ECAETC, this form is an evaluation form in the sense that it provides ECAETC Site Directors with basic information about potential co-sponsors' plans for future ECAETC programs.

(2) Networking and Information Dissemination

Much of the success of the HRSA ETC Program hinges on establishing effective relationships with local, state and federal agencies and professional associations in the

region in order to provide education and training to health care providers.

Documentation of networking and dissemination contacts provide ECAETC with some indication of the extent to which its sites have developed linkages and liaisons with organizations, associations and agencies in the region for the benefit of health professionals needing education about AIDS.

Networking and information dissemination activities are tracked via The Networking and Information Dissemination Record.

(3) Education and Training Programs Provided

ECAETC tracks its education/training offerings using The Program and Service Record. This form provides for the collection of information on the nature and scope of the Center's educational programs and audiences served. Data on each offering include: site; date; title; level of ETC involvement; training method; media support; attendance by discipline, by ethnic background, and by urban/rural distribution; and participating staff.

A. Monitoring

As noted above, ECAETC has established a monitoring system data base that can include program and service record reports, attendance sheets, and networking forms to keep track of activities and contacts. A variety of summary data can be generated: individual case records, program titles, lists of participants attending a given activity, activities within sites, activities within a specified time period, various target audiences, as examples.

Yearly site visits are conducted by central headquarters staff. Documents are reviewed and the quality of functioning at each site is discussed. The evaluator conducts an "interview based case study" which facilitates analysis of the key issues affecting the site over the course of the year. A formal report is generated and included in the progress report. A sample of an Evaluative Site Visit (July 1988) can be found in Appendix III.

B. Output Evaluation

ECAETC reports that, on the average, at least one education and training event is offered weekly. As of Spring 1990, ECAETC reports that 39,300 participants attended education and training programs and that an estimated 173,000 additional health care professionals were reached through satellite video and audio teleconferences for an estimated total of 212,300 health care professionals reached.

c. Cost Efficiency and Cost Effectiveness

ECAETC reports, annually, on cost per program but does not, to date, generate cost efficiency or cost effectiveness analysis.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

ECAETC products are submitted for three levels of review: all materials are reviewed within the site by identified experts in the area; they are then revised and shared among the various sites for an across site review; material is then submitted to the advisory committee for the third level of review by outside experts.

In some instances, the formative evaluation is expanded to include a field test. This is the preferred method of the Kentucky site in the development of their curricula, although they have not yet had the opportunity to implement this phase.

OSU has conducted a field test of its "Vignettes for Physicians" computer-assisted instructional module. For the field test, five copies of the instructional module which included the diskettes, the documentation describing the programs and a draft of its CME posttest questionnaire were sent to each of the Site Directors. The Site Directors were to choose five physicians in their areas to serve as field test participants. Participants were to try out the CAI modules on their own PCs. Participants were asked to provide feedback on the modules in the following areas:

Content

- Importance
- Practical Value
- Improvement in participant's knowledge
- Participant's interest in the material
- Adequacy of coverage of AIDS topics
- Would participant recommend module to others

Educational Media Used

- Quality of computer presentation
- Ease of use
- Value of format

A review of selected evaluation questionnaires revealed a positive response to both the content and the computer format with only minor problems encountered in the use of the modules.

In addition, the field test provided for more qualitative feedback on the content. Participants were asked to make printed copies of the material at any point where they encountered difficulty and to return their comments on these sheets.

An example of the format used for product development and evaluation can be found in Appendix IV.

V. APPROACHES TO EVALUATING EDUCATION AND TRAINING OFFERINGS

A. Standardization of Evaluation

A generic form, The ECAETC Program Evaluation Card, has been developed to evaluate any of ECAETC's programs. It is an optional form available to all sites and allows ECAETC program attendees to give basic evaluative feedback on the specific offering. The form allows for the systematic collection of data on the participant's assessment of content (importance, practical value and improvement of knowledge) as well as their assessment of the educational process (quality of presentations, quality of handouts, quality of setting). The Program and Service Record form can be found in Appendix V.

B. Formative Evaluation of Training Events

Various sites report that they regularly use evaluation forms that include questions about the process, content, and faculty for training events. The University of Michigan site, for example, includes a general evaluation form (see Appendix VI) to be filled out by participants that includes the following items:

- 0 major area of practice
- o assessment of the experience:
  - was this course a learning experience?
  - would you recommend this course to others?
- o open ended judgments:
  - what parts were least valuable?
  - what topics should be included in future courses?
  - what speakers should be invited back?
  - what speakers had unsatisfactory presentations?
  - comments
- o ratings of course elements:
  - to what extent was material too advanced or too elementary?

The train-the-trainer programs (TOT) developed at the Kentucky site include a post session evaluation instrument that asks participants to rate various elements of the conference (see Appendix VII, pages 18-20)

C. Approaches to Evaluating Training Outcomes

The Kentucky site, with its emphasis on train-the-trainer activities, has developed a reporting instrument that facilitates the examination of training outcomes. The training plan (see Appendix VII, pp 13-14) included in the TOT participant packages lists a series of questions that may serve as a guide for planning future training activities. Participants are asked to complete this form and submit it to the University for each training event. Thus, this form can serve as a potent follow-up to the training. Participants are asked to identify the following:

- o target audience
- o recruitment plans
- O needs assessment
- o major content (outline/schedule)
- o length of program

- o methods
  - -speakers
  - -audio visuals
  - -skill demonstration/practice
  - -discussion questions/interactive activities
  - -handouts and aids
  - -instructional set/closure
  - -facilities
  - -evaluation methods

The site reports that phone follow-ups to participants enable the site to determine which participants are actually conducting activities.

1. Evaluation of Program Effectiveness

Programs are evaluated by participant assessments which include opportunities for respondents to rate various elements of the educational experience.

The Kentucky site TOT program for dental professionals includes a post session evaluation instrument that asks participants to rate their level of confidence about their knowledge and abilities in a variety of areas. This instrument and others referred to above are part of Appendix VII. The post session evaluation instrument may be found on pp. 18-20. Participants offer a rating of 1 (no confidence) to 4 (very confident) for the following items: (form attached)

- o AIDS epidemiology, transmission, and treatment
- o Infection control procedures
- o Recognizing and treating oral manifestations of HIV disease
- o Analyzing training needs and setting goals
- 0 Planning an effective training program
- o Evaluating a training program.

In addition, participants are asked to indicate a yes/no to each of the following items:

- o The program increased my knowledge of HIV disease‘
- o The program increased my knowledge of infection control
- o The program increased my knowledge of dental management related to HIV disease
- o I developed new skills as a trainer from this program

Answers to these questions offer an indication of participants’ assessment of program effectiveness.

2. Evaluation of Program Impact

Evaluation of impact has not been explicitly addressed by the ECAETC. Some evaluation activities which begin to address the issue of impact have been planned by ECAETC. A report issued in early November 1990, notes a follow-up to the AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals which is able to offer a measure of professional impact resulting from the additional training provided to

dental professionals by those trained at the February 1990 session (included as part of Appendix VII).

Short-term impact is a measure of the immediate changes produced by an education or training. ECAETC's initial evaluation plan included "Trainee Assessment ", which, depending on methodology, could serve to evaluate short-term impact. As previously mentioned, it is not clear whether this evaluation strategy will still be pursued.

ECAETC evaluation forms now regularly include an item for behavioral intention ("What will you do differently as a result of your participation in this program?"). Answers to this question can provide baseline data for subsequent follow-up studies.

The University of Michigan site, for example, includes a general evaluation form to be filled out by participants that includes a measure of behavioral intent: "as a result of this conference, will you do anything differently in your work setting?" (see Appendix 6, item 5).

The ECAETC program included needs assessments, which if pursued vigorously, could have provided baseline data for subsequent studies of mid-range impact. However, methodological and implementation problems limited the usefulness of the data:

- As discussed in the case study, the generalizability of the data collected in the survey of primary care providers is limited to one state due to the skewed response to that survey.
- The rather informal, key informant approach to assessing the needs of organizations serving low-income and minority populations, and the needs of high risk populations and those providing their care limits ECAETC's ability to use this information for baseline data to an anecdotal assessment of the impact of its program on these groups.
- A systematic assessment of curriculum needs has not yet been conducted. The proposed "discrepancy model" methodology to collect baseline data coupled with qualitative data to track ECAETC's activities to influence curriculum has the potential of yielding good data for the assessment of impact of this aspect of its program.

Further, no plan is currently in evidence to do repeat needs assessments and thereby document changes.

VI. EVALUATION CONDUCTED

In Year-One, the bulk of the programs delivered were the short, content lectures. The collection of evaluative data, using the Program Evaluation Card (Appendix V) had not been as widespread as it was hoped. Assessments were completed by 2,717 attendees, about 12% of the 22,470 individuals attending ECAETC's offerings. In the case of the Kentucky site, for instance, no data was forthcoming. On the other hand, for those that were more directly under the control of ECAETC, feedback on program

quality and materials was more readily available (e.g. Ohio site obtained assessments from 23-29% of their attendees).

On the whole, the results were favorable. 88% recognized the importance/value of the training content. 92% reported an increase in their knowledge. 88% attested to the quality of the presentations and materials. 88% felt that the overall quality of the program/presentation was good.

Site Directors have been encouraged to use similar, and more extensive, forms. These forms tend to collect qualitative data that will enable the site to improve future programs (i.e. formative evaluation data). They ask for participant feedback on the most valuable and least valuable aspects of the program as well as specific ways future programs could be improved.

Some of the sites have actually begun to address the "outcome" issue by asking participants "as a result of this program, will you do anything different in your work setting?" (See Appendix VI).

Specific examples of evaluations conducted and of the reports generated are included below.

A. Evaluation of an Annual Conference

ECAETC's first Annual Conference, held September 23 and 24, 1988 in Cincinnati was evaluated by Evaluation Coordinator, Bob Aron, using quantitative and qualitative methods. The evaluation report, included as Appendix VIII, considered specific questions related to the goals and objectives of the conference. Although this activity took place two years ago, the specific information is offered here to illustrate an evaluative analysis of an event:

Evaluation Questions and Answers:

- Why was ECAETC unable to meet its projected target of 1,000 conference participants?

  This question was investigated from the perspective of the Ohio site, the other ECAETC sites and the Continuing Medical Education Office. This aspect of the evaluation revealed that the magnitude of the marketing task was not fully appreciated by all concerned and that various planners did not fully understand the role of their co-planners.

- Did the General Session reach the appropriate audience?

  The objective of the conference to reach 30% physicians, 30% nurses and 30% other. Instead, only 19% of those who attended were physicians and 16% were nurses. The vast majority (37%) were dentists. The evaluation does not attempt to explain why the focus of the conference was changed to attract dentists.

Only 11% of the conference attendees came from rural areas. Although no locational target had been set for the conference, the response from rural providers was lower than ECAETC's expectations. This focused attention on the need to do a better marketing job to this target for future conferences.

The ethnicity of the conference attendees was two-third white and one-third minority. No comment was made regarding this.

o Did the General Session meet the needs/expectations of the participants?

Over two-thirds of the participants felt the conference met or exceeded their expectations. However, the most useful information, in terms of formative evaluation, comes from those who were not fully satisfied. From these participants, ECAETC learned the importance of the use of good audiovisuals and handouts and obtained suggestions for future topics to be covered.

o Did the Workshop sessions meet the needs/expectations of the participants?

Three workshops were offered: Treatment of Persons with AIDS; Ethical/Legal Issues-Who Can You Tell; and Understanding the Patient with AIDS. The freedom to choose from among the workshops provided an ad hoc "demand assessment" in which the participants Voted with their feet. " The greatest number (53%) chose ethical/legal issues, while the fewest (13%) chose understanding the patient.

Response with regard to how well expectations of workshops were met parallel those of the general session.

o How were the adjunct features of the conference received?

Three adjunct features of the conference were investigated: the National Hospice Organizational Conference; the Academic Dentistry and AIDS Training Institute; and the resource display/purchase area.

It was felt that the combination of these three adjunct features with the conference was a productive symbiotic relationship, particularly as the first two contributed to the attendance of the conference itself.

o What were the greatest weaknesses of the conference?

The greatest weaknesses centered around logistics and point to the importance of logistical issues in conducting a successful conference.

B. Evaluation of Computer-Assisted Instruction (CAI) Programs

When ECAETC published its first computer-assisted instruction program, **"AIDS** – Vignettes for Physicians" two evaluation instruments were included in the commercially packaged program. The first was included to provide the ETC with ongoing feedback from the users regarding the appropriateness of content as well as the usefulness of the media format. The second is a post-program knowledge test which, in addition to enabling users to obtain Continuing Medical Education (CME) credit for having gone through the program, could provide the ETC with outcome data for evaluating the effectiveness of this program. Results of these evaluations are not currently available.

C. Evaluation of **Michigan** Based Program: Providing Care for Persons with HIV/AIDS

Offered in October **1989,** the Statewide conference for Michigan Physicians, Nurses, Social Workers, and Other Health Care Professionals was offered to assist health care professionals to make the transition to providing care for patients with HIV. Two hundred and seven health care professionals attended the conference and, of these, 152 completed the evaluation form. Participants were asked to rate the conference by answering the question "was this course a learning experience", On a rating scale of **1(no)** to **5(yes),** the participants offered a mean rating of 4.1. Participants were asked to rate the material presented in the course on a five-point scale of 1 -(too elementary) to 5 (too advanced) and offered a mean rating of 2.8. Furthermore, 63% of the respondents noted that they will do something different as a result of attending the conference. The statements and comments offered by respondents are listed in the evaluation report . No summary statements ***or*** analyses are offered in the report. The entire report is included as part of Appendix IX.

D. ECAETC and **MATEC** Sponsored Conference: AIDS/HIV Continuity of Care **Conference**

A U.S. Public Health Service sponsored program AIDS/HIV Continuity of Care was presented by two ETC programs, ECAETC and MATEC, to meet the AIDS education needs of community and migrant health center staff. Forty-seven health care professionals attended the conference, twenty-four of whom completed evaluation forms. An evaluation report was prepared by Patricia Lavanhar, the program specialist at MATEC. Participants were asked to offer a rating of various program components on a 1 (little or no help) to 5 (very helpful) scale. Overall, the conference received a rating of 4.0. The Evaluation Report includes a summary discussion and participant comments and are included as Appendix X.

E. University of Kentucky Based Program: AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals

This training program, offered in February 1990, was offered to train select dental professionals to provide instruction about HIV to practicing dental professionals in their communities. The five goals of the training programs were:

- o disseminate factual information
- o facilitate the acquisition of knowledge
- o impact attitudes and values
- o enlist and reinforce positive behaviors
- o field test textual materials.

Participants are asked to complete a **"profile"** form. This form may be found in Appendix VII, p. 15. Of the 17 respondents, nine are female, three fourths are white and one quarter black and one quarter are dentists, and all worked in urban settings. The previous training experience among participants varied.

The evaluation report, including the appendices with the program agenda, program objectives, the training plan, the participant profile instrument, the faculty profile, and the post-session evaluation instrument may be found in Appendix VII. The majority of participants noted that the program met their expectations and offered high ratings for facilities, faculty, content, materials, and instructional activities. In addition, respondents reported a high level of confidence about their knowledge and abilities in the major content areas of the training program. A majority of participants reported an increase in knowledge and skills as a result of at tending the program. The evaluation summary can be found on pages 8 and 9 of Appendix VII.

An updated report (prepared on October 31, 1990) and included as part of Appendix VII, reports on a follow up evaluation of trainees. Of the 17 participants, 11 (65%) reported conduction training of other dental health professionals. Of these, 8 returned the Confirmation of Training Delivery forms . Reports from these 8 professionals indicate that they trained a total of 275 persons and covered topics such as infection control, dental management, AIDS core curriculum, as well as legal and ethical issues.

SUMMARY OF ISSUES AND CHALLENGES FOR THE FUTURE

The major thrust of **ECAETC's** evaluation is on project monitoring activities and counts of attendees. However, ECAETC has not yet defined the impact that it hopes its organization and activities will have on health and medical care practice nor has it attempted to measure its impact in terms of changes in knowledge, attitudes, intended and actual behavior. It should do so to justify its existence both to its funder and its constituency.

As had been recommended at the site visit, a question such as **"what will** you do differently as a result of this training program" has been added to the Program Evaluation form. If the use of this form or its local variant is required for all sessions provided under ECAETC auspices, then ECAETC can report a measure of impact. Follow-up queries to program participants would enable the sites or the central headquarters to measure reported change.

The newly established data base now enables the sites to submit program specific evaluation forms as well as raw data for entry and summation. If this process were to become a regular procedure and if a commonly agreed upon set of items (such as professional self efficacy and/or behavioral

intention) were identified across all sites, ECAETC would be in a strong position to analyze program outcome.

All products intended to change attitudes or behavior should be evaluated as to the actual outcomes produced as part of the pilot testing. A good start has been made in this area in the piloting of the CAI materials. However, more attention needs to be given to uncovering unintended messages.

At a minimum, all curricula published by ECAETC should be pilot tested to determine the extent to which the intended outcomes (knowledge, attitude, intention, behavior, etc.) are actually achieved by the content and format of the curriculum.

ECAETC's plans for needs assessments should be re-examined. Initial plans called for annual surveys of client organizations. Instead, the Criteria/Assessment Advisory Committee was used as a vehicle for conducting key informant assessments. The initial plan should be reconsidered as a mechanism for more broadly documenting shifting needs.

The needs assessment survey conducted among primary care providers proved to be of limited usefulness for procedural rather than conceptual reasons. The value of such an assessment still remains. Consideration should be given to revising and replicating this survey, with each implementation site responsible for respondents in their catchment areas.

ECAETC should continue to document its development and evolution through the evaluative case history methodology.

APPENDIX1

Evaluation Audit: Audit Procedures, Findings, and Issues

Protecting Programs from Evaluations: A Formative Evaluation and Audit

AUDIT PROCEDURES, FINDINGS, AND ISSUES

Jennifer C. Greene
Joan Doughty
Jeanne Dumont

Cornell University

Panel presentation at the Annual Meeting of the American Evaluation Association, New Orleans, October 1988.

10/27/88

Overview of Audit Procedures and Major Issues

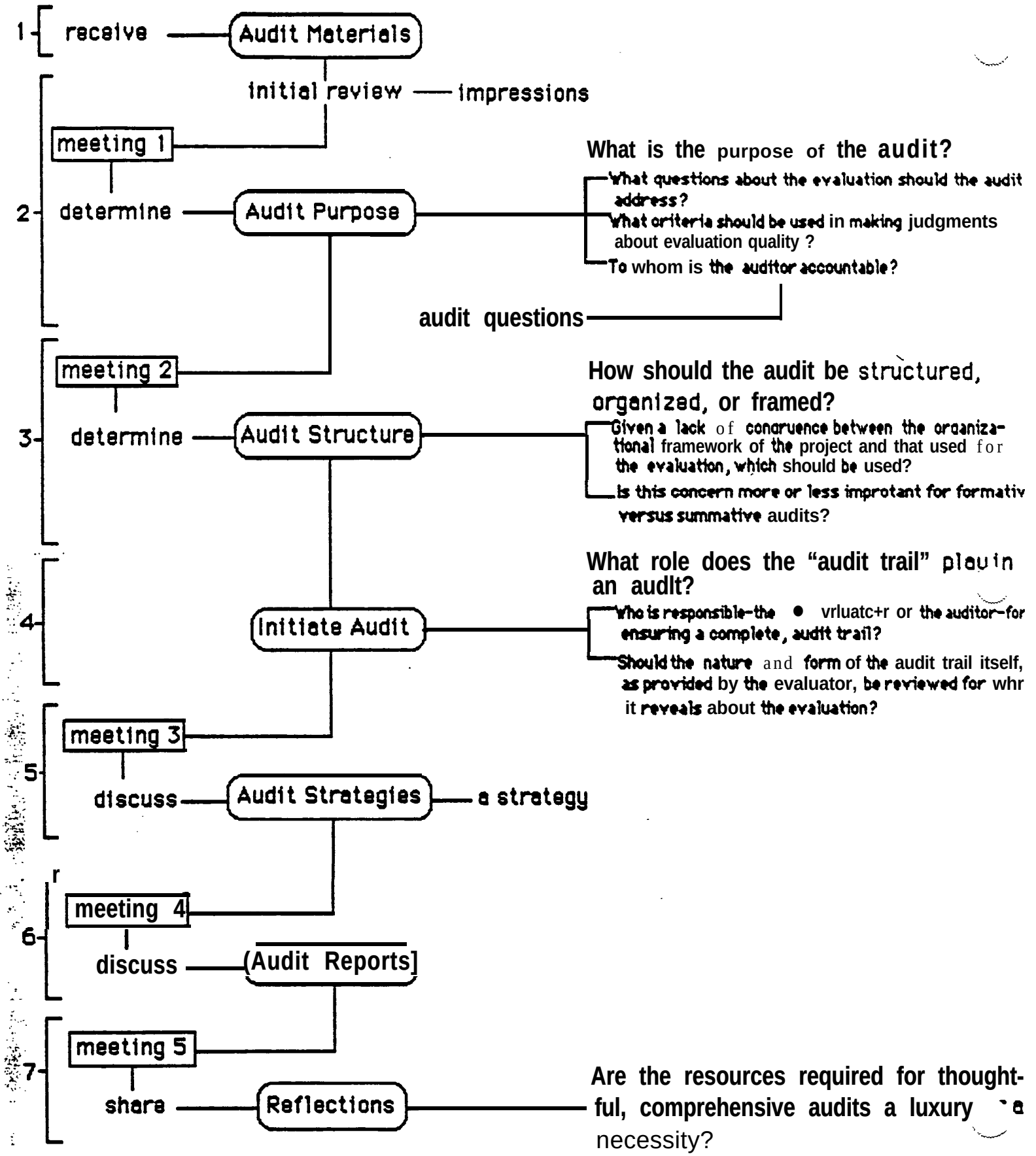


Table 1

Audit Trail kfaterials

Set 1 -- Initially received: Project Year One "Summary Progress Report"

Status and Comments per Objectives

- Goal I: Organizational Function
  - *MPOIA. Establish and maintain the ECAETC at The Ohio* State *University in* collaboration *with [the other four* sites].
    - *SMOIA2. By 10/1/87, Project Staff will have conducted a two-day* organizational meeting *and committed* co *a schedule of regular* meetings...
- Goal II: Materials Development Function
- Goal III: Education and Training Function
- Goal IV: Information Collection and Dissemination Function
- Goal V: Undergraduate and Graduate Curriculum Development and Infusion Function

Appendix A -- Interim Evaluation Report (9/1/87 to 7/31/88)

- I. Introduction
- II. Summary of Outcomes
- III. Development of Evaluation Instruments
- IV. Development of the ECAETC: An Evaluative Case Study
- V. Evaluation of Existing Educational Materials
- VI. ECAETC Program Evaluation Results
- Attachments
  - 1.0 Evaluation Instruments
  - 2.0 Audiovisual Reviews
  - 3.0 Distributors and Producers of AIDS Audiovisual Materials
  - 4.0 Database of Material AIDS Organizations and Professional Associations

Appendix B -- Subcontracts
Appendix C -- Memoranda of *Agreement*
Appendix D •• *ECAETC* Personnel by site
Appendix E -- Computer-based Communication System
Appendix F -- Needs Assessment Survey Instrument
Appendix G -- Needs Assessment Survey Results
Appendix H -- Criteria/Assessment Advisory Committee Results
Appendix I -- Protocol for Annotation of Existing Educational Materials
Appendix J -- Professional Liaison Committee Results

---

set 2 -- During phone conversation with evaluator

Answers to specific questions abut project and evaluation materials
The evaluator's view that his role was one of limited power and influence in the project

---

Table 1 (continued)

Set 3 -- Forwarded upon request

Minutes from site directors meetings (prepared by project director)
Information regarding the federal site visit (July 1988)
Original evaluation design (2-page narrative)
Interview questions for evaluation case study site visits
Draft of one of the evaluation instruments

Table 2

Audit Questions

1. What is the methodological quality *of* the evaluation?

   a. Is the selection of methods appropriate and professionally sound? How well does this selection meet **standards/criteria** of feasibility, utility, propriety, and accuracy (e.g., reliability, validity or dependability, confirmability)?

   b. Is the implementation of methods appropriate and professionally sound? How well does this implementation meet standards of feasibility, utility, propriety, and accuracy?

2. How well is the evaluation fulfilling its stated purpose, to evaluate the **"scope** and effectiveness" (range and **quality)**[a] *of* **ECAETC's** training and education efforts?

3. How well is the evaluation contributing meaningfully to program **improvement?**

4. How well are the evaluation's interim results and conclusions supported by, grounded in, or confirmable by the evaluation data?

5. Is the set of methods as a whole coherent, defensible, and professionally sound?

[a] This definition of "scope and effectiveness" was supplied by the evaluator upon request.

Table 3
Our Seven Separate Audits

Project goal	Substantive chunk	Relevant evaluation activities
I. Organization	(1) Organization	* Case study methods and results * Networking and Information Dissemination Record and data from Tables 3, 6, 9, 12, 15, 18
II. Materials Development	(2) Assessment of knowledge and awareness about AIDS	* Case study methods and results
	(3) Assessment of existing training materials	* Databases attached to evaluation report * Documentation of project activities * Case study methods and results
	(4) Development of AIDS training experiences	* Application to Co-Sponsor Educational Programs * Program Evaluation Card * Case study methods and results
III. Education and Training	(5) Dissemination of project-developed AIDS training programs	* Program and Service Record and data from Tables 1, 4, 7, 10, 13, 16 * Program Evaluation Card and data from Tables 2, 5, 8, 11, 14, 17 * Case study methods and results

Table 3 **(continued)**

Project goal	Substantive chunk	Relevant evaluation activities
IV. Information Collection and Dissemination	(6) Collection of information related to the AIDS **virus** and to existing educational materials	* Database policies and descriptions * Case study methods and results
	(7) Information dissemination and networking	* Networking and Information Dissemination Record and data from Tables 3, 6, 9, 12, 15, **18** * Database descriptions and policies * Case study methods and results
V. (N/A for year one)		

Table 4
Audit Report Format-Sample

AUDIT REPORT #

I. PROJECT COMPONENT
Statement about substantive chunk.
Reference to relevant project Goal, MPO___,SMOs___

II RELEVANT EVALUATION ACTIVITIES

Instruments and data:

e.g., Database descriptions and policies, including Attachment #_to evaluation report

e.g., Case study -- methods and results

III. AUDIT FINDINGS

Question ***1a:*** *Selection of me thuds appropriate, sound?*

The database descriptions and policies

The case study

Question ***1b:*** *Implementation of methods appropriate, sound?*

The implementation information available on database description and policies. Information available on the case study.

Question 2: How well is the evaluation fulfilling its own stated purpose -to evaluate the "scope *and effectiveness" of project activities?*

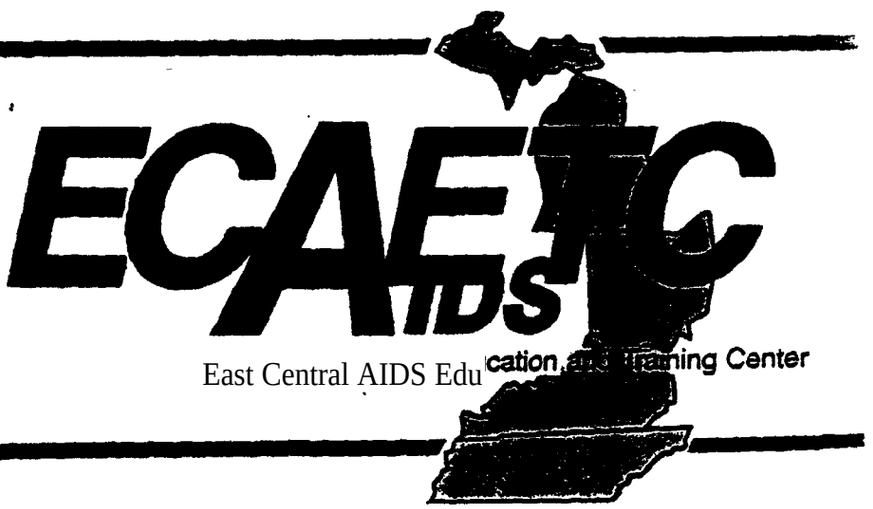
and so forth

APPENDIX II

Database Handouts - August 17, 1990

DATABASE HANDOUTS

AUGUST 17, 1990



ETC PROGRAM AND SERVICE RECORD

Directions:

The Purpose of this reporting procedure is to document the nature and scope of activities sponsored or assisted by an ETC and their regional sites per month. Each record should be completed for each documented activity. In each record listed, please attach an agenda and a list of faculty and/or contributions if appropriate.

Explanation of Cateaories

1. **Site** - The two letter site designation should be entered here.

2. **Date** - The date (yy mm dd) of each activity.

3. Title - The title should identify the activity being documented.

4. Hours - This category defines "hours" in terms of the hours learners spend in a planned educational activity. It does not refer to the variable hours a learner might devote to an activity in excess of planned hours. Document only whole and half hours.

5. Topics - Training issues addressed in an educational offering. (see attached)

6. Soonsorshio Code - This category specifies the nature of sponsorship or assistance provided by the ETC.

   A = Sole Soonsorshio.
   B = Co-Soonsorshio (with one or more agencies or groups. All co-sponsors should b listed on agenda attached for each activity).
   C = Other. Assistance with resource contribution (whether financial, material, space or personnel); assistance, with no resource contribution - (this somewhat ambiguous classification refers to intangible, but legitimate, assistance provided that does not include tangible resource contributions). Presentation only (this category may include academic/scholarly or other presentations)

7. Method - This category permits classification of educational methods used.

   A = Conference/Symposium
   B = Clinical Teaching/ Case Teaching
   C = Lecture
   D = Follow-up/Advanced
   E = Self-instruction
   F = Teleconferences
   G = Train-the-Trainer
   H = Workshop
   I = Other

8. Activity Status - This 'category indicates whether or not an activity is a stand alone, one-time program or part of a sequence (for example, a course or weekly seminar).

9. Total Participants - List total number of individuals attending the educational activity.

10. Objective - The specific measurable objectives which the (Optional) documented activity meets should be identified by number (if applicable).

East Central AIDS Education and Training Center
PROGRAM & SERVICE RECORD

(1) Site [_ _] (CI, KY, MI, OH, TN) (2) Date [_ _ _ _ _ _] y y m m d d

(3) Title [_ _] (25 letters maximum)

(4) Hours [_ _ _]

(5) Objectives per proposal* [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

* completed by Site Director

(6) Code [_]
A = sole sponsorship
B = co-sponsorship
C = assistance/resource contribution
D = assistance/no resource contribution
E = no assistance/presentation only

(7) Method [_ _ _]
A = Didactic
B = Group Process
C = Self study

(8) Media [_ _ _ _ _ _ _]
D = OMEN (Ohio Med Ed Network)
E = CAI (Computer Assisted Instruction)
F = Videotape
G = Workbook
H = Lecture/Discussion
I = Workshop
J = TeleConference

(9) Audience (No. of Participants)

MD [_ _ _ _]
RN [_ _ _ _]
DDS [_ _ _ _]
Al lied Health [_ _ _ _]

SW/Counselor [_ _ _ _]
Physician's Assistant [_ _ _ _]
EMT [_ _ _ _]
Other [_ _ _ _]

(10) Specify "Other" [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

(11) No. Minorities:
Black American [_ _ _ _]
Mainland PR [_ _ _ _]
Am. Indian [_ _ _ _]
Other Hisp. [_ _ _ _]
Mexican-Am. [_ _ _ _]
Asian Am. [_ _ _ _]
Other [_ _ _ _]

(12) No. Urban [_ _ _ _]
No. Rural [_ _ _ _]

(13) Site Staff [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

(14) Other Staff [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

ECAETC SITES ANNUAL **SUMMARY** PROGRAM & SERVICE RECORD (Rev. **8/08/90**)

ALL SITES ALL SITES ALL SITES ALL SITES

Cumulative hours : Events/Activities:
Hrs Cumulative 1564 Cumulative: 443

Nature of sponsorship or assistance provided

Sole sponsorship	**70**
Co-sponsorship	**168**
Assistance/resource contribution	162
Assistance/no resource contributed	25

Method Code Media Code

Didactic count	368	Omen count	15	Workbook count	4
Group Process cnt	117	**CAI** count	**0**	**Lec/Discuss** count	343
Self Study count	5	Videotape count	79	Workshop count	**56**
				TeleConf count	**29**

Audience Count Number of Minorities Urban/Rural Location

MO count	6232	Black count	2037	Urban count	6524
RN Count	3550	Am. Indian count	0	Rural count	3108
DDS count	**74**	Mainland PR count	25		
Allied Count	**1175**	Other Hisp count	**22**		
SW Conslr count	1561	Am Asian count	**126**		
Phys Asst count	174	Other Minorty cnt	579		
Emt count	284	Mexican Am count	54		
Other count	**8415**				
Total	**21465**	Total	2843		

* SUMMARY DATA *

TOPICS

13 l.Attitude Change 140 **2.Clinical** Manifestation 2 **3.Cultrl** Factors
30 **4.Ethical/Legal** 200 **5.Epidemological/Prev** 141 **6.Immuno/Virology**
38 **7.Longterm** Care 13 B.Neuropsychiatric 19 **9.Proph.** Care
48 **10.Psychosocial** 19 **11.Risk** Assmt./History 8 **12.Special** Pop
4 **13.Substance** Abuse 24 **14.Testing/Counseling** 56 **15.Treatment**
15 **16.Women &** Rprdctv 42 **17.Workplace** issues 165 **18.Dscplne** Spcfc
63 **19.Comprhnsv** Prog 25 **20.Other**

OBJECTIVES

	A1	A2	A3	A4	A5	A6	A7	**B1**	**B2**	**B3**	C1	**C2**	C3	**D1**	**D2**	03
II	0	000000000000														
III	0	10	0	6	0	0	0	0	1	**0**	**0**	3	0	0	1	2
IV	0	0	10	0	5	2	0	0	0	0	0	0	0	0	0	0

CRITERION/CONTENT STATEMENTS CRITERION/CONTENT STATEMENTS

487 I **Basic** Science of Virus	246 241	1.2.	
2 29 II Political, Legal & Govrnmt	9	**3.**	
175 III Indirect Care Network & Ref	89 21 21 22 22	**4.5.6,7.8.**	
296 IV **Direct** Patient Care	44 25 205 22	**9.10.11.12.**	
42 V Testing	14 15 13	**13.14.15.**	
5 VI Patient Behaviors	2 0 2 **1**	**16.17.18,19.**	
49 VII Provider Behaviors	0 146 2 0 0	**20.21.22.23.24.25**	
A 42s **VIII Psychosocial** t s	22 20	26.27.	
7 IX Minority/Cultural Issue	4 3	28.29.	
4 x Human Sexuality	13 0 0	30.31.32.33.	
25 XI Communication	25	34.	
2 XII Alcohol and Orug Abuse	2	35.	

On-Site Program Registratfan Form
Title of Program
Date

1. Name _____
Last first M.I.

Addrsss _____

_____

_____

2. Sex Male_ Female___

3. Ethnic Background (please check one)

Asian/Pacific Islander ____
Black (Non-Hispanic) ____
Caucasian (Nan-Hispanic) ____
Mexican/American ____
Nat ive American ____
Puerto Rican ____
Other Hispanic ____
Other ____

4. Discipline (please check one)

A. Phvsician (includes M.D., 0.0.)
___ Practitioner (any specialty)
___ Medical Students
___ Medical Residents (any specialty)
___ Medical School Faculty

B. Nurse (includes R.N. diploma, BAN., M.S.N., Ph.D.)
___ Practitioner (any specialty)
___ Nursing Student
___ Nursing School Faculty

C. Mid-Level Practitioner (health professionals with advanced clinical training in delivery of primary health care)
___ *Nurse* Practitioner (C.R.N.P., N.P.)
___ Nurse Midwife
___ Physicians; Assistant (P.A., P.A.C.)

D. Dentist
___ Practitioner (practicing Dentist)
___ Dental Student
___ Dental Resident
___ Dental School Faculty

E. _ Mental Health' Provider
(Includes: Counsalor, Caseworker, Social Worker, Psychologist, Drug and Alcohol Counselors, Mental Retardation Personnel, Psychiatric Aides, Human Service Workers (i.e., Children Services, Geriatric Services).

F.___ Allied Health Professional
(Includes: Oietitians, Paramedics, EMT's, Medical Technologist, Occupational Therapists, Pharmacists, Physical Therapists, Respiratory Therapists, Radiation Technicians, Infection Control Practitioner, Public Health Personnel, Dental Hygienist, Dental Assistant, LPN)

G_ _ Other Health
(Includes: Heaith Educator, Clergy, Administrator, Case Manager, Corrections health personnel, Hospital Support Staff (housekeeping, dietary, security), Human Resources, Nursing support staff (nurses aides, orderlies), Laboratory Personnel).

H_ _ Other Non-Health
(Includes: higner education faculty not in health, correctional officers, non-health administrators, police, firefighter, educators).

5. Type of Institution - Identify the type of institution where you are currently employed. (please check one)

___ A. Academic Institution
Include in this category: College, University, Community College, Technical School, Nursing School, or other health professions schools.

___ B. Community Based Organization
Include in this category: AIDS CBO, Volunteer Organization

___ C. Community Migrant Health Center
include in this category: Federally Funded, Non-federally Funded

___ D. Substance Abuse Treatment/Mental Health
Include in this category: Drug Treatment Clinics, Residential Drug Treatment, Methadone Maintenance, Alcohol Treatment Canter, Community Mental Health Center, Psychiatric Outpatient Services.

___ E. Hospital
Include in this category: General Hospital, Specialty Hospital; including Psychiatric, State Mental Hospitals, State Mental Retardation Facilities, Private Hospitals, outpatient hospital services, designated hospitals AIDS units.

___ F. Long-term Care
Include in this category: Hospice, Nursing Home, Rehabilitation Centers, Personal Care Boarding House, Skilled Nursing Facilities

___ G. Private Practice

___ H. Public Health Agency
Include in this category: Public Welfare, County Health Departments, Children and Youth Services, Geriatric Services, Public Health Nursing or other public heath services or human service agencies receiving federal, state, or local funding.

___ I. Other
Include in this category: Emergency Services, Canections (prison, jail), Home Care, HMO, School (primary or secondary), Women's Health Services, Planned Parenthood, Family Planning Services.

6. Indicate the site of your clinical practice (check one).

___ Rural
___ Urban (includes suburban)

7. A. Indicate the total number of clients/patients you' serve annually.

_____

B. Estimate the percentage of your total clients/patients who are minority clients/patients.

_____%

C. Estimate the pertsntaae of your total clients/patients who are HIV+ clients/patients.

_____%

III Integrated Database Format for Program Date‘ Collection/Reporting

{ Title: AIDS ETC Program & Service Record.-- Integrated Relational Database }
{ Description: This is a relational database demonstrating the computerization }
{ of national data collecting requirements. Data collected and entered in this }
{ format can be analyzed by statistical summary options in the program. }
{ Author: Neil R. Smith, Evaluation Coordinator: ECAETC }

(8/05/90) AIDS EDUCATION AND TRAINING CENTERS
NATIONAL PROGRAM AND SERVICE RECORD

(1) Site (2) Date [12/06/88]
mm dd yy

(Screen sensitive information is available called "validation list".
To access, press <Alt-V> for a listing, then press <Return> for selection)

(1a) National Site:[ ]: ----> [1

(3) Title:[Family Practice Residents Aids Education 1

(4) Hours: [1] | SUMMARY DATA HOURS: [ ]|

(5) TOPICS: - Indicate the training issues or topics addressed in each educational offering. Please indicate all that apply. Check primary and additional classification on list below. Topic listing is available through <Alt-V> key. Also, see list below.

TOPIC CODE [ ] Description of primary topic: <Alt-V> for listing

Check all topics that this activity/event may be classfied under.

[ ] 1.Attitude Change [] 2.Clinical Manifestation [] 3. Cultural Factors
[ ] 4.Ethical/Legal [] 5.Epidemiological/Prev [ ] 6. Immuno/Virology
[ ] 7.Longterm Care [] 8.Neuropsychiatric Manif.[ ] 9. Prophylactic Care
[] 10.Psychosocial [] 11.Risk Assmt/History [ ] 12. Special Pop.
[] 13.Substance Abuse [] 14.Testing/Counseling [] 15. Treatment
[] 16.Women&Reprdctv [ ] 17.Workplace Issues [] 18. Dscplne Spcfc
[ ] 19.Comprhnsve Program [] 20. Other

TOPICS SUMMARY DATA

[ ] 1.Attitude Change [ ] 2.Clinical Manifestation [ ] 3.Cultural Factors
[ ] 4.Ethical/Legal [ ] 5.Epidemiological/Prev [ ] 6. Immuno/Virology
[ ] 7.Longterm Care [ ] 8.Neuropsychiatric Manif.[ ] 9. Prophylactic Care
[ ]10.Psychosocial [ ]11.Risk Assmt/History [ ]12. Special Pop
[ ]13.Substance Abuse [ ]14.Testing/Counseling [ ]15. Treatment
[ ]16.Women&Reprdctv [ ]17.Workplace Issues [ ]18. Dscplne Spcfc
[ ]19.Comprehensive Program [ ]20. Other

(6) Sponsorship Code:

Place code number here -->[ ] and check
In addition, check as many others that apply
[ ] 1 = Sole sponsorship
[ ] 2 = Cosponsorship
[ ] 3 = Other

SUMMARY DATA
Summary based upon entire or subset of database

[ ] Code number Count
[ ] 1= sole spon. Count
[ ] 2= co-span Count
[ ] 3 = other Count

(7) Method:
Check main method code -> [8] Group Process

Below check again and all others that apply.

[ ]	1 = Clinical Teaching (Didactic)	[ ] I = Didactic
[x]	2 = Conference or Symposia	[ ] 2 = Conf.or Symp.
[x]	3 = Lecture	[ ] 3 = Lecture/Dis
[ ]	4 = Self Study (Self Instruction)	[ ] 4 = Self Study
[ ]	5 = Small Group Discussion	[ ] 5 = Sm. Group
[ ]	5 = Teleconference	[ ] 5 = TeleConf
[ ]	6 = Train-the-Trainer	[ ] 6 = Train-Trainer
[ ]	7 = Workshop	[ ] 7 = Workshop
[ ]	8 = Other	[ ] 8 = Other

SUMMARY DATA

Counts of Method

(8) Activity Status: Is this program part of a sequence of training?

[ ] Yes
[1] No

SUMMARY DATA
of a sequence of training?

[ ] Yes Count
[ ] No Count

a follow up session ?

[ ] Yes
[ ] No

a follow up session ?

[ ] Yes Count
[ ] No Count

(9) Total Participants:- List total number of individuals attending the educational activity

Total *Number* of Participants [ ]

SUMMARY DATA

[ ] Total No. Count

9a) Sex: List numbers of individuals by sex or no response:

Male	[ ]	[ ] Male Count
Female	[ ]	[ ] Female Count
No Response	[ ]	[ ] No Response Count

SUMMARY DATA

9b) Ethnic Background:
Indicate the race/minority status of participants attending the training session
Please indicate the number of participants who do not respond.

1 = Asian/Pacific Island	[ ]	[ ] 1 = Am Asian
2 = Black (Non-Hispanic)	[ ]	[ ] 2 = Black Am.
3 = Caucasian (Non-Hispanic)	[ ]	[ ] 3 = Caucasian
4 = Mexican/American	[ ]	[ ] 4 = Mexan Am
5 = Native American	[ ]	[ ] 5 = Am Indian
6 = Puerto Rican	[ ]	[ ] 6 = Mainland P.R.
7 = Other Hispanic	[ ]	[ ] 7 = Other Hisp
8 = Other	[ ]	[ ] 8 = Other Minority
9 = No Response	[ ]	[ ] 9 = No Responses
Minority SUM	[ ]	[ ] Minority SUM

(10) Oiscipl ine:

Place totals below. Press <Alt-Z> for complete description of category

SUMMARY DATA

Counts on all Classifications

1.) Physicians Total	[18]	[ ] Phys. Total Count
la.) Practitioner (any specialty)	[ ]	[ ] la.) Practitioner
Ib.) Medical Student	[ ]	[ ] lb.) Med Student
Xc.) Resident (any specialty)	[ ]	[ ] lc.) Resident
Id.) Medical School Faculty	[ ]	[ ] 1d.) Med School Fac.
2.) Nurses Total (RN, BSN, MSN, PhD)	[6]	[ ] Nurses Total Count
2a.) Practitioner (any specialty)	[ ]	[ ] 2a.) Practitioner
2b.) Nursing Student	[ ]	[ ] 2b.) Nurse Student
2c.) Nursing School Faculty	[ ]	[ ] 2c.) Nursing Sch Fac
3.) Midlevel Practitioner Total Health Prfssnals with advncd clncl trning in dlvring primry health care	I . 1	[ ] Midlevel Pract, Cnt.
3a.) Nurse Practitioner (CRNP, NP)	[ ]	[ ] 3a.) Nurse Prac. Cnt
3b.) Nurse Midwife	[ ]	[ ] 3b.) Nrs Midwife Cnt
3c.) Physicians Assistant (PA, PAC)	[ ]	[ ] 3c.) Phys Assistant
4.) Mental Hlth Prvders Total: (Press <Alt-Z>)	[ ]	[ ] Mental Hlth Prvders:
5.) Dentists Total	I . 1	[ ] Dentists Total Count
5a.) Practitioner (practicing Dent.)	[ ]	[ ] 5a.) Practitioner
5b.) Dental Student	[ ]	[ ] 5b.) Dental Student
5c.) Dental Resident	[ ]	[ ] 5c.) Dental Resident
5d.) Dental School Faculty	[ ]	[ ] 5d.) Dental Sch Fac.
6.) Allied Hlth Prfssnls: (Press <Alt-Z>)	[ ]	[ ] Allied Hlth Prfssnls
7.) Other Health (Press <Alt-Z>)	[ ]	[ ] Other Total Count
Specify Other: [Medical Student	]	
8.) Other Non-Health	[ ]	[ ] Other Non-Health
Specify Other: [	]	

(11) Type of Institution:

Press <Alt-Z> for complete definition of the institution

SUMMARY DATA

Summary Counts

[ ] 1.) Academic Institution	[ ] 1.) Academic Inst
[ ] 2.) Community Based Orgnztion	[ ] 2.) Comm Based Org.
[ ] 3.) Community Migrant Hlth Cntr	[ ] 3.) Comm Mig. Hlth C
[ ] 4.) Substance Abuse Trt/Mental Hlth	[ ] 4.) Drug Trtmnt/M H
[ ] 5.) Hospital	[ ] 5.) Hospital
[ ] 6.) Long-term Care	[ ] 6.) Long-term Care
[ ] 7.) Private Practice	[ ] 7.) Private Practice
[ ] 8.) Public Health Agency	[ ] 8.) Public Hlth Agnc
[ ] 9.) Other	[ ] 9.') Other

(12) Characteristics of the Clinical Practice of Participants:

SUMMARY DATA

I.) Urban or Rural Participants:
Indicate number of rural or urban participants attending through self report

[2] Rural number
2] Urban number (& suburban)

[ ] Rural number
[ ] Urban & suburban

2.) Clients Served:

Calculate the total average number of clients/patients served annually by participants in the program. --->[1

[ ] Client average served

3.) Minorities Served:

(Question to be asked of participants then summed and averaged by site director and placed below.)

Calculate the average percentage of total clients/patients who are minorities served by this program's participants. ---> [%]

[%] Average of percentage averages of minorities served annually

4.) HIV Positive/AIDS Clients:

Calculate the average percentage of total client/patients who are HIV+ served by the participants in this program. ---> [%]

[%] Average of the percentage averages of HIV+ served annually

ECAETC AIDS
East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Department of Family Medicine
1314 Kinnear Road, Area 300
Columbus, Ohio 43212
614-292-1400
FAX: 614-293-4318

Program Evaluation Form

Date _____

Program Title _____

Your profession and practice specialty _____

_____

Your practice setting is (please circle): Rural Suburban Urban

1. Please rate the following by checking boxes:

	Exceeded Expectations	Met Expectations	Disappointing
A. Appropriateness of Content			
B. Completeness of Content			
C. Use of Audiovisuals			
D. Interactive Call-in			

2. What did you find most valuable? _____

_____

3. What did you find least valuable? _____

_____

4. Please describe what you might do differently in your practice having experienced this program.

_____

_____

(OVER)

5. What do you consider to be your own AIDS risk because of your work?

☐ None ☐ Low ☐ High

6. Are there additional topics that you would liked to have seen?

_____

_____

7. How did you learn about this program? _____

_____

a. Would you be willing to participate in advanced "train-the-trainer" sessions and make AIDS related presentations to other health professionals? (Please circle)

No YES

If your answer is yes, would you please provide your name, address and telephone number:

Name _____

Address _____

_____

Telephone No. (____) _____

9. We are extremely concerned about reaching the widest possible diversity of groups with our educational programs. It would be very helpful if you would indicate your ethnic background and sex (Phase check):

Black American	___	Puerto Rican	___
White	___	Mexican American	___
American Indian	___	Other Hispanic	___
Asian American	___	Other	___
Male	___	Female	___

Other Comments:

PLEASE RETURN YOUR COMPLETED FORM TO THE LOCAL TELECONFERENCE DIRECTOR. Thank you for your participation.

PROGRAM EVALUATION FORM

Case Number [60.10000]

Date 3/6/90 (Enter date as 00/00/90 or 0/0/90)
{ Note: To find event title hit <alt-V> to see 3 list of titles. }
{ Next, select title date then hit <Enter>. Then tab to next question.}

Event Title OMEN March 5-9, 1990
HIV/AIDS in the Emergency Room
OMEN Network. (123 sites) & Columbus, OH

Media Type for this Event [d]

D = OMEN	[X]
E = CAI	[ ]
F = Videotape	C l
G = Work book	[I
H = Lecture/Discussion	[ ]
I = Workshop	[I
J = TeleConference	[ ]

Profession Respondent:
(Please Check one response:

(X) M D
( ) RN
( ) DDS
( ) Allied Health
() SW/Counselor
( ) PA's
() EMT
( ) Other Med

Practice Specialty:
PSYCHIATRIC AND GENERAL PRACTICE

Your practice setting is (please check)
(X) Rural () Urban () Suburban ( ) No Res

1. Please rate the following by checking the boxes :

	Exceeded Expectations	Met Expectations	Disappointng	No Response
A. Appropriateness of Content		X		
B. Completeness of Content		X		
C. Use of Audiovisuals		x		
D. Interactive Call-in		X		

2. What did you find most valuable ?

Comment 2.1:GENERAL PREVENTION OF AIDS

Comment 2.2:

Comment 2.3

3. What did you find least valuable?

Comment 3.1:

Comment 3.2:

Commnet 3.3:

4. Please describe what you might do differently in you practice having experienced this program.?

Comment 4.1:TO PRESENT INFECTION (AIDS) MEDICAL MANAGEMENT OF ?

Comment 4.2:

Comment 4.3:

5. What do you consider to be your own AIDS risk. because of your work ?

[ ] None [ ] Low [X] High [ ] No Ans

6. Are there additional topics you would like to have seen?

Comment 6.1:TO PREVENT DISEASE (AIDS)

Comment 6.2:

Comment 6.9:

7. Ho44 did you learn about this program?

Comment 7.1:

Comment 7.2:

Comment 7.5:

8. Would you be willing to participate in advanced "train-the-trainer" sessions and make AIDS related presentations to other health professionals (Please check)

[I NO [ ] YES [X] No response

Which type of education credit do you wish to receive ?
(Answer only if you are to receive credit)
[ ] Category I CME
[ ] Family Physician
[ ] Nurse Contact Hours

If you checked YES to Question # 8 or you want continuing education credit, then please fill out you name, address, and telephone number.

(Last name - space..First name: Doe M
Last name: , First:
Street Address: (Only street number and name)

City:
State:
Zip Code:
(area code..space..digit 1 2 3..space..last digits)
614 555 1212
Telephone:

9. We are extremley concerned about reaching the widest possible diversity of groups with our educational programs. It would be very helpful if you-would indicate your sex and-ethnic status if appropriate.

[ ] Black (Ncn-Hispanic)
[X] Caucasian
[ ] American Indian
[ ] American Asian
[ ] Mexican American
[ ] Mainland PR
[ ] Other Hispanic
[ ] Other Minority
(internal data) --> [ ] MINORITY SUM
(excludes Caucasian)

Sex: [X] Male
[ ] Female

Other Comments:

1 st Comment

2 nd Comment

3 rd Comment

More Said ? (Check here if there are any stray comments written anywhere else on this form)
---> [I

PROGRAM EVALUATION FORM (Rev. 8/14/90)

Event Title: OMEN March 5-9, 1990
HIV/AIDS in the Emergency Room
OMEN Network (123 sites) & Columbus, OH

Media Type		Profession Type		
: OMEN	112	: MD	8	8.5%
: CAI		: RN	53	56.5%
: Videotape		: DDS	2	2%
: Workbook		: Allied Health	0	1%
: Lecture/Discussion		: Social Workers/Coun	1	1%
: Workshop		: Physician's Asst.	0	
: Teleconferance		: EMT	10	10.6%
		: Othr Medic.31	20	21.2%

Your practice setting is (please check)			
:Rural	44	37%	
:Urban	18	15%	
:Suburban	39	33%	
:No Response	18	15%	

1. Please rate the following by checking the boxes.

	Exceeded Expectations		Met Expectations		Dis-appointing		No Response	
A. Appropriateness of Content	6%	7	77%	86	13%	14	4%	5
B. Completeness of Content	6%	7	88%	90	9%	10	14%	5
C. Use of Audiovisuals	10%	11	72%	81	12%	14	6%	7
D. Interactive Call-in	5%	6	44%	51	9%	10	42%	49

Your awn AIDS risk because of your work?			Your Sex		
: None	6	5%	Male	28	31%
: Low	54	49%	Female	62	69%
: High	42	38%			
: No Ans	9	8%			

8. Would you be willing to pariticipate in advanced "train-the-trainer" sessions and make AIDS related presentatians to other health professionals ?

: YES	70% 72	NO	15% 15	N/R	15% 16

Which type of education *credit do you wish to receive'?*

: Category I CME	0
: Family Physician	0
: Nurse Contact Hours	3

Minarity *Status.*

	0	Black (Non-Hispanic)
85%	81	Caucasian
3%	3	American Indian
6%	6	American Asian
	0	Mexican American
	0	Mainland PR
1%	1	Other Hispanic
4%	4	Other Minority

CEU REQUEST (Teleconferences & Omen)

Event/Activity Attended:

OMEN March 5-9, 1990

Professional Classification:

MD:[ ] RN:[x] DDS:[I Allied:[ ] SW:[I PA:[ ] EMT:[ ] OTH:[ ]

Credit Type Requested :

[ ] Category I CME [ ] Family Physician [x] Nurse Contact Hours

Person Data:

Last: She 11 house , First: Doris I-.

Street Address: (Only street number and name)
909 T.H. 148 N

City: Sycamore
state: OH
Zip Code: 44882
Telephone: 419 927 2211

LABELS EXAMPLE

LOU ANN FULMER, MSN, RN
VISITING NURSE SERVICE
1.200 MCARTHUR DRIVE
AKRON OH 44320

ZELDA SNELL
8046 WADSWORTH ROAD

WADSWORTH OH 44281

MARY MEBERT
916 ANDREWS ROAD

MEDINA OH 44256

NORAH BERTSCHY, RN
1000 E. WASHINGTON ST.

MEDINA OH

RHONDA DAILEY
115 E. MEMORIAL DRIVE

POMEROY OH 45769

MARY BETH ROSE, RN
RT. 1 BOX 260 TAYLOR ROAD

PT. PLEAS WV 25550

JUDY RIDDLE
KDMC STAFF DEVELOPMENT
2201 LEXINGTON AVENUE
ASHLAND KY 41101

PAM TOLLIVER
RR #1 bOX 1990

gREENUP KY 41144

DAVID TOLICH .
HILLSIDE REHABILITATION HOSPITAL
8747 SQUIRES LANE NE
WARREN OH 44484

TITA E. ROACH
217 PARK DRIVE

DIXON IL 61021

ECAETC AIDS
East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Department of Family Medicine
1314 Kinnear Road, Area 300
Columbus, Ohio 43212
614-292-1400
FAX: 614-293-4318

1990 ATTENDANCE SHEET

PROGRAM: _____
HOSPITAL: _____

NAME (Please Print)		NAME (Please Print)	
1.		18.	
2.		19.	
3.		20.	
4.		21.	
5.		22.	
6.		23.	
7.		24.	
8.		25.	
9.		26.	
10.		27.	
11.		28.	
12.		29.	
13.		30.	
14.		31.	
15.		32.	
16.		33.	
17.		34.	

USE ADDITIONAL SHEETS IF NECESSARY

The above named persons participated in this program on: _____

SIGNATURE _____ TITLE _____

ATTENDANCE SHEET

CASE NUMBER: [60] Cumulative Case Count:

PROGRAM/EVENT OMEN March 5-9, 1990
HIV/AIDS in the Emergency Room
OMEN Network (123 sites) & Columbus, OH

HOSPITAL NAME: G. Pierce Wood Memorial Hospital
Address 1st1ine Clinical Director
Address 2nd line 5100 Highway 31
City Arcadia
state FL
Zip-code 33821-9627

ATTENDANCE NUMBER [28]

NOTE: From attendance sheet, count and post various professionals. Also, count unclassifiable and post
Practice of Respondent:
(Please Check one response)

[28] MD
[1 RN
[1 DDS
[ ] Allied Health
[ ] SW/Counselor
[ ] Physician's Assistent
[ ] EMT
[ ] Other professional
Other's profession [ ]

[ ] UNCLASSIFIABLE UNCLASSFIABLE COUNT

POSTING OF NAMES:

Directions: Please type last name first, first name last, then degree.

NAME (Please Print)

1name Khan, **Barkat,** MD
2name Black, Jarrett, MD
Sname Agudo, Francisco, **MD**
4name **Morales, Otto, MD**
Sname Morales, Amilia, MD
6name Torres, Humberto, MD
7name **Tornin,** Evidio, MD
Sname **Renfrew,** Murray, ND
Sname Rubio, Flavio, MD
10name Solomon, Richard, MD
11name Verde, Eliseo, MD
12name **Triana,** Elizabeth, MD
13name Long, Charles, MD
14name Majumder, Santi, MD
16name Kim, Jung, MD
17name Fernandes, Cipriano, MD

ATTENDANCE SHEET

18name	Kim, Yung, MD
19name	Ro, Kyoung, MD
20name	Bell, James, MD
21name	Riggs, Lawrence, MD
22name	Benoit, Eddy, MD
23name	Pestana, Alfonso, MD
24name	Beltran, Leonido, MD
25name	Cabrera, Olrando, MD
26name	Yero, Emilio, MD
27name	Pera, Sergio, MD
28name	Lomangcolab, Pablo, MD
29name	Adeni, Suguna, MD
30name	
31name	
32name	
33name	

ECAETC AIDS
East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Department of Family Medicine
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Columbus, Ohio 43212
614-292-1400
FAX: 614-293-4318

HIV/AIDS: A Primary Care Disease of the 90's

A Regional Workshop for Health Care professionals

Evaluation
5/12/90

1. Were the following objectives met:

   a. Describe AIDS epidemiology, pathogenesis, and transmission facts. ___yes n o

   b. Recognize an appropriate HIV risk assessment and sexual history interview. ___yes n o

   c. Review practical patient management and counseling guidelines. ___yes n o

   d. Review recent legislation and insurance issues. ___yes ___no

   e. Discuss the concerns of Persons with AIDS (PWA's). ___yes n o

2. Evaluate:

Rob Crane, M.D.				
Knowledge of content	poor	fair	good	excellent
Clarity of presentation	poor:	fair	good	excellent
Charlene Buckner, R.N., CIC				
Knowledge of coritent	poor	fair	good	excellent
Clarity of presentation	poor	fair	good	excellent
Steve				
Knowledge of content	poor	fair	good	excellent
Clarity of presentation	poor	fair	good	excellent

(OVER)

3. The facilities were: poor fair good excellent

4. Were your personal objectives for the day met: ___yes ___no

COMMENTS

5. What topics would you like to see presented in the future?

Please return to:

East Central AIDS Education and Training Center
The Ohio Stat8 University
Department of Family Medicine
Area 300, 1314 Kinnear Road
Columbus, Ohio 43212

East Central AIDS Education and Training Center

NETWORKING AND INFORMATION DISSEMINATION RECORD

(1) Site [_ _] (CI, KY, MI, OH, TN)

(2) Date [_ _ _ _ _ _]
y y m m d d

(3) Agency/Individual Contacted:

(4) Description of Communication:

(5) Anticipated Outcome

(6) Objectives Per Proposal:

(7) Site Staff:

(8) Other Staff:

ECAETC NETWORKING AND INFORMATION DISSEMINATION RECORD

Directions for Completing Record and Explanation of Categories

DIRECTIONS. The purpose of this reporting form is to document the nature and scope of networking, linkage, and information exchange activities undertaken by ECAETC staff in order to meet Center objectives. The form is loosely structured in order to give you opportunity to document your linkage efforts in a narrative format. Please complete one form for each key networking contact and outcome you consider important in establishing your Site within your state and East Central region. Please complete this for all key contacts per month since September 1, 1987.

EXPLANATION OF CATEGORIES

(1) Site. The two-letter site designation should be entered here.

(2) Date. The date (YY/MM/DD) of each activity documented should be entered here.

(3) Agency/Individual Contacted. Identify the agency, association, institution, and/or individual contacted.

(4) Description of Communication. In one or more sentences or phrases, please document the nature and scope of any communication relevant to establishing important networks, linkages, etc., with agencies in your state and in the region.

(5) Anticipated Outcomes. Please document any formal and informal linkages or understandings created/established.

(6) Objectives Per Proposal. The specific measurable objectives (see original proposal) which the documented activity meets should be identified by number, i.e., SMO IV.B.l.

(7) Site Staff. List the names and affiliations of ECAETC personnel who participated in the delivery of the educational activity.

(8) Other Staff. List the names and affiliation of non-ECAETC personnel who participated in the delivery of the educational activity.

October 23, 1989

APPENDIX III

Evaluative Site Visit

ECAETC
East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Department of Family Medicine
80902 University Hospitals Clinic
456 West Tenth Avenue
Columbus, Ohio 43210
614-293-8188

EVALUATIVE SITE VISIT
EAST CENTRAL AIDS EDUCATION AND TRAINING CENTER
THE OHIO STATE UNIVERSITY
GRANT NUMBER BRT000005-01-0
JULY 25-27, 1988

Introduction

The purpose of the grant project is ***to*** *establish and maintain the East Central AIDS Education* ***and*** *Training Center for Health Professionals* ***(ECAETC)*** *through the* ***cooperative and collaborative efforts and relationships of Ohio State University, University of Kentucky, Meharry Medical College, University of Michigan,*** *and* ***Cincinnati Board of Health, committed to the development and dissemination of information and materials to facilitate rapid and meaningful education and training of health care professionals relevant to prevention and care regarding*** AIDS. To this'end, it should be apparent that the region served by ECAETC is comprised of the states of Michigan, Ohio, Kentucky, and Tennessee.

The evaluative report describes the progress made in achieving the above stated purpose. In order to provide a structure for the report, it has been determined that it would be best to develop the report around the project goals, major project objectives, and specific measurable objectives as delineated in the original proposal. Therefore, each project goal is stated with the subsumed major project objectives. In essence, the specific measurable objectives are the driving force behind the methodology; hence, they too will be stated and commented upon in order to give a measure of the progress which has been made. Appendices will be used to elaborate on relevant issues. As a result, the narrative per each specific measurable objective, when taken with that of other specific measurable objectives under a given major project objective, will provide the means to determine the progress on each major project objective. In turn, the same would be true with major project objectives and the respective project goals.

CENTER **HEADQUARTERS**

The Ohio State University
Department of Family Medicine
80902 University Hospitals Clinic
466 West Tenth Avenue
Columbus, Ohio 43210
614-293-6166

REGIONAL SITES

The Ohio State University

Tennessee AIDS Consortium
c/o Meharry Medical College

University of Kentucky

The University of Michigan

Cincinnati Health Department in
Cooperation with The University
of Cincinnati Medical Center

PROJECT GOAL I - ORGANIZATIONAL FUNCTION: Promote and assist in the establishment of organizational arrangements within or among state and local agencies, health care professions schools and programs, and health professions associations which will improve the development and dissemination of educational materials and the multifaceted delivery of AIDS education and training.

Major Project Objective I.A.: Establish and maintain the East Central Region AIDS Education and Training Center for Health Professionals (ECAETC) at The Ohio State University in collaboration with the University of Kentucky, Meharry Medical College, University of Michigan, and Cincinnati Board of Health

Soecific Measurable Objective I.A.1: The ECAETC will be established by 9/1/87 with the central administrative office at The Ohio State University and with respective site offices at the University of Kentucky, Meharry Medical College, University of Michigan, and Cincinnati Board of Health.

STATUS: Accomplished

COMMENT: This SMO was accomplished through the budgeting processes (Appendix A) and through the official recognition of the respective Memoranda of Agreement (Appendix B) as submitted by each Project Site office prior to, and as a part of, the development of the grant proposal.

Soecific Measurable Objective I.A.2: By 10/1/87, Project Staff will have conducted a two-day organizational meeting and committed to a schedule of regular meetings of one per month in Year-One, one every two months in Year-Two, and one every three months in Year-Three.

STATUS: Accomplished

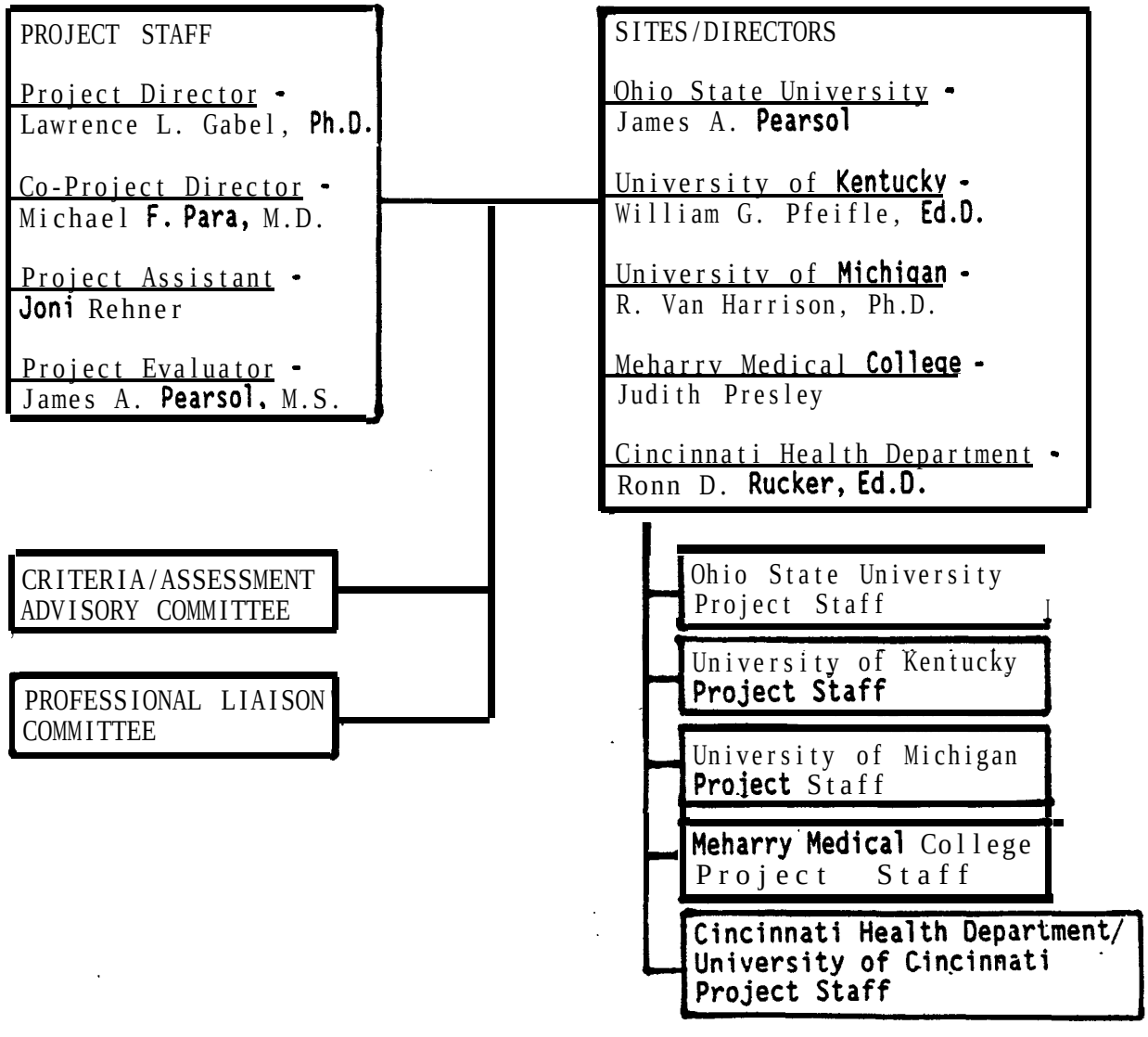
COMMENT: The first meeting was not scheduled until mid-October in that the organizational meeting in Washington of all Project Sites was not held until the first of October. Since that time, a schedule of regular meetings has been maintained. However, ***at the January meeting of the Project Site Directors, it was determined that such meetings should be held on a basis of approximately every six weeks. It was important to the group that this action be taken in that it was believed that more time was being taken than was necessary for*** the ***work of*** the ***project given how much time was involved in meetings and how little time was left on a weekly basis to work on the actual project at the respective Sites.*** Ultimately, only the months ***of February*** and ***April*** were ***excluded. At this time*** there ***is no reason to believe that a meeting will not be held every two months in Year-Two and at least once quarterly in Year-Three.***

Specific Measurable Objective I.A.3: By **10/1/87,** Project Staff will **have** determined and published the means by which administrative issues are handled at each Site and between the Sites.

STATUS: Accomplished

COMMENT: The administrative issues of each Project Site are handled locally, Therefore, at the central office there is no published protocol specifying administrative issues at a given Site. Regarding the overall administrative organizational plan, it is depicted as follows; please see Appendix I for a complete listing of Project Staff members at each Site as well as a more complete description of the administrative organizational plan.

Administrative Organizational Plan



Specific Measurable Objective I.A.4: By 10/1/87, Project Staff will have finalized all respective roles, established formal lines of communication, assured that all project personnel at each Site understand the various project components, and established short-range and long-range tasks to be undertaken as appropriate.

STATUS: Accomplished

COMMENT: Minutes of the meetings held at each Site between various project personnel indicate that each Site is functioning independently and in an appropriate coordinated role with the other Sites. Additionally, the Site Reports given ***at each Project Site Directors' meeting provides a means to monitor the process.***

Major Project Objective 1.8.: Align the respective Scopes of Work such that the appropriate personnel can undertake the task of facilitating the exchange of AIDS information and expertise and by providing training to those for whom AIDS educational programs can make a difference in the prevention, diagnosis, counseling, and management of patients and their families.

Soecific Measurable Objective I.B.l: By 11/30/87, the respective Scopes of Work will be developed in sufficient detail such that development and dissemination work can be undertaken at the Sites individually and collectively.

STATUS: Accomplished

COMMENT: Actually we found that the ***Scopes of Work (Appendix B) as presented in the original proposal were adequately detailed. As the project personnel have met on*** a ***monthly basis, what was meant by these scopes of work has become much better understood and there has been an articulation and integration of the resources available at each Site through the various Project Staff meetings. We truly have been quite impressed with the ability of so many different people in the various locations to be able to work together so harmoniously.***

Soecific Measurable Objective I.B.2: By 12/31/87, organizational logistics will have been established to assure the timely and efficient conduct of each Scope of Work and in a coordinated fashion between Sites.

STATUS: Accomplished.

COMMENT: Again, 'it must be noted that the organizational logistics have been established at each Site and the various Site personnel are to be complimented for the individual wor' that they do at their respective Sites as well as the

coordinated work they do across the Sites such that the Center is in fact a true **regional reality.** Part of what contributes to **this** is the computer-based communication link established through CompuServe (Appendix **D).** This **allows** for immediate communication as we77 as sending and receiving of larger documents, such as our various-databases (Appendix 0).

Soecific Measurable Objective **I.B.3:** By **12/31/87,** each Site will have prepared and distributed to all other Sites complete descriptions of prior experiences in educating and training as related to this project such that each Site can initiate replication in Year-One as appropriate in the respective service area.

STATUS: Accomp 7 **ished**

COMMENT: The activity of replicating education and training **experiences** across the Sites was **less** successful than anticipated. It turned out that each of the Sites did not have that much going on prior to this project which could be "packaged" **for** rep7 **icat** ion. Therefore, the. amount of **replication** which was possible in Year-One was less than was anticipated when the proposal was prepared. However, as demonstrated by the Center Report done by Jim Pearso7, considerable education and training occurred in Year-One, irrespective of **replication.** Hence, we were **fully** able to meet the intent of this specific measurable objective.

PROJECT GOA III: MATERIALS DEVELOPMENT FUNCTION: Research, design, and develop AIDS training materials for use with health care professionals.

Major Project Objective **II.A:** Determine baseline knowledge related to diagnosis and treatment and awareness of community resources related to counseling and management.

Soecific Measurable Objective II.A.l: By **2/29/88,** assess the needs and concerns of primary care **physicians** and other primary care health professionals in the region.

STATUS: Accomp 7 **i** shed

COMMENT: The work required to do a major needs assessment **across** the four states was quite staggering. This could 'have been completed by **2/29/88** if we had been **satisfied** to do a less-than-quality job. However, since it was **desirable** to develop **a pilot instrument,** to assure adequate **reliability,** and validity, **and to** refine **the instrument,** it took, some **time** (Appendix **E).** **As a result,** the work was not completed **until** early April **(Appendix** F).

Soecific Measurable Obiective II.A.2: By 2/29/88, assess the concerns of public health departments and community health agencies which serve low-income and minority residents in the region.

STATUS: Accomplished

COMMENT: It was possible to accomplish SMO II.A.2 through the meeting and work of the Criteria/Assessment Advisory Committee. This group met in January, 1988, and produced a comprehensive report (Appendix G).

Soecific Measurable Objective II.A.3: By 2/29/88, assess the concerns of the high-risk populations and those who directly provide their health care in the region.

STATUS: Accomplished

COMMENT: SMO II.A.3 was accomplished in the same manner as SMO II.A.2. That is, it was accomplished as per the meeting of the Criteria/Assessment Advisory Committee in January, 1988 (Appendix G).

Major Project Objective II.B: Determine the extent to which AIDS training materials already exist, assess their availability and cost, assess their potential usefulness and/or applicability to ECAETC training efforts, and include in the data bank for dissemination.

Soecific Measurable Objective II.B.1: By 10/31/87, begin and continue computerized and manual literature search methods to identify existing AIDS training materials, both written and mediated.

STATUS: Ongoing

COMMENT: The work related to SMO II.B.1 is being directed by the University of Kentucky. A protocol has been developed that allows the personnel there to take the leadership role but which allows personnel at the other Sites to contribute to the work.

Specific Measurable Objective II.B.2: By 11/31/87, begin and continue to annotate (based on direct review whenever possible) identified AIDS training materials that currently exist.

STATUS: Ongoing

COMMENT: This SMO will continue through the project. Again, this responsibility was assumed by the Project Staff personnel at the University of Kentucky (Appendix H).

Specific Measurable 12/31/87, we began: and continue to categorize annotations (e.g., by level, by profession, by material format, etc.) for ease of retrieval and possible use.

STATUS: Ongoing

COMMENT: This SMO will continue throughout the project. Again, this responsibility was assumed by the Project Staff personnel at the University of Kentucky (Appendix I).

Specific Measurable Objective II.B.4: By 1/31/88, share annotations on a regular basis for inclusion into the regional data bank for dissemination or utilization by ECAETC institutions in the region.

STATUS: Ongoing

COMMENT: The annotations are shared on a regular basis through the newsletter which is a part of the project. Again, the University of Kentucky is taking the lead role in this element of the methodology.

Major Project Objective II.C: Research, design, and develop written and mediated AIDS training materials as necessary to address deficits in existing training materials (per MPO 11.8).

Specific Measurable Objective II.C.1: By 8/31/88, use the results of activities associated with MPO II.A and MPO II.B to design short-term intensive AIDS training experiences at a core interdisciplinary level making sure to address knowledge, skills and psychosocial as well as other affective elements related to caring for patients and families in the primary care setting.

STATUS: Ongoing

COMMENT: Work related to SMO II.C.1 was initiated formally with the first meeting of the Criteria/Assessment Advisory Committee in January, 1988. At the March meeting of the Project Site Directors, much work and attention was given to what the curriculum is to comprise regarding interdisciplinary materials. With this determined, it was agreed that the Cincinnati Health Department/University of Cincinnati would take the lead role in developing these educational materials by 8/31/88.

Specific Measurable Objective II.C.2: Use the results of activities associated with MPO II.A and MPO II.B to design short-term intensive AIDS training experiences directed. specifically to:

A. Primary care physicians by 8/31/88.
B. Dentists by 8/31/88.
C. Nurses by 8/31/88.
D. Allied health professionals by 8/31/88.
E. Physicians assistants by 8/31/89.
F. Clinical counselors by 8/31/89.

STATUS: Ongoing

COMMENT: The progress regarding SMO II.C.2 is very similar as in SMO II.C.1. However, it should be noted that in Year-One the University of Kentucky is taking the respon.sibi7it.v for the dental materials, whereas The Ohio State University is raking responsibility for the physicians, nurses, and allied health professional materials. As ***per meetings with and conversations with the Project Officer, it was determined that it would be appropriate to develop a short-term intensive experience for EMTs. This work was undertaken by the University of Michigan Site and was completed by early June, 1988.***

The Ohio Site personnel decided that to do all of the materials related to physicians, nurses, and allied health professionals by the end of Project Year-One was not the bes: approach for them. Instead, they have elected to phase the work over the three years and to provide more than was originally proposed. An additional benefit is that the materials developed in Years Two and Three can better take into account changing needs and changing issues related to AIDS.

Regarding dentistry, this work is progressing nicely and will be completed by 8/31/88. More is being produced than was originally proposed in that it is being designed to be used with dental assistants and technicians as well as with dentists.

Specific Measurable Objective II.C.3: Produce and distribute one 3-hour Computer Assisted Instruction program for microcomputer use for:

A. Physicians and dentists by 5/88.
B. Nurses by 5/89.
C. Physician assistants and allied health professionals by 12/89.

STATUS: Accomplished

COMMENT: The work has progressed as projected to ***develop. the computer assisted instruction program 'for physicians and dentists. As it developed, it was determined that there would be one program for physicians and a separate program***

for dentists. Therefore, more is being delivered than was originally indicated. As a result, we are just completing the piloting phase and expect to be marketing both programs beginning in Project Year Two.

Major Project Objective **II.D:** Research, design; and develop **train-the-**trainer experiences and programs developed with the express purpose of preparing key individuals to replicate AIDS training experiences and to do so in an effective manner.

Byecifi8/31/88,able Objective II.D.1: e l o p **train-**the-trainer materials and experiences to facilitate replication of **core-interdisciplinary AIDS** training information/experiences on a regional basis.

STATUS: ***Ongo*** *i ng*

COMMENT: ***This work has proceeded*** *in concert with* ***SMO*** ***II.C.1.*** *The University of Kentucky personnel are responsible for all train-the-trainer materials and experiences produced as per the project .*

Specific Measurable Objective **II.D.2:** In conjunction with efforts to develop profession-specific training materials and experiences, develop train-the-trainer materials and experiences to facilitate replication of profession-specific **AIDS** training information/ experiences on a regional basis for:

A. Primary care physicians by **8/31/88.**
B. Dentists by **8/31/88.**
C. Nurses by **8/31/88.**
D. Allied health professionals by **8/31/88.**
E. Physicians assistants by **8/31/89.**
F. Clinical counselors by **8/31/89.**

STATUS: Ongoing

COMMENT: This work has proceeded in concert with SMO II.C.2. ***THe*** *University of Kentucky personnel are responsible for* ***all*** *train-the-trainer materials. and experiences produced as per the project.*

PROJECT GOAL III • EDUCATION AND TRAINING FUNCTION: Disseminate AIDS training programs for health care professionals.

Major Project Objective **III.A:** Disseminate ECAETC-developed AIDS training programs on local, state, and regional levels.

Specific Measurable **Objective III.A.1:** Produce and conduct **OMEN** programs emanating from The Ohio State University **to reach** approximately 1,700 physicians per program including:

A. One program in 11/87.
B. One program in 2/88.
C. One program in 5/88.
D. Six programs between 9/88 and 5/89.
E. Six programs between 9/89 and 5/90.

STATUS: Ongoing

COMMENT: As planned, one program was aired in 11/87 as well as one program in 2/88. The titles of these programs were:
(1) "Acute Viral Infections of the Central Nervous System," and
(2) "Criteria for ***Blood Transfusions: Should Me Reexamine Old Standards?"***

Regarding the one program ***to be*** aired in ***5/88, it was determined that this would not be done until late in Project Year-One or early in Project Year-Two. Programming for OMEN is such that more lead time was needed than would have been provided if we had continued to anticipate doing this in 5/88.***

Soecific Measurable Objective III.A.2: Produce and conduct four programs per year on the Ohio Cable Health Education Network which is available to 90 percent of all health professionals in Central Ohio (approximately 38,600).

STATUS: Ongoing

COMMENT: The programs to be produced for distribution on the cable network are just now being produced. This is because we first needed to determine the curricular issues to be addressed in relation to ***the other educational materials being developed (core-interdisciplinary and profession-specific). As well, we needed to bolster the Project Staff with persons whose expertise was in this area. Therefore, during Project Year-One we will not be able to reach the 38,600 as projected in this specific measurable objective. Regrettably, sufficient foresight did not exist in the preparation of the project application to anticipate these problems.***

Soecific Measurable Objective III.A.3: Beginning in Year-Two, product and transmit via telecommunications four programs per year directed at an interdisciplinary audience; this is predicted to reach a regional audience in the order of 200,000 health care professionals pre program.and allows for live two-way discussion via telephone networking.

STATUS: *Not applicable in Project Year-One.*

COMMENT: *Even though these activities are to be conducted in Project Years* ***Two*** *and Three, considerable planning work has gone into the preparation for the activities. This includes hiring two Graduate Research Associates to* ***develop*** *an* ***overall*** *plan and to coordinate this with a77 Site offices.*

Specific Measurable Objective III.A.4: During Project Year-Three, facilitate the expansion of the Ohio Cable Health Network (per SMO III.A.2) into all of Ohio, Michigan, Kentucky, and Tennessee as well as the [illegible] service area at a level comparable to that which exists in Ohio; this is calculated to provide an audience of health care professionals in the order of **2,000,000.**

STATUS : *Not applicable in Project Year-One.*

Soecific Measurable **Objective III.A.5:** Conduct an annual major two-day conference on AIDS using nationally known speakers and targeted at an audience of 1,000 to include approximately **one-**third **physicians,** one-third nurses, and one-third other health care providers:

A. Year-One in Columbus, Ohio, in **5/88.**
B. Year-Two in Ann Arbor, Michigan, in **5/89.**
C. Year-Three in Nashville, Tennessee, in **5/90.**

STATUS: Ongoing

COMMENT: ***Major*** *planning has been undertaken regarding the annual conference. Instead of holding the conference in* ***5/88,it*** has been determined *that it is better to* ***hold*** *it in* ***9/88.*** *As we17 the site* ***will*** *be Cincinnati, Ohio, as opposed to Columbus; this is done in recognition of the central* ***location of*** *Cincinnati within the four-state region.*

This *function is being combined with the Institutes as proposed in Specific Measurable Objective* ***III.C.l. This is because of*** *the similarity in concept, because of the site choice of* Cincinnati, *and because of the planning during* Project ***Year-One*** *of the Site Directors.*

Specific Measurable Objective III.A.6: Beginning **9/1/88,** sponsor **core-interdisciplinary** training programs (per SMO II.C.l) for local and state audiences of health care providers; the ECAETC **will average at** least three such programs per Site **to** a minimum of 75 participants per offering.

STATUS: ***Not applicable*** *in Project Year-One.*

Specific Measurable Objective III.A.7: Beginning 9/1/88, sponsor profession-specific training programs (per SMO II.C.2) for local and state audiences of health care providers; the ECAETC will average at least three such programs per site to a minimum of 75 participants per offering.

STATUS: Not applicable in Project Year-One.

Major Project Objective III.B: Disseminate ECAETC-developed train-the-trainer programs on local, state, and regional levels.

Specific Measurable Objective III.B.1: Beginning 9/1/88, offer interdisciplinary care train-the-trainer programs (per SMO III.B.1) for local, state, and regional audiences of health care providers; the ECAETC will average at least one such program per site to a minimum of 75 participants per offering.

STATUS: Not applicable in Project Year-One.

Specific Measurable Objective III.B.2: Beginning 9/1/88, offer profession-specific train-the-trainer programs (per SMO III.B.2) for local, state, and regional audiences of health care providers; the ECAETC will average at least one such program per Site to a minimum of 75 participants per offering.

STATUS: Not applicable in Project Year-One.

Major Project Objective III.C: Provide technical assistance in the design and implementation of appropriate AIDS inservice and continuing education programs for health care providers.

Specific Measurable Objective III.C.1: Design and sponsor (with appropriate ECAETC input) an annual three-day AIDS Training Institute to be held in Lexington, Kentucky, at the end of each project year, for an estimated 500 individuals in the region who are responsible for AIDS training.

STATUS: Ongoing

COMMENT: The determination has been made that the Institute will be expanded to institutes. As a result, these institutes will be held in conjunction with the annual conference (see SMO III.A.5). A unique and interesting design has been constructed by the Project Site Directors and much excitement is building with regard to the anticipated results. As stated previously, this is all scheduled for 9/88.

Soecific Measurable Objective III.C.2: Respond to requests for direct consultation and follow-up on program design, presentation skills, utilization of training resources, etc., from ECAETC and regional AIDS trainers on a formal (e.g., information packets, resource lists, etc.) and information (e.g., telephone, correspondence, and direct contact) basis.

STATUS: ***Ongoing***

COMMENT: *An evaluation system has* ***been developed and is in place to demonstrate the 7evel of activity with regard to respondingto requestsfor direct consultation and follow-up on program design, etc., from other individuals (Appendix J).***

PROJECT GOAL IV - INFORMATION COLLECTION AND DISSEMINATION FUNCTION: Collect and disseminate to the health care community information on AIDS research, clinical care,, educational programs, and instructional resources.

Major Project Objective IV.A: Disseminate updated information regarding HTLV-III/LAV to the various health care communities served by the ECAETC.

Soecific Measurable Objective IV.A.1: Beginning 11/1/87, collect. catalogue, and store as appropriate both printed and non-printed materials related to HTLV-III/LAV.

STATUS: Ongoing

COMMENT: This work is being directed by the University of Cincinnati as a part of the subcontract with the Cincinnati Health Department. Major progress has been made and the results re available through that Project Site.

Soecific Measurable Objective IV.A.2: Beginning 11/1/87, conduct a monthly computerized search of appropriate information systems for articles and data related to HTLV-III/LAV, saving pertinent information in a data base.

STATUS: Ongoing

COMMENT: Again, this work is being directed by the personnel at the University of Cincinnati as per the subcontract with the Cincinnati Health Department.

Soecific Measurable Objective IV.A.3: Beginning 1/1/88, develop' and distribute a.quarterly newsletter for sharing abstracts, clinical developments, and so forth, regarding HTLV-III/LAV with heal th professionals.

STATUS: Ongoing

COMMENT: The work was begun even before the quarter beginning 1/1/88. It was expected that the first newsletter would be distributed in the first quarter of 1988; however, the first edition will be distributed late in Project Year-One. The newsletter will be distributed not to specific individuals, but to associations and entities which are interested in AIDS issues such that the content of the newsletter can be disseminated by those groups.

Major Project Objective IV.B: Disseminate information regarding AIDS education and training resources, curricular materials, and ***courses.***

Sbecific Measurable Objective IV.B.1: Beginning 11/1/87, compile information about resources available in the ECAETC region, to include listings of seminars, symposia, panels, and continuing and inservice programs for inclusion into the ECAETC data bank and for regional dissemination.

STATUS: Ongoing

COMMENT: To accomplish this objective, each Site Director is submitting listings of educational programs done within the region even though we are not responsible for them. This information is catalogued in a Center data base and is available for dissemination though the newsletter as we17 as on a call-in basis.

Sbecific Measurable Objective IV.B.2: Beginning 11/1/87, compile existing academic AIDS course/program descriptions within the ECAETC region for inclusion in the ECAETC data bank as appropriate.

STATUS; Ongoing

COMMENT: Again, the information needed regarding this SMO is developed and submitted by each Site Director. That information is included in a Center data base; this information is available per request and is distributed through the newsletter.

Specific Measurable Objective IV.B.3: Respond to requests on a local, state and regional basis for information on AIDS resource materials and training opportunities, as facilitated by ECAETC regional linkages as well as liaisons and linkages nationally.

STATUS: Ongoing

COMMENT: Surprisingly, this activity began even before we were quite ready for it. Because we quickly got our name out ***and the function of*** the ***Center, a number of persons began to turn to each of the Site offices as well as the Center office for information about AIDS training opportunities. We have been able*** to ***respond to each one of these in a timely manner and have developed a recording system through our Evaluation Coordinator.***

Major Project Objective IV.C: Provide advice, assistance, and educational services in support of AIDS training in ECAETC region · hosptials, agencies, associations, colleges and universities, and other organizations/entities.

Specific Measurable Objective IV.C.l: Beginning **1/1/88,** liaison with hosptials, home health agencies, ambulatory clinics, etc., to support their efforts to provide AIDS training programs and/or experience for their practitioners.

STATUS: Ongoing

COMMENT: This ***work is beginning to gain momentum as we make contact with the various agencies and associations which are responsible to these entities.***

Specific Measurable Objective IV.C.2: The AIDS informational network concept in the ECAETC region by developing direct communication links and liaisons as appropriate to:

A. State deoartments for human resources and health;
B. AIDS screening centers;
C. Local health departments;
D. Hospice departments;
E. **Longterm** care associations;
F. AHECs;
G. Hospital associations; and
H. Regional universities and community colleges.

STATUS: *Ongoing*

COMMENT: Essentially this is being done by the Site ***Directors contacting the various appropriate agencies within*** *their states. We have established these information networks and* ***this*** *work* ***will*** *continue to gain momentum,* ***as*** *we are able* ***to*** *accomplish* ***other work which we*** *have before us,* ***particularly*** *the* ***developmental work*** *of the* ***educational materials. The work of the Professionaf Liaison Committee has been particularly useful in this regard (Appendix K).***

APPENDIX IV

Sample : Product Development/Evaluation

T · H · E
OHIO
STATE
UNIVERSITY

Division of Computing Services
For Medical Education and
Research

076 Health Sciences Library
376 West Tenth Avenue
Columbus, OH 43210-1240
Phone 614-292-6192

August 9, 1988

Ronn Rucker
Cincinnati Health Center
3101 Burnett Avenue.
Cincinnati, Ohio 45229

Dear Ronn:

At tie AIDS meeting in Columbus, July 25 through 27th, we provided you with five copies of AIDS 'Vignettes for physicians' with associated documentation. If you have already had physicians review these materials and have returned them to me, we sincerely appreciate your assistance and prompt response to our request.

If you have not returned all of the diskettes and associated documentation to us after the materials have been reviewed, please do so as soon as possible. we are in the final phases of revising these materials and preparing them for distribution at the September conference. Input from you and the physician reviewers you ask to examine these programs are critically important to us in creating the highest quality product possible. Please forward the diskettes and associated documentation back to me within the next couple of days.

We appreciate your support and assistance in these endeavors. Copies of the final product will be provided to you in September.

Sincerely yours,

Ron

Ronald C. Comer, Ph.D.
Director

RCC/lf

cc: Larry Gabel

(this letter also sent to:

William Pfeifle
Judy Presley
R. Van Harrison

T · H · E
OHIO
STATE
UNIVERSITY

Division of Computing Services
For Medical Education and
Research

076 Health Sciences Library
376 West Tenth Avenue
Columbus, OH 43210-1240
Phone 614-292-6192

TO: Ronn Rucker
William Pfeifle
Judy Presley
R. Van Harrison

FROM: Ronald C. Comer, Ph.D. rcc
Director

SUBJECT: Field Test of Computer-Assisted Instruction Vignettes

DATE: July 26, 1988

Enclosed are five copies of the "Vignettes for Physicians" that we have prepared for field trial at your site. We would be most appreciative if you would ask at least five physicians with whom you are familiar to review and evaluate the four vignettes and the associated documentation. We would like for you to retrieve the diskettes and the documentation from your reviewers, package the materials, and return all of it to us no later than August 9, 1988.

Each packet of materials that you hand out to physicians should consist of:

1) two diskettes, Disk I (Vignettes 1 and 2) and Disk II (Vignettes 3 and 4)
2) documentation describing the programs
3) an evaluation instrument to evaluate the programs
4) a continuing medical education posttest questionnaire.

You and your physician reviewers are free to make suggestions on any of these materials.

Your review and critical comments are extremely important in creating a high quality, final product for distribution. We would like to know of any problems that are encountered in using these materials. If a reviewer encounters a problem during a vignette, and has a printer attached to his/her computer, please ask them to use the shift and print screen (PrtSc) keys and write comments on the printed copy of the screen with which the problems occurred.

We sincerely appreciate your assistance in evaluating the vignettes. Please return the documentation and each of the diskettes (there should be a total of 10 diskettes) to:.

Dr. Ronald C. Comer
076 Health Sciences Library
376 West 'Tenth Avenue
Columbus, Ohio 43210-1240

We will revise the programs and documentation based upon these reviews. The final version of the vignettes will be available for general distributionatthe September conference.

/lf

EVALUATION INSTRUCTIONS AND QUESTIONNAIRE

AIDS - Vignettes for Physicians

INSTRUCTIONS

We would like you to: 1) follow the procedures below and 2) give us your critical evaluation of the AIDS computer-based instructional vignettes. We want you to comment on the content as it is presented: but, we also want your perspectives on the educational advantages and disadvantages of the computer-based instruction approach.

There are two key steps in the evaluation process -- 1) while you are completing the computer-based lessons, you can stop and print the screen (press the shift and **PrtSc keys** simultaneously) and write your suggestions for changes on the printed version **of** the screen, and 2) complete the attached questionnaire (one for each.case).

Both steps are crucial in our efforts to revise and fine-tune the computer-based lessons; therefore, even'though it will slow you down somewhat, please be sure to stop and print screens in any instances where you think something should be revised, added, or deleted.

Your evaluations of the AIDS computer-based lessons will be confidential, but be assured that we value your suggestions highly and will use your suggestions to improve the lessons. THANKS **FOR YOUR HELP.**

---- REMEMBER ----

1. PRINT SCREENS AND WRITE. COMMENTS ON THE **PRINTOUTS** **ANYTIME** YOU WISH TO CHANGE, ADD, OR DELETE SOMETHING.

2. COMPLETE AND RETURN THE ATTACHED **QUESTIONNAIRES** ALONG WITH THE TWO **DISKETTES** TO YOUR AIDS' SITE DIRECTOR.

East Central
AIDS
Education And Training Center

presents

AIDS
Acquired Immune Deficiency Syndrome
Vignettes for Physicians
Four Case Presentations

Professional Consultant (Author)
Michael F. Para, M.D.
Associate Professor, Internal Medicine
Associate Professor, Microbiology and Immunology

developed by the
Division of Computing Services
College of Medicine

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Program Guide (Read before reviewing vignettes)

This guide provides information and instructions for participation in AIDS - Vignettes for Physicians. Excerpts from this guide appear in the program to facilitate proper execution of the program.

Vignettes Each vignette, designed to be completed in one sitting (15-25 minutes), is a case presentation which:

* describes the role of a primary care physician in a specific simulated situation;
* focuses on one or more of the basic questions which may arise in connection with medical practice associated with AIDS;
* varies individual participation according to responses given; and
* provides basic AIDS and related information.

The interaction within a vignette places you in the role of the physician. For most questions, you will be asked to respond by selecting from available multiple choice/dichotomous options (A, B, C, Y/N, etc.). In a few instances, you will be asked to enter a narrative text response. Narrative responses should brief and specific to the question asked.

Interruptions which are external to the flow of the vignette but essential to the situation, appear throughout each vignette in a framed overlay to pose a question, monitor your decision or discuss important factors, behaviors, and practices, etc. Even though the vignette varies according to your response, all material essential for objective achievement is presented.

Cases (vignettes) 1 and 2 are contained on Disk I and 3 and 4 are contained on Disk II.

DISK1

Case 1 - Karen A 24-year-old female presenting for a premarital pelvic examination

The interaction of Case 1 focuses on the evaluation of Karen's risk for HIV infection, the discussion of the pros and cons of HIV antibody testing and the determination of her need for an HIV antibody test.

Attheconclusion of this vignette, you should be able to:
1. identify modes of HIV transmission.
2. identify epidemiologic features of AIDS, risk groups.
3. recognize the relative importance of issues pertaining to the discussion of sexual practices and AIDS.
4. justify HIV antibody testing; evaluate risk of HIV infection.

Case 2 - Ann A 65-year-old female with generalized lymphadenopathy

This vignette focuses on the identification of Ann's problem, discussion of her current situation and alternatives for the future, and the evaluation of the infection control practices in a physician office. Participants are given the opportunity to review CDC's infection disease control recommendations and to profile their present control.

At the conclusion of this vignette, you should be able to:
1. outline the clinical spectrum of early HIV infection; indicate when HIV antibody testing is appropriate.
2. recognize that the typical office might already be performing the care but not using safety precautions.
3. propose proper infection control practices intheoffice.
4. recognize the epidemiology of HIV and blood transfusion.
5. justify reporting practices.

Disk II

Case 3 - Tom 25-year-old male presenting with hemorrhoidal pain

The identification of Tom's current problem, a discussion of his lifestyle, safe sex practices, and the psycho-social implications associated with testing of the HIV antibody, and the recognition of the role of the primary care physician in infection prevention education are the foci of Case 3.

At the conclusion of this vignette, you should be able to:
1. discuss sexuality in routine practice.
2. recognize the role of the primary care physician in infection prevention education.
3. suggest safe sex practices.
4. exhibit perception of homosexual lifestyle.

Disk II

Case 4 - School Board Member Chairman of the AIDS Policy Committee

This vignette places a primary care physician in the role of chairman of the AIDS Policy Committee of a local school board. Created for the purpose of defining essential points to be included, the committee discusses the composition of an admission review panel; reviews related studies, guidelines, recommendations and existing AIDS policies; and suggests activities related to the implementation of an appropriate policy.

At the conclusion of this vignette, you should be able to:

1. discuss the likelihood of casual transmission.
2. recognize one role the primary care physician might assume as a community educator regarding AIDS.
3. recognize AFRAIDS (acute fear reaction to AIDS).
4. identify epidemiological features of HIV infection in hemophilia.
5. suggest essential points (based on national recommendations) to be included in an AIDS policy for a local school board.

Continuing Medical Education - Physician's Recognition Award

The Ohio State University College of Medicine's Center for Continuing Medical Education (CCME) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The CCME office has designated that AIDS - Vignettes for Physicians (cases 1, 2, 3 and 4) meets the criteria for 2.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

CCME will provide a certificate to those who achieve a satisfactory score on the post-test included with this program. **To obtain credit, complete and mail the pre-addressed CME registration form, the answer sheet, and a print of the completion statement for each of the four (4) cases.**

Program Operations

Color or Monochrome Screen Displays
One of the first decisions you are asked to make upon accessing the program is to adjust the BRIGHTness and/or CONTRAST for optimal readability of displayed alphabet containing the various colors used in the program. On the same screen, you are given the opportunity to change all text screen displays to white text on a black screen.

If you have a monochrome monitor it is suggested that you type **M** (and press **Enter**) for a monochrome display. (Note: if you do not like the monochrome display, type C (and press Enter) for the return of the color display. Press **ENTER** when adjustments are complete.

Note: Make your decision here — color or monochrome. This adjustment screen is the only opportunity you have to make the change — without rebooting the disk and starting over.

General Directions

Each time **Enter.Continue** appears in the lower right-hand corner of the screen, press the ENTER Key to continue. When you see a flashing cursor, the program is ready for a response from you. Press the **ENTER** key after typing each response.

Information about your other options at any point in the program appears in a footer across the bottom of the screen. Note: When **M.Main Menu** is a prompt in the footer, you may return to the Main Menu by pressing **M (and Enter)**.

Use the **Back-Arrow** Key (located above the **ENTER** Key) to edit responses BEFORE pressing the **ENTER** Key.

Back Page

Limited backpaging is available when indicated in the footer of the vignettes. You may page back to review previously displayed material. Responses cannot be changed but you may page forward, one screen at a time or return automatically to the screen at which you invoked backpage.

When **PgUp.Back** appears in the left hand corner of the footer, you may invoke backpage by pressing the PgUp key — and continue backpaging with each stroke of the PgUp key until the limit is reached. At that point, **PgUp.Back** is not a valid option (the prompt is nut displayed). Other prompts that appear in the footer related to backpaging are:

PgDn.Forward (Press the **PgDn** key to page forward)

End.Resume (Press the **End** key to jump to the screen where you started backpaging)

If you invoke backpage while the program is awaiting a response, **Answer Question** appears in the right corner of the footer when you return (using the **PgDn** or **End key**) to the screen where you started backpaging. Otherwise, **Enter.Continue** appears. Proceed as directed — respond or press the **Enter** key to continue.

Printing

To receive a print of any screen during your interaction, be sure the printer is on and then press the **Shift** Key and the **PrtSc** Key simultaneously. At the conclusion of Case 2, you are asked if you would like a print of your Office Practice Profile (CDC Infectious Disease Control recommendations for office practice). If yes, follow printing instructions given on screen.

To Start the Program (boot the disk)

System Requirements - IBM PC or 100% compatible microcomputer; at least 256K of memory; color or monochrome display monitor; color graphics adapter card or equivalent — graphics screens will not print on computers with a monochrome card.

Place the disk (label side up) in Drive A of an IBM PC and turn on the power. The rest is automatic. Proceed as directed in the guide and program. After pressing Enter at the end of a vignette, you are automatically returned to the Main Menu.

You may also boot the disk in Drive A by simultaneously pressing the **Ctrl, Alt and Del** keys.

ECATEC

CME Post Test Questions for HIV CAI

1. All of the following would place a young woman at high risk for HIV infection EXCEPT?
   a) IV drug abuse and sharing needles
   b) Sexual intercourse with an IV drug abuser
   c) Sexual intercourse with a bisexual male
   d) Sexual intercourse with a heterosexual male
   e) sexual intercourse with a hemophiliac male.

2. Which of the following has been shown to transmit HIV — one answer or more than one
   a) Use of illicit IV drugs but never using a shared or used needle
   b) Kissing with salivary exchange.
   c) Heterosexual intercourse without anal sex
   d) Orogenital sexual contact
   e) Eating food contaminated with HIV

3. All of the following concerning the testing for HIV antibodies are true EXCEPT:
   a) Should be done on all sexually active individuals
   b) Does not directly measure the presence of virus
   c) Might be considered for a patient with his second bout of gonorrhea
   d) Is done routinely on military recruits and active duty members of the armed forces
   e) May give the wrong results (false positive or f-negative)

4. Blood was first screened for HIV antibody in:
   a) I.983
   b) 1985
   c) 1986
   d) 1987
   e) 1988

5. Is the blood supply now absolutely free of HIV?
   a) Yes
   b) No
   c) Might be

6. Time till seroconversion (from HIV infection till detectable antibodies) for the vast majority of infected individuals is
   a) less than 1 month
   b) less than 2 months
   c) less than 6 months
   d) less than 12 months

7. At the present time the risk of HIV acquisition from a unit of blood is closest to which of the following?

a) 1 in 100
b) 1 in 1,000
c) 1 in 10,000
d) 1 in 100,000
e) zero

8. All of the following are recommended by the CDC for infection control of HIV in the medical setting EXCEPT:

a) Gloves should be worn for touching all body fluids, mucous membranes or non-intact skin.
b) Gloves should be worn for handling items or surfaces soiled with body fluids.
c) Gloves should be worn for any patient contact with a known HIV infected individual.
d) Masks and protective eyewear or face shields should be worn during procedures likely to generate splashes to prevent exposure of mouth, nose and eyes.
e) Gowns or aprons should be worn during procedures likely to generate splashes

9. All of the following are recommended by the CDC for infection control of HIV in the medical setting EXCEPT:

a) Needles should be recapped or bent before disposal.
b) Disposable items should be placed in puncture resistant containers kept as close as practical to area of use.
c) Reusable sharp items should be placed in a puncture resistnat container for transport to reprocessing area.
d) Mouthpieces, resuscitation bags or other ventilation devices should be available in areas where resuscitation is predictable.
e) Spills of blood or body fluids shold be cleaned with gloves or with soap and water. They then should be disinfected with any approved tuberculocidal "hospital disinfectant" such as a 1 to 10 dilution of bleach.

10. After getting a positive EIA for antibodies to HIV in a low risk person (non IV drug using heterosexual) your best course of action should be to:

a) inform the patient that they have AIDS
b) inform the patient that they are infected by HIV
c) inform the patient their EIA was positive and but you need to double check the EIA
d) don't say anything to the patient until you double check the EIA
e) repeat the EIA and have a western blot performed before telling the patient

11. Patients infected with HIV (carrying antibody):
a) Will all die of AIDS
b) Have an incidence of AIDS at 5 yrs. after HIV infection that is 15 to 20% and at 7 yrs of about 35%
c) Have an incidence of AIDS at 5 yrs after HIV infection that is 15 to 20% and at 7 yrs of about 35% but ultimately what percent of infected will develop AIDS is unknown as yet
d) Have an incidence of AIDS at 5 yrs after HIV infection that is 50% and at 7 yrs of about 90%

12. If a married heterosexual man is infected with HIV, ~~their~~ her spouse:
a) should be informed by the physician of ~~their~~ his partner's HIV infection
b) should be informed of ~~their~~ her partner's infection by the infected patient
c) by law must be informed by the physician of ~~their~~ her spouse's infection
d) by law must not be informed by the physician of ~~their~~ her spouse's infection

13. What is the approximate prevalence of HIV infection in the wives of HIV infected hemophilic men (assume that the hemophilic men were infected by HIV from 1981 to 1984)
a) 0-5%
b) 10-25%
c) 50-75%
d) nearly 100%

will this information be dated after publication of AIDS vignettes

14. A sexual history should be obtained:
a) whenever there is genital pathology on exam
b) whenever the patient gives history of exposure to an STD
c) whenever the patient complains of genitourinary symptoms
d) on all patients a part of their complete history and physical exam

15. Homosexuality is a mental illness:
a) True
b) False
c) Sometimes

16. Testing all homosexuals to antibodies to HIV is good practice.
a) True
b) False

17. The best reason for testing homosexual men for HIV antibodies is: (select one)
a) To determine if they are infected
b) To help reinforce safer sexual behavior
c) To limit the spread of HIV
d) To relieve the stress of thinking they are infected

18. AIDS education should begin:
a) In grades 11 or 12
b) In grades 9 or 10
c) In grades 7 or 8
d) In grades 5 or 6
e) As early as possible

19. HIV infection in hemophiliacs is
a) less than 1% - very rare
b) 1-10% - uncommon
c) 10-40% - common
d) 40-80% - very common
e) more than 80% - nearly all

20. In the absence of sexual contact and needlestick injury there is evidence that HIV has been transmitted in:
a) a school environment
b) a non-health industry work environment
c) a health industry work environment
d) the homes of HIV infected individuals
e) None of the above

Answer key?

EVALUATION QUESTIONNAIRE

Program Name: AIDS - Vignettes for Physicians CASE 1 (Karen)

Medical Specialty Family Practice

Evaluation of content (circle one selection for each item)

1. Importance of content

a. not important
b. of little importance
(c) important
d. essential

2. Practical value of content

a. none
b. of some value
(c) valuable
d. exceptional

3. Improvement of your knowledge

a. none
(b) a little
c. considerable
d. exceptional

4. Your interest in material

a. of little interest
b. somewhat interesting
(c) interesting
d. extremely interesting

5. Coverage of AIDS topics

a. too detailed
(b) appropriate
c. too superficial

6. Would you recommend this program to a colleague?

(a) yes
b. no
c. undecided

Evaluation of computer displays and interaction

7. Quality of the computer presentation

a. poor
b. fair
(c) good
d. exceptional

8. Ease of use

a. impossible to use (please comment)
b. somewhat complicated
(c) easy to use (minor problems)
d. very easy to use (no problems)

9. Educational value of format

a. of no use
b. of little educational use
(c) useful educationally
d. very useful educationally

10. Comments on content or computer interaction:

see notes on attached printouts

EVALUATION QUESTIONNAIRE

Program Name: AIDS - Vignettes for Physicians CASE 2 (Ann)

Medical Specialty Family Practice

Evaluation of content (circle one selection for each item)

1. Importance of content

a. not important
b. of little importance
c. important
(d.) essential

2. Practical value of content

a. none
b. of some value
(c.) valuable
d. exceptional

3. Improvement of your knowledge

a. none
b. a little
(c.) considerable
d. exceptional

4. Your interest in material

a. of little interest
b. somewhat interesting
(c.) interesting
d. extremely interesting

5. Coverage of AIDS topics

a. too detailed
(b.) appropriate
c. too superficial

6. Would you recommend this program to a colleague?

(a.) yes
b. no
c. undecided

Evaluation of computer displays and interaction

7. Quality of the computer presentation

a. poor
b. fair
(c.) good
d. exceptional

8. Easeofuse

a. impossible to use (please comment)
b. somewhat complicated
(c.) easy to use (minor problems)
d. very easy to use (no problems)

9. Educational value of format

a. of no use
b. of little educational use
(c.) useful educationally
d. very useful educationally

10. Comments on content or computer interaction:

see comments on printouts attached

EVALUATION QUESTIONNAIRE

Program Name: AIDS - Vignettes for Physicians CASE 3 (Tom)

Medical Specialty Family Practice

Evaluation of content (circle one selection for each item)

1. Importance of content

a. not important
b. of little importance
c. important
(d.) essential

2. Practical value of content

a. none
b. of some value
(c.) valuable
d. exceptional

3. Improvement of your knowledge

a. none
b. a little
(c.) considerable
d. exceptional

4. Your interest in material

a. of little interest
b. somewhat interesting
(c.) interesting
d. extremely interesting

5. Coverage of AIDS topics

a. too detailed
(b.) appropriate
c. too superficial
(see below comment)

6. Would you recommend this program to a colleague?

(a.) yes
b. no
c. undecided

Evaluation of computer displays and interaction

7. Quality of the computer presentation

a. poor
b. fair
(c.) good
d. exceptional

8. Ease of use

a. impossible to use (please comment)
b. somewhat complicated
(c.) easy to use (minor problems)
d. very easy to use (no problems)

9. Educational value of format

a. of muse
b. of little educational use
(c.) useful educationally
d. very useful educationally

10. Comments on content or computer interaction:

Would liked to have had a screen with the 25 diseases which are sexually transmitted

EVALUATION QUESTIONNAIRE

Program Name: AIDS - Vignettes for Physicians CASE 4 (AIDS Policy Committee)

Medical Specialty Family Practice

Evaluation of content (circle one selection for each item)

1. Importance of content

a. not important
b. of little importance
(c.) important
d. essential

2. Practical value of content

a. none
b. of some value
c. valuable
(d.) exceptional

3. Improvement of your knowledge

a. none
b. a little
c. considerable
(d.) exceptional

4. Your interest in material

a. of little interest
b. somewhat interesting
(c.) interesting
d. extremely interesting

5. Coverage of AIDS topics

a. too detailed
(b.) appropriate
c. too superficial

6. Would you recommend this program to a colleague?

(a.) yes
b. no
c. undecided

Evaluation of computer displays and interaction

7. Quality of the computer presentation

a. poor
b. fair
c. good
(d.) exceptional
(see below)

8. Ease of use

a. impossible to use (please comment)
b. somewhat complicated
(c.) easy to use (minor problems)
d. very easy to use (no problems)

9. Educational value of format

a. of no use
b. of little educational use
c. useful educationally
(d.) veryusefuledwlticmal3.y

10. Comments on content or computer interaction:

I liked the way the correct answer was highlighted in white on the screen after a choice was made.

APPENDIX V

ECAETC Program and Service Record

ECAETC PROGRAM AND SERVICE RECORD

Directions for Completing Record and Explanation of Categories

DIRECTIONS. The Purpose of this reporting procedure is to document the nature and scope of activities sponsored or assisted by the ECAETC Sites per month. Each record should be completed for each documented activity. Therefore, there will be one record for each activity; the total number of each record will equal the number of activities reported forthenmth. For each record listed, please attach an agenda and a list of faculty and/or contributors if appropriate.

EXPLANATION OF CATEGORIES

1. Site. The two-letter site designation should be entered here.

2. Date. The date (yymmdd) of each activity documented should be enteredhere.

3. Title. Thetitlewillidentifythe activity to be documented. In the case of either sponsored or assisted activities, repeats of activities should be recorded in the monthly report of the month in which the activity was repeated. (This assumes that you will maintain an awareness and record of assistance given to others over time.)

4. Hours. This category defines "hours" in terms of the hours planned for an educational activity; "activities" might range from a one-hour lecture to a three-day workshop. Hours does not refer to the hours devoted to an activity by the learner (as in the variable hours which might be recorded for CAI). Document only whole and half hours, starting with a minimum of one hour.

5. Objectives. The specific measurable objectives (see original proposal) which the documented activity meets should be identified by number, i.e., SMO IV.B.1.

6. Code. This category specifies the nature of sponsorship or assistance provided by the ECAETC site.

A = sole sponsorship.
B = co-sponsorship (with one or more agencies or groups. All co-sponsors should be listed on agenda attached for each activity).
C = assistance, with resource contribution (whether financial, material, space, or personnel).
D = assistance, with no resource contribution (this somewhat ambiguous classification refers to intangible, but legitimate, assistance provided that does not include tangible resource contributions).

ECAETC PROGRAM AND SERVICE RECORD
Directions: **Page Two**

7. **Method.** This category permits classification of educational methods used during an activity. The following methods should cover most, if not all, ECAETC sponsored or assisted educational events'.

A = Didactic
B = Group Process
C = Self-study

8. Media. This category describes the educational media used in an activity.

D = OMEN (Ohio Medical Education Network)
E = CAI (Computer Assisted Instruction)
F = Videotape
G = Workbook
H - Lecture/discussion
I = Workshop
J = Teleconference

9. **Audiences (Number of participants).** These are the current target audiences for the ECAETC. Total numbers of participants should be recorded by health professional audience for each activity. Use the Other category to report the numbers for each health professional group not indicated by one of the other specified target audiences.

10. Specify any audience noted in the Other category under item (9).

11. **Number who are minorities.** Estimate the total numberofminorities who participated in the activity.

12. **Number Urban, Number Rural.** Indicate the number of participants coming from urban and/or rural areas.

13. site staff. List the names and affiliations of ECAETC personnel who participated in the delivery of the educational activity.

14. **Other Staff.** List the names and affiliations of non-ECAETC personnel who participated in the delivery of the educational activity.

November 28, 1988
/mar

East Central AIDS Education and Training Center
PROGRAM & SERVICE RECORD

(1) Site [_ _] (CI, KY, MI, OH, TN) (2) Date [_ _ _ _ _ _] y y m m d d

(3) Title [_ _] (25 letters maximum)

(4) Hours [_ _ _]

(5) Objectives per proposal [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

(6) Code [_]
A = sole sponsorship
B = co-sponsorship
C = assistance/resource contribution
D = assistance/no resource contribution

(7) Method [_ _ _]
A = Didactic
6 = Group Process
C = Self' study

(8) Media [_ _ _ _ _ _ _ _ _ _]
D = OMEN (Ohio Med Ed Network)
E = CAI (Computer Assisted Instruction)
F = Videotape
G = Workbook
H = Lecture/Discussion
I = Workshop
J = Teleconference

(9) Audience (No. of Participants)

MD [_ _ _ _ _]
RN [_ _ _ _ _]
DDS [_ _ _ _ _]
Allied Health [_ _ _ _ _]
SW/Counselor [_ _ _ _ _]
Physician's Assistant [_ _ _ _ _]
EMT [_ _ _ _ _]
Other [_ _ _ _ _]

(10) Specify "Other" [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

(11) No. Minorities:
Black American [_ _ _ _ _] Mainland PR [_ _ _ _ _]
Am. Indian [_ _ _ _ _] Other Hisp. [_ _ _ _ _]
Mexican-Am. [_ _ _ _ _] Asian Am. [_ _ _ _ _]
Other [_ _ _ _ _]

(12) No. Urban [_ _ _ _ _]
No. Rural [_ _ _ _ _]

(13) Site Staff [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

(14) Other Staff [_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _] (20 letters maximum)

APPENDIX VI

University of Michigan, General Evaluation Form

University of Kansas Medical Center

COURSE EVALUATION

Course Title

Course Dates

Please complete the following evaluation form and return it to the Registration Desk prior to your departure. The course planning committee needs your reactions and suggestions to begin to develop next year's conference. Thank you for your assistance.

1. Your major area of practice (circle one):

   Nurse Radiologist Radiation Therapist Radiology Technologist

   Other (please specify) _____

2. Was this course a learning experience? **5** 4 3 2 I
   Yes No

3. What parts of the course did you find most valuable?

   _____

   _____

   _____

4. What parts of the course did you find least valuable?

   _____

   _____

   _____

5. As a result of this conference, will you do anything differently in your work setting?

   Yes No If yes, give an example: _____

   _____

6. Please list topics you would like included in future courses of this kind.

   _____

   _____

7. To what extent do you feel that material presented in the course was too advanced or too elementary?

5 4 3 2 1
Too advanced Too elementary

8. Speakers that should be invited back: (You need not list all speakers.)

_____

_____

_____

9. Speakers whose presentations were unsatisfactory:

_____

_____

_____

10. Would you recommend this course to others? Yes No
If yes, please complete the following information for that person, clinic, or hospital:

Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____

11. How did you learn about our program?

_____ Advertisement: Name of Journal/Paper _____

_____ Brochure

_____ Past Attendance

_____ Colleague

12. General Comments: _____

_____

_____

_____

APPENDIX VII

University of Kentucky: Preliminary Program Report, AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals

PROGRAM REPORT: AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals. October 31, 1990.

PRELIMINARY PROGRAM REPORT

AIDS and HIV Disease:

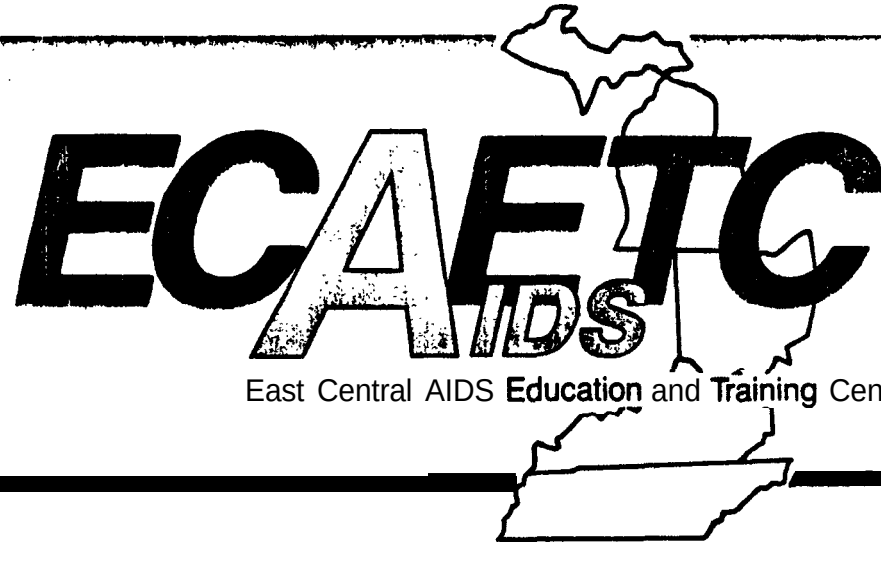
Effective Training Strategies for Dental Health Professionals

Ann ***H. Crowe,*** *M.S.S.W., A.C.S.W.*

Paula Parise, R.D.H., **M.S.**

University *of Kentucky*

February 28, 1990



PROGRAM DESCRIPTION

A program entitled AIDS *and HIV Disease: Effective Training Strategies for Dental* Health *Professionals* was held February 1 -2, 1990 at the University of Kentucky in Lexington, Kentucky. The event was jointly sponsored by ACT Lexington, Procter & Gamble, and the East Central AIDS Education and Training Center at the University of Kentucky. The participants of the training program included dentists, dental hygienists, dental assistants, and dental laboratory technicians.

The Need *for Training*

Persons with AIDS and HIV disease have expressed.serious concerns related to dental care during their illness. Some have experienced blatant discrimination. while others have encountered dental professionals who do not feel competent or comfortable treating patients with HIV disease. A need exists for education and training of dental professionals related to AIDS and HIV disease to dispel the myths regarding treatment, improve access to care, and impact upon their attitudes, values and behaviors.

Purpose

The purpose of the training program was to train select dental professionals in Kentucky and surrounding states to provide instruction about HIV to practicing dental professionals in their communities. Upon completion of the training program, the trainees were prepared to conduct training efforts with professional peers. Hence, the five goals of the training program were to:

- disseminate factual information:
- facilitate the acquisition of knowledge:
- impact upon attitudes and values:
- enlist and reinforce positive behaviors of dental professionals regarding AIDS and HIV disease: and
- field test textual materials developed by the University of Kentucky for this and other training programs.

Program objectives are included in Appendix B.

Curriculum Design and Materials

The curriculum design of the lraintng program built discipline-specific (dental) content on a core base of AIDS information. Train-the-trainer techniques and strategies were interspersed with dental and AIDS content. Program content included train-the-trainer sessions, an AIDS update, Lhe dental perspective on HIV disease, and the preparation of a dental training program on AIDS.

Curricular materials included five training modules and a trainer's guide developed for the training program by the University of Kentucky. These materials were field tested at the training program. Materials evaluation forms were distributed with each module. A training plan form was provided for future training programs planned and conducted by the participants. Refer to Appendix C for the training plan.

PARTICIPANT PROFILE

Recruitment

The participants of the training program were recruited by the University of Kentucky staff from a network of dental professionals who shared the commitment to participate in training sessions to increase knowledge and impact the values and behaviors of other dental health care professionals. All professional members of the dental team were represented in the participant roster.

Geographic *Distribution*

Participants were recruited from a four state region (Kentucky. Tennessee; West Virginia, and Indiana). Efforts were made to recruit participants from all areas of Kentucky as well as surrounding states in our service area.

Twelve (79%) of the participants were from Kentucky. The breakdown of participants from Kentucky was as follows.

Ashland	1
Bowling Green	2
Frankfort	1
Lexington	5
Louisville	1
Owensboro	1
Paducah	1
TOTAL	12

The remainder of the participants were from:

Charleston, WV	1
Indianapolis, IN	1
Nashville, TN	3
TOTAL	5

The following collective information about the program participants was obtained from a Participant Profile. See Appendix D for the participant profile instrument and collected raw data.

Discipline

Of the 17 participants, four were dentists, six were dental hygienists, 4 were dental assistants, and three were dental laboratory technicians. One of the speakers (a dentist) also attended the program, but was not included as a participant. Many of the participants were also dental educators.

Age, Gender, and Race

The ages of the participants ranged from 30 to 57 years with a mean of 41 and mode of 40. The gender breakdown was relatively even, with 8 male and 9 female participants. Four (24%) of the participants were Black: the other participants (13) were White.

Education

The educational background of the participants varied from attending college, to obtaining an associate degree, a baccalaureate degree, a masters degree, and/or a doctorate or professional degree. Multiple responses were tabulated for this item on the Participant Profile.

Employment Setting and *Length of* Employment

Employment settings varied widely among the participants and multiple responses were reported for the related item on the Participant Profile. One participant reported working in a hospital, one was employed in a health department, two owned independent dental laboratories, and five worked in private practice settings. Eleven of the participants (65%) reported being employed by an educational program. Years of employment with current employers ranged from 6 to 12 months (13%) to 21 to 25 years (6%). The majority of responses were reported for 1 to 2 years with current employer (29%). 5 to 10 years (24%). and 11 to 15 years (24%). Twelve of the participants (71%) worked in an urban setting, four (24%) worked in a small town, and one participant reported both urban and small town employment status. None of the participants worked in a rural setting.

Sources *of* AWS *Information*

Multiple responses were reported for the profile item relating to the sources from which participants obtained most information about AIDS. Thirteen of the participants (76%) obtained AIDS information from professional journals and continuing education (including conferences). Other sources of AIDS information included professional experience (35%), the media (29%), personal experience (18%), and formal education and training (12%).

Training *Experience*

Twelve of the participants *(70%)* had experience conducting education/training programs: six reported some experience, i.e., an occasional part of their professional activities. and six reported a great deal of experience, i.e., a major part of their professional activities. One participant reported very little prior experience, and the remaining participants (4) had no prior experience conducting education/training programs.

Summary

The variations among program participants were complimentary. While some participants shared job titles or educational backgrounds, each participant had unique experiences to share with the group. Continuing education courses and professional journals were the primary sources of AIDS information for most of the participants. Training experience among participants varied: 12 had a great deal to some experience training, 5 reported very little to no prior experience. Participants were enthusiastic and participatory throughout the two-day program.

FACULTY PROFILE

Program faculty consisted of eight speakers including an infection control specialist, a physician experienced in treating persons with HIV disease, a dentist with experience in treating the oral manifestations of HIV disease, instructional design experts, and a person with AIDS. Faculty descriptions are contained in Appendix E.

Geographic Distribution

All of the program faculty were from Kentucky with the exception of one who was from Indianapolls. Indiana. Five of the program faculty members were from the University of Kentucky. Of these five, four were on staff of the East Central AIDS Education and Training Center at the University of Kentucky. The remaining faculty member from the University of Kentucky was a physician from the Chandler College of Medicine. The remaining two presenters were from Bowling Green and Owensboro. Kentucky.

Discipline, Educational *Background, and Experience*

Disciplines and educational backgrounds varied widely among the program faculty. Similarities were found among employment settings of the program faculty. Almost all of the speakers had an affiliation with academic institutions.

- Two speakers with expertise in training and curriculum design were employed by the University of Kentucky in multiple capacities.
- Two presenters were materials developers and trainers with discipline-specific backgrounds (social work and dental hygiene) employed by ECAETC at the University of Kentucky.
- One speaker was a physician and faculty member at the University of Kentucky Chandler College of Medicine with experience treating persons with AIDS.
- One speaker was an infection control specialist and Director of Allied Health Programs at Western Kentucky University with a background in dentistry.
- One presenter was a dentist at Indiana University, School of Dentistry, with experience in treating oral manifestations of AIDS.
- One faculty member was a person with AIDS and the Director of Kentuckiana People with AIDS Coalition (KIPWAC).

POST-SESSION *EVALUATION*

The program was evaluated using a post-session evaluation form to assess participants' degree of satisfaction. The following information was obtained from post-session evaluation data. An eleven item instrument was used to acquire the data. Items #1 through #8 were close-ended including rating scales and comments. Items #9 through #11 were open-ended. Appendix F contains the Post-session Evaluation Instrument with collected raw data and evaluation comments.

Reason *for* Attending and Expectations *(Item #1 & #4)*

Multiple responses were recorded for item 1 regarding the reason for attending the program. All of the participants reported attending because the content was pertinent and relevant to their work.

Comments to this item included:

- the need to be better informed
- recommended by AHEC
- a very timely topic of concern

On a scale of 1 to 5. with five being the highest rating, the vast majority of the participants reported that the program completely or nearly completely met their expectations.

Comments included:

- *very well* thought *out*
- far exceeded *all expectations*
- *very well* organized

Additional comments provided topics for inclusion in future dental (and other) training programs.

- *more on* legal/ethical *aspects*
- more on *dental laboratory* information
- more time *for* Dental Management
- *a* preliminary education session

Registration and Facilities *(Item #2 & #3)*

Favorable responses were recorded for the registration process and the physical facilities.

Comments included:

- *the registration* was *very* quick *and easy*
- *once the* thermostat was adjusted the *physical* facilities *were excellent*

Confidence (Item #5 & #6)

On a scale of one to five, the participants consistently reported a high level of confidence about their knowledge and abilities of the major content areas of this training pro ram: basic AIDS content, infection control, oral manifestations of HIV disease, analyzing training needs and planning an effective program, and implementing and evaluating a training program.

Comments to this item revealed the following.

- The information on analyzing, planning, implementing and evaluating training was new to some of the participants and they were not necessarily familiar with this information prior to the training program.

The level of content, instructional materials and instructional activities also received the highest ratings regarding appropriateness.

Comments included:

- the need for time for questioning and discussion following each section *(RE: instructional activities)*

Program Presenters/Presentations (Item #7)

Program presentations were assessed on a scale of one to five, in terms of organization, relevance, and stimulation. Very good to excellent ratings were reported for all of the nine presentations except one. One presentation received an average rating for stimulation.

Comments to this item included:

- the need for more time for sessions on adult learners and the training framework
- the need for advanced infection control content
- a critique of transparencies used in one program presentation

Statements *(Item #8)*

Almost all (89% to 94%) of the participants responded positively to statements assessing increase in knowledge and skills regarding training and HIV disease as a result of attending the program. All of the participants reported that the program was relevant to their jobs, and all of the participants would recommend the program to others.

Comments included:

- the content of program was appropriate
- some got a little involved
- I would recommend this program to others

Open-ended Items (#9 - #11)

The open-ended items elicited information regarding the most helpful components of the program, potential program changes, and additional comments. Responses were favorable and complimentary.

Most *Helpful:*

- the Resource Guides and the associated printed materials
- audio-visual production
- planning a program and organizing content
- the psychosocial aspects of HIV disease
- effective presentations
- participant interaction and networking

Program *Changes:*

- *allow* **more** *time for discussion*
- more content on *oral* manifestations
- an *emphasis* on the *clinical implications* of *HIV disease*
- the *legal/ethical* issues of *HIV* and *dentistry*
- *the financial* approach to *management* of *HIV* disease
- *focus* on providing dental care *for* infected persons

Additional Comments:

- *I* gained *some very valuable information.* materials *and* contacts
- you *guys* did a *wonderful* **job**
- *I think* the *program was* excellent
- the printed materials distributed are *invaluable*

Summary

Overall, data from the post-session evaluation revealed general enthusiasm for the content, organization and presentations of the program. For many of the participants the emphasis on training strategies was most useful. As a result of the program, participants were eager and prepared to begin planning their training programs.

Future **Activities**

A final program report will be completed in August 1990. This report will contain evaluation information regarding the training programs conducted by the participants of the tram-the-trainer program. The final report will also include information regardin the impact of the curriculum design, the content of the instructional materia4s, and the tram-the-trainer program.

Follow-up plans include written and telephone communication requesting post-field test feedback on materials and training plans, We will also offer assistance to participants during various stages of their training efforts.

SUMMARY

The two-day program entitled ***AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals*** was held February 1 - 2, 1990 in Lexington. Nine sessions were offered interspersing AIDS core content, dental-specific issues. and training techniques. Three sessions focused on training needs and a training framework, two focused on train-the-trainer skills, two on AIDS-specific content (basic science and psychosocial aspects), and two on dental-specific issues (infection control and dental management). The conference was jointly sponsored by ACT Lexington, Procter & Gamble, and the East Central AIDS Education and Training Center at the University of Kentucky.

The participants responding to the Participant Profile were most likely to be between 33 and ***44*** years of age and White. Ninety-four percent held undergraduate, masters, or doctorate or professional degrees. All the disciplines in dentistry were represented: four dentists, six dental hygienists, four dental assistants, and three dental laboratory technicians. The largest single group of respondents (65%) worked in educational programs. The majority of respondents have been in their present positions less than two years. The largest group (71%) worked in urban settings. however, 24% responded working in a small town.

A post-session evaluation form was used to determine participants' satisfaction with the program. All participants (17) returned this form. The majority of respondents indicated they attended the program because the content was pertinent. All participants were recruited by ECAETC, University of Kentucky staff. Eighty-nine percent rated the registration process as very efficient, and sixty-one percent rated the physical facilities as excellent. Nearly forty percent rated the program as completely meeting their expectations (rating of 5 on the 5-point scale). while fifty percent rated it a 4 on the five point scale.

The majority of the participants indicated the confidence level of 4 on the five-point scale in the following:

AIDS epidemiology and transmission	55%
Infection control	44%
Oral manifestations	39%
Training needs and goals	72%
Planning training	55%
Implementing training	56%
Evaluating training	61%

Greater confidence, (a 5 on the 5-point scale) was noted in the area of infection control by forty-four percent of the respondents. A lower level of confidence was noted in the area of oral manifestations. It is suspected that the lower confidence in the area of oral manifestations was reported by participants who work in non-clinical positions.

The majority if the respondents found the level of content and instructional activities to be appropriate (a 4 on the 5-point scale). Sixty-seven percent rated the instructional materials as very appropriate.

Participants raled the sessions/presenters highly. Using a five-point rating system, and considering three categories (organization, relevance, and stimulation), all sessions were rated 3 (average) or above. The majority of ratings were 4 (very good) or above.

More than 90% of respondents answered affirmatively to statements that new information on HIV was provided by the program: the program increased knowledge of HIV, and new training skills were developed. They would also recommend this program to others.

Almost all comments written on the evaluation form were positive. Several statements indicated that participants would have preferred more time for the program, particularly for discussion and activities, and additional information on the legal/ethical aspects of AIDS and HIV disease. Most mentioned their interest in future programs.

A final report will be completed in August 1990 containing the results of this train-the-trainer program in terms of the training efforts conducted by the participants.

Follow-up plans include written and telephone communication requesting post-held test feedback on materials and training plans. We will also offer assistance in their training efforts.

APPENDICES

APPENDIX A: Program Agenda

APPENDIX B: Program Objectives

APPENDIX C: Training Plan

APPENDIX D: Participant Profile Instrument

APPENDIX E: Faculty Profile

APPENDIX F: Post-session Evaluation Instrument

APPENDIX A

PROGRAM AGENDA

Thursday, February 1

8:30 - 9:00	Registration
9:00 - 9:30	Welcome and Introductions
9:30 - 10:30	Train-the-Trainer Training as it relates to the AIDS epidemic and dental professionals Needs of Adult Learners Training Framework - Analyzing and goal setting
10:30 - 10:45	Break
10:45 - 12:10	AIDS Update Epidemiology, Transmission, and Treatment
12:15 - 1:30	Lunch Psychosocial Aspects of HIV Disease
1:45 - 4:30	Train-the-Trainer. Preparing and Designing a Training Program -Writing Objectives -Researching and Organizing Content -Selecting Instructional Materials and Methods -Developing a Session Plan -Effective Presentations

Friday, February 2

8:30 - 10:15	AIDS and Dentistry: Infection Control
10:15 - 10:30	Break
10:30 - 12:15	AIDS and Dentistry: Management
12:15 - 1:15	Lunch
1:15 - 1:45	Train-the-Trainer Information Resources for updating Developing handouts and visual aids Program planning and organizing
1:45 - 2:30	Individual Prenaration of Training Program
2:30 - 3:00	Train-the-Trainer Evaluating Training
3:00 - 3:45	Participant Exchange Sharing of training program design
3:45 - 4:00	Data Collection and Closure

APPENDIX B

PROGRAM OBJECTIVES

Upon completion of the dental training program the participant will be able to:

1. Briefly profile the AIDS epidemic in terms of epidemiology and transmission; virology and treatment: and psychosocial issues.
2. List specific infection control methods recommended by the CDC and ADA for the prevention of occupational exposure to blood-borne diseases.
3. Recognize the oral manifestations of AIDS and HIV disease and appropriate treatment and/or need for patient referral.
4. Describe training as it relates to the AIDS epidemic and dental health professionals.
5. Outline a training framework for preparing and designing a training program.
6. Give examples of writing objectives: the process of researching and organizing content, selecting instructional materials and methods, and developing a session plan: and the elements of effective presentations.
7. Identify three information resources and the process involved in updating training materials.
8. Develop color slides and overhead transparencies for a training program.
9. Plan, organize and implement a training program for dental professionals within his or her own community.
10. Evaluate the effectiveness of a training program.

APPENDIX C

TRAINING PLAN

Use the following questions as a guide to help you plan your training activity. Fill in as much information as possible during this program and leave a copy with the conference organizers. Complete the plan in preparation for your training activity and mail a copy, along with the confirmation form. when you complete your training event.

1. How many training activities do you plan to conduct in the next six months?_____

2. What is the anticipated date of the (first) program you are planning?_____

3. Who is your target audience?_____

   a. How large a group do you hope to train?_____

   b. How do you plan to recruit your participants?_____

   c. What do you already know about the potential participants and what information do you need to obtain?

      _____

      _____

4. What is the major content you plan to include in your training activity? Give a brief outline or schedule:

   _____

   _____

   _____

5. How long will the program be?

   _____

6. How will each content area be presented?

   _____

   _____

   a. Have you identified speakers?_____

      _____

   b. Are there audio visuals you plan to use?_____

      _____

   c. Can skills be demonstrated and practiced?_____

      _____

   d. Will you use discussions, questioning. or other interactive activities?_____

      _____

7. What handouts and visual aids xieed to be prepared? _____

8. How will you handle the Instructional Set and Closure? _____

9. What facilities will YOU need for the program? _____

10. How will you evaluate the program? _____

Name(s) of Trainer(s):

_____

_____

_____

Return copy of completed form to:

Ann Crowe/Paula Parise
ECAETC
Medical Center Annex #3
University of Kentucky
Lexington, Ky. 40536-0218

APPENDIX D

PARTICIPANT PROFILE INSTRUMENT

Please answer the following questions to provide collective information about the participants in this session. All information is anonymous and confidential.

1. Age at last birthday: **Range = 30-57, Mean=41, Median=40, Mode=33,** 36. 44

2. Gender: Male **8(47%)** Female **9(53%)**

3. **Race/Ethnicity**
   - **4(24%)** African American/Black
   - **13(76%)** White
   - Hispanic/Latino/Mexican
   - Native American/ Indian
   - Asian
   - Other

4. Highest Educational Level Completed (Multiple Responses)
   - **3(18%)** Attended College
   - **3(18%)** Masters degree
   - **2(12%)** Associate degree
   - **5(29%)** Doctorate or professional degree
   - **6(35%)** Baccalaureate
   - Vocational or Program (please specify) _____
   - Other (please specify) _____

5. Please indicate the discipline(s) of which you are a member or with which you most closely identify and/or the type of work you currently do. (Multiple Responses)
   - **4(24%)** Dentist
   - **6(35%)** Dental Hygienist
   - **4(24%)** Dental Assistant
   - **3(18%)** Dental Laboratory Technician
   - **5(29%)** Teacher/Educator
   - Administrator
   - **3(18%)** Other (please specify) _____

6. In what type of agency or setting do you work? **(Multiple** Responses)
   - **1(16%)** Hospital
   - **5(29%)** Private Practice
   - **11(65%)** Educational Program
   - Outpatient Clinic
   - **2(12%)** Independent Laboratory
   - **1(6%)** Health Department
   - **3(18%)** Other (please specify) _____

7. How long have you worked in your present position? (Multiple Responses)
   - Less than six months
   - **2(12%)** 6 - 12 months
   - **4(24%)** 11 - 15 years
   - **5(29%)** 1 - 2 years
   - **2(12%)** 16 - 20 years
   - 3 - 4 years
   - **1(6%)** 25 years
   - **4(24%)** 5 - 10 years
   - 26 - 30 years

8. Do you work in (Multiple Responses)
   12(71%) an urban setting **4(24%)** a small town **1(6%)** a rural setting

9. From which source have you obtained most of your information about AIDS prior to this conference? (Check all that apply.) **(Multiple** Responses)
   - **2(12%)** Formal Education and Training
   - **3(18%)** Personal Experience
   - **13(76%)** Continuing Education
   - **6(35%)** Professional Experience
   - **13(76%)** Professional Journals
   - **5(29%)** Media
   - **1(6%)** Other (please specify) _____

10. What is your experience with conducting education/training programs?
    - **4(24%)** No prior experience
    - **1(6%)** Very little prior experience (a rare part of professional activities)
    - **6(35%)** Some experience (an occasional part of professional activities)
    - **6(35%)** A great deal (a major part of professional activities)

APPENDIX E

FACULTY PROFILE

Terence R. Collins, **M.D.,** M.P.H. is professor of medicine in the Department of Preventive Medicine at the University of Kentucky. He is experienced in treating people with HIV disease and the public health perspective. Epidemiology, transmission, and treatment *of* **AIDS** are the topics he will address.

Ann H. Crowe, M.S.S.W. is a Senior Curriculum Media Development Specialist with the East Central AIDS Education and Training Center at the University of Kentucky. She will introduce the topics of adult learners and a training framework.

Ron Jerrell is active in Kentuckiana People With AIDS Coalition and national AIDS organizations. He will participate in the program to share the psychosocial implications of HIV disease and needs related to dental care.

Ruby **Meador, R.D.H.,** M.P.H., Ph.D. is the Director of the Allied Health Department at Western Kentucky University. She is a charter member of ASK and has served on that board. She is also a member of OSAP and has presented at state and national levels. Dr. Meador will address the topic of infection control.

Paula **Parise,** R.D.H., M.S. is a Senior Curriculum Media Development Specialist with the East Central AIDS Education and Training Center at the University of Kentucky. Her presentations will focus on AIDS training needs of dental professionals and evaluation of training.

William G. Pfiefle, Ed.D. is Assistant Dean of Academic Affairs of the College of Allied Health Professions at the University of Kentucky. He is active in the Teacher Improvement Program System (TIPS) network. His expertise is in train-the-trainer strategies.

Jack Schaaf, **D.D.S.,** is the Director of the Special Patient Care Clinic at Indiana University in Indianapolis which provides treatment for HIV infected patients. The Dental Management component of the program will be covered by him.

Betty B. Spohn, M.S.L.S., is Director of the Office of Educational Development, College of Allied Health Professions at the University of Kentucky. She is also the Director of Teacher Improvement Program System (TIPS). She will present train-the-trainer strategies.

APPENDIX F

POST-SESSION EVALUATION INSTRUMENT

1. Why did you attend this conference?

   15 Pertinent content
   5 Work/requirement/relevance
   1 The speaker(s)
   Other (please specify)_____

2. Please rate the registration process:

Very efficient	16 5 89%	1 4 6%	3	2	1 1 6%	Very inefficient

Comments:_____

3. Please rate the physical facilities:

Excellent	5 61%	4 33%	3 6%	2	1	Unacceptable

Comments:_____

4. To what extent did this conference meet your expectations?

Completely	7 5 39%	9 4 50%	1 3 6%	2	1	Not' at all

Comments:_____

5. How confident do you feel about your knowledge and abilities in the following areas?

	Very Confident				No Confidence
AIDS epidemiology. transmission, and treatment	4 5 22%	10 4 55%	2 3 11%	2	1
Infection control procedures	8 5 44%	8 4 44%	2 3 11%	2	1
Recognizing and treating oral manifestations of HIV disease	3 5 17%	7 4 39%	6 3 33%	2	1 1 6%
Analyzing training needs and setting goals	3 5 17%	13 42%	2 3 11%	21	
Planning an effective training program	3 5 17%	10 4 55%	5 3 28%	2	1
Implementing an effective training program	4 5 22%	9 4 50%	5 3 28%	2	1
Evaluating a training program	3 5 17%	11 4 61%	4 3 22%	2	1

(over, please)

APPENDIX F continued

6. How appropriate for you were:

	Very Appropriate				Not Approprla te
The level of the content	6 **5** **33%**	10 455%	2 **3** **11%**	2	1
The instructional materials	12 **5** **67%**	**6** **4** 33%	3	2	1
The instructional activities	8 **5** **44%**	'9 **4** **50%**	**1** **3** **6%**	2	1

7. Please assess the program presentations. Rate each area by using the following scale:

5 = **Excellent** 2 = Fair
4 = Very Good 1 = Poor
3 = Average NA = Did not attend session

	Organized	Relevant Content	Stimulating
Training Needs (Paula **Parise)**	**81/18** **4.50**	**80/18** **4.44**	**76/18** 4.22
Adult Learners & Training Framework (Ann Crowe)	**90/18** 4.44	**77/18** 4.28	**73/18** 4.05
AIDS Epidemiology. Transmission, and Treatment (Terry Collins)	**75/18** 4.17	**76/18** 4.22	**66/18** 3.67
Psychosocial Issues (Ron **Jerrell)**	**75/18** 4.17	**76/18** 4.61	**66/18** 4.50
Train-the-Trainer **(Bill Pfeifle)**	**80/17** **4.71**	**80/17** 4.71	**79/17** 4.65
Train-the-Trainer (Betty Spohn)	**82/17** 4.82	**81/17** 4.76	**80/17** **4.71**
Infection Control (Ruby **Meador)**	**71/17** 4.18	**69/16** 4.31	**69/17** 4.06
Dental Management (Jack **Schaaf)**	**71/15** 4.73	**73/15** 4.87	**67/15** 4.47
Evaluating Training (Paula **Parise)**	**70/16** 4.38	**70/16** 4.38	**69/16** 4.31

(over, please)

a. Please answer yes or no to the following statements.

Yes	No	
17/94%		The program increased my knowledge of HIV disease.
18(100%)	—	The program increased my knowledge of infection control.
16(94%)	1(6%)	The program increased my knowledge of dental management related to HIV disease.
17(94%)	1(6%)	I developed new skills as a trainer from this program.
17(94%)	1(6%)	The content of the program was appropriate for my background.
18(100%)	—	The program was relevant to my job.
18(100%)	—	I would recommend this program to others.

9. What was most helpful to you about this conference?

10. What would you change if you could?

11. Additional Comments:

APPENDIX F continued

EVALUATION COMMENTS

1. was asked, see the need to be better informed.
   Recommended by AHEC
   A very timely topic of concern

2. very easy and quick

3. cold first day, very good refreshments
   after the thermostat was adjusted
   I'm UK alum. What did you expect?

4. More on legal/ethical aspects
   Very well though out and planned
   Far exceeded all expectations. At times though I did feel somewhat overwhelmed at points with the amount of material presented, but will digest more of it when I go home.
   Very well organized.
   I truly didn't know what to expect. But I was very informed and touched. I saw a whole different side of the issue.
   I would have liked more specific lab info.. although I expect to find it in the manual.
   Great conference. I would have liked more time for Dental Management.
   I could have used a preliminary education class (Dept of Ed.)
   Very sorry that I was not able to be present for all segments of this program

5. This aspect was new to me! (Re: analyzing, planning, implementing and evaluating training)
   On this information (RE: analyzing. planning, implementing and evaluating training)
   Only because I didn't understand so much of it (RE: rating of 4 on recognizing and treating oral manifestations)
   After having time to research the wonderful material you presented us - this confidence level will rise (RE: first three items)

6. More time needed for question and answer/discussion following each section (RE: instructional activities)

7. Too basic for participants (RE: Relevant Content - Infection Control)
   I enjoyed the Boston accent (RE: Stimulating - Evaluating Training)
   Needed more time (RE: Adult learners and training framework1
   Transparencies too busy, printing too small (RE: AIDS epidemiology. transmission, and treatment)

8. Most of it (RE: content of program was appropriate)
   Some got a little involved - deep for me (RE: content of program was appropriate)
   Definitely (RE: I would recommend this program to others)

9. Most Helpful

The Resource Guides and the associated printed materials developed and distributed were/are very good
Guidelines on how to plan a program
Dental Management and some of the points made about transparencies
Gaming Information, getting a plan together.
All of the data that we received. Contacts, where to find resource material
Overview of epidemiology
Preparing and designing program - organizing content and effective presentations
All was helpful - but what made me really think about my true feelings was Ron Jerrell's talk. It made me aware of problems and aspects I had never thought of before.
All the resource material to take back and use.
All facets were concise and to the point - very thorough!
Having the opportunity to listen, to talk to, and learn from an individual who has AIDS.
Giving more effective presentations
New AIDS info: Resource guide - getting all addresses, numbers, etc. together is great (invaluable)
A good outline on how to organize, plan session. All handouts were exceptional
Interaction with other participants - and positive reinforcement about what I am involved in respective of DX and Treatment of HIV disease
Realizing how important it is to use universal, sterilization and infection control on all patients.
Information and training materials are all relevant and practical (unlike many training I've attended, I'm going home with things I can really use!!)
Information on program planning

10. What Would You Change?

Nothing I am aware of
Allow more time for discussion
Add a U.K. ball game. The training I though was excellent. Perhaps break group into specific fields with specific emphasis.
Depends on participants
Was given the impression that it would be mostly on AIDS, just a small bit on training or instruction techniques. It was a little confusing at first because of that. It was a good mixture of the two.
I don't know that I could improve on the seminar in any way.
More emphasis on clinical implications, less on development of training program planning. Training info was quite well presented but lengthy.
Probably would have less printed material - 3 binders full of information is a lot of material to review.
More dental facts presented
More content information on AIDS. A little less time spent on organization of course.
The financial approach to management of HIV disease and focus on providing dental care for infected persons.
Nothing
More time during patient management section for information/questions on legal/ethical issues of HIV and dentistry
Nothing

11. Additional Comments

I had a great time!
I thought it was great and I gained some very valuable Information, materials and contacts - you guys did a wonderful job.
I would have enjoyed visiting a lab in the area where (?) infection control is effectively practiced.
I think the program was excellent
This was a very good program. Very well organized - opportunity to network.
I really wasn't sure what to expect, but I felt it was going to be geared toward AIDS knowledge and a little on the training aspect. At the 1/2 way point of the first day I was a little confused as to why I was asked to come and exactly what was expected in the next day and 1/2. By the end of the day today, it all fell into place. Also the information that I felt I needed was presented. I have enjoyed the past 2 days.
This had to be the most professional, well run, and concise seminar I've ever attended. All the work really showed through.
The printed materials distributed will be invaluable. They are extremely well organized! Very well done!! Thank you.
Overall a very good conference
I'm excited I was able to attend. Very valuable training
I think it would be helpful to have been given an established "ideal' outline of a program to present. Such as areas that must be covered then participants could embellish this outline and present as they wished. Such as done in teaching CPR course, etc.
None
Congratulations to all of you on a fob well done and then some! Whew!!!
Aren t you glad it's over?!
Excellent Program. I appreciate all the work which went into planning the program. I was especially impressed by the emphasis on education and planning strategies. Thanks!

PROGRAM REPORT

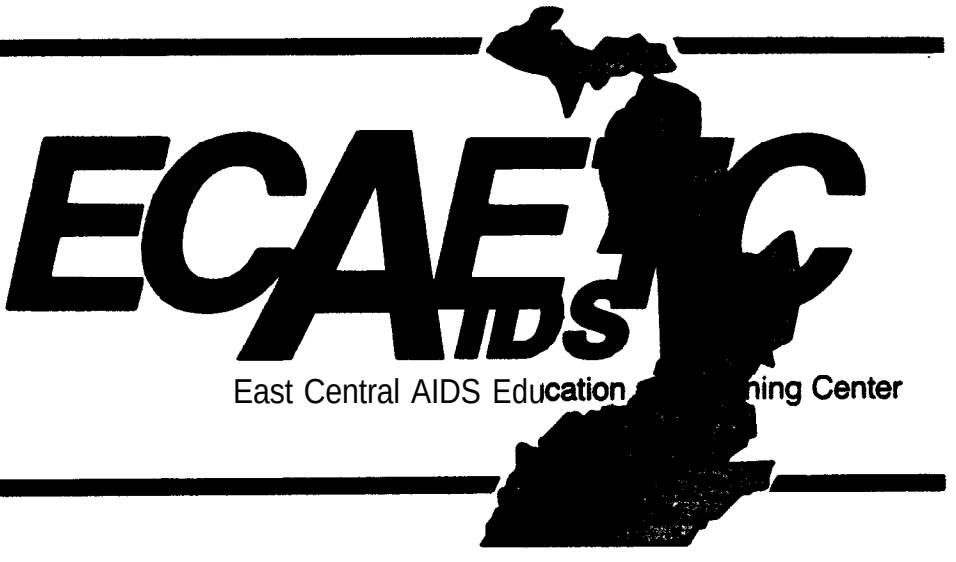
AIDS and HIV Disease:
Effective Training Strategies for Dental Health Professionals

Prepared by

Ann **H. Crowe**

University of Kentucky

October **31. 1990**



PROGRAM SUMMARY

A two-day program entitled AIDS and HIV Disease: Effective Training *Strategies for Dental Health Professionals was* held February 1 - 2. 1990 at the University of Kentucky. The conference was jointly sponsored by ACT Lexington, Procter & Gamble, and the East Central AIDS Education and Training Center at the University of Kentucky.

The 17 participants represented all the disciplines in dentistry and included four dentists, six dental hygienists, four dental assistants, and three dental laboratory technicians. Nearly two-thirds of the participants are involved in dental education programs.

The majority of participants indicated they attended the program because the content was pertinent to their professional interests. The program content consisted of three major components.

- AIDS core curriculum: Basic Science and Psychosocial Aspects
- Dental-specific issues: Infection Control and Dental Management
- Training techniques: Training Needs, A Training Framework and Presentation Skills

A post-session evaluation form indicated that nearly forty percent rated the program as completely meeting their expectations (rating of 5 on the 5-point scale). while fifty percent rated it a 4 on the five-point scale. The majority of the respondents found the level of content and instructional activities to be appropriate (a 4 on the b-point scale). Two-thirds (67%) rated the instructional materials as very appropriate.

More than 90% of respondents answered affirmatively to statements that: (1) new information on HIV disease was provided by the program: (2) the program increased knowledge of HIV; and (3) new training skills were learned. They also indicated they would recommend this program to others.

Almost all written comments were positive. Several statements indicated that participants would have preferred more time for the program, particularly for discussion and activities, and/or additional information on the legal/ethical aspects of AIDS and HIV disease. Most mentioned an interest in future training programs.

As a condition of attending this program participants agreed to conduct at least one training program for other dental professionals within a six month period. Time was allotted within the program for participants to develop an initial training plan and to receive feedback from faculty and other participants.

RESULTS OF FOLLOW-UP EVALUATION

Contact was maintained with program participants throughout the six month period following the conference. Technical assistance was available if requested. Participants agreed to complete at least one training program and provide written feedback on a *Confirmation of Training Delivery* form. Contact was made in September with those who had not returned the form.

Of the 17 participants, 11 (65%) reported conducting training of other dental health professionals. Of these, 8 returned the *Confirmation of Training Delivery* form containing the data presented below. It should be noted that these statistics underestimate the impact and cost effectiveness of this program as the data of three participants is not included.

Of those who had not conducted a training session, personal and family illnesses, other work responsibilities, and lack of opportunities were most commonly cited as the reasons. Several indicated that, although they were unable to complete a training program within the six-month time frame, they have plans to conduct future training sessions.

The 8 participants who provided data reported training a total of 275 persons. Contact hours were calculated by multiplying the number of participants in each training session by the number of hours of training provided. (See Appendix A.)

Not all participants reported the racial composition of their training groups. However, the data available indicated the follow distribution.

	Original Training Group	Their Trainees
Black	4 (24%)	12 (8%)
Caucasian	13 (76%)	132 (91%)
Other		1 (1%)

The approximate distribution among urban and rural trainees indicated by those who reported this data was 56% rural or small town and 44% urban. The original training participants and their trainees represented a wide geographic distribution. (See Appendix B.)

	Original Training Group	Their Trainees
Kentucky	11	108
Tennessee	3	13
West Virginia	1	9
Indiana	2	15
Pennsylvania		130

In preparation for this program a Resource Guide related to dental health was developed by the project Information Specialist. It was later requested that this be duplicated and provided to all ECAETC Sites. As a result, one Site requested permission to distribute the Guide to health care professionals in another state.

The eight participants who provided data also reported the most frequently utilized training methods were:

Lecture	78%
Audio-visuals	78%
Handouts	67%
Discussion	56%

Less frequently used approaches included:

Guest speakers	33%
Demonstrations	11%

The topics presented in the training sessions conducted by the original group of participants were as follows.

Infection Control	5
Dental Management	5
AIDS Core Curriculum	5
Legal and Ethical Issues	2
Miscellaneous (Personal risk reduction; Hepatitis Vaccination)	2

All those completing the *Confirmation of Training Delivery* form indicated that the program was helpful. Comments concerning what was most helpful included the following.

- The idea to explore the legal aspects of the AIDS patient.
- All: Slides are great.
- Infection Control Manual biggest help.
- Resources
- Closure and set - Helps to better organize my thoughts for my presentation.

None of the participants indicated that they encountered any problems in their training delivery. However, three stated that they would like further assistance as follows.

- Provide us with a list of courses that other participants are sponsoring. Also a mailing list of Dentists and auxiliary in the Kentucky area.
- Current copy of the revised Infection Control Manual.
- New information as mentioned in media
- Possibly by assisting MARETC in providing an additional one day training on specific 'train-the-trainer" subjects such as gcal setting, writing objectives, researching and organizing content, effective presentations. evaluation, etc.

Funding for this program was provided by ACT Lexington ($1,000). Procter & Gamble ($2.000). and the East Central AIDS Education and Training Center at the University of Kentucky. For this pilot program expenses included the travel, lodging and meals for participants and faculty, speakers' honoraria, audio-visual equipment. reproduction of participant materials, and miscellaneous items for a total program cost of $3.335. Given the number of trainees from the original group and their subsequent training sessions, the expenditures can be broken down as follows:

Cost per participant ($3335/292)	$11.42 each
Cost per contact hour ($3335/1332)	2.50

The program brochure containing a program description. objectives, agenda and faculty list is attached as Appendix C.

Appendix A

SUMMARY DATA OF DENTAL HEALTH
PROFESSIONALS TRAINED

275 DENTAL PROFESSIONAL8 **TRAINED**

- 135 **Dentists**
- 74 Dental Hygienists
- 34 Dental Assistants
- **30 Laboratory** Technicians
- **2 Others**

1,111 Contact Hours of 'Raining

↑

17 PARTICIPANTS
DENTAL **TRAIN-THE-TRAINER PROGRAM**

- 4 Dentists
- 6 Dental Hygienists
- 4 Dental **Assistants**
- 3 Laboratory Technicians

221 Contact Hours of Training

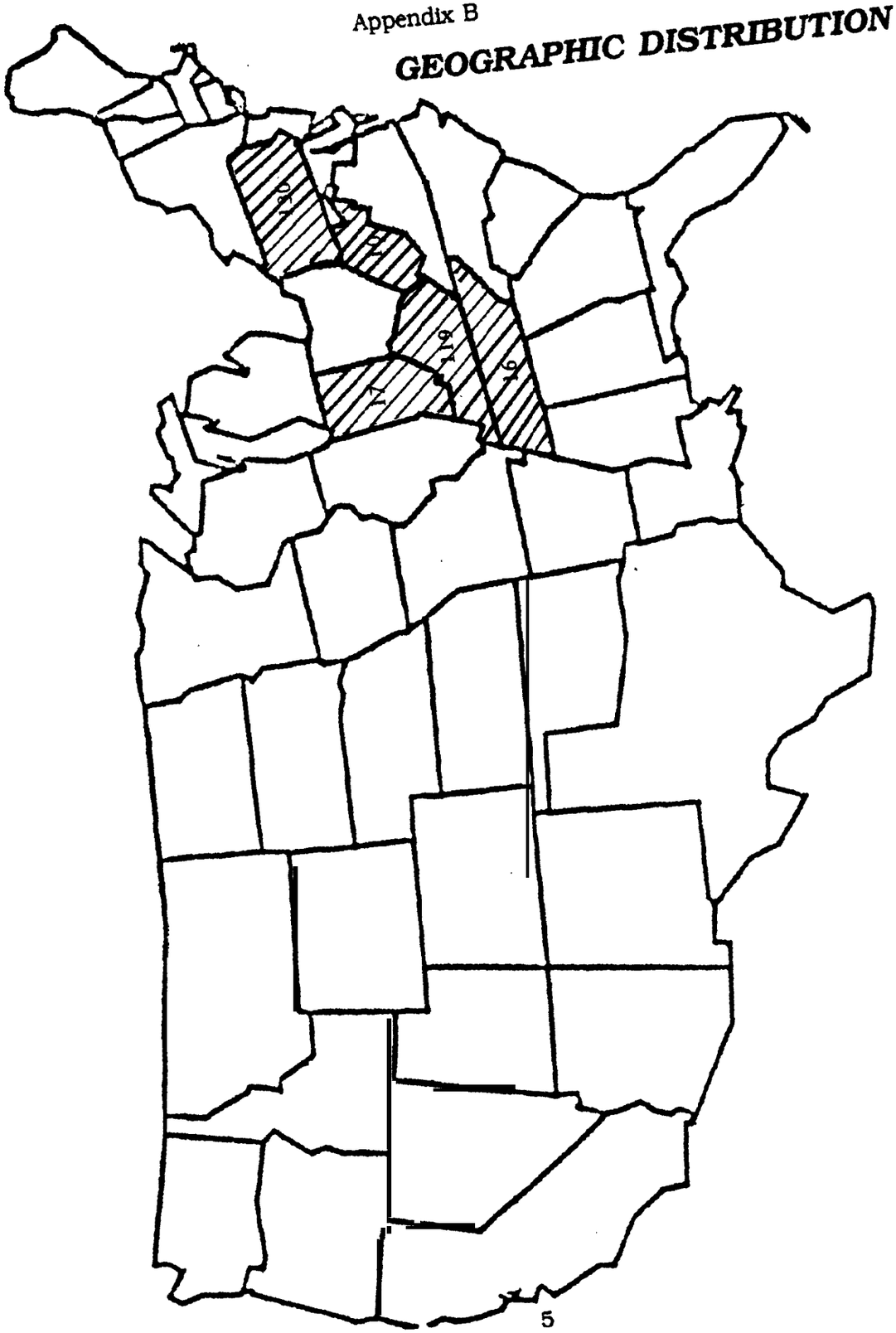
↑

8 FACULTY

- 2 Core AIDS Content - 2.5 hrs.
- 2 Dental Content - 3.5 hrs.
- **4 Train-the-Trainer** Content - 6 **hrs.**

Appendix B

GEOGRAPHIC DISTRIBUTION



Appendix C

AIDS AND HIV DISEASE:

EFFECTIVE TRAINING STRATEGIES

FOR DENTAL HEALTH PROFESSIONALS

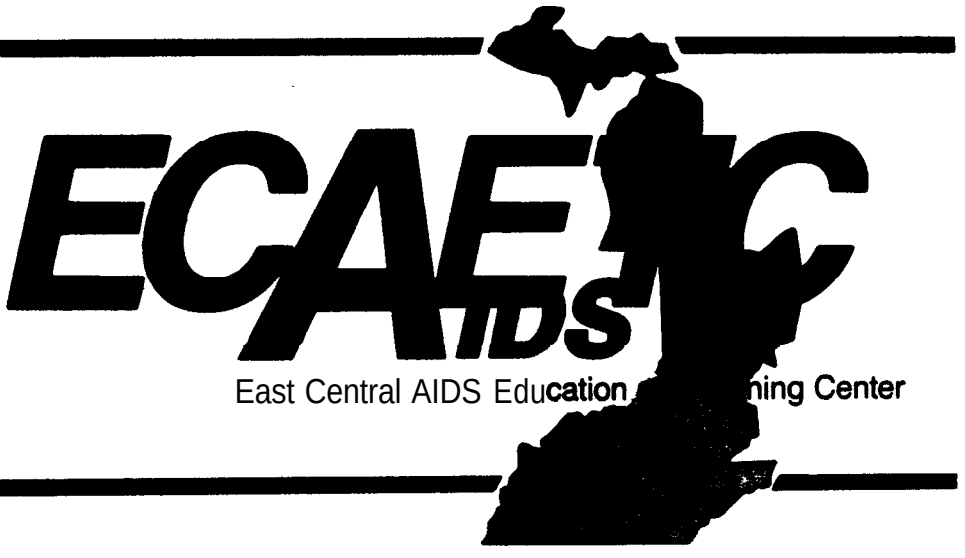
February 1-2, 1990

University of Kentucky

Co-Sponsored by

AIDS CRISIS TASK **FORCE** OF LEXINGTON

PROCTER & GAMBLE



PROGRAM DESCRIPTION

Persons with AIDS and HIV disease have expressed serious concerns related to dental care during their illness. Some have experienced blatant discrimination, while others have encountered dental professionals who do not feel competent or comfortable treating patients with HIV disease. There is a need for education and training of dental professionals related to AIDS and HIV disease to dispel the myths regarding treatment, improve access to care. and impact upon their attitudes, values and behaviors.

The purpose of the training program, **AIDS and HIV Disease: Effective Training Strategies for Dental Health Professionals**. is to train select dental professionals to provide instruction about AIDS to practicing dental professionals in their communities. The goal of the training program is four-fold, to

- disseminate factual information:
- facilitate the acquisition of knowledge:
- impact upon attitudes and values; and
- enlist and reinforce positive behaviors of practicing dental professionals regarding AIDS and HIV disease.

The curriculum design of the training program builds discipline-specific (dental) content on a core base of AIDS information. Train-the-trainer techniques and strategies are interspersed with dental and AIDS content. Curricular materials include five training modules and a facilitator's guide developed for the training program by the University of Kentucky. Upon completion of the training program, the trainees will be prepared to conduct training efforts on community, regional, and statewide levels.

PROGRAM OBJECTIVES

Upon completion of the dental training program the participant will be able to:

1. Briefly profile the AIDS epidemic in terms of epidemiology and transmission; virology and treatment: and psychosocial issues.
2. List specific infection control methods recommended by the CDC and ADA for the prevention of occupational exposure to blood-borne diseases.
3. Recognize the oral manifestations of AIDS and HIV disease and appropriate treatment and/or need for patient referral.
4. Describe training as it relates to the AIDS epidemic and dental health professionals.
5. Outline a training framework for preparing and designing a training program.
6. Give examples of writing objectives: the process of researching and organizing content, selecting instructional materials and methods, and developing a session plan: and the elements **of effective presentations.**
7. Identify three information resources and the process involved in updating training materials.
8. Develop color slides and overhead transparencies for a training program.
9. Plan, organize and implement **a training** program for dental professionals within his or her own community.
10. Evaluate the effectiveness of a training program.

AGENDA

Thursday, February 1

8:30 - 9:oo	Registration
9:oo - 9:30	Welcome and Introductions
9:30 - 10:30	Train-the-Trainer, Training as it relates to the AIDS epidemic and dental professionals Needs of Adult Learners Training Framework - Analyzing and goal setting
10:30 - 10:45	Break
10:45 - 12:10	AIDS Update Epidemiology, Transmission, and Treatment
12:15 - 1:30	Lunch Psychosocial Aspects of HIV Disease
1:45 - 4:30	Train-the-Trainer Preparing and Designing a Training Program -Writing Objectives -Researching and Organizing Content -Selecting Instructional Materials and Methods -Developing a Session Plan -Effective Presentations

Friday, February 2

8:30 - 10:15	AIDS and Dentistry Infection Control
10:15 - 10:30	Break
10:30 - 12:15	AIDS and Dentistry Dental Management
12:15 - 1:15	Lunch
1:15 - 1:45	Train-the-Trainer Information Resources for updating Developing handouts and visual aids Conference planning and organizing
1:45 - 2:30	Individual Preparation of Training Program
2:30 - 3:00	Train-the-Trainer Evaluating Training
3:oo - 3:45	Participant Exchange Sharing of training program design
3:45 - 4:00	Data Collection and Closure

FACULTY

Terence R. Collins, M.D., M.P.H. is professor of medicine in the Department of Preventive Medicine at the University of Kentucky. Epidemiology, transmission, virology and treatment of AIDS are the topics he will address.

Ann H. Crowe, M.S.S.W. is a Senior Curriculum Media Development Specialist with the East Central AIDS Education and Training Center at the University of Kentucky She will introduce the topics of adult leakers and a training framework.

Ruby Meador, R.D.H., M.P.H., Ph.D. is the Director of the Allied Health Department at Western Kentucky University. She is a charter member of ASK and has served on that board. She is also a member of OSAP and has presented at state and national levels. Dr. Meador will address the topic of infection control.

Paula Parise, R.D.H., M.S. is a Senior Curriculum Media Development Specialist with the East Central AIDS Education and Training Center at the University of Kentucky .Her presentations will focus on AIDS training needs of dental professionals and evaluation of training.

William G. Pfiefle, Ed.D., is Assistant Dean of Academic Affairs of the College of Allied Health Professions at the University of Kentucky. His expertise is in train-the-trainer strategies.

Jack Schaaf, D.D.S., is the Director of the Special Patient Care Clinic at Indiana University in Indianapolis which provides treatment for HIV infected patients. The Dental Management component of the program will be covered by him.

Bet B. Spohn, M.S.L.S., is Director of the a ffice of Educational Development. College of Allied Health at the University of Kentucky. She is also the Director of TIPS. She will present train-the-trainer strategies.

Ron Jerrell will participate in the program to share the psychosocial implications of HIV disease and needs related to dental care.

PARTICIPANTS

Professionals from the following groups have been invited to participate:

- Dentists
- Hygienists
- Assistants
- Laboratory Technicians

APPENDIX VIII

Evaluation of the First ECAETC Conference

ECAETC
East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Department of Family Medicine
80902 University Hospitals Clinic
456 West Tenth Avenue
Columbus, Ohio 43210
614-293-8188

To: ECAETC Site Directors and Roger Verny

From: Bob Aron, Evaluation Coordinator

Date: October 20, 1988

Subject: Evaluation of the First ECAETC Conference

Attached is a copy of the evaluation report for the first ECAETC conference, held September 23 and 24, 1988 in Cincinnati. This report vas completed in compliance with the stated intent of the project propoeal. The report relies on data collected by this evaluator using quantitative and qualitative methods. Although this is an independent assessment of the conference, the comments and suggeetlone of ECAETC staff, conference participants, and others vere considered and included. This report is intended to be more than a critique of a single event. It is hoped that this document will provide information useful in facilitating future ECAETC conferences.

cc Larry Gabel
Mike Para

CENTER HEADQUARTERS

The Ohio State University
Department of Family Medicine
B0902 University Hospitals Clinic
456 West Tenth Avenue
Columbus. Ohio 43210
614-293-8188

REGIONAL SITES

The Ohio State University

Tennessee AIDS Consortium
c/o Meharry Medical College

University of Kentucky

The University of Michigan

Cincinnati Health Department in Cooperation with The University of Cincinnati Medical Center

Evaluation of the First ECAETC Conference

Prepared by

Robert Aron
ECAETC Evaluation Coordinator

East Central AIDS Education and Training Center
Columbus, Ohio

October 20, 1988

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Summary

The first AIDS education conference sponsored by the East Central AIDS Education and Training Center (ECAETC), held on September 23 and 24, 1988, was both extremely well received by participants and fell far short of the number of professionals it was intended to reach. The planning and promotion of the conference was complicated from the inception by organizational constraints facing ECAETC as it developed during its first year, Yet, the conduct of the conference met expectations of most of the participants through informative lectures and workshops.

Future conference planners are encouraged to begin preparations early, consider carefully a marketing plan, and attend to the logistic details of the conference.

Evaluation of the First ECAETC Conference

This is the evaluation report of the first East Central AIDS Education and Training Center (ECAETC) conference, held September 23 and 24, 1988 in Cincinnati, Ohio. The conference was titled: The Primary Care Response to AIDS, and intended for an interdisciplinary primary care audience in the region served by ECAETC. ECAETC was established September 1, 1987 as a regional consortium of educational institutions in Michigan, Ohio, Kentucky and Tennessee to train and educate a wide variety of healthcare professionals in matters related to AIDS. Funding for ECAETC is from the United States Health Resources and Services Administration, Grant Number: **BRT000005-01-0.**

One of the "Major Project Objectives", as stated in the original grant application proposal, is to "disseminate ECAETC-developed AIDS training programs on local, state and regional levels" (p. 64). Under this major objective is the "Specific Measurable Objective" (III.A.5) pertaining to this conference. It states that ECAETC will:

> "conduct an annual major two-day conference on AIDS using nationally known speakers and targeted at an audience of 1,000 to include approximately one-third physicians. one-third nurses, and one-third other health care providers." (p. 64)

Although originally scheduled for May 1988 in Columbus, Ohio, the conference date and location were changed to accommodate logistical and administrative constraints encountered during the start-up of ECAETC.

This report will be divided into five major sections as follows:

I. The Discrepancy between the Specific Measurable Objective and the Conference Results

II. Evaluation of the General Session

III. Evaluation of the Workshops

IV. Other Aspects of the Conference

v. Recommendations

I. THE DISCREPANCY BETWEEN THE SPECIFIC MEASURABLE OBJECTIVE AND THE CONFERENCE RESULTS

The objective for this conference was to hold a conference on AIDS, featuring nationally recognized speakers, for 1,000 healthcare professionals equally divided between physicians, nurses and others. There were 194 registrants including those attending under co-sponsorship with the National Hospice Organization. Of these persons who registered via ECAETC mailings approximately 20% of were physicians, and 16% were nurses. As a result of the smaller numbers of registrants than intended, as the conference date approached, the original program (Appendix A) had to be modified (Appendix B). Although not all the intended speakers were included on the program, nationally recognized speakers did present.

A number of causes may have contributed to the conference as it finally evolved. Several persons involved in the development and administration of the conference offered these points:

ECAETC Ohio Site Perspective

1. Much of the conference was not organized prior to the change of ECAETC directors on June 15, 1988.

2. Letters to speakers, confirming telephone calls and requesting a presentation outline, did not get mailed until June 21, 1988.

3. Workshops were not finalized until the end of August, and then only three of the six workshop presenters, as originally planned, provided outlines of their presentations. This caused delays in finalizing the registration announcement.

4. Throughout the latter part of the Summer the ECAETC Director was also occupied with writing the ECAETC evaluation report, overseeing several instructional materials development projects, and attending out-of-town meetings.

5. No full time secretary was available for ECAETC until July 7, 1988.

6. It is felt that the University Continuing Medical Education office did not provide the detailed guidance required of an inexperienced group at setting up a conference for the first time.

Continuina Medical Education Office Perspective

1. Large conferences take a great deal of logistic input by the sponsoring organization, especially in recognizing and establishing a specific target audience. This is something that the CME office is not capable of doing, especially on a regional basis. General mailing lists have usually only a 1 % response rate. Some of the lists provided by the ECAETC sites were very general. This problem was compounded by the lateness of the mailings.

2. It takes about two to three weeks to print announcements. Delays in sending out announcements were caused by not having the content far enough in advance.

3. Consideration by ECAETC was not given to the impact that other AIDS conferences in the same region and time frame would have on how individuals would choose to attend.

4. Without a "big name" speaker(s), a unique program, and a careful job of marketing it would be unrealistic to expect more than 200 persons to attend a conference when other options, including other conferences are open to them.

5. Additional logistical assistance should come from the nearest site to the conference, especially with regard to assisting in hotel and facilities arrangements.

Other ECAETC Sites Perspectives

1. The other sites indicated that they were not asked to help in the planning and promoting of the conference.

2. Members of sites indicated that the centralized effort to promote the conference removed them from a process which might have helped them to understand more clearly the specifications of mailing list required.

3. The conference should be located close *to* the site hosting/organizing the conference.

Comment

A combination of factors seems to have caused the problems that resulted in the discrepancy between the planned and actual attendance. These would include the assumption on the part of ECAETC that the CME office would be able to reach the intended

target audience. However, it also seems that the CME office assumed, or did not communicate the need for the local sites to put more effort into honing the mailing lists and finding other means to market the conference. Based on the techniques used to market this conference the number that did attend is not unrealistic.

An important mitigating factor, with regard to communication and administration, is the transition between ECAETC directors and the lack of office support until July. This may be why there was an over reliance on existing mechanisms to market the conference with less attention given to the new and innovative support committees established by ECAETC (e.g. Professional Liaison Committee) and contacts with professional organizations.

To the credit of those who coordinated the conference, when the conference had to be pared down it was done very effectively. Those who attended the conference were not left with the feeling that something was missing. Facilities were appropriately proportioned to the number of participants and quality presenters were provided.

II. EVALUATION OF THE GENERAL SESSION

The General Session of the conference, in which all the participants were invited together, took place on September 23, 1988, from 9:00 am to 2:45 pm. An evaluation form was used for this session (Appendix C).

The Participants

Not all the participants completed evaluation forms. Sixty-three forms were returned for the General Session. This represents about 67 % of the participants.

Of those participants returning the form, and responding with profession information, we have the following breakdown:

Profession	Number	Percent
Dentist	23	37.1 %
MD	12	19.4 %
RN	10	16.1 %
Education	9	14.5 %
Other	8	12.9 %
	62	100.0 %

These participants came predominantly from urban settings (83%), with 11.3 % coming from rural areas and 5.7 % from suburbs.

The ethnic/racial background of the participants was also documented. Sixty participants reported this information as follows:

Ethnic/Racial	Number	Percent
White	46	76.7 %
Black	7	11.7 %
Asian American	1	8.3 %
Hispanic*	1	1.7 %
Other		1.7 %
	60	100.0 %

* Cuban American

Comment

If this data is representative of the population ECAETC is trying to serve there is a problem with reaching those in rural areas. Based on the data received, there may be two distinctly different causes of the problem or there may be one in common. The first explanation may be that this group simply was not notified of the conference in time or not at all. The announcement of the conference did go out late, and the mailing lists used by ECAETC are still evolving. The second explanation might be that those with minimally staffed rural practices will always find it difficult to get away for any type of conference, even those held on the weekend. If this is the case, and a survey might be informative, then other means will have to be employed to reach rural practices.

Responses

Over two-thirds of the participants found the General Session to meet their expectations in terms of the appropriateness of the content, the completeness of the content and the use of audiovisuals. Nearly 20 % felt that the appropriateness of the content exceeded their expectations and 14 % felt that the completeness of the content exceeded their expectations. However, almost 10 % were disappointed with the audiovisuals. Some of the written comments echoed this disappointment in terms of the lack of visuals, the poor quality of visuals and the complete lack of handouts.

Other written comments focused on the need for more depth in the treatment of subjects covered during the general session, such as in workshops. Interest was also expressed in hearing presentations on the broader socio-political-economic impact of AIDS, counseling issues and rural and suburban issues. There was, however, minimal concern raised about the presentation approach of the speakers.

Comment

Even without handouts and the cancellation of desirable presentations this general session was very well received. One additional measure of success is the number of persons interested in working further with ECAETC by participating in "train-the-trainer" programs so that they can make AIDS related presentations to other healthcare professionals. More than half of those completing evaluation forms indicated such an interest and provided their names and phone numbers.

I II. EVALUATION OF THE WORKSHOPS

On September 23, 1988, three workshops, with open registration, were held concurrently from 3:00 to 5:00 pm:

1. Treatment of Persons with AIDS
2. Ethical/Legal Issues
3. Understanding the Patient with AIDS

Fewer participants responded to the evaluation form (Appendix D) than attended these workshops.

Workshop	Number of Participants*	Evaluation Forms Returned
Treatment	25	8
Ethical/Legal	40	14
Understanding	10	0

From the forms that were returned it is evident that the participants felt similarly about these workshops as they did about the General Session. Essentially they met their expectations, and in some cases exceeded expectations. Although this evaluator observed that the format of the workshop was predominantly lecture, those responding to the evaluation form indicated that there was the right balance between lecture and discussion. Most felt that some or all the material would be applicable to their practice. However, comments about handouts surfaced again. Although these workshops were clearly successful, consideration in the future should be given to providing handouts and enhancing audiovisuals.

* Based on estimates.

IV. OTHER ASPECTS OF THE CONFERENCE

There are a number of other aspects of the conference worth documenting. These strengths and weakness, in addition to those described throughout this report, are as follows:

Strengths

1. National Hospice Organization Conference. The ECAETC conference was coordinated with the National Hospice Organization (NHO) conference with the intention of providing an institute for those interested in hospice care (Appendix E). Fifteen participants of the ECAETC conference also attended the NHO conference. Also, participants of the NHO conference frequented the ECAETC display area. A number of hospice care professionals tried the ECAETC CAI program on AIDS and indicated that it would be useful for their colleagues.

2. Academic Dentistry and AIDS Trainina Institute. This institute was co-sponsored and funded by Proctor and Gamble (Appendix F). It was intended to prepare dentist affiliated with academic institutions to:

   - Develop new course materials
   - Modify curriculum
   - Consult to clinical facilities
   - Become resource individuals to continuing education programs

   Materials, including slides, were provided to the participants for this purpose.

   This was a *by invitation only" event. However, it attracted to other parts of the conference a great number of dentists. The dentists were exceedingly pleased with the Institute and the rest of the conference. A number of them indicated that this was the best information they have gotten on AIDS.

   Some of the dentists attending were representatives of other AIDS Education and Training Centers from throughout the country. They were excited to participate in this pilot conference of ECAETC, making contacts and collecting ideas to bring back to their programs.

3. AIDS related books. One of the most complete selections of AIDS related books and pamphlets was on display throughout the conference. Cokesbury Bookstore of Columbus provided these books for purchase. This was a very popular attraction in the display area of the conference.

4. AIDS CAI. The availability of the Computer-Assisted Instruction (CAI) for AIDS education developed by ECAETC was of great interest to a number of people, who took up to twenty minutes to try one of the computerized case studies.

Weaknesses

1. Reaistration at the conference. Registration at the conference was not effective. Staffing was limited. Of particular concern was the lack of organization of this activity. There was an understanding that the CME office would provide this function. There appeared to be a lack of CME office representation at key times. As a result, special registration for the concurrent National Hospice Organization conference was difficult for participants of the ECAETC conference, and discouraging to some.

2. A number of logistical details were overlooked when providing information to the participants:

   a) Not everyone had name tags:
   b) There was no provision for efficiently making name tags for those who did not have them:
   c) The Ohio State University logo was used on name tags and folders of information instead of the ECAETC logo.
   d) Hotel staff was not aware of the logistics (location, etc.) of the conference;
   e) Information provided to the participants was incomplete -- room locations and agenda details were missing.

2. Morning coffee. A number of people were disappointed that coffee was not provided before the opening of the conference. There was also concern that water was not provided at the participants' tables.

V. RECOMMENDATIONS

1. The process of planning the next conference should begin **immediately,** giving enough time for the selection of choice speakers, locations and effective logistics, including marketing.

2. If the CME function of a university is not capable of efficiently and effectively marketing ECAETC conferences, or facilitating the marketing of conferences, then this should be an internal function of ECAETC. It is expected that the collective wisdom and dedication of the ECAETC staff can accomplish successful ventures even where there may be a lack of specific conference coordination experience.

3. A conference coordinator may need to be appointed/hired to oversee the next conference(s) and work-closely with the ECAETC director, the site directors, and the university CME function.

4. The site hosting the conference should be expected to help with local logistical details as they arise.

5. An attempt should be made to get nationally recognized speakers, at least for the keynote address.

6. The extensive contacts and networking capabilities of ECAETC must be utilized in marketing conferences. This includes connnittees established by ECAETC, such as the Liaison **Committee,** and contacts with regional and national professional organizations.

7. More consideration must be given to the impact of ECAETC programs versus other competing programs.

a. There must be more attention to logistical detail in running the conference. The location for central activities, such as poster sessions, displays and demonstrations must be well staffed. More information must be provided to the participants as to where they must go for each activity offered, including room locations for workshops and meals.

9. Participants should be provided with a list of presenters' addresses in addition to the list of participants.

10. Handouts should be provided for every presentation. These can be anything from an abstract, to copies of overheads and slides.

11. A large conference should receive official recognition. from the community hosting it. Letters from the mayor, local congressmen and health officials should be included in the conference packet.

12. Information on extra-conference activities, such as area restaurants and sites, should be provided.

13. Representatives of all other AIDS Education and Training Centers from throughout the country should be invited to attend ECAETC conferences.

14. Conference materials must reflect ECAETC sponsorship of the conference, including the use of the ECAETC logo on name tags and materials provided.

Appendix A

Original Conference Program

THE PRIMARY CARE RESPONSE TO AIDS

REGIONAL CONFERENCE & INSTITUTES FOR HEALTH PROFESSIONALS

September 23-24, 1998
Sponsored by **East** Central AIDS **Education** and **Training Center**

Day 1. September 23

10 00 a m. Welcome **and Introductions**
Donald C *Harrison M D* . Senior Vice Presi- den, and Provost for Health Affairs Univer- sity of Cincinnati Medical Center
Lawrence L Gabel Ph 0. Associate Professor. Dept of Family Medicine. *The* Ohio bate University
Deria Foster Moore. R 0. *M* S Public Health Nutritionist. AIDS Services Program. Health Resources and Services Administration
Comments by a person *with AIDS*

10:30 **The AIDS Epidemic** In **America**
Mathilde Krim. Ph 0. Founding Chair, *Board* of Directors, American Foundation for AIDS Research

11:10 **How** HIV Leads to AIDS: **Pathogenesis** • d **Transmission**
Evelyn C *Hess. M D* ,McDonald Professor of Medicine, Director, Division of Immunol- ogy, University of Cincinnati Medical Center

11:40 Natural History of HIV **Infection: Assess- ment of Disease Progression**
John P Phair M 0 Professor of Medicine, Northwestern University School of Medicine, Director, Chicago Multiple Center AIDS Cohort Study

12:20 LUNCH

1:30 p.m. **Early** and **Late** Clinical **Manifestations of** HIV **Infection**
Michael F Pan. M 0. Associate Professor, Department of Internal Medicine. Infec- tious Diseases. The Ohio State University

2:05 **False Positives,** False **Negatives: Issues in Serology** and **Patient Testing**
Thomas Zuck. M 0 Director. Hoxworth Blood Center

2'45 **BREAK**

3:00-5.00 Workshops

1. Treatment of Persons **with** AIDS —
Harold A *Kessler. M 0.* Rush-Presbyterian St. Lukes Medical Center. Co-Investigator, Chicago AIDS Clinical Trial Group
Dr. Para moderating Questions and Answer Period

2. Designing and **Delivering** Community **Resources —**
Rev. Carl *Bean,* Minority AIDS Project, Los Angeles

3. **Ethical/Legal** Issues — Whom Can You Tell? Whom Must You Tell? —
James Childs. Th 0 Dean of Academic Affairs, Professor cl Ethics, Trinity Lutheran Seminary and *Elliot T Fishman* Office of Affirmative Action *The* Ohio *State* University

4 AIOS Education **for** Your **Patients —**
Edward T Bope M 0 Director, Family Prac- tice Residency Program. Riverside Metho- dist Hospitals & Clinical Associate Profes- sor, Department cl Family Medicine. Tne Ohio State University and Others

6:00 **Psychosocial Issues** lor AIOS **Patients** and Their **Families**
John *Fryer. M 0.* Professor and Psychiatry, Temple University Health Sciences Center
(Sponsored by National Hospice Organization)

7:00 **Reception**
(Sponsored by National Hospice Organization)

PROFESSIONAL TRAINING INSTITUTES

Day 2, **September** 24

10:00 a.m. - 3:30 p.m.

1 Academic **Dentistry** and AIDS Training **Institute**
Sponsored by Proctor A Gamble (by invitation only)

The purpose of this institute is to train dental faculty who will serve as resource individuals for their uni- versities and other professionals in the regions sewed by the AIDS Education and Training Centers

2. AIDS: **Developing Effective Hospital** Worker **Pro- tection Policies —**
Co-sponsored by the Ohio Hospital Association

Institute Faculty *William Weimer,* Vice President for Human Resources. Ohio Hospital Association, *Susan Harwood.* Office cl Health Standards. U S. Dept. of Labor *Timothy Townsend. M D* . Dept of Epidemiology. John Hopkins University *Robert Campbell.* Director. AIDS Activity Office. *O h m* Dept. cl Health *DeDorah Coleman.* Infection Con- trol Nurse. Columbus Health Department *David Taylor. Ph* 0. St Elizabeth Medical Center Dayton Ohio

The purpose of this session is to review the problem of developing effective hospital worker protection policies, methods lo, implementation cl new pro- tection policy standards and discussion cl univer- sal precautions work task classifications and what to do when a worker has an exposure

3. Sale Sex Counseling Skills **for** Health **Profes- sionals:** Issuer in **Alternative Lifestyles** and **Sex- ual History** Taking
Leonard H Calabrese 0 0. *F A C P* Head Sec tion of Clinical Immunology Cleveland Clinic Foun- dation and *Buck Harris.* Consultant Ohio Dept of Health

The purpose 01 me session is to provide participants with an overview and practice in appropriate coun- seling and sexual history taking skills

4 Developing Community Based **Support** Services **for** Persons **with AIDS**
Marshall *Brown* Program Coordinator. AIDS Research and Education Committee The Ohio State University. and Others

The purpose of this session is to pre-sent examples of successful community based support services in the central region of the United States and to pro- vide participants with the skills am, knowledge for developing kke services to, persons with AIDS in their home communities

5. AIDS and People of Color: Issues **for** Health **Care Providers**
Mark Carter. Consultant Ohio Dept of Health. Ses- sion Coordinator and Moderator *Jill Silverthorn.* Representatives of Columbus AIDS Task Force. *Terresia L Hawthorne, M* 0 *Marcia Chambers Ed D* . and *Alyce Walker,* Ohio AIDS Activities Office. Ohio Dept. cl Health

The purpose of this session is to review and discuss a number of issues related to AIDS and People of Color, for example, general information on homo- phobia and the minority community minority women and AIDS. cultural sensitivity for health pro- fessionals, and patient education for minority per- sons with AIDS

6 **AIDS** and **the Office Staff**
Carol Hayes and Associates, Health Consultants. East Lansing, Michigan

The purpose of this session is to locus on those issues which are a unique concern in the physicians office Three topics will be explored in detail Legal Concerns. Infection Control Issues. and Evaluation of HIV Testing Sources

(continued)

7 **Spiritual Assessment, Pastoral** Issues. an Bereavement Issues **for** Persons **with** AIDS an **Their** Care Providers

Cynthia Snodgrass Director of Bereavement Ser- ces Hospice of Dayton Session Coordinator *Re Walter Sherman* President of AIDS Volunteers Cincinnati. *Rev Brad Lutz.* Resident Manager Caracole House Cincinnati *Rev Jeffrey Hamilto-* Pastoral Counselor Miami Valley Hospital *Diann Miller* Psy D Psychological Resident Middleto- Regional Hospital

The purpose of this session is to review spiritu assessment and spiritual issues that pertain to con cerns of persons with AIDS. their loved ones an their families. and to discuss and review bereave- ment issues of persons with AIDS and their families

8. **Hospice: Clinical Update —**

Sponsored by National Hospice Organization (Pleas contact the National Hospice Organization for mor information about this session)

Additional support provided by:

Burroughs-Welcome
Proctor & Gamble
Smith, Klein and French

Endorsed by:

National Hospice Organization
Ohio Hospital Association
Michigan Hospital Association
Kentucky Hospital Association
West Virginia Hospital Association

Appendix B

Modified Conference Program

East Central AIDS Education and Training Center

Center Headquarters
The Ohio State University
Oepanment of Family Medicine
80902 University Hospitals Clinic
456 W&t Tenth Avenue
Columbus, Ohio 43210
614-293-8188

>> REVISED CONFERENCE PROGRAM <<
Release date: September 19, 1988

THE PRIMARY CARE RESPONSE TO AIDS
REGIONAL CONFERENCE FOR HEALTH PROFESSIONALS
September 23 and 24

Sponsored by the East Central AIDS Education and Training Center

September 23rd Program

9:00 - 10:00 a.m. REGISTRATION - Cincinnati Convention Center

10:00 a.m. Welcome and Introductions
Donald C. Harrison, M.D., University of Cincinnati
Lawrence L. Gabel, Ph.D., The Ohio State University
Deria Foster Moore, R.d., M.S., Health Resources and Services Administration
Comments by a person with AIDS

10:30 The AIDS Epidemic in America
Mathilde Krim, Ph.D., American Foundation for AIDS Research

11:10 How HIV Leads to AIDS: Pathogenesis and Transmission
Evelyn C. Hess, M.D., University of Cincinnati Medical Center

11:40 Natural History of HIV Infection: Assessment of Disease Progression
John P. Phair, M.D., Northwestern University School of Medicine

12:20 LUNCH

1:30 p.m. Early and Late Clinical Manifestations of HIV Infection
Michael F. Para, M.D., The Ohio State University

2:05 False Positives, False Negatives: Issues in Serology and Patient Testing
Thomas Zuck, M.D., Hoxworth Blood Center

2:45 BREAK

(Over, please)

CENTER HEADQUARTERS

The Ohio State University
Department of Family Medicine
80902 University Hospitals Clinic
456 West Tenth Avenue
Columbus. Ohio 43210
614-293-81 88

REGIONAL SITES

The Ohio State University

Tennessee AIDS Consortium
c/o Meharry Medical College

University of Kentucky

The University of Michigan

Cincinnati Health Department in Cooperation with The University of Cincinnati Medical Center

3:00 - 5:00 p.m. workshops

1. Treatment of Persons with AIDS - Harold A. Kessler, M.D., Rush-Presbyterian St. Lukes Medical Center
   Michael Para, M.D., The Ohio State University

2. Combined Workshop

   a) Ethical/Legal Issues-Whom Can You Tell? Whom Must You Tell? - James Childs, Th.D., Trinity Lutheran Seminary
   Elliott Fishman, Esq., The Ohio State University

   b) Understanding the Patient with AIDS - Edward T. Bope, M.D., Riverside Methodist Hospitals & The Ohio State University
   Pam Jelly Boyers, M.S., The Ohio State University

6:00 Psychosocial Issues for AIDS Patients and Their Families
John Fryer, M.D., Temple University Health Sciences Center
(Sponsored by National Hospice Organization)

7:00 Reception
(Sponsored by National Hospice Organization)

September 24th Program

8:30 a.m. - 3:30 p.m. ACADEMIC DENTISTRY AND AIDS TRAINING INSTITUTE
(Co-sponsored by Procter and Gamble--BY INVITATION ONLY)

8:30 a.m. - 5:00p.m. NATIONAL HOSPICE ORGANIZATION--AIDS 88 PROGRAM
(Co-sponsored by NHO and ECAETC)
>> SPECIAL REGISTRATION REQUIRED <<
For registration information, call Jon Hollett, OSU-CCME (614)292-4985

CONFERENCE HEADQUARTERS HOTEL: CLARION HOTEL (CINCINNATI)
CONFERENCE LOCATION: CINCINNATI CONVENTION CENTER

FOR MORE INFORMATION, call Mary Ann Rausch, Department of Family Medicine, The Ohio State University (614)293-8188.

Appendix C

General Session Evaluation Form

East Central AIDS Education and Training Center

Evaluation Form
General Session **(Day 1, 10:00am-2:45pm)**

Your profession and practice **specialty** _____

Your practice setting is (please **circle): Rural Suburban Urban**

1. Please rate the following by checking boxes:

	Exceeded Expectations	**Met Expectations**	**Disappointing**
A. Appropriateness of Content			
B. Completeness of Content			
C. Use of Audiovisuals			

2. Do you expect that the content covered will be applicable to your practice?

c l **Not Applicable** c l **Somewhat** Applicable c l **Very** Applicable

3. **What did you find most** valuable? _____

_____

4. **What** did you find **least valuable?** _____

_____

5. Are there additional topics **that you would** like to have *seen?*

_____

_____

>> FORM CONTINUES ON BACK <<

6. How did you learn about this program? _____

_____

7. Would you be willing to participate in advanced 'train-the-trainer' sessions and make AIDS related presentations to other health professionals? (Please circle)

NO YES

If your answer is yes, would you please provide your name, address and telephone number:

Name _____

Address _____

_____

Telephone No. (_____) _____

8. We are extremely concerned about reaching the widest possible diversity of groups with our educational programs. It would be very helpful if you would indicate your ethnic background and sex (Please check):

Black American	____	Puerto Rican	____
White		Mexican American	____
American Indian	----	Other Hispanic	____
Asian American	----	Other	____

Hale ____ Female ____

Other Comments:

Thank you for your participation, ECAETC.

Appendix D

Workshop Evaluatio Form

ECAETC
East Central AIDS Education and Training Center

Workshop Evaluation Form

Date _____

Workshop Title _____

Your profession and practice specialty _____

_____

Your practice setting is (please circle): Rural Suburban Urban

1. Please rate the following by checking boxes:

	Exceeded Expectations	Met Expectations	Disappointing
A. Appropriateness of Content			
B. Completeness of Content			
C. Use of Audiovisuals			
D. Fostered Participation			

2. How was **the ratio** of ***lecture to*** discussion?

☐ Too **Much** Lecture ☐ Right Balance ☐ Too **Much Discussion**

3. Do you expect **that the content covered will be applicable** to **your** practice?

☐ N o t **Applicable** ☐ **Somevhat** Applicable ☐ **Very** Applicable

4. What did you find **most valuable?** _____

_____

>> FORM CONTINUES ON BACK <<

5. What did you find least valuable? _____

_____

6. Are there additional topics that you would like to have seen?

_____

7. How did you learn about this program? _____

_____

8. Would you be willing to participate in advanced "train-the-trainer' sessions and make AIDS related presentations to other health professionals? (Please circle)

NO YES

If your answer is yes, would you please provide your name, address and telephone number:

Name _____

Address _____

_____

Telephone No. (_____) _____

9. We are extremely concerned about reaching the widest possible diversity of groups with our educational programs. It would be very helpful if you would indicate your ethnic background and sex (Please check):

Black American	____	Puerto Rican	
White		Mexican American	----
American Indian	----	Other Hispanic	----
Asian American	____	Other	____

hale ____ F e m a l e

Other Comments:

Thank you for your participation, ECAETC.

Appendix E

National Hospice Organization Conference Program

The National Hospice Organization Presents

Regional *Conferences on Clinical Management and Care of Terminally Ill Persons with AIDS*

3 Regional Locations:

Springfield, Massachusetts - *September 15 &* 76, 7988
Omaha, Nebraska - *September 20 &* 27, 7988
Cincinnati, Ohio - *September* 23 *&* 24, 7988

PROGRAM OBJECTIVES:

This conference is designed to provide personnel who serve on the hospice interdisciplinary teem with a review of clinical issues associated with the management of care for Persons with AIDS (PWA). It will also define administrative strategies that hospice programs will need to consider during these next several years of growth of admissions of Persons with AIDS.

Drawing on the skills of experienced faculty, hospice interdisciplinary team members will learn how to work together to respond to me major forces and trends affecting the delivery of hospice care to PWA in today's environment

WHO SHOULD ATTEND:

Hospice interdisciplinary team members from operational hospice programs that have begun to provide hospice care to Persons with AIDS or plan to provide care in the next year The conference is designed to provide the latest developments in hospice clinical management and team care to physicians, nurses, social workers. clergy and spiritual counselors, psychologists, administrators, medical directors, patient care coordinators, directors of volunteers, and directors of bereavement Also, other individuals interested in learning about clinical team management of terminally ill Persons with AIDS and their families may attend.

PROGRAM AT A GLANCE:

MY #1	4:00 - 8:00 p.m.	Registration
	5:30 - 7:00 p.m.	Opening Plenary Session
	7:00 - 8:00 p.m.	Opening Reception
DAY #2	8:30 - 10:00 a.m.	Workshop Session #1
	10:00 - 10:30 a.m.	Break
	10:30 - 12:00 p.m.	Workshop Session #2
	12:00 - 1:30 p.m.	Lunch
	1:30 - 3:00 p.m.	Workshop Session #3
	3:00 - 3:30 p.m.	Break
	3:30 - 5:00 p.m.	Workshop Session #4
	Conference Ends	

NATIONALLY KNOWN FACULTY:

A number of outstanding hospice clinical, interdisciplinary team, and management/administrative personnel have agreed to serve as faculty for these conferences. Some of these include:

Beverly Barbo ..... author and speaker, Lemborg, Kansas

Peggy **Beckman** ..... INOVA Home Care, Springfield, Virginia

Paul **Brenner** ..... Montgomey Hospice Society, Chevy Chase, Mary/and

John Fryer, M.D. ..... temple University Health Sciences Center, Philadelphia, Pennsylvania

Interdisciplinary Team Staff. .. Homo Care and Hospice Program, VNA of San Francisco, California

Monica Koshuta ..... Hospice of Weshington, Washington, DC

Jeanne Parker-Martin ..... Home Care and Hospice Program, VNA of San Francisco, California

Claire Tehan ..... Hospital Home Health Care Agency, Torrance, California

Bill **Wallace** ..... The Grady Hospice, Atlanta, Georgia

CONFERENCE FORMAT:

The Conference will begin on the evening of the scheduled day with a plenary session keynote address, followed by an opening reception (Day 1). The next day will feature workshops designed specifically for each region (Day 2). Participants wilt be able to attend four (4) of these workshops. Lunch will be provided.

OPENING PLENARY SESSION:

Each conference will begin with a plenary session featuring a major speaker who is very knowledgeable of me AIDS issues and is active in the hospice movement. Speakers will keynote the conference by defining the issues and concerns. including: Homophobia in society, deep-seated fears about me risk of exposure to HIV, the physical deterioration of the PWA as me disease progresses, and me mental and emotional toll AIDS takes on both patients and caregivers. Plenary speakers will include:

John Fryer, M.D., Associate Professor of Psychiatry at Temple University Health Sciences Center in Philadelphia, PA. Or. Fryer has a distinguished career as a clinician and teacher. He has spoken widely on issues of AIDS and how it has affected patients, families and society.

Beverly Barbo, a mother whose son died of AIDS. Ms. Barbo will talk about the impact of AIDS on the family and survivors as they deal with the issues of caring for and living with persons wim AIDS.

CHOICE OF CONCURRENT SESSIONS:

The conference emphasizes the sharing of experiences through problem solving workshops. Team members will also identify barriers to creating and maintaining effective interdisciplinary teams through the examination of their own personal orientations and perceptions. Emphasis will also be placed on understanding the personalities and lifestyles of PWA and how hospice personnel can work together to become more effective and productive in providing care.

Workshops will be offered based upon the interest expressed by registrants. In this way, each conference will be tailored to meet the specific needs of each region of the country. A minimum of 10 workshops will be offered at each location.

Participants will choose six (6) of the workshops listed below. Out of these six choices, attendees will be scheduled for four of the most popular workshops.

Workshop #1 *Lifestyle Issues of Persons with AIDS that Affect Services*

Workshop #2 *Innovative Case Management of AIDS Patients*

Workshop #3 *Spiritual Care for AIDS Persons*

Workshop #4 *AIDS/ARC* **Bereavement** *Support* **Groups**

Workshop #5 *Psychosocial Issues of AIDS Patients*

Workshop #6 *Clinical Management* **in** *the* **Home** *Setting*

Workshop #7 **Emotional** *Impact on the Hospice Staff*

Workshop #8 *Bereavement Issues for Survivors*

Workshop #9 *Family Systems Approaches to* **Care**

Workshop #10 *Effective* **Networking to Support AIDS** *Hospice Care*

workshop #11 *Management of Inpatient Hospice Care*

Workshop #12 *Group Residential Cafe for PWA's*

workshop #13 *Staff Training and Development*

Workshop #14 *infection Control and Risk Management*

Workshop #15 *Perspectives on PWA Families*

Appendix F

Academic Dentistry and AIDS Training Institute Program

ECAETC DENTAL PROGRAM

8:30 .	OVERVIEW ECAETC James Pears01
8:45	Diagnosis and Management Oral Lesions Associated with HIV Infection Joan A. Phelan, D.D.S.
10:00	Coffee Break
10:30	Oral Lesions continued
11:15	Medical Management of HIV-Infected Patients During Dental Care Michael F. Para, M.D.
12:oo	Lunch
l:oo	Diagnosis and Management of HIV Associated Periodontal Lesions James R. Winkler, D.D.S.
2:30	Coffee Break
3:oo	Periodontal Lesions continued
3:30	Transmission of AIDS Slide Review George G. Blozis, D.D.S.

ECAETC
East Central AIDS Education and Training Center

Evaluation Form
General Session (Day 1, 10:00am-2:45pm)

Your profession and practice specialty _____

_____

Your practice setting is (please **circle**): Rural Suburban Urban

1. Please rate the following by **checking boxes**:

	Exceeded Expectations	Met Expectations	Disappointing
A. Appropriateness of Content			
B. Completeness of Content			
C. Use of Audiovisuals			

2. **Do you expect** that the content covered will be applicable to your practice?

☐ Not Applicable ☐ **Somevhat** Applicable **c l** **Very** Applicable

3. **What did you** find most valuable? _____

_____

4. **What did you find least valuable?** _____

_____

5. Are there additional topics **that you would like to have seen?**

_____

_____

>> FORM CONTINUES ON BACK <<

6. **How did you learn about** this program? _____

_____

7. Would you be willing to participate in advanced "train-the-trainer" sessions and make AIDS related presentations to other health professionals? (Please circle)

NO **YES**

If your answer is yes, would you please provide your name, address and telephone number:

Name _____

Address _____

_____

Telephone No. (_____) _____

8. **We are** extremely concerned about reaching the **widest** possible diversity of groups with our educational programs. It would be very helpful if you **would indicate your ethnic background and sex (Please check):**

Black American	____	**Puerto Rican**	
White	____	**Mexican American**	----
American Indian		**Other** Hispanic	____
Asian American	____	**Other**	____

Male ____ Female ____

Other Comments:

Thank you for your participation, ECAETC.

APPENDIX IX

University of Michigan: Participant's Reaction
Caring for Persons with HIV/AIDS

University of Michigan - Evaluation Example

Caring for Persons with HIV/AIDS

October 27, 1989

Participant's Reaction

Total Participants: 207
Total Responses: 152

1. Your major area of practice:

Training Health Care Professional	1	Infection Control	5
AIDS Service Organ.	1	Social Work	25
Home Care	3	Counseling	9
H.M.O. U.R.	1	Family Practice	7
Nursing	32	oncology	2
Internal Medicine	16	STD Intervention	1
Pediatrics	2	Psychiatry	7
Health Planning	2	Psycho-social R&D	1
EM/GP	6	Pathology	1
Administration	8	Student Health	2
Teaching	1	Occupational Therapy	3
Hemodialysis	1	Substance Abuse Prev.	3
Geriatrics	1	Laboratory	2
AIDS	1	other	7

2. **Was this course a learning experience?**

5		61
4		62
3		
2	21	1
1		1
No Reply		7

MEAN=4.1

3. **What parts of the course did you find most valuable?**

Quality of speakers; Medical update - Dr. Para; Cultural sensitivity; legal ramifications
PWA - excellent panel - please thank them! Counseling adolescents, Prejudice-Ms. Lara, Mr. Jolman's handout, Ethical/Legal.
Discussion of treatment
Discussion of occupational risk factors and cultural/racial issues.
Morning plenary session, 2 workshops in pm on Taking Histories (Sexual & Drug)
Generally valuable thought
I found all sessions of some value, and consider it hard to distinguish which one was most valuable.
Sexual/and Drug history sessions; Dealing with adolescents
Legal aspect of HIV/AIDS affected individuals
Cultural aspects, Networking with other professionals.
Dr. Para's lectures were very practical for my clinical practice.
Taking sexual history; teaching safer sex; legal aspects; ethnicity
The focus on 4 areas attracted me.
Pre & Post test counseling; Counseling adolescents; teaching heterosexuals.
Race & Culture
Those that dealt with care of and resources for HIV

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Most Valuable Continued:

Out patient therapies for HIV infection use of AZT. Aids panel opportunistic diseases and treatment.
Update information on Dx,Rx & Occupational related and also better insight into aids patient feelings and needs.
Prejudice (Ms. Lara & Dr. Stein); Counseling (Dr. Ostrow Only)
Plenary sessions esp. Dr. Steins and ethnic issues.
The individual workshops
Plenary sessions were all good.
The broad based knowledge multi-disciplined Medical/Social/Cultural/Emotional Lots of valuable pertinent info by establish practitioners.
Workshops-Post counseling, Pre Counseling, Dr. Pam's presentation on treatment
Individual workshop; Info on Children and adolescents.
Dr. Para's sessions were done very well PWA panel very interesting.
All of it! Congratulations on a job well done!!
The afternoon workshops under the counseling group
Information on clinical management of HIV positive person-both verbal and written.
The medical oriented talks especially new treatment.
Course pack/High quality presenters/Format of overview and breakout sessions and outlines/Excellent division according to instructor.
Adolescent counseling-Carmody;Michael Pam-Out patient therapies; Margaret Campbell Ethics; G. Lara-Prejudice;T. Stein-Prejudice; Hill-Post Test Counseling.
The PWA panel was excellent
Sex history; Post Test
All
Ethnic and law discussion.
I enjoyed everything I attended.
Probably on Para's presentation on medication.
Counseling.
Dr. Para's speeches.
Developing tx teams, creating resources, prejudice-challenging ourselves.
Ind. sessions
Lupe Lara's talk
Interaction with PWA
Outpatient Therapies for HIV infection; Occupational HIV transmission; Taking a drug his tory
Everything
Occupational HIV transmission; PWA panel
History-taking sessions
Both lectures & workshops
Para's comments & summaries, Handout from Burnouts-Well done
Lawyer stuff and Guadalupe Lara was excellent.
Scientific ie. Medical drug and therapy; Medico-legal aspects re: taking care of patients.
Actually, all of this ambitious program was very valuable.
Morning Plenary sessions.; Presentation of concurrent statistics and new findings from research. The concurrent session re: People with AIDS; Occupational transmission of HIV
Plenary sessions-these speakers had more time.

Most valuable continued:

HIV counseling-Special population.
Plenary sessions
Occupational HIV transmission; Access to experimental therapies.
Counseling skills, cultural considerations.
Legal aspects & ethics
PWA panel was excellent, creating resources-inspiring and informative; Good handouts.
Management of home health care; Developing HIV treatment teams.
Each session was informative.
Clinical & social issues.
HIV test counseling; Complications: applying law and ethics by Ed. Goldman; Prejudice: by Lara; Resolving legal and ethical problems
Prejudice, race and culture; special problems for TUDSHIV
Information on referral and counseling for women and children.
Mr. Pam-gave excellent clear presentations. Kathyrn Schmidt - her program will be a good referral/info source. Also, she is a good presenter
PWA panel sharing their needs, ethnic point of view & treatment
PWA Panel-Guadalupe Lara
PWA workshops
Occupational transmission, legal aspects.
PWA panel; the choice of all the sessions you offered.
The general/basic information; ethical and legal issues!
Information explaining AIDS.
I felt the treatment therapy review was helpful, and the risk assessment by Dr. Levine was superb. The comments by Dr. Stein were well taken as well.
Ethics
AIDS update; counseling adolescents; prejudice/ethics
Legal & ethical issues, counseling adolescents great!
Lara Guadalupe & Terry Stein prejudice challenging ourself.
Michael Pope, M.D., Robert Fekety, M.D.
Clinical and provider care.
Occupational HIV transmission access to experimental protocols and new drugs; Pre-test counseling of high risk individuals.
Handout and creating resources.
Dr. Michael Para had information that was informative and useful. The initial orientation sessions were all very good and well presented.
Small workshops; Cultural sensitivity.
Clinical care symposiums
PWA exposure, resources available
All of it up: being aware of large the scale is moving, and the effects will have on the world, if this problem is not resolved.
Adolescent work
Useful workshops on team development & teens
Legal and ethical issues, PWA panel
Legal & ethical problems and counseling adolescents.
Dr. Para - David Ostrow
The PWA's panel was most informative but I was impressed with everyone I heard - All were organized and had much to say to teach.

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Most Valuable Continued:

New treatment - research in AIDS
Taking care of ourselves very elementary, redundant all except Cynthia
All
Medical Clinical - Pope, Para, Fekety PWA panel
Counseling adolescents by Connie Carmody
Medical aspects of AIDS (treatment)
Clinical sessions; talk on "Burnout"
Dr. Ostrow - behavioral indicators to A Guadalupe Lara excellent too short though
Stress protocols and new drugs.
Presentations
Pre-test counseling; Prejudice/Ms. Lara; complications.
The individual workshops.
The whole conference was positive.
Law and ethics
How we are learning to deal with these patients.
Data
Dr. Para; post-testing.
Clinical presentations, Dr. F. Cohen, Dr. Para and counseling adolescents, prejudice by G. Lupa; Burnout & C. Edwards-Tuttle
Recognizing AIDS in children, outpatient therapies for HIV occupational transmissions.
Individual sessions on topics of your choice to enhance your own practice.
All the sessions I attended were very informative. There were many I would like to also attend.
I enjoyed all of the sessions-Dr. Para was very informative.
Organization and Resources.
All were good
The workshops; the overall lectures were too general
Handouts-comprehensive packet of info was essential thanks!
Outpatient therapies for HIV infection health maintenance and patient therapy diagnosis and therapy of opportunistic infections.
See general comments.
Legal ramifications, ethical questions.
1. Outpatient therapies for HIV. 2. Health maintenance and outpatient therapy.
Michael Para presentation was very good. Dr.Ostrow's presentation was too academic and not clinical enough oriented. Nick Hills presentation was very interesting but it applied to special inner city populations.
All
Children and AIDS; adolescents & AIDS
Smaller group work-shop and the variety in selections.
Need for extensive counseling.
Tx of scronday infection
All
Health maintenance in outpatient therapy for HIV infection; HIV test counseling; Recognizing AIDS in children.
The organization of the course, outstanding pacing, the quality of the speakers was high (knowledgeable, message properly targeted to audience) Overview topics up front helped a lot.

Most valuable continued:

Open forum-PWA
All the updated details on treatment, community resource and areas to increase access.
Practical sessions; treatment, diagnosis
The sessions were short enough that you could get a lot of information from all aspects of care.
All of Dr. Para's lectures
Dr. Michael Para's lectures; all morning sessions helpful. Handouts very good!
Michigan update; Workshops

4. **What parts of the course did you find least valuable?**

It felt "rushed' from the start. It felt like you tried to pack too much in. Should have allowed moving time between sessions. As a presenter, it was a pressure to feel like you were pushing preceding speaker out of room and getting a late start and not having time to "set up" before participants arrived.
Dr. Stein's reading, poor evaluation form.
Discussion of IV drug use & AIDS
Legal/ethical
Burn-out (too basic, boring, nothing new-why a nurse and not a social worker or psychologist?)
Speaker on Burnout
None
Stress/burnout/legal ethics.
Info given in session on burnout could have been obtained in a magazine article.
Government grant session.
Managing home care-minimal clinical application. If burnout lecture necessary.
Speakers do not need to start with basic information on HIV/AIDS, stress, adolescent stages etc. I am sure every person here knows the basics or they would not be MD RN's MSW etc.
All quite good
Burn out S/S
Session on burnout-1 believe most health care workers are already well aware of this information.
Coverage of gay teens during counseling adolescents.
Some small sessions too specific for Detroit area.
The 2:20 on Bum out was information we all already know.
Plenary II/Afternoon session.
I enjoyed the conference - I would have like the opportunity to attend other session than those registered for - perhaps next year should be over two days.
"Burnout"
Too large a group - this limited or abolished discussion/interaction with presenters.
Too many speakers trying to cover too much in such a short time.
Statistics in 2nd part of Ostrow - discussion preferred the a.m. overview useful_ - Wonderful to give snacks/lunch. Give light lunch not dinner and non-sugar snacks.
Ostrow Pretest counseling; Edwards-Tuttle
This is difficult to answer because all the sessions and talks I attended were good to excellent.

Least valuable continued:

Counseling adolescence: I didn't want to relearn Human growth & development and pre-test: Not enough "Hands-on" information.
N/A
Treatment of **AIDS**
Nothing
1. Burn-out presentation. 2. Having to choose a topic would prefer 2 or 3 day workshop where everything is available to all.
Burn-out.
Out patient therapies.
Bum-out
Burn-out session
"Caring for each other"
Pm-test counseling of High Risk individuals.
None
Stress management; Race and **Culture.**
Burn-out - was too general of topic needed more info. related to AIDS. What about the effects of tx burnout of patient.
OP therapies
Terry Stein's about anti-gay stigma
Speakers who in speeches simply had us think about all the questions - not good for seeking some answers.
I found all aspects valuable.
Plenary and workshops on accessing funds and maternal and infants AIDS
Goldman's presentation - in plenary session.
Individual session speakers were too rushed.
Presentation of pre-printed material - this can be read on own time.
statistics.
Pm-test counseling of high risk individuals.
burnout
Ask & Listen: Taking a good sex history.
Access to government HIV program funds.
None
"Burnout"
Burnout: Caring for each other by Cynthia Edwards-Tuttle; Race and culture by Hill.
Post-test counseling; Stress/burnout discussion.
There were so many topics in so little time - they became hors d'oeuvres, no time for main course.
HIV test counseling
Stress management
Session on burnout
The technical aspects/presentations not enough time for all presenters too short of workshops.
All the technical explanations could have been shorter.
Experimental protocols.
Bum-out; highly technical
Funding. Resource guides, funding sources would have been helpful.
Too many speakers were not able to elaborate on their areas of expertise.

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Least valuable continued:

PWA panel
Sessions were not allowed enough time to present.
Presenter reading statistics provided in hand-outs and presenter reading all their presentation.
Course components supported by assentions ie. lecture on burnout
N/A
N/A
None
Stress management (did not even spell or pronounce correctly)
All was informative and interesting.
Lawyer's talk
Talks on counseling.
PWA panel - It's difficult to have a panel representing "typical" patients whatever that means panels typically represent those who have successfully networked systems and are "doing well"
2nd half of prejudice.
Some of the small group discussion.
Terry Stein
Lack of time for speakers in the plenary sessions.
It was valuable but, workshop on creating resources was vague from title impression was that specific type agencies, DSS resources would be specific.
Challenging ourselves.
For myself - I can not counsel these patients - therefore though interesting I can't use this information.
Pre-test - PWA
None
The large group sessions appeared to be very rushed.
None
None were bad
The raising of questions without answer I have plenty of questions. I come to conferences for answer or at least opinions.
Speakers who read from their outlines/handouts and did not expand on their material.
General information on the virus; pre-post test counseling.
Prejudice
None
Occupational hazard - discussion which occurred between small group discussion in am & pm.
Dr. Stein - I don't appreciate speakers who read their presentations.
None
None
One or two speakers of the plenary session.
The overwhelming amount of handouts staples would have helped me get organized.
None
AIDS in children.
Dr. Cohens lecture - difficult to follow and understand point being made.
Prejudice: challenging other part II

5. As a result of this conference will you do anything different in your work setting?

Yes	**95**	**63%**
No	**45**	
No Reply	12	

Examples:

Apply current law to practical in areas of defiency
Use some of the handouts and subject matter in presentations.
Alter HIV group education session substance abuse clients, based on PWA panel.
Certain questions will be raised pertaining to some subjects covered legal and hospital concerns and in my consultative business
Use different approach taking history from patient of different cultural background
Education and history taking.
I don't think I will feel that the AIDS patient should be treated as an out cast.
New ways to open up communication
Better individual teaching in prevention to clients one on one.
Establish network for HIV/AIDS patient in our community
Continue to push CMH for further training and providing counseling/therapy for HIV+ and PWA clients.
Hopefully improved counseling for teens.
More detailed history, dig deeper for community resources.
I now understand some of the dynamics associated with AIDS
Counseling ethnic groups and positive testers/ARC clients on behaving medicine.
I will be less frightened to get involved with this population and more committed to contributions.
Be more aware of questions asked to obtain risk access information.
Give more encouragement for early testing of high risk persons.
Post test counseling approaches.
Take better drug and sex histories (and more thorough)
Formalize protocols for follow up on HIV+ asymptomatic persons according to more up to date information.
Continue to educate on homo-phobia. Take better sexual histories encourage testing for HIV.
Train staff
More sex history; Focus more on safe sex and safety with drug use.
Family issues.
Maybe a little more on the job counseling.
Push for more staff education.
Re examine prejudices.
Improve pie-test counseling.
Arrange follow up service information.
I was familiar with most of those who presented.
Continue to be advocate for sexual oriented resources for care/treatment of AIDS
Education and policies on AIDS over and above what we have done already.
Realistic referrals.

Examples of doing anything different continued:

Probably - will consider all information to develop local program in small community/hospital.
Hopefully pick up cases earlier, greater sensitivity
More information given regarding culture aspects.
Helpful in policy discussion making.
Re-evaluate pre-test counseling content.
Increase referrals and education regarding.
How to take a drug use history.
Continue at full force, but understanding we can do only so much in the time constraints were under - but don't give up hope.
Make more pertinent and realistic policies.
I be better able to confront colleagues treating HIV patients poorly.
Pass along information to co-workers, direct care staff and home providers.
I will probably encourage HIV testing to high risk individuals more strongly.
More informed, culturally considerate sessions.
Intervention to system and sign of the disease, prevention skills/planning.
Expand on current interventions at the training school.
Invest mom time in pm-test counseling.
Be aole to accept HIV client without prejudice.
Perhaps develop a support group.
Will attempt to educate any and all who will listen - we need an "AIDS team"
Take and share this information with co-workers and department head for more awareness and developing of more resources prior to more incidence of cases.
Clinical applications.
Try to use information in developing S.W. role with this population.
More service.
Interaction with doctor doing assessment
Be more aware of precautions that are necessary and take them, and make myself more available to patients and families in need of further information on AIDS & HIV
More education to clients.
Data presentation
We are well up on everything-although a smaller hospital.
Education of information
Take a better drug, alcohol history and more through sexual history
Try some of the counseling tips and work with staff to prevent burnout.
Handling adolescent patients.
I will use the outline of text guide provided by Dr. Para.
Counsel more
Educate staff re: precautions, application to clinical practice.
Better self protection for self as well as staff members.
Able to deal with AIDS patients easier and counsel.
Give training at work location
More STD counseling and encourage testing.
Take more explicit sexual histories in you AIDS people.
Several
Possibly give greater thought to cultural, and ethical prejudices.
Counseling techniques, how to obtain pertinent information.

Examples of doing anything different continued:

Counsel my patients more
More thorough history and physical exam among patients and possible AIDS
Counseling the adolescent type 3R's tips for resource gathering (network, network,network)
Update staff with all relevant data.
I shall attempt to get various patients involved n treatment protocols.
Assist in developing policies and procedures.
Summary data completely in all patients tested positive.
Encourage more testing.
More planning and case management.

6. **Please list topics you would like included in future courses of this kind.**

1) AIDS impact on health cam system and study as a whole; will there be enough beds in 5 years? What is overall. 2) More meat or 1' physician regarding suppurative series.
Same content
Homosexuality 101
Nutrition, alternative treatments.
AIDS and Gay/Bisexuals
More detail about heterosexual transmission of AIDS and also stats on health care providers with AIDS and transmission to clients they care for.
Resources, working with the families of HIV persons
Continue work; Interdisciplinary work
Exactly what to teach families about communicability when caring for HIV + patients.
Legal and Ethics to be expanded
More concentration on women and children and AIDS issues.
More involvement of PWA's, Wellness groups, more nursing clinical care.
Infection control - policy writing.
More of Guadeloupe Lara
Concrete resources - updates always needed.
Drug therapies and protocols to elevate side effects ie. N/U
More accurate coverage of homosexuality, particularly gay teens, as well as more time dedicated to IVDU issues.
Workshop on ethnic issues.
Spirituality and HIV & AIDS, where with med. treatment.
More of the same over longer periods of time ie 45 minutes too short
More information and updates on drugs and drug trials.
Ethnic sensitive practice approaches - Ms. Lara did an excellent job.
More on working with family members, partners, etc.
Homophobine strategies to deal with it/Power & Control Rel. of AIDS to cocaine continue update:
Definite things to tell AIDS/HIV+ (Pm-test)
Family issues
Resolving legal & ethical problems
Further experimental topics.
Drug update (yearly)
Handling the active AIDS in the home

Future topics continued:

Other infectious diseases.
I would like to see at least one conference get past AIDS 101 and start really working on some of the enormous gaps. So many of us already know and work with the gaps.
Continue with panels of PWA - to service as quality control measure for what is or isn't being done.
International aspects of AIDS - US & Europe U.S. & Africa
Resources available to special populations.
More information/courses re: Pre & Post test counseling; also developing an AIDS treatment team.
More nursing based home health care ideas/information
More clinically oriented.
More focus on needs of "special groups, i.e. children, minorities, with time to adequately cover these topics.
More about values clarification
More ethical/legal aspects for child welfare arena
Although I understand this conference was geared toward physical health care. of persons with normal intelligence I would like to see some topics in mental health DD populations.
A time set aside for networking other than lunch. Perhaps 10-15 minute between sessions.
Address less common risk factors ie Coag. disorder, transfusion, neonate
Networking between hospitals/social agency
Availability of receiving prescribed drugs. (ie. druggist, pharmacies that will supply drug necessary.
Sexual orientation sensitivity but not Dr. Stein's monologue.
Prevention, progress to the solution for reducing or terminating the illness, disease of AIDS.
More on adolescents.
Elementary educational intervention/prevention.
Fuller discussion of ethics/resource allocation.
More case histories and discussion of how to.
Update on medical drugs, counseling.
More information on existing hospital care programs; possibly have some display booths.
Service for HIV Women and Children
1) M.S.R.A. 2) Preventive medicine.
Update on Research and drug as new information is discovered.
More on actual therapy scenarios of medical problems of HIV+ individual
Any new breaking information on the virus/epidemic
AIDS 101
More clinical
Try a meeting in Battle Creek/Lansing area.
Greater participation from participants, more question/answer periods, not so rushed. Hand-on re: legal issues for HIV persons, resources actual services available more discussion re: ethics, feelings, prejudices etc..
Legal issues surrounding guardianship, power of Attorney and family's rights to make decision around care of patient. If family's disagree. Liability.
Yearly update.

Topics included in future courses continued:

Hepatitis B-virus
More topics on working with drug using adolescents.
More information re: funding please ask Ken Pape from DSS to speak next time!!!
Have HIV patients conduct open forum for group.
Counseling family members
STD vs. AIDS; Substance Abuse & AIDS; STD what is it and how to treat; Women & AIDS

7. **To what extent do you feel that material presented in the course was too advanced or too elementary?**

5	
4	1
	11
4	116 18
1	0
No Reply	5

MEAN=2.8

8. Speakers	**Should return**	**Should not return**
Bracho		0
Campbell	2:	0
Carmody	8	3
Chandraskar	4	0
Cohen	8	4
Cole	11	1
Dunivan	10	0
Edwards-Tuttle	5	12
Fekety	8	0
Goldman	21	4
Hacker	21	0
Hill, J.	2	0
Hill, N.	17	10
Kosik	1	0
Lara	57	0
Levine	18	1
Lipschutz	1	1
ostrow	17	14
Para	70	0
Philpot	1	3
Plotkin	8	1
Pope	17	1
Schmidt	8	0
Scott	1	1
Stein	22	12
Szuba	0	3
All	21	0

Caring for Person with HIV/AIDS

9. Would you recommend this course to others?

Yes	130	86%
No	3	
No Reply	19	

10. How did you learn about our program?

Advertisement	2
Brochure	121
Past Attendance	
Colleague	2 :

11. General Comments:

Less workshops; more relevancy and make the workshops longer.
Good program!
Good job!!
One of the best seminars of any # type, I have ever attended
Excellent conference - excellent handouts excellent speakers.
Excellent day! Loved hand-outs so I didn't have to take notes!
This conference is very educational. With the increasing patients suffering from AIDS, If this conference gives one an insight in the early detection of AIDS, the people follow up and proper counseling that is need for individual suffering from HIV infections.
Very good
Liked course have been treating patients (HIV) for 5 years.
A well spent day.
This was a well organized seminar with many extremely knowledgeable guest speakers! Suggest panel discussion be scheduled in PM also for those who missed AM schedule. I heard it was great! Excellent seminar!
Not bad, very rushed and not in-depth enough re: issues which are of concern to me. Legal discussion was irrelevant. My clients. want to know information regarding how it will affect them personable, not how it affects hospitals administration personnel, etc.
I expected to learn a lot I didn't know about HIV infection and the epidemic. Almost all the information given was known to me and I do not work in this field exclusively.
Very good but workshops ran one upon the other - need better scheduling.
Allow time to get from one session to the next due to the fact that some sessions started before others finished, therefore you miss important passed out materials as well as info.
Enjoyed the brief sessions on various topics. Although not possible to go into great depth with the time constraints, I found the sessions informative and provided resources for more indepth learning/research of the topics. Also enjoyed the multidisciplinary focus and text of AIDS topic.
Excellent job! !
Well organized presentation with attention to participants' comfort through in topics addressed.
Nice balance between therapeutic (need more) and humanist.
No provision for questions at the time of each lecture.

General Comments continued:

Our lunch could have been eaten faster if cut-up chicken was used instead 1/2 chicken I felt rushed during lunch otherwise everything was very **well** organized.

The workshop (concurrent sessions) could have been more organized ie having moderators to introduce speakers. Also, there were not enough handouts available at the concurrent session.

All round program excellent

Impressed with the speakers; the amount of written information

I wish there was more time available for "group participation - questions & answer" periods. I enjoyed this seminar greatly.

Hotel difficult to find - Hotel name not clearly visible on 9 mile road; none on hotel canopy different than listed.

Speakers didn't have enough time to cover their topics. I think there were too many workshops and too much information was attended tot he course.

Too much good material to limit to 1 day - nice job

All in all a worthwhile conference.

To many unqualified speakers.

Excellent!! Among the best conferences I have ever attended (and I am no neophyte!)

Excellent conferences: Would like to see this on an expanded time frame or love info. from unattended conference available. Can't be in 2 places @ one time.

Very impressed with organization, etc. Thank so much.

Good conference.

Very good learning experience.

Very informative seminar, much needed and long overdue - keep up the good work. Thanks

Very annoying rattle in the large room.

Consider data very educational

Workshops should be trimester.

Need to informalize sessions a bit more rather than didactic small group.

The rooms were too hot in lower levels and l-10 upstairs.

More time needs to be allowed for each session - far to short to cover issues.

Wealth of **information** presented, not enough time **alotted** per speaker.

I agree with Dr. Terry Stein that we need to bring the aspect of homosexuality and AIDS, discrimination and stigma into the open.

Overall a very good and informative seminar.

This was well planned conference with excellent sessions available. As with most conferences time limits are problem. Understanding $ constraints etc. I would still like to recommend this to be spread out into a 2 day or day and 1/2 conference (either that or more time for clinical manifest. disease process etc.)

Helpful programming.

Too much packed into too short a time. The **structure** was too tight.

Overall, conference ran smoothly! Some speakers rudely refused to abide by time-limits, ie. Dr. Cohen. I think planners accomplished their goal of presenting "something for everyone".

Would have been helpful to have representatives from wellness CID and other agencies that provide services to this population - post session on services in state.

Speakers like Dr. **Para** should avoid monotones monologue. He should use the microphone! Ms. Guadalupe **Lara** was a very dynamic speaker the program as a whole was very enlightening and educational.

Caring for Person with HIV/AIDS

General Comments continued:

Great workshop
Would like to see similar courses offered twice yearly.
Very good conference comfortable facility - nice refreshments and continental breakfast. Lunch was good except chicken (a little under cooked and difficult to cut due to bones).
Had to leave early due to emergency message.
Consider having in midstate ie Mt. Pleasant - or even Lansing.
Individual session had much to offer maybe too much. The speakers all announced they only had so much time & seemed rushed. I am not sure they were able to share all they had come to share. Less slides and stats with handouts we can read the handouts.
Found the conference center satisfactory for the program - appreciated the detailed program schedules and conference center map, well - marked session rooms. did not like "operating" on the chicken for lunch! Very good strudel! Really in general the day went very well! Thanks - good value for $55.00
Course directors might have had an attempt to curtail a speaker from trial of convincing participants to accept homosexuality/and put aside their "moral" ethnicity and religious convictions.
Need forum for more questions/answer 'within workshop environment. I did like the tracks but thought the sessions to be too short.
Very good
Longer session would allow more in depth information to be presented. In rare and culture session presentations were terribly general. It would be helpful to have specific research presented as well as resources for further education.
Excellent
Effectively presented - good attention to staying on time. Thank you.
Felt overwhelmed - too much material too condensed.
It was a very well prepared. Thanks.
All speakers pressured for time. With time of Q&A
Very helpful to have update on the topic.
Availability of vegetarian meal. Although I requested such a meal on my registration form. I did not receive. My meal of steamed vegetable until the very end of the lunch hour. Not everybody eats meat!
Excellent conference.
Scope of conference is ambitious and broad, so depth in any area is difficult, out was accomplished through fairly comprehensive handouts (at least in the clinical care track.
Thank you!
Very informative and innovating seminar.
Well organized and good information. I like the way schedule was maintained.
Next time, please make this a 2-day seminar. I would have like to attend more workshops. Also, there wasn't enough time for discussions in workshops.
Excellent conference but why, may I ask, do only the physicians have their M.D.'s after their name?
To much covered in too short time and so source data was rushed through.
Overall valuable experience - very informative.
Good conference. I think it could be handled in 1 1/2 or 2 days. Often time I feel some pertinent information was missed because of the ending of a session. More diet pop too!

Caring for Persons with HIV/AIDS

General Comments continued:

1). Not enough repetition of small sessions to be able to attend most of them. 2). Squeezed too much into too little time. If you need two days to cover material adequately, why one day with material covered incompletely and in a hurry?

Schedule - too time limiting, speakers appeared to have to rush to meet time limit, often questions not answered or asked in order to attend next session - 2 day seminar would have been better.

Great conference.

Excellent conference worth my 2+ hour drive!

Too much was packed into too short a time there were always 2 sessions going on that I would to attend

Too much pertinent data rushed through in a short period a time. Inadequate amount of time for speakers.

Too much rushing

Excellent; a bit much for one day but it was a challenge to keep up! - Also, the written handouts are fantastic!

Too much information for one day - would recommend 2 days so speakers could go into more detail & not sound so rushed. I felt badly that so much expertise was only skimmed.

Needed monitors in halls and rooms; needed someone to introduce panel speakers in rooms; staple speakers and room placement)too many loose pages) and more color coding of papers. Having coffee by registration desk (a.m.) caused caffeine addicts in conference to go in and out of room disturbing all of us.

Perhaps should have been spread out in 2 days so it wasn't so rushed. A participant list would have been helpful.

Need a specific course/or 1' care physician with similar format.

APPENDIX X

Evaluation Report: MATEC and ECAETC
AIDS/HIV Continuity of Care Conference

EVALUATION REPORT

U. S. Public Health Service
Region V Office
Community/Migrant Health Centers

AIDS/HIV
CONTINUITY-OF-CARE
CONFERENCE

June 26 & 27, 1989

Presented bv:

Midwest AIDS Training and Education Center
and
East Central AIDS Education and Training Center

Prepared By:
Patricia Lavannar,
Program Specialist

July, 1989

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INTRODUCTION

The University of Illinois at Chicago was the site for the June 26 and 27, 1989 AIDS/HIV Continuity-of-Care Conference sponsored by the U.S. Public Health Service, Region V Office and presented by the Midwest AIDS Training. and Education Center (MATEC)* and the East Central AIDS Education and Training Center (ECAETC)*. The conference was offered by Region v to meet the AIDS-education needs of its community and migrant health-center clinical staff.

There were 47 Professionals in attendance at the conference:

10 Social Workers/Counselors	1 Clergy
7 Registered Nurses	1 Dietician
7 LPN's/Nurses AIDS	1 Educational Administrator
7 Health Administrators	1 Medical Lab Worker
4 Health Educators	1 Nurse Practitioner
2 AIDS Specialists	1 Public Health Policy

Twenty-seven (57%) attendees represented Public Health Service outpatient clinics. Although the conference was to focus on the specific, identified needs of community/migrant health centers, the conference was opened to other interested Professionals. Eighteen faculty participated in the program.

Of the 47 attendees, 24 (51%) submitted evaluations which reflect the degree to which their individual needs were met. The evaluation report is divided into three parts: the Evaluation Ratings. a Summary Report, and Recommendations. Included in the Appendix are lists of the written comments made on the evaluations by the attendees as well as a copy of the Evaluation Form and the Agenda.

*MATEC and ECAETC are two of thirteen regional centers dedicated to AIDS training and education for health professionals and funded by the U.S. Public Health Service, Health Resource and Services Administration. This conference was made possible by contract with the Public Health Service, Order No. RO-V-1739-88 and No. RO-V-1740-88.

EVALUATION

47 Conference Attendees
24 Evaluations Received (51%)

The intent of this evaluation was to determine if attendees' needs were met. Attendees were requested to evaluate each component of the program as to its value to themselves, not as to the specific quality of the presentation or presenter. Thus, someone already knowledgeable about a specific program component, would probably not find that component as useful as a component with which they were less *or* not familiar, and would rate each accordingly.

Each component or sub-component was ranked from "1" to "5" with "1" indicating the component was of "little or no nelp and "5" indicating the component was "very helpful".

"1" = Little or No Help "5" = Very Helpful

1. AIDS/EPIDEMIOLOGY UPDATE 3.0

   - o VIDEO (3.3)
   - o JUDITH COOKSEY. M.D. (3.8)
   - o SMALL GROUPS (2.5)
     - Black Issues (3.0)
     - Drug Issues (1.2)
     - Gay/Bisexual Issues (1.0)
     - Hispanic Issues (4.0)
     - Women and Chi ldren Issues (3.5)
   - o LARGE GROUP SUMMARY (2.2)

EVALUATION

2. SHARING/LAVERN			4.4
3. AIDS PREVENTION			4.0
4. HIV TESTING/COUNSEL=			4.2
o VIDEO		(4.0)	
o RONN RUCKER, Ed.D.		(4.3)	
5. CASE MANAGEMENT			3.2
6. COMMUNITY RESOURCES			4.0
o VIDEO		(3.7)	
o SMALL GROUPS		(4.3)	
- Illinois	(3.2)		
- Indiana	(5.0)		
- Michigan/Ohio	(4.2)		
- Minnesota	(4.5)		
- Wisconsin	(4.5)		
7. TRAIN-THE-TRAINER			4.2
8. MANUALS/HANDOUTS			4.7
		OVERALL RANK	4.0

SUMMARY

Fifty-one percent (24) of the 47 conference attendees submitted program evaluations. Each component of the program was evaluated using a five-point scale, with "5" indicating the component was very helpful and "1" Indicating the component was of little or no help to a specific individual.

Overall, the conference received a rating of 4.0. In that 43 percent of the attendees did not represent the professional staff for which the conference was developed, the 4.0 rating suggests a very positive result.

The program manual and handouts recieved the highest rating, 4.7. Other program components receiving 4.0 or greater are: Sharing/Lavern, mother of a deceased HIV positive baby (4.4); HIV Testing and Counseling (4.2); and Community Resources (4.0). No component received a score of less than 3.0 overall.

Specific comments made by attendees on each component and sub-component of the program can be found in the APPENDIX.

RECOMMENDATIONS

Based on the evaluations, the following recommendations are made:

1. Increase program sponsor's marketing effort for the conference.
2. Increase time for networking, in total and by individual states.
3. Provide the opportunity to rotate through a number of small groups rather than limiting selection to one small group.
4. Add to faculty, a registered nurse who is working with AIDS patients.
5. Shorten segment on case management.
6. Increase length of time for train-the-trainer or have optional section for those desiring additional help in this area.
7. Continue to utilize a person with AIDS as a part of the faculty.

a. Continue to provide manuals.

Most of the above recommendations would require a greater time commitment for the conference. Two days, rather than one and one-half days, should provide adequate time for implementing the recommendations given.

APPENDIX

COMMENTS

1. **AIDS/EPIDEMIOLOGY UPDATE**

o **VIDEO**

- Helpful
- No new information
- Too much inaccurate information
- Big numbers/Big deal
- I've seen better and I've seen wors8
- Physician is very homophobic, misinformed. Blames homosexuals for the spread of AIDS. Otherwise, technically accurate and acceptable.
- No new information
- Knowledgeable prior to conference

o **JUDITH COOKSEY, M.D.**

- Informative
- Needed additional time for questions
- Interesting statistics
- Good communicator
- Very effective

o **SMALL GROUPS**

WOMEN AND CHILDREN ISSUES

- Good speaker/good information
- Leader shared experiences not encountered by me

COMMENTS

WOMEN AND CHILDREN ISSUES (Continued)

- Incomplete information
- No information on children - minimal information on women
- No indepth coverage
- Great

DRUG ISSUES

- Needed more examples of risk-reduction education among IVDUs
- Not enough people in session to make it useful, but a good idea
- Not wel 1 organized
- Not much information on AIDS

BLACK ISSUES

- Content good
- Time-frame deplorable. missed next session
- Talked too long
- Leader not wi 11 ing to discuss any issues but her own
- More than 30 minutes over allotted time and terribly insensitive to time limitation, which I perceive as "very poor"
- Excel lent presenter
- Great audience participation

COMMENTS

o **LARGE GROUP**

- Too informal - not much information exchanged
- Missed this Session due to overtime on Black Issues
- Poorly organized session
- Not too informative
- No designated reporters to summarize
- More constructive comments needed

COMMENTS

2. SHARING/LAVERN

- Impressive **individual**
- **It's always helpful to get this kind of input**
- **Good presenter, good information**
- **She's "O.K."! Valuable insights!**
- **Good to hear her personal experience**
- **A very courageous presentation**
- **Identify with her feelings! Great!**
- **Short, concise (just right)**
- **A new experience to hear it**
- **Had prior "sharing" with 5 PWA's, but is appreciated as each is different**
- **Great to have her here, but I didn't learn much**
- **Excellent professional and personal sharing**

COMMENTS

3. AIDS PREVENTION

- An excellent review
- Excellent presentation - point was made
- Good speaker - excellent for uninformed listeners
- Knowledgeable prior to conference
- Well informed - good delivery
- Useful, clear, direct
- I've heard most Of this
- Good example of effective and frank public Speaking
- Ruben Blades' video good. Nothing new but well organized and presented.
- Video (condoms), excellent with Ruben Blades

COMMENTS

4. HIV TESTING/COUNSELING

- **VIDEO**
  - Straight up! To the point!
  - Technically helpful
  - Succinct and to the point
  - Very basic video
  - Great material
  - Prior training
  - Physician is very homophobic and misinformed. He indicates that HIV positive persons are very likely to commit suicide which is not accurate. Otherwise, acceptable.
- **RONN RUCKER. Ed.D.**
  - Good discussion leader
  - Most of this, I've heard before
  - Excellent Presenter
  - Material was very good
  - Prior training
  - Good Speaker
  - Straight forward, *very* enlightening

COMMENTS

5. CASE MANAGEMENT

- Handouts were excellent and I will use them
- This particular talk was not helpful to me as I supervise a prenatal program
- We already have a system in place
- Speaker was boring
- Good materials
- Material was excellent but could have been presented in one-third the time
- Good combination of handouts and A-V screen
- Good handouts, however, talk too redundant
- Excellent basic information *on* case management. Needed more emphasis on actual management and problems related to AIDS cases. Excellent handout material
- Good material - boring delivery
- Good handouts - lifeless presentation
- I've heard most of this before
- Much too lqng and wordy - handout would have been suff i cent
- Excel 1 ent handouts - presentation duplicated handouts

COMMENTS

6. COMMUNITY RESOURCES

- **VIDEO**
  - A very informative film
  - Excellent video
  - Good general information
  - Torture - beautifully done but inappropriate for me, my area of expertise
  - I have the video'
  - Appropriate link between Care Management and Community Resources
  - Good for comparison
  - Nice production
  - What about State Health Department or residences for HIV/homeless individuals?
- **SMALL GROUPS BY STATE**

ILLINOIS

- Not much information presented - pleasant
- Need list of centers that offer services

INDIANA

- Great
- Poor turnout/attendance
- Fun to network

COMMENTS

0 SMALL GROUPS BY STATE (Continued)

OHIO/MICHIGAN

- Excellent for networking - needed much more time
- More time for networking - ways of identifying and accessing existing resources

WISCONSIN

- Good to be able to share information

COMMENTS

7. TRAIN-THE-TRAINER

- Had prior training in this area
- Handout very good
- I've no previous training experience – very good
- Good handout/talk
- More time!
- Could be a workshop by itself
- Great information
- Very Good

COMMENTS

8. MANUALS/HANDOUTS

- Very thorough
- Very comprehensive
- Excellent variety
- Nice production - good information
- Looks good
- Will be extremely helpful to me!
- Good

ADDITIONAL COMMENTS

- I was very pleased with the conference and the participants.
- Most of the information was read by the presenters - no personal input - rather dry.
- Uncomfortable seating
- Friendly, accommodating registration area
- Much good information in manuals and handouts!
- Much information can be generalized to other settings. Thank you.
- Need a faculty sheet with small biographical sketches.
- A breakout group for community health centers alone would have been helpful to me.
- Thank you
- I could have used more time, perhaps in a workshop format, to discuss problems I encounter and to share with people in a more personal way. Such things as access to resources and identifying resources are my concerns. The manuals will be helpful. Thank you.
- Temperature/humidity very uncomfortable which detracted from learning.
- Supply pads of paper for notetaking.
- I wanted to attend ALL of the small group discussions and found it frustrating not to be able to rotate through each session.
- This evaluation form is an excellently "laid out" form.. .easily read and completed.
- Rows of tables preferable to auditorium-style seating.
- Would have liked an RN working with AIDS patients to present a session.

ADDITIONAL COMMENTS

- Small group leaders for the "Responses to AIDS Update" were not in touch with needs of participants.
- Should include a clinical-base session for non-clinical attendees.

EVALUATION

AIDS/HIV
CONTINUITY-OF-CARE CONFERENCE

June 26 & 27, 1989

We hope you have found this program helpful. To assist us In the evaluation and revision of the *program,* we would appreciate your comments.

Please rank the items below, with "5" being very helpful and '1' belng of little or no help. Please comment on why any segment *of* the program was not particularly helpful to you. (e.g., Knowledgeable about topic priorto the conference.)

	5 4 3 2 1	COMMENTS
1. AIDS Epidemiology Update		
Vldeo		
Judith Cooksey, M.D.		
Small Group _____ (Identify)		
Large Group Summary		
2. Sharing/LaVern		
3. AIDS Prevention		
4. HIV Testing/Counseling		
Video		
Ronn Rucker, Ed.D.		
5. Case Hanagement		
8. Community Resourceq		
Video		
Small Group _____ (Give State)		
7. Train-the-Trainer		
Manual/Handouts		
9. Additional Comments (Use *other* side)		

- THANK YOU -

PL/6-89

MATEC

Midwest AIDS Training & Education Center

AND

ECAETC AIDS

AGENDA

U.S. Public Health Service
Region V Office

COMMUNITY/MIGRANT HEALTH CENTERS
AIDS/HIV CONTINUITY-OF-CARE CONFERENCE

presented by

Midwest AIDS Training and Education Canter
and
East Central AIDS Education and Tralnlng Center

June 26-27, 1989

MONDAY, JUNE 26: 1989

12:45 p.m.	REGISTRATION	Cathy Mays
1:15 p.m.	Opening Remarks	Nathan Llnsk, PhD Norris Lewis, MO James A. Pearsol
1:30 p.m.	AIDS/Epidemiology Update (Video)	James A. Pearsol Judith Cooksey, MD
2:10 p.m.	Responses to AIDS Update	
	* Black Issues (206A)	Melody Jackson, PhD
	* Drug Issues (206B)	Wendell Johnson
	* Gay/Bisexual Issues (213A)	Caryn Berman, ACSW
	* Hispanic Issues (213B)	Jorge Arteaga
	* Women and Children Issues (Chicago "A")	Marcia Harris, RN,MS
2:45 p.m.	BREAK	
3:00 p.m.	Summary: Responses to AIDS Update	Nathan Llnsk, PhD
3:20 p.m.	Sharing	LaVern
3:50 p.m.	AIDS Prevention	Ronn Rucker, EdD
4:30 p.m.	Closing Comments/Evaluation	James A. Pearsol
4:45 p.m.	ADJOURN	

MATEC

Midwest AIDS Training & Education Center

AND

ECAETC AIDS

AGENDA

U.S. Public Health Service
Region V Office

COMMUNITY/MIGRANT HEALTH CENTERS
AIDS/HIV CONTINUITY-OF-CARE CONFERENCE

presented by

Midwest AIDS Training and Education Center
and
East Canttal AIDS **Education** and **Training** Canter

June **26-27, 1989**

TUESDAY, JUNE 27, 1989

8:30 a.m.	COFFEE PLUS	
9:00 a.m.	HIV fasting & Counseling (Video)	Ronn Rucker, **EdD**
9:45 a.m.	Case **Management-Part** I	Douglas R. Horton, **PhD**
10:30 a.m.	BREAK	
10:45 a.m.	Case Management-Part **II**	Douglas R. **Horton, PhD**
11:30 a.m.	**Community** Resources **(Video)**	**James** A. Pears01
12: **15 p.m.**	**Community Resources** by **State**	
	* **Illinois** **(Chicago** 'A')	**David** Ley, **MSW**
	* Indiana **(216)**	Anna Farringer
	* Michigan (Chicago **"B")**	**James A. Pearsol**
	* **Minnesota** **(Chicago "A")**	**Frances Smith**
	* **Ohio** **(SRH 218)**	Ronn **Rucker,EdD**
	* **Wisconsin** **(SRH 219)**	**Mary** Brown, **RN**
12:45 p.m.	**LUNCH (On own - U of I** Hospital Cafeteria or Cantcnnial **Room)**	
1:45 p.m.	Federal Resources	John **Krzemian**
2:30 p.m.	**train-the-trainer; Part I**	**Ann Crowe, MSSW**
3:15 p.m.	**BREAK**	
3:30 p.m.	**Train-the-Trainer: Part** II	Ann **Crowe, MSSW**
4:oo p.m.	Closing **Comments/Evaluations**	Nathan **Linsk, PhD**
4:15 p.m.	**ADJOURN**	

Continuity of Care Conference
The University of Illinois at Chicago
June 26-27, 1989

PROGRAM REGISTRATION (please print)

Name | Job Title | Profession

Employer | Employer's Address | City | State | Zip

( ) Daytime Telephone

POST BY JUNE 12, 1989 to:

Cathy Mays
Department of Medical Social Work (M/C 779)
The University of Illinois at Chicago
808 South Wood Street
Chicago, Illinois 60612
(312) 996-1373

PLEASE REPRODUCE FOR ADDITIONAL REGISTRATIONS

PROGRAM **DETAI**

- Location:
  The University of Illinois at Chicago
  Chicago **Illini** Union
  Chicago "A" Room
  828 South Wolcott Avenue
  Chicago, Illinois 60612
  (Map available upon request)
- Registration/Emergency Number:
  Cathy Mays, MATEC
  (312) 996-1373
- PHS Information Contact:
  Norris S. Lewis, MD
  Public Health Service Region V
  (312) 353-1662
  (800) 621-3996 (Outside Illinois)
  (800) 572-2509 **(Illinois)**
- Scholarship/Hotel information:*
  Mark Meyer
  Government Travel Agency
  (312) 341-9177

*Contact immediately

ECAETC and MATEC are two of thirteen regional centers funded by the U.S. Public Health Service, Health Resources and Services Administration, and dedicated to AIDS training and education for health professionals. This conference is made possible by contract with the Public Health Service, Order No. RO-V-1739-88 and No. RO-V-1740-88.

MATEC
Midwest AIDS Training & Education Center

And

ECAETC AIDS
East Central AIDS Education and Training Center

Present

AIDS/HIV CONTINUITY OF CARE CONFERENCE

June **26-27, 1989**
The University of Illinois at Chicago

Sponsored by
U.S. Public Health Service
Region V Office

CONFERENCE OBJECTIVES

Upon completion of this conference, participants should be able to:

- Describe current AIDS epidemiological factors
- Identify AIDS issues related to Blacks, Hispanics, gays/bisexuals, women and children, and intravenous drug users
- Explain AIDS prevention measures
- Discuss HIV testing and counseling
- Apply case-management techniques appropriate to their work settings
- Identify and access community and Federal resources for persons with AIDS
- Integrate innovative training techniques into their staff education programs

AGENDA

Monday, June 26, 1989

12:45 p.m.	Registration
1:15 p.m.	Opening Remarks
1:30 p.m.	AIDS Epidemiology Update
2:00 p.m.	Issues of Blacks, Hispanics, Gays/Bisexuals, Women and Children, and Intravenous Drug Users
3:30 p.m.	AIDS Prevention
4:45 p.m.	Adjourn

Tuesday, June 27, 1989

8:30 a.m.	Coffee
9:00 a.m.	HIV Testing and Counseling
9:45 a.m.	Case Management Techniques
11:30 a.m.	Community Resources
12:45 p.m.	LUNCH
1:45 p.m.	Federal Resources
2:30 p.m.	Train-the-Trainer Strategies
4:15 p.m.	Adjourn

FACULTY

- Jorge Arteaga
  Head AIDS Educator/Counselor
  Erie Community Health Center
- Caryn Berman, ACSW
  Site Coordinator
  Northern Illinois MATEC
- Marcia Harris, RN, MS
  Coordinator, Project Reach
  UIC Department of Psychiatry
- Melody Jackson, PhD
  Vice President
  Human Resources Development Institute
- Wendell Johnson
  Ethnographer
  UIC AIDS Demonstration Project
- John Krzemian
  Health Resources and Services Administration
  Office of Special Projects
- Norris S. Lewis, MD
  Medical Director, Region V
  U.S. Public Health Service
- Nathan Linsk, PhD
  Project Director, MATEC
- Douglas R. Morton, PhD
  Case Coordinator, Project Director
  Illinois Planning Council on Developmental Disabilities
- Paula Parise
  Senior Curriculum Media Specialist
  ECAETC Kentucky
- James A. Pearsol
  Center Director, ECAETC
- Ronn Rucker, EdD
  Site Director, ECAETC Cincinnati

THE HID-ATLANTIC AIDS REGIONAL EDUCATION AND TRAINING CENTER

RVALUATION REVIEW

I. OVERVIEW

The Mid-Atlantic AIDS Regional Education and Training Center (MAARETC) program is coordinated at the Headquarters Center lodged in the President's Office of the University of Maryland at Baltimore. Local activities are carried out by five Area Resource Centers (ARCs): the Maryland Area Resource Center (MARC) at the University of Maryland at Baltimore; the Virginia ARC at the Medical College of Virginia; the District of Columbia-Metro ARC at Georgetown University School of Medicine; Delaware ARC at Wilmington Hospital; the West Virginia ARC at West Virginia University School of Medicine. In addition, the Johns Hopkins University Public Health ARC was established with a special public health focus.

The program strategy of the MAARETC is to provide a framework through which institutions and organizations within its region can collaborate on meeting the training needs of health professionals. Within this framework, it pursues two programmatic directions: enhancing professional expertise for those entities and organizations which have current experience with HIV and AIDs; and training a cadre of professionals who can serve as "trainers" for their own professional organizations and workplaces. MAARETC's programs target (1) practicing health and social service professionals and (2) students in the care-giving professions.

Two regional training programs have been developed: Home Health Care training and the MAARETC Dental Training program. These programs are implemented by each of the local ARCs. The ARCs have carried out a variety of other trainings, the Maryland ARC and Virginia ARC being the most active.

Particularly in the early stages of the project, evaluation was output-oriented. Formative evaluation of training is done for most events. Evaluation is built into the two regionwide programs, that of the Dental Training program having the most extensive collecting effectiveness and impact as well as formative evaluation data. As time goes on, the ARCs are initiating more and more evaluation of their own offerings.

II. ADMINISTRATION OF THE EVALUATION PROCBSS

A. The Evaluation Plan

1. The Plan as Proposed

The ETC developed an ambitious evaluation plan as part of its initial proposal. The initial evaluation design included both formative and summative evaluation as well as cost/benefit analysis.

Formative Evaluation. The objective of the formative evaluation component was to assess the consistency of delivery of the training program and participant satisfaction. The formative evaluation was to be designed to

measure dimensions related to program delivery by the training team and receipt of the program by trainees. Both the training team and trainees_ were to participate in the evaluation.

A Likert-scale questionnaire was to be administered anonymously to training team members to assess the ability of the educational elements to achieve stated goals through the objectives, content, teaching methods, trainee knowledge base, and trainer-trainee interaction. Written comments on the same areas were to be solicited concurrently.

Trainees were to complete a participant evaluation form assessing the utility, clarity, and perceived value of the training received. They were also to be asked to rate the appropriateness of each educational element's content, objectives, teaching methods, teaching competence and trainer-trainee interaction. Finally, suggestions for additions and deletions to the program were to have been solicited.

Data from all sources was to be categorized by professional discipline and analyzed. This information was to be used to (a) modify emphasis in course content and/or teaching strategies to reflect the needs of different groups, (b) provide detail on the actual process of delivering the program, and (c) facilitate replication of the training program by others.

Summative Evaluation. The summative evaluation was designed to assess the impact of the training program's substantive elements. The summative evaluation was to be conducted on two levels.

First, the short and long-term impact of the training program on the participant's AIDS-related knowledge, attitudes and professional practices was to be assessed. Data to assess short-term changes were to be obtained at the beginning and end of the training offering. In addition, whenever feasible, behavioral data were to be obtained pertaining to the reduction of high-risk practices and the containment of HIV infection. Data regarding long-term changes in the participants' knowledge, attitudes and practices were to be obtained via mailed questionnaire and test, six months after completing the training. Changes in the behavior and professional practices of health care providers that persist after six months were considered one measure of the quality of the care delivered to persons with AIDS and ARC.

Second, information regarding the efficiency and effectiveness of "training trainers" was to be obtained. The database was to include data about the type and number of consultation services provided, educational programs conducted, the number of participants and information regarding types of health care professionals and non-professionals participating in educational programs planned and conducted by trainers trained through the educational program of the center.

Cost/Benefit Analysis. Cost/benefit data were to be kept regarding the cost of providing each module and the core program. Costs were to be recorded for salaries and educational material development, duplication and distribution, hours of staff time necessary for face-to-face training encounters and other budgetary expenditures (e.g., updating materials, space, etc.). Data were to be summarized and a cost per trainee for each module and core program delivered were to be calculated. The same data were to be

collected for the "training trainers" educational programs and a cost per trainer calculated.

Variables. Variables that were to have been examined in determining short and long-term outcomes focused on knowledge, skills and attitudes:

- o Knowledge

  Medical and Psychiatric Aspects: immunology; epidemiology; clinical syndromes and treatment; obstetric/pediatric issues; screening; health maintenance and prevention in high risk groups and asymptomatic populations; signs and symptoms of dementia; anxiety; and neurologic assessment.

  Psychosocial Aspects: reactions to screening; impact of positive test results; coping; grieving process; support systems; and referral and resources.

- o Skills

  Changes in Practice Patterns: use of screening measures; recognition of early signs and symptoms; use of CDC guidelines; and management in inpatient and outpatient settings;

- o Attitudes

  Personal Values: HIV and AIDS as a punishment; populations at risk; methods of transmission; prevention; exposure to patients or at-risk groups in the workplace, school, social groups, and homes; and responsibilities toward sexual and/or "shooting gallery" partners.

  Person Behaviors: practices to reduce risk; counseling patients and peers; behavior toward patients and peers who care for AIDS patients and risk group members; and behaviors of peers toward self.

  Common Fears of Health Professionals

Evaluation Methodology. The evaluation plan called for knowledge to be assessed using paper and pencil tests, simulated case studies, and decision tree analysis for clinical decision-making. A series of pre/post tests were to be developed based on the content included in each module. The tests to assess changes in knowledge and professional practices were to consist of multiple choice, true-false or short answer questions designed for factual recall of information and application of information in a clinical situation.

The instruments to assess changes in attitudes were to employ attitude assessment scales and focus on personal and professional skills and attitudes in dealing with AIDS and ARC patients, their families, sexual partners, significant others, and members of risk groups. In addition, randomized response techniques and role play were to be used to evaluate attitude change.

Reliability and validity of the instruments were to be established by pilot testing and appropriate revision of the instruments as necessary.

2. **Implementation of the Plan**

The evaluation plan was written to correspond with the highly centralized program model initially envisioned for MAARETC. This model called for development of a core curriculum with complementary modules to be used regionwide. With a shift to a decentralized model with a high degree of autonomy in program design and implementation, and the abandonment of its planned comprehensive curriculum, corresponding specific aspects of the evaluation plan no longer apply. However, the basic formative and summative evaluation design is still applicable to the programs offered by the individual ARCs as well as the regional MAARETC programs.

In the first year, evaluation activities got a slow start. At tempts to obtain pre-training data on the degree of expertise participants had in recognizing symptoms of HIV infection or in treating AIDS proved more difficult than expected. Ascertaining short-term attitudinal changes also proved more complex than originally anticipated. Finally, clinical skills training was only beginning in Year 01 and thus there was little opportunity to evaluate this dimension of training.

Entering the third year of the project, the evaluation response has been mixed. The evaluation design for MAARETC's regional dental program closely parallels that of the plan, and evaluation efforts are underway regionwide. The evaluation design of the regional Home Health Care training has been limited to formative evaluation, although at least one of the ARCs had expanded the scope of the evaluation they conducted on their own sessions. The Maryland ARC put considerable effort into implementing the evaluation plan in connection with several of their more intensive programs. Several of the other ARCs have expressed interest in expanding the scope of their evaluation activities.

B. Locus of Responsibility

1. Staff

Both the initial grant proposal and the Year 02 continuation proposal called for a .30 FTE Evaluation Specialist to work with the Curriculum and Evaluation Council to refine the evaluation plan for implementation regionwide, and with Area Resource Center faculty to design, pilot test, implement evaluation activities and to analyze the results. The Evaluation Specialist, was to report to the Education Director and was to be responsible for drafting all reports regarding evaluation outcomes for submission to the Project Director.

At the end of the first year, an Evaluation Specialist still had not been hired. In July 1989, John Bonnage, Ph.D. was appointed Education Director, succeeding Dr. Pounds in this position. As the full-time Education Director, evaluation became one of Dr. Bonnage's responsibilities, along with supervising curriculum development and technical assistance to the ARCs in program implementation.

2. Advisory

The Curriculum and Evaluation Coordinating Council functions in an advisory capacity with regard to the ETC's formative evaluation, analyzing several proposed evaluation instruments.

3. Sub-Contractors

In Year 02 of the project, the Virginia, DC-Metro, Delaware, and West Virginia ARCs were each slated to have a local Evaluation Specialist, devoting 10-50 percent time to the state's evaluation activities. In Year 03, all six ARCs were expected to have local evaluation input. For the most part, however, this responsibility has generally fallen to the ARC's principal coordinator and education coordinator.

4. Evaluation Consultants

Leonard Cohen, D.D.S. and Edward Grace, M.S. (psychology) at the Department of Oral Health Care Delivery of the UMAB Dental School serve as evaluation consultants to the MAARETC Dental Program. They are responsible for designing an evaluation of the program's outcomes and analyzing the data.

C. Coordination of Evaluation Activities

The Curriculum and Evaluation Coordinating Council is the formal mechanism for oversight and coordination of the evaluation efforts of the Areas Resource Centers. Members include representation from each Area Resource Center as well as others. It has served this function to some extent, particularly with regard to specifying a common data set for collecting output data. However, the Education Coordinator is better positioned to serve the coordination function within the normal course of his role as program liaison with the ARCs, and has been doing so.

D. Reporting of Findings

ARCs are required to report the results of their evaluation activities to the ETC on a quarterly basis. To date, these reports have been focused on reports of events held and individuals trained, with a narrative description of other activities conducted. Initially, the format of these reports differed among the ARCs. In October 1989, a common data set for reporting educational activities was agreed upon; subsequent reports reflect this.

III. APPROACHES TO PROJECT EVALUATION

A. Monitoring

The ETC's initial proposal contains a detailed workplan which includes timeframes for conducting each of the activities. The workplan covers each of the three years of the project period. This workplan provides a good baseline against which to monitor project progress. The Year 02 continuation

application compares projected milestone dates with actual completion dates, as well as providing a revised **timeline** for Year 02 activities.

B. **Output Evaluation**

At the October 1989 meeting of the Curriculum and Evaluation Council, the six **ARCs** agreed upon eight areas of information that would be collected for every educational activity held. These included:

- the number of professionals attending the program;
  their professions;
  the location of the activity (geographic region served);
- the date of the activity;
- the content of the presentations;
- the faculty members;
- gender of participants; and
- ethno-cultural minority participants.

Each ARC was responsible for collecting and summarizing these data. In response, Dr. Jonathan Cohn, Director of the Maryland ARC developed a computerized database for cataloging and analyzing output data. The database, stored in d-Base, is organized by training session and includes the following fields:

Category of training
- Session title
  Speaker(s)
- Event title
- Start and end date
- Location
- County
- Sponsors
  Number of attendees
- Number of contact hours
- **Attendee-hours**
  Attendees by profession and status (i.e. graduate or student)
- Attendees by **ethnicity/race**
- Training methods
  Types of media used

MARC's data collection instrument is included in Appendix I.

In output reports, individual sessions are sorted by category of training and date. Category 1 includes off-campus trainings sponsored in whole or in part by the Maryland AIDS Professional Education Center (MAPEC). Category 2 includes off-campus trainings in which MAPEC supplied one or more speakers, or offered other support, without co-sponsorship. Category 3 includes episodic AIDS educational activities on the UMAB campus. Category 4 includes regularly scheduled AIDS educational activities on the UMAB campus.

Group summary statistics follow each category listing, and summary statistics for the entire reporting period appear at the end of the listing. Three items are summed in the group and final summaries: total number of attendees, the total number of contact hours, and the product of the two as the attendee-hours. Ethnicity of the participants is included in individual reports only when reasonable estimates are available. Therefore, when **ethnicity/race** is reported by category and in the final summary, it is less than the total number of participants.

A table, also included in Appendix I, combines the group summaries and the final summary in **MARC's** report of its activities for the year ending April 6, 1990.

Efforts are underway to make **MARC's** system a model for the entire ETC. MAABETC has worked with the Data Management unit at UMAB to modify the system and make it more user-friendly. Preliminary revisions have been circulated to the other **ARCs** with an eye toward implementing a single, uniform database in the near future. An effort will be made, at the headquarters level, to recast data collected prior to October 1989 into the current format.

In reporting its outputs, **MAARETC** compares actual numbers of professionals trained against its proposed number. In its first year, it far surpassed its regional objectives. In Year 01, 13,773 individuals participated in **MAARETC** activities as opposed to the 1,000 that had been originally targeted. Every ABC except DC-Metro surpassed its total training target; the Maryland and Virginia **ARCs** exceeded profession-specific targets for almost every category. Appendix II includes Year 01 targets and outputs.

C. Cost Efficiency and Cost Effectiveness

While the evaluation of costs is a part of the evaluation plan, there has been little emphasis placed on this aspect of the evaluation.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

MAABETC training products include its curricula "Clinical Manifestations and Treatment of HIV Infection" and "Epidemiology, Transmission, and Prevention of AIDS and HIV Infection," and its dental teaching slide set. These products **are** distributed to the **ARCs** for use and adaptation in local training efforts. Peedback'from the **ARCs** on these products is seen as an informal field test .

V. APPROACHES TO EVALUATING EDUCATION AND TRAINING OFFERINGS

This section provides examples of methodological approaches used in evaluating training events and their training outcomes. In Section VI, the evaluations that have been conducted for specific programs and events are described; copies of the instruments can be found in the appendices referenced in that section.

A. Standardization of Evaluation ETC-Vide

MAARETC feels that broad spectrum evaluation of knowledge, attitudes and behavior of professional groups on a region-wide basis would be interesting from a research perspective but would be of limited practicality in guiding the curriculum planning for the individual Area Resource Centers.

Standardized evaluation instruments have been developed, though, and are being used extensively for formative evaluation of training events and regionwide for MAARETC's regional Home Health Care and Dental Training programs.

1. "How Did Ve Do?"

MAARETC has adopted the "How Did We Do?" form developed by the Emory AIDS Training Network as a standard evaluation tool to be used for events offered by the ARCs. This tool primarily collects formative evaluation data about the event, but also begins to look at effectiveness through an "intention to behave" quest ion.

The variables collected for formative evaluation include:

- usefulness and practicality of the content;
- adequacy of time to cover the material;
- helpfulness and adequacy of the teaching materials;
- adequacy of response to participants' questions; and
- degree to which teaching was tailored to the skill level of the participants.

Each instructor is to be listed with suggestions for how the individual could "do a better job next time." Suggestions on how the workshop in general could be improved are also solicited.

To begin to assess the effectiveness of the workshop in stimulating changes in behavior, a question on behavioral intent is included: "What will you do differently at work as a result of this workshop?" The primary effect that the workshop had on participants is identified by asking participants to "write down one fact or idea from the workshop that you learned and that seems important to you."

A copy of the "How Did We Do?" form is included in Appendix III.

2. Home Health Care Training

A standardized evaluation form has been developed to be used in conjunction with the regional Home Health Care training. The questionnaire collects demographic data on the participants, formative evaluation data about the program, data to begin to assess the effectiveness of the program, and data to be used in assessing marketing strategies.

The demographic data on participants is used for reporting of training outputs and includes:

ethnicity (American Indian/Eskimo, Black, Asian, Caucasian, Hispanic/Latino, other);
job (nurse practitioner, registered nurse, nursing assistant, **dietician,** counselor, home health aide, social worker, lpn, other);
sex
age
- number of years in home health work
primary site of work (hospice, **home health care agency/ department, public health department, visiting nurse organization, other)**

The formative evaluation data on the structure, process and content of the offering includes the following dimensions:

usefulness in the participant's daily work;
- general usefulness of the information covered;
helpfulness/usefulness of individual sessions;
- adequacy of time for the session in general, for questions;
assessment of **the** presenters' knowledgeability;
comfort of the meeting space;
helpfulness of the reference material;
additional topics of interest.

Preliminary assessment of the program's effectiveness is tapped by asking participants to report the degree to which they feel the program has increased their comfort with HIV patients.

The questionnaire also attempts to determine which marketing efforts have been most effective in recruiting participants. Choices include: brochure/flier; through work; a friend; radio/television; and other.

There is one potential difficulty with using this form in standardized format ETC-wide. The form asks for feedback on the usefulness of four sessions designated in the curriculum: Introductory Session/Exercise; Overview of AIDS; Infection Control; and, Medical Treatment/Case Management. When the curriculum is implemented by the ARCs, it is often modified but the form is still used. In such cases, the session titles and content do not correspond to that on the form, making it difficult for the participants to respond.

A copy of **the data collection instrument is included in Appendix IV.**

3. MAARETC Dental Training Program

The MAARETC Dental Training Program is based on a diffusion model in which trainers are prepared at several levels in each state; these trainers go on to provide training to dental students and community providers.

A standardized evaluation design has been developed through a contract with Leonard Cohen, D.D.S. and Edward Grace, M.S. at the Department of Oral Health Care Delivery at UMAB Dental School. The evaluation consists of a core component for the generic dental training program and a supplemental evaluation component for the train-the-trainers program.

The core component consists of an evaluation of program effectiveness, focusing on changes in attitudes and behavior as measured through pre and post-training testing, and an evaluation of program impact measured through a 3-6 month follow-up. For the most part, the same information is collected on the pre-test, the post-test and the follow-up questionnaire providing a baseline view, a view of changes and intentions immediately after training, and a view of the degree to which intentions were translated into practice. The design includes tracking variables as follows:

	Pre-Test	Post-Test	Generic Follow-up	Trainers Follow-up
participant's hepatitis-B immunization status	X		X	X
plans for hepatitis immunization in the future	X		X	X
reasons for not receiving immunization	X		X	X
participants estimate of % of patients in his/her practice at risk of HIV infection	X		X	X
number of HIV+ patients participant has treated in his/her career	X		X	X
opinion as to best place to treat healthy HIV+ patients	X	X	X	X
concerns about treating healthy HIV+ patients	X	X	X	X
HIV screening procedures followed in the practice	X		X	X
infection control procedures and policies in place in the practice	X		X	X
attitudes towards the provider's right to choose who to treat, relative concern over treating HIV infected patients versus hepatitis-B infected patients, biases towards people with AIDS and people engaged in risky behaviors, and willingness to treat HIV-infected individual	X	X	X	X
most effective training approach to expand role in caring for HIV+ patients	X			

The pre-test, post-test and follow-ups are linked via an identification number derived from the Social Security number.

In addition to tracking the above variables, other specific information is gathered through the various instruments. On the pretest, demographic and profession-related information is collected including:

- sex
- age
- race
- occupation (dentist, hygienist, dental assistant, office manager/receptionist, other)
- year of graduation from dental or dental hygiene school
- number of hours per week spent in patient care

The post-training questionnaire gathers formative evaluation data on the session:

- were objectives clear;
- how well did the course reflect the objectives;
- how relevant were the topics to your practice;
- which topics needed deeper coverage; and
- which topics could be deleted.

It also solicits interest in further training, including train-the-trainers programs, as well as the participant's willingness to be contacted by mail as part of the follow-up evaluation (if so, contact information is obtained). The follow-up questionnaire associated with the train-the-trainers component includes questions regarding the degree to which the program had prepared participants adequately to train other dental personnel on specific topics (infection control, clinical diagnosis/manifestations, clinical treatment, government regulations), ways in which the course might be improved, as well as the number of infection control courses presented and individuals trained.

These instruments have undergone considerable testing, and are being **used to evaluate dental training throughout the region.** It is anticipated that there will be some modification after full-scale implementation of the evaluation. Copies of these instruments are included in Appendix V.

B. Approaches to the Formative Evaluation of Training Events

The "How Did We **Do?"** form is used as a standard tool for evaluation of the structure, process and content for many of the events offered by the ARCs. Standard but different approaches to formative evaluation of each of **MAARETC's** two regional programs are in place as discussed in Section V.A. above.

The Maryland ARC takes a very practical approach to formative evaluation of its offerings, as described in Section **VI.C.** below. Intensive courses are subjected to detailed formative evaluation at the outset and the results fed back into course improvement. Ultimately a maintenance level of formative evaluation is built into ongoing courses. "One-shot" presentations are

subjected to broad formative questions to ensure that the course planners continue to tune into the needs of the providers and provider agencies they serve; detailed evaluation with an eye toward improving specific components of the training was deemed unnecessary.

One of the most common approaches to formative evaluation of MAARETC/ARC offerings has been to solicit feedback from participants by means of a post-training questionnaire. Common dimensions measured are 'educational quality" and "usefulness, " borrowed from the evaluation of the "AIDS and the Primary Care Provider" curriculum developed under the sponsorship of the Society for General Internal Medicine. These dimensions are measured relative to the overall offering and individual sessions. In other cases, individual sessions of training events and the presenters who made the presentations have been evaluated on the dimensions of content, delivery and practicality. In addition to using rating scales, most post-training questionnaires include open-ended questions about the most useful and least useful aspects of the training.

A somewhat different approach to formative evaluation was used in the evaluation of MAARETC's Dental Train-the-Trainers program. As part of the 3-4 month post-training follow-up, participants were asked to assess the training in retrospect as to whether the training adequately prepared the participant to train other dental personnel in specific topic areas. On follow-up, participants were also asked how the course could have been improved based on their experience implementing their own training since taking the course.

More informally, each ARC makes use of the "peer education principle" which allows faculty in the Area Resource Centers to determine response to the content of a program. This is done by monitoring the number of people who respond to marketing efforts, gauging audience loss during the presentation, and obtaining verbal feedback at faculty meetings.

C. Approaches to Bvaluating Training Outcomes

Outcomes examined in MAARETC evaluations include effectiveness in conveying knowledge, effectiveness in changing attitudes and perceptions, effectiveness in changing readiness or intention to act, impact in terms of actual changes in behavior and tasks actually executed.

1. Evaluation of Program Effectiveness

The evaluation plan called for the evaluation of short-term effectiveness via pre/post-testing of knowledge and attitudes to measure change and the evaluation of longer-term effectiveness via six month follow-up to measure the persistence of these changes. No standardized approach has actually been implemented. A number of different approaches or combinations of approaches have been noted from among the evaluations conducted or being planned by MAARETC and its ARCs:

- pre and post-training testing;
- pre and post-training self-reporting;

- post-training self-reporting;
- follow-up testing; and
- follow-up self-reporting.

Pre and Post-Training Testing. The Maryland ARC utilizes pre and post-training testing to measure changes in knowledge associated with the HIV Counselor Training Program, and to measure changes in knowledge, comfort level, concerns and attitudes, as well as interest in particular topics as a result of participation in the Home Health Care training.

The knowledge pre/post test for the HIV Counselor Training program is a 25-item instrument containing 17 multiple choice questions, and 8 true/false questions adapted from a 45-item instrument developed by a program in New Jersey.

The Home Health Care pre/post test contains 16-multiple choice knowledge questions, 22 items which tap comfort, concerns and attitudes by asking for agreement or disagreement with statements using a 6-point scale, questions which ask participants to express their interest in 9 specific topic areas along a 5-point scale. This instrument was adapted from one developed by Margaret Grade at the University of California/San Francisco, initially consisting of over 100 items.

The MAARETC Dental Program also uses a pre/post-training test approach to evaluate attitude changes such as attitudes toward one's practice being regulated, biases towards individuals engaging in high risk behavior, and willingness to treat HIV+ patients. It utilizes the same approach as the Home Health Care instrument, including 10 statements with which participants are asked to agree or disagree on a 5-point scale.

West Virginia is planning to begin pre and post-training testing to assess changes in knowledge produced by its training programs.

Pre and Post-Training Self-Reporting. The MAARETC Dental Program uses pre and post-training self-reporting as the basis for the evaluation of its immediate effectiveness in changing perceptions (the degree to which they are already treating infected individuals, the degree of risk they encounter when treating HIV+ healthy individuals), readiness to act (opinion on appropriateness to treat HIV+ individuals in a private practice) and intended behavior (plans to be immunized for hepatitis-B).

Post-Training Self-Reporting. Several approaches to post-training self-reporting have been used to assess training effectiveness. The first, and most straight-forward, is the approach used to evaluate the effectiveness of MAARETC's Home Health Care training. On the standard one-page evaluation questionnaire is an item that states: "As a result of this program, I think I'll feel more comfortable with HIV patients," asking respondents to select "a lot more comfortable," "somewhat more comfortable," and "not more comfortable."

The Maryland ARC experimented with the use of a more elaborate approach to post-training self-reporting in its assessment of the effectiveness of both

its HIV Counselor training and its longer Home Health Care trainings in changing knowledge and proficiencies directly related to the workshop's_ learning objectives. As part of the pre-training mailing, MARC asked participants to rate their knowledge or proficiency with regard to a number of items corresponding to the course learning objectives. Ratings were on a S-point scale. At the close of the workshop, participants were asked to assess their level of knowledge or proficiency on these same items: 1) in retrospect, as it was when they entered the course, and 2) as it was then at the end of the course. This allows for two measures of effectiveness: 1) the degree to which training was perceived to have increased participants knowledge and proficiency, and 2) the degree to which the training gave its participants a more realistic basis for self-assessment.

The **"How** Did We **Do?"** form assesses the effectiveness of a course in stimulating participants into action by asking about behavioral intent. At the completion of the course, participants are asked **"what** will you do differently at work as a result of this course?" MARC has experimented with several ways of asking this question in its evaluation of its HIV Counselor **training** course.

Follow-Up Testing. As part- of its planned evaluation of training effectiveness, the West Virginia ARC will include a six-month follow-up knowledge test to determine the persistence of knowledge changes measured directly after training.

Follow-Up Self-Reporting. Longer term effectiveness of the MAARETC Dental Training is assessed by comparing pre-training and follow-up responses to show either the persistence of changes measured directly after training or the development of even more favorable views after analyzing what was learned in training or reassessing attitudes back in the context of their practice. Variables analyzed in the assessment of longer term effectiveness include perceptions of the degree to which they are already treating HIV+ patients, the appropriateness of treating HIV+ healthy patients in settings like their own, and the risks they face in treating HIV+ healthy patients, as well as attitudes which impede providers from becoming more involved in the care of HIV infected patients.

2. Evaluation of Program Impact

MAARETC is beginning to take a preliminary look at the impact of its programs on the community of health care providers. Using needs assessments conducted by various agencies in the states served by MAARETC, the Education Coordinator compares results of evaluations conducted on **MAARETC/ARC** offerings with like variables in the needs assessments. "Comfort with HIV infected patients" is one important variable studied. The percentage of providers of a given discipline expressing comfort on the needs assessment serves as a baseline. Percentages of **MAARETC/ARC** trainees expressing comfort as measured on post-training evaluation instruments is expected to be higher and increasing, and such trends are monitored.

At the present time, assessment of the impact of training on specific behaviors is being conducted only in conjunction with the Dental Training Program and utilizes the follow-up self-reporting approach. Impact is demonstrated by comparing pre-test responses with follow-up responses to

measure actual changes in behavior: immunization for hepatitis-B, HIV screening procedures in place and infection control procedures being utilized. Evaluation of the train-the-trainers component of the Dental Training program further seeks to document impact by asking respondents to report the number of trainings, specifically in infection control, they have conducted since completing the course, as well as to report the number of individuals attending these events.

D. Unique and Interesting Evaluation Techniques

1. "Initial Response" Evaluation of Counseling Skills

The Maryland ARC is in the process of finalizing a methodology for evaluating the effectiveness of its HIV Counseling training program in improving counseling skills of the participants, particularly their ability to respond quickly and appropriately to statements of clients that potentially have significant consequences.

The technique makes use of a paper and pencil test administered before and after training. The test presents statements that might be typically made by clients in a pretest or posttest counseling situation. Some of the statements being tested for use in the final test version include:

Pre-Test Counseling Session

" I just want you to know, if this test is positive, I'm going to kill myself!"

" You know, I'm sure there's nothing wrong with me, but, you know, just to be on the safe side...you know, maybe I should get this test."

" One thing is for sure - if I've got this HIV, I'm going to get who ever gave it to me!"

Post-Test Counseling with Negative Results

" Wow, what a relief! I'm never going to have sex again! "

" I don't believe you, I want to believe you, but I know I must have this thing. My lover does, my friends.. .I just want to know the truth."

" Thank you, thank you! This is wonderful news! Well, I'm out of here!"

Post-Test Counseling with Positive Results

" No - this can't be true...Oh my God, I'm going to die!"

" I knew it, I knew it. God damn it, somebody's going to pay for this!"

Participants are asked to write down the first thing they would say to the client following each of the statements. A rating scale is under development to assess these initial responses. The draft scale is as follows:

Detracts (-1)

- negates or denies feelings
- makes assumptions
- does not accurately reflect feelings or content
- advice-giving
- judgmental attitude expressed

Neutral (0)

- non-harmful
- allows interaction to continue
- reflects content alone

Somewhat Facilitative (+1)

- accurately reflects feelings

Very Facilitative (+2)

- accurately reflects feelings and content

The specific statements on the pre-training questionnaire and on the post-questionnaire are not the same, but the situations they represent are--pre-test counseling session, post-test counseling with negative result, post-test counseling session with positive result. Pre and post-training responses are to be matched via Social Security number and changes calculated.

VI. BVALUATION CONDUCTED

The degree of emphasis on evaluation has varied among the ARCs. All of the ARCs collect output data according to MAARETC's standard data set and formative evaluation data using the "How Did We Do?" form. The ARCs conduct evaluation of the events they do as part of the regional Home Health Care and Dental training programs using, at a minimum, the associated evaluation tools. Virginia and the DC-Metro ARC conduct additional evaluation, where necessary, for continuing education credits. The Maryland ARC has undertaken a substantial amount of evaluation, broadening their evaluation of events conducted as part of regional programs and developing unique evaluations for other offerings. Virginia is using time series needs assessment data to gauge the impact of its collective educational activities, and is beginning to evaluate the impact of individual offerings. West Virginia is currently planning an evaluation of the outcome of its training offerings. In situations where activities are co-sponsored with other agencies, the

evaluation data to be collected are agreed upon by the ARC and its co-sponsors.

A. MAARETC Regional **Programs**

The evaluation of **MAARETC's** Home Health Care Training is predominately formative in nature and is conducted by the **ARCs** as an integral part of their training. These evaluations are discussed as part of the evaluations carried out by the ARCs.

The methodology for the evaluation of the MAARETC Dental Training program is discussed in various subsections of Section V. Implementation of this methodology began regionwide in the spring of 1990. The **ARCs** administer the pre and post-training questionnaires as an integral part of the generic dental training and the dental train-the-trainers activities. The forms are then sent to the evaluation contractor at UMAB for analysis. Data have begun coming in from most of the ARCs, but the contractor is awaiting a larger volume before beginning analysis. Follow-up questionnaires will be sent out by the evaluation contractor as soon as **3-4** months have elapsed from the date of training.

B. Virginia ARC (VARC)

1. Needs Assessments As Baseline for Evaluation of Impact

In 1988, the Virginia Department of Health commissioned a series of statewide profession-specific needs assessments. These studies were conducted under the direction of Judy Bradford, **VARC's** evaluation specialist, in her capacity as researcher at Virginia Commonwealth University. Under the auspices of the VARC, **Ms.** Bradford prepared a report which extrapolated from the statewide data regional data corresponding with the catchment areas of the Regional Resource Centers as a baseline for an evaluation of impact. One of the findings from an initial analysis showed that knowledge of the subject is not enough to change behavior, suggesting that trainings must focus on attitudes and be interactive in order to be effective.

The follow-up round of studies will begin in the fall of 1990, and will provide data to begin to identify changes in provider knowledge, attitudes and practices towards patients. While the ETC program is not the only source of educational interventions for health care professionals in Virginia, it is one of the most significant. Therefore, changes in KAB can be largely attributed to VARC staff activities carried out collectively as part of their ETC role together with their other educational responsibilities.

The survey for the follow-up round is considerably briefer than that of the original needs assessments, and has a decidedly education-oriented focus. The VARC staff were intimately involved in the planning of the survey. In addition to **KAB** data, the follow-up survey will provide information about what training methods and approaches worked, what did not work in terms of training, and what more needs to be done. The studies themselves will be conducted with state funds. An oversample of providers in the regions served by the Regional Resource Centers will be financed by the VARC.

2. "AIDS Home Care: The Challenge of the 90s"

In March, 1990, Virginia ARC conducted four of its planned five home health training sessions under the auspices of the local HIV Resource and Consultation Centers. Each of the programs was a day-long event. In total, 181 participants attended. Participants were predominantly registered nurses, with a substantial number of nursing assistants, social workers, home health aides and counselors from public health departments, home health care agencies, hospitals and hospices.

The program was based on the regional Home Health Care curriculum. The morning program included an introductory session, a videotape on HIV testing, and a session on psychosocial issues. The afternoon consisted of four concurrent sessions which were each repeated twice. These included clinical management of the AIDS patient at home, community support services, stress management, and pediatric AIDS. The program included problem-solving exercises for nursing situations.

The event was evaluated using the standard questionnaire described in Section V.A.2. The four programs received remarkably similar evaluations. All sessions were rated highly, as were the presenters. Time allocations were also rated as appropriate. Participants would have liked to have had additional topics covered, particularly medications and medical management, nursing assessment and community resources, as well as more intensive training on home management.

The program was judged to have been quite effective in increasing participants' feeling of comfort in engaging in future encounters with HIV patients; more than 50% feeling a lot more comfortable as a result of the program and only a few stating that they did not feel more comfortable at all as a result of the program.

Approximately 2/3 of the participants had heard about the program via the mailed brochure and 1/3 through their work.

Copies of the reports are included as Appendix VI.

3. "AIDS in Adult Institutions"

Under the direction of Judy Bradford, a significant evaluation is underway of the VARC's "AIDS in Adult Institutions," a training for individuals in counseling roles within the state corrections system. Trainees included rehabilitation counselors, chaplains, nurses and others who perform counseling functions, as well as institutional trainers. Four one-day sessions were presented around the state in the fall of 1989. Topics included a medical and epidemiological overview, psychosocial issues, risk reduction education and counseling, values clarification, infection control and issues specific to counseling.

The evaluation design consists of a pre-training assessment of knowledge and attitudes coupled with a 3-4 month post-training follow-up survey. Variables examined prior to training included:

- experience with AIDS/HIV known and suspected cases ;
- perception of personal risk;
- willingness to provide care;
- perceptions and misconceptions about the risk of transmission;
- knowledge about HIV antibody testing;
- opinion about groups who should be tested for HIV; and
- attitudes and opinions about ethical, legal and work-related issues.

In addition, participants were asked to indicate what topics they would like more information on and the plans they had for using information learned at the AIDS training program.

The analysis of pre-training data for more than 180 mental health, medical and non-care providers has been analyzed. Most respondents indicated that they had worked with known (83%) or suspected (90%) HIV+ cases. Respondents* perception of personal risk of being infected ranged from 8% among non-care providers to 17% among medical staff. Participants indicated a general willingness to work with IV drug users (89%) and gay/bisexual men (87%), but were less willing to work with known HIV-infected inmates (77%). Respondents 'tended to overestimate the risk of infection from such things as having a blood transfusion, being coughed or sneezed on by an infected person, and sharing a razor or toothbrush with an infected person. Respondents felt that people being admitted to hospital, food handlers, physicians and other health care workers should be tested for the AIDS virus. The low proportion of respondents agreeing that employers should have the right to test employees was significant. For the most part, respondents intended to use information from the training to protect themselves from infection and to better inform others how to do so. 69% intended to disseminate the information gained in training but only 25% intended to do so in a formal way (i.e. provide training programs to other staff).

The post-training follow-up study is currently underway. Data were collected via mailed questionnaires and are being analyzed. The evaluation will measure both the longer term effectiveness of the training in terms of knowledge retention, and the impact as measured by how participants actually used the information they received during training.

A copy of the pre and post-training questionnaires, and the analysis of the pre-training data are included in Appendix VII.

C. Maryland ARC (MARC)

For purposes of evaluation, MARC views its training activities in three groups. For short, didactic presentations which are meant to respond to informational needs, not much is done in the way of evaluation. Particularly in the early days of the program, speakers resisted evaluation; more openness to evaluation has been noted as relationships have developed and trust was built with the ARC. Often such short presentations are done as part of a co-sponsored event, in which case, the co-sponsoring agency's evaluation instruments are frequently used.

For customized trainings provided in response to a specific request, a brief evaluation is used. It is generally formative in nature, focusing on the structure, process and content of the session, and occasionally on the effectiveness of the training. A sample of an instrument used to evaluate a customized training course is included in Appendix VIII.

Ongoing programs--the more intensive courses which are repeated in different localities around the state--are the focus of MARC's evaluation efforts. Because they are repeated, these programs are subjected to extensive formative evaluation. **Pre/posttesting** for knowledge change is usually done.

The evaluation instruments themselves, not just the course they are intended to evaluate, are modified based on experience gained with each repetition. In the early stage of the process, there was heavy borrowing from existing instruments. As the evaluations have matured, the instruments have been tailored to the specific needs of the course. For the most part, the evaluation procedures and instruments have now been finalized with an eye toward conducting summative evaluation.

Clinical training has been the least evaluated of MARC's activities. As **MARC** expands its clinical training opportunities beyond UMAB house staff to serve more community providers, its evaluation efforts in this area are expected to expand as well.

1. HIV Counselor Training

One of the highlights of the Maryland **ARC's** program is the HIV Counselor Training that is presented under the auspices of the Maryland AIDS Professional Education Center, and its co-sponsor, the AIDS Administration of the Maryland Department of Health and Mental Hygiene. The 4-day program, which began targeting counselors at the state counseling and testing sites located in the county health departments, has expanded its focus and is open to others as well. The program was offered every six weeks in 1989 and is scheduled to be repeated six times in 1990.

The program is subject to extensive evaluation. Each time the course has been given, it has been evaluated and the results analyzed. The summary data are provided **to the trainers for guidance in future trainings.**

The evaluation process and its instruments have evolved over the course of the project, moving from an intensely formative one to its current final form which will be used in the summative evaluation.

The evaluation report on the November 27-30, 1989 course serves as an example of the evaluation conducted during the formative stage. The evaluation utilized a set of pre-course instruments and a set of post-course instruments.

Pre-Course Evaluation Packet	Post-Course Evaluation Packet
Pre-course self-assessment of knowledge and proficiency	Post-course self-assessment of knowledge and proficiency
Knowledge test	Knowledge test
"Initial Response" test--version A	"Initial Response" test--version A
	Participant evaluation of the course and instructors

Formative evaluation was based on the post-course participant evaluation of the course and instructors. The objective of the formative evaluation was to identify high quality trainers to serve as ongoing faculty for the course and to identify what aspects of the course the participant found most useful. Features of the overall course were rated on a 6-point scale. (This component of the evaluation was borrowed from the one developed by the AIDS Task Force of the Society of General Internal Medicine for its "AIDS & the Primary Care Provider curriculum. It includes the dimensions of overall quality, overall usefulness, lectures and speakers, trainer modeling, skill practice, clarity, relevance, realistic attainability, teacher/learner directed, and flexibility). Each of the 20 segments of the course and the corresponding presenter(s) were rated for content, delivery, and practicality on a 5-point scale. Where audiovisuals were used, they were rated as well.

In the November course, all aspects of the course were rated highly as were most of the presenters. In response to the question "what was the most helpful aspect of the course?" no one aspect predominated. In general, the credibility of the presenters created a positive learning environment, as did the informal atmosphere. Role playing and modeling seemed to contribute most to skill-building in counseling. Learning that the counselor won't always be successful in achieving behavior change relieved the anxiety of a number of the participants. Informally, the opportunity to network was appreciated.

Evaluation of the learning climate did not yield much useful information. The most often-cited weakness of the workshop was the physical environment, primarily the lack of heat in the training room. The one substantive angle had to do with time allocation. Participants felt that they needed more information but at the same time felt that a four-day experience was too much. Several suggested breaking the workshop up into two shorter sessions.

Evaluation of effectiveness was based on the three pre/post-course components as well as the post-course participant evaluation. In this evaluation, a number of dimensions of the program's effectiveness are evaluated: effectiveness in increasing knowledge; effectiveness in increasing perceived competence, effectiveness in increasing counseling skills and, effectiveness of the course in stimulating HIV-related action.

Effectiveness in increasing knowledge is evaluated from data obtained from the Knowledge Test. The same test is administered before and after the course, and the pre/post-course responses of each participant are matched. During the formative evaluation period, it was noted that this questionnaire was too extensive. The response rate was so low that no meaningful analysis could be performed. The questionnaire, now in its final form, has been pared down from 45 to 25 items.

Data on effectiveness in increasing perceived competence (knowledge and skills) was obtained from the post-course data in which participants assessed their own proficiency as it had been when they entered the course and as it was at the close of the course. This approach proved difficult to implement and the data were difficult to interpret. The approach, which was borrowed from the Society of General Internal Medicine evaluation, is being revised to better reflect the nature of the program it is meant to evaluate.

The effectiveness of thq course in improving counseling skills was measured using the "Initial Response" methodology described in Section V.D.l. This methodology shows promise; the instruments and the rating scales are being refined.

Effectiveness in stimulating a desire to do something differently was approached through an open-ended question on the post-course participant evaluation of the course. MARC has experimented with various approaches to asking this question. One approach, again borrowed from the Society of General Internal Medicine questionnaire: "list a few personal goals, activities, and collaborative arrangements that you would be interested in pursuing during the next six months as a result of your participation in the course," yielded rich and focused responses, suggesting that the course was highly effective in terms of stimulating participants to become more involved in HIV counseling for IV drug users. Most of the participants indicated that they were going to consciously work on their counseling skills based on what they had learned in the course. Others who had not been counselors, indicated that they wanted to become involved. Some wanted to train co-workers. However, a number of trainers felt that, as phrased, this question did not address the objectives of the HIV Counselor workshop. The question, which no longer taps behavioral intent directly, is currently phrased: "One way this experience has changed my thinking is..." The quality of the responses will be examined to determine which approach yields the most useful data.

It was hoped that the question on behavioral intent could serve as a baseline for a follow-up study to gauge the workshop's actual impact on work-related behavior. Funds were sought from AMFAR to conduct such a study but were not forthcoming. MARC still hopes to find funding for this impact assessment.

A copy of the evaluation report of a recent HIV Counselor Training, representing the most recent set of evaluation instruments, is included in Appendix IX.

2. Home Health Care Training

The local application of the MAARETC Home Health Care curriculum is the

second of MARC's programs to undergo more intensive evaluation. This evaluation is still evolving, but is nearing final form.

Along the way, MARC has experimented with a number of approaches. In particular, MARC tested several versions of the pre-course/post-course self-assessment of knowledge levels and proficiency described above with regard to the HIV Counselor course. At the present time, this approach has been set aside but may reappear in a revised format.

In its current form, MARC's evaluation of its Home Health Care Training carried out as part of the regional program is based on two data collection instruments: 1) a customized Course Evaluation form; and 2) a pre/post-training KAB test.

The customized Course Evaluation form includes four sections:

- the extent to which the stated objectives of the course were met;
- the quality of the presentations made by faculty members;
- the overall quality of the course; and
- the demographics of the participant.

The extent to which the course met its stated objectives and the quality of the presentations made by faculty members are based on participant ratings along a 5-point scale. Typically, the Home Health Care course is a one-day event. If the course is abbreviated, these sections are customized to reflect the course modification. The overall evaluation is broad, and includes items relating both to formative evaluation and to the evaluation of effectiveness. Items are phrased as positive statements and are rated on a 5-point scale. Formative evaluation variables include:

- adequacy of time for questions;
- knowledge of the presenters;
- additional topics that needed to be covered;
- usefulness of the information;
- adequacy of time for the overall program;
- comfort of the meeting space; and
- helpfulness of the instructional materials.

Effectiveness is determined from two items:

- " Today's program will be used by me in my daily work"; and
- " As a result of this program, I think I'll feel more comfortable with HIV patients."

Until recently, the standard MAARETC Course Evaluation form developed for use with the Home Health Care curriculum has been used. The demographic data section of the MAARETC form has now been incorporated into MARC's customized instrument.

The primary mechanism for evaluating effectiveness of the course in improving knowledge, attitudes and intended behavior is the pre/post-training KAB. The instrument used for this assessment was adapted from a pre/posttest developed by Margaret Grade at the University of California/San Francisco. At the outset, the entire instrument, consisting of over 100 items, was used and included many items unrelated to the content of the Home Health Care training. The instrument has now been pared down to include 47 items that better reflect the course they are meant to evaluate.

The current version of the instruments are included in Appendix X.

VII. SUMMARY OF ISSUES AND CHALLENGES FOR THE FUTURE

Both MAARETC's program and evaluation activities have been slow in starting. To a large extent, both have been a result of staffing changes. However, as the project enters its third year, the intensity and quality of evaluation activities have been increasing.

A notable milestone was the development by the Maryland ARC of an excellent training database and MAARETC's efforts to use it as the basis for a standard approach to collecting and analyzing output data regionwide.

The evaluation methodology developed for the MAARETC Dental Training Program is elegant, yet simple. Variables relate directly to the training objectives; questionnaire items tap these variables in subtle ways. Collectively, the instruments measure several dimensions of effectiveness, and examine impact within the limitation that there has been no attempt to control for confounding environmental factors.

The Maryland ARC should be commended for its evaluation efforts, particularly the use of formative evaluation to directly shape their education and training programs. There is a commitment to evaluating training outcomes, although some of these efforts have not been as productive as they could be; instruments which have been borrowed from other programs do not necessarily relate to the objectives of MARC offerings. Analyses are routinely performed on the data collected and results are fed back to trainers. The value of these analyses could be improved in the future by including more interpretation of the data. A further challenge for MARC in the future is to develop methodologies for assessing the effectiveness and impact of its clinical training opportunities.

The Virginia ARC has been involved in a number of evaluation activities aimed at assessing the impact of its programs. It has undertaken a program-specific evaluation with regard to training activities for the state corrections department as well as using time series needs assessment data to monitor the collective impact of all of its activities.

The other ARCs have begun to show interest in expanding their evaluation activities. This interest needs to be translated into action. The ARCs do not seem to have obtained the local evaluation expertise they had initially planned to incorporate into their staffing. In the absence of local evaluation staff, the MAARETC Education Coordinator might take a more proactive role in providing technical assistance in this area. In fact, at

least one of the ARCs has indicated that it would like more guidance from the MAARETC headquarters on evaluation. Many examples of practical evaluation methods are now available, both within the region and elsewhere in the national ETC network, to assist the ARCs in designing workable evaluations to meet their specific needs.

APPENDIX1

Output Evaluation--Maryland ARC

1. Data Collection Instrument
2. Education and Training Outputs for Year 02

MARYLAND AIDS PROFESSIONAL EDUCATION CENTER
TRAINING REPORT FORM

TRAINER: _____
TITLE: _____

ON-CAMPUS Y N
LOCATION _____
COUNTY _____

START DATE _____
END DATE _____

TYPE OF SPONSORSHIP: 'l-Off campus/ MACEP sponsor'
2-MACEP provided speaker or limitdd support to outside agency
3-On-campus activity
OTHER SPONSORS _____

STYLE OF EVENT: LECTURE CONFERENCE WORKSHOP COURSE SKILL SESSION OTHER

NUMBER OF STUDENTS/PARTICIPANTS _____ NUMBER HOURS _____
NUMBER BY CATEGORY:

PHYSICIANS _____	SOCIAL WORKERS _____
PHYSICIAN ASSISTS _____	COUNSELORS _____
NURSE PRACTITIONERS _____	DENTISTS _____
NURSES _____	DENTAL/OTHERS _____
NURSE ASSISTANTS _____	EMT _____
	OTHERS _____

RACE/ETHNICITY OF PARTICIPANTS (APPROXIMATE NUMBER):

AMERICAN INDIAN _____	WHITE' _____
ASIAN _____	HISPANIC _____
BLACK _____	OTHER _____

METHODS OF PRESENTATION: LECTURE Q&A ROLE PLAY CASE STUDY GROUP PANEL OTHER

AUDIOVISUALS: SLIDES TRANSPARENCIES VIDEO WORKBOOK BLACKBOARD/FLIPCHART COMPUTER FILM OTHER

COMMENTS:

Education and Training Outputs of the **Maryland** ARC

Year Ending April 1990

	Category 1	Category 2	Category 3	Category 4	Total
Trainings	14	29	47	6	96
Contact Hours	153.5	53.5	78.5	273.5	559
Attendees	1032	729	1079	219	3059
Attendee-Hours	5154.5	1306.5	1459	3982.0	11902
Attendees	Grad/Stud	Grad/Stud	Grad/Stud	Grad/Stud	Grad/Stud
MD	181 / 0	141 / 6	193 / 338	67 / 3	582 / 347
NP	1 / 0	1 / 0	9 / 0	10 / 0	21 / 0
PA	0 / 0	1 / 0	0 / 0	0 / 0	1 / 0
RN	266 / 0	85 / 0	19 / 0	3 / 0	373 / 0
DDS	302 / 0	47 / 0	42 / 300	0 / 132	391 / 432
Hygienist	197 / 0	0 / 0	12 / 20	0 / 0	209 / 20
Soc. Worker	4 / 0	47 / 0	1 / 54	2 / 0	
Counselor	21 / 0	15 / 0	3 / 0	0 / 0	54 39 / / 54 0
EMT	0 / 0	0 / 0	1 / 0	0 / 0	1 / 0
Pharmacist	0 / 0	0 / 0	0 / 0	0 / 0	0 / 0
JD	0 / 0	0 / 0	2 / 10	0 / 0	2 / 10
Other	67 / 0	385 / 0	36 / 26	2 / 0	490 / 26
NA	2 / 0	2 / 0	12 / 0	0 / 0	16 / 0
Am. Indian	0	0	2	0	2
Hispanic	1	1	10	0	12
Asian	21	9	51	5	86
White	406	151	419	32	1008
Black	24	176	112	9	321
Other	0	0	1	0	1

APPENDIX II

Year 01 Education and Training Targets and Outputs

YEAR ONE TRAINING OBJECTIVES

Mid-Atlantic AIDS Regional Education and Training Center

PROPOSED NUMBER TRAINED

DISCIPLINE	MD	DC	VA	WV	DE	TOTALS
Physicians	85	85	85	25	20	300
Dentists	57	57	57	16	13	200
Nurses	57	57	57	16	13	200
Pharmacists	28	28	28	8	7	100
Social Workers	28	28	28	8	7	100
Lawyers	14	14	14	4	4	50
Allied Health	14	14	14	4	4	50
TOTALS	283	283	283	83	65	1000

ACTUAL NUMBER TRAINED

DISCIPLINE	MD	DC	VA	WV	DE	TOTALS
Physicians	1369	99	1131	279	135	3013
Dentists	1625	- - -	10	- - -	- - -	1635
Nurses	731	- - -	715	239	212	1897
Pharmacists	150	- - -	40	- - -	- - -	190
Social Workers	177	118	- - -	- - -	7	302
Lawyers	563	- - -	680	- - -	___	1243
Allied Health	- - -	- - -	275	- - -	72	347
Health Profnl s	4340	- - -	- - -	650	156	5146
TOTALS	8955	217	2851	1168	582	13773

APPENDIX III

Standardized Evaluation -- "How Did We Do?"

HOW DID WE DO?

ID EVENT CODE

Workshop Title _____ City and State _____

Date _____ Instructor(s) _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job Please don't sign your name.

Circle one number for each question	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. Was the content useful and practical?	1	2	3	4	5
2. Was there enough time to cover all the material?	1	2	3	4	5
3. Were the handouts and other teaching aids helpful and adequate?	1	2	3	4	5
4. Did you receive satisfactory answers to your questions?	1	2	3	4	5
5. Did the instructor seem aware of your particular skill level, and teach accordingly!	1	2	3	4	5
6. Did the instructor seem to have adequate knowledge and skill to teach this workshop?	1	2	3	4	5
7. Did you read a workshop announcement before you came to the workshop today?		YES	☐	NO	
If yes, did it give you a good idea of what the workshop would cover?	☐	YES	☐	NO	

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

_____

_____

9. What will you do differently at work as a result of this workshop!

_____

_____

10. Please evaluate your instructor. If there were two or more instructors, be sure to mention each by name. How can the instructor do a better job next time?

Instructor #1 _____

_____

Instructor #2 _____

_____

Instructor #3 _____

_____

11. In your opinion, how could this workshop be improved?

_____

_____

12. What are your future AIDS training needs?

_____

_____

MANY THANKS!

APPENDIX IV

Standardized Evaluation -- Home Health Care Training

Course Evaluation

MID-ATLANTIC AIDS REGIONAL EDUCATION AND TRAINING CENTER

Home Health Care Training Sessions

Your comments are invaluable in helping us to plan for future programs. Please fill in your responses to the following questions. Thank very much!

1. Today's program will be useful for me in my daily work:

_ Very useful _ Somewhat useful __ Little use __ No real use

2. In general, the information I learned was useful:

__ Very useful __ Somewhat useful __ Little use _ No real use

3. As a result of this program, I think I'll feel more comfortable with HIV patients:

_ A lot more comfortable _ Somewhat more comfortable __ Not more comfortable

4. The Introductory Session/Exercise was helpful:

_ Very Helpful _ Somewhat helpful _ Not very helpful _ Not helpful at all

5. The Overview of AIDS was useful for me:

__ Very useful _ Somewhat useful _ Not very useful _ Not useful for me

6. The Infection Control section was useful for me:

__ Very useful _ Somewhat useful _ Not very useful _ Not useful for me

7. The Medical Treatment section was useful for me:

_ Very useful __ Somewhat useful _ Not very useful _ Not useful at all

8. There was enough time for us to ask questions:

__ Too much time _ Exactly enough time __ Too little time _ No time at all

9. In general, the presenters were knowledgeable:

__ Very knowledgeable _ Somewhat knowledgeable _ Not very knowledgeable

10. There were some topics that we needed to cover, but didn't get to:

___ A lot of things ___ A few things Nothing, we did it all

Please list those topics: _____

11. For this type of program, was the time available adeauate?

___ Too long ___ About right ___ Too short

11. Was the meeting space comfortable?

Very comfortable ___ Somewhat comfortable ___ Not very comfortable

12. Were the handout and reference materials helpful?

__ Very Helpful __ Somewhat helpful __ Not very helpful __ Not helpful at all

13. How did vou hear about todav's conference?

___ Brochure/flier ___ From a friend Other
___ Through my work Radio/television (Please specify:)

Please tell us a little about you: (Check one for each category)

Ethnicitv

___ American Indian/Eskimo ___ Asian ___ Hispanic/Latino
___ Black ___ Caucasian (white) ___ Other (Please specify)

Job Title

___ Nurse Practitioner ___ Dietician ___ Social Worker
___ Registered Nurse ___ Counselor ___ Licensed Practical Nurse
___ Nursing Assistants ___ Home Health Aide ___ Other (Please specify)

Sex ___ Female ___ Male

Age

___ Less than 20 ___ 31-40 ___ 51-60
___ 20-30 ___ 41-50 ___ Over 60

Number of Years in Home Health Work

Both in this job and elsewhere, how many years have you worked in home health care?

___ Less than one year ___ 3-4 years ___ 6-7 years
___ 1-2 years ___ 5-6 years ___ Over 7 years
___ Not applicable (not in home health care)

Primary Site of Work

Please indicate your primary site of work:
___ Hospice
___ Home Health Care Agency/Department
___ Public Health Department
___ Visiting Nurse organization
___ Other (Please specify): _____

THANK YOU !!

APPENDIX V

Standardized Evaluation -- Dental Training Program

TRAINING **FOR HEALTH CARE PROVIDERS ON INFECTION CONTROL AND AIDS**

Dear Participant:

Welcome! We are very happy to have you attending our training program. It is important to us to know if we are meeting both your needs and our objectives. It is for this reason that we ask your participation in our evaluation efforts. Please answer all questionnaires as completely as possible. Your cooperation is greatly appreciated.

We ask that you not put-your name on the questionnaires. You will be asked, instead, for an ID code. Please use the following formula to arrive at your unique ID code and place this code wherever it is requested. Your responses will be kept confidential.

Example

First Letter of Your Last Name ___ Bill Smith

Last 4 digits of Soc. Sec.# S.S. #212-34-1234

ID = S 1234

Again, thank you for your cooperation.

ID_____

Dental Care Professional8 Pro-Test

The answers to these questions are very important. Please take the time to answer each question carefully by filling in the blank or circling the most appropriate response. All responses are confidential and no names will appear on any **forms *or*** publications.

1. Sex: a. male b. female

2. Age : _____ years old

3. Race:
   a. Caucasian
   b. Black
   c. Oriental
   d. Other: _____

4. Occupation:

   a. dentist
   b. hygienist
   c. dental assistant
   d. office manager or receptionist
   e. other: _____

5. Year of graduationfrom dental or dental hygiene school? **19** ___

6. Number of hours you spend per week in patient care? _____ hours

7. Number of formal infection control or AIDS courses attended, other than this course? If none, please enter 0. _____

8. Total number of hours spent in these previous courses? If none, please enter 0. _____ hours

9. Have you been immunized against hepatitis B? 1 Yes 2 No

10. If you have not been immunized against hepatitis B, do you plan to do so? 1 Yes 2 No

11. If you have not yet taken the hepatitis vaccine, are any of the following the reasons why? Circle all that **apply.** If you have been immunized, skip this question.

a.	risk of infection is low	1 Yes	2 No
b.	I require further information	1 Yes	2 No
c.	vaccine too expensive	1 Yes	2 No
d.	vaccine safety not established to my satisfaction	1 Yes	2 **No**
e.	I have had prior exposure	1 Yes	2 No
f.	other: _____	1 Yes	2 No

12. By your best estimate, what % of patients in your practice are at risk for AIDS/HIV infection? _____%

13. To your knowledge, in your career have you ever treated patients who are HIV+ *or* who have had AIDS? 1 Yes 2 No

14. If yes, approximate number: _____

15. In your opinion, the best place to treat healthy HIV+ patients is:

a. private practice
b. dental school
c. private hospital clinics
d. existing public hospital clinics
e. special public health clinics

16. If you have any concerns about treating healthy HIV+ patients, which of the following are your greatest concerns? Circle only 2 responses.

If you do not have any concerns, check here [ ] and skip this question.

a. If I treated HIV+ patients, I would be placed at increased risk.
b. It would be difficult to deal with staff-fears.
c. If I treat HIV+ patients my other patients may be reluctant to continue in my care.
d. I do not have the skills I need to effectively and safely treat HIV+ patients.
e. I don't approve of the lifestyles of HIV+ patients.
f. I fear being overwhelmed with HIV+ patients.
g. Other: _____

17. In your practice, which of the following procedures do you use to screen patients for HIV+/AIDS? Circle **all** that apply.

	Always	Sometimes	Never
a. take a thorough medical history	1	2	3
b. do a thorough oral screening	1	2	3
c. take a thorough drug-use history	1	2	3
d. ask patients if they are at risk	1	2	3
e. list high-risk groups and ask if they belong	1	2	3
f. take a thorough sexual history	1	2	3

If *you* never screen, check here [ ].

18. Which of the following approaches do you think will be the most effective means to expand the role of yourself and others in car' for HIV+ individuals? Circle the 2 most important approaches.

a. continuing education courses that focus on medical/dental aspects of HIV infection
b. continuing education courses that focus on ethical and legal issues that arise in the care of HIV+ individuals
c. continuing education courses which include supervised clinical experiences with HIV+ patients
d. help confronting fears and/or negative feelings about individuals at high risk for HIV infection
e. more access to dental subspecialty consultants (including telephone "hot-lines")
f. more access to medical subspecialty consultants (including telephone "hot-lines")
g. other: _____

19. Presently in your practice, do you use gloves, masks, and protective eyewear when working with all, selected, or none of your patients?

	All Patients	Selected	None
a. gloves	1	2	3
b. mask	1	2	3
c. protective eyewear	1	2	3

20. If you wear gloves, do you change them after every patient? 1 Yes 2 No

21. Do you have a formal written infection control protocol for the management of your office? 1 Yes 2 No

22. Why did you choose to attend this particular course? Circle all that apply.

a. to learn about infection control
b. to learn about HIV+/AIDS
c. to learn about OSHA, MOSH, and other federal and/or state regulations
d. other: _____
e. other: _____

On a scale from 1 (completely disagree) to 5 (completely agree), how do you feel about the following statements?

		completely disagree				completely agree
23.	Each dental professional has the right to decide individually whether or not to accept healthy HIV+ patients.	1	2	3	4	5
24.	Professional standards should be set by professional associations and followed by all practitioners.	1	2	3	4	5
25.	Each dental professional has the right to decide individually whether or not to accept patients infected with hepatitis B.	1	2	3	4	5
26.	I would be more frightened caring for a HIV+ patient than one with infectious hepatitis.	1	2	3	4	5
27.	AIDS patients deserve what is happening to them.	1	2	3	4	5
28.	I have strong negative feelings concerning intravenous drug users.	1	2	3	4	5
29.	I have strong negative feelings concerning homosexuals.	1	2	3	4	5
30.	I know how to screen for the oral manifestations of HIV infection.	1	2	3	4	5
31.	I prefer to refer persons at risk for HIV or persons who are HIV+ (but no medical complications) to other dental professionals for routine dental treatment.	1	2	3	4	5
32.	If persons at risk for HIV or persons who are HIV+ (but no medical complications) come to me for routine dental treatment, I will provide it.	1	2	3	4	5

We sincerely thank you for your participation.

Date: ___/ ___/ 89 ID _____

Dental Care Professionals Post-Test and Course Evaluation

Please answer each question carefully by filling in the blank or circling the most appropriate response. All responses are confidential and no names will appear on any forms or publications.

1. How clearly were the course objectives stated?

very clearly 1 2 3 4 5 poorly stated

2. How well did the course reflect these objectives?

very reflective 1 2 3 4 5 not reflective

3. How relevant were the topics to your practice?

very relevant 1 2 3 4 5 not relevant

4. What topics/areas would you want addressed in more detail?

_____

_____

5. What topics/areas would you want deleted?

_____

_____

6. Please indicate whether this course met your expectations/ objectives in the following areas. If you did not have any specific expectations/objectives in a particular area, please circle N/A (not applicable).

a. to learn about infection control — 1 Yes 2 No 3 N/A
b. to learn about HIV+/AIDS — 1 Yes 2 No 3 N/A
c. to learn about OSHA, MOSH, and other federal and/or state regulations — 1 Yes 2 No 3 N/A
d. other: _____ — 1 Yes 2 No
e. other: _____ — 1 Yes 2 No

7: By your best estimate, what % of **patients** in your practice are at risk for AIDS/HIV infection? ____%

a. If you have not been immunized against hepatitis B, do you plan to do so? If you have been immunized or have had prior exposure, skip this question. 1 Yes 2 No

9. In your opinion, the best place to treat healthy HIV+ patients is:

a. private practice
b. dental school
c. private hospital clinics
d. existing public hospital clinics
e. special public health clinics

10. If you have any concerns about treating healthy HIV+ patients, which of the following are your greatest concerns? Circle only 2 responses.

If you do not have any concerns, check here [ ] and skip this question.

a. If I treated HIV+ patients, I would be placed at increased risk.
b. It would be difficult to deal with staff-fears:-
c. If I treat HIV+ patients my other patients may be reluctant to continue in my care.
d. I do not have the skills I need to effectively and safely treat HIV+ patients.
e. I don't approve of the lifestyles of HIV+ patients.
f. I fear being overwhelmed with HIV+ patients.
g. Other: _____

11. Would you be interested in receiving additional training on AIDS? 1 Yes 2 No

12. Would you be interested in receiving additional training on AIDS that would prepare you to train other dental personnel? If so, please leave your name and address with us. 1 Yes 2 No

On a scale from 1 (completely disagree) to 5 (completely agree), how do you feel about the following statements?

	completely disagree				completely agree
13. Each dental professional has the right to decide individually whether or not to accept healthy HIV+ patients.	1	2	3	4	5
14. Professional standards should be set by professional associations and followed by all practitioners.	1	2	3	4	5
15. Each dental professional has the right to decide individually whether or not to accept patients infected with hepatitis B.	1	2	3	4	5
16. I would be more frightened caring for a HIV+ patient than one with infectious hepatitis.	1	2	3	4	5
17. AIDS patients deserve what is happening to them.	1	2	3	4	5
18. I have strong negative feelings concerning intravenous drug users.	1	2	3	4	5
19. I- have strong negative feelings concerning homosexuals.	1	2	3	4	5
20. I know how to screen for the oral manifestations of HIV infection.	1	2	3	4	5
21. I prefer to refer persons at risk for HIV or persons who are HIV+ (but no medical complications) to other dental professionals for routine dental treatment.	1	2	3	4	5
22. If persons at risk for HIV or persons who are HIV+ (but no medical complications) come to me for routine dental treatment, I will provide it.	1	2	3	4	5

23. Do you have any other comments that you think would be helpful to us in planning future courses?

_____

_____

_____

Thank you for *your* help.

Date: ___/___/89 ID_____

FOLLOW-UP EVALUATION

Please fill in your name and address below if we may contact you for a brief mail follow-up in several months. Your name will not appear on any of your questionnaire responses and will be used only to enable us to contact you.

Your cooperation is greatly appreciated!

Name _____

Street Address _____

City/Zip _____

ID_____

Dental Care Professionals Course Follow-up

The answers to these questions aro very important. Please take the time to answer each question carefully by filling in the blank or circling the most appropriate response. All responses are coafidontirl and no names will appear on any forms or publications.

1. Have you been immunized against hepatitis B? a Yes 2 No

2. If you have not been immunized against hepatitis B, do you plan to do so? 1 Yes 2 No

3. If you have not yet taken the'hepatitir vaccine, are any *of the* following the reasons why? Circle all that apply. If you have been immunized, skip this question.

   a. risk of infection is low 1 Yes 2 No
   b. I require further information 1 Yes 2 No
   c. vaccine too expensive 1 Yes 2 No
   d. vaccine *safety* not established to my satisfaction 1 Yes 2 No
   e. I have had prior exposure 1 Yes 2 No
   f. other: _____ 1 Yes 2 No

4. By your beet estimate, what % of patients in your practice are at risk for AIDS/HIV infection? ____%

5. To your knowledge, in your career have you ever *treated* patients who are HIV+ or who have had AIDS? 1 Yes 2 No

6. If yes, approximate number: _____

7. In your opinion, the best place to treat healthy HIV+ patient8 is:

   a. private practice
   b. dental school
   c. *private* hospital clinics
   d. existing public hospital clinics
   e. special public health clinics

a. If you have any **concerns** about treating healthy HIV+ patients, which of the following are your greatest concerns? Circle **only** 2 responses.

If you do not have any *concerns,* check here [] and skip this question.

a. If I treated HIV+ patients, I would be placed at **increased** risk.
b. **It would** be difficult to deal with staff **fears. .**
c. If I **treat HIV+** patients my other patients nay be reluctant to continue in my care.
d. I **do** not have the skills I need to effectively and safely treat HIV+ patients.
e. I don't approve *of* the lifestyles of **HIV+** patients.
f. I fear being overwhelmed with HIV+ patients.
g. Other: _____

9. In your practice, which **of** the following procedures do you use to **screen** patients for **HIV+/AIDS?** Circle all that apply.

	Always	Sometimes	Never
a. take a thorough medical history	1	**2**	**3**
b. do a thorough *oral screening*	**1**	**2**	3
c. take a thorough drug-use **history**	**1**	2	3
d. ask patient8 if they are at risk	1	2	3
e. list high-risk groups and ask if they belong	1	2	3
f. take a thorough sexual history	**1**	2	3

If you never screen, check here [].

10. Presently in your practice, do you use gloves, masks, and protective eyewear **when** working with all, selected, or none of **your patients?**

	All	**Selected Patients**	**None**
a. gloves	**1**	**2**	**3**
b. mask	**1**	**2**	3
c. protective eyewear	**1**	2	3

11. If you ***wear* gloves,** do you change them after every patient? **1** Ye8 2 no

12. Do you have a **formal** written infection **control protocol** fox the management **of your** office? 1 **Yes** **2 No**

On a scale from 1 (completely disagree) to 5 (completely agree), how do you feel about the following statements?

		completely disagree				completely agree
13.	Each dental professional has the right to decide individually whether or not to accept healthy HIV+ patients.	1	2	3	4	5
14.	Professional standards should be set by professional associations and followed by all practitioners.	1	2	3	4	5
1s.	Each dental professional has the right to decide individually whether *or* not to accept patients infected with hepatitis B.	1	2	3	4	5
16.	I would be more frightened caring for a HIV+ patient than one with infectious hepatitis.	1	2	3	4	5
17.	AIDS patients deserve what is happening to them.	a	2	3	4	5
18.	I have strong negative feelings concerning intravenous drug users.	1	2	3	4	5
19.	I have strong negative feelings concerning homosexuals.	1	2	3	4	5
20.	I know how to screen for the oral manifestations of HIV infection.	1	2	3	4	5
21.	I *prefer to refer* persons at risk for HIV or *persons* who *are* HIV+ *(but no* medical complications) to other dental professionals for routine dental treatment.	1	2	3	4	5
22.	If persons at risk for HIV or persons who are HIV+ (but *no* medical complications) come to me for routine dental treatment, I will provide it.	1	2	3	4	5

We ● inczoroly thank you for your participation. Please return your questionnaire in the enclosed e nvelope.

ID_____

AIDS Trainer Program Course Follow-up

The *answers to these* question5 are very important. Please take the time to answer each question carefully by filling *in* tha blank or circling the most appropriate response. All responses are confidential and a0 names will appear on any form8 or publications.

1. Have you been immunized against hepatitis B? 1 Yes 2 No

2. If you have not been immunized against hepatitis B, do you plan to do so? 1 Yes 2 No

3. If you have not yet taken the hepatitis *vaccine, are any* of the following the reason5 why? Circle all that apply. If you have been immunized, 5kip this question.

   a. risk of infection is low 1 Yes 2 No
   b. I require further information 1 Yes 2 No
   c. *vaccine too expensive* 1 Yes 2 No
   d. vaccine safety not established to my satisfaction 1 Yes 2 No
   e. I have had prior exposure a Yes 2 No
   f. other: _____ 1 Yes 2 No

4. By your best estimate, what % of patient5 in your practice are at risk *for* AIDS/HIV infection? _____%

5. To your knowledge, in your career have you ever treated patients who are HIV+ or who have had AIDS? 1 Yes 2 No

6. If yes, approximate *number:*

7. In your opinion, the best place to *treat healthy* HIV+ patient8 is:

   a. private practice
   b. dental school
   c. private hospital clinics
   d. existing public hospital clinics
   e. special public health clinics

a. If you have any concerns about treating healthy HIV+ *patients,* which of the following are your greatest **concerns?** Circle only 2 responses.

If you do not have any **concerns,** check here [] and skip this question.

a. **If** I treated **HIV+** patients, **I** would be placed at increased risk,
b. It would be difficult to deal **with rtaff** fears.
c. If I treat **HIV+** patients my other **patients** may be reluctant to continue in my care.
d. I do not have the skills I need to effectively and safely treat HIV+ patients.
e. I don't approve of the lifestyles of **HIV+** patients.
f. **I** fear being overwhelmed with HIV+ patients.
g. Other: _____

9. In your practice, which of the following procedures do you use to screen patients for **HIV+/AIDS?** Circle all that apply.

	Always	Sometimes	Never
a. take a thorough **medical** history	1	2	3
b. do a thorough oral screening	1	**2**	**3**
c. take a thorough drug-use history	1	2	3
d. ask patients if they are at risk	**1**	2	**3**
e. list high-risk groups and ask if they belong	1	2	3
f. take a thorough sexual history	1	2	3

If you never screen, check here [ ].

10. Presently in your practice, do you use gloves, masks, and ***protective*** eyewear when working with all, selected, ***or*** none of your **patients?**

	All	**Selected Patients**	**None**
a. gloves	a	**2**	**3**
b. mask	**1**	**2**	3
c. protective eyewear	a	**2**	3

11. If you wear gloves, do you change them **after every** patient? a **Yes** 2 lo

12. Do you have a formal written infection control **protocol for** the management of ***your*** office? a Yes 2 **No**

On a scale from 1 (completely disagree) to 5 (completely agree), how do you feel about the following statements?

	completely disagree				completely agree
13. Each dental professional has the right to decide individually whether or not to accept healthy HIV+ patients,	1	2	3	4	5
14. Professional standards should be set by professional associations and followed by all practitioners.	1	2	3	4	5
15. Each dental professional has tht right to decide individually whether or not to accept patients infected with hepatitis B.	1	2	3	4	5
16. I would be more frightened caring for a HIV+ patient than one with infectious hepatitis.	1	2	3	4	5
17. AIDS patients deserve what is happening to them.	a	2	3	4	5
18. I have strong negative feelings concerning intravenous drug users.	1	2	3	4	5
19. I have strong negative feelings concerning homosexuals.	1	2	3	4	5
20. I know how to screen for the oral manifestations of HIV infectian.	1	2	3	4	5
21. I prefer to refer persons at risk for HIV or persons who are HIV+ (but no medical complications) to other dental professionals for routine dental treatment.	1	2	3	4	5
22. If persons at risk for HIV or persons who are HIV+ (but no medical complications) come to me for routine dental treatment, I will provide it.	1	2	3	4	S

The aut few questions relate specifically to the course(s) you have presented as • trainer.

23. Do you feel the AIDS trainer continuing education course you took adequately prepared you to train other dental personnel in the following areas? Please responsed for each area listed.

a.	infection control	1 'II.8	2 No
b.	clinical diagnosis/manifestation8 of HIV+/AIDS patients	1 Yes	2 No
c.	clinical treatment of HIV+/AIDS patient8	1 Ye8	2 No
d.	OSHA, MOSH, federal and State regulations	1 Ye8	2 NO

24. HOW many AIDS infection control courses have you presented since you took the instructor training course? If none, please enter "0".

25. Approximately, how many individuals have attended these courses? If none, please enter "0". _____

26. Based on your own *experiences as* a trainer since taking the AIDS trainer course, how could the course have been improved? Please be as specific a8 possible?

_____

_____

_____

_____

_____

_____

We sincerely thank you for your participation. Please return your questionnaire in the enclosed envelope.

APPENDIX VI

Evaluation Conducted -- Virginia's Home Health Care Training Program

Summary Evaluation - AIDS/HIV Infection: A Home Care Response
Northern Virginia HIV Resource and Consultation Center
March 20, 1990

Number of participants: 35

Number of surveys returned: 29 (83%)

Rating Scale 5 = excellent
4 = good
3 = satisfactory
2 = fair
1 = poor

Average Ratina

3.66 1. Today's program will be useful for me in my daily work:

20 - very useful: 8 - somewhat useful: 1 - little use

3.72 2. In general, the information I learned was useful:

21 - very useful: 8 - somewhat useful

3.63 3. As a result of this program, I think I'll feel more comfortable with HIV patients:

17 - a lot more comfortable: 10 - somewhat more comfortable: 2 - was already comfortable

3.70 4. The Introductory Session/Exercise was helpful:

16 - very helpful; 7 - somewhat helpful

3.78 5. The Overview of AIDS was useful for me:

19 - very useful: 8 - somewhat useful;
1 - not very useful

3.79 6. The Infection Control section was useful for me:

23 - very useful: 6 - somewhat useful

3.73 7. The Symptom Management section was useful for me:

16 - very useful: 6 - somewhat useful

8. There was enough time for us to ask questions:

3 - too much time: 26 - enough time

9. In general, the presenters were knowledgeable:

26 - very knowledgeable; 3 - somewhat knowledgeable

10. There were some topics that we needed to cover, but didn't get to:

3 - a lot: a - a few; 15 - nothing, we covered everything

0 universal precautions - 2
0 legal aspects - 1

11. For this type of program, was the time available adequate?

6 - too long; 20 - about right; 2 - too short

3.41 12. Was the meeting space comfortable?

14 - very comfortable; 13 - somewhat comfortable;
2 - not very comfortable

3.82 13. Were the handout and reference materials helpful?

23 - very helpful; 5 - somewhat helpful

14. How did you hear about today's conference?

13 - brochure; 19 - via work

Ethnicity

Black - 11 Asian - 1 Caucasian - 15

Job Title

R.N. - 5
Nursing Assistants - 7
Physical Therapist - 1
Social Workers - 2
LPN - 1
Home Health Aide - 1
Other - 3

Sex

Female - 29 Male - 0

Less than 20 - 1
20-30 - 4
31-40 - 10
41-50 - 8
51-60 - 5
Over 60 - 2

Number of Years in Home Health Work

Less than 1 year - 2
1-2 years - 1
3-4 years - 2
5-6 years - 1
6-7 years - 3
Over 7 years - 11

Primary Site of Work

Hospice - 7
Home Health Agency - 1
Health Department (Home Health Division) - 5
Visiting Nurse Organization - 2
Hospital - 2
Other - 6

county

Alexandria - 2
Arlington - 11
Fairfax - 15
Loudoun - 0
Fauquier - 2
Falmouth - 2
Prince William - 2
Maryland - 2

Summary Evaluation - AIDS/HIV Infection: A Home Care Response For Professionals
Northern Virginia HIV Resource and Consultation Center
March 22, 1990

Number of participants: 98

Number of surveys returned: 85 (87% returned)

Rating Scale: 5 = excellent
4 = good
3 = satisfactory
2 = fair
1 = poor

Average Rating		
3.65	1.	Today's program will be useful for me in my daily work: 61 - very useful; 21 - somewhat useful
3.87	2.	In general, the information I learned was useful: 71 - very useful: 11 - somewhat useful
3.63	3.	As a result of this program, I think I'll feel more comfortable with HIV patients: 71 - a lot more comfortable; 34 - somewhat more comfortable; 1 - not more comfortable; 6 - wasn't comfortable
3.55	4.	N/A
3.80	5.	The Overview of AIDS was useful for me: 66 - very useful; 15 - somewhat useful: 1 - not very useful
3.62	6.	The Infection Control section was useful for me: 51 - very useful; 29 - somewhat useful; 1 - not very useful
3.69	7.	The Medical Treatment/Case Management section was useful for me: 48 - very useful: 22 - somewhat useful;

8. There was enough time for us to ask questions:

2 - too much time: 43 - enough time; 33 - too little time

4.0 9. In general, the presenters were knowledgeable:

85 - very knowledgeable

10. There were some topics that we needed to cover, but didn't get to:

4 - a lot; 36 - a few: 17 - nothing, we covered everything

- o Changing Public's Perceptions of AIDS Patients
- o More Specific Situations in the Home - 4
- o Homophobia - 1
- o Health Care Workers Fears - 1
- o Community Resources

11. For this type of program, was the time available adequate?

1 - too long: 63 - about right; 16 - too short

3.31 12. Was the meeting space comfortable?

31 - very comfortable: 39 - somewhat comfortable; 7 - not very comfortable

3.78 13. Were the handout and reference materials helpful?

62 - very helpful; 17 - somewhat helpful

14. How did you hear about today's conference?

57 - brochure: 36 - via work; 7 - via friend

Ethnicity

Black - 9 Asian - 3 Caucasian - 66' American Indian - 2

Job Title

Counselor - 6
LPN - 1
Nurse Practitioner - 2
Physical Therapist Assistant - 1
RN - 63
RT - 2
STD Rep. - 1
Social Worker - 8
Other - 1

Sex

Female - 82 Male - 3

Less than 20 - 0
20-30 - 13
31-40 - 30
41-50 - 10
51-60 - 10
Over 60 - 1

Number of Years in Home Health Work

Less than 1 year - 5
1-2 years - 10
3-4 years - 2
5-6 years - 2
6-7 years - 5
Over 7 years - 17

Primary Site of Work

Hospice - 10
Hospitals - 21
Home Health Agency - 13
Health Department (Home Health Division) - 14
Mental Health Care Centers - 3
Social Services Department - 4
Substance Abuse Treatment Programs - 2
Residental - 2
Visiting Nurse Organization - 6
Other - 2

county

Alexandria - 18
Arlington - 17
Fairfax - 26
Fredericksburg - 2
Loudoun - 4
Centerville/Albemarle - 7
Fauquier - 1
Prince William - 9
Culpeper - 2
Front Royal - 1
Stafford - 1
Hampton - 1
Harrisonburg - 2
Washington DC - 3
Maryland - 6

Course Evaluation

MID-ATLANTIC AIDS REGIONAL EDUCATION AND TRAINING-R

Home Health Care Training Sessions

Your comments are invaluable in helping us to plan for future programs. Please fill in your responses to the following questions. Thank very much!

1. Today's program will be useful for me in my daily work:

   47 Very useful 36 Somewhat useful 3 Little use 1 No real use

2. In general, the information I learned was useful:

   57 Very useful 30 Somewhat useful 1 Little use 1 No real use

3. As a result of this program, I think I'll feel more comfortable with HIV patients:

   51 A lot more comfortable 33 Somewhat more comfortable 4 Not more comfortable
   2 Not uncomfortable

4. The Introductory Session/Exercise was helpful:

   51 Very Helpful 33 Somewhat helpful _ Not very helpful _ Not helpful at all

5. The Overview of AIDS was useful:

   64 Very useful 24 Somewhat useful 3 Not very useful _ Not useful for me

6. The Infection Control section was useful for me:

   54 Very useful 26 Somewhat useful 4 Not very useful 1 Not useful for me

7. The Medical Treatment/Case Management section was useful for me:

   37 Very useful 26 Somewhat useful 6 Not very useful 1 Not useful at all

8. There was enough time for us to ask questions:

   1 Too much time 81 Exactly enough time 6 Too little time 1 No time at all

9. In general, the presenters were knowledgeable:

   80 Very knowledgeable 6 Somewhat knowledgeable _ Not very knowledgeable

10. There were some topics that we needed to cover, but didn't get to:

    5 A lot of things 42 A few things 25 Nothing, we did it all

Please list those topics: _____

OVER PLEASE!

1- IV Drug Use
1-More on infeition control
1-Foster care
1-Impact on Social Services
4-Community resources
1-Resources list
4-Nursing assesment
1-Workplace precautions
2-Legal issues
7-Medications and medical management

11. **For this type of program, was the time available adequate?**

___ Too long 76 About right 2 Too short

11. **Was the meeting space comfortable?**

48 **Very** comfortable 27 Somewhat comfortable 2 Not very comfortable

12. Were the **handout and reference materials helpful?**

53 Very Helpful 25 Somewhat helpful 1 Not very helpful ___ Not helpful at all

13. **How** did **you hear** about **today's conference?**

50 Brochure/flier
28 Through my work
1 From a friend
___ Radio/television
2 Other (Please specify:)

Please tell us a little about you: (Check one for each category)

Ethnicity

1 **American Indian/Eskimo**
28 Black
1 Asian
49 Caucasian **(white)**
___ Hispanic/Latin0
___ Other (Please specify)

Job Title

___ Nurse **Practitioner**
42 Registered Nurse
11 Nursing Assistants
___ **Dietician**
1 Counselor
11 Home Health Aide
12 Social Worker
3 Licensed Practical Nurse
___ Other (Please specify)
1 Case Manager
1 Educator

Sex 72 Female 4 Male

Age

___ Less **than** 20
11 **20-30**
26 3140
28 **41-50**
17 **51-60**
3 Over 60

Number of Years in Home Health Work

Both in this job and elsewhere, how many years have you worked in home health care?

1 **Less than one year**
6 **1-2 years**
8 **3-4 years**
9 **5-6 years**
5 **6-7 years**
23 **Over 7 years**
___ **Not applicable (not in home health care)**

Primary Site of Work

Please **indicate your primary site of work:**

5 **Hospice**
16 **Home Healtb Care Agency/Department**
27 Public Health **Department**
2 **Visiting Nurse organization**
1 Other **(Please specify):** Nursing home

THANK YOU!!

13 Hospital
3 Case manager/Rehabilitation
9 Social Services
2 Nurse educator
1 Counselor
1 Administrator.

Summary Evaluation - AIDS/HIV Infection: A Home Care Response
Northern Virginia HIV Resource and Consultation Center
March 28, 1990

Number of participants: 48

Number of surveys returned: 46 (96%)

Rating Scale: 5 = excellent
4 = good
3 = satisfactory
2 = fair
1 = poor

Average Rating

3.59 1. Today's program will be useful for me in my daily work:

28 - very useful; 17 - somewhat useful; 1 - little use

3.76 2. In general, the information I learned was useful:

35 - very useful; 11 - somewhat useful

3.63 3. As a result of this program, I think I'll feel more comfortable with HIV patients:

29 - a lot more comfortable: 17 - somewhat more comfortable;

3.55 4. The Introductory Session/Exercise was helpful:

24 - very helpful; 20 - somewhat helpful;
2 - not very helpful

3.61 5. The Overview of AIDS was useful for me:

29 - very useful; 16 - somewhat useful;
1 - not very useful

3.52 6. The Infection Control section was useful for me:

25 - very useful; 20 - somewhat useful;
1 - not very useful

3.65 7. The Symptom Management section was useful for me:

27 - very useful; 12 - somewhat useful;
1 - not very useful

8. There was enough time for us to ask questions:

2 - too much time; 39 - enough time: 4 - too little time

9. In general, the presenters *were* knowledgeable:

42 - very knowledgeable; 4 - somewhat knowledgeable

10. There were some topics that we needed to cover, but didn't get to:

l - a lot; 8 - a few; 28 - nothing, we covered everything

o More on Safer Sex - 1
o Treatment Plans For AIDS Patients - 1

11. For this type of program, was the time available adequate?

4 - too long; 38 - about right; 3 - too short

3.40 12. Was the meeting space comfortable?

21 - very comfortable: 21 - somewhat comfortable;
3 - not very comfortable

3.85 13. Were the handout and reference materials helpful?

39 - very helpful; 7 - somewhat helpful

14. How did you hear about today's conference?

13 - brochure; 19 - via work; 1 - friend; 1 - radio;
1 - school

Ethnicity

Black - 12 Asian - 1 Caucasian - 30

2 - Hispanic/Latin0 2 - Other

Job Title

CBO - 1
Clinic - 10
College - 1
CSB - 1
Ex. Dir. - 1
Hospital - 3
Intake - 2
Nursing Homes - 2
Nurse Sup. - 1
Pharm. Rep. - 1
PMD's office - 1
Physical Therapist - 1
Physical Therapist Assistant Students - 10
Social Service Department - 2
Volunteers - 1

Sex

Female - 42 Male - 4

Less than 20 - 1
20-30 - 11
31-40 - 12
41-50 - 15
51-60 - 4
Over 60 - 2

Number of Years in Home Health Work

Less than 1 year - 3
l-2 years - 5
3-4 years - 4
5-6 years - 3
6-7 years - 1
Over 7 years - 10

Primary Site of Work

Hospice - 3
Home Health Agency - 12
Health Department (Home Health Division) - 8
Visiting Nurse Organization - 2
Other - 2

County

Alexandria - 1
Arlington - 13
Fairfax - 26
Loudoun - 0
Fauquier - 2
Prince William - 3
Washington DC - 1

APPENDIX VII

Evaluation Conducted

Evaluation of VARC's "AIDS in Adult Institutions"

AIDS TRAINING PROGRAMS FOR ADULT INSTITUTIONS

NEEDSASSESSMENTSURVEY

1. What is your occupation?

- ☐ Counselor
- ☐ Teacher
- ☐ Training Officer
- ☐ Other (please specify) _____

2. What region of the state do you work in?

- ☐ Northwest
- ☐ Northern
- ☐ Southwest
- ☐ Central
- ☐ Eastern

3. What is your best estimate of the total number of AIDS cases in your region of the state?

- ☐ 1 - 50
- ☐ 51 - 100
- ☐ 101 - 200
- ☐ 201 - 300
- ☐ 301 - 400
- ☐ 401 - 500
- ☐ more than 500

4. What is your best estimate of the total number Of AIDS cases in the correctional facilities in your region?

- ☐ 1 - 10
- ☐ 11 - 25
- ☐ 26 - 50
- ☐ 51 - 75
- ☐ 75 - 100
- ☐ more than 100

5. Since you heard about AIDS, have you worked with inmates who you knew to be...

	YES	NO
IV drug users	☐	☐
Gay or Bisexual men	☐	☐
HIV-infected	☐	☐

6. Have you worked with inmates who you suspected were ...

	YES	NO
IV drug users	☐	☐
Gay or Bisexual man	☐	☐
HIV-infected	☐	☐

7. How willing are you to work with Inmates who are ...

	VERY	SOME WHAT	NOT TOO	NOT AT ALL
IV drug users	☐	☐	☐	☐
Gay or bisexual men	☐	☐	☐	☐
HIV-infected	☐	☐	☐	☐

8. Which of the following statements are true about a person who has a 'confirmed positive antibody test", that is when both the ELISA results AND the Western blot results are positive.

	TRUE	FALSE	DON'T KNOW
A CONFIRMED POSITIVE ANTIBODY TEST MEANS THAT A PERSON ...			
Will develop AIDS	1	2	8
Has AIDS	1	2	8
Is immune to the virus	1	2	8
Is carrying the AIDS virus	1	2	8
Can transmit the AIDS virus to others	1	2	8

9. Which of the following statements are true if a person receives a nsgstive test result, that is when both the ELISA reruns AND the Western blot results are negative.

	TRUE	FALSE	DON'T KNOW
A NEGATIVE TEST MEANS THAT A PERSON IS...			
Definitely not carrying the virus	1		8
Probably not carrying the virus	1	I	8
Cannot acquire the virus	1	2	8
Can still get the virus from others	1	2	8

10. How Likely do you think it is that a person will contract the AIDS virus if they . . .

	VERY	SOME WHAT	NOT VERY	NOT AT ALL
Sit in the same room with an HIV Infected person	1	2	3	4
Hug an HIV Infected client	1	2	3	4
Touch chairs, paper, pencils or other objects that an HIV Infected client has touched	1	2	3	4

11. Which, if any of the following groups of people do you feel should be screened, that is tested for the AIDS virus?

	YES	NO	DON'T KNOW
People who are being admitted to the hospital	1	2	
People who are going to have surgery	1	2	3
People who handle food In public places	1	2	3
People who are enterlng prison			3
Pregnant women	1	2	3
People who are gettlng married	1	2	3
Physicians	1	2	3
Other health care workers			
Gay men	1	2	3
Lesbians	1	2	3
Bisexual people	1		
Prostitutes	1	2	3
IV drug users	1	2	3
Other (specify)_____			

12. How likely do you think it is that a person could become HIV-infected from....

	VERY	SOME WHAT	NOT VERY	NOT AT ALL
Having a blood transfusion	1	2	3	4
Donating blood	1	2	3	4
Using public facilities, such as buses, telephones, etc.	1	2	3	4
Using public toilets	1	2	3	4

13. How likely do you think it is that a person could become HIV-infected if a person who is infected . . .

	VERY	SOME WHAT	NOT VERY	NOT AT ALL
Kissed them on the cheek	1	2	3	4
Kissed them on the mouth	1	2	3	4
Shook hands with them	1	2		4
Had sexual intercourse without using a condom	1	2	3	4
Shared an IV needle with them	1	2	3	4
Coughed or sneezed on them	1	2	3	4
Lived in the same house with them	1	2	3	4
Shared a razor or a toothbrush	1	2	3	4

14. The following statements are suggestions that have been made about dealing with the problem of AIDS. For each one, please indicate if you strongly agree (I), agree (2), disagree (3), or strongly disagree (4).

	SA	A	D	SD
Health care workers who work with HIV-infected clients should be paid more money	1	2	3	4
Employera should have the right to test their employees for HIV	1	2	3	4
Laws should be passed to protect people from discrimination because of HIV/AIDS	1	2	3	4
Medical clinics should be set up to provide treatment for HIV-infected people	1	2	3	4
People with AIDS should be isolated or quarantined	1	2	3	4
Public institutions should not have to admit HIV-infected patients/clients	1	2	3	4
People should be able to refuse to work with HIV-infected clients	1	2	3	4

15. How likely do you think it is that you personally will become HIV-infected?

c I very likely
☐ Somewhat likely
☐ Not too likely
a Not at all likely

16. How much do you feel you know about AIDS/HIV infection?

a A lot
☐ ISoma
☐ Not very much
☐ Nothing

17. Have you been tasted for the HIV/AIDS antibody?

c YES I
☐ NO

IF YES, have you received a positive result from one or more of the times you have been tested?

☐ YES
☐ NO

18. Which of the following topics related to AIDS would you like to have more information about? *(circle* all that apply)

Medical Information about AIDS 01
AIDS-related symptoms 02
Psychological effects of AIDS 03
Psychological effects of HIV-infection 04
Legal aspects of AIDS 05
Effects on patients' lives 06
What type of care is needed 07
How much care is needed 08
Methods of AIDS prevention 09
Advances In treatment/prevention 10
How to give preventive education 11
Community resources for dealing with people who are HIV-infected 12
Community resources for helping family and friends of HIV-infected individuals 13
Medical care for HIV-Infected individuals 14
Financial help for HIV-infected individuals 15
Effects *on* family and friends 16
Antibody testing 17
Infection control 18
Civil rights of AIDS/HIV-Infected individuals 19
Other 20

19. What do you plan to do with the information you learn from thls AIDS Training Program? (check all that apply)

- ☐ Disseminate Information about AIDS and HIV-infection to other staff
- ☐ Provide training programs for other staff about AIDS and HIV-Infectlon
- ☐ Serve as the AIDS/HIV-infection resource person In my organization
- ☐ Learn to protect myself from infection
- ☐ Better inform others how to protect themselves
- ☐ Provide appropriate counseling for HIV-infected individuals
- ☐ Provide appropriate counseling for families of HIV-infected individuals
- ☐ Determine my rote In meeting the educational needs of clients during incarceration
- ☐ Determine my role in meeting the educational needs of clients upon release Into the community
- ☐ Identify community resources and local AIDS service organizations

AIDS TRAINING PROGRAMS FOR ADULT INSTITUTIONS

FOLLOW-UP SURVEY

1. How relevant to your job **requirements** did you find the information presented during the AIDS **Training?** (please check one)

- ☐ Very relevant
- ☐ somewhat relevant
- ☐ Not too relevant
- ☐ Not at all relevant

2. How **useful** dii you find the **information** presented during the AIDS Training session for **the following** areas of interest7 (circle one for each **topic)**

	VERY	SOME WHAT	NOT VERY	NOT AT ALL
General **overview** of HIV infection	1	2	3	4
Medical aspects of HIV infection	1	2	3	4
Scope and trends of HIV problem	1	2	3	4
Infection **control/universal** precaution	1	2	3	4
Counseling issues	1	2	3	4
Risk reduction		2	3	4
Community resources	1	2	3	4

3. What Is your occupation?

- ☐ Counselor
- ☐ **Teacher**
- ☐ **Training** Officer
- ☐ Nurse
- ☐ Other (please **specify)** _____

4. What Is your best estimate of the total number of AIDS cases in your **region** of the state?

- ☐ **1 - 50**
- ☐ 51 - **100**
- ☐ 101 - **200**
- ☐ **201 - 300**
- 0 **301 - 400**
- a **401 - 500**
- ☐ more than 500

5. **What Is** your best estimate of the total number of AIDS cases in the correctional facilities in **your region?**

- 0 1 - 10
- ☐ 11 - **25**
- ☐ **26 - 50**
- E I 61 - 76
- 0 **76 - 100**
- ☐ more than 100

6. How willing are you to work **with** Inmates who are ...

	VERY	SOME WHAT	NOT TOO	NOT AT ALL
IV drug **users**	☐	☐	☐	☐
Gay or **bisexual** men	☐	☐	☐	☐
HIV-infected	☐	☐	☐	☐

7. Which of the following statements are true about a person who has a 'confirmed positive antibody test", that is when both the ELISA results AND the Western blot results are positive.

A CONFIRMED POSITIVE ANTIBODY TEST MEANS THAT A PERSON ...	TRUE	FALSE	DON'T KNOW
Will develop AIDS	1	2	8
Has AIDS	1	2	8
Is Immune to the virus	1	2	8
Is carrying the AIDS virus	1	2	8
Can transmit the AIDS drus to others	1	2	8

8. Which of the following statements are true if a person receives a negative test result, that is when both tho ELISA results AND the Western blot results are negative.

A NEGATIVE TEST MEANS THAT A PERSON IS ...	TRUE	FALSE	DON'T KNOW
Definitely not carrying the virus	1	2	8
Probably not carrying the virus	1	2	8
Cannot acquire the virus	1	2	8
Can still get the virus from others	1	2	8

9. How Likely do you think it is that a person will contract the AIDS virus if they ...

	VERY	SOMEWHAT	NOT VERY	NOT AT ALL
Sit In the Same room with an HIV infected person	1	2	3	4
Hug an HIV Infected client	1	2	3	4
Touch chairs. paper, pencils or other objects that an HIV Infected client has touched	1	2	3	4

10. Which, if any of the following groups of people do you feel should be screened, that is tested for the AIDS virus?

	YES	NO	DON'T KNOW
People who are belng admitted to the hospital	1	2	3
People who are going to have surgery		2	3
People who handle food in public places		2	3
People who are entering prison	1	2	3
Pregnant women	1	2	3
People who are getting married	1		3
Physicians	1		3
Other health care workers		2	3
Gay men	1	2	3
Lesbians	1		3
Bisexual people		2	3
Prostitutes	1	2	3
IV drug users	1	2	3
Other (specify)_____			

11. How likely do you thlnk it Is that a person could become HIV-infected from....

	VERY	SOMEWHAT	NOT VERY	NOT AT ALL
Having a blood transfusion	1	2	3	4
Donating blood	1	2	3	4
Using public facilities, such as buses, telephones, etc.		2		4
Using public toilets	1	2	3	4
Had sex with an HIV-Infected person without using a condom	1	2	3	4
Shared an IV needle with an HIV-infected person	1	2	3	4
Was coughed or sneezed on by an HIV-infected parson	1	2	3	4
Lived in the same house with an HIV-Infected person	1	2	3	4
Shared a razor or a toothbrush with an HIV-Infected person	1	2	3	4

12. The following statements are suggestions that have been made about dealing with the problem of AIDS. For each one, please indicate if you strongly agree (1), agree (2), disagree (3), *or* strongly disagree (4).

	SA	A	D	SD
Health care workers who work with HIV-infected clients should be paid more money	1	2	3	4
Employers should have the right to test their employee: for HIV	1	2	3	4
Laws should be passed to protect people from discrimination because of HIV/AIDS	1	2	3	4
Medical clinics should be set up to provide treatment for HIV-infected people	1	2	3	4
People with AIDS should be Isolated or quarantined	1	2	3	4
Public Institutions should not have to admit HIV-infected patients/clients	1	2	3	4
People should be able to refuse to work with HIV-infected clients	1	2	3	4

13. How likely do you think it is that you personally will become HIV-infected?

☐ Very likely

c l Somewhat likely

c l Not too likely

c l Not at all likely

14. How much do you feel you know about AIDS/HIV infection?

☐ A lot

☐ Some

a Not very much

c l Nothing

15. Have you been tested for the HIV/AIDS antibody?

☐ Y E S ☐ NO

IF YES, have you received a positive result from one *or* more of the times you have been tested?

☐ YES ☐ NO

16. Which of the following topics related to AIDS would you like to have more information about? (circle all that apply)

Medical information about AIDS 01
AIDS-related symptoms 02
Psychdogkal effects of AIDS 03
Psychological effects of HIV-infection 04
Legal aspects of AIDS 05
Effects on patients' lives 06
What type of care is needed 07
How much care is needed 08
Methodsof AIDS prevention 09
Advances In treatment/prevention 10
How to give preventive education 11
Community resources for dealing with people who are HIV-infected 12
Community resources for helping family and friends of HIV-infected individuals 13
Medical care for HIV-infected individuals 14
Financial help for HIV-Infected individuals 15
Effects on family and friends 16
Antibody testing 17
Infection control 18
Civil rights of AIDS/HIV-infected individuals 19

17. Please list any AIDS reiated areas in which you think additional training would be beneficial.

_____

_____

_____

_____

_____

_____

18. What have you done with the information you learned from the AIDS Training Program? (check all that apply)

- ☐ Disseminated information about AIDS and HIV-infection to other staff
- ☐ Provlded training programs for other staff about AIDS and HIV-infection
- ☐ Serve as the AIDS/HIV-infection resource person in my organization
- ☐ Learned to protect *myself* from Infection
- ☐ Informed others how to protect themselves
- ☐ Provided counseling for HIV-infected individuals
- ☐ Provided counseling for families of HIV-infected Individuals
- ☐ Oetermined my role in meeting the educational needs of clients during incarceration
- ☐ Determined my *role* in meeting the educational needs of clients upon release Into the community
- ☐ Identified community resources and local AIDS service organizations

OTHER _____

_____

_____

_____

_____

_____

MEMORANDUM

draft

FROM: Sylvia K. Scherr, Administrator
Maryland AIDS Professional Education Center
University of Maryland at Baltimore

TO: Faculty, "Basic HIV Counselor Course"
May 29 - June 1, 1990, Hagerstown, Maryland

DATE: August 28,1990

Enclosed for you is a sample evaluation form used by the participants in this course, and our new computerized tally of their evaluation ratings. The format reflects the evaluation form, and provides you with participants ratings of success in attainment of objectives (columns K - U), speaker effectiveness (only yours is provided), and overall educational quality (column AI) and usefulness (column AJ). These catagories were rated according to the following scale:

Not effective = 1 2 3 4 5 = Very Effective

In addition to the numerical rating, students written comments in section three are also included for your information, as is participant performance on the knowledge assessment pre and post course. I know this format is not quite as readable as our prior one, and that less information is provided to you regarding your individual presentation. However, it is far less laborious for the participants and the staff to collect and produce, and now that our course is on such an even keel, it seemed unnecessary to continue to collect as much data as was appropriate earlier. It is hoped that this information will still be useful to you.

The participants professions are as listed below:

1.	A.A.	2.	B.A.	3.	B.S.N.
4.	BFA, MFA	5.	MS	6.	RN
7.	L.G.S.W.	8.	M.ED.	9.	MS, CRNP
10.	B.A., CAC	11.	M.S.W., L.G.S.W.		

Your assistance and continued participation in this important training are most appreciated, The Maryland AIDS Professional Education Center looks forward to continuance of our mutual collaboration on this outstanding educational offering. Thank you,

Enclosure
bc: Jonathan Cohn, MD
Claire Walsek, RN,MS
Sarah Bur, RN, MP
Joan Garrity
Joyce Harper, MD
Iris Beard, M.E.D.
John W. Warren, MD

AIDS-RELATED KNOWLEDGE AND ATTITUDES

STAFF NEEDS ASSESSMENT

VIRGINIA DEPARTMENT OF CORRECTIONS

LIST OF FIGURES

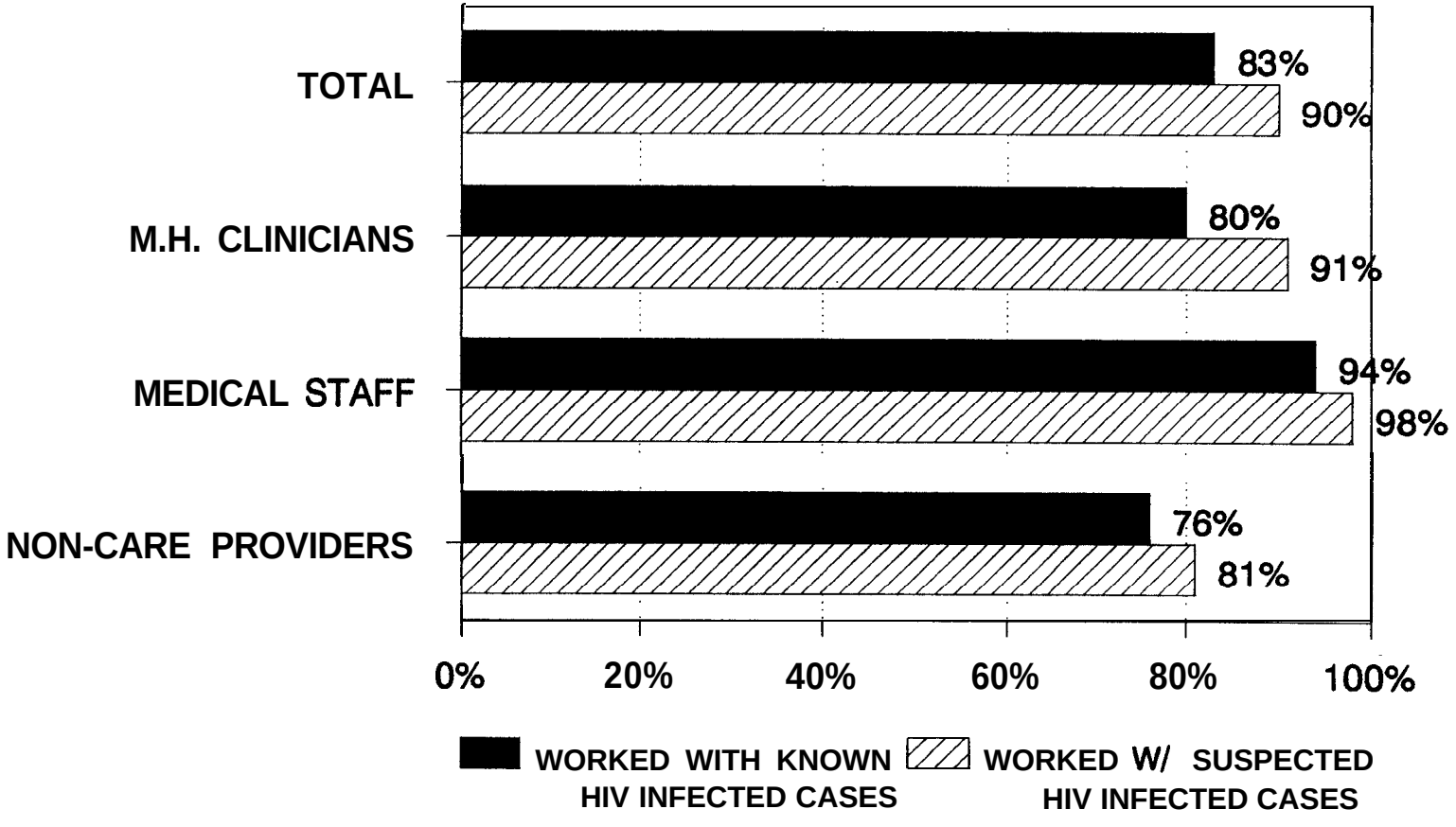
Experience with AIDS and HIV
Perception of Personal Risk
Willingness to Provide Care
Misconceptions about Risk of Transmission
Knowledge of Testing
Groups who Should be Tested for AIDS Virus
Groups who Should be Tested for AIDS Virus (annotated)
Attitudes and Opinions
AIDS Related Topics Respondents Would Like More Information
Plans for Information Learned at AIDS Training Program

LIST OF TABLES

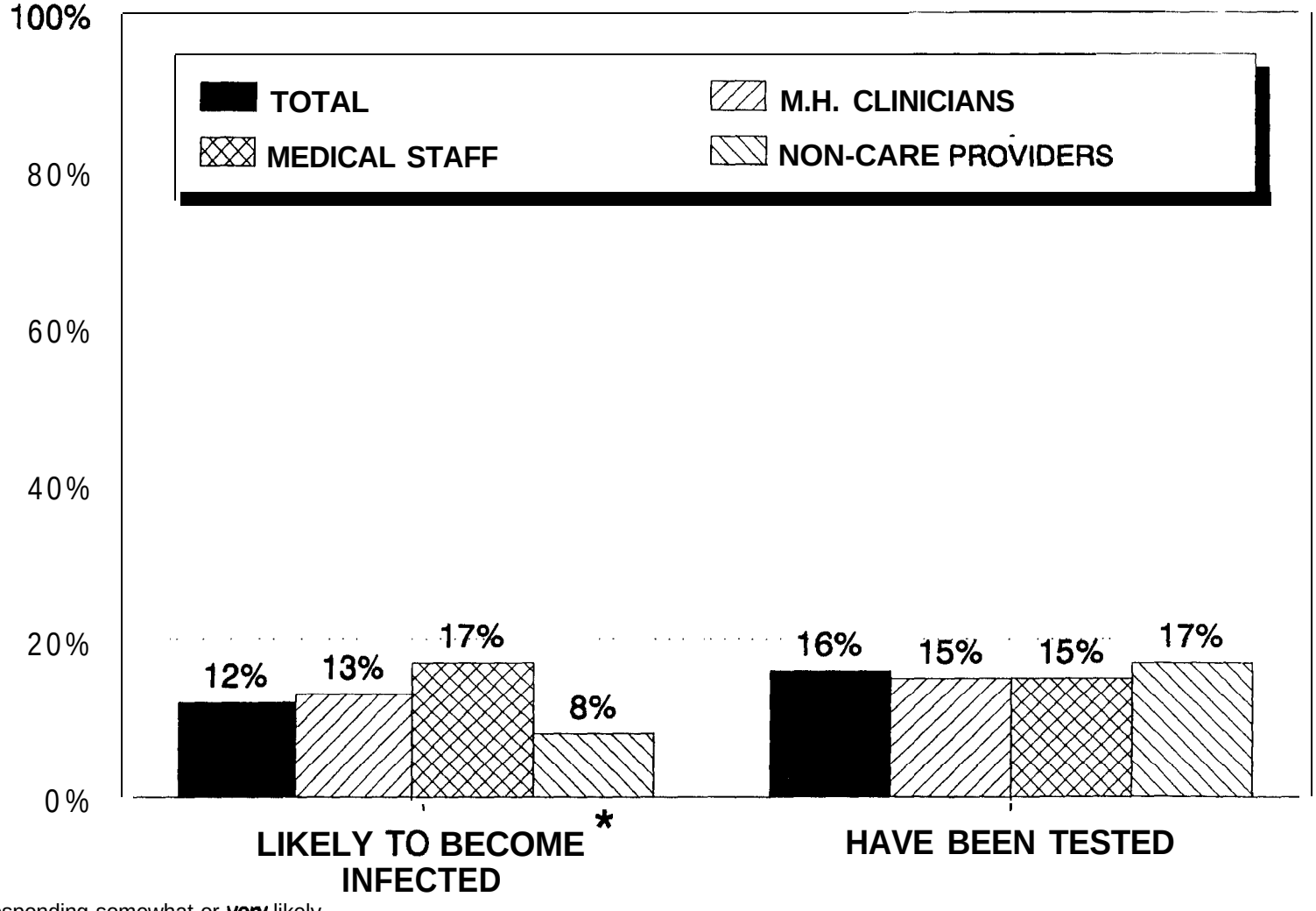
Table 1 : Closeness to AIDS
Table 2 : Extent of Experience
Table 3 : Estimated Number of AIDS Cases
Table 4 : Willingness to Treat
Table 5 : Likelihood of Transmission
Table 6 : Groups Who Should be Tested for HIV+
Table 7 : Attitudes and Opinions
Table 8 : Knowledge of Testing
Table 9 : Additional Information Desired
Table 10 : Plans for Information Learned at Training

EXPERIENCE WITH AIDS/HIV

CORRECTIONS STAFF



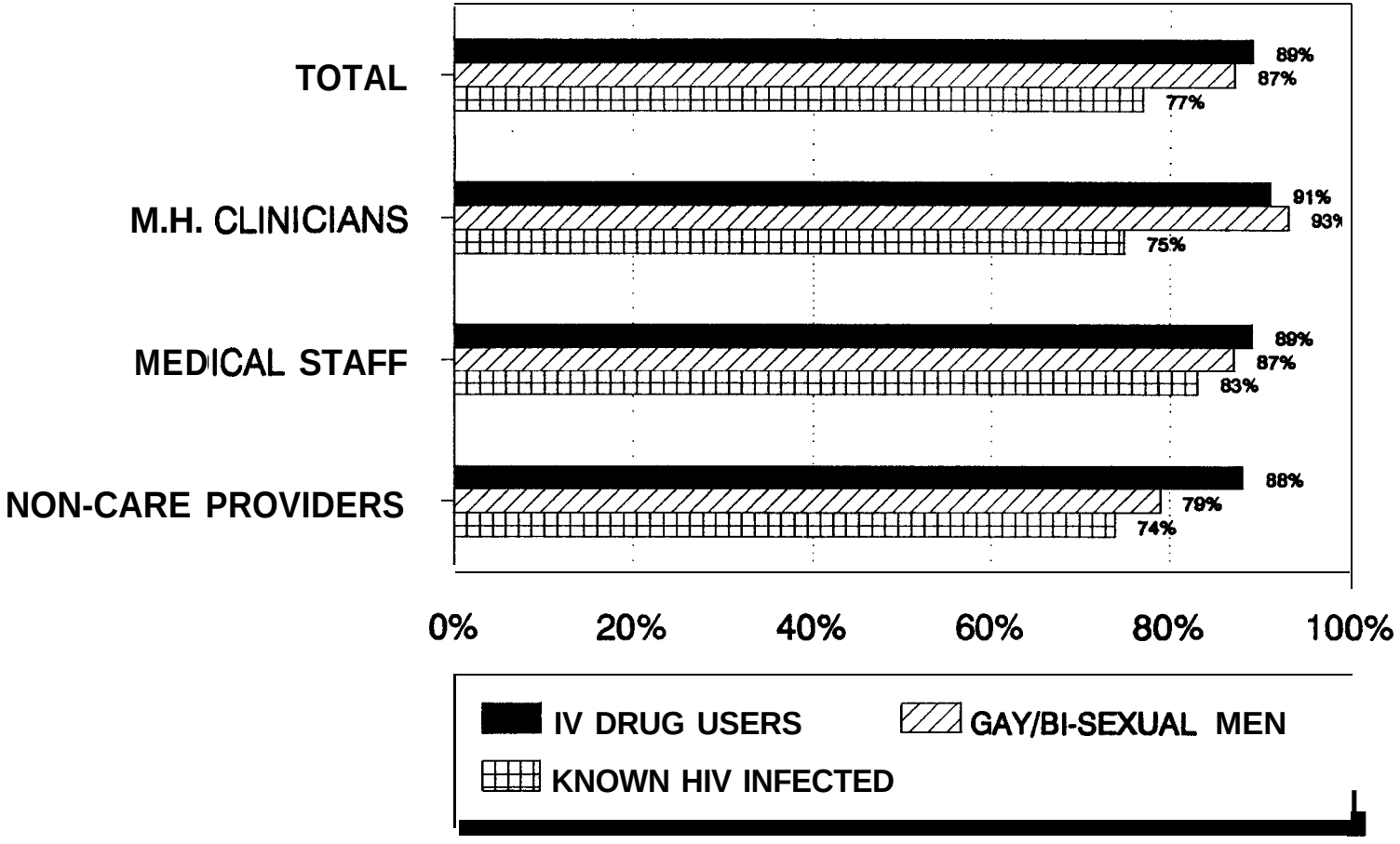
PERCEPTION OF PERSONAL RISK
CORRECTIONS STAFF



* % responding somewhat or very likely

WILLINGNESS TO PROVIDE CARE*

CORRECTIONS STAFF



*Percentage noting somewhat/very willing

MISCONCEPTIONS ABOUT RISK OF TRANSMISSION

CORRECTIONS STAFF'

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
OVERESTIMATION OF RISK				
Having a blood transfusion	72	80	68	65
Being coughed or sneezed on by an HIV-infected person	68	71	60	71
Sharing a razor or a toothbrush with an HIV-infected person	78	79	72	85
Living in the same household with an HIV-infected person	45	45	39	51
Being kissed on the mouth by HIV-infected person	44	48	4 0	43
Donating blood	39 .*	53	23	36
Using public toilets	36	41	33	32
Being kissed on the cheek by HIV-infected person	29	35	20	30
Using public facilities, such as buses, telephones, etc.	26	31	19	26
Shaking hands with an HIV-infected person	18	20	14	19
UNDERESTIMATION OF RISK				
Sharing an IV needle with an HIV-infected person	5	5	6	4
Having sexual intercourse without using a condom with an HIV-infected person	9	10	11	6

* Percentage overestimating/underestimating risk

.* Significant at <.01

KNOWLEDGE OF TESTING
CORRECTIONS STAFF .

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
A **CONFIRMED POSITIVE ANTIBODY** TEST MEANS THAT A PERSON ...				
Will develop AIDS (don't know)	28	28	20	36
Has AIDS (false)	58	56	66	52
Is immune to the virus (false)	78	69	91	79
Is carrying the AIDS virus (true)	89	86	100	83
Can transmit the AIDS virus to others (true)	84 **	82	96	73
A NEGATIVE TEST MEANS THAT A PERSON IS ...				
Definitely not carrying the virus (false)	61	59	74	53
Probably not carrying the virus (true)	72	78	61	73
Cannot acquire the virus (false)	83	80	87	85
Can still get the virus from others (true)	86	83	94	85

* Percentage responding correctly
** Significant at <.01

GROUPS WHO SHOULD BE TESTED FOR AIDS VIRUS

CORRECTIONS STAFF .

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
People who are being admitted to the hospital	71 **	70	59	84
People who are going to have surgery	87	90	85	86
People who handle food in public places	73 **	76	53	84
People who are entering prison	87	90	80	90
Pregnant women	82	85	77	84
People who are getting married	83	86	74	88
Physicians	71 * =	77	52	82
Other health care workers	71 **	77	52	81
Gay men	82	84	81	80
Lesbians	78	81	74	77
Bisexual people	81	84	83	76
Prostitutes	91	94	90	88
IV drug users	91	97	87	89

*
** Percentage responding yes, of those who answered yes or no. "Don't know" was coded as missing. Significant at <.05

GROUPS WHO SHOULD BE TESTED FOR AIDS VIRUS

CORRECTIONS STAFF .

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
People who are being admitted to the hospital	71 (9)*	70 (11)	59 (9)	84 (8)
People who are going to have surgery	87 (5)	90 (8)	85 (4)	86 (2)
People who handle food in public places	73 (7)**	76 (5)	53 (10)	84 (7)
People who are entering prison	87 (6)	96 (7)	86 (8)	90 (4)
Pregnant women	82 (7)	85 (8)	77 (4)	84 (7)
People who are getting married	83 (9)	86 (8)	74 (6)	88 (11)
Physicians	71 (9)**	77 (12)	52 (6)	82 (6)
Other health care workers	71 (10)**	77 (12)	52 (8)	81 (10)
Gay men	82 (6)	84 (7)	81 (0)	80 (9)
Lesbians	78 (8)	81 (11)	74 (2)	77 (10)
Bisexual people	81 (6)	84 (7)	83 (0)	76 (9)
Prostitutes	91 (7)	94 (7)	90 (2)	88 (11)
IV drug users	91 (7)	97 (8)	8' (2)	89 (10)

( ) = % who responded "don't know."

* Percentage responding yes, of those who answered yes or no. "Don't know" was coded as missing.

** Significant at <.05

ATTITUDES AND OPINIONS
CORRECTIONS STAFF *

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
Health care workers who work with HIV infected clients should be paid more money	83	78	89	83
Employers should have the right to test employees	49 **	40	44	65
Laws should be passed to protect people from discrimination because of HIV/AIDS	75	72	81	74
Medical clinics should be set up to provide treatment for HIV-infected people	96	95	96	96
People with AIDS should be isolated or quarantined	30	30	29	30
Public institutions should not have to admit HIV infected patients/clients	17	12	21	21
People should be able to refuse to work with HIV infected clients	52	56	44	53

* Percentage agreeing
** Significant at <.02

AIDS RELATED TOPICS RESPONDENTS WOULD LIKE MORE INFORMATION ON CORRECTIONS STAFF *

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
AIDS-related symptoms	61	57	64	63
Psychological effects of AIDS	59	65	58	51
Legal aspects of AIDS	58	59	53	63
Advances in treatment/ prevention	55	49	60	60
Medical information about AIDS	54	48	60	56
How to give preventive education	53	47	53	61
Psychological effects of HIV infection	51	56	47	47
Methods of AIDS prevention	47	46	36	58
Infection control	45	39	54	44
Civil rights of AIDS/HIV infected individuals	44	48	34	47
Community resources for people who are HIV infected	44	48	42	40
Antibody testing	43	44	38	46
Type of care needed	43	42	45	42
Medical care for HIV infected individuals	40 **	36	60	28
Effects on family and friends	39	38	29	49
Community resources for helping family and friends	38	42	33	37
Financial help for HIV infected individuals	37	41	29	39
Effects on patients' lives	36	39	33	33
How much care is needed	28	25	31	32

* Percentage responding yes
** Significant at <.01

PLANS FOR INFORMATION LEARNED AT AIDS TRAINING PROGRAM

CORRECTIONS STAFF •

	TOTAL	M.H. CLINICIANS	MEDICAL STAFF	NON-CARE PROVIDERS
Disseminate information to other staff	69	63	69	77
Provide training programs for other staff	25 **	14	24	42
Serve as AIDS/HIV resource person in organization	25	23	27	26
Learn better to protect myself from infection	62	58	65	63
Better inform others how to protect themselves	72 **	60	85	77
Provide appropriate counseling for HIV infected individuals	45	60	47	21
Provide appropriate counseling for families of HIV infected	17	20	14	14
Determine role in meeting educational needs of clients during incarceration	56	57	60	53
Determine role in meeting educational needs of clients upon release	32	35	36	23
Identify community resources and local AIDS service organizations	36	43	33	28

*
** Percentage responding planned to do activity
Significant at <.01

Table 1 : Closeness to AIDS

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Likelihood of personally becoming HIV infected																
Very likely	2	1%	2	3%	0	0%	0	0%	1	2%	1	2%	0	0%	0	0%
Somewhat likely	21	11%	8	10%	9	17%	21	42% 8%	5	11%	3	5%	4	11%	7	16%
Not too likely	89	48%	35	44%	32	59%			23	49%	29	52%	15	43%	21	48%
Not at all likely	74	40%	34	43%	13	24%	27	51%	18	38%	23	41%	16	46%	16	36%
Personal knowledge about AIDS/HIV infection																
A lot	25	13%	7				5	9%	4	9%	8	14%	8	23%		7%
Son	128	69%	56	7%::	3513	24% 65%	37	69%	32	68%	39	79%	25	71%	3:	70%
Not very much	32	17%	15	19%	6	11%	11	20%	10	21%	9	16%	2	6%	10	23%
Nothing	1	1%	9	0%	0	0%	1	2%	1	2%	0	0%	0	0%	0	6%
Boon tested for HIV																
Yes	29	16%	12	15%	8	15%	9	17%	4	9%	7	13%	8	23%	9	20%
No	158	84%	67	85%	46	85%	45	83%	43	91%	49	88%	27	77%	36	80%
Received a positive teat result																
Yes	3	11%	1	9%	1	13%	1	13%	0	0%	2	33%	0	0%	1	11%
No	24	89%	10	91%	7	88%	7	88%	4	100%	4	67%	7	100%	8	89%
Received a positive test result	3	2%		1%	1	2%	1	2%		0%	2	4%	0	0%	1	2%
No	124	13%	69	13%	47	13%	47	13%	44	98%	50	87%	29	19%	37	17%
									0		2		0		1	
									4		4		7		8	

Table 2 : Extent of Experience

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-core providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Worked w/inmates – known IV drug users																
Yes	178	94%	76	95%	53	98%	49	89%	41	85%	56	98%	34	94%	44	100%
No	11	6%	4	5%	1	2%	6	11%	7	15%	1	2%	2	6%	0	0%
Worked w/inmates – known gay or bisexual men																
Yer	164	97%	78	97%	54	100%	52	93%	43	91%	57	100%	34	94%	46	100%
No	6	3%	2	2%	0	0%	4	7%	4	9%	0	0%	2	6%	0	0%
Worked w/inmates – known HIV infected																
Yes	149	63%	61	80%	49	94%	39	76%	33	77%	52	91%	29	83%	31	77%
No	30	17%	15	20%	3	6%	12	24%	10	23%	5	9%	6	17%	9	22%
Worked w/suspected IV drug users																
Yer	164	97%	81	100%	52	100%	51	91%	44	92%	56	100%	35	97%	46	100%
No	5	3%	0	0%	0	0%	5	9%	4	8%	0	0%	1	3%	0	0%
Worked w/suspected gay or bisexual men																
Yes	164	96%	79	99%	53	100%	52	95%	45	96%	55	100%	34	94%	46	100%
No	4	2%	1	1%	0	0%	3	5%	2	4%	0	0%	2	6%	0	0%
Worked w/suspected to be HIV infected																
Yes	164	98%	70	91%	52	98%	42	81%	39	85%	53	96%	32	89%	36	88%
No	18	10%	7	9%	1	2%	10	19%	7	15%	2	4%	4	11%	5	12%

Table 3: Estimated Number of AIDS Cases

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-co re providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Estimate of AIDS cases in region																
1-50	40	21%	18	23%	10	19%	12	21%	11	23%	9	16%	6	17%	14	30%
51-100	27	14%	9	11%	6	15%	10	16%	8	17%	8	14%	2	6%	7	15%
101-200	2 6	14%	6	8%	12	23%	8	14%	9	19%	3	5%	1	3%	12	26%
201-300	26	15%	13	16%	6	11%	9	16%	7	15%	8	14%	10	29%	3	7%
301-400	6	4%	3	4%	1	2%	4	7%	2	4%	3	5%	2	6%	0	0%
401-500	14	7%	6	8%	5	9%	3	5%	1	2%	3	5%	5	14%	5	11%
More than 500	45	24%	24	30%	11	21%	10	16%	9	19%	22	39%	9	26%	5	11%
Estimate of AIDS cases in facility																
1-10	51	27%	16	23%	13	25%	20	36%	18	38%	9	16%	7	19%	16	37%
11-25	4 3	23%	18	23%	14	26%	11	20%	12	26%	12	21%	7	19%	le	23%
26-50	34	16%	15	19%	9	17%	10	18%	8	17%	14	25%	6	17%	6	14%
51-75	21	11%	9	12%	6	11%	6	11%	2	4%	6	11%	6	17%	7	16%
75-100	15	8%		8%	2	4%	7	13%	2	4%	6	11%	4	11%		7%
More than lee	23	12%	1x	15%	9	17%	2	4%	5	11%	10	16%	6	17%	31	2%

Actual number of AIDS cases in region:*

Region I (Northwest) - 87
Region II (Northern) - 586
Region III (Southwest) - 91
Region IV (Central) - 307
Region V (Eastern) - 305

* Includes cases entered as of 12/12/89

Table 4 : Willingness to Treat

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eostern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
How willing to work with IV drug users																
Very willing.....	74	40%	31	40%	22	42%	21	38%	16	35%	20	36%	21	58%	14	31%
Somewhat willing.....	92	49%	39	51%	25	47%	28	50%	23	50%	28	51%	12	33%	29	64%
Not too willing.....	15					6%	6	11%	5	11%	4	7%	3	8%	2	4%
Not at all willing.....	5	3%	6	1%	3	6%	1	2%	2	4%	3	5%	0	0%	0	0%
How willing to work with gay or bisexual men																
Very willing.....	66	36%	27	36%	20	38%	19	34%	14	30%	17	31%	19	54%	13	29%
Somewhat willing.....	94	51%	43	57%	26	49%	25	45%	22	48%	30	55%	13	37%	29	64%
Not too willing.....	18	10%	5	7%	4	8%	9	16%	6	13%	5	9%		9%	3	7%
Not at all willing.....	7	4%	1	1%	3	6%	3	5%	4	9%	3	5%	3	0%	0	0%
How willing to work with HIV infected																
Very willing.....	61	33%	25	33%	20	38%	16	29%	13	28%	16	29%	19	53%	10	23%
Somewhat willing.....	81	44%	32	42%	24	45%	25	45%	19	41%	26	47%	10	28%	26	59%
Not too willing.....	31	17%	16	21%	5	9%	10	18%	9	20%	9	16%	6	17%	6	14%
Not at all willing.....	12	6%	3	4%	4	8%	5	9%	5	11%	4	7%	1	3%	2	5%

Table 5 : Likelihood of Transmission

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
From blood transfusion																
Very likely	78	42%	36	46%	23	43%	19	35%	19	46%	19	35%	11	31%	26	58%
Somewhat likely	56	36%	27	34%	13	25%	16	30%	16	34%	19	35%	9	26%	12	27%
Not very likely	51	27%	16	20%	17	32%	16	33%	11	23%	17	31%	15	43%	7	16%
Not at all likely	1	1%	0	0%	0	0%	1	2%	1	2%	0	0%	0	0%	0	6%
From donating blood																
Very likely	13	7%	6	8%	4	8%	3	6%	3	6%	3	6%	0	0%	6	13%
Somewhat likely	18	16%	13	16%	2		3	6%	2	4%	7	13%	1	3%	7	16%
Not very likely	42					4%	13	25%	14	30%	14	26%	5	14%	9	26%
Not at all likely	112	83%	23	29%	45	71%	34	64%	28	66%	30	56%	29	83%	23	51%
From public facilities, buses, phones																
Very likely	3	4%	2	3%	1	2%	0	0%	0	0%	1	2%	0	0%	2	4%
Somewhat likely	7	21%	193	25% 4%	27	13% 4%	122	4%	2	4%	3	6%	0	0%	1	2%
Not very likely	38							22%	16	22%	10	19%	7	20%	11	24%
Not at all likely	136	74%	53	69%	43	81%	46	74%	34	74%	40	74%	28	80%	31	69%
From using public toilets																
Very likely	5	3%					1	2%	1	2%	2	4%	0	0%	1	2%
Somewhat likely	14	8%	7	9%	2	4%	5	9%	5	11%	5	9%	0	0%	3	7%
Not very likely	47	26%	22	28%	14	27%	11	21%	12	26%	13	24%	9	26%	13	29%
Not at all likely	117	64%	46	59%	35	67%	36	68%	28	61%	35	64%	25	74%	28	62%
Sitting in same room w/H IV+						0%										
Somewhat likely	1	1%	1	1%	6	8%	0	0%	0	0%	0	0%	0	0%	1	2%
Not very likely	12	6%	6	8%	4		2	4%	3	7%	4	7%	0	0%	5	11%
Not at all likely	174	93%	70	91%	49	92%	55	96%	43	93%	52	93%	36	100%	39	87%
Hugging HIV+ client																
Somewhat likely	3	2%	2	3%	1	2%	0	0%	0	0%	1	2%	0	0%	2	4%
Not very likely	23	12%	11	14%	5	9%	7	12%	7	15%	5	9%	3	8%	7	16%
Not at all likely	161	86%	64	83%	47	89%	50	88%	39	85%	50	89%	33	92%	36	80%
Touching objects touched by HIV+																
Somewhat likely	6	3%	3	4%	0	0%	3	5%	2	4%	2	4%	1	3%	1	2%
Not very likely	31	17%	12	16%	11	21%	8	14%	8	18%	6	11%	3	8%	13	29%
Not at all likely	149	80%	62	81%	42	79%	45	80%	35	78%	48	86%	32	89%	31	69%

(continued)

Table 5 : Likelihood of Transmission

	Total		Occupation						Region of state							
	N	%	M.H. Clinicianr		Medical staff		Non-care providera		Western		Nort hern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Beingkissed on cheek by HIV+																
Veryilkely	3	2%	2	3%	1	2%	0	0%	0	0%	2	4%	1	3%	0	
Somewhat likely	8	4%	5	6%	3	6%	0	0%	0	0%	5	9%	0	0%	3	8%
Not very likely	43	23%	20	26%	7	13%	16	30%	19	41%	10	18%	5	15%	8	18%
Not at all likely	130	71%	50	65%	43	80%	37	70%	27	59%	39	70%	28	82%	33	75%
Being kissed on mouth by HIV+																
Very likely	26	14%	14	16%	5	10%	7)	13%	7	15%	8	15%	3	9%	7	16%
Somewhat likely	55	30%	23	38%	16	31%	16	30%	16)	35%	20	37%	5	15%	13	30%
Not very likely	64	35%	24	31%	20	38%	20	38%	19	41%	16	30%	15	44%	13	30%
Not at all likely	37	20%	16	21%	11	21%	10	19%	4	9%	10	19%	11	32%	11	25%
Shaking hands w/HIV+																
Very likely	1	1%	1	1%	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%
Somewhat likely	3	2%	2	3%	0	0%	1	2%	0	0%	2	4%	1	3%	0	0%
Not very likely	28	16%	12	16%	7	14%	9	17%	9	20%	7	13%	4	12%	7	17%
Not at all likely	146	82%	60	80%	43	86%	43	81%	37	80%	42	81%	29)	85%	35	83%
Had **sex** w/HIV+ without using a condom																
Very likely	168	91%	70	90%	48	89%	50	94%	46	98%	49	88%	28	80%	42	98%
Somewhat likely	13	7%	5	6%	5	9%	3	6%	1	2%	5	9%	6	17%	1	2%
Not very likely	3	2%	2	3%	1	2%	0	0%	0	0%	1	2%	1	3%	0	0%
Not at all likely	1	1%	1	1 %	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%
Shared IV needle w/HIV+																
Very likely	17.3	95%	73	95%	49	94%	51	96%	46	98%	49	89%	34	100%	41	95%
Somewhat likely	6	3%	3	4%	2	4%	1	2%	1	2%	5	9%	0	0%	0	0%
Not very likely	1	1%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	1	2%
Not at all likely	2	1%	1	1%	1	2%	0	0%	0	0%	1	2%	0	0%	1	2%
Coughed or rneeted on by HIV+				9%												
Very likely	14	8%		20%	10 4	19% 8%	11 3	21% 6%	3	7%	4	7%	2	6%	5	13%
Somewhat likely	36	20%	15						9	20%	16	29%	4	11%	6	15%
Not very likely	72	40%	32	42%	17	33%	23	44%	29	63%	17	31%	14	40%	11	27%
Not at all likely	58	32%	22	29%	21	40%	15	29%	5	11%	18	33%	15	43%	18	45%

(cant inued)

Table 5 : Likelihood of Transmission

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-core providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Live In somehouse w/HIV+																
Very likely.....	4	2%	3	4%	1	2%	0	0%	0	0%	1	2%	0	0%	2	5%
Somewhat likely.....	17	9%	7	9%	3	6%	7	13%	2	4%	10	18%	2	6%	2	5%
Not very likely.....	62	34%	25	32%	17	31%	20	38%	22	47%	15	27%	14	40%	10	23%
Not at all likely.....	101	55%	42	55%	33	61%	26	49%	23	49%	29	53%	19	54%	29	67%
Share a razor or toothbrush w/HIV+																
Very likely.....	75	41%	28	37%	21	40%	26	50%	20	43%	24	44%	7	21%	21	50%
Somewhat likely.....	67	37%	32	42%	17	32%	18	35%	22	47%	17	31%	17	50%	11	26%
Not very likely.....	26	14%	10	13%	12	23%	4	8%	3	6%	7	13%	8	24%	7	17%
Not at all likely.....	13	7%	6	8%	3	6%	4	8%	2	4%	6	11%	2	6%	3	7%

Table 6 : Groups Who Should Be Tested for HIV+

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
People admitted to hospi tol																
Yes.....)	113	65%	47	63%	25	54%	41	77%	29	67%	29	58%	25	71%	26	67%
No.....	45	26%	20	27%	17	37%	8	15%	10	23%	14	28%	7	26%	13	31%
Dont know.....	16	9%	8	11%	4	9%	4	8%	4	9%	7	14%	3	9%	1	2%
People having surgery																
Yes.....	146	83%	62	83%	40	82%	44	85%	35	81%	38	75%	29	85%	40	91%
No.....	21	12%	7	9%	7	14%	7	13%	5	12%	8	16%	5	15%	3	7%
Dont know.....	9	5%	6	8%	2	4%	1	2%	3	7%	5	10%	0	0%	1	2%
People who handle food in public places																
Yes.....	119	67%	54	72%	23	48%	42	78%	31	72%	30	58%	20	59%	37	84%
NO.....	45	25%	17	23%	20	42%	8	15%	9	21%	15	29%	12	35%	6	14%
Dont know.....	13	7%	4	5%	5	10%	4	7%	3	7%	7	13%	2	6%	1	2%
People entering prison																
Yes.....	147	82%	63	84%	37	74%	47	87%	36	80%	43	83%	25	74%	40	91%
No.....	21	12%	7	9%	9	18%	5	9%	5	11%	7	13%	6	18%	2	5%
Dont know.....	11	6%	5	7%	4	8%	2	4%	4	9%	2	4%	3	9%	2	5%
Pregnant women																
Yes.....	135	77%	56	78%	37	74%	42	78%	33	75%	36	68%	25	78%	38	88%
No.....	29	16%	10	14%	11	22%	8	15%	7	16%	12	23%	5	16%	4	9%
Dont know.....	12	7%	6	8%	2	4%	4	7%	4	9%	5	9%	2	6%	1	2%
People getting married																
Yes.....	134	76%	57	79%	34	69%	43	78%	36	80%	36	69%	21	64%	38	88%
No.....	27	15%	9	13%	12	24%	6	11%	4	9%	10	19%	9	27%	4	9%
Dont know.....	15	9%	6	8%	3	6%	6	11%	5	11%	6	12%	3	9%	1	2%
Physicions																
Yes.....	113	65%	49	67%	23	49%	41	77%	31	74%	30	59%	18	55%	32	74%
No.....	45	26%	15	21%	21	45%	9	17%	7	17%	16	31%	11	33%	9	21%
Dont know.....	15	9%	9	12%	3	6%	3	6%	4	10%	5	10%	4	12%	2	5%
Other health care workers																
Yes.....	111	64%	50	68%	23	48%	38	73%	29	71%	29	56%	19	56%	32	74%
No.....	45	26%	15	20%	21	44%	9	17%	6	15%	17	33%	11	32%	9	21%
Dont know.....	18	10%	9	12%	4	8%	5	10%	6	15%	6	12%	4	12%	2	5%

(continued)

Table 6 :Groups Who Should De Tested for HIV+

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Control		Eastern	
Gay men																
Yes	139	77%	57	78%	43	81%	39	72%	33	75%	42	81%	23	66%	38	84%
No	31	17%	11	15%	10	19%	10	19%	7	16%	8	15%	10	29%	5	11%
Oont know	10	6%	5	7%	0	0%	5	9%	4	9%	2	4%	2	6%	2	4%
Lesbians																
Yes	126	72%	52	72%	38	73%	36	69%	29	67%	38	75%	19	58%	37	82%
No	36	20%	12	17%	13	25%	11	21%	9	21%	10	20%	10	30%	6	13%
Dont know	14	8%	8	11%	1	2%	5	10%	5	12%	3	6%	4	12%	2	4%
Bisexual people																
Yea	139)	77%	57	78%	44	83%	38	69%	33	73%	43	81%	22	63%	38	86%
No	32	18%	11	15%	9	17%	12	22%	8	18%	8	15%	11	31%	4	9%
Dont know	16	6%	5	7%	0	6%	5	9%	4	9%	2	4%	2	6%	2	5%
Prost i tutes																
Yes	156	65%	66	88%	47	89%	43	78%	371	82%	49	91%	26	74%	40	89%
No	15	8%	4	5%	5	9%	6	11%	3	7%	3	6%	6	17%	3	7%
Dont know	1 2	7%	5	7%	1	2%	6	11%	5	11%	2	4%	3	9%	2	4%
IV drug users																
Yer	140	85%	57	89%	41	85%	42	81%	36	86%	42	91%	22	71%	36	88%
No	13	8%	2	3%	6	13%	5	10%	2	5%	2	4%	6	19%	3	7%
Dont know..	11	7%	5	8%	1	2%	5	10%	4	10%	2	4%	3	10%	2	5%

Table 7 : Attitudes and Opinions

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-core providers		Western		Northern		Control		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Health care workers should be paid more																
Strongly agree.....	67	47%	30	39%	33	61%	24	44%	23	50%	29	54%	13	37%	20	44%
Agree.....	65	35%	29	38%	15	28%	21	39%	16	35%	19	35%	12	34%	16	36%
Disagree.....	26	14%	13	17%	5	9%	8	15%	5	11%	6	11%	10	29%	5	11%
Strongly dieagree.....	6	3%	4	5%	1	2%	1	2%	2	4%	0	0%	0	0%	4	9%
Employerr have right to test employee8 for HIV																
Strongly agree.....	34	19%	12	16%	8	15%	14	27%	10	22%	a	15%	5	14%	9	21%
Agree.....	54	30%	18	24%	16	30%	20	38%	16	35%	15	29%	10	29%	13	30%
Disagree.....	67	37%	34	46%	21	39%	12	23%	18	39%	23	44%	9	26%	15	35%
Strongly disagree.....	25	14%	10	14%	9	17%	6	12%	2	4%	6	12%	11	31%	6	14%
Non-dircrimination laws should be passed																
Strongly agree.....	55	31%					14	27%	11	25%	15	29%	13	37%	15	35%
Agree.....	79	44%	22	29%	19	37%	24	47%	21	48%	26	50%	13	37%	18	42%
Disagree.....	34	19%	18	24%	5	10%	11	22%	10	23%	9	17%	7	20%	7	16%
Strongly disagree.....	10	6%	3	4%	5	10%	2	4%	2	5%	2	4%	2	6%	3	7%
Med. clinics should be set up for HIV+ people																
Strongly agree.....	103	56%					21	40%	19	41%	35	65%	21	60%	25	57%
Agree.....	72	39%	28	38%	18	22%	30	57%	22	48%	18	33%	13	37%	18	41%
Dlragree.....	8	4%	4	5%	2	4%	2	4%	5	11%	1	2%	1	3%	1	2%
People w/AIDS should be isolated/quarantined																
Strongly agree.....	18	10%	8	11%	3	6%	7	13%	2	9%	4	7%	2	6%	7	17%
Agree.....	36	20%	15	20%	12	23%	9	17%		4%	15	28%	7	20%	10	24%
Dieagree.....	87	48%	36	47%	22	42%	29	55%	31	67%	26	48%	12)	34%	17	40%
Strongly diragree.....	40	22%	17	22%	15	29%	8	15%	9	20%	9	17%	14	40%	8	19%

(continued)

Table 7 : Attitude8 and Opinions

	Total		Occupation						Region of state							
	N	%	M.H. Clinician8		Medical staff		Non-core providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Should not have to admit HIV+ patients/clients		8%		4%		9%										9%
Agree	15	9%	3	8%	6	11%	4	8%	4	9%	3	8%	2	6%	6	14%
Disagree	80	46%	37	49%	28	38%	25	48%	26	58%	29	55%	18	29%	16	37%
Strongly disagree	67	37%	29	39%	22	42%	16	31%	10	22%	17	32%	22	63%	17	40%
Should be able to refuse to work w/HIV+ client8																
Strongly agree	23	13%	18	13%	6	11%	7	14%	8	18%					7	16%
Agree	70	39%	32	43%	18	33%	28	39%	15	33%	4	8%	3	9%	17	40%
Disagree	60	33%	23	31%	18	33%	19	57%	18	48%	27	51%	10	29%	12	28%
Strongly disagree	27	15%	10	13%	12	22%	5	10%	4	9%	17	28%	17	20%	7	16%

Table 8 : Knowledge of Testing

	Total		Occupation						Region of state							
			M.H. Clinicions		Medical star f		Non-core providers		Western		Northern		Control		Eastern	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Confirmed positive—will develop AIDS																
True	48	30%	17	25%	19	43%	12	26%	12	29%	17	36%	6	19%	11	31%
False	67	42%	33	48%	16	36%	18	38%	16	38%	22	47%	13	41%	15	43%
Dant know	45	28%	19	28%	9	20%	17	36%	14	33%	8	17%	13	41%	9	26%
Confirmed, positive— has AIDS																
True	34	21%	12	18%	14	30%	8	17%	7	17%	11	22%	8	24%	6	17%
False	94	58%	38	56%	31	66%	25	52%	24	57%	29	59%	16	48%	23	66%
Dont know	35	21%	18	26%	2	4%	15	31%	11	26%	9	18%	9	27%	6	17%
Confirmed pos. — is immune to virus																
True	7	4%	5	7%		5%	0		1	2%	1	2%	0	0%	5	14%
False	123	78%	46	69%	49	91%	37	7::	29	71%	40	87%	25	78%	25	71%
Dont know	28	18%	16	24%	2	5%	10	21%	11	27%	5	11%	7	22%	5	14%
Confirmed pos. — is carrying AIDS virus																
True	159	89%	64	86%	51	100%	44	83%	35	81%	51	94%	31	86%	38	93%
False	3	2%	1	1%	0	0%	2	4%	0	0%	2	4%	1	3%	0	0%
Dont know	16	9%	9	12%	0	0%	7	13%	8	19%	1	2%	4	11%	3	7%
Confirmed pos. — con transmit virus to others																
True	16	3%	61	82%	49	96%	2	73%	33	72%	42	94%	20	0%	31	88%
False	23	13%	94	12% 5%	02	0% 4%	12	24% 4%	9	21% 7%	3	6%	7	19%	4	10% 2%
Oont know																
Negative — definitely not carrying virus	31	19%					11	22%								
True	102	61%	42 12	59% 17%	34 a	74% 17%	26	53%	26 9	62% 21%	54 7	68% 14%	18 4	58% 13%	22 10	56% 26%
False																
Dont know	33	20%	17	24%	4	9%	12	24%	7	17%	9	18%	9	29%	7	18%

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Table 8 : Knowledge of Testing

	Total		Occupation						Region of state							
	N	%	M.H. Clinician*		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Negative – probobl y not carrying virus																
False	123	72%	57	78%	15	31%	36	73%	28	20%	46	75%	27	82%	26	65%
True	22	13%	5	7%	16	33%	2	4%	6	4%	7	11%	0	0%	7	17%
Dont know	26	15%	11	15%	4	8%	11	22%	6	15%	7	13%	6	18%	7	17%
Negot ive – person cannot acquire the virus																
True	8	5%	3	4%	5	11%	0	0%	1	2%	2	4%	3	9%	2	5%
False	136	83%	56	80%	40	87%	40	85%	35	85%	43	91%	23	72%	31	79%
Dont know	19	12%	11	16%	1	2%	7	15%	5	12%	2	4%	6	19%	6	15%
Negative – can still get the virus from others																
True	153	86%	62	83%	47	94%	44	85%	36	82%	48	91%	32	91%	35	85%
False	9	5%	4	5%	3	6%	2	4%	3	7%	3	6%	0	0%	1	2%
Dont know	15	8%	9	12%	0	0%	6	12%	5	11%	2	4%	3	9%	5	12%

Table 9 : Additional Information Desired

	Totol		Occupation						Region of stote							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Medical information about AIDS																
Yes, checked item	104	54%	39	48%	33	60%	32	56%	23	48%	34	60%	17	46%	28	61%
Did not check	89	46%	42	52%	22	40%	25	44%	25	52%	23	40%	20	54%	18	39%
AIDS-related **syptoms**																
Yes, checked item	117	61%	46	57%	35	64%	36	63%	28	58%	32	56%	23	62%	32	70%
Did not check	76	39%	35	43%	20	36%	21	37%	20	42%	25	44%	14	38%	14	30%
Psychological effects of AIDS																
Yes, checked item	114	59%	53	65%	32	58%	29	51%	26	54%	35	61%	21	57%	30	65%
Did not check	79	41%	28	35%	23	42%	28	49%	22	46%	22	39%	16	43%	16	35%
Psychological effects of HIV+																
Yes, checked item	98	51%	45	56%	26	47%	27	47%	25	52%	27	47%	20	54%	24	52%
Did not check	95	49%	36	44%	29	53%	30	53%	23	48%	30	53%	17	46%	22	48%
Legal orpecto of AIDS																
Yes, checked item	113	59%	48	59%	29	53%	36	63%	27	56%	38	67%	18	49%	26	57%
Did not check	80	41%	33	41%	26	47%	21	37%	21	44%	19	33%	19	51%	20	43%
Effects on patients lives																
Yes, checked item	69	36%	32	40%	18	33%	19	33%	17	35%	22	39%	10	27%	18	39%
Did not check	124	64%	49	60%	37	67%	38	67%	31	65%	35	61%	27	73%	28	61%
What type of core is needed																
Yes. checked item	83	43%	34	42%	25	45%	24	42%	20	42%	21	37%	16	43%	24	52%
Did not check	110	57%	47	58%	30	55%	33	58%	28	58%	36	63%	21	57%	22	48%
How much core Is needed																
Yes, checked item	55	28%	20	25%	17	31%	18	32%	12	25%	18	32%	6	16%	17	37%
Did not check	138	72%	61	75%	38	69%	39	68%	36	75%	39	68%	31	84%	29	63%
Methods of AIDS prevent ion																
Yes. checked item	90	47%	37	46%	20	36%	33	58%	26	54%	28	49%	13	35%	21	46%
)id not check	103	53%	44	54%	35	64%	24	42%	22	46%	29	51%	24	65%	25	54%
4dvonces in treatment/prevention																
Yes, chroked item	107	55%	40	49%	33	60%	34	60%	27	56%	31	54%	21	57%	25	54%
)id not check	86	45%	41	51%	22	40%	23	40%	21	44%	26	46%	16	43%	21	46%

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Table 9 : Additional Information Desired

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-core providers		Western		Northern		Central		Eostern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
How to give preventive rducat ion																
Yes, checked item.....	102	53%	38	47%	29	53%	35	61%	25	52%	33	58%	17	46%	25	54%
Did not check.....)	91	47%	43	53%	26	47%	22	39%	2 3	48%	24	42%	20	54%	21	46%
Community resourcea for people w/AIDS																
Yes, checked item.....	85	44%	39	48%	23	42%	23	40%	21	44%	32	56%	11	30%	19	41%
Did not check.....	108	56%	42	52%	32	56%	34	69%	27	56%	25	44%	26	70%	27	59%
Community resources for family and friends																
Yes. checked item.....	73	38%	34	42%	18	33%	21	37%	21	44%	23	48%	9	24%	17	37%
Did not check.....	120	62%	47	58%	37	67%	36	63%	27	56%	34	69%	28	76%	29	63%
Medical care for HIV+ individuals																
Yes, checked item.....	78	40%	29	36%	33	60%	16	28%	17	35%	24	42%	12	32%	23	50%
Did not check.....	115	69%	52	64%	22	49%	41	72%	31	65%	33	58%	25	68%	23	50%
Financial help for HIV+ individuals																
Yes, checked item.....	71	37%	33	41%	16	29%	22	39%	17	35%	22	39%	8	22%	22	48%
Did not check., ...	122	63%	48	59%	39	71%	35	61%	31	65%	35	61%	29	78%	24	52%
Effects on family and friends																
Yes. checked item.....	75	39%	31	38%	16	29%	28	49%	20	42%	22	39%	13	35%	19	41%
Did not check.....	118	61%	50	62%	39	71%	29	51%	28	58%	35	61%	24	65%	27	59%
Antibody testing																
Yes, checked item.....	83	43%	36	44%	21	38%	26	46%	19	46%	28	49%	13	35%	21	46%
Did not check.,.....	110	57%	45	56%	34	62%	31	54%	29	60%	29	51%	24	65%	25	54%
Infection control																
Yes. checked item.....	87	45%	32	40%	30	55%	25	44%	19	40%	30	53%	12	32%	24	52%
Did not chock....	106	55%	49	60%	25	45%	32	56%	29	60%	27	47%	25	68%	22	48%
Civil rights of AIDS/HIV infected																
Yes, checked item..	85	44%	39	48%	19	35%	27	47%	20	42%	28	49%	14	38%	20	43%
Did not oheak.....	106	56%	42	52%	36	65%	30	53%	26	58%	29	51%	23	62%	26	57%

Table 10: Plans for Information Learned at Training

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical staff		Non-care providers		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Will disseminate info to other staff																
Yes, checked item.....	133	69%	51	63%	38	69%	44	77%	31	65%	32	56%	33	89%	33	72%
Did not check.....	60	31%	30	37%	17	31%	13	23%	17	35%	25	44%	4	11%	13	28%
Will train to other staff on AIDS/HIV infection																
Yes, chocked itom.....	48	25%	11	14%	13	24%	24	42%	16	33%	5	9%	12	32%	11	24%
Did not check.....	145	75%	70	86%	42	76%	33	58%	32	67%	52	91%	25	68%	35	76%
Will serve as AIDS resource person																
Yes, checked Item.....	49	25%	19	23%	15	27%	15	26%	13	27%	13	23%	9	24%	12	26%
Did not check.....	144	75%	62	77%	40	73%	42	74%	35	73%	44	77%	28	76%	34	74%
Learn to protect myself from infect ion																
Yes, chocked Item.....	119	62%	47	58%	36	65%	36	63%	35	73%	33	58%	19	51%	30	65%
Did not check.....	74	38%	34	42%	19	35%	21	37%	13	27%	24	42%	18	49%	16	35%
Better inform others how to protect themselves																
Yes, chocked item.....	140	73%	49	60%	47	85%	44	77%	36	75%	43	75%	26	70%	33	72%
Did not check.....	53	27%	32	40%	8	15%	13	23%	12	25%	14	25%	11	30%	13	28%
Provide counseling for HIV Infected																
Yes, checked item.....	87	45%	49	60%	26	47%	12	21%	19	40%	31	54%	13	35%	23	50%
Did not check.....	106	55%	32	40%	29	53%	45	79%	29	60%	26	46%	24	65%	23	58%
Provide counrrling for families																
Yes, checked iton.....	32	17%	16	20%	8	15%	8	14%	5	10%	11	19%	5	14%	10	22%
Did not check.....	161	83%	65	80%	47	85%	49	86%	43	90%	46	81%	32	86%	36	78%

(continued)

Table 10 : Plans for Information Learned at Training

	Total		Occupation						Region of state							
	N	%	M.H. Clinicians		Medical rtaf f		Non-core providera		Western		Northern		Central		Eastern	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%
Role— ● due. needs of incarcerated clients																
Yes, checked item.....	109	56%	46	57%	33	60%	30	53%	24	50%	37	65%	19	51%	27	59%
Did not check.....	84	44%	35	43%	22	40%	27	47%	24	50%	20	35%	18	49%	19	41%
Role —educ. needs of cl ients upon release																
Yes, checked item.....	61	32%	28	35%	20	36%	13	23%	13	27%	20	35%	10	27%	17	37%
Did not chock.....	132	68%	53	65%	35	64%	44	77%	35	73%	37	65%	27	73%	29	63%
Identify community resources																
Yes, chocked item.....	69	36%	35	43%	18	33%	16	28%	17	35%	18	32%	8	22%	24	52%
Did not check.....	124	64%	46	57%	37	67%	41	72%	31	65%	39	68%	29	78%	22	48%

APPENDIX VIII

Evaluation Conducted

Sample Instrument Used by MARC to Evaluate Customized Training Courses

MARYLAND AIDS PROFESSIONAL EDUCATION CENTER

Course Evaluation

We are interested in your evaluation of this program, and will use this information to plan future education programs. We thank you for your assistance.

Part One: Objectives

Please evaluate the extent to which the stated objectives for this program have been achieved.

	not at all				very much so
1. Explaining the natural history, transmission, and prevention of HIV.	1	2	3	4	5
2. Identifying values and barriers which affect communication with clients.	1	2	3	4	5
3. Identifying methods for coping with stress.	1	2	3	4	5

Part Two: Faculty

Please evaluate the content, delivery, and organization of the presentations made by each faculty member.

		poor				excellent
1. Debra Kosko	content	1	2	3	4	5
	delivery	1	2	3	4	5
	organization	1	2	3	4	5

Comments_____

2. Jeanine Driscoll	content	1	2	3	4	5
	delivery	1	2	3	4	5
	organization	1	2	3	4	5

Comments_____

Part Three: Overall Evaluation

	not at all				very much so
1. Usefullness of audio/visual materials	1	2	3	4	5
Comments _____					
2. Usefullness of handouts	1	2	3	4	5
Comments _____					
3. How useful was this program to you?	1	2	3	4	5
4. Rate the overall quality of this educational program.	1	2	3	4	5

We welcome any additional comments or sugestions to assist us in developing future educational programs:

_____

_____

_____

APPENDIX IX

Evaluation Conducted

MARC Evaluation of HIV Counselor Training Courses

1. Cover memo returning results to faculty
2. Course Evaluation Form (Maintenance level formative evaluation)
   Analysis of Course Evaluation responses
2: Sample Pre/Post-Training Knowledge test
5. Analysis of Pre/Post-Training Testing
6. Sample "Initial Response" Pre and Post-Training Tests, and Rating Scale

Please complete for our records:
Profession: __Nurse __Counselor __Social Worker __Physician __Other _____

county: _____ SS#: _____ Date: _____

AIDS ADMINISTRATION, DHMH • MARYLAND AIDS PROFESSIONAL EDUCATION CENTER

HIV COUNSELOR TRAINING **COURSE EVALUATION**

~~April 17-20, 1990~~ May 29 • a 1, 1990
Elkton, Maryland Hagerstown M

We are interested in your reactions to this workshop, and will use the information you share with us in planning for future trainings. We thank you for your cooperation.

PART ONE: OBJECTIVES

Please evaluate to what extent the stated objectivesof this conferencehave been achieved for you using the following scale:

NA = Not Applicable Not At All = 1 2 3 4 5 = Very Much So

1.	Explaining the epidemiology, natural history, transmission and prevention of HIV disease.	NA	1	2	3	4	5
2.	Understanding HIV antibody testing	NA	1	2	3	4	5
3.	Recognizing the psycho-social aspects of HIV infection for patients and their significant others	NA	1	2	3	4	5
4.	Identifying effective counseling techniques	NA	1	2	3	4	5
5.	Providing HIV antibody pre-and post-test counseling	NA	1	2	3	4	5
6.	Being aware of the special needs of drug abusing clients	NA	1	2	3	4	5
7.	Describing HIV partner notification in Maryland and related counselor responsibilities	NA	1	2	3	4	5
8.	Being aware of the special implications of HIV for women	NA	1	2	3	4	5
9.	Describing mental health aspects of HIV disease	NA	1	2	3	4	5
10.	Identifying stress managementtechniquesfor the HIV counselor	NA	1	2	3	4	5

PART TWO: SPEAKER EFFECTIVENESS

		Not Effective				Very Effective
Primary Faculty:	Joan Garrity	1	2	3	4	5
	Sarah Bur	1	2	3	4	5

		Not Effective				Very Effective
Guest Faculty:	Iris Beard	1	2	3	4	5
	John Budin, M.D.	1	2	3	4	5
	William Lowry	1	2	3	4	5
	Kim Seechuk	1	2	3	4	5

Comments: _____

PART THREE: SUMMARY

1.	Please rate the overall educational quality of this workshop.	Poor	1	2	3	4	5 Excellent
2.	How useful was this training to you?	Poor	1	2	3	4	5 Excellent

3. What was the most helpful aspect/information in this training?

4. List the least helpful aspects of this training.

5. One way this experience has changed my thinking is:

6. Was the physical environment conducive to learning (ie., lighting, noise level, etc)? If not, how could it be improved?

7. We welcome any suggestions for improvement, additional comments, or desires for future training needs you have.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. WHEN FINISHED, PLEASE RETURN TO SYLVIA SCHERR - ADMINISTRATOR, MARYLAND AIDS PROFESSIONAL EDUCATION CENTER, BOX 243, 22 S. GREENE STREET, BALTIMORE, MD 21201-l 595. THANK YOU.

HIVHAGER.XLS

	A	B	C	D	E
1	HIV COUSELOR TRAINIG MAY 29-JUNE 1, 1990 HAGERSTOWN, ND				
2					
3			KNOWLEDGE ASSESSMENT		
4	PARTICIPANTS		PRE-TEST	POST-TEST	CHANGE
5	1		12	23	11
6	2		20	23	3
7	3		17	23	6
8	4		19	24	5
10	5		15	23	8
	6		17	23	6
11	7		15	18	3
12	8		16	22	6
13	9		17	24	7
14	10		15	18	3
15	11		16	24	8
16	12		13	0	-20
17	13		17	19	6
18	14				20
19	15		17	24	7
281	16		20	23	3
21	171		18	231	5
22	18		221	23	1
23	19		20	22	2
24	20		15	22	7
25	21		23	24	1
26	22		121	20	8
27	23		15	25	10
28	24		14	22	8
29	25		23	23	0
30	26				0
31	27				0
32	28				0
34	30				0
35					0
36	SUMS		4281	535	187
37	MEANS		17.121	21.4	3.56666667

HIVHAGER.XLS

	F	G	H	I	J	K	L
1							
2							
3		INITIAL RESPONSE				EVALUATION	
4		#1	#2	CHANGE		1	2
5				0		4	4
6				0		4	5
7				0		3	4
8				0		5	5
9				0		5	5
10				0		5	4
11				0		5	5
12				0		3	4
13				0		5	5
14				0		4	4
15				0		4	4
16				0		5	5
17				0		4	5
18				0		3	5
19				0		3	4
20				0		4	3
21				0		5	5
22				0		5	5
23				0		5	5
24				0		5	4
25				0		3	5
26				0		4	4
27				0		4	4
28				0		5	5
29				0		5	5
30				0		4	4
31				0		4	5
32				0			
38				0			
35				0			
36		0	0	0		115	122
37		#DIV/0!	#DIV/0!	0		4.259	4.519

HIVHAGER.XLS

	M	N	O	P	Q	R	S	T	U	V
1										
2										
3	OBJECTIVES									
4	3	4	5	6	7	8	9	10	SUM	
5	4	4	4	4	4	4	4	2	38	
6	4	5	5	4	3	5	5	4	44	
7	4	3	3	3	4	4	3		31	
8	5	5	4	4	4	4	3	3	42	
9	5	5	4	4	4	4	4	5	45	
10	4	5	5	4	4	5	5	5	46	
11	5	5	5	4	4	5	3	4	45	
12	4	5	4	4	4	4	3	3	38	
13	5	5	5	4	5	5	4	3	46	
14	3	3	4	3	3	5	3	3	35	
15	5	5	5	3	3	4	5		38	
16	5	5	5	3	3	5	5		41	
17	5	5	5	5	4	5	4	3	45	
18	5	5	5	3	4	3	3		36	
19	4	4	5	5	4	4	4		37	
20	4	3	3	3	3	3	3	4	33	
21	4	5	5	4	4	5	4	4	45	
22	5	5	5	3	5	5	5		43	
23	5	5	5	4	4;		5	5	4	47
24	5	4	5	4	5	5	4	4	45	
25	3	3	4	3	4	3	2	1	31	
26	5	5	5	4	4	3	4	4	42	
27	5	5	5	4	4	4	4		39	
28	5	5	5	5	5	5	4	5	49	
29	5	5	5	4	4	3	4		40	
30	4	5	5	4	3	4	3		36	
31	4	5	5	3	4	4	4		38	
32									0	
33									0	
34									0	
35										
36	121	124	1251		102	106	115	161	1095	
37	4.481	4.593	4.63	3.778	3.926	4.259	3.852	3.588	36.5;	

HIVHAGER.XLS

	W	X	Y	Z	AA
1					
2					
3	PART TWO - SPEAKER EFFECTIUENESS				
4	GARRITY	BUR	BEARD	BUDIN	'LOWRY
5	4	4	4	4	4
6	5	5	3	4	5
7	4	4	4	4	4
9	5	51	4	3	3
	5	5	5	4	4
10	5	5	4	4	
11	5	5	4		4
12	5	5	3	4	4
13	5	5		3	3
14	5	5	3 4;	3	4
15	5;	5		3	4
16	5	5	3	5	4
17	5	5	3i	3	4
19	5	5			3
	4	4	4	4	4
20	4	4	3	3:	3i
21	5	5	4	4	5
22	5	5	4	3	4
23	5	5	3	3	4
24	5	5	3i	3	3
25	4	3	3	2	4
26	5	5	4	31	5
27	5	5	4	4	4
28	51	5	5	5	5
29	5	5	5;	4	5
30	4	4	31	3	4
31	5	3	2	3	3
32					
33					
34					
35					
36	1291	126	91i	881	183
37	4.777777778	4.666666667	3.64	3.52	3.96153846

HIVHAGER.XLS

	AB	AC	AD	AE	AF	AG
1						
2						
3				FACULTY-SUMS		
4	SEECHUK			PRIMARY	SECOND	TOTAL
5	4			8	16	24
6	3			10	15	25
7	4			8	16	24
8	3			10	13	23
9	5			10	18	28
10	5			10	13	23
11	4			10	12	22
12	4			10	15	25
13	5			10	14	24
14	4			10	15	25
15	2			10	9	19
16	4			10	16	26
17	5			10	15	25
18				10	3	13
19	4			8	16	24
20	2			8	11	19
21	4			10	17	27
22	4			10	15	25
23	3			10	0	23
24	4			10	13	23
25	3			7	12	19
26	5			10	17	27
27	4			10	16	26
28	5			0	20	30
29	4			0	18	28
30	3			0	13	21
31	3			0	11	19
32				0	0	0
33				0	0	0
34				0	0	0
35						
36	100			219	369	637
37	3.846153846			7.3	12.3	21.2333333

HIVHAGER.XLS

	AH	AI	AJ	AK
1				
2				
3		SUMMARY		
4		1	2	SUMS
5		4	4	8
6		5	5	10
7		4	4	8
8		5	5	10
9		5	4	9
10		5	5	10
11		5	5	10
12		4	5	9
13		5	5	10
14		4	4	8
15		5	5	10
16		5	5	10
17		5	5	10
18		5	5	10
19		4	4	8
20		4	4	8
21		5	5	10
22		5	5	10
23		5	5	10
24		5	5	10
25		4	3	7
26		5	4	9
27		5	5	10
28		5	5	10
29		4	3	7
30		4	4	8
31		4	5	9
32				0
33				0
34				0
35				
36		125	123	248
37		4.62962963	4.55555556	8.26666667

HIV COUNSELOR TRAINING COURSE EVALUATION
May 29June 1, 1990
Hagetstown, Maryland

Part Two: Speaker Effectiveness

Comments

1. Would have liked more information to help clients who are developing symptoms.

2. Joan and Sarah were very, very informed. I liked the atmosphere and "special effects" **used to present material.**

5. John **Budin,** M.D., needed more time. John and Sarah are very dynamic instructors-I really enjoyed the complete workshop. You kept all interesting, relaxed, and full of information, given us much to take home, **plus the** resources.

8. Iris-spoke too fast and gave info re: completing forms et al which would be better addressed in different setting.

9. John **Budin** was a very good speaker, provided interesting case studies and insight, but did not have enough time. I felt cheated out of a very important part of this program.

10. I am still of the personal belief that some behaviors are wrong no matter how prevalent the behavior is **but** I love all people and accept them where they are unjudgemental.

14. I could have done without guest speakers-I feel Joan and Sarah came off with such enthusiasm that they would have been better at teaching. I enjoyed seeing tape of patient.

17. Please allow more time for Dr. **Budin--it** was somewhat rushed and is indeed an important **part of the whole picture.**

18. More time allowed to John **Budin.**

20. Iris-information too fast.

23. It was very enlightening to hear someone who was HIV+.

28. Iris Beard and John **Budin** were given less than one hour and rushed at the end of the day. They were not able to present in a related manner.

Part Three: Summary

3. What was the most helpful aspect/information in this training?

1. **Explanation of conversion window.**

2. Counselor training, reinforcement of information.

3. Role-playing, talking with people in similar fields of experience.

4. Counselor techniques.

5. Learning in counseling there is no exact way to counsel in AIDS as in any counseling.

8. I understand more about HIV, I learned a lot of tactics on how to interview patients.

7. Individual (3 person) groups for practicing counselor/client/observer.

8. HIV and drugs, the dreaded role play, recognizing similarities in training, meeting folks involved in the field, etc.
9. The role playing helped me to identify areas of improvement but gave me a chance to observe others.
10. HIV content-coveringcounselor skills.
11. The comprehensive, sensitive, skillful teaching of how to do pre- and post-test counseling.
12. Network of resources (people).
13. The updating initial knowledge with the latest info.
14. Learning more about HIV infection, having HIV infected patient coming to talk with us, and role modeling between Joan and Sarah-would have liked more.
15. Women and HIV.
16. You don't have to know it all--there are many available resources.
17. Test interpretation in role playing, participants from vast areas.
18. Practice session for counseling.
19. Explaining HIV disease and specifics of transmission. Using counseling skills in practice.
20. Working in groups, being able to understand and giving the right information.
21. Information (factual) about AIDS, what health departments are doing.
22. Information presented in a discussion type setting involving all members.
23. The quality of concern that the instructors had for this area, notebook full of information.
24. Counseling skills around this issue since I work in addiction.
25. HIV antibody testing results.
26. Insight into the specifics of counseling and specifics of pre- and post-test counseling experience.
27. Finding out what HIV counselors should know and what skills to use in HIV counseling.

4. List the **least** helpful aspects of this training.
1. None other than 3 hours driving everyday.
2. The talk on statistics.
4. Everything was very helpful, I cannot identify.
7. The discussion of forms by Iris. It seems like that should be an individual agency problem. It would be ideal if there were State-wide forms for all HIV testing.
8. Counseling and testing site program.
PWA-becauseof continued exposure.
9. I can't think of any.
10. I would like to have seen more training on counselling clients on plans after the interviews.
11. STD slide presentation.
13. All will be helpful.

14. I would have liked to have gone into the medical aspects of HIV infection, so that if questions arise, I would be able to answer them.
18. The numbers, "What did Kim talk about?"
17. What State agencies' policies are, what your duties are.
18. Statistical data presentation by Seechuk.
20. None.
21. Counseling techniques-most social workers have extensive training in this area.
23. The skill practices.
25. Partner notification.
28. Extensive amount of time given to own feeling and attempts to counsel in non-clinic (HIV) setting.
27. Disconnections: need smooth transition between components.

5. One way this experience has changed my thinking is:
2. Has reinforced my thinking.
4. It has cleared up my misgivings.
5. Again no specific way to-important for Rx of AA/NA before the HIV disease.
8. I feel more secure that I will do my job right.
7. Caused more frustration in thinking of how poorly our HD deals with the clients' needs. (Some administrators meet their needs only).
8. N/A-I'm still a "bleeding heart pinkocommie" and happy to see so many others.
9. I realized that my concern about time limitations occurs in other settings. But that effective information gathering and counselling can still be done well. I am more aware of the important areas that I need to focus on.
10. More knowledge of national aspect; ie. relation to drugs, problems in women, pregnancy, etc.
11. Much needs to be done with and for the professionals who are handling this component of the epidemic.
12. Reassurance.
13. To keep up to date on new literature/studies and it reinforces the networking value.
14. We've come a long way-education professionals but so much more needs to be done to rid the stigma of "AIDS" as a dying disease. More hope needs to be given.
15. There is no right **or wrong way to counsel.**
16. The importance and need for pre/post-counseling.
17. Importance of "total" pre-testing-hit all educational aspects of HIV.
18. Broaden my base of knowledge-moreeffective counseling techniques.
19. HIV+ reaches everyone.
20. Stressful and how counselors and clients deal with problems.

21. More frightened than when I started. it's more persons than I had thought.
22. I realize I need to be more in tune with identifying feelings in people.
23. It has increased my knowledge base related to HIV infection.
24. Increased my awareness and seriousness of this disease, increased my awareness about what needs to be addressed around the test issue.
25. I have developed a real understanding of how stressful HIV testing is for the counselor and client.
26. I feel I can explain or allow the patient to explain their feelings, with enough control to keep the whole generally focused.
27. There is still so much to learn, share, and do.

6. **Was the physical environment conducive to learning (ie., lighting, noise level, etc.)? If not, how could it be improved?**

1. Noise level on last day was distraction (they were setting up for a prom in the next room).
2. Yes.
4. We had very little distractions. There was no problem.
5. Yes.
7. Yes.
8. Some difficulty with heat/sound and lighting but overall very good facility.
9. Fine. Could you inform the Ramada Inn chain's interior decorator not the use he color orange?
10. It was fine for me.
11. Yes.
12. Yes-a bit much orange!
14. I was very comfortable, there were enough breaks, and I really liked the 1 1/2 hour lunch, which gave me time to read my manual and to review what was said.
15. Yes.
16. For the most part.
17. Somewhat noisy at times, temperature uneven from day to day.
18. O.K.
19. Lighting could have been a bit brighter.
20. Excellent.
21. Air conditioning didn't work.
23. Good.
24. Yes.
25. The original room was great. The second room was set up different. We had people on the other side of the table who sometimes got in the way.
26. The room, especially the halls, smelt unclean, musty; leaky ceiling.
27. No orange, poorly sound-proofed room. Temperature control very poor. Ceiling tiles fell in Room I. tights flickered. Chairs were not comfortable.

7. We welcome any suggestions for improvement, additional comments, or **desires for future training needs you have.**

1. **closer** to Cumberland.
2. You guys are great! Segments are interesting, diverse, etc. to give information and maintain interest. Nicely interactive.
4. I really couldn't suggest any improvement.
5. The notebook was very useful-organizedto keep (hopefully) updated,
6. All the nurses or counselors should learn about how to deal with different culture patients, too-so we're not accidentally insulting the patient's culture.
9. Very good presentation, no additional comments.
11. You are both exceptional trainers! Thank you for four days of quality inservice!
13. No suggestions; the best seminar/sessions I have attended in several years. Thank you.
14. Longer.
15. We covered a lot of information in a short amount of time.
17. Excellent conference.
20. Keep your training to 30 health care providers-no more. Better to learn in smaller groups.
21. Should have 10 minute break every hour. Encourage more interaction between participants.
22. Being able to do initial response sheets and going over them in groups was extremely helpful.
23. Have available fruit, cheese, or crackers instead of mints.
25. Less time on feelings more on content. The AIDS questionnaire is vital for funding, grants, and statistics and was covered too quickly,
26. More truth in advertising, **ie.** heavy counseling emphasis.
Intermix didactics with counseling exercises to aid those with some counseling background from becoming bored or displaced mentally.
27. Brewed **decaf** coffee.

1

13/25

NAME: _____
S.S.#: _____
DATE: 5/29/90

HIV Counselor Training
AIDS Administration, **Maryland DHMH**
Pre-test

Dear Participant:

Don't panic. This is not a test! The only way to show that this four-day counselor training is worthwhile is to assess what knowledge you have gained from the beginning to the end of the course. Thanks for your cooperation!

A. MULTIPLE **CHOICE:** Please write the number that indicates the best answer on the line to the right of the question

1. HIV primarily infects: 1. 1

   1. T helper cells
   2. Killer T cells
   3. **B** cells
   4. Squamous epithelial cells
   5. Polymorphonuclear leukocytes

2. What is the chance that a baby of an **HIV** infected pregnant woman will be infected? 2. 2

   1. less than 10%
   2. **20-50%**
   3. **50-75%**
   4. **70-90%**
   5. 100%

3. **HIV** infection in a baby can be reliably diagnosed with an **HIV** antibody test at: 3. 2

   1. birth
   2. 3-5 months
   3. 6-8 months
   4. 12-14 months
   5. 15-18 months

4. Which of the following sexual activities between a **HIV** infected man and an uninfected woman poses the **GREATEST** risk of transmitting **HIV** infection to the woman? 4. 1

   1. anal intercourse
   2. vaginal intercourse
   3. rimming
   4. woman performing oral sex on man
   5. fisting

5. In most people infected with BIV, it takes **how long** for antibodies to appear? 5. 2

   1. 6- 12 days
   2. 6 weeks to 6 months
   3. 2 - 4 years
   4. 2 - 15 years

6. The **most significant indicator that a client is immediate danger of commiting suicide is:** 6. X 4

1. **lack of a support** system
2. a plan for suicide and the means to carry it out
3. lack of immediate plans to stay involved in work or other activities
4. fear of disclosure of antibody status

7. The **most common ways HIV is transmitted are:** 7. 2

1. blood, saliva and vaginal secretions
2. sexual intercourse, blood to blood, perinatal
3. needlesticks, non-intact skin and mucous membrane contact
4. airborne and vector transmission

8. **Which of the following is true about pneumocystis pneumonia:** 8. 4

1. **It causes AIDS.**
2. **It is a mild lung infection.**
3. **It cannot be prevented.**
4. **It is one of many AIDS-defining illnesses.**
5. **A** common symptom is coughing up blood.

B. **MULTIPLE/MULTIPLE CHOICE:** Please **write the NUMBER** that **indicates the best answer.**

9. **Which of the following is TRUE regarding pregnancy and HIV infection:** 9. X 3

a. **Women with HIV infection have more rapid progression of HIV disease if they are pregnant.**
b. **It is recomended that HIV infected women not breast feed.**
c. **C-Section delivery is recomended for** BIV **infected women.**
d. **HIV infected women should avoid having sex while pregnant.**

1. a only
2. b only
3. a and b
4. a, b and c
5. **a,** b, c and d

10. Cocaine: 10. 5

a. can be snorted
b. can be smoked
c. can be injected
d. is a stimulant
e. initially decreases interest in sex

1. a only
2. a and c
3. a, b and c
4. a, b, c and d
5. a, b, c, d and e

11. At the Maryland State Laboratory, an overall BIV antibody test interpretation of indeterminant can mean: 11. ___

a. ELISA positive/Western Blot indeterminant
b. ELISA positive/Western Blot negative
c. inadequate serum to perform test

1. a only
2. b only
3. a or b
4. b or c
5. a, b or c

12. The handling of partner notification is: 12. 4

a. a relevant patient concern which should be handled without health department interference.

b. a relevant issue that the HIV Counselor should address with the seropositive client.

c. an extremely sensitive issue which should only be discussed if the patient requests assistance.

d. a relevant issue that the HIV Counselor should address in the pre-test counseling session.

1. a only
2. b only
3. a and c
4. b and d
5. a, b, c, and d

13. If a patient's ELISA test is positive and the Western Blot is negative it means: 13. ~~X~~ —

a. the patient may be in the process of seroconverting
b. the patient should be encouraged to return in six weeks for a repeat blood test
c. the ELISA may be false positive

1. a only
2. b only
3. a and b
4. b and c
5. a, b and c

14. Which of the following methods of taking drugs place you directly at risk for HIV infection: 14. 4

a. smoking
b. intravenous injection
c. skin popping
d. snorting

1. a only
2. b only
3. a and b
4. b and c
5. a, b, c and d

15. Which of the following is true about a health care worker who gets a needlestick from from a needle which was used on an HIV infected patient: 15. ~~X~~ 5

a. A negative HIV antibody test 6 months after the accident indicates that transmission of HIV most likely has not occurred.
b. The likelihood of becoming infected with HIV is less than 1%.
c. The likelihood of becoming infected with HIV is 1-2%.

1. a only
2. b only
3. c only
4. a and b
5. a and c

16. Reuropsychiatric symptoms seen in BIV infected persons may be attributed to:

16. ___

1. invasion of the central nervous system by HIV
2. infectious agents other than HIV
3. tumors of the central nervous system
4. psychological reactions to being HIV infected
5. toxic/metabolic reactions such as medication side effects or nutritional deficiencies

1. a only
2. b only
3. **a, b, c**
4. **a, b, c, d**
5. **a, b, c, d, e**

17. In counseling about safer sex, the best approach with resistant clients is to:

17. 5

a. allow the client to explore their resistance
b. help the client to develop strategies to reduce risk
c. strongly insist on the use of condoms
d. strongly promote abstinence, so that other techniques appear more attractive by comparison
e. show pictures of seriously ill AIDS patients to encourage awareness of the consequences of unsafe sex

1. a only
2. b only
3. c only
4. a and b
5. **a, b, c, d, e**

C. **TRUE** OR FALSE - ON **THE ANSWER SHEET CIRCLE** "1" FOR **TRUE** OR "2" FOR FALSE

		TRUE	FALSE
18.	The main goal of pre-test counseling is to convince the client to be tested for **HIV antibodies**	18. 1	(2)
19.	Since risk-reduction **messages** were included in pre-test counseling, it is not necessary to repeat them during a post-test counseling session.	19. 1	(2)
20.	Asking a client directly about suicidal intent will not encourage the person to commit suicide.	~~20.~~ **1**	(2)
21.	A few cases of AIDS have been traced to saliva exchange in kissing,	~~21.~~ (1)	2
22.	Even if an addict is **HIV** infected, the addiction should generally be treated as the primary disease.	22. (1)	2
23.	In the United States, all blood for transfusion has been tested since May, 1983.	~~23.~~ (1)	2
24.	False positives with the ELISA could be due to the fact that a person has an illness that cross-reacts with the ELISA	24. (1)	2
25.	If an ELISA test is positive, the client's blood sample must be retested with a Western Blot to determine whether the client is truly HIV+.	**25.** (1)	2

HIV COUNSELOR TRAINING

Date: May 29 - June 1. 1990

PRE-TEST/POST-TEST SUMMARY

Total number of Participants = 27

Pre-test Mean = 66%
Median = 68%
Range = 32% - 88%

Post-test Mean = 88%
Median = 88%
Range = 76% - 100%

Analysis of Individual Questions:

Number of Incorrect Answers

Question #	Pre-test	Post-test	Question #	Pre-test	Post-test
1.	1	0	13.	13	5
2.	17	0	14.	14	4
3.	21	1	15.	14	5
4.	8	4	16,	13	3
5.	6	0	17.	12	6
6.	7	1	18.	4	0
7.	4	3	19.	2	2
a.	0	1	20.	6	4
9.	20	5	21.	3	4
10.	12	0	22.	6	0
11.	22	12	'23.	8	4
12.	3	3	24.	8	1
			25.	2	2

RECEIVED AUG 0 6 1990

State of Maryland

AIDS ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • (301) 225-1052

Adele Wilzack, R.N., M.S.
Secretary

Kathleen F. Edwards. Ph.D., R.N.
Director

MEMORANDUM

TO: Sylvia Scherr
Beth Wells
Joan Garrity

FROM: Sarah Bur SB

DATE: August 2, 1990

Enclosed is draft Initial Response Rating Scale and copies of responses from before and after the Elkton training. Please rate both according to the scale and then return.

Thanks! I'll schedule a follow-up meeting to discuss the reliability of our scale

SB:vl

Attachments

TTY for the Deaf:
Baltimore Area 383-7555

Draft 7/27/90

INITIAL RESPONSE RATING SCALE

Detracts (-1)

- negates or denies feelings
- makes assumptions
- does not accurately reflect feelings or content
- advice - giving
- judgmental attitude expressed

Neutral (0)

- non-harmful
- allows interaction to continue
- reflects content alone

Somewhat Facilitative (+1)

- accurately reflects feelings

Very Facilitative (+2)

- accurately reflects feelings and content

#1 April 17-20 Elkton md

Q# 1. "I just want you to know, if this teat is positive, I'm going to kill myself!"

# participant		
23	1.	Let's discuss the alternatives.
2	2.	Let's discuss your personal life style regarding your sexuality and substance use. From this information, I can evaluate your level of risk that you have incurred in the put. This will give us both the opportunity to look at your risk level and what the outcome of the test might be, and maybe we can go from there to look at options and health care.
24	3.	I know your scared about taking the test, but let's wait and see what the results show, then we can deal with this feeling.
9	4.	Thanks for letting me know how you're feeling. I want us to talk about this for a few minutes because this is very important.
14	5.	"I know this is very frightening, hut then are some medicines that are helping people."
1	6.	"If that is the way you are feeling, perhaps we need to take a look at whether you should have the test done at this time."
8	7.	Well, I hope you know that there are other options available to you, I hope you'll at least talk to ma before you kill yourself."
15	8.	You feel a positive test is the end - is that tight?
19	9.	Tell me why you want to kill yourself if this test is positive.
21	10.	"Let's talk about what the test results mean and then you can decide whether or not you want to be tested."
16	11.	You're concerned about having a. positive test. Tell me what you're thinking.
7	12.	I want to be able to say I don't have AIDS and be able to prove it.
13	13.	That's one option, however, you can still live a fulfilling life for several more years as you don't have any of the symptoms yet.
11	14.	That's fine - but just because the test is positive does not mean you will definately develop AIDS. Let's talk about this.
22	15.	I can understand what you mean, since all the news is filled with the fatality of the disease.
4	16.	Let me explain what test results mean so that you understand.
10	17.	"Let's talk about it!"
6	18.	It's scary facing the unknown, let's try to support each other.
18	19.	You start talking about killing yourself, let's talk about the test and what it means first.
20	20.	Why?
25	21.	This idea upsets you.
17	22.	You sound very angry about this.
12	23.	"That is an issue that we'll need to discuss before you take the test, and this might not even be the appropriate time for you to take the test..."
3	24.	Let's talk about this.
5	25.	You'd always have that option. You might consider learning a little more and living with it a while before you decide what to do.

ELKTON, MARYLAND
APRIL 20, 1990
INITIAL RESPONSE **#2**

11 One thing is for sure - If I've got this HIV, I'm going to get whoever gave it to me.

1. "You know, I'm sure there's nothing wrong **with me, but,** you know, just to be on the safe **side...you know, maybe** I **should** get this test."

1. YOU are concerned about your health and **if** you **have been** exposed to HIV.

2. You seem to be uncertain about being tested, Perhaps if we take a few minutes to talk about what high risk behavior **puts** a person at risk. Then you can decide whether you should be tested at this time.

3. Let's talk about what the test is about and then you **can** make an informed choice about taking it or not taking it.

4. You sound undecided about the test. Let's talk **about** this. After an explanation of the test, you can think about what you'd like to do.

5. Have you thought about how you might react if your test were positive?

6. Sounds like you're sure about whether **or not** to take the HIV test. Maybe we need to look at together-the changes that would occur with you if you decide to take the test. If after that you're not ready, then maybe you shouldn't take the test.

7. You are probably right since only about 2% of the people tests are infected. How did you come to rake that **assumption?**

8. I think that's a great reason to get tested, let's explore your situation.

9. If you've that sure, are you certain you want to take the **test? Maybe we could** talk about **this** a bit **more.**

10. Let's take some time and talk **about it, so** you'll understand the positives and negatives.

11. That **sounds** like a good **idea! Let's** talk a little more about the test, then you can decide for **sure.**

12. That can be a very difficult **decision to make** - coming in here to get the HIV test.

13. Have you engage in any risky behaviors such as same sex, **I.V.** use and feel you may have been infected.

14, I think its good that you want to know about your health, please let me tell you some things about the teat.

15. It sounds like you're having some concerns...

16. It sounds like you may be having some doubts.

17. You sound like you are not sure if you want to have this test done.

18. I sounds like you're not sure if you want to have this test done. Let's discuss some of the implication8 of testing and then you can decide whether or not to have this test.

19, You sound very confused as 'to whether you should have this test done.

20. I think it's really a good idea for you if you want to play it safe.

21. It sounds like you want to be sure that you stay on the safe side and do not get AIDS,

22. You sound a little hesitant‘ and unsure about really having this test done.

23. Let us talk about what this HIV test is all about.

24. It sounds as if you are still undecided about taking the test. Let me explain to you exactly what is involved in the testing procedure. Perhaps this will enable you to decide what course of action you would'like to take.

25. You're worried about being tested?

S.S.# 212-78-5168 (1)

Date: 5/29/90 - PRE COURSE
#2

INITIAL RESPONSE

Below are three **opening statements from** three different **clients.** Write beneath **each** statement you very next **verbal** response. Write the actual vords you think you vould say, in quotation **form.** Please write legibly.

1. (**Pre-test** counseling session)

"One thing is for sure - if **I've** qot this HIV, I'm qoinq to get **who ever gave it to me!"**

Well, I'm sure you would be angry but I believe most importantly instead of revenge it can be more helpful to learn how to care for yourself and to protect others.

Your statement gives me great concern for others and for yourself

2. (Post-test counseling session - negative result)

"Thank you, thank you! This is vonderful **news!** Well, **I'm** out **of here!!"**

I think we still need to talk about risk reduction.

3. (Post-test counseling session - positive result)

"No- this can't be true...Oh my God, I'm going to die!"

Not necessarily. I'm sure this is quite a shock. Take some time to process it.

S.S.# [redacted]

Date: June 1, 1990

#2

(1)

INITIAL RESPONSE

Belov *are* three **opening statements *from*** three **different clients,** Write **beneath each statement you very next verbal response. Write the actual vords you think you vould say, in quotation form. Please write legibly.**

1. **(Pre-test** counseling session)

"One thing is for sure - if I've got this HIV, I'm going to get who ever gave it to me!"

Let's talk about what a positive HIV result would mean to you.

2. (Post-test counseling session - negative result)

"Thank you, thank you! This is vonderful nevs! Well, **I'm** out of here **!!"**

Do you think we could talk about what this means to you?

3. (Post-test counseling session - positive **result)**

"No- this can't be **true...Oh** my God, **I'm** going to **die!"**

This is quite a shock. Can we talk about your feelings?

APPENDIX X

Evaluation Conducted

Instruments Used to Evaluate MARC Home Health Care Training Courses

SS#_____ Date_____ County of Employment_____

MARYLAND AIDS PROFESSIONAL EDUCATION CENTER

Course Evaluation

5/16/90 Home Health

We **are interested in** your evaluation of this program, and will use this information to plan future education programs. We thank you for your assistance.

Part One: Objectives

Please evaluate the extent to which the stated objectives for this program have been achieved.

		not at all				very much so
1.	identifying professional/personal values as barriers to care of the HIV/AIDS patient in the home.	1	2	3	4	5
2.	Describing the natural history, transmission, and prevention of HIV.	1	2	3	4	5
3.	Describing the neuropsychiatric manifestations of HIV infection.	1	2	3	4	5
4.	Identifying communication interventions with the illness response to HIV infection; i.e., depression, anger, suicidality, the manipulative personality.	1	2	3	4	5
5.	identifying psychosocial issues for both the HIV/AIDS patient and the nurse.	1	2	3	4	5
6.	Identifying a stress management technique.	1	2	3	4	5
7.	Identifying legal issues related to HIV/AIDS.	1	2	3	4	5
a.	Describing nursing case management of HIV/AIDS patients in the home.	1	2	3	4	5

Part Two: Faculty

Please evaluate the presentations made by each faculty member.

			poor				excellent
1.	Joan Garrity	N/A	1	2	3	4	5
2.	Jean Trotter	N/A	1	2	3	4	5
3.	Debra Kosko	N/A	1	2	3	4	5
4.	Edith Creef	N/A	1	2	3	4	5
5.	John Budin	N/A	1	2	3	4	5
6.	Richard North	N/A	1	2	3	4	5

Comments _____

Part Three: Overall Evaluation

		not at all				very much so
1.	Today's program will be used by me in my daily work.	1	2	3	4	5
2.	As a result of this program, I think I'll feel more comfortable with HIV patients.	1	2	3	4	5
3.	There was enough time for us to ask questions.	1	2	3	4	5
4.	In general, the presenters were knowledgeable,	1	2	3	4	5
5.	There were some topics that we needed to cover, but didn't get to.	1	2	3	4	5
6.	In general, the information I learned was useful.	1	2	3	4	5
7.	For this type of program, was the time available adequate?	1	2	3	4	5
8.	Was the meeting space comfortable?	1	2	3	4	5
9.	Were the handouts and reference materials helpful?	1	2	3	4	5

10. How did you hear about today's conference? ___brochure/flier ___from a friend through my work ___radio/television ___other (Please specify)_____

11. What additional program would be of interest to you? _____

Part Four: Demographic Data (Check **one for each category)**

Total number of HIV/AIDS patients cared for in the last 3 months: _____

Total number of HIV/AIDS patients you have cared for ever: _____

Primary **Site** of Work

Please indicate your primary site of work: ____Hospice ____Home Health Care Agency/Department ____Public Health Department ____Visiting Nurse Organization ____Other (Please specify): _____

Number of **Years in Home Health Work:** Both in this job and elsewhere, how many years have you worked in home health care?

____Less than one year ____1-2 years ____3-4 years 6-7 years ____5-6 years Over 7 years ____Not **applicable (not in home health care)**

Ethnicity

____American Indian/Eskimo ____Asian ____Hispanic/Latino
Black ____Caucasian (white) ____Other (Please specify)

Job Title

____Nurse Practitioner ____Dietician ____Physician Assistant ____Counselor
____RegisteredNurse ____Social Worker ____Nursing Assistant ____HomeHealthAide
____Licensed Practical Nurse ____Other (Please specify)

Sex: ____Female ____Male **Age:** ____Less than 20 ____31-40 ____51-60
____20-30 ____41-50 ____Over 60

SS# _____ DATE: _____ County, State of Einployment _____

THE NURSING CHALLENGE:

HOME CARE OF THE HIV/AIDS PATIENT

This questionnaire is intended to allow us to better understand health concerns and opinions about HIV/AIDS in order to enhance educational offerings. It is'not a test, nor is it a means of assessing individuals so much as health care workers in general.- Some of the questions are provocative. Please be candid and frank. Your responses are strictly confidential, and will be used in planning future courses.

THE ITEMS BELOW ARE STATEMENTS ABOUT HEALTH CONCERNS -- ESPECIALLY OPINIONS AND CONCERNS ABOUT AIDS -- AND PERSONAL ATTITUDES AND TRAITS GERMANE TO HEALTH CARE. PLEASE MARK THE EXTENT TO WHICH YOU PERSONALLY AGREE OR DISAGREE WITH THEM, USING A SCALE OF 1 to 6:

Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1 ------	2 --------	3 ------	4 -------	5 -------	6 -------

___ 1. I feel professionally competent to care for persons with AIDS.

___ 2. I would be Willing to eat in a restaurant where I knew the chef had AIDS.

___ 3. People with AIDS should absolutely abstain from sex.

___ 4. I don't find it particularly difficult to get along with‘demanding, needy people.

___ 5. I often have tender, concerned feelings for people with AIDS.

___ 6. The rights of AIDS patients (e.g., privacy and confidentiality) have been overemphasized.

___ 7. Given a choice, I would prefer not to work with AIDS patients.

___ a. Blacks and Hispanics have been unjustly victimized by AIDS.

___ 9. AIDS makes my job a high risk occupation.

___ 10. I find the thought of homosexual acts disgusting.

___ 11. It is pointless to give drug abusers medical advice: they ignore it.

___ 12. I am comfortable talking to a dying person about death.

___ 13. I would rather work with a better class of people than AIDS patients.

___ 14. I sometimes think when people have a misfortune they only get what they deserve.

___ 15. I am comfortable with the thought of my own death.

Strongly Disagree	Moderately Disagree	slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1 ------	2 --------	3 ------	4 ------	5 --------	6 ------

___ 16. If a child of mine showed homosexual tendencies, I would want him/her to get psychiatric treatment.

___ 17. I would prefer to refer persons with AIDS to my professional colleagues.

18. Because of germs, I prefer not to use public restrooms.

___ 19. AIDS patients have as much right to quality medical care as anyone else.

___ 20. I am uncomfortable asking patients about the possibility and details of their drug use.

___ 21. Even were I to follow strict infection control measures, it is likely that I would become infected with HIV if I were working with AIDS patients over a long period of time.

___ 22. It is wrong to blanketly condone the use of condoms.

THE FOLLOWING QUESTIONS WERE DEVELOPED FOR PEOPLE **AT VARIOUS LEVELS** OF THEIR **TRAINING AND PRACTICE.** **SOME** OF THE ITEMS ARE QUITE DIFFICULT AND **SOME** ARE ELEMENTARY. IF YOU DO NOT KNOW AN ANSWER, PLEASE SIMPLY INDICATE WHAT YOU THINK THE CORRECT ANSWER MIGHT BE.

___ 23. **Human** immunodeficiency virus (HIV):
[1] **Is** a new mutation of the HTLV-III virus which was first implicated in the etiology of AIDS;
[2] Causes lymphadenopathy but not AIDS;
[3] Is the internationally agreed upon name for the AIDS virus, formerly known as HTLV-III, **LAV,** or ARV;
[4] Is widespread in Africa but has not yet been observed in America;
[5] Is a cofactor in the transmission of the AIDS virus.

___ 24. **AIDS** is caused by:
[1] A protozoan
[2] A bacteria
[3] A fungus
[4] A retrovirus
[5] None of the above

25. While recapping a needle, a health care worker sustains an accidental needle-stick injury after drawing blood from a 41-year old AIDS patient who is also Hepatitis B surface antigen positive. The following is/are true:
[I] A negative HIV antibody test on the nurse's blood six months after the accident virtually rules out transmission of HIV.
[2] The nurse has a greater risk of acquiring HIV infection than Hepatitis B infection.
[3] Like many such needle-stick injuries, this accident could have been avoided if recapping had not occurred.
(43 1 & 3
[5] 1, 2, & 3

26. The likelihood of the health care worker becoming infected with HIV after the accidental needle stick is:
[1] 0
[2] Less than 1%
[3] 2-10%
[4] 20-50%
[5] 70-100%

27. HIV primarily infects:
[1] B cells
[2] Squamous epithelial cells
[3] T helper cells
[4] Killer T cells
[5] Polymorphonuclear leukocytes

28. In the U.S. Today, the approximate percentage of AIDS patients who are heterosexual is:
[1] 0
[2] 4%
[3] 7%
[4] 25%
[5] 33%

29. The U.S. Public health service has estimated that by the end of 1991, the approximate cumulative number of U.S. AID8 cases will be:
[1] 2,700
[2] 27,000
[3] 270,000
[4] 2,700,000
[5] 22,270,000

30. In the U.S. today, most people infected with HIV are:
[1] Persons with AIDS.
[2] Persons with AIDS-related complex.
[3] Living in San Francisco or New York..
[4] Intravenous drug users.
[5] Persons who are asymptomatic and appear healthy.

31. Altered mental status in people infected with HIV is usually due to each of the following except:
[1] HIV encephalopathy;
[2] Anemia;
[3] CNS opportunistic infection or neoplasm:
[4] Illicit drug intoxication or withdrawal;
[5] Medications.

32. HIV infects each of the following cells except:
[1] T-helper lymphocytes
[2] Monocytes and macrophages
[3] Brain microglial cells
[4] Epstein-Barr virus infected B lymphocytes
[5] Hepatocytes

33. Human body fluids shown to be involved in the transmission of HIV include:
[1] Blood and blood products
[2] Saliva and urine
[3] Semen
[4] 1 & 3
[5] 1, 2, & 3

34. The clinical manifestations of HIV which are newly discovered disease entities include:
[1] Kaposi's Sarcoma;
[2] Hairy leukoplakia;
[3] Pneumocystis carinii pneumonia:
[4] None of the above: all were previously known;
[5] 2 & 3

35. According to the Centers for Disease Control, the approximate percentage of persons with AIDS who have acquired HIV infection via a still "undetermined" route is:
[1] 0
[2] 3%
[3] 10%
[4] 17%
[5] 33%

36. The average time from inoculation with HIV to seroconversion is:
[1] 24 Hours
[2] 3 Days
[3] l-4 Weeks
[4] 6-12 Weeks
[5] 6 Months

37. Your intent is to measure the blood pressure, pulse, respiratory rate and temperature of an AIDS patient. You should:
[1] Place a disposable mask over your nose and mouth before seeing the patient.
[2] Wear a gown while seeing the patient and dispose of it afterwards.
[3] Wash your hands after seeing the patient.
141 Wash your hands with iodine (Betadine) after seeing the patient.
[5] All of the above.

___ 38. With respect to infection control measures, the Centers for Disease Control recommend that those patients to be considered potentially infectious for HIV include:

[1] Any person who, in the last ten years, has had sex with a homosexual or bisexual man: had a blood or blood-product transfusion: and/or has shared needles used for intravenous injections.
[2] Children of mothers with AIDS/HIV infection.
[3] All patients regardless of membership in a specific risk group.
[4] 1 & 2
[5] 1, 2, & 3

PLEASE INDICATE THE **DEGREE TO** WHICH YOU HAVE AN INTEREST IN **THE FOLLOWING TOPICS, USING A SCALE OF 1** to **5:**

No Interest	Slight Interest	Moderate Interest	Strong Interest	Very Strong Interest
1	2	3	4	5

___ 39. Natural History, transmission and prevention of HIV.

___ 40. Nursing management of HIV/AIDS patients in the home.

___ 41. AIDS prevention (including sex and drug counseling).

___ 42. Psychosocial issues of AIDS

___ 43. Ethical/legal issues of AIDS

___ 44. Identification of professional/personal values as barriers to care of the HIV/AIDs patient.

___ 45. Neuropsychiatric manifestations of HIV infection.

___ 46. Communication interventions with the illness response to HIV infection.

___ 47; Stress management.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN IT TO SYLVIA SCHERR, MARYLAND AIDS PROFESSIONAL EDUCATION CENTER (301) 328-8639.

Questionnaire courtesy of Margaret Grade, Ph.D., UCSF.

210 LINCOLN STREET
BOSTON, MASSACHUSETTS 02111

3613

AIDS Regional Education and Training Centers Evaluation

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JSI

JOHN SNOW, INC.

MIDWEST AIDS TRAINING AND EDUCATION CENTER

EVALUATION REVIEW

I. OVERVIEW

The Midwest AIDS Training and Education Center (MATEC) comprises a six-state region (Illinois, Indiana, Iowa, Minnesota, Missouri, Wisconsin) and operates through seven regional sites to administer programs for health professionals addressing knowledge and skills about AIDS and HIV infection. The organizational goals are clearly delineated and include the establishment of the MATEC at the University of Illinois at Chicago in collaboration with seven other institutions, the development of seven area sites for an AIDS education network, and the implementation of general AIDS-related programs as well as programs to meet site specific needs.

The education and training activities include train-the-trainer programs for selected health professionals, seminars and workshops for primary care providers, one and two-day workshops targeted to specific health professionals, training programs specifically geared to training representatives of minorities and health providers to minorities, as well as telecommunications programs, video tape programs, and the development of curricula and teaching materials. Furthermore, activities include the provision of updates of new and timely information and the provision of a support system for area health professionals.

To date, evaluations of education and training programs have been formative and process oriented, The various MATEC sites are collecting basic information on participant assessment of the content and objectives of various programs and trainings. Work groups, comprised of members from the various sites, have been exploring the utilization of standardized evaluation formats for some outcome measures. In the spring of 1990, the various sites agreed to use a uniform instrument for a pre/post-training assessment of attitudes and knowledge of participants in all programs over four hours in length.

II. THE ADHINISTRATION OF TEE EVALUATION PROCESS

A. The Evaluation Plan

MATEC initially focused attention on project monitoring and on formative evaluations to improve and refine program offerings. Attention is now being placed on outcome evaluation.

1. The Evaluation as Proposed

The overall evaluation goal is formative in nature and was focused on the evaluation of program outcomes and the provision of a feedback loop to introduce refinements. In order to do this, MATEC proposed activities that would include both qualitative and quantitative measures of program effectiveness.

Needs Assessment: MATEC intended to collect data on the numbers and locations of health care professionals and identify training needs and/or gaps in existing training. The methods of data collection were not specified but this assessment was to be carried out by each site at the start of each grant year. Furthermore, MATEC planned to collect data on the status of HIV infection within the region from all available sources to assist in targeting decisions and curriculum update.

Assessment of Education and Training Programs: MATEC proposed to utilize questionnaires to test knowledge and attitudes of participants before and after training. A brief annual follow-up survey was to be mailed to a sample of participants to determine utilization of information/skills in practice. The initial plan called for each site to adapt evaluation materials for their program.

The training-the-educator program was to be evaluated by the trainers, educators and health care professionals through the utilization of descriptive reports. Participants were to be surveyed regarding their evaluation of the training experience. A feedback loop was to facilitate program revisions. In addition, a series of small studies was proposed to examine what factors account for change or a lack of change in provider attitudes and/or practice.

Quality control was to be maintained through semi-annual review of training materials.

Process Evaluation and Accountability: An information management system was planned to evaluate the efficiency and effectiveness of the education/training program based on the stated goals and objectives of site programs. Quarterly reports were to include number and types of professionals reached, geographic location, organizational affiliations, co-sponsoring arrangements, type of training provided, number of hours of training, cost per trainee, and a summary of participant evaluation and planned program revisions.

The MATEC organization was to be assessed at 6 and 12 months through an evaluation completed by each site. Questions included the ability of the central and regional advisory councils to recruit a broad-based interdisciplinary membership, ability to develop a recognizable center, and effectiveness of support services.

Cost Effectiveness Evaluation: A cost effectiveness analysis was to be based on the information obtained from the process evaluation as well as the volume and activity reports.

2. The Implementation of the Evaluation Plan

The evaluation plan, which has evolved over time, incorporates regional office as well as site specific activities. MATEC oversees the project evaluation and the various sites are responsible for program evaluation. The monitoring activities are well developed and allow for in-depth analysis by regional headquarters. As is appropriate for early program activities, the evaluation focus has been primarily process oriented; activities are detailed in Sections III through VI, below, All sites report use of process evaluations for program offerings. Plans for year 03 focus on outcome data

constitutes a quality program?" with a view toward developing specific standards across sites.

On-going discussions at the Coordinating Council meetings have led to the development of a plan to assess short-term impact through the use of a pre/post-test measure of attitudes. Sites have agreed to use a uniform instrument for all programs over four hours in length.

3. Subcontractors

Each site is responsible for evaluation studies of site programs. Site directors report that all programs (not including brief presentations and lectures) are to be evaluated. Often, the evaluation forms are developed by program co-sponsors, particularly when programs are offered for continuing education .credi ts. In such cases, the co-sponsor sends the results to MATEC. Generally the program evaluation focuses on process issues. Site specific activities include the regular use of process evaluations designed to be program specific and focused on participant assessment of program activities and objectives.

C. Coordination of Evaluation Activities

Subcontracts stipulate the requirement of site participation in evaluation activities. This information is collected and analyzed by the regional headquarters which prepares a quarterly summary report. This information is available in the Training Grant Continuation Application and quarterly report for education and training activities.

D. Reporting of Findings

All sites submit program reports to the MATEC central office. These include program outlines, evaluation instruments used, and evaluation results. All summary progress reports submitted by regional headquarters include site specific reports of activities under each objective. In addition, sites prepare and submit evaluation reports, as appropriate, that have been prepared for contracts with co-sponsors. For example, the Northern Illinois site prepared an evaluation report for the Chicago Department of Health, summarizing findings for a series of trainings conducted in year 01.

III. APPROACHES TO PROJECT EVALUATION

MATEC regional headquarters takes an active oversight role: conducting site visits, requiring regular reports in specified formats, as well as procuring, analyzing, and summarizing pertinent data, and facilitating the development of uniform measures. Each site is responsible for the regular submission of a work plan which lists the various ETC goals and objectives, the specific action steps to be taken to meet each objective, and the delineation of progress to date. Sites submit information pertaining to each educational offering which is then tracked and summarized by the regional headquarters. Data is submitted in specified reporting formats to enable regional headquarters to conduct a variety of analyses.

MATEC regional headquarters maintains a strong facilitating and supportive role and is knowledgeable about the various site activities. Timely analysis is conducted on materials and statistics sent into the regional office. Furthermore, the central office reports that a trustful atmosphere has been established to support a collaborative effort among the various sites and institutions.

A. Monitoring

MATEC regional headquarters conducted site visits in year two and used a. uniform but informal protocol. The protocol listed evaluation questions and discussion items in each of the following areas:

- Quality assurance
- Linkages
- Space resources
- Fiscal operations
- Expertise of faculty
- Training programs (record review, targeting; program design)
- Marketing

A copy of the site visit protocol is included in Appendix I.

Following the site visit, feedback was provided via follow-up letters to each site. The letters themselves indicate that discussion was thorough, that strengths were highlighted, needed progress noted, suggestions made, and that linkages were established with other programs. Some of the problems identified related to minimal funding and therefore limited staff. Often, this means that the project coordinator is responsible for all of the training. Expanded and a more carefully monitored use of train-the-trainer programs are under discussion among all of the sites. Other issues related to the depth of program content.

After the follow-up letters were sent out, a conference call enabled the central office to communicate findings across sites and offer a summary of the diversity of programs. Regular phone and mail contacts continue throughout the year. A repeat of these site visits are planned for year 03.

The Training Grant Continuation Application (4/89) contains a progress report on MATEC Year 01 Objectives. MATEC reports on the meetings of the Coordinating Council, the establishment of cooperative relationships with various associations and institutions, the development of all sites with long term plans and programs underway.

All summary progress reports submitted by the regional headquarters include site specific reports of activities under each objective. This in-depth overview is made possible by the regular meetings and up-dates and by the requirement that all program facilitators complete a program data form and submit it to the central office. The program data form includes general program information, participant information and program design information, as well as program strengths and weaknesses. Facilitators are also asked to submit materials used. This information enables the central office to

analyze the numbers of people served and the types of programs offered by site and region and to develop a cost effectiveness analysis.

B. Output Evaluation

Data for output evaluation are collected via a ETC-wide Program Data Form which includes general information about the program and its design,and summary information about the participants. A copy of this form is included in Appendix II.

A spreadsheet of training activities detailing date, number of participants, minority status of participants, program length, contact hours, target audiences and professional groups reached for each training event is maintained by the regional office. Program faculty at each site is responsible for collecting this information and forwarding it to the central office. As a result, regional headquarters is able to develop summary reports for detailing region wide and site specific program topics and participant counts, participant occupation listings, minority case-load reports. These summary reports are included in Appendix III. Furthermore, for each category of program offerings, regional headquarters is able to print out program title, program dates, total number of participants, minorities, program length, contact hours, target audience categories, and occupation codes. Printouts for Provider Programs and Train-the-Trainer Programs are also included in Appendix III.

Output data includes information on program distribution, training productivity by site, changes by site, and preliminary cost analysis. Samples of these reports are included in Appendix III. MATEC regional headquarters reports that sites have begun activities in long range planning, have met with advisory groups on a regular basis, and have offered from 11 to 168 programs per site. Over 700 hours of programming are reported with over 9,500 health professionals reached in the first year of activity. From April 1989 to May 1990, MATEC, as a region, had conducted 40 training of trainers events. Faculty development and medical student peer education programs are included in this number. As is noted in the case study report, these 40 programs reached 800 participants. In addition, there were 527 direct trainings during the same time period, reaching 26,233 participants. Overall, as of mid April, 1990 over 478 programs were offered throughout the region.

In addition, summary program statistics are prepared for each site. For example, the Northern Illinois MATEC Summary Program Statistics report lists events, participants, average participants per event, and contact hours for each quarter, One can easily note, as a result, that in the first three quarters of year two, the Northern Illinois site offered 129 events to a total of 3,889 participants, averaging 30 participants per event, for a total of 12,986 contact hours. As a sample, the summary report for Northern Illinois MATEC is included in Appendix III.

Northern Illinois, which represents the area with the largest percentage of AIDS cases **(47%)** in the ETC area, had the largest number of trainees (4,719); but Indiana, Wisconsin, and Southern Illinois each trained over 3,500 participants.

C. Cost Efficiency and Cost Effectiveness

MATEC formulates an analysis of program outputs based on number of course offerings, number of participants, and overall costs. Both cost per participant and cost per contact hours were calculated by regional headquarters. The findings indicate that in year 02, the average cost per participant was $37.19 and the average cost per contact hour was $10.18. Needless to say, this type of analysis does not make provision for the varying depth of program offerings. An analysis of costs, by site for both direct training and for train-the-trainer programs is included in Appendix IV.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

The Minnesota Site has developed two, well-received manuals: Living With AIDS and Taking Care Manual. These materials have been used at the two annual conferences of professionals and comments and reviews were solicited. The Missouri site has developed curriculum and a video for nursing home staff. A draft of the print document was planned for July/August 1990. Indiana has collated a series of affective exercises found to be useful-in trainings focused on psycho-social issues of HIV/AIDS. Regional Headquarters is developing a patient simulation guideline for HIV/AIDS related cases. A dental curriculum is near completion.

Thus far, there is no formal process for review and evaluation of products developed. MATEC plans to develop a standardized procedure during the latter part of 1990.

V. APPROACHES TO EVALUATING EDUCATION AND TRAINING OFFERINGS

Initially, the individual sites held all responsibility for the evaluation of education and training offerings. The independence of the various sites and a recognition of the need for each site to determine and tailor program offerings were important in the development of the ETC. Over time, however, a collaborative environment enabled the ETC to move in the direction of greater standardization for quality assurance and for evaluation.

A. Standardization of Evaluation RTC-Wide

Each site has used its own method of evaluating education and training programs. Generally, these evaluations have been formative in nature and process-oriented. These evaluations have enabled the various sites to monitor participant response to program content, process, and faculty. However, in the spring of 1990, an evaluation questionnaire was developed (with the assistance of other ETC and NIMH evaluators) and will be utilized across sites for all programs four hours or longer.

The evaluation consists of a pre-program questionnaire which asks participants to offer a code number and provide general demographic information including experience with HIV/AIDS related care. Participants are asked to offer a rating (1=strongly agree, 5=strongly disagree) for a series

of 25 items related to attitudes, knowledge, behavioral intention, and self efficacy. A sampling of questions are:

- I have adequate knowledge to protect myself from getting AIDS from patients;
- AIDS infection control procedures are sufficient to protect health care providers;
- Given the choice, I would rather not work with patients with AIDS;
- Homosexuals who contract AIDS are getting what they deserve; and
- I am comfortable providing care to persons with HIV infection.

The post-program questionnaire consists of 30 items. The additional five items, previously utilized by JSI and ABT Associates for joint conference evaluations, include:

I leave this conference with additional knowledge about HIV/AIDS;
My objectives for attending this conference were met;
I leave this conference with changed views about HIV/AIDS issues;
I leave this conference with stronger skills related to my professional practice and HIV/AIDS; and
I feel prepared to talk with clients who are worried about their AIDS related risk status.

A copy of this standardized Program Evaluation form is included in Appendix V.

B. Approaches to the Formative Evaluation of Training Events

Each site engages in some level of formative process-oriented evaluation for program offerings. When an event is co-sponsored or is offered for continuing education credits, the standard evaluation forms used by the sponsoring or accrediting agencies are used. Generally the process evaluation queries participants regarding the program faculty, the program content, and the site. In addition, the report includes a listing of participants' comments which are quite useful for program planning and revision.

For an example of the type of forms in use, the AIDS/HIV Invitational Clinical Nurse Educators Program offered at the University of Wisconsin-Madison (November 1989) included an evaluation form that asked participants to assess various program components by rating (on a one to nine scale) the items such as: general organization of the program, length of the program, information received, information presented, knowledge gained, location, facility, appropriateness of presentations, relevancy of instructional materials, contribution to participants ability to function in clinical setting. In addition, participants were asked to assess faculty on nine items, and add additional comments related to content, faculty, panelists, and coordinators.

Another example, from the Northern Illinois site, asks participants to offer ratings on a variety of workshop components and additionally, to specify what each instructor could do better next time and how the workshop could be improved. In addition, the inclusion of questions such as "write down one fact or idea from the workshop that you learned, and that seems important to you" enables planner to compare objectives with participant gains. The summary reports offer percentages for each response category as well as a listing of answers to the open-ended questions.

Several sites report the existence of a feedback loop from participants to program planners and can offer examples of program revision based on participant feedback.

C. Approaches to Evaluating Training Outcomes

The measurement of program outcome has been under discussion since project inception. This discussion process has proven fruitful, in that all parties have come to agree that outcome evaluation is important and that a uniform measurement procedure is acceptable. Regional headquarters notes that this participatory process, involving members from all of the sites, was necessary to develop trust in the evaluation process and to assure compliance with a standardized form, once developed.

The evaluation questionnaire, described in Section V.A., to be utilized across sites for all programs four hours or longer includes measures of attitudes, self efficacy, and knowledge. Once these forms are in regular use, across sites, the regional office evaluator (Mr. Chene) plans to subject the instrument to appropriate parametric tests, solicit comments from the various sites, and develop a shorter form. Once a standardized form is in regular use, regional headquarters will be able to report on some training outcomes.

Several sites include a question on their evaluation forms that offers a measure of behavioral intention. The Northern Illinois site, for example, asks participants to indicate what they will do differently at work as a result of this workshop.

D. Unique and Interesting Evaluation Techniques

Both the Northern and Southern Illinois sites are involved in developing AIDS-related Standardized Patient Encounter for training medical students and residents. The evaluation component involves video monitoring of the doctor patient encounter for later viewing and analysis and a follow-up session between doctor and patient where the patient offers a critique of the encounter. A formal analysis of the video and/or of the patient response could provide an in-depth evaluation of a training. No written material is as yet available for this component.

VI. EVALUATIONS CONDUCTED

Site activities include train-the-trainer programs, training for staff of a variety of institutions, peer educators training, AIDS overview programs,

and continuing education programs; preliminary outlines for curricula; work with professional schools to assess current course content; the development of a newsletter, collection of publications, and the development of a resource center. The evaluations used thus far consist of participant assessments of program offerings (client satisfaction) with some measures of self-assessment. The self assessments, when used, follow the adult education model of asking participants to offer an indication of their ability to meet a program objective. Samples of the evaluation instruments and evaluation reports/summaries are included in Appendix V. Included are the following:

- Evaluation Report: AIDS/HIV Continuity-of-Care Conference
- Evaluation Report: Mini-Residency
- Evaluation Summary: Chicago-Read Mental Health Center
- Evaluation Summary: Central Iowa AIDS Symposium
- Evaluation Summary: Nursing's Response to HIV' Infection (Wisconsin)
- Evaluation Summary: HIV Infection (Southern Illinois)
- Evaluation Summary: HIV Update (Missouri)

Some available examples of a program and evaluation are briefly described under each of the following program categories.

A. Training-of-Trainers (TOT)

A variety of train-the-trainer (TOT) programs are reported for each site. Wisconsin has focused on dentists and nurses; Northern Illinois focuses on its established faculty, social workers from hospital settings; and staff at a variety of state institutions; Indiana offers TOT programs to a variety of health care professionals in home health, long term care, nursing schools, and the state's Department of Mental Health; Southern Illinois has worked with existing AIDS trainers; Iowa has offered **TOTs** to infection control specialists; Minnesota has trained medical students; and Missouri plans to focus on nursing home staff.

MATEC does not offer one uniform TOT; each site designs and offers its own. However, MATEC reports that the organization has recently reached consensus about shared definitions and common activities for train-the-trainer programs (quality guidelines). To date there is no shared means of evaluating these programs.

An example of an evaluation of a train-the-trainer program is the evaluation conducted for the **"AIDS/HIV** Continuity of Care Conference" for staff of the Community and Migrant Health Centers, offered by the US Public Health Service Region V Office and co-sponsored by MATEC and ECAETC. This

program offered attenders several in-depth presentations, some followed by small group discussions and large group summaries. Topics included AIDS Epidemiology, Sharing, AIDS Prevention, HIV Testing/Counselling, Case Management, Community Resources and Train-the-Trainer.

The evaluation report notes that program participants included social workers, nurses, health administrators, and health educators. Just over half (24) of the 47 participants completed the evaluation form. The intent of the evaluation was to determine if attenders' needs were met. Participants were asked to rate the various program components. The conference received an overall rating of 4.0 on a 1 to 5 scale, with 5 indicating "very helpful". The program manual and handouts received a very high rating of 4.7. The report is included in the appendix, as noted above.

B. Direct Education Programs for Practicing Health Professionals

1. "Nursing's Response to HIV Infection"

The example here is from the Wisconsin site. A continuing education program Nursing's Response to HIV Infection, sponsored by the MATEC in collaboration with the University of Wisconsin-Madison School of Nursing and the Wisconsin Division of Health in April 1990, serves as an example of an evaluation for a direct education program for practitioners. This full day program offered presentation of HIV updates, an overview of drugs and therapies, prevention education, and nursing activities (including the support of coping and self perception functions, of cognitive-perceptual functions and of nutritional-metabolic functions) as well as a panel of persons affected by HIV infection.

The evaluation report notes that one-hundred and forty-five participants completed evaluation forms for this workshop. The evaluation form included demographic data, experience with HIV/AIDS patients, participant assessments of the degree to which specific objectives were achieved, and participant ratings of faculty. Overall, ratings were in the range of 3.5 to 4.2 on a 1 to 5 scale with 5 representing the category "well done". The presenters received ratings of 3.6 to 4.5 and the panelists ratings of 5.0 on a 1 to 5 scale with 5 representing "excellent". In addition, participants were asked to complete a pre and post questionnaire focused on attitudes and self assessment items. Analysis (to date) consisted of a listing of the percentage of participants within each rank. With further analysis and/or follow up it will be possible to compare pre and post test mean scores for the attitude items for any statistically significant change. The full report is included in the appendix, as noted above.

2. Overview of 25 Offerings of the Northern Illinois MATEC

Another example is from the Northern Illinois site and consists of an overview of twenty five AIDS educational training sessions for personnel of the CDOH neighborhood clinics conducted from June through August 1989, reaching 808 employees. A detailed evaluation report was prepared for the Chicago Department of Health and includes a description of the activities, of program participants, and program evaluation results. Of the 808 individuals, 586 returned the program evaluation forms for a 70% response rate.

Questions l-7 focused on program content, timing, handouts, answers to questions, instructors' awareness of audience level and instructors' knowledge. Overall all seven items were given high ratings with well over 70% of participants agreeing with positive statements. For the general evaluation comments, most wrote that training was very informative and beneficial to their practice. A behavioral intention question was included in the evaluation and asked the participants to indicate what they would do differently at work as a result of the workshop. A majority of respondents listed the use of universal precautions as the change they will undertake in their work environment and many indicated that while they had been aware of the need for universal precautions, they now understood that use of precautions would reduce their risk of exposure to HIV.

In addition, participants were given a quiz to assess their knowledge on AIDS. Of the 808 participants receiving the quiz, 376 returned them for a response rate of 47%. The average quiz score was 66%. For participants in clinical sessions, the average score was 68% and for non-clinical sessions, the average score was 57%. Mixed session participants had an average score of 78%. The quiz consisted of nine questions. The questions and the percentage with correct responses are offered below:

Knowledge Quiz Item	Percentage Correct
1. Identify 3 methods of transmission	71%
2. Identify 3 methods of reducing risk of exposure from sexual contact	67%
3. Identify 2 methods of reducing risk of exposure from IV-drug users	86%
4. Identify 2 possible interpretations of a negative HIV antibody test	83%
5. Explain the iceberg theory as it applies to the clinical spectrum of HIV	84%
6. Identify 3 psychosocial concerns of people with HIV	67%
7. Identify 3 fears healthcare workers have about HIV infection	26%
8. Define universal precautions	67%
9. Identify approximate percentages of Chicago AIDS cases by race	74%

The evaluation report, prepared by MATEC, included a program assessment with specific recommendations for further training. This type of report is not unusual. A similar report was prepared for the Office of AIDS Prevention of the Chicago Department of Health in April 1990 after a series of 10 inservice training sessions were offered to 125 participants. Both reports are included in the appendix, as noted above.

C. Hini-Residencies

The example here is from the Northern Illinois site. A mini-residency program, a joint effort of the US Public Health Service, Region V, MATEC, the Cook County Hospital AIDS Prevention Service, was piloted at The University of Illinois at Chicago on November 10 and December 6 and 7 1989. The first two

program days consisted of several presentations, a focused Standardized Patient Encounter followed by case conference and a panel discussion. The third day consisted of Team Conferences, Case Management presentations and discussions, a clinical observation and an evaluation. The Standardized Patient Encounter has its own evaluation component with patients offering specific feedback to the clinicians and with opportunities for video review and analysis.

The evaluation report, included in the appendix, notes that four health care professionals attended the program and three attenders completed the evaluation form. The evaluation queried participants regarding their assessment of various program components. The program received a rating of 3.9 on a scale of 1 to 5 with 5 indicating "very helpful". Most (60%) of the individual program components received ratings of 4.0 or greater. There is no written report analyzing the video review or patient analysis.

VII. SUMMARY OF ISSUES AND CHALLENGES FOR TEE FUTURE

MATEC needs to examine its overall reporting processes because of a tendency to under-report its activities. For example, the site visits conducted by central office staff, although noted in quarterly reports, were not highlighted as an evaluation activity. The protocol developed for the visits, the focus and depth of the discussions held, and the nature of the suggestions made indicate that this activity serves as a valuable formative evaluation procedure for the overall project development.

A real strength of MATEC is the strong role taken in requiring site specific information and then processing and summarizing site specific and regional data. Regional headquarters can thus offer detailed and timely analysis of project activities.

"Modeling" is a key strategy in education and could serve the evaluation efforts. If activities coordinated by the regional office always contained an evaluation component, the regional office could be viewed as "modeling" the importance of evaluation activities. For example, training programs presented at Coordinating Council Meetings could always incorporate an outcome evaluation component. In this way, the evaluation effort is highlighted and a variety of program evaluation methods could be used and discussed. In addition, an emphasis on outcome evaluation efforts would be considerably strengthened if an evaluation consultant were available to all sites. This centrally located person could be available to assist in the development of site or program specific evaluation design and in follow-up queries.

The outcome evaluation efforts can be further supported if the existing data reporting forms asked for additional information from each program. For example, the forms could include requests for summary information pertaining to participant self-assessments or reports of behavioral intent. Many programs already ask this information on their own evaluation forms and summarize them in their reports. Regionwide summary information regarding behavioral intent can offer insight into project effects.

The development of an attitude pre/post-test instrument to be used uniformly across sites for all programs exceeding four hours duration, will

certainly contribute to a stronger outcome evaluation focus. MATEC reports that the consensus to utilize a uniform instrument was the result of trust building and collaboration. As the ETC gains in strength, there is a potential to make stronger demands on project sites so that uniform processes and evaluations can be used for all train-the-trainer programs and other in-depth workshops.

In addition, a follow-up phone or mail study of reported behavioral change among a sampling of participants in each state who attended full day workshops could be conducted from the central office to further support more in-depth evaluation. For some sites, findings could be compared with the post session behavioral intention item included on many of the evaluation forms.

The use of the Standardized Patient Encounter can offer an opportunity for in-depth evaluation of training. As part of the Standardized Patient Encounter, the clinician and patient are video taped and, after the clinician has an opportunity to write a report, the patient offers specific feedback. Presently, evaluations consist of participant assessments. However, an evaluation checklist could be used for the video review and the patient analysis, thereby offering a summary assessment of practitioner skills.

Expertise in Organizational Development is a real strength of MATEC. The methods used in monitoring overall MATEC activities have been informed by organizational development concepts. In addition, MATEC sites routinely perform organizational development assessments when they are planning training programs. There are several examples of activities and trainings that could be written as in-depth case studies with implications for application elsewhere. MATEC would be well-served by having an appropriate staff write up an analytic case study for a variety of organizational development activities. This type of qualitative evaluation report can be most helpful to others.

APPENDIX I

Project Monitoring -- Site Visit Protocol

Site Visit Protocol

Item/Questions	Evaluation Method/Discussion Items
I. Quality Assurance	If formal system, review record8 or note8 on review of program, If informal, interview Site Director and Coordinator and talk with actual presenters about what if any "standards" were requested of them.
Is there any system to assure that programs are of high quality? Are there articulated standards for what is considered "quality"? Try to ascertain if there is an ideal in mind and if programs are reviewed in some formal or informal way.	Suggest articulation of standards, at least very basic ones, and then review of programs against these.

II. Linkages

What linkages exist (bring along whatever has been written up till now; 1st year 6 month report, year-end report, etc.)

What is the focus for maintaining and developing new linkages? How does it benefit the MATEC program?

What evidence of linkages exists? (May be necessary for renewal application)

Interview Site Director and Coordinator and Adv. Committee if possible. Review records if they exist.

Discuss the possible benefits of linkages, including actual assistance in developing programs as well as political and p.r. value,

III. Space Resources

Are they adequate? What are the politics of space at the institution?

Observe space assignments.

Discuss the impact of space politics on institutionalizing the project.

IV. Fiscal Operations

Who is responsible? Does the Site staff get information on where the MATEC funds are going and how they are being used? Problems with reporting **8s we** have requested? How **is** income accounted for?

Interview fiscal person (who is responsible in reality, **not on paper).** Look **over** records if appropriate; particularly income beyond MATEC.

V. Expertise of Faculty	Review any written records of faculty evaluation, request for trainers with match of faculty, etc.
How is "faculty" defined? How are faculty expertise and training slots matched? Is there any quality assurance? (see I above) Are trainers reviewed prior to presenting? after presenting the first time? ever? Is the system formal or informal? Who is responsible for the evaluation?	If nothing in writing, interview Site Director and Coordinator about how they choose trainers. Discuss possible systems for more matching of trainers with trainings.

VI. Training Programs

Records - What information is kept on each event? Planning documents? Indication of consultation with target audience?	Review records and interview staff‘;-'
Program Targeting - How are programs **decided on?** ***Use scenarios:*** if **doctors** group **needs program,** but you have no budget for it, what do you do? etc. What groups do you target? By profession and discipline. Do you review who you have trained to see who you haven't trained? What is done with the information? Does Advisory Council help decide?	Review training plan if it exists. Review any evidence that participants have been assessed by target group. Interview staff re:decision making about where to put scarce resources.

VI, Training Programs (continued)

Program Design - How is 8 program designed? Is the design formalized by a written plan? Are there "stock" programs that are tailored to requests? Are these in writing? How is the decision made 8s to length, teaching methodology, and content? Who makes the decisions?	Again, look at written materials that exist. Interview staff about decisions. Discuss the value of developing stock programs.

VII. Marketing

Does any formalized marketing plan exist? If not, what are the thoughts on marketing - directions that are planned?

Look at image as a marketing concept; materials, etc.

Review plan if formal or interview staff if not.

Discuss the value of image' development and targeting in marketing of program, and discuss the different "audiences"; MATEC Central, HRSA, as well as more traditional ones like the trainees themselves.

APPENDIX II

Output Analysis -- Program Data Form

Program ID **(leave** blank)*_____

Midwest AIDS Training and Education Center
Program Data Form

Please complete this form in its entirety. Information requested must fit in the space provided,

(NOTE: If program is part of a larger event, provide information on MATEC program only.)

PART I: GENERAL PROGRAM INFORMATION

Name of Trainer/Coordinator:

Title of Program:

Is this a Train-the-Trainer Program? **Yes** ☐ **No** ☐

Is this a Second Generation Training? **Yes** ☐ **No** ☐

If part of larger event, title of that event:

Date(s) of Program: __/__/__ To: __/__/__

Name of facility where program was held:

City:

MATEC Site: (circle one) MN IA MO NI SI IN WI CM

Sponsorship by MATEC: (circle one) Sole = 1 Co-sponsor = 2

If CO-SPONSOR, **contribution** of MATEC: (check all that apply)

☐ 1. Planning Assistance
☐ 2. Financial Assistance
☐ 3. Evaluation Assistance
☐ 4. Provided Speakers
☐ 5. Provided resource materials
☐ 6. Provided meeting site
☐ 7. Other (please list)

What target group was the program designed for? (list disciplines and/or settings)

Length of program: (round to the nearest full hour) ____ hours

Fee charged to participants: $____

PART II: PARTICIPANT INFORMATION

(IN THIS SECTION, MARE ESTIMATES IF UNIVERSAL DATA ARE NOT AVAILABLE. TOTAL NUMBERS OF PARTICIPANTS, HOWEVER, MUST BE AN ACTUAL NUMBER. TOTALS IN EACH CATEGORY MUST EQUAL TOTAL NUMBER OF PARTICIPANTS)

Total Number of Participants: _____
Total Number of Minority Participants by Category

1. African American/Black

___ 2 Latino/Hispanic

- 3 Asian

4. Native American/Indian

5. White/Caucasian

Other

___ 7. unknown

Total Participants by Setting (where direct services are provided)

___ 1. Hospital

___ 2. Freestanding Community Health Clinic (CHC's, etc.)

___ 3. Home Health Care Agency

___ 4. Long Term Care Facility/ Nursing Home

___ 5. Private Office

___ 6. University-based Training Program

___ 7. Chemical Dependency Treatment Facility

___ 8. Commnun.ity Mental Health Center

___ 9. Public Health Dept./Office

___ 10. Corrections Facility

11. School/Univ. Student Health Facility

12. unknown

___ 13. N/A - Does not provide services

___ 14. Other (please list)

Total participants whose patient loads fall into the following categories:

___ 1. 0 - 10% minority patients

2. 11 - 25% minority patients

3. 26 - 50% minority patients

4. More than 50% minority patients

5. unknown

___ 6. N/A - Does not provide services

PART II: PARTICIPANT INFORMATION, Continued

Total number of participants in each of the following disciplines, by practicing **(P)** or student **(S)** status:

	Number of PIS		Number of PIS
1.	Registered Nurse	10.	Physical/Occup./Resp. Therapist
2.	Physician/M.D./D.O.	11.	Housekeeping/Maint. Worker
3.	Dentist	12.	Med. Lab. Worker
4.	Social Worker	13.	Dietician/Nutritionist
5.	Dental Auxiliary	14.	EMT/First Responder
6.	LPN/Nurse Aides/CNA	15.	Pharmacist
7.	Chemical Dependency Counselor	16.	Nurse Pract./Phys. Asst.
8.	Health Educator	17.	Psychologist/Ment.Hlth.Worker
9.	Administrator/Manager	18.	Unknown

19. Other/list _____

20. Other/list _____

21. Other/list _____

22. Other/list _____

PART III: PROGRAM DESIGN INFORMATION

AIDS content included in the program: (check all that apply)

- 1. Epidemiology
- 2. Immunology
- 3. Virology
- 4. Transmission
- 5. HIV Disease Spectrum
- 6. Symptoms/Diseases
- 7. Treatment/Issues
- 8. Testing/Counseling
- 9. Prevention
- 10. Infection Control
- 11. Case Management
- 12. Primary Care
- 13. Tertiary/Long Term Care
- 14. Psychosocial Issues
- 15. Neurological Issues
- 16. Sexuality
- 17. Legal/Ethical Issues
- 18. Other (please list) _____
- 19. Other (please list) _____

Method of Instruction: (check all that apply)

- 1. Lecture
- 2. Computer-Assisted Instruction
- 3. Panel Discussion
- 4. Roleplay
- 5. Group Discussion
- 6. Videotape
- 7. Question & Answer Session
- 8. Demonstration
- 9. Other _____

Media used: (check all that apply)

- 1. Slides
- 2. Transparencies
- 3. Audiotape
- 4. Videotape/film
- 5. Books
- 6. Printed Material (Other than books)
- 7. Computer
- 8. Flipchart/Blackboard
- 9. "Props"/Real Objects
- 10. Other _____

PART IV: ADDITIONAL INFORMATION FOR REPORTING TO FUNDING SOURCES

THE FOLLOWING IN-FORMATION HAS BEEN REQUESTED BY HRSA AND SHOULD BE SUBMITTED IF IT IS AVAILABLE. IF NO QUANTITATIVE INFORMATION IS AVAILABLE, NARRATIVE DESCRIPTION IS STILL VALUABLE. PLEASE ATTACH A BRIEF NARRATIVE IF THERE IS NOT SUFFICIENT ROOM HERE.

1. Minority participants by discipline, e.g., how many African American physicians attended the program? Latino dentists?

2. Discipline by setting, e.g., how many nurses from hospitals attended the program, physical therapists from outpatient clinics?

PLEASE ATTACH SIX (6) SETS OF PROGRAM MATERIALS, E.G., BROCHURES, FLYERS, OUTLINES, ORIGINAL PRODUCTS DEVELOPED FOR THIS PROGRAM, ADVERTISEMENTS, ETC.
[If materials are excessively bulky or expensive to duplicate, please attach two (2) complete sets and four (4) Tables of Content or other summarizing material]

PART V: INFORMATION FOR SHARING WITH OTHER SITES

What were this particular program's strengths?

What were its weaknesses?

General comments that may be of help to others planninga similar program:

APPENDIX III

Output Analysis -- Reports

1. MATEC Listing of Programs
2. MATEC Participant Occupation Report
3. Provider Program Listing
4. Train-The-Trainer Program Listing
5. Program Distribution
6. Northern Illinois MATEC Summary Program Statistics

Midwest AIDS Training and Education Center
Listing of Programs

MATEC site	Program Dates:	Program Topic	Participant Count
** MATEC SITE CM			
CM	06/26/89-06/27/89	AIDS/HIV CONTINUITY OF CARE CONF.	47
CM	10/11/89-10/11/89	ETC'S AS RESOURCE TO SOCIAL WORKERS	25
CM	12/14/89-/ /	FUNDING SOURCES FOR AIDS/HIV SERVIC	54
CM	12/15/89-/ /	AIDS/HIV SERVICE COMMUNITY BUSED	36
** Subtotal **			162

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE IA			
IA	04/08/89-04/09/89	BEFORE IT HITS HOME (DRAMAT. PROD.)	460
IA	04/19/89-04/20/89	AIDS: TODAY'S CHALLENGE	220
IA	05/12/89-05/12/89	AIDS: ISSUES AND CHALLENGES	91
IA	05/25/89- / /	CME HOW TO DO IT CONFERENCE	18
IA	06/02/89- / /	AIDS SYMPOSIUMFOR HEAL TH PROF.	92
IA	09/08/89-	AID5 89:INTERDISCIPLINARY CONFERENC	104
IA	10/17/89-10/17/89	CULTURALLY SPECIFIC AIDS EDUCATION	105
IA	12/01/89- / /	AIDS IN THE OFFICE ENVIRONMENT	44
IA	06/11/89- / /	AIDS/HIV INFECTION UPDATE	15
IA	06/12/89-06/13/89	13TH ANNUAL IA INFEC. CONTROL SEMIN	87
IA	02/11/90- / /	AIDS: THECHRISTIAN CHALLENGE	61
** Subtotal **			1297

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE IN			
IN	04/05/89- / /	PREVENTING AIDS	18
IN	04/13/89- / /	STATE LEGISLATION REGARDING AIDS	31
IN	04/26/89- / /	COMMON PROGLEMS IN OFF. MGT. OF HIV	6
IN	04/28/89- / /	PROFESSIONAL EDUC. IN AIDS/HIV CARE	16
IN	04/29/89- / /	AIDS PANEL	30
IN	05/01/89- 05/02/89	INF. CONTROL & UNIV. PRECAUTIONS	18
IN	05/02/89- / /	INTRODUCTION 'TO HIV INFECTION	140
IN	05/04/89- 05/05/89	HIV TESTING & CLIENT COUNSELING	11
IN	05/08/89- / /	HIV SRV.CONCPTS IN CLIENT ED.	21
IN	05/10/89- / /	HIV PREV. IN MCH SERVICE CONCEPTS	18
IN	05/12/89- / /	OVERVIEW HIV/AIDS PATIENT CARE	60
IN	05/15/89- / /	HIV/AIDS & NEUROMUSCULAR PROBLEMS	28
IN	05/18/89- 05/18/89	HIV PREVENTION IN MCH PROGRAMS	9
IN	05/24/89- / /	WORKING WITH HIV INFECTION	71
IN	&z/01/89- 06/02/89	HIV & HBV RISK ASSESSMENT	50
IN	06/05/89- / /	UPDATED OVERVIEW OF AIDS & HIV INF.	35
IN	06/20/89- / /	S. XND. CONF. OF UNITED METHODISTS	300
IN	06/21/89- / /	S. IND. CONF. OF UNITED METHODISTS	800
IN	(X3/22/89- 06/22/89	PHYSICAN SEM ON MAGT OF HIV INFECT	14
IN	06/29/89- / /	AIDS IN 'THE WORKPLACE	35
IN	07/21/89- 07/22/89	HIV INF. IN PRIM. MED. PRACTICE	108
IN	07/26/89- / /	INTRO TO HIV/AIDS FOR RESP. THER.	18
IN	08/07/89- / /	HIV PREVENTION IN CHEM. DEP. TRTMT.	8
IN	08/15/89- / /	AIDS.HIV INF.,& ADDICTIONS PROGRAMS	30

Midwest AIDSTraining **and** Education **Center**
Listing of Programs

MATEC Site	**Program bates:**	**Program Topic**	Participant Count
IN	08/ L /89- / /	AIDS.HIV INF . .& ADDICTIONS PROGRAMS	32
IN	08/23/89- / /	AIDS,HIV INF., & ADDICTION PROGRAMS	18
IN	08/24/89- / /	OVERVIEW OF AIDS/HIV INF. & PREV.	34
IN	09/06/89- / /	GRAND ROUNDS.OCC.RISK IN HIV INF.	150
IN	09/11/89- / /	OVERVIEW OF HIV INF. & INF. CONTROL	17
IN	09/13/89- 09/14/89	AIDS/HIV & CHEM.DEP. ISSUES	27
IN	09/18/89- / /	COMP. CARE FOR AIDS/HIV PATIENTS	18
IN	09/18/89- 09/18/89	ORAL MANIFESTATION OF HIV+/MAGI	20
EN	09/18/89- / /	AIDS OVERVIEW FUR FOSTER PARENTS	8
IN	09/19/89- / /	HIV PREV. IN CHEM. DEP. PROGRAMS	
IN	09/20/89- 09/21/89	AIDS,HIV INF. . & CHEM. DEPENDENCY	40
IN	09/26/89- / /	OVERVIEW OFAIDS/HIV	110
IN	09/28/89- / /	AIDS PATIENTS IN MY CARE	25
IN	10/04/89- 10/04/89	UPDATE ON AIDS/HIV INFEC 4 CORK PER	13
IN	10/17/89- 10/17/89	COPING W/ STRESS OFAIDS/HIV CARE	70
IN	10/18/89- 10/19/89	AIDS,HIV INFECTION& CHEM DEPENDENCY	22
IN	11/02/89- 11/02/89	AIDS/HIV RESEARCH & TREATMENT UPDAT	35
IN	11/06/89- 11/06/89	NURSING GRAND ROUNDS	80
IN	11/07/89- 11/27/89	HIV WORKSHOP FORINSTITUOF HIGHER	68
IN	11/14/89- 11/15/89	HIV ANTIBODY TESTING & COUNSELING	15
IN	11/15/89- 11/15/89	ORAL MANIF/DENMGT OF HIV+ PATIENTS	19
IN	11/15/89- / /	DENTAL TREATMENT OF HIV+ PATIENT	19
IN	11/17/89- 11/17/89	PROFESPRACT ISSUES IN CAR FOR HIV/	15
IN	11/17/89- 11/17/89	OCCUPATIONAL RISKS OFTHE AIDS VIRU	5
IN	11/18/89- 12/06/89	AIDS HIV MINI-RESIDENCY	9

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
IN	11/21/89- 11/21/89	ORAL MANIFEST OF HIV+ & MANAGEMENT	30
IN	11/21/89- / /	TREATMEN T/MANAGEMENT OF HIV+PATIENT	20
IN	11/21/89- 11/21/89	AIDSPATIENTSIN MY CARE	71
IN	11/27/89- / /	URAL MANIFESTATIONS/DENTAL MGMT HIV	8
IN	11/28/89- / /	OVERVIEWOF HIV FUR WELFARE WORKERS	110
IN	11/30/89- / /	GRAND ROUNDS IN MEDICINE	30
IN	12/05/89- / /	AIDS PATIENTS INMY CARE	37
IN	12/13/89- 12/14/89	AIDS, HIV INFECTION &CHEM DEPENDEN	12
IN	04/25/89- / /	TEACHING BASICS H IV&INF. CONTROL	4
IN	04/26/89- / /	TEACHING BASICS HIV &INF. CONTROL	13
IN	07/10/89- / /	AIDS TRAINER UPDATE	51
IN	07/13/89- / /	AIDS TRAINING UPDATE	16
IN	08/03/89- / /	AFFECTIVE TECH . IN HIV EDUCATION	8
IN	08/31/89- / /	HIV PREV . EDUC. UPDAT E FOR SCHOOL RN	11
IN	10/05/89- 10/06/89	PREVENTION AND CARE	16
IN	10/10/89- 10/11/89	PRE/POST TEST COUNSELING FOR HIV	17
IN	10/12/89- 10/12/89	HIV UPDATE: INFECTION CONTROL	15
IN	11/01/89- 11/02/89	AIDS,HIV INFEC & CHEM DEPEN ISSUES	40
IN	11/15/89- 11/17/89	HIV ANTIBODY TESTING & COUNSELING	13
IN	11/30/89- / /	TEACHING THE BASICS ABOUT AIDS/HIV	8
IN	01/10/90- / /	TREAETING 'THE HIV+DENTAL PATIENT	69
IN	01/24/90- 01/25/90	AIDS HIV INFECTION AND CHEM DEPEND	25
IN	02/02/90- / /	MANAGEMENT OF EARLY HIV DISEASE	36
IN	02/07/90- / /	PSYCHOSOCIAL OVERVIEW OF HIV INFECT	35
IN	02/09/90- / /	HIV AND OCCUPATIONAL SAFETY	20

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
IN	02/09/90- / /	HIV/AIDS ON THE COLLEGE CAMPUS	12
IN	02/09/90- / /	CLINICAL OVERVIEW OF HIV INFECTION	118
IN	02/15/90- / /	TREATMENT/MANAGEMENT OF HIV+PATIENT	15
IN	02/19/90- / /	MANAGEMENT OF EARLY HIV DISEASE	30
IN	02/20/90- / /	MANAGEMENT OF EARLY HIV DISEASE	25
IN	02/21/90- 02/22/90	AIDS, HIV INFECTION & CHEM DEPENDEN	18
IN	02/21/90- / /	TREATING PATIENTS WITH HIV DISEASE	30
IN	02/24/90- / /	ISSUES PROSPECTIVE FOSTER PARENTS	15
IN	03/07/90- 03/08/90	AIDS HIV INFECTION ISSUES PROG STAF	34
IN	11/28/90- / /	AIDS PATIENTS IN LONG TERM CARE	12
IN	02/12/90- / /	DENTAL TREATMENT OF THE HIV PATIENT	24
IN	03/22/90- / /	HIV/AIDS UPDATE	25
IN	03/21/90- / /	HIV/AIDS UPDATE	12
IN	03/20/90- / /	AIDS UPDATE	23
IN	03/01/90- / /	HIV UPDATE: BIOPSYCHOSOCIAL REALITY	96
IN	03/29/90- / /	AIDS PATIENTS IN MY CARE	20
IN	03/29/90- / /	AIDS/HIV UPDATE	25
IN	04/03/90- / /	AIDS TRAINER PROGRAM	35
IN	04/02/90- / /	AIDS TRAINER UPDATE	14
** Subtotal **			4049

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE MN			
MN	04/07/89- 04/07/89	AIDS EDUCATION & HEALTHCARE WORKERS	40
MN	04/11/89- 04/11/89	AIDS ED. TO HEALTH CARE STUD. & WORK	40
MN	04/18/89- 04/18/89	AIDS IN THE NURSING HOME	30
MN	04/19/89- 04/19/89	AIDS IN GENERAL	26
MN	04/19/89- 04/19/89	AIDS AND YOU	48
MN	04/25/89- 04/25/89	AIDS&HEALTH CARE WORKERS	27
MN	04/27/89- 04/27/89	AIDS EDUCATION	70
MN	04/28/89- 04/28/89	AIDS& THE HEALTH CARE WORKER	75
MN	05/02/89- 05/02/89	THE ETHICAL ASPECTS OF AIDS	50
MN	05/02/89- / /	AIDS AND HOMOSEXUALITY	37
MN	05/17/89- 05/17/89	AIDS EDUCATION &RISKS	6
MN	06/01/89- / /	LOSS CONTROL WORKSHOP	8
MN	06/10/89- 06/10/89	AIDS& HEALTH CARE WORKERS	14
MN	06/20/89- / /	PUBLIC HEALTH EDUC. AND AIDS	33
MN	06/21/89- / /	GENERAL AIDS PRESENTATION	10
MN	07/06/89- / /	AIDS INFO. FOR HEALTH CARE WORKERS	14
MN	07/11/89- / /	AIDS AND THE HEALTH CARE WORKER	47
MN	07/12/89- / /	AIDS AND THE HEALTH CARE PROF.	10
MN	07/19/89- / /	AIDS	19
MN	07/20/89- / /	AIDS	28
MN	08/02/89- / /	AIDS &THE HEALTH CARE WORKER	26
MN	08/03/89- / /	AIDS SEMINAR	32
MN	08/17/89- / /	AIDS SEMINAR	35
MN	08/31/89- / /	AIDSN AND THE HEALTHCARE PROF.	11

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program bates:	Program Topic	Participant Count
MN	09/20/89- / /	AIDS PRESENTATION	6
MN	09/26/89- / /	AIDS AWARENESS IN HLTH.CARE SETTING	2[illegible]
MN	09/26/89- / /	AIDS PRESENTATION	39
MN	09/28/89- 09/29/89	BEHAVIOR CHANGE THROUGH EDUCATION	220
MN	10/10/89- 10/10/89	BEHAVIOR CHANGE	57
MN	10/11/89- 10/11.89	AIDS	25
MN	10/14/89- 10/14.89	BEHAVIOR CHANGE	17
MN	10/17/89- 10/17/89	STUDENT HUMAN SER TECH AIDS TRAININ	37
MN	10/17/89- 10/17/89	AIDS TRAINING FOR HEALTH CARE WORKE	40
MN	10/17/89- 10/17/89	UNIVERSAL PRECAUTIONS	32
MN	10/18/89- 10/18/89	AIDS ON THE COLLEGE CAMPUS	78
MN	10/27/89- 10/27/89	AIDS PRESENTATION	25
MN	12/02/89- 12/02/89	AIDS UPDATE FOR HEALTH CARE PROFESS	97
MN	12/08/89- / /	CARING RESPONSE TO PPL W/HIV IN LTC	18
** Subtotal **			1450

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE MO			
MO	04/12/89- / /	AIDS UPDATE	30
MO	04/13/89- 04/14/89	HIV PSYCHOSOC ASSESSMENT / INTERVENTI	24
MO	04/14/89- / /	PREPARING TO CAE FOR AIDS PATIENTS	93
MO	04/25/89- / /	AIDS UPDATE	49
MO	05/01/89- / /	AIDS & NURSING HOME ADMINISTRATION	11
MO	05/01/89- 05/01/89	AIDS AND NURSING HOME ADMINISTRATIO	14
MO	05/02/89- / /	AIDS AND NURSING HOME ADMN.	41
MO	05/02/89- 05/02/89	AIDS AND NURSING HOME ADMINISTHATIO	50
MO	05/04/89- 05/05/89	CASE MGMT. FOR THE HIV INFECTED	12
MO	05/13/89- / /	HIV UPDATE	148
MO	05/ I-8/89-- i /	AIDS AND NURSING HOME ADMN.	24
MO	05/18/89- 05/18/89	AIDS AND NURSING HOME ADMINISTRATIO	13
MO	05/19/89- / /	AIDS AND NURSING HOME ADMN.	54
MO	05/19/89- / /	AIDS AND NURSING HOME ADMN.	19
MU	05/22/89- 05/23/89	DEALING WITH THE AIDS PATIENT	27
MO	05/23/89- / /	HOME HEALTH NURSING	42
MO	06/05/89- / /	AIDS UPDATE	82
MO	06/14/89- / /	AIDS UPDATE	19
MO	06/14/89- / /	AIDS UPDATE	123
MO	06/22/89- / /	AIDS AND SURGERY	20
MO	06/23/89- 06/26/89	HIV ASSESSMENT & INTERVENTION	77
MO	06/30/89- 06/30/89	AIDS AND NURSING HOME ADMINISTRATIO	14
MO	07/14/89- / /	AIDS INFORMATION	30
MO	07/25/89- / /	AIDS UPDATE	5

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
MO	08/10/89- / /	AIDS UPDATE	63
MO	08/10/89- / /	AIDS UPDATE	62
MO	08/25/89- / /	HIV/AIDS UPDATE FOR DENTISTS	74
MO	09/06/89- / /	AIDS 101 FOR MEDICAL STUDENTS	123
MO	09/22/89- / /	AIDS WORKSHOP	19
MO	10/04/89- 10/04/89	AIDS IN PERSPETIVE	40
MO	10/06/89- 10/06/89	CARE OF PERSON W/HIV INFECTION AIDS	524
MU	10/06/89- 10/06/89	HIV TRANSMISSION & PREVENTION	124
MO	10/12/89- / /	AIDS	112
MO	10/13/89- 10/13/89	AIDS: A PREVENTIVE PERSPECTIVE	112
MO	10/19/89- 10/19/89	BASIC INFECTION CONTROL IN CLINIC	53
MO	10/19/89- 10/20/89	WHERE WE ARE. WHERE WE'RE GOING	196
MO	10/27/89- 10/27/89	AIDS AND NURSING HOME ADMINISTRATIO	46
MU	12/01/89- 12/01/89	SEMINAR ON AIDS	35
MO	01/23/90- / /	BODY SUBSTANCE PRECAUTIONS	30
MO	01/26/90- / /	CME NETWORK T-RAINING	19
MO	01/27/90- / /	AIDS UPDATE	35
MO	02/07/90- / /	HIV UPDATE	20
MO	02/15/90- / /	UNIVERSAL PRECAUTIONS	13
MO	02/15/90- / /	INFECTION CONT'ROL NURSE'S UPDATE	13
MO	02/16/90- / /	AIDS UPDATE	18
MO	02/16/90- / /	AIDS UPDATE	32
MO	02/19/90- / /	AIDS 101	58
MO	02/19/90- / /	HIV UPDATE	18
MO	04/03/90- / /	EDUCATING YOUR STAFF ABOUT AIDS	94

Midwest AIDS 'Training and Education Center
Listing of Programs

MATEC site	Program Dates:	Program Topic	Participant Count
** Subtotal **			2934

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE NI			
NI	03/27/89- 06/02/89	AIDS LECTURES	125
NI	04/04/89- / /	INFANTS AI-RISK TELECONFERENCE	70
NI	04/06/89- / /	HIV TEST COUNSELING IN THE HOSPITAL	55
NI	04/15/89- 04/15/89	MEDICAL EDUCATION IN THE YEAR 2000	12
NI	04/19/89- / /	AIDS AND THE DENTAL PRACTICE	96
NI	04/20/89- / /	AIDS IN THE WORKPLACE	40
NI	04/21/89- / /	AIDS &THE DENTAL PRACTICE	78
NI	04/25/89- / /	OBTAINING A SEXUAL HISTORY	14
NI	04/26/89- / /	NEUROPSYCHIATRIC ASPECTS OF AIDS	65
NI	04/26/89- / /	NEUROPSYCHIATRIC ASPECTS OF AIDS	22
NI	04/28/89- / /	BURN-OUT PREVENTION FOR CAREGIVERS	14
NI	05/04/89- 05/04/89	EMERGING ISSUES FOR MENTAL HEAL PRO	12
NI	05/05/89- / /	AIDS IN THE WORKPLACE	4
NI	05/08/89- / /	AIDS INTHE WORKPLACE	19
NI	05/08/89- / /	APPL. OF POLYMERASE CHAIN REACTIONS	9
NI	05/08/89- / /	AIDS PREVENTION IN HI RISK TEENS	15
NI	05/08/89- / /	MED.ASPECTS OF AIDS IN CHILDREN	10
NI	05/20/89- / /	MD RESPONSIBILITIES UNDER AIDS LAW	50
NI	05/23/89- / /	AIDS AND MENTAL HEALTH CONFERENCE	85
NI	05/24/89- / /	UPDATE ON AIDS ISSUES	3
NI	06/02/89- / /	CDOH AIDS TRAINING	16
NI	06/02/89- / /	CDOH AIDSTRAINING	26
NI	06/12/89- / /	AIDS RESEARCH UPDATE: NEUROPSY. FEDS	14
NI	06/14/89- / /	CDOH AIDS TRAINING	85

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
NI	06/14/89- / /	CDOH AIDS TRAINING	8
NI	06/14/89- / /	CDOH AIDS TRAINING	10
NI	06/16/89- / /	CDOH AIDS TRAINING	43
NI	06/16/89- / /	CDOH AIDS TRAINING	25
NI	06/20/89- / /	UNIVERSAL PRECAUTIONS - HIV/HBV	23
NI	06/20/89- / /	CDOH AIDS TRAINING	30
NI	06/20/89- / /	CDOH AIDS TRAINING	35
NI	06/23/89- / /	CDOH AIDSTRAINING	36
NI	C&/23/89- / /	CDOH AIDS TRAINING	27
NI	06/26/89- / /	UNIVERSAL PRECAUTIONS-HIV/HBV	12
NI	06/29/89- / /	CDOH AIDS TRAINING	77
NI	06/29/89- / /	CDQH AIDS TRAING	31
NI	06/30/89- / /	CDOH AIDSTRAINING	31
NI	06/30/89- / /	CDOH AIDS TRAINING	32
NI	06/30/89- / /	UNIVERSAL PRECAUTIONS	5
NI	07/10/89- 07/14/89	UNIVERSAL PRECAUTIONS	69
NI	07/10/89- / /	UNIVERSAL PRECAUTIONS	15
NI	07/12/89- / /	CDQH AIDS 'TRAINING	34
NI	07/12/89- / /	CDOH AIDS TRAINING	13
NI	07/12/89- / /	CDOH AIDS TRAINING	41
NI	07/13/89- / /	UNIVERSAL PRECAUTIONS	12
NI	07/14/89- / /	CDOH AIDS TRAINING	75
NI	07/14/89- / /	CDOH AIDS TRAINING	33
NI	07/14/89- / /	CDOH AIDS TRAINING	20
NI	07/14/89- / /	UNIVERSAL PRECAUTIONS	46

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
NI	07/14/89- / /	UNIVERSAL PRECAUTIONS	24
NI	07/19/89- / /	UNIVERSAL PRECAUTIONS	14
NI	07/19/89- 07/20/89	UNIVERSAL PRECAUTIONS	20
NI	07/24/89- 08/03/89	UNIVERSAL PRECAUTIONS	109
NI	07/28/89- / /	CDOH AIDS TRAINING	25
NI	08/01/89- 08/03/89	AIDS AND THE MENTAL HEALTH PROFESS.	6
NI	08/02/89- / /	UNIVERSAL PRECAUTIONS	9
NI	08/03/89- / /	UNIVERSAL PRECAUTIONS	7
NI	08/07/89- 08/18/89	UNIVERSAL PRECAUTIONS	64
NI	08/08/89- / /	UNIVERSAL PRECAUTIONS	6
NI	08/09/89- / /	UNIVERSAL PRECAUTIONS	5
NI	08/09/89- / /	UNIVERSAL PRECAUTIONS	10
NI	08/14/89- / /	UNIVERSAL PRECAUTIONS	5
NI	08/16/89- / /	CDOH AIDS TRAINING	18
NI	08/16/89- / /	IMPACT OF AIDS ON AGING SOCIETY	17
NI	08/16/89- / /	UNIVERSAL PRECAUTIONS	6
NI	08/17/89- 08/17/89	UNIVERSAL PRECAUTIONS	4
NI	08/17/89- / /	CDOH AIDS TRAINING	29
NI	08/18/89- / /	CDOH AIDS TRAINING	38
NI	08/21/89- / /	UNIVERSAL PRECAUTIONS	8
NI	08/23/89- / /	UNIVERSAL PRECAUTIONS	5
NI	08/24/89- / /	PSYCHOSOCIAL ISSUES RELATED TO AID	16
NI	08/24/89- / /	AIDS& LONG TERM CARE	99
NI	08/24/89- / /	UNIVERSAL PRECAUTIONS	14
NI	08/30/89- / /	COUNSELING HIV+ INMATES	6

Midwest AIDS Training and Education Center
Listing of Programs

MAETC Site	Program Dates:	Program Topic	Participant Count
NI	08/31/89- 08/31/89	UNIVERSAL PRECAUTIONS	32
NI	08/31/89- / /	UNIVERSAL PRECAUTIONS	6
NI	09/07/89- / /	HIV COUNSELING AND TESTING	36
NI	09/08/89- / /	HIV COUNSELING AND TESTING	24
NI	09/11/89- / /	ROLE OF COLLEGES & UNIVERSITIES	13
NI	09/11/89- 09/11/89	UNIVERSAL PRECAUTIONS	8
NI	09/12/89- 09/12/89	UNIVERSAL PRECAUTIONS	23
NI	09/13/89- / /	UNIVERSAL PRECAUTIONS	5
NI	09/14/89- 09/14/89	UNIVERSAL PRECAUTIONS	11
NI	09/14/89- / /	AIDS IN 'THE WORKPLACE	5
NI	09/16/89- / /	AIDS & EARLY CHILD CARE SERVICES*	24
NI	09/19/89- / /	HIV COUNSELING AND TESTING	18
NI	09/20/89- 09/20/89	UNIVERSAL PRECAU TIONS	3
NI	09/20/89- / /	AIDS IN THE WORKPLACE	50
NI	09/21/89- / /	UNIVERSAL PRECAUTIONS	23
NI	09/23/89- / /	AIDS IN THE WORKPLACE	20
NI	09/25/89- 09/25/89	UNIVERSAL PRECA'JTION	7
NI	09/26/89- / /	UNIVERSAL PRECAUTIONS	10
NI	09/Z&/89- / /	CASE MGMT/HIV INFECTED DRUG ABUSER	37
NI	09/27/89- / /	UNIVERAL PRECAUTIONS	14
NI	09/27/a??- / /	CASE MGMT/HIV INFECTED DRUG ABUSER	13
NI	09/27/89- / /	UNIVERSAL PRECAUTIONS	10
NI	09/28/89- / /	UNIVERSAL PRECAUTIONS	14
NI	09/29/89- / /	HIV COUNSELING AND TESTING	11
NI	09/30/89- / /	CASE MGMT/HIV+ CLIENTS	14

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
NI	10/03/89- 10/04/89	UNIVERSAL PRECAUTIONS	20
NI	10/03/89- / /	AIDS AND EARLY CHILDCARE SERVICES	90
NI	10/05/89- 10/05/89	UNIVERSAL PRECAUTIONS	
NI	10/08/89- 10/08/89	EDUC=AWARENES,INFO,DECISION,SOLUTIO	78
NI	10/13/89- 10/13/89	UNIVERSAL PRECAUTIONS	9
NI	10/16/89- 10/16/89	AIDS AND THE AGING NETWORK	30
NI	10/16/89- 10/16/89	AIDS & THE AGINGNETWORK	25
NI	10/19/89- / /	AIDS &THE PRIMARY CARE MD	24
NI	10/23/89- 10/23/89	BEHIND **THE SCENES:** PLANNING **AIDS ED**	100
NI	10/27/89- 10/27/89	NAT'L LATINO/HISPANIC AIDS TELECONF	7?
NI	10/27/89- 10/27/89	**WORK** GRP ON HIV ED/TRAINSOC WOK CU	12
NI	11/01/89- 11/01/89	OAK PARK FAMILY SER PRESENTATION	25
NI	11/02/89- 11/03/89	FOSTER PAR CON: CARING/HIV INFEC CH	50
NI	11/08/89- 11/08/89	UNIVERSAL PRECAUTIONS	12
NI	11/28/89- / /	AIDS AND ADOLESCENTS	70
NI	12/01/89- 12/01/89	CARE FOR THE CAREGIVER	27
NI	12/01/89- 12/01/89	WORLD AIDS DAY SEMINAR	60
NI	12/04/89- 12/04/89	WOMEN &AIDS: UNSEEN EPIDEMIC	55
NI	12/06/89- 12/06/89	WOMEN &AIDS: UNSEEN EPIDEMIC	37
NI	12/12/89- / /	HIV TEST COUNSELING	46
NI	12/14/89- / /	HIV 'TEST COUNSELING	63
NI	12/14/89- / /	ISSUES SURROUNDING HOMOSEXUALITY	120
NI	05/10/89- / /	TECHNIQUES FOR AIDS EDUCATION	5
NI	05/31/89- / /	UNIVERSAL PRECAUTIONSTRNG. PROG.	9
NI	06/15/89- 06/16/89	SOCIAL WKRS. TRAINING OTHERS	12

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
NI	06/19/89- 06/20/89	UNIVERSAL PRECAUTIONS. HIV/HBV	38
NI	09/20/89- / /	AIDS BASICS FOR PEER EDUCATORS	35
NI	11/17/89- 11/17/89	FACULTY DEVELOPMENT WORKSHOP	12
NI	11/20/89- 11/20/89	AIDS EDUCATION STUD TRAIN PROGRAM	5
NI	11/30/89- 12/07/89	MINI-RESIDENCY	3
NI	01/05/90- / /	UNIVERSAL PRECAUTIONS	11
NI	01/12/90- / /	AIDS PREVENTION AND EDUCATION	39
NI	01/26/90- / /	CHC PROJECT PLANNING MEETING	14
NI	02/07/90- / /	GAY AND LESBIAN RELATIONSHIPS	23
NI	02/07/90- / /	CHICAGO READ MHC AIDS TRAINING	22
NI	02/07/90- / /	AIDS IN THE WORKPLACE	16
NI	02/12/90- / /	SOMERSET HOUSE AIDS INSERVICE TRAIN	25
NI	02/13/90- / /	SOMERSET HOUSE AIDS PNSERVSCE TRAIN	17
NI	02/14/90- / /	CHICAGO READ MHC AIDS TRAINING	16
NI	02/19/90- / /	SOMERSETHOUSE AIDS INSERVICE TRAIN	22
NI	w/19/90- / /	SOMERSET HOUSE AIDS INSERVICE TRAIN	12
NI	02/20/90- / /	SOMERSET HOUSE AIDSINSERVICE TRAIN	14
NI	02/20/90- / /	SOMERSET HOUSE AIDS INSERVICE TRAIN	14
NI	02/21/90- / /	CHICAGO REAR MHC AIDS TRAINING	11
NI	02/22/90- 02/23/90	ENDING ISOLATION: AIDSHIVIN FAMILY	160
NI	02/23/90- / /	BILL OF RIGHTS FOR HIV-AFFEC FAMILI	20
NI	02/28/90- / /	CHICAGO READ MHC AIDSTRAINING	8
NI	03/02/90- / /	FACULTY DEVELOPMENT WORKSHOP	12
NI	03/o-7/90- / /	AIDSIN THE WORKPLACE	50
NI	03/07/90- / /	KOMED AIDS TRAINING -CHC	22

Midwest AIDS 'Training and Education Center
Listing **of Programs**

MATEC Site	Program Dates:	**Program** Topic	**Participant** Count
NI	03/08/90- 03/09/90	CDOH MHC AIDSTRAINING	25
NI	03/09/90- / /	FACULTY DEVELOPMENTWORKSHOP	12
NI	03/12/90- / /	CDOH MHC AIDS TRAINING	19
NI	03/15/90- / /	EPIDEMIOLOGY AND AIDS PREVENTION	53
NI	02/08/90- / /	SOMER	3
NI	02/13/90- / /	CDOH MHC AIDS TRAINING	4
NI	03/01/90- / /	CDOH MHC AIDS TRAINING	3
NI	03/15/90- / /	CH'GO READ MHC TRAIN TRAINER WKRSHP	
NI	03/19/90- 03/23/90	CDOH MHC AIDS TRAINING	22
NI	03/26/90- / /	CDOH MHC TRAINING	14
NI	03/21/90- / /	GAY/LESBIAN/BI SUBSTANCE ABUSERS	43
NI	03/22/90- / /	LEGAL ASPECTSOF AIDS	25
NI	03/23/90- / /	MANAGEMEN T-HIVASYMPTOMATIC PATIENT	18
NI	03/30/90- / /	SOCIAL WORKCURRICULUM PLANNING MTG	
NI	03/29/90- / /	ORGANIZING AGENCY RESOURCES FOR AID	21
NI	03/30/90- / /	CDOH MHC AIDS TRAINING	22
NI	03/28/90- / /	CDOH **MHC TRAINING**	23
NI	04/02/90- / /	**OPENING MINDS&DOORS: STRATEGY DEVEL**	120
NI	04/16/90- 04/17/90	**CDOH MMC** AIDSTRAINING	22
NI	04/20/90- / /	FACULTY DEVELOPMENT WORKSHIP	
NI	04/18/90- / /	KOMED AIDS TRAINING	**20**
NI	04/05/90- / /	IL MIGRANT COUNCIL TRAINING	12
** Subtotal **			

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
** MATEC SITE SI			
SI	04/05/89-04/05/89	AIDS	43
SI	04/05/89-04/05/89	TALKING WITH THE DYING & AIDS	42
SI	04/11/89-04/11/89	AIDS & NURSING	10
SI	04/13/89- / /	AIDS & THE FACTS	200
SI	04/14/89- / /	AIDS TASK FORCE UPDATE	9
SI	04/17/89-04/21/89	AIDS AWARENESS WEEK	300
SI	04/18/89-04/18/89	AIDS UPDATE	60
SI	04/19/89-04/19/89	MULTIDISCIPLINARY APPROACH & AIDS	114
SI	04/20/89-04/20/89	AIDS & NURSING	14
SI	04/20/89-04/20/89	METRO AREA AIDS RESOURCES	13
SI	04/22/89-04/22/89	SURVIVING LOSS	97
SI	05/20/89-05/20/89	PHYSICIANS RESPONSIBILITIES IN IL	10
SI	05/30/89-05/30/89	CLINICAL MANIFESTATIONS IN AIDS PTS	47
SI	06/01/89-06/01/89	AIDS PATIENTS IN THE DENTAL OFFICE	40
SI	06/01/89-06/01/89	AIDS IN THE COMMUNITY	107
SI	#6/&S/89-04/06/89	AIDS UPDATE	19
SI	06/20/89-06/20/89	INFECTION CONTROL IN DENTAL CLINIC	48
SI	07/06/89- / /	HIV IMPLICATIONS IN PTS W/TUBERCULO	90
SI	07/13/89- / /	THE HIV AND TB CONNECTION	18
SI	07/13/89- / /	CRYPTOMENINGITIN IN IV DRUG USERS	20
SI	07/14/89- / /	PNEUMOCYSTIS CARINII PNEUMONIA	15
SI	07/14/89- / /	AIDS OVERVIEW	33
SI	07/18/89- / /	PRIMARY HIV INFECTION	15
SI	07/19/89- / /	AZTUSE/HLTH CARE WRKR.EXPOSURE	8

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Count
SI	07/25/89- / /	AIDS AND PNEUMONIA ETIOLOGY	12
SI	08/22/89- / /	AIDS REVIEW/INFEC.CONTROL/LT CARE	109
SI	09/13/89- / /	LONG TERM CARE ISSUES & AIDS	54
SI	09/19/89- / /	"AIDS"	29
SI	09/19/89- / /	DASA - TESTING & COUNSELING	18
SI	09/26/89- / /	AID"; & I-HE CORNFIELD	43
SI	09/27/89- / /	DASA - CASE MANAGEMENT	13
SI	09/28/89- / /	AIDS 101	45
SI	09/29/89- / /	UNIVERSAL PRECAUTIONS	106
SI	10/03/89- 10/03/89	AIDS OVERVIEW	80
SI	10/17/89- 10/17/89	HIV & TB CONNECTION	41
SI	10/31/89- 10/31/89	AIDS IN SOUTHERN ILLINOIS	27
SI	11/08/89- 11/08/89	AIDS:ISSU IN MATERNAL/CHIL HEL SET-I	33
SI	11/08/89- 11/08/89	AIDS:ISSIN MATERNAL CHIL HEL SETT	16
SI	11/10/89- 11/10/89	HISTOPLASMOSIS:EMEG PROM HIV	43
SI	11/14/89- 11/14/89	AIDS RESOURCE DAY	209
SI	12/04/89- 12/05/89	HIV TESTING&COUNSELING-IHA PROGRAM	41
SI	12/05/89- / /	DISSEMINATED HISTOPLASMOSIS IN AIDS	12
SI	12/06/89- 12/07/89	HIV TESTING & COUNSELING IHA PROGRA	49
SI	12/14/89-	HIV INFECTION CARINGFOR INDIVIDUAL	120
SI	C&2:,89- / /	AIDS: A PRACTICAL APPROACH	72
SI	10/06/89- / /	AIDS IMPLICATIONS FOR LUNG TERM CAR	26
SI	10/18/89- 10/18/89	AIDS-TEAM TEACHING:IVDU	7
SI	10/19/89- 10/19/89	AIDS: A PRACTICAL APPROACH	81
SI	10/20/89- 10/20/89	AIDS TEAM TEACHING, III	6

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Participant Cbunt
SI	10/23/89-10/23/89	AIDS/TEATEAC-DIAS TREA'TMENT III	6
SI	11/09/89-11/09/89	HIV UPDATE	2s
SI	11/16/89-11/16/89	HIV/AIDS:A PRACTICAL APPROACH	65
SI	01/16/90-/ /	AIDS UPDATE	37
SI	01/24/90-/ /	AIDS UPDATE	64
SI	02/01/90-/ /	UNIVERSAL PRECAUTIONS& HIV	65
SI	02/06/90-/ /	AIDS/HIV & ITS CORRELATION W/HTLV-1	20
SI	02/07/90-/ /	MD UPDATE:MATERNAL CHILD HIV ISSUES	'27
SI	02/09/90-/ /	UPDATE ON HEPATITIS B& HIV	21
SI	02/20/90-/ /	CLSNCIAL SPECTRUM OF HIV PATIENTS	98
SI	02/27/90-/ /	EVAL . OF INDETERMINATE WESTERN BLOT	8
SI	02/21/90-/ /	STD-HIV UPDATE	59
SI	03/15/90-/ /	AIDS UPDATE	82
SI	03/13/90-/ /	HIV WITH STAPAUREUS SINUSITUS	12
SI	03/20/90-/ /	AIDS AND CRYPTOMENINGITIS	12
SI	03/21/90-/ /	RENAL FAILURE IN AIDS PATIENTS	55
SI	04/10/90-/ /	DIAGNOSIS/THERAPY INFECTION HIV PAT	24
SI	03/27/90-/ /	AIDS EDUCATION	'26
SI	03/22/90-/ /	NURSING AND THE AIDS EPIDEMIC	197
SI	04/05/90-/ /	AIDS OVERVIEW	51
SI	04/05/90-/ /	AIDS UPDATE	25
SI	04/12/90-/ /	AIDS IN 1990	340
SI	04/16/90-/ /	AIDS EPIDEMIC	46
SI	04/03/90-/ /	AIDS OVERVIEW	22
SI	04/04/90-/ /	CRYPTOCOCCAL MENINGITIS IN AIDS PA7	17

Midwest AIDS Training and Education Center
Listing of Programs

MAIEC Site	Program Dates:	Program Topic	Participant Count
SI	04/03/90- / /	AIDS UPDATE	21
31	03/27/90- / /	AIDS.PERICARDITIS.PULMONARY INFILTR	15
** Subtotal **			4104

Midwest AIDS Training and Education Center
Listing of Programs

MATEC Site	Program Dates:	Program Topic	Par-ticipant Count
** MAT-EC SITE WI			
WI	04/05/89- 04/05/89	NURSING'S RESPONSE TO AIDS	150
WI	04/13/89- / /	AIDS UPDATE	250
WI	04/24/89- 04/24/89	AIDS POLICY UPDATE	100
WI	05/11/89- /	AIDS INSERVICE	79
WI	o&24/89- 05/24/89	AIDS UPDATE	23
WI	06/18/89- / /	AIDS LEGISLATION IN WISCONSIN	2000
WI	06/20/89- 06/28/89	AIDS INSERVICE	95
WI	07/13/89- / /	AIDS 101 FOR DIETARY STAFF	15
WI	07/20/89- / /	AIDS ISSUES FOR NURSING HOMES	35
WI	08/10/89- / /	AIDS IN THE INPATIENT PSYCH SETTING	30
WI	09/07/89- / /	AIDS POLICIES/PROC. FOR NURS. HOMES	25
WI	09/09/89- / /	LEGAL ISSUES/AIDS & HIV INFECTION	31
WI	09/15/89- / /	CLINICAL. ASPECTS OF AIDS	45
WI	09/15/89- / /	AIDS IN WISCONSIN	146
WI	11/18/89- / /	CHEM DEPENDENT POPULATION AIDS RISK	36
WI	11/22/89- / /	HIV ANTIBODY COUNSELING TRAINING	6
WI	11/28/89- / /	HIV ANTIBODY COUNSELING TRAINING	8
WI	12/06/89- / /	OVERVIEW OF HIV INFECTION	6
WI	12/06/89- / /	AIDS EDUCATION RESOURCES IN WISC	45
WI	12/13/89- / /	UNIVERSAL PRECAUTIONS	69
WI	12/13/89- / /	AIDS OVERVIEW	3
WI	04/07/89- 04/08/89	TRANSMISSIBLE DISEASE EDUC. PROJECT	7
WI	09/10/89- 09/10/89	AIDS/HIV CLINICAL NURSE ED PROG	SO
WI	10/06/89- 10/07/89	TRANSMISSIBLE DISEASE ED PROJECT	10

Midwest AIDS Trainin
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MATEC Program Site	Dates:	Program Topic
WI	11/17/89- 11/18/89	TRANSMISSIBLE DISEASE PROJECT
WI	12/06/89- / /	CARING FOR PWA's AT HO
WI	01/03/90- / /	UNIVERSAL PRECAUTIONS F UP
WI	01/09/90- / /	UNIVERSAL PRECAUTIONS F UP
WI	01/09/90- / /	UNIVERSAL PRECAUTIONS
WI	01/10/90- / /	UNIVERSAL PRECAUTIONS FOLLOW-UP
WI	01/16/90- / /	UNIVERSAL PRECAUTIONS FOLLOW-UP
WI	01/23/90- / /	UNIVERSAL PRECAUTIONS FOLLOW-UP
WI	01/31/90- / /	AIDS 101
WI	02/08/90- / /	INFORMATION DISSEMINATION HIV
WI	02/16/90- / /	CARING RE AIDS-PROFESS A APPROAC
WI	03/19/90- / /	AIDS/HIV: THE SPECTRUM OF C
WI	03/06/90- / /	&IDS/HIV THE SPECTRUM OF INFECTIONS
WI	04/17/90- / /	SPECTRUM OF CARE FOR HIV INFECTION
WI	03/20/90- / /	EVERYTHING YOU WAN T KNOW ABC HIV
WI	03/20/90- / /	EVERYTHING YOUWANT KNOW ABO HIV
WI	03/15/90- / /	AIDS 101FOR NURSING HOMES
WI	04/05/90- / /	AIDS 101 FOR NURSING HOMES
WI	03/22/90- / /	HIV SPECTRUM/UNIVERSAL PRECAU/LEGAL

** Subtotal **

*** Total ***

Midwest AIDS Training and Education Center
Participant Occupation Report

As of : 05/08/90

Occupation Types

1. Registered Nurse
2. Physician
3. Dentist
4. Social Worker/Counselor
5. Dental Hygienist/Technician
6. LPN/Nurse Aides
   Clergy
8. Educator
9. Health Administrator
10. Physical/Occup. Therapist
11. Housekeeping/Maint. Work
12. Med. Lab. Worker
13. Dietician/Nutritionist
14. Emerg. Med. 'Tech.
15. Pharmacist
16. Nurse Pract./Phys.Asst.
17. All Others

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MATEC Site: CM

Pi-oat-am count:	4
Total Participants:	162
Total Participants For Whom Occupation is Known	162
Total Unknown:	0
Percentage Unknown:	0.00 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
	22	13 58 %	0	0.00 %
2.	23	14.20 %		0.62 %
3.	2	1.23 %	0	0.00 %
4.	31	19.14 %	4	2.47 %
5.	0	0.00 %	0	0.00 %
6.		4.32 8	0	0.00 %
7.	1	0.62 %	0	0.00 %
8.	0	0.00 %	0	0.00 %
9.	32	19.75 %	0	0.00 %
10.	0	0.00 %	0	0.00 %
11.	0	0.00 %	0	0.00 %
12.	1	0.62 %	0	0.00 %
13.	1	0.62 %	0	0.00 %
14.	0	0.00 %	0	0.00 %
15.	0	0.00 %	0	0.00 %
16.		0.62 %	0	0.00 %
17.	0	0.00 %	36	22.22 %

MATEC Site: IA

Program count:	11
Total Participants:	1297
Total Participants For Whom Occupation is Known:	1295
Total Unknown:	2
Percentage Unknown:	0.15 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
	356	27.49 %	0	0.00 %
	88	6.80 %	0	0.00 %
3.	0	0.00 %	0	0.00 %
	143	11.04 %	0	0.00 %
5.	5	0.39 %	0	0.00 %
6.	63	4.86 %	0	0.00 %
7.	24	1.85 %	0	0.00 %
8.	76	5.87 %		0.00 %
	34	2.63 %		0.00 %
10.	5	0.39 %	0	0.00 %
11.	0	0.00 %	0	0.00 %
12.		0.69 %	0	0.00 %
13.	0	0.00 %	0	0.00 %
14.	12	0.93 %	0	0.00 %
15.	3	0.23 %	0	0.00 %
16	2	0.15 %	0	0.00 %
17.	409	31.58 %	66	5.10 %

MATEC Site: IN

Program count:	93
Total Participants:	4049
Total Participants For Whom Occupation is Known:	3896
Total Unknown:	153
Percentage Unknown:	3.78 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
1.	438	11.24 %	76	1.95 %
2.	319	8.19 %	330	8.47 %
3.	188	4.83 %	0	0.00 %
4.	393	10.09 %		0.03 %
5.	34	0.87 %	0	0.00 %
6.	75	1.93 %	0	0.00 %
	1216	31.21 %	0	0.00 %
8.	26	0.67 %	0	0.00 %
9.	186	4.77 %	0	0.00 %
10.	9	0.23 %	28	0.72 %
11.	22	0.56 %	0	0.00 %
12.	88	2.26 %	0	0.00 %
13.	29	0.74 %	0	0.00 %
14.	1	0.03 %	0	0.00 %
15.	0	0.00 %	0	0.00 %
16.	11	0.28 %	0	0.00 %
17.	69	1.77 %	357	9.16 %

MATEC Site: MN

Program count:	38
Total Participants:	1450
Total Participants For Whom Occupation is Known:	1443
Total Unknown:	7
Percentage Unknown:	0.48 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
1.	394	27.30 %	9	0.62 %
2.	26	1.80 %	16	1.11 %
3.	0	0.00 %	0	0.00 %
4.	10	0.69 %	0	0.00 %
5.	0	0.00 %	0	0.00 %
6.	163	11.30 %	95	6.58 %
7.	4	0.28 %	0	0.00 %
8.	14	0.97 %	0	0.00 %
9.	35	2.43 %	35	2.43 %
10.	40	2.77 %	37	2.56 %
11.	44	3.05 %	4	0.28 %
12.		0.07 %	11	0.76 %
13.	23	1.59 %	0	0.00 %
14.	0	0.00 %	0	0.00 %
15.	0	0.00 %	0	0.00 %
16.	20	1.39 %	0	0.00 %
17.	204	14.14 %	258	17.88 %

MATEC Site: MO

Program count :	49
Total Participants:	2934
Total Participants For Whom Occupation is Known:	2931
Total Unknown:	3
Percentage Unknown:	0.10 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
1.	1141	38.93 %	88	3.00 %
2.	403	13.75 %	123	4.20 %
3.	83	2.83 %	0	0.00 %
4.	169	5.77 %	8	0.27 %
5.	0	0.00 %	0	0.00 %
6.	151	5.15 %	35	1.19 %
7.	12	0.41 %	0	0.00 %
8.	101	3.45 %	0	0.00 %
	232	7.92 %	0	0.00 %
10.	1	0.03 %	0	0.00 %
11.	13	0.44 %	0	0.00 %
12.		0.17 %	0	0.00 %
13.	1	0.03 %	0	0.00 %
14.	39	1.33 %	0	0.00 %
15.	4	0.14 %	0	0.00 %
16.	31	1.06 %	25	0.85 %
17.	35	1.19 %	231	7.88 %

MATEC Site: NI

Program count:	171
Total Participants:	4891
Total Participants For Whom Occupation is Known:	4194
Total Unknown:	697
Percentage Unknown:	14.25 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
1.	760	18.12 %	12	0.29 %
2.	264	6.29 %	107	2.55 %
3.	64	1.53 %	0	0.00 %
	729	17.38 %	57	1.36 %
5.	59	1.41 %	0	0.00 %
6.	188	4.48 %	17	0.41 %
	28	0.67 %	0	0.00 %
8.	158	3.77 %	8	0.19 %
9.	192	4.58 %		0.02 %
10.	16	0.38 %	0	0.00 %
11.	111	2.65 %	0	0.00 %
12.	177	4.22 %	4	0.10 %
13.	64	1.53 %	7	0.17 %
14.	2	0.05 %	0	0.00 %
15.	19	0.45 %	129	3.08 %
16.	23	0.55 %	0	0.00 %
17.	69	1.65 %	929	22.15 %

MATEC Site: SI

Program count:	76
Total Participants:	***4104***
Total Participants For Whom Occupation is Known:	4079
Total Unknown:	5
Percentage Unknown:	0.12 %

Percentages listed below are of those for whom an occupation is known

	Practioners		Students	
	1138	*27.76* %	292	7.12 %
2.	743	18.13 %	385	3.39 %
3.	56	1.37 %	57	1.39 8
4.	***217***	5.29 %	151	3.68 %
5.	***45***	1.10 %	32	0.78 %
6.	217	5.29 %	14	0.34 %
7.	15	0.37 %	0	0.00 %
8.	126	3.07 % I	86	2.10 %
9.	80	1.95 %	***20***	0.49 %
10.	17	0.41 %	30	0.73 8
11.	11	0.27 8	0	0.00 %
12.	61	1.49 %	33	0.81 %
13.	12	0.29 %	20	0.49 %
14.	13	0.32 %	20	0.49 %
15.	32	0.78 %	2	0.05 %
lb.	7	0.17 %	0	0.00 %
17.	80	1.95 %	87	2.12 %

TEC Site: WI

Program count:	43
Total Participants:	3834
Total Participants For Whom Occupation is Known:	1.834
Total Unknown:	2000
Percentage Unknown:	52.16 %

Percentage; Listed below are of those for whom an occupation is known

	Practioners		Students	
1.	566	30.86 %	46	2.51 %
2.	470	25.63 %	0	0.00 %
3.	30	1.64 %	0	0.00 %
4.	20	1.09 %	50	2.73 %
5.	0	0.00 %	0	0.00 %
6.	252	13.74 %	0	0.00 %
7.	1	0.05 %	0	0.00 %
8.	31	1.69 %	0	0.00 %
9.	113	6.16 %	10	0.55 %
10.	19	1.04 %	20	1.09 %
11.	51	2.78 %	0	0.00 %
12.	3	0.16 %	0	0.00 %
13.	37	2.02 %	10	0.55 %
14.	0	0.00 %	0	0.00 %
15.	1	0.05 %	0	0.00 %
16.	0	0.00 %	0	0.00 %
17.	0	0.00 %	104	5.67 %

Midwest AIDS Training and Education Center
Minority Case-Load Report

As of : 05/08/90

Minority Types

MATEC Site: CM
Program count per site: 4

African American	Latino	Asian	Native American	White	Other	Unknown
40	17	0	4	101	0	0

#of Participants w/ patient loads in the following categories:

0 - 10% minority:	0
11 - 25% minority:	32
26 - 50% minority:	22
more than 50 % minority:	64
unknown	44

MATEC Site: IA
Program count per site: 11

African American	Latino	Asian	Native American	White	Other	Unknown
222	41	13	6	1004	11	0

# of Participants w/ patient loads in the following categories:

0 - 10% minority:	364
11 - 25% minority:	42
26 - 50% minority:	100
more than 50 % minority:	110
unknown :	681

MATEC Site: IN

Program count per site: 93

African American	Latino	Asian	Native American	White	Other	Unknown
185	15	8	1	2222	8	1610

# of Particinants w/ patient loads in the following categories:

0 -	10% minority:	240
11 -	25% minority:	219
26 -	50% minoritv:	162
more than	50 % minority:	83
	unknown	3345

MATEC Site: MN

Program count per site: 38

African American	Latin0	Asian	Native American	White	Other	Unknown
54	2	17	7	825	4	541

# of Participants w/ patient loads in the following categories:

0 -	10% minority:	273
11 -	25% minority:	24
26 -	50% minority:	32
more than	50 % minority:	0
	unknown	1121

MATEC Site: MO

Program count per site: 49

African American	Latin0	Asian	Native American	White	Other	Unknown
449	21	45	28	2380	11	0

# of Participants w/ patient loads in the following categories:

0 -	10% *minority:	242
11 -	25% minority:	415
26 -	50% minority:	65
more than	50 % minority:	95
	unknown	2111

MATEC Site: NI

Proqram count per site: 171

African American	Latino	Asian	Native American	White	Other	Unknown
1049	281	242	50	2498	7	695

# of Participants w/ patient ioads in the followinq categories:

0 - 10% minority:	324
11-25% minority:	189
26 - 50% minority:	263
morethan50% minot-itv:	1104
unknown	3011

MATEC Site: SI

Grout-am count per site: 76

African American	Latin0	Asian	Native American	White	Other	Unknown
459	49	35	0	3060	59	442

# of Participants w/ patient loads in the following categories:

0 - 10% minority:	1596
11 - 25% minoritv:	178
26 - 50% minority:	291
more than 50 % minoritv:	174
unknown	1265

MATEC Site: WI

Program count per site: 43

African American	Latin0	Asian	Native American	White	Other	Unknown
SO	32	73	9	3444	67	159

# of Participants w/ patient loads in the following categories:

0 - 10% minority:	3470
11 - 25% minority:	37
26 - 50% minority:	17
more than 50 % minority:	14
unknown	296

Number of Programs (All Sites): 485
Totals for all programs: Total. 8 (of known)

1.) African American:	2508	13.01 %
2.) Latino:	458	2.38 %
3.) Asian:	433	2.25 %
4.) Native American:	105	0.54 %
5.) White:	15534	80.60 %
6.) Other:	236	1.22 %
Total Reporting Occupation	19274	
Unknown	3447 / 22721	15.17 %

# of Participants w/ Patient Loads in the Following Categories

0 - 10% minority:	0509
11 - 25% minority:	1736
26 - 50% minority:	952
more than 50 8 minority:	1644
unknown :	11880

10,841

22,721

MATEC SITE	PROGRAM TITLE BEGIN - END DATES	TOTAL MINOR- PART.	LENGTH: CONTACT (Hrs.): HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17-20	21
CH	AIDS/HIV CONTINUITY Of CARE cont. 06/26/89 - 06/27/89	47	20 13.0	611.0 PNS COMMUNITY & MIGRANT HEALTH CENTERS	7	4	0	10	0	7	1	0	IO		0	1	1	0	0	IV		0
CH	ETC'S IS RESOURCE TO SOCIAL WORKERS 10/11/89 - 10/11/89	25	10 1.0	75,0 SOCIAL WORK EDUCATORS	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CH	FUNDING SOURCES FOR AIDS/HIV SERVIC 12/14/89 - / /	54	23 1.0	54.0 COMMUNITY HEALTH PROVIDERS	10	10	0	0	0	0	0	0	15	0	0	0	0	0	0	0	19	0
CH	AIDS/HIV SERVICE COMMUNITY BASED 12115189 - / /	36	a 1.0	36.0 COMMUNITY HEALTH PROVIDERS	5	10	2	0	0	0	0	0	10	0	0	0	0	0	0	0	9	0
IA	BEFORE IT HITS HOME (DRAMA. PROD.) 04/08/89 - 04/09/89	460	125 2.0	920.0 UNIV. STUDENT HEALTH PERSONNELL	15	ii	9	24	0	0	0	20	9	0	0	0	0	0	0	0	381	0
IA	AIDS: TODAY'S CHALLENGE 04/19/89 - 04/20/89	220	49 8.0	1160.0 MDS. RNS. SVS. COUNSELORS. ALLIED HEALTH	bb	b	0	28	5	so	2	39	2	5	0	5	0	12	0	0	0	0
IA	AIDS: ISSUES AND CHALLENGES 05/12/89 - 05/12/89	91	0 6.0	146.0 MDS. RNS. SVS. COUNSELORS. LABSTAFF.ETC.	50	18	0	3	0	11	2	1	5	0	0	2	0	0	0	0	1	0
IA	CL HOW 10 BO II CONFERENCE 05/25/89 - / /	18	0 5.0	90.0 MEDICAL EDUCATION PROFESSIONALS	2	12	0	0	0	0	0	0	3	0	0	0	0	0	0	0		10
IA	AIDS SYMPOSIUM FOR HEALTH PROF. 06/02/89 - / /	92	11 4.0	368.0 NOS. RNS. SWS. OTHER HEALTH PROFESSIONALS	60	14	0	10	0	0	0	2	5	0	0	0	0	0	0	0	1	0
IA	AIDS 89: INTERDISCIPLINARY CONFERENC 09/08/89 - / /	104	4 6.0	624.0 All HEALTH PROFESSIONALS	49	23	0	18	0	0	0	3	b	0	0	2	0	0	2	0	1	0
IA	CULTURALLY SPECIFIC AIDS EDUCATION 10/17/89 - 10/17/89	105	86 5.0	525.0 BLA CONTEENS. RN'S LPN'S CLERGY OTHER COM WO	5	1	0	43	0	2	20	5	0	0	0	0	0	0	0	1	28	0
IA	AIDS IN THE OFFICE ENVIRONMENT 12/01/89 - / /	44	1 2.0	88.0 ALL HEALTH PROFESSIONALS	11	3	0	17	0	0	0	6	5	0	0	0	0	0	0	1	1	0
IA	LIDS: THE CHRISTIAN CHALLENGE 02/11/90 - I /	61	0 1.0	61.0 CHURCH MEMBERS CONCERNED ABOUT AIDS	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	61	0
IN	PREVENTING AIDS 04/05/89 - I /	18	9 3.0	54.0 FOOD SRV..HOUSEKEEPING & SECURITY	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	14	0
IN	STATE LEGISLATION REGARDING AIDS 04/13/89 - / /	31	I 1.0	31.0 MEDICAL TECHNOLOGISIS	0	0	0	0	0	0	0	0	0	0	0	31	0	0	0	0	0	0
IN	COMMON PROBLEMS IN OFF. MGT. Of HIV 04/26/89 - / /	6	0 3.0	18.0 PRIMARY CARE PHYSICIANS	0	b	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	PROFESSIONAL WC. IN AIDS/HIV CARE 04/28/89 - / /	Ib	0 1.0	16.0 SIGMA THETA TAU NURSES HONOR SOCIETY	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS PANEL 04/29/89 - / /	30	2 1.0	30.0 PRIMARY CARE PHYSICIANS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	INF. CONTROL & UNIV. PRECAUTIONS 05/01/89- 05102189	18	1 2.0	36.0 STATE HEALTH DEPARTMENT HOSPITAL INSPECTORS	12	0	0	U	0	6	0	0	b	0	0	0	0	0	0	0	0	0
IN	INTRODUCTION TO HIV INFECTION 05/02/89 - / /	140	a 1.0	140.0 SOPHOMORE MEDICAL STUDENTS	0	140	0	0	0	0	U	0	0	0	0	0	0	0	0	0	0	0
IN	HIV TESTING & CLIENT COUNSELING 05/04/89 - 05/05/89	II	0 14.0	154.0 MATERNAL AND CHILD HEALTH CLINIC STAFF	8	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0
IN	NIV SRV. CONCPTS IN CLIENTED. 05/08/89 - / /	21	0 8.0	168.0 MCH CLINIC STAFF	17	0	0	0	0	0	0	0	1	0	0	0	3	0	0	0	0	0
IN	HIV PREV. IN MCH SERVICE CONCEPTS 05/10/89 - I I	18	0 a.0	144.0 MATERNAL & CHILD HEALTH CLINIC STAFF	7	0	1	5	0	1	0	2	2	0	0	0	1	0	0	0	0	0

MATEC SITE	PROGRAM TITLE BEGIN END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hrs.);	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14
IN	OVERVIEW HIV/AIDS PATIENT CARE 05/12/89 - / /	60	2	1.0	60.0	MEDICAL SOCIAL WORK DIRECTORS	0	0	0	60	0	0	0	0	0	0	0	0	0	0
IN	HIV/AIDS & NEUROMUSCULAR PROBLEMS 05/15/89 - 1 /	23	0	2.0	56.0	PHYSICAL THERAPY STUDENTS	0	0	0	0	0	0	0	0	0	23	0	0	0	0	0	0	0
IN	HIV PREVENTION IN MCH PROGRAMS 05/18/89 - 05/18/89	9	0	8.0	72.0	STAFF IN MCH CLINICS	5	0	0	1	0	0	0	1	1	0	0	0	1	0	0	0	0	0
IN	WORKING WITH HIV INFECTION 05/24/89 - / /	71	3	4.0	284.0	CHEM.DEPENDENCY/PSYCHIATRIC TREATMENT STAFF	31	0	0	3	0	0	1	0	1	7	0	1	1	0	0	0	26	0
IN	HIV & HBV RISK ASSESSMENT 06/01/89 - 06/02/89	50	5	1.0	50.0	MEDICAL LABORATORIES	0	0	2	0	0	0	0	0	0	0	0	48	0	0	0	0	0	0
IN	UPDATED OVERVIEW OF AIDS & HIV INF 06/05/89 - / /	35	4	4.0	140.0		0	0	0	35	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	S. IND. CONF. Of UNITED METHODISTS 06/20/89 - / /	300	0	1.0	300.0	METHODIST CLERGY AND LAY VOLUNTEERS	0	0	0	0	0	0	300	0	0	0	0	0	0	0	0	0	0	0
IN	S. IND. CONF. Of UNITED METHODISTS 06/21/89 - / /	800	0	1.0	800.0	METHODIST CLERGY AND LAY VOLUNTEERS	0	0	u	0	0	0	800	u	0	0	0	0	0	0	0	0	0	0
IN	PHYSICIAN SEM ON MAGT OF HIV INFECT 06/22/89 - 06/22/89	14	4	4.0	56.0	PRISON DOCTORS STATEWIDE	0	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
IN	AIDS IN THE WORKPLACE 06/29/89 - 1 /	35	5	1.0	70.0	SOCIAL WORKERS	0	0	0	35	3	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	HIV INF. IN PRIM. MED. PRACTICE 07/21/89 - 07/22/89	108	7	17.0	1836.0	PRIMARY CARE PHYSICIANS	2	4	1	2	2	0	0	0	3	11	0	0	0	0	0	0	24	0
IN	INTRO TO HIV/AIDS FOR RESP. THER. 07/26/89 - / /	18	2	4.0	72.0	RESPIRATORY THERAPISTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0
IN	HIV PREVENTION IN CHEM. DEP. TRTMT. 08/07/89 - 1 /	8	0	3.0	24.0	FEDERAL CDTP REGULATORY PROGRAM STAFF	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS, HIV INF. & ADDICTIONS PROGRAMS 08/15/89 - / 1	30	3	7.0	210	0 CHEM. DEP. TRTMT PROG. ADMINISTRATORS	4	0	0	1	0	0	0	0	12	0	0	0	0	0	0	0	1	0
IN	AIDS, HIV INF., & ADDICTIONS PROGRAMS 08/17/89 - / /	32	5	7.0	224.0	CHEN. DEP. TRTMNT. PROG. ADMINISTRATORS	1	2	0	10	0	0	1	0	15	0	0	0	0	0	0	0	3	0
IN	AIDS, HIV INF., & ADDICTION PROGRAMS 08/23/89 - / /	19	1	1.0	12b.0	CHEN. DEPTRTMT. PROG. ADMINISTRATORS	1	0	0	6	0	0	0	0	10	0	0	0	0	0	0	0	1	0
IN	OVERVIEW OF AIDS/HIV INF. & PREV. 08/24/89 - /	34	9	1.0	68.0	INPATIENT PSYCH/CDTP SUPPORT STAFF	0	0	u	0	11	0	u	1	0	0	14	0	13	0	0	0	6	0
IN	GRAND ROUNDS: OCC. RISK iii HIV INF. 09/06/89 - / /	150	12	1.0	150.0	MED. FACULTY. HOUSE STAFF. AND STUDENTS	0	150	0	0	0	0	u	0	0	0	u	0	0	U	0	0	0	0
IN	OVERVIEW Of HIV INF. & INF. CONTROL 09/11/89 - / /	17	3	2.0	34.0	HOME HEALTH NURSES AND AIDES	5	0	0	0	0	12	0	0	0	0	0	0	0	0	0	3	0	0
IN	AIDS/HIV & CHEM. DEP. ISSUES 09/13/89 - 09/14/89	27	12	14.0	378.0	CHEM. DEP./ADDICTIONS COUNSELORS	0	0	0	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	CONP. CARE FOR AIDS/HIV PATIENTS 09/18/89 - / /	18	3	2.0	56.0	HOME HEALTH NUHSES RHO AIDES	6	0	0	0	0	12	0	0	0	0	0	0	0	0	0	u	0	0
IN	ORAL MANIFESTATION OF HIV+/MAGT 09/18/89 - 09/18/89	20	0	1.0	20.0	PRACTICING DENTISTS	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS OVERVIEW FOR FOSTER PARENTS 09/18/89 - / /	A	1	3.0	24.0	STAFF, MATERNITY HOME/ADOPTION/FOSTER CARE	0	0	U	8	0	0	0	0	0	0	3	0	0	0	0	u	0	0
IN	HIV PREV. IN CHEM. DEP. PROGRAMS 09/19/89 - / /	7	0	6.0	42.0	ADDICTIONS COUNSELORS IN COURT REF. PROGRAMS	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	7	0
IN	AIDS, HIV INF., & CHEM. DEPENDENCY 09/20/89 - 09/21/89	40	12	14.0	560.0	CHEM. DEP./ ADDICTIONS COUNSELORS		0	u	27	0		1	1	0	2	0	0	0	0	0	0	0	0
IN	OVERVIEW Of AIDS/HIV 09/26/89 - / /	110	10	1.0	110.0	CATHOLIC CLERGY AND LAY LEADERSHIP	0	0		0	0	0	110	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS PATIENTS IN NV CARE 09/28/89 - / /	25	1	7.0	115.0	NURSES, MEDICAL SOCIAL WORKERS	23	0	0	2	0	0	0		3	0	0	0	0	0	0	0	0	0

MATEC SITE	PROGR BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: CONTACT (Hrs.): HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	A
IN	UPDATE ON AIDS/HIV INFEC & CORRPER 10/04/89 - 10/04/89	13	1	3.0 39.0	STATE/COUNTY CORRECTIONAL OFFICIALS	0	0	0	2	0	0	0	0	2	0	0	0	0	0	0	
IN	COPING W/STRESS OFAIDS/HIVCARE 10/17/89 - 10111189	70	0	1.0	70.0 HOSPITAL EMPLOYEES	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS,HIV INFECTION& CHEM DEPENDENCY 10/18/89 - 10/19/89	22	2	1b.0	352.0 CHEMICAL DEPENDENCY COUNSOLORS	5	0	0	14	0	0	0	0	0	0	0	0	0	0	3	0
IN	AIDS/HIV RESEARCH & TREATMENT UPDAT 11/02/89 - 11/02/89	35	5	1.0	35.0 HOSPITAL SOCIAL SERVICE DEPARTMENT	0	0	0	25	0	0	0	0	0	0	0	0	0	0	10	0
IN	NURSING GRAND ROUNDS 11/06/89 - 11/06/89	80	0	1.6	66.0 HOSPITAL PROFESSIONAL EMPLOYEES	50	0	0	4	0	0	1	0	0	0	0	0	9	0	0	0	1b	0
IN	HIV WORKSHOP FOR INSTITU Of HIGHER 11/07/89 - 11/27/89	68	0	2.0	136.0 COLLEGE ADMIN. FACULTY AND STUDENT REPRESENTA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	68
IN	HIV ANTIBODY TESTING & COUNSELING 11/14/89 - 11/15/89	15	1	15.0	221.0 NUR. COUN WORK W/DEVELO DISABLED CLIENTS RES	10	0	0	1	0	0	0	10	0	0	2	0	0	0	0	1	0	
IN	ORAL MANIF/DEN MGT OF HIV+ PATIENTS 11/15/89 - 11/15/89	19	0	3.0	17.0 DENTIST & DENTAL AUXILIARIES	0	0	16	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
IN	DENTAL TREATMENT Of HIV+ PATIENT 11/15/89 - / /	19	2	4.0	16.0 DENTISTS, HYGENISTS, DENTAL ASSISTANTS	0	0	7	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	PROFES PRACT ISSUES IN CAR FOR HIV/ 11/17/89 . 11/17/89	15	6	1.0	15.0 MEMBERS IN PRIMARY HEALTH CARE ASSOCIATION	3	8	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0
IN	OCCUPATIONAL RISKS OF THE AIDS VIRU 11/17/89 - 11/17/89	5	2	1.0	5.0 MEMBERSHIP, IPHCA	1	0	0	0	0	3	0	0	0	0	0	0	0	0	0	10	0	
IN	AIDS HIV MINI-RESIDENCY 11/18/89 - 12/06/89	9	3	13.0	111.0 MD's & NURSE PRACTICIONERS II EARY HLTH CENTS	6	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	
IN	ORAL MANIFEST Of HIV+ & MANAGEMENT 11/21/89 - 11/21/89	36	0	1.0	50.0 GRADUATE DENTISTS	0	0	27	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	TREATMENT/MANAGEMENT Of HIV+PATIENT 11/21/89 - / /	20	5	1.0	10.0 GRADUATE PERIDONTAL STUDENTS	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS PATIENTS IN HV CARE 11/21/89 - 11/21/89	71	0	7.0	497.0 NUARSES AND NURSING STUDENTS	71	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	ORAL MANIFESTATIONS/DENTAL MENT HIV 11/27/89 - / /	8	0	2.0	16.0 DENTISTS AND DENTAL AUXILIARIES	0	0	5	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	OVERVIEW OF HIV FOR WELFARE WORKERS 11/28/89 - / /	110	0	5.0	130.0 ISDPW MANAGERS AND SUPERVISORY PERSONNEL	0	0	0	0	0	0	0	0	110	0	0	0	0	0	0	0	0	0
IN	GRAND ROUNDS IN MEDICINE 11/30/89 - / /	50	C	0.0	0.0 PHYSICIANS	2	25	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0
IN	AIDS PATIENTS IN NY C M 12/05/89 - / /	57	0	1.0	2Yi.0 NURSES AND NURSING STUDENTS	18	0	0	0	0	16	0	0	0	0	0	0	0	0	0	3	0	
IN	AIDS, HIV INFECTION a CHEM DEPENDEN 12/13/89 - 12/14/89	12	0	12.1	114.0 ADDICTIONS COUNSELORS	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	TREAETING THE HIV+ DENTAL PATIENT 01/10/90 - / /	69	4	2.0	138.0 DENTISTS	0	0	b9	0	U	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS HIV INFECTION AND CHEM DEPEND 01/24/90 - 01/25/90	25	0	14.0	350.0 ADDICTIONS COUNSELORS	3	0	0	11	0	2	0	0	0	0	0	11	0	0	0	1	0	0
IN	MANAGEMENT OF EARLY NIV DISEASE 02/02/90 - / /	36	0	1.1	36.0 MEDICAL RESIDENTS AND STUDENTS	0	36	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	PSYCHOSOCIAL OVERVIEW Of HIV INFECT 02/07/90 - / /	35	8	1.0	35.0 ENTIRE STAFF Of CENTER	3	2	0	1	0	0	0	0	1	0	0	2	0	0	0	1	25	0
IN	HIV AND OCCUPATIONAL SAFETY 02/09/90 - / /	20	0	1.0	20.0 RADIOLOGY FACULTY AND RESIDENTS	U	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	HIV/AIDS ON THE COLLEGE CAMPUS 02/09/90 - / /	12	0	1.0	12.0 HEATH/HUMAN SERVICE STUDENTS PROVIDERS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	
IN	CLINICAL OVERVIEW OF NIV INFECTION 02/09/90 - / /	118	3	2.0	23b.0 MEDICAL STUDENTS	0	118	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

MATEC SITE	PROGRAM TITLE BEGIN - END DATES	TOTAL PART.	MINUT TIES	LENGTH (HRS.)	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION OCCUPATION CODE 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
IN	TREATMENT/MANAGEMENT Of HIV+PATIENT 02/15/90 I /	15	0	2.0	30.0	PRIVATE PRACTICE DENTISTS	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	MANAGEMENT OF EARLY HIV DISEASE 02/19/90 - / /	50	J	1.3	JO.O	MEDICAL RESIDENTS AND STUDENTS	0	50	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	MANAGEMENT Of EARLY HIV DISEASE 02/20/90 - / /	25	2	1.0	21.0	MEDICAL RESIDENTS AND STUDENTS	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	AIDS. HIV INFECTION & CHEM DEPENDEN 02/21/90 - 02/22/90	18	0	16.0	288.0	ORUG COUNSELORS	3	0	0	11	0	1	0	0	1	0	0	3	0	0	0	0	1	1
IN	TREATING PATIENTS WITH HIV DISEASE 02/21/90 - / /	30	5	2.0	60.0	SOCIAL SCIENCE/PRE-HEALTH PROFESSIONALS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	JO	0
IN	ISSUES PROSPECTIVE FOSTER PARENTS 02/24/90 - / /	15	0	2.0	30.0	VOLUNTEER FOSTER PARENTS-'TENDER CARE PROGRAM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	0
IN	AIDS HIV INFECTION ISSUES PROG STAF 03101190 -03/08/90	34	2	14.0	476.0	DRUG&ALCOHOL COUNSELORS	7	0	0	23	0	1	0	0	1	0	0	0	0	0	0	0	2	0
IN	AIDSPATIENTS IN LONG TERM CARE 11/28/90 - / */	12	6	1.0	24.0	MANAGEMENT TEAM-LARGE SNF/ICF LTC FACILITY	5	0	0	3	0	0	0	0	1	1	1	0	1	0	0	0	0	0
IN	HIV/AIDS UPDATE 03/22/90 - / /	25	0	1.0	50.0	COUNTY WELFARE ADMINISTRATORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	0
IN	HIV/AIDS UPDATE 03/21/90 /	12	0	2.0	24 0	COUNTY WELFARE ADMINISTRATORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	0
IN	AIDS UPDATE 03/20/90 - / /	23	0	2.0	46.0	COUNTY/DISTRICT WELFARE ADMINISTRATORS	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	23	0
IN	HIV UPDATE: BIOPSYCHOSOCIAL REALITY 05101190 . //	96	1	8.0	168.0	DIRECT SERVICE PERSONNEL OF HOSPITAL	37	0	0	2	0	14	0	0	0	1	3	4	0	0	0	0	11	0
IN	AIDS PATIENTS IN MY CARE 03/29/90 - / ,	20	0	7.0	140.0	RN's, LPN's, STUDENTS	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
IN	AIDS/HIV UPDATE 03/29/90 - / I	25	1	2.0	50.0	COUNTY WELFARE DIRECTORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	0
MN	AIDSEDUCATION & HEALTHCARE YORKERS 04/07/89 - 04/07/89	40	0	1.0	40.0	NURSING HOMESTAFF	0	0	0	0	0	34	0	0	0	0	1	0	0	0	0	0	0	0
MN	AIDS 10.10 HEALTHCARE STUD.& YORK 04/11/89 - 04/11/89	40	0	2.0	80.0	HUMAN SERVICES STUDENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40	0
MN	AIDSINTHE NURSING HOME 04/18/89 - 04/18/89	30	0	1.0	30.0	NURSES CNAS, ETC NURSING HOME	2	0	0	0	0	21	0	0	0	0	3	0	4	0	0	0	0	0
MN	AIDS IN GENERAL 04119119 -04/19/89	26	0	1.0	26.0	HIGH SCHOOL STUDENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	0
MN	AIDSAND VW 04/19/89 - 04/19/89	48	0	1.0	48.0		0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	45	0
MN	AIDS & HEALTH CARE WORKERS 04/25/89 - 04/25/89	27	0	1.0	27.0	LPNS. RNS	2	0	0	0	0	20	0	0	3	0	2	0	0	0	0	0	0	0
MN	AIDS EDUCATION 04/27/89 . 04/27/89	70	0	1.0	70.0	NURSES	20	0	0	1	0	50	0	0	0	0	0	0	0	0	0	0	0	0
MN	AIDS & THE HEALTHCARE YORKER 04/28/89 . 04/28/89	75	0	1.0	75 0		11	0	0	2	0	50	0	0	0	3	5	0	0	0	0	0	22	0
MN	THE ETHICAL ASPECTS OF AIDS 05/02/89 - 05/02/89	50	0	1.0	50.0	COLLEGE STUDENTS	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	49	0
MN	AIDS AND HOMOSEXUALITY 05/02/89 - / /	37	0	2.0	74.0	MINISTERS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37	0
MN	AIDS EDUCATION & RISKS 05/17/89 05/17/89	6	0	1 0	5 0	CITY ADMINISTRATORS DEALING W/FIRE-RESCUE	0	0		0	0	0	0	0	4	0	0	0	0	0	0	0	2	0
MN	LOSS CONTROL WORKSHOP 06/01/89 - / /	8	0	1.0	8.0	CITY CLERKS ADMINISTRATORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
MN	AIDS & HEALTH CARE WORKERS 06/10/89 - 06110189	14	0	1.0	14.0	NURSES AND NURSES ASSTS	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	12	1	0

NAIEC SITE	PROGRAM BEGIN . END DATES	TOTAL PART	MINOR- ITIES	LENGTH: (Hrs):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11					
NW	PUBLIC HEALTH EDUC. AND AIDS 06/20/89 - / /	33	1	2.0	66.0	HOSP. ADMINISTRATION STUDENTS	0	0	0	0	0	0	0	0	33	0	0	0	0	0	0	0
NN	GENERAL AIDS PRESENTATION 06/21/89 - / /	10	1	1.0	10.0	NURSES AND MAINTENANCE STAFF	3	0	0	1	0	2	0	2	0	0	0	0	0	0	0	2	0
MN	AIDS INFO. FOR HEALTH CARE WORKERS 07/06/89 - / /	14	4	2.0	28.0	HEALTH CARE GROUP HOME YORKERS	11	0	0	1	0	0	0	0	1	0	1	0	1	0	0	0	10	0
MN	AIDS AND THE HEALTH CARE WORKER 07/11/89 - / /	47	1	1.0	41.0	NURSING HOME STAFF	12	0	0	0	0	15	0	0	0	0	9	0	4	0	0	0	7	0
NW	AIDS AND THE HEALTH CARE PROF. 07/12/89 - / /	10	2	2.0	20.0	LPI'S	0	0	0	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0
MN	AIDS 07/19/89 - / /	19	4	1.0	19.0	HEALTH CARE WORKERS	0	16	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0
MN	AIDS 07/20/89 - / /	28	19	1.0	28.0	MEDICAL ASSISTANTS. NURSE AIDES	1	0	0	0	0	14	0	2	0	0	0	0	0	0	0	9	2
MN	AIDS & THE HEALTH CARE WORKER 08/02/89 - / /	26	6	1.0	26.0	HEALTH CARE WORKERS	3	0	0	1	0	10	0	1	0	2	1	0	5	0	0	3	0
NN	AIDS SEMINAR 08/03/89 - / /	32	11	1.0	32.0	HEALTH CARE PROFESSIONALS	3	0	0	1	0	5	0	0	0	6	5	0	1	0	0	0	11	0
MN	AIDS SEMINAR 08/17/89 - / /	35	3	1.0	35.0	HEALTH CARE PROFESSIONALS	3	0	0	3	0	16	0	1	0	0	1	0	5	0	0	0	0	0
MN	AIDSN AND THE HEALTH CARE PROF. 08/31/89 - / /	11	2	1.0	11.0	NEO. TECH. STUDENTS	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0
MN	RIDS PRESENTATION 09/20/89 - / /	6	0	1.0	5.0	HEALTH CARE PROFESSIONALS	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MN	AIDS AWARENESS IN HLTH.CARE SETTING 09/26/89 . / /	23	9	1.0	23.0	NURSING HOME STAFF	9	0	0	0	0	10	0	0	0	0	3	0	1	0	0	4	0	5
NW	AIDS PRESENTATION 09/26/89 - / /	39	0	1.0	39.0	PHYSICAL THERAPISTS	0	3	0	0	3	0	0	0	0	27	0	0	0	0	0	0	0	0
MN	BEHAVIOR CHANGE THROUGH EDUCATION 09/28/89 - 09/29/89	220	0	1.0	220.0	REGISTERED NURSES IN INFECTION CONTROL	220	0	0	3	0	0	0	0	0	3	3	0	0	0	0	0	0	0
MN	BEHAVIOR CHANGE 10/10/89 - 10/10/89	57	9	1.0	57.0	NURSES	57	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MN	AIDS 10/11/89 - 10/11/89	25	2	1.0	25.0	HEALTH WORKERS	8	0	0	0	0	10	0	0	2	0	4	1	0	0	0	0	0	0
NW	BEHAVIOR CHANGE 10/14/89- 10114189	17	0	1.0	1326.0	DOCTORS OFCHIROPRACTIC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17	0
MN	STUDENT HUMAN SER TECH AIDS TRAININ 10/17/89 - 10/17/89	37	0	1.0	31.0	STUDENT HUMAN SERVICES TECH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37	0
MN	AIDS TRAINING FOR HEALTH CARE WORK 10/17/89- 10111189	40	0	1.0	40.0	THERAPISTS	0	0	0	0	0	0	3	4	0	27	0	0	0	0	0	0	6	0
MN	UNIVERSAL PRECAUTIONS 10/17/89 - 10/17/89	32	2	1.0	32.0	HEALTH CARE WORKERS	3	0	0	1	0	11	0	0	0	0	7	0	1	0	0	0	9	0
MN	AIDS ON THECOLLEGE CRNPUS 10/18/89 - 10/18/89	78	0	3.0	234.0	OR. NURSES. CAMPUS HEALTH CLINIC ADMINISTRATO	24	26	0	0	0	0	0	0	24	0	0	0	0	0	0	4	0	0
MN	AIDS PRESENTATION 10/27/89 - 10/27/89	25	4	0.0	0.0		0	0	3	0	0	0	0	1	0	0	0	0	0	3	0	0	24	0
MN	AIDS UPDATE FOR HEALTH CARE PROFESS 12/02/89 - 12/02/89	97	1	2.0	194.0	DRS Of PODIATRY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	97	0
MO	AIDS UPDATE 04/12/89 - / /	30	3	1.0	30.0	NURSING MANAGERS & SUPERVISORS	30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0
MO	NIV PSYCHOSOCASSESSMENT/INTERVENTI 04/13/89 - 04/14/89	24	0	0.0	0.0	CASE MGMT. WORKERS. MENTAL HLTH PROFESSIONALS	8	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	PREPARING TO CAE FOR AIDS PATIENTS 04/14/89 . / /	93	1	30.0	2790.0	PHYSICIANS	0	93	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0

MATEC / SITE	PROGRAM TITLE / BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hrs.).	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION, OCCUPATION CODE													
							1	2	3	4	5	6	7	8	9	10	11	12	13	14
MO	AIDS UPDATE 04/25/89 - / /	49	11	1.0	49.0	OB/GYN & NURSERY NURSES IN UNIV HOSPITAL	33	0	0	0	0	16	0	0	0	0	0	0	0	0
MO	AIDS & NURSING HOME ADMINISTRATION 05/01/89 - / /	11	0	3.0	33.0	NURSING HOME ADMINISTRATORS	1	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMINISTRATIO 05/01/89 - 05/01/89	14	0	3.0	42.0	INSTI ADV NURS. ENVIR SANITARIANS. CL SOC WOR	0	0	0	0	0	0	0	0	14	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMN. 05/02/89 - / /	41	8	3.0	123.0	NURSING HOME ADMINISTRATORS	8	0	0	0	0	4	0	0	0	0	2	0	1	0
MO	AIDS AND NURSING HOME ADMINISTRATIO 05/02/89 - 05/02/89	30	5	3.0	90.0	AADV NURSE. SANITARIANS. CLI SOC WOR.RES INSP	0	0	0	0	0	0	0	0	30	0	0	0	0	0
MO	CASE MGNT. FOR THE HIV INFECTED 05/04/89 - 05/05/89	12	2	0.0	0.0	CASE MANAGEMENT SOCIAL WORKERS & NURSES	7	0	0	5	0	0	0	0	0	0	0	0	0	0
MO	HIV UPDATE 05/13/89 - / /	148	7	7.0	1036.0	PRIMARY CARE PHYSICIANS IN S.W. MISSOURI	5	136	0	3	0	0	1	0	3	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMN. 05/18/89 - / /	24	0	3.0	72.0	NURSING HOME ADMINISTRATORS	2	0	0	0	0	6	0	0	0	0	1	0	0	0
MO	AIDS AND NURSING HOME ADMINISTRATIO 05/18/89 - 05/18/89	13	1	3.0	39.0	ADV NURSE. SANITARIANS. CL SOC WORK RES INSPE	0	0	0	0	0	0	0	0	13	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMN. 05/19/89 - / /	54	6	3.0	162.0	NURSING HOME ADMINISTRATORS	5	0	0	0	0	5	1	0	0	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMN. 05/19/89 - / /	19	4	3.0	57.0	NURSES.SANITATIANS.SW.INSPECTORS	0	3	0	0	0	0	0	0	14	0	0	0	0	0
MO	DEALING WITH THE AIDS PATIENT 05/22/89 - 05/23/89	27	4	1.0	27.0	PHYSICIANS. RESPIRATORY THERAPIST. NURSES	9	2	0	0	0	0	0	0	0	0	0	0	0	0
MO	HOME HEALTH NURSING 05/23/89 - / /	42	3	2.0	84.0	HOME HEALTH NURSES	31	0	0	0	0	11	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 06/05/89 - / /	82	16	4.0	328.0	HOSPITAL-BASED NURSES	82	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 06/14/89 - / /	19	3	0.0	0.0	NURSES & AIDS IN THE LODGE'S NURSING HOME	7	0	0	0	0	12	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 06/14/89 - / /	123	37	1.0	123.0	NURSES FROM MO DEPT OF CORRECTIONS STATEWIDE	48	0	0	0	0	75	0	0	0	0	0	0	0	0
MO	AIDS AND SURGERY 06/22/89 - / /	20	2	1.0	20.0	SURGERY RESIDENTS	0	20	0	0	0	0	0	0	0	0	0	0	0	0
MO	HIV ASSESSMENT & INTERVENTION 06/23/89 - 06/26/89	77	12	11.0	847.0	MENTAL HEALTH PROFESSIONALS & OTHER HLTH PROF	30	0	0	47	0	0	0	0	0	0	0	0	0	0
MO	AIDS AND NURSING HOME ADMINISTRATIO 06/30/89 - 06/30/89	14	0	3.0	42.0	ADV NURS. CLI SOC WORK. RES CAR FAC INSPECTOR	4	3	0	0	0	0	0	0	7	0	0	0	0	0
MO	AIDS INFORMATION 07/14/89 - / /	30	5	4.0	120.0	NURSING HOME INSPECTORS	13	0	0	17	0	0	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 07/25/89 - / /	5	0	2.0	10.0	STUDENT NURSE PRACTITIONERS	0	0	0	0	0	0	0	0	0	0	0	0	5	0
MO	AIDS UPDATE 08/10/89 - / /	63	9	1.0	63.0	MENTAL HOSPITAL AND CLINIC WORKERS	26	14	0	8	0	0	0	0	0	0	0	0	6	0
MO	AIDS UPDATE 08/10/89 - / /	62	6	1.0	62.0	MENTAL HEALTH HOSPITAL AND CLINIC WORKERS	34	8	0	12	0	2	0	1	1	1	0	0	0	0
MO	HIV/AIDS UPDATE FOR DENTISTS 08/25/89 - / /	74	0	2.0	148.0	DENTISTS	0	0	74	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS 101 FOR MEDICAL STUDENTS 09/06/89 - / /	123	25	1.0	123.0	FIRST YEAR MEDICAL STUDENTS	0	123	0	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS WORKSHOP 09/22/89 - / /	19	2	2.0	38.0	CLINICAL PSYCHOLOGISTS AND STUDENTS	2	0	2	4	0	0	3	0	0	3	0	4	0	0
MO	AIDS IN PERSPETIVE 10/04/89 - 10/04/89	40	9	2.0	80.0	MEDICAL TECHNOLOGISTS	3	4	0	2	2	4	0	3	1	0	2	0	0	0

RATEC SITE	PROGR. BEGIN - HO DATES	TOTAL PART.	MINOR- ITIES	LENGTH: CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES														
						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
MO	CARE OF PERSON W/HIV INFECTION AIDS 10106189 - 10/06/89	524	89	0.0 4192.0	NURSES	406	56	0	12	0	0	0	14	0	0	0	0	0	1	4	11	20
MO	HIV TRANSMISSION & PREVENTION 10/06/89 - 10/06/89	124	8	1.0 121.0	RN BSN	8:	2	0	3	0	2	0	20	5	0	0	0	0	0	0	b	5	0
MO	AIDS 10/12/89 - / /	112	102	1.0 112.0	BLACK PHYSICIANS, NURSES & HEALTH CARE PROF.	51	16	3	5	0	0	3	12	4	0	0	0	0	0	0	1	Ib	0
MO	AIDS: A PREVENTIVE PERSPECTIVE 10/13/89 - 10/13/89	112	102	1.0 112.0	BLACK PHYS. NURSES. HEALTH CARE PROFESSIONALS	51	16	3	5	0	0	3	12	4	0	0	0	0	0	0	2	16	0
MO	BASIC INFECTION CONTROL IN CLINIC 10/19/89 - 10119189	53	3	2.1 106.0	CLINICAL HEALTH CARE PROFESSIONALS	Ib	0	0	0	0	6	0	3	4	0	0	5	0	1	0	3	J	0
MO	WERE WE ARE, WHERE WE'RE GOING 10119189 -10/20/89	196	37	12.0 2352.0	ALL HEALTH CARE PROFESSIONALS	71	9	0	25	0	7	4	39	22	0	0	0	0	2	0	1	16	0
MO	AIDS AND NURSING HOME ADMINISTRATIO 10/27/89 - 10/27/89	4b	5	3.0 138.0	NURSING HOME STAF AND ADMINISTRATORS	18	0	0	0	0	3	0	0	24	0	1	0	0	0	0	0	0	0
MO	SEMINAR ON AIDS 12/01/89 - 12/01/89	35	1	4.0 140.0	LPN STUDENTS	0	0	0	0	0	35	0	0	0	0	0	0	0	0	0	0	0	0
MO	BODY SUBSTANCE PRECAUTIONS 01/23/90 - / /	30	2	2.0 60.0	NURSING SIUOENIS	30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	CNE NETWORK TRAINING 01/26/90 - / /	19	1	3.0 11.0	MED.DENTAL.OSTEOSCHOOLS;HEALTH DEPT;PROF ASS	1	7	3	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 01/27/90 - / /	35	1	4.0 140.0	EMERGENCY MEDICAL TECHNICIANS IN MO	0	0	0	0	0	0	0	0	0	0	0	0	0	35	0	0	0	0
MO	HIV UPDATE 02/07/90 - / /	20	3	2.0 40.0	OB/GYN NURSE PRACTIONER STUDENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0
MO	UNIVERSAL PRECAUTIONS 02/15/90 - / /	13	1	1.0 13.0	INFECTION CONTROL NURSES	13	0	0	0	0	0	0	0	0	0	0	0	U	0	0	0	0	0
MO	INFECTION CONTROL NURSE'S UPDATE 02/15/90 - / /	13	1	4.0 52.0	INFECTION CONTROL NURSES	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 02/16/90 - / /	18	2	1.0 18.0	MD's, RN's, ATTENDANTS	11	3	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
MO	AIDS UPDATE 02/16/90 - / /	32	0	1.0 32.0	1ST/EAR NURSING STUDENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0
MO	AIDS LOL 02/19/90 - / /	58	5	1.0 58.0	RN STUDENTS	58	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	NIV UPDATE 02/19/90 - / /	18	0	1.0 18.0	OPTHAMOLIGISTS	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MO	EDUCATING YOUR STAFF ABOUT AIDS 04103190 - / /	94	4	3.0 282.0	NURSING HOME ADMINISTRATORS	9	0	0	11	0	0	0	0	74	0	0	0	0	0	0	0	0	0
MI	AIDS LECTURES 03/27/89 - 06/02/89	125	0	4.0 100.0	PHARMACOLOGY STUDENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	125	0	0	0
MI	INFANTS RI RISK TELECONFERENCE 04/04/89 - / /	10	0	2.0 140.0	MDS, RNS, SYS. EDUCATORS	22	2	1	25	0	19	0	6	7	0	0	0	1	0	0	0	2	0
MI	HIV TEST COUNSELING IN THE HOSPITAL 04/06/89 - / /	35	0	1.0 35.0	HOSPITAL SOCIAL YORK DIRECTORS	0	0	0	35	0	0	0	0	0	0	0	0	0	0	0	U	0	0
MI	MEDICAL EDUCATION IN THE YEAR 2000 04/15/89 - 04/15/89	12	0	2.0 24.0	PHYSICIANS, MEDICAL STUDENTS	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0
MI	AIDS AND THE DENTAL PRACTICE 04/19/89 - / /	96	18	4.0 384.0	DENTISTS &NO HYGIENISTS	0	9	JO	0	14	0	0	0	1	9	0	0	0	0	0	0	0	51
MI	AIDS IN THE WORKPLACE 04/20/89 - / /	40	20	1.0 40.0	COLLEGE AFFIRMATIVE ACTION ADMINISTRATORS	0	0	0	5	0	0	0	5	0	0	0	0	0	0	0	0	JO	0
MI	AIDS & THE DENTAL PRACTICE 04/21/89 - / /	78	19	4.0 312.0	DENTISTS 6 HYGIENISTS	0	9	16	0	24		0	0	0	0	0	0	1	0	0	0	0	38
MI	OBTAINING A SEXUAL HISTORY 04/25/89 - / /	14	3	4.0 56.0	GRADUATE NURSING STUDENTS	14	0			0		0	0	0	0	0	0	3	0	0	0	0	0

MATEC SITE	PROGRAM TITLE BEGIN - END DATES	TOTAL MINOR- PART.	LENGTH: CONTACT HOURS		TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODE: 1	2	3	4	5	6	7	8	9	10	11	12	13	14			
MI	NEUROPSYCHIATRIC ASPECTS OF AIDS 04/26/89 - / /	65	10	3.0	195.0 COUNSELORS/PASTORS/SOCIAL YORKERS	0	0	0	65	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	NEUROPSYCHIATRIC ASPECTS OF AIDS 04/26/89 - / /	22	2	2.0	44.0 PHYSICIANSAND NURSES	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	BURN-OUTPREVENTION FOR CAREGIVERS 04/28/89 - / /	14	1	4.0	56.0 SOCIAL WORKERS	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	EMERGING ISSUES FORMENTAL HEAL PRO 05/04/89 - 05/04/89	12	0	2.0	26.0 MENTALHEALTH PROFESSIONALS	6	0	0	3	0	0	0	0	2	0	0	0	0	0	0	1	0
MI	AIDS IN THE WORKPLACE 05/05/89 - / /	4	1	6.0	16.0 SOCIAL SERVICE ADMINISTRATORS	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	1	0
MI	AIDS IN THE WORKPLACE 05/08/89 - / /	19	3	1.0	19.0 INDUSTRIAL HEALTH PROFESSIONAL NOS AND RNS	3	5	0	1	0	0	0	0	0	0	0	0	0	0	0	10	0
MI	APPL. Of POLYMERASE CHAIN REACTIONS 05/08/89 - / /	9	3	2.0	18.0 PHYSICIANS. LABORATORY SPECIALISTS	2	1	1	0	0	0	0	0	0	0	0	1	0	0	0	4	0
MI	AIDS PREVENTION IN MI RISK TEENS 05/08/89 - / /	15	12	1.0	15.0 SCHOOL NURSES/SOCIAL WORKERS/EDUCATORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
MI	MED. ASPECTS Of AIDS IN CHILDREN 05/08/89 - / /	10	0	1.0	10.0 SCHOOL NURSES. SOCIAL WORKERS. EDUCATORS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0
MI	NO RESPONSIBILITIES UNDER AIDS LAW 05/20/89 - / /	50	17	2.0	100.0 FAMILY PHYSICIANS	0	50	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	AIDS AND MENTAL HEALTH CONFERENCE 05/23/89 - / /	85	15	8.0	680.0 HO'S, RN'S. SOCIAL WORKERS & OUTREACH WORKERS	2	0	0	22	0	0	2	1	0	0	0	0	0	0	0	9	49
MI	UPDATE ON AIDS ISSUES 05/24/89 - / /	5	5	2.0	10.0 SUBSTANCE ABUSE COUNSELORS	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0
MI	CDOH AIDS TRAINING 06/02/89 - / /	16	8	4.0	64.0 DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	1	0	0	0	1	0	0	1	0	0	0	13	0
MI	CDOH AIDS TRAINING 06/02/89 - / /	26	5	4.0	104.0 DEPT.OF.HEALTH CLINICAL SIbff	3	1	0	0	1	2	0	0	0	0	0	0	1	0	0	0	18
MI	AIDS RESEARCH UPDATE: NEUROPSY.PEDS 06/12/89 - / /	14	4	1.0	28.0 AIDS RESEARCHERS/HUMAN SERVICES SIbff	2	1	0	2	0	0	0	4	1	0	0	0	0	0	1	3	0
MI	CDOH AIDS TRAINING 06/14/89 - / /	85	13	4.0	340.0 DEPT. Of HEALTH CLINICAL STAFF	20	15	0	3	0	15	0	0	0	0	0	25	3	0	1	0	2	1
MI	CDOH AIDS TRAINING 06/14/89 - / /	8	3	4.0	32.0 DEPT. Of HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	1
MI	CDOH AIDS TRAINING 06/14/89 - / /	10	9	4.0	40.0 DEPT. Of HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	9	0
MI	CDOHAIDS MINING 06/16/89 - / /	43	31	6.0	112.0 DEPT OF HEALTH CLINICAL STAFF	18	6	0	0	0	0	0	1	1	0	0	0	2	2	0	0	1 12
MI	CDOH AIDS TRAINING 06/16/89 - / /	25	15	4.0	100.0 DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	2	1	0	0	0	0	0	0	2	0	0	0	20	0
MI	UNIVERSAL PRECAUTIONS - HIV/HBV 06/20/89 - / /	23	14	1.0	23.0 INTERNS/PHYSICIANS	0	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	CDOH AIDS TRAINING 06/20/89 - / /	30	14	4.0	120.0 DEPT.OF HEALTH CLINICAL STAFF	11	7	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	9
MI	COOH AIDSTRAINING 06/20/89 - / /	35	14	4.0	140.0 DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	0	3	0	0	0	0	0	2	4	0	1	0	10	15
MI	CDOH AIDS TRAINING 06121189 -/ /	36	18	4.0	144.0 DEPT.OFHEALTH CLINICAL STAFF	8	3	2	1	1	4	0	0	0	0	0	1	0	0	1	0	0	11
MI	CDOH AIDS TRAINING 06/23/89 - / /	27	10	4.0	108.0 DEPT.OF HEALTH NON-CLINICAL STAFF	1	0	0	0	0	1	0	0	0	0	0	0	3	0	2	0	20	0
MI	UNIVERSAL PRECAUTIONS-HIV/HBV 06/26/89 - / /	12	1	1.0	12.0 OB/GYNE INTERNS/PHYSICIANS	0	1	0	3	0	1	0	0	0	0	0	0	0	0	1	0	0	0
MI	CDOH AIDS TRAINING 06/29/89 - / /	77	11	4.0	308.0 DEPT.OF HEALTH CLINICAL STAFF	0	2	0	0	2	7	0	0	4	3	0	6	1	0	1	0	15	0

MATEC SITE	PROGR. BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hrs.):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
MI	CDOH AIDS TRAING 06/29/89 - / / I	31	17	4.0	124.0	DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3	
MI	CDOH AIDS TRAINING 06/30/89 - / /	31	27	4.0	124.0	DEPT. Of HEALTH CLINICAL STAFF	10	4	0	2	0	5	0	0	0	0	0	0	3	0	0	0	0	7
MI	CDOH AIDS TRAINING 06/30/89 - I I	32	6	4.0	128.0	DEPT. Of HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0	24	0	
MI	UNIVERSAL PRECAUTIONS 06/30/89 - / I	5	2	1.0	5.0	NURSES & OIHER HOSPITAL PERSONNEL	2	0	0	0	0	0	0	0	10	0	0	0	0	0	2	0	0	
MI	UNIVERSAL PRECAUTIONS 07/10/89 - 07/14/89	69	33	1.0	69.0	NURSES & ORTHER HOSPITAL PERSONNEL	35	1	0	0	1	5	0	0	3	0	0	1	0	0	2	0	21	0
MI	UNIVERSAL PRECAUTIONS 07/10/89 - / /	15	3	1.0	11.0	NURSES & OTHER HOSPITAL PERSONNEL	2	2	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0
MI	CDOH AIDS TRAINING 07/12/89 - / /	34	27	4.0	136.0	DEPT. Of HEALTH CLINICAL STAFF	18	4	1	0	1	0	0	0	0	1	0	2	0	0	0	1	0	6
MI	COOH AIDSTRAINING 07/12/89 - / I	13	13	4.0	52.0	DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	2	7
MI	CDOH AIDS TRAINING 07/12/89 - / /	41	12	4.0	164.0	DEPT. OF HEALTH NON-CLINICAL STAFF	1	0	0	1	0	3	0	0	0	0	0	0	3	0	I	O	3	29
MI	UNIVERSAL PRECAUTIONS 07/13/89 - / /	12	b	1.0	12.0	NURSES & OIHER HOSPITAL PERSONNEL	11	0	0	0	0		10	0	0	0	0	0	0	0	0	0	0	0
MI	CDOH AIDS TRAINING 07/14/89 - / /	75	43	4.0	300.0	DEPT. OF HEALTH CLINICAL STAFF	19	10	1	0	0	10	0	0	0	0	u	5	0	0	2	1	0	27
MI	CDOH AIDS TRAINING 07/14/89 - / /	33	10	4.0	132.0	DEPT. Of HEALTH Ron-CLINICAL STAFF	0	0	0	3	0	0	0	0	0	0	0	0	4	0	0	0	26	0
MI	CDOH AIDS TRAINING 07/14/89 - / I	20	10	4.8	00.0	DEPT. OF HEALTH NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	17	0
MI	UNIVERSAL PRECAUTIONS 07/14/89 - / /	46	40	1.0	46.0	NURSES & OIHER HOSPITAL PERSONNEL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46	0
MI	UNIVERSAL PRECAUTIONS 07/14/89 - / /	24	12	1.0	24.0	NURSES & OTHER HOSPITAL PERSONNEL	21	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSALPRECAUTIONS 07/19/89 - / I	14	3	1.0	14.0	NURSES 4 OTHER HOSPITAL PERSONNEL	13	0	0	0		10	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 07/19/89 - 07/20/89	20	10	1.0	20.0	NURSES b OTHER HOSPITAL PERSONNEL	11	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	I
MI	UNIVERSAL PRECAUTIONS 07/24/89 - 08/03/89	109	45	1.0	109.0	HOSPITAL HOUSEKEEPING STAFF	0	0	0	0	0	0	0	0		2	0	95	0	0	0	0	12	0
WI	CDOH AIDS TRAINING 07/28/89 - / /	25	8	4.0	100.6	DEPT. OF HEALTH CLINICAL STAFF	2	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	20	0
MI	AIDS AND THE MENTAL HEALTH PROFESS. 08/01/89 - 08/03/89	6	0	7.0	42.0	PSYCHOLOGY GRADUATE STUDENTS	1	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 08/02/89 - t /	9	6	1.0	9.0	NURSES & OTHER HOSPITAL PERSONNEL	7	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 08/03/89 - / /	7	4	1.0	7.0	NURSES 6 OTHER HOSPITAL PERSONNEL	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 08/07/89 - 08/18/89	64	15	1.0	64.0	NURSES AND OIHER HOSPITAL PERSONNEL	5?	u	0	0	0	2	0	0	0	0	0	0	0	0	0	2	1	0
MI	UNIVERSAL PRECAUTIONS 08/08/89 - / /	6	b	1.0	6.0	NURSES & OTHER HOSPITAL PERSONNEL	6	3	0	0	0	0	0	0	0	U	0	0	0	0	0	0	0	0
WI	UNIVERSAL PRECAUTIONS 08/09/89 - / /	5	4	1.0	5.0	NURSES & OIHER HOSPITAL PERSONNEL	0	9	0	0	0	0	u	0	0	0	0	5		0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 08/09/89 - / /	10	4	1.0	10.0	NURSES 6 OTHER HOSPITAL PERSONNEL	19	u	0	0	1	0	u	u	0	0	0	0		0	0	u	0	0
MI	UNIVERSAL PRECAUTIONS 08/14/89 - / /	5	I	1.0	5.0	NURSES & OTHER HOSPITAL PERSONNEL	2	3	0	1	0	u	0	0	u	0	0	0	0	u	0	0	1	1

RATEC SITE	PROGRAM TITLE BEGIN END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hr 5.1)	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODE 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
MI	CDOH AIDS TRAINING 08/16/89 - / /	18	10	4.0	11.0	DEPT. OF HEALTH CLINICAL STAFF	0	2	0	4	0	1	0	0	2	0	0	0	0	0	0	1				
MI	IMPACT OF AIDS ON AGING SOCIETY 08/16/89 - / /	17	3	1.0	17.0	SOCIAL WORKERS ,ADMINISTRATORS	1	0	0	8	0	0	0	0	2	0	0	0	0	0	0	0	3	2		
MI	UNIVERSAL PRECAUTIONS 08/16/89 - / /	6	2	1.0	6.0	NURSES & OTHER HOSPITAL PERSONNEL	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 08/17/89 - 08/17/89	4	3	1.0	4.0	NURSES AND OTHER HOSPITAL PERSONNEL	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	1	0		
MI	COON AIDS TRAINING 08/17/89 - / /	29	18	4.0	116.0	DEPT. OF HEALTH CLINICAL STAFF	0	2	0	6	3	1	0	2	2	0	0	1	0	0	0	2	13	0		
MI	CDOH AIDS TRAINING 08/18/89 - / /	38	19	4.0	152.0	DEPT. OF HEALTH CLINICAL STAFF	1	2	0	3	0	2	0	2	2	0	0	1	0	0	0	0	16	9		
MI	UNIVERSAL PRECAUTIONS 08/21/89 - / /	8	5	1.0	8.0	NURSES & OTHER HOSPITAL PERSONNEL	7	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 08/23/89 - / /	5	3	1.0	5.0	NURSES & OTHER HOSPITAL PERSONNEL	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
MI	PSYCHOSOCIAL ISSUES RELATED TO AID 08/24/89 - / /	16	5	2.0	32.0	SUBSTANCE ABUSE COUNSELORS/SOCIAL WORKERS	0	1	0	12	0	0	0	1	2	0	0	0	0	0	0	0	0	0		
MI	AIDS & LONG TERM CARE 08/24/89 - / /	99	9	4.0	396.0	LONG TERM CARE ADMIN., RN. SW	34	2	0	8	9	4	0	4	20	3	5	0	3	0	0	0	6	10		
MI	UNIVERSAL PRECAUTIONS 08/24/89 - / /	14	3	1.0	14.0	NURSES & OTHER HOSPITAL PERSONNEL	12	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0		
MI	COUNSELING HIV+ INMATES 08/30/89 - / /	6	6	3.0	18.0	PRISON HEALTH/AIDS EDUCATORS	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 08/31/89 - 08/31/89	32	10	1.0	32.0	NURSES AND OTHER HOSPITAL PERSONNEL	0	0	0	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 08/31/89 - / /	6	3	1.0	6.0	NURSES & OTHER HOSPITAL PERSONNEL	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
MI	HIV COUNSELING AND TESTING 09/07/89 - / /	36	20	6.0	216.0	RNS. SOCIAL WORKERS & COUNSELORS	4	1	0	25	0	2	0	3	0	0	0	0	0	0	0	0	0	1		
MI	NIV COUNSELING AND TESTING 09/08/89 - / /	24	4	6.0	144.0	RN'S, SOCIAL WORKERS AND COUNSELORS	6	0	0	14	0	0	0	0	1	0	0	0	0	0	0	0	3	0		
MI	ROLE OF COLLEGES & UNIVERSITIES 09/11/89 - / /	13	4	2.0	26.0	AIDS EDUCATORS	0	1	0	5	0	0	0	5	1	0	0	0	0	0	0	0	1	0		
MI	UNIVERSAL PRECAUTIONS 09111119 - 09/11/89	8	5	1.0	8.0	NURSES AND OTHER HOSPITAL PERSONNEL	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 09/12/89 - 09/12/89	23	10	1.0	23.0	NURSES AND OTHER HOSPITAL PERSONNELLL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	0		
MI	UNIVERSAL PRECAUTIONS 09/13/89 - / /	5	2	1.0	5.0	NURSES & OTHER HOSPITAL PERSONNEL	4	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		
MI	UNIVERSAL PRECAUTIONS 09/14/89 - 09/14/89	11	4	1.0	11.0	NURSES AND OTHER HOSPITAL PERSONNEL	4	2	0	1	0	0	0	0	0	2	0	0	0	0	0	0	1	1		
MI	AIDS IN THE WORKPLACE 09/14/89 - / /	5	3	1.0	10.0	AFFIRMATIVE ACTION OFFICERS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0		
MI	AIDS & EARLY CHILD CARE SERVICES* 09/16/89 - / /	24	1	2.0	48.0	TEACHERS/EARLY CHILD CARE DIRECTORS	1	1	0	1	0	0	0	22	0	0	0	0	0	0	0	0	0	0		
MI	HIV COUNSELING AND TESTING 09/19/89 - / /	18	0	6.0	108.0	RNS. SOCIAL YORKERS, SUB. ABUSE COUNSELORS	2	0	3	12	0	1	0	0	0	0	0	0	0	0	0	0	2	0		
MI	UNIVERSAL PRECAUTIONS 09120189 - 09/20/89	3	0	1.0	3.0	NURSES AND OTHER HOSPITAL PERSONNEL	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
MI	AIDS IN THE WORKPLACE 09/20/89 - / /	50	3	2.0	100.0	HOSPITAL DEPT MANAGERS	3	0	0	0	0	0	0	0	10	0	7	2	0	0	1	0	0	26		
MI	UNIVERSAL PRECAUTIONS 09/21/89 - / /	23	13	1.0	23.0	NURSES AND OTHER HOSPITAL PERSONNEL	0		1	0	0	0	0	0	0	0	0	23	0	0	0	0	0	0		

RATE/ SITE	PROGRAM BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: CONTACT (Hrs.): HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 2 3 4 5 6 7 8 9 11
MI	AIDS IN THE WORKPLACE 09/23/89 - / /	20	8	1.0	20.0 OCCUPATIONAL HEALTH NURSES	20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
MI	UNIVERSAL PRECAUTION 09/25/89 - 09/25/89	1	1	1.0	7.0 NURSES AND OTHER HOSPITAL PERSONNEL	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1 0
MI	UNIVERSAL PRECAUTIONS 09/26/89 - / /	10	7	1.0	10.0 NURSfS AND OTHER HOSPITAL PERSONNEL	0 0 0 0 0 0 0 0 0 0 0 10 0 0 0 0 0 0
MI	CASE MGNT/HIV INFECTED DRUG ABUSER 09/26/89 - / /	37	13	6.0	222.0 SOCIAL WORKERS & SUB. ABUSE COUNSELORS	2 0 0 28 0 1 0 0 2 0 0 0 0 0 0 1 2 1
MI	UNIVERAL PRECAUTIONS 09/27/89 - / /	14	6	1.0	14.0 NURSES AND OTHER HOSPITAL PERSONNEL	0 0 1 0 0 0 0 0 0 0 0 13 0 0 0 0 0 0
MI	CASE MGNT/HIV INFECTED DRUG ABUSER 09/27/89 - / /	13	0	6.0	78.0 SOCIAL WORKERS & SUB. ABUSE COUNSELORS	4 0 0 b 0 1 0 0 0 0 0 0 0 0 0 0 2 0
MI	UNIVERSAL PRECAUTIONS 09/27/89 - / /	10	5	1.0	10.0 NURSES AND OTHER HOSPITAL PERSONNEL	0 0 0 0 0 0 0 0 0 0 0 0 10 0 0 0 0 0 0
MI	UNIVERSAL PRECAUTIONS 09/28/89 - / /	14	5	1.0	14.0 NURSfS AND OTHER HOSPITAL PERSONNEL	0 0 0 0 0 0 0 0 0 0 0 14 0 0 0 0 0 0
MI	HIV COUNSELING AND TESTING 09/29/89 - / /	11	9	6.0	66.0 HISPANIC COUNSELORS AND HEALTH PROVIDERS	0 0 0 9 0 0 0 0 0 0 0 0 0 0 0 0 2 0
MI	CASE MGNT/HIV+ CLIENTS 09/30/89 - / /	14	7	8.0	112.0 HISPANIC COUNSELORS & HEALTH PROVIDERS	2 10 7 0 0 0 0 2 0 0 0 0 0 0 0 1 1
MI	UNIVERSAL PRECAUTIONS 10/03/89 - 10/04/89	20	5	1.0	20.0 NURSfS AND OTHER HEALTH PERSONNEL	0 0 0 0 0 0 0 0 1 0 0 0 4 0 0 0 15 0
MI	AIDS AND EARLY CHILD CARE SERVICES 10/03/89 - / /	90	48	2.0	180.0 EARLY CHILD CARE PROGRAM DIRECTORS	0 0 0 9 0 0 2 39 0 0 0 0 1 0 0 0 11 28
MI	UNIVERSAL PRECAUTIONS 10/05/89 - 10/05/89	1	1	1.0	1.0 NURSES AND OTHER HOSPITAL PERSONNEL	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
MI	EDUC=AWARENES.INFO.DECISION.SOLUTIO 10/08/89 - 10/08/89	78	9	5.0	390.0 MEDICAL ASSISTANTS/RN'S/LPN'S	3 1 0 0 0 1 0 5 3 0 0 3 0 0 0 2 60 0
MI	UNIVERSAL PRECAUTIONS 10/13/89 - 10/13/89	9	9	1.0	9.0 NURSfS MO OTHER HOSPITAL PERSONNEL	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 9 0
MI	AIDS AND THE AGING NETWORK 10/16/89 - 10/16/89	50	7	1.0	30.0 LONG-TERM CARE PROVIDERS	5 0 0 10 0 3 3 0 3 0 0 0 0 0 0 0 0 6
MI	AIDS & THE AGING NETWORK 10/16/89 - 10/16/89	25	7	1.0	25.0 SERVICE PROVIDERS TO THE ELDERLY	1 0 0 5 0 0 2 2 2 0 0 0 0 0 0 0 0 7
MI	AIDS & THE PRIMARY CARE MD 10/19/89 - / /	24	10	1.0	24.0 PRIMARY CARE MD's	0 24 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
MI	BEHIND THE SCENES:PLANNING AIDS ED 10/23/89 - 10/23/89	100	35	2.0	200.0 HEALTH EDUCATORS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 100 0
MI	NAT'L LATINO/HISPANIC AIDS TELECONF 10/27/89 - 10/27/89	72	56	4.0	288.0 HISPANIC COMMUNITY LEADERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 72 0
MI	WORK GRP OF HIV ED/TRAIN SOC WOR CU 10/27/89 - 10/27/89	12	3	4.0	48.0	0 0 0 8 0 0 0 4 0 0 0 0 0 0 0 0 0 0 0
MI	OAK PARK FAMILY SER PRESENTATION 11/01/89 - 11/01/89	25	2	2.0	10.0 SOCIAL SERVICE EMPLOYEES	2 0 0 11 0 0 2 0 0 0 0 0 0 0 0 0 0 0
MI	FOSTER PAR CON: CARING/HIV INFEC CH 11/02/89 - 11/03/89	50	15	10.0	100.0 FOSTER PARENTS & CHILD PLACEMENT STAFF	0 1 4 0 0 1 1 0 0 0 0 0 0 0 0 0 36 4
MI	UNIVERSAL PRECAUTIONS 11/08/89 - 11/08/89	12	7	1.0	12.0 NURSfS & OTHER HOSPITAL PERSONNEL	3 0 0 0 0 0 0 1 2 0 0 0 0 0 0 0 1 0
MI	AIDS AND ADOLESCENTS 11/28/89 - / /	10	40	8.0	560.0 COMMUNITY BASED AIDS EDUCATORS	0 0 0 10 0 0 0 10 0 0 0 0 0 0 0 0 15 30
MI	CARE FOR THE CAREGIVER 12/01/89 - 12/01/89	27	9	8.0	216.0 HOSPITAL BASED AIDS HEALTH CARE PROVIDERS	10 0 0 0 1 1 5 9 0 0 0 0 0 0 0 0 0 1
MI	WORLD AIDS DAY SEMINAR 12/01/89 - 12/01/89	60	30	2.0	120.0 HOSPITAL EMPLOYEES	0 0 0 0 0 0 0 0 1 0 0 1 10 0 1 0 7 10

MATEC SITE	PROGRAM TITLE BEGIN - END DATES	TOTAL PART	MINOR- ITIES	LENGTH (Hrs.):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10							
MI	WOMEN & AIDS: UNSEEN EPIDEMIC 12/04/89- 12104189	55	23	6.0	330.0	SUBSTANCE ABUSE COUN & OTHER SER PROVIDERS	10	9	9	33	9	9	0	3	1	0	0	0	1	0	0	0	
MI	WOMEN& AIDS: UNSEEN EPIDEMIC 12/06/89 - 12/06/89	37	9	6.0	222.0	SUBSTANCE ABUSE COUN & SER PROVIDERS	1	0	0	24	0	3	0	2	2	0	0	0	0	0	0	5	2
MI	HIVTEST COUNSELING 12/12/89 - / /	46	1	8.0	568.0	HOSPITAL NURSES AND SOCIAL WORKERS	12	0	0	7	0	0	1	0	1	0	0	0	0	0	0	1	14
MI	HIV TESTCOUNSELING 12/14/89 / /	63	5	8.0	504.0	HOSPITAL NURSES AND SOCIAL YORKERS	22	0	0	10	0	0	1	0	0	0	0	1	0	0	1	0	28
MI	ISSUES SURROUNDING HOMOSEXUALITY 12/14/89 - / /	120	22	1.0	120.0	MD.s, RN's, SW's, ALLIED PROFESSIONS	11	20	6	30	3	14	7	4	1	2	0	3	4	0	2	1	7	0
MI	MINI-RESIDENCY 11/30/89 . 12/07/89	3	1	26.0	78.0	COMM HEALTH CLINICIANS	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	UNIVERSAL PRECAUTIONS 01/05/90 . / /	11	6	1.0	11.0	NURSES AND OTHER HOSPITAL PERSONNEL	0	10	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	AIDS PREVENTION AND EDUCATION 01/12/90 - / /	39	18	2.0	78.0	HIGH SCHOOL SOCIAL WORKERS	1	c	0	30	0	0	0	5	0	0	0	0	0	0	0	0	5	
MI	CHC PROJECTPLANNING MEETING 01/26/90 - / /	14	6	4.0	56.0	COMMUNITY/MIGRANT HEALTH CENTER DIRECTOS	3	2	0	2	0	0	1	0	2	0	0	0	0	0	0	2	1	1
MI	GAY AND LESBIAN RELATIONSHIPS 02101490 - / /	23	5	2.0	46.0	GRADUATE SOCIAL WORK STUDENTS	0	0	0	19	0	1	0	2	1	0	0	0	0	0	0	0	0	0
MI	CHICAGO READ MHC AIDS TRAINING 02/07/90 - / /	22	0	3.0	66.0	MENTALHEALTHCENTER PROFESSIONALS	6	0	0	2	0	0	0	1	9	0	0	0	0	0	0	4	0	
MI	AIDS IN THE WORKPLACE 02/07/90 - / /	16	3	1.0	16.0	UNIVERSITY ADMINSTRATORS	0	0	0	1	0	0	0	0	3	0	0	1	0	0	1	0	10	0
MI	SOMERSET HOUSE AIDSINSERVICETRAIN 02/12/90 - / /	25	22	1.0	75.0	NURSING HOMESTAFF	0	0	0	0	0	12	0	0	1	0	0	1	1	0	0	1	6	3
WI	SOMERSET HOUSE AIDS INSERVICE TRAIN 02/13/90 - / /	17	11	1.0	51.0	NURSING HOME STAFF	0	0	0	0	0	15	0	0	0	0	1	0	0	0	0	1	0	
WI	CHICAGO READ MHC AIDS TRAINING 02/14/90 - / /	16	5	3.0	48.0	MENTAL HEALTH CENTER PROFESSIONAL STAFF	3	0	0	4	0	0	0	0	7	0	0	0	0	0	0	2	0	
WI	SOMERSETHOUSE AIDS INSERVICE TRAIN 02/19/90 - / /	22	20	3.0	66.0	NURSING HOMESTAFF	0	0	0	0	0	11	0	0	2	0	2	0	0	0	0	3	4	
MI	SOMERSET HOUSE AIDSINSERVICETRAIN 02/19/90 - / /	12	10	3.0	36.0	NURSING HOMESTAFF	3	0	0	1	0	9	0	0	0	0	0	1	0	0	0	1	0	
MI	SOMERSET HOUSE AIDSINSERVICETRAIN 02/20/90 - / /	14	9	1.0	42.0	NURSING HOMESTAFF	0	0	0	0	0	7	0	1	0	2	0	0	0	0	0	0	4	
MI	SOMERSET HOUSE AIDS INSERVICE TRAIN 02/20/90 - / /	14	9	1.0	12.0	NURSING HOMESTAFF	0	0	0	0	0	7	0	1	0	2	0	0	0	0	0	0	4	
MI	CHICAGO READ MHC AIDS TRAINING 02/21/90 - / /	11	0	1.0	33 C	MENTAL HEALTH PROFESSIONAL CENTER STAFF	1	1	0	1	0	0	0	1	7	0	0	0	0	0	0	0	0	0
MI	ENDING ISOLATION: AIDSHIV IN FAMILY 02122190 -02/23/90	160	0	12.0	1910.0	FAMILIES, SERVICE PROVIDERS,COMMUNITY LEADERS	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	160
WI	BILL Of RIGHTS FOR HIV-AFFEC FAMILI 02/23/90 - / /	20	13	1.0	10.0	SERVICE PROVIDERS WORKING WITH FAMILIES	2	0	0	10	0	1	0	2	0	0	0	0	0	0	0	0	0	6
MI	CHICAGO READMHC AIDSTRAINING 02/28/90 - / /	8	0	3.0	24.0	MENTAL HEALTH CENTER PROFESSIONALS	1	0	0	3	3	0	0	0	0	0	0	0	0	0	0	2	0	
MI	FACULTY DEVELOPMENT WORKSHOP 03/02/90 - / /	12	3	12.0	144.0	MATEC FACULTY MEMBERS	3	2	0	0	2	3	0	2	0	0	0	0	0	0	0	1	0	
WI	AIDS IN THE WORKPLACE 03/07/90 - / /	50	22	2.0	100.0	US DEPT Of EDUCATIONEMPLOYEES	0	0	0	0	3	0	0	0	1	0	0	0	0	0	0	50	0	
MI	KOMED AIDS TRAINING -CHC 03/07/90 - / /	22	22	4.0	88.0	COMMUNITY HEALTH CENTER STAFF	4	1	0	0	0	1	0	2	3	1	1	2	0	0	1	3	3	
MI	CDOH MHC AIDS TRAINING 03/08/90 . 03/09/90	25	23	6	150.0	MENTAL HEALTH CENTER CLINICAL STAFF	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	

MATEC SITE	PROGRAM TITLE / BEGIN - END DATES	TOTAL PARTICIPATIONS	MINOR ACTIVITIES	LENGTH (Hrs.)	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
MI	FACULTY DEVELOPMENT WORKSHOP 03/09/90 - / /	12	7	4.0	48.0	MATEC FACULTY MEMBERS	2	0	0	3	0	0	0	2	2	0	0	0	1	0	0	0	1	0
MI	CDOH NHC AIDSTRAINING 03/12/90 - / /	19	11	6.0	114.0	MENTALHEALTH CENIER STAFF	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	5	0
MI	EPIDEMIOLOGY AND AIDS PREVENTION 03/15/90 - / /	53	9	1.0	53.0	MED STUDENTS	0	53	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	CDOH NHC AIDS TRAINING 03/19/90 - 03/23/90	12	21	4.0	152.0	MENTAL HEALTH CENIER CLINICAL STAFF	1	0	0	11	0	0	1	0	0	1	0	0	0	0	0	0	2	0
MI	CDOH NHC TRAINING 03/26/90 - / /	14	9	6.0	84.0	MENTAL HEALTH CENIER CLINICAL STAFF	1	0	0	10	0	0	0	0	0	1	0	0	0	0	0	1	1	0
MI	GAY/LESBIAN/BI SUBSTANCE ABUSERS 03/21/90 - / /	43	2	6.0	258.0	SUBSTANCE ABUSE COUNSELORS	4	0	0	28	0	5	0	2	3	0	0	0	0	0	0	0	1	0
MI	LEGAL ASPECTS OF AIDS 03/22/90 - / /	25	6	1.0	21.0	INFECTIOUSDISEASE PHYSICIANS	19	0	0	0	0	0	0	1	0	0	0	0	0	0	5	0	0	0
MI	MANAGEMENT-HIV ASYMPTOMATIC PATIENT 03/23/90 - / /	18	9	3.0	14.0	PHYSICIANS AND NURSES	3	11	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
MI	SOCIAL WORK CURRICULUM PLANNING MTG 03/30/90 - / /	9	3	3.0	4S.0	SOCIAL WORKERS	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	ORGANIZING AGENCY RESOURCES FOR AID 03/29/90 - / /	21	5	4.0	168.0	PROVIDERS TO DEVELOPMENTALLY DISABLED	4	0	0	9	0	0	0	1	5	0	0	0	0	0	0	0	2	0
MI	CDOH NHC AIDS TRAINING 03130190 -/ /	22	19	3.0	66.0	MENTAL HEALTH CENTER NON-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0
MI	CDOH NHC TRAINING 03/28/90 - / /	23	12	1.0	69.0	MENTALHEALTH CENTER NUN-CLINICAL STAFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	0
WI	OPENING MINDS&DOORS: STRATEGY DEVEL 04/02/90 - / /	120	15	1.0	840.0	HEALTH ADMIN. SOCIAL WORKERS, LTC PROVIDERS	26	0	0	34	0	0	0	0	34	0	0	0	2	0	0	0	24	0
MI	CDOH NHC AIDS TRAINING 04/16/90 - 04/17/90	22	9	6.0	132.0	NHC CLINICAL STAFF	0	0	0	18	0	0	0	0	1	1	0	0	0	0	0	0	2	0
MI	FACULTY DEVELOPMENT WORKSHIP 04/20/90 - / /	9	5	4.0	36.0	MATEC FACULTY MEMBERS	2	1	0	2	0	0	0	3	0	0	0	0	0	0	0	0	1	0
MI	KOMED AIDS TRAINING 04/18/90 - / /	2)	14	3.0	60.0	CLINICAL STAFF, SOCIAL WORKERS	3	4	0	0	0	5	0	0	0	0	0	2	0	0	0	1	2	3
MI	ILMIGRANT COUNCIL TRAINING 04/05/90 - / /	12	6	2.0	24.0	RN's, COMMUNITY WORKERS	5	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	3	1
SI	AIDS 04/05/89 - 04/05/89	43	0	2.0	86.0	NOS	0	43	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	TALKING WITH THE DYING & AIDS 04/05/89 - 04/05/89	42	0	4.0	168.0		30	0	0	3	0	2	0	0	1	2	2	0	0	0	0	0	2	0
SI	AIDS & NURSING 04/11/89 - 04/11/89	10	0	2.0	20.0	NURSES	7	1	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0
SI	AIDS A THE FACTS 04/13/89 - / /	200	34	2.0	400.0	NURSES	160	0	0	0	0	40	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS TASK FORCE UPDATE 04/14/89 - / /	9	0	2.0	18.0	MULTIDISCIPLINARY	2	2	0	2	0	0	1	0	0	0	0	0	0	0	0	0	2	0
SI	AIDS AWARENESS WEEK 04/17/89 - 04/21/89	300	56	10.0	3000.0	HEALTH PROFESSIONALS (STUDENTS)	20	0	0	40	JO	0	0	30	20	20	0	20	20	20	0	0	80	0
SI	AIDS UPDATE 04/18/89 - 04/18/89	60	0	2.0	120.0	MEDICAL STUDENTS	0	60	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
SI	MULTIDISCIPLINARY APPROACH & AIDS 04/19/89 - 04/19/89	114	0	4.0	456.0	NURSES &OTHER DISCIPLINES	61	1	0	1	13	2	0	1	0	0	0	5	0	1	1	0	24	0
SI	AIDS& NURSING 04/20/89 - 04/20/89	14	0	2.1	28.0	NURSES	14	0	0	0	u	0	u	0	0	0	0	0	0	0	0	0	0	0
SI	METRO AREA AIDS RESOURCES 04/20/89 - 04/20/89	13	0	2.0	16.0	MULTIDISCIPLINARY	3	0	0	5	6	0	1	1	0	0	1	0	0	0	0	0	3	0

MATEC SITE	PROGRAM TITLE BEGIN - END DATES	TOTAL PARTICIPANTS	MINOR (Hrs.)	LENGTH: CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
SI	SURVIVING LOSS 04/22/89 - 04/22/89	91	0	3.0	291.0 MULTIDISCIPLINARY	26	0	0	26	0	0	0	14	1	0	0	0	0	7	0	0	13	0			
SI	PHYSICIANS RESPONSIBILITIES IN IL 05/20/89 - 05/20/89	10	1	2.0	20.0 PHYSICIANS	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	CLINICAL MANIFESTATIONS IN AIDS PTS 05/30/89 - 05/30/89	47	9	2.0	94.0 MDS, RESIDENTS, MEDICAL STUDENTS	2	43	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0			
SI	AIDS PATIENTS IN THE DENTAL OFFICE 06/01/89 . 06101189	40	0	5.0	120.0 DENTISTS, DENTAL ASSISTANTS, AND HYGIENISTS	0	0	15	0	10	0	0	0	0	0	0	0	0	0	0	0	15	0			
SI	AIDS IN THE COMMUNITY 06/01/89 - 06/01/89	107	3	3.0	321.0 RNS	107	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	AIDS UPDATE 06/06/89 - 06/06/89	19	2	1.0	19.0 MEDICAL STUDENTS	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	INFECTION CONTROL IN DENTAL CLINIC 06/20/89 - 06/20/89	48	9	2.0	96.0 2ND VR DENTAL STUDENTS ENTERING CLINICALS	0	0	48	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	HIV IMPLICATIONS IN PTS W/TUBERCULO 07/06/89 - / /	90	13	4.0	360.0 RNS	60	10	0	2	0	14	0	2	1	0	0	0	0	0	0	1	0	0			
SI	THE HIV AND TB CONNECTION 07/13/89 - / /	11	5	1.0	18.0 MDS, RNS	10	6	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0			
SI	CRYPTONEMINGITIINIM IV DRUG USERS 07/13/89 . / /	20	5	2.0	40.0 RI. MD	5	10	0	1	0	0	0	1	1	0	0	0	0	0	2	0	0	0			
SI	PNEUMOCYSTIS CARINII PNEUMONIA 07/14/89 - / /	15	5	3.0	45.0 MD	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	AIDS OVERVIEW 07/14/89 - / /	33	9	2.0	66.0 MEDICAL STUDENTS	0	33	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	PRIMARY HIV INFECTION 07/18/89 - / /	15	4	2.0	30.0 HEALTH CARE MD & RN	3	9	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	0			
SI	AZT USE/HLTH CARE WRKR.EXPOSURE 07/19/89 - / /	8	1	2.0	16.0 NO. RN	3	3	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0			
SI	AIDS AND PNEUMONIA ETIOLOGY 07/25/89 - / /	12	2	2.0	24.0 MDS	1	10	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0			
SI	AIDS REVIEW/INFEC.CONTROL/LT CARE 08122119 -/ /	109	1	6.0	654.0 LONGTERM CARL PERSONNEL	21	0	0	2	0	49	0	0	JO	0	4	0	2	0	0	0	0	1			
SI	LONGTERM CARE ISSUES & AIDS 09/13/89 - / /	54	1	4.0	216.0 RN	49	0	0	0	0	2	0	1	1	0	0	1	0	0	0	0	0	0			
SI	"AIDS" 09/19/89 - / /	19	8	2.0	18.0 LONG TERM CARE NURSING ASSISTANTS	6	0	0	0	0	20	0	0	0	0	3	0	0	0	0	0	0	0			
SI	DASA - TESTING & COUNSELING 09/19/89 - / /	18	0	6.0	108.0 SUBSTANCE ABUSE COUNSELORS	1	0	0	12	0	2	0	0	0	0	0	0	0	0	0	0	0	2			
SI	AIDS & THE CORNFIELD 09/26/89 . I /	43	2	3.0	129.0 MD	0	43	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	DASA - CASE MANAGEMENT 09/27/89 - I /	13	0	6.0	18.0 SUBSTANCE ABUSE COUNSELORS	4	0	0	6	0	1	0	0	0	0	0	0	0	0	0	0	0	2			
SI	AIDS 101 09/28/89 . / /	45	4	2.0	90.0 MEDICAL STUDENTS	0	45	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0			
SI	UNIVERSAL PRECAUTIONS 09/29/89 - / I	106	7	6.0	636.0 INFECTION CONTROL NURSES	79	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	AIDS OVERVIEW 10/03/89 - 10/03/89	80	10	2.0	160.0 MEDICAL STUDENTS	0	80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	HIV & TB CONNECTION 10/17/89 - 10/17/89	41	4	2.0	82.0 MEDICAL STUDENTS	0	41	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
SI	AIDS IN SOUTHERN ILLINOIS 10/31/89 - 10/31/89	27	0	3.0	81.0 NURSES, VAMC, OTHER HEALTH PROFESSIONALS	10	0	1	2	4	1	0	6	2	0	0	1	0	0	0	0	0	0			
SI	AIDS:ISSU II MATERNAL/CHIL HEL SETT 11/08/89 - 11/08/89	33	20	2.0	66.0 ACUTE CARE PROFESSIONALS	12	0	9	0	0	3	0	10	1	0	0	0	0	0	0	0	1	0			

MATEC SITE	PROGRAM BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hrs.):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	.	.	.
SI	AIDS:ISS IN MATERNAL CHIL HEL SETT 11/08/89 - 11/08/89	16	8	2.0	52.0	PUBLIC HEALTH PROFESSIONALS	8	0	0	2	0	2	0	9	0	0	0	0	0	0	0	1	4	0
SI	HISTOPLASMOSIS:EMEG PROM HIV 11/10/89 - 11/10/89	43	4	1.0	43.0	MEDICAL STUDENTS	0	40	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
SI	AIDS RESOURCE DAY 11/14/89 - 11/14/89	209	128	4.0	036.0	HEALTH PROFESSIONAL STUDENTS	11	8	2	84	0	0	0	37	0	15	0	10	0	0	2	0	0	0
SI	HIVTESTING&COUNSELING-IHA PROGRAM 12/04/89 - 12/05/89	41	12	10.0	410.0	INFECTION CONTROL SOCIAL SERVICE COUNSELORS	23	0	0	17	0	0	0	1	0	0	0	0	0	0	0	0	0	0
SI	DISSEMINATED HISTOPLASMOSIS II AIDS 12/05/89 - / /	12	0	2.0	24.0	MD's, RN's	3	5	0	0	0	0	0	2	0	0	0	0	0	0	11		0	0
SI	HIV TESTING & COUNSELING IHA PROGRA 12/06/89 - 12/07/89	49	6	10.0	490.0	INFECTION CONTROL NURSES, SOC SERV COUNSELORS	23	0	0	24	0	0	0	2	0	0	0	0	0	0	0	0	0	0
SI	HIV INFECTION CARING FOR INDIVIDUAL 12/14/89 - / /	120	22	7.0	840.0	MD's, RN's, SOCIAL WORKERS	15	20	6	30	3	14	1	4	2	2	0	3	4	0	2	1	7	0
SI	AIDS UPDATE 01/16/90 - / /	37	6	2.0	74.0	MEDICAL STUDENTS	0	37	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS UPDATE 01/24/90 - / /	44	7	3.0	192.0	HOSPITAL STAFF: RN, LABTECH, XRAY	39	2	0	1	0	7	0	3	1	0	2	4	3	1	1	0	0	0
SI	UNIVERSAL PRECAUTIONS & HIV 02/01/90 - / /	65	11	2.0	130.0	HEALTH CARE PROFESSIONALS	27	2	0	9	0	0	0	23	4	0	0	0	0	0	0	0	0	0
SI	AIDS/HIV & ITS CORRELATION W/HTLV-I 02/06/90 - / /	20	5	2.0	40.0	MD's, RW's, PhD's	5	8	0	1	0	0	0	10		0	0	2	0	0	2	1	0	0
SI	MD UPDATE:MATERNAL CHILD HIV ISSUES 02/07/90 - / /	27	4	2.0	54.0	MD's	17	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	UPDATE ON HEPATITIS B & HIV 02/09/90 - / /	21	1	2.0	42.0	MD's	4	13	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0
SI	CLINCIAL SPECTRUM Of HIV PATIENTS 02/20/90 - / /	98	5	2.0	196.0	PHYSICIANS	38	22	0	2	0	17	1	0	2	6	0	5	1	1	3	0	0	0
SI	EVAL. OF INDETERMINATE WESTERN 0101 02/27/90 - / /	8	0	1.0	0.0	MD's	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS UPDATE 03115190 - / /	82	5	2.0	164.0	MD's	0	82	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS EDUCATION 03/27/90 - / /	26	2	2.0	52.0	SOCIAL YORKERS, SOCIAL YORK STUDENTS	0	0	0	22	0	2	0	2	0	0	0	0	0	0	b	0	0	0
SI	AIDS OVERVIEW 04/05/90 - / /	51	3	3.0	153.0	MD's	0	51	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EI	AIDS UPDATE 04/05/90 - / /	25	1	1.0	21.0	MD's	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS IN 1990 04/12/90 - / /	340	51	1.0	2300.0	MD's, NURSES, ETC	145	70	7	40	0	40	2	3	1	1	0	10	2	0	9	3	7	0
SI	AIDS EPIDEMIC 04/16/90 - / /	46	4	2.0	92.0	HEALTH CARE STUDENTS	10	0	0	17	0	0	0	19	0	0	0	0	0	0	0	0	0	0
EI	AIDS OVERVIEW 04/03/90 - / /	22	0	2.0	44.0	MEDICAL STUDENTS	0	22	0	0	0	0	0.	0	0	0	0	0	0	0	0	0	0	0
MI	NURSING'S RESPONSE TO AIDS 04/05/89 - 04/05/89	150	10	1.0	1050.0	NURSES IN ALL SETTINGS	148	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
MI	AIDS UPDATE 04/13/89 - / /	250	12	1.0	210.0	PHYSICIANS	0	250	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	AIDS POLICY UPDATE 04/24/89 - 04/24/89	100	8	1.0	100.0	STUDENTS OF HEALTH PROFESSIONAL SCHOOLS	10	0	0	50	0	0	0	0	10	20		0	0	10	0	0	0	0
MI	AIDS INSERVICE 05/11/89 - / /	79	4	2.0	158.0	NURSES RI LONG-TERM CARL FACILITY	35	1	0	0	0	44	0	0	0	0	0	0	0	0	0	0	0	0
MI	AIDS UPDATE 05/24/89 - 05/24/89	23	2	2.0	46.0	MDS Of SHEBOYGAN COUNTY MEDICAL SOCIETY	0	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

MATEC SITE	PROGRAM TITLE BEGIN END DATES	TOTAL PART.	MINOR- ITIES	LENGTH. (Hrs.):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION. OCCUPATION CODES 1 2 3 4 5 6 7 8 9 10 11 12 13 14
WI	AIDS LEGISLATION IN WISCONSIN 06/18/89 - / /	1000	80	1.0	2000.0	CAPITOL SUNDAY IV PROGRAM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	AIDS INSERVICE 06/20/89 - 06/28/89	95	2	2.0	190.0	ENTIRE STAFF Of NURSING HOME	9 0 0 2 0 48 0 0 3 2 11 0 14 0 0 0 6 0
WI	AIDS 101 FOR DIETARY STAFF 07/13/89 - / /	15	0	1.0	15.0	DIETARY DEPT. STAFF	2 0 0 0 0 0 0 0 0 0 0 0 0 11 0 Q 0 0 0
WI	AIDS ISSUES FOR NURSING HOMES 07/20/89 - / /	35	0	2.0	70.0	NH ADMNS. DONS. INFEC. CONTROL PERSONNEL	25 0 0 0 0 0 0 0 0 10 0 0 0 0 0 0 0 0 0 0
WI	AIDS IN THE INPATIENT PSYCH SETTING 08/10/89 - / /	30	0	1.0	30.0	PSYCHIATRIC HOSPITAL STAFF	15 4 0 5 0 0 0 0 6 0 0 0 0 0 0 0 0 0 0
WI	AIDS POLICIES/PROC. FOR NURS. HOMES 09/07/89 - / /	25	1	2.0	50.0	SUPERVISORY/ADMIN. STAFF Of NURSING HONE	22 0 0 0 0 0 0 0 0 3 0 0 0 0 0 0 0 0 0 0
WI	LEGAL ISSUES/AIDS & HIV INFECTION 09/09/89 - / /	31	0	2.0	62.0	HOSPITAL MIDDLE MGMT.	0 0 0 0 0 0 0 0 0 31 0 0 0 0 0 0 0 0 0 0
WI	CLINICAL ASPECTS OF AIDS 09/15/89 - / /	45	0	1.0	45.0	HOSPITAL MEDICAL STAFF	0 45 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	AIDS IN WISCONSIN 09/15/89 - / /	146	20	1.0	292.0	PHYSICIANS	0 146 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	CHEM DEPENDENT POPULATION AIDS RISK 11/18/89 - / /	36	5	2.0	72.0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 36 0
WI	NIV ANTIBODY COUNSELING TRAINING 11/22/89 - / /	6	1	2.0	12.0	NURSES	b 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	HIV ANTIBODY COUNSELING TRAINING 11/28/89 - / /	8	0	2.0	16.0	CLINICS. NURSING UNITS	8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	OVERVIEW OF HIV INFECTION 12/06/89 . / /	6	2	2.0	12.0	NURSING STUDENTS	6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 U 0 0
WI	AIDS EDUCATION RESOURCES IN WISC 12/06/89 - / /	45	0	1.0	15.0	NURSING ADMINSTRATORS OF SMALL HOSPITALS	0 0 0 0 0 0 0 0 45 0 0 0 0 0 0 0 0 0 0
WI	UNIVERSAL PRECAUTIONS 12/13/89 - / /	69	69	1.0	69.0	ENTIRE NURSING HOME STAFF	10 0 0 4 0 33 0 1 1 4 11 0 3 0 0 0 2 0
WI	AIDS OVERVIEW 12/13/89 - / /	3	1	3.0	9.0	RN's	3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	CARING FOR PWA's AI HOME 12/06/89 - / /	16	0	2.0	32.0	PERSONAL CARE WORKERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 U 16 0
WI	UNIVERSAL PRECAUTIONS FOLLOW UP 01/03/90 - / /	20	0	1.0	20.0	RN's, LPN's	11 0 0 0 0 6 0 1 10 0 0 0 0 0 0 0 1 0
WI	UNIVERSAL PRECAUTIONS FOLLOW UP 01/09/90 . / /	12	0	1.0	12.0	OFFICE/ACTIVITY STAFF, SOCIAL SERVICE STAFF	0 0 3 0 0 0 1 0 0 0 0 0 0 0 0 0 a 0
WI	UNIVERSAL PRECAUTIONS 01/09/90 - / /	16	0	1.0	16.0	DIETARY DEPT	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 16 0
WI	UNIVERSAL PRECAUTIONS FOLLOW-UP 01/10/90 - / /	13	0	1.0	13.0	HOUSEKEEPING, LAUNDRY, MAINTENANCE	0 0 0 0 0 0 0 0 0 0 0 10 0 0 0 0 6 0
WI	UNIVERSAL PRECAUTIONS FOLLOW-UP 01/16/90 - / /	23	0	1.0	23.0	NURSING ASSISTANS	0 0 0 0 0 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	UNIVERSAL PRECAUTIONS FOLLOW-UP 01/23/90 - / /	26	0	1.0	26.0	NURSING ASSISTANTS	0 0 0 0 0 a 0 0 0 0 0 0 0 0 0 0 0 0 0 0
WI	AIDS 101 01/31/90 - / /	31	1	1.0	31.0	ALL EMPLOYEES	2 0 0 2 0 11 0 1 1 1 8 0 0 0 0 0 5 0
WI	INFORMATION DISSEMINATION OH HIV 02/08/90 - / /	25	0	1.0	25.0	NURSING INSTRUCTORS IN VTAE DISTRICTS	0 0 0 0 0 0 0 25 0 0 0 0 0 0 0 0 0 0 0 0
WI	AIDS/HIV: THE SPECIRUN Of CARE 03/19/90 - / /	9	0	1.0	9.0	NURSING, PHARMACY	6 3 3 0 0 0 3 0 2 0 0 0 0 0 1 0 0 0 0 0
WI	AIDS/HIV THE SPECTRUM Of INFECTIONS 03/06/90 - / /	3	1	1.0	3.0	NURSING.	0 0 0 0 1 0 0 0 0 0 0 0 1 0

HATEC SITE	PROGRAM BEGIN - END DATES	TOTAL PART.	MINOR- ITIES	LENGTH: (Hrs.):	CONTACT HOURS	TARGET AUDIENCE	PARTICIPATION: OCCUPATION CODE: 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
WI	SPECTRUM OF CARE FOR HIV INFECTION 04/17/90 - / / I	159	7	8.0	1272.0	NURSES	156	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0
WI	EVERYTHING YOU WANT KNOW ABOUT HIV 03/20/90 - / / I	19	1	1.0	19.0	NUSERS, PI. 01. SOCIOAL WORKERS	15	0	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0
WI	EVERYTHING YOU WANT KNOW ABOUT HIV 03/20/90 - I /	14	1	2.0	28.0	HOME HEALTH AIDES	1	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0
WI	AIDS 101 FOR NURSING HOMES 03/15/90 - / /	45	0	1.0	45.0	ENTIRE NURSING HOME STAFF	6	0	0	3	0	18	0	1	4	4	6	0	3	0	0	0	0
WI	AIDS 101 FOR NURSING HOMES 04/05/90 - / /	61	0	1.1	61.0	ENTIRE STAFF OF NURSING HOME	9	0	0	0	0	29	0	2	3	7	8	0	3	0	0	0	0
WI	HIV SPECTRUM/UNIVERSAL PRECAU/LEGAL 03/22/90 - i /	13	0	13.0	169.0	111 CMC STAFF	2	2	0	0	0	0	0	0	1	0	0	1	1	0	0	0	6	0

MATEC Site	# of Events	# of Participants	# of Minorities	Total Length	Total Contact Time
CM	4	162	61	18.0	616.0
IA	9	1195	282	39.0	1521.0
IN	78	3764	188	341.0	13182.0
MM	37	1432	84	121.0	6253.0
MO	49	2934	554	156.0	8281.0
MI	160	4751	1661	522.0	21040.0
SI	59	3404	506	181.0	9911.0
WI	38	3702	227	18.0	6422.0

434 1402

3 5

TOTAL - PROVIDER

# of Events	# of Participants	% of Minorities	Total Length		Total Contact Time
434	21344	3563	1461	0	74634.0

Occupation Totals: (All Programs) (Percentages listed are of those for whom an occuuation is known)

1.) Registered Uurse	4693	25.39	10.) Physical/Occup. Therapist	220	1.19
2.) Physician	S024	16.36	11.) Housekeeping/Maint.	252	1.36
3.) Oentist	429	2.32	12.) Ued. Lab. Worker	354	1.92
4.) Social Worker/Counselor	1894	10.25	13.) Dietician/Nutritionist	203	1.10
5.) Dental Hygienist/Tech.	149	0.81	14.) Emerg. Med. Tech.	83	0.45
6.) LPN/Nurse Aides	1255	6.79	15.) Pharmacist	180	0.91
7.) Clergy	1296	7.01	16.) Nurse Pract./Phys.Asst.	115	0.62
8.) Educator	572	3.10	17 - 20.) Other	2839	15.36
9.) Health Administrator	923	4.99	21.) Unknoun	2863	

Percentages based on a total of 18481 people in known occuuation listings.

Occupation is Unknown for 2863 of 21344 or 13.41 % of all participants

MATEC STTE	PROGRAM TITLE BEGIN - END DATES	TOTAL PART	MINOR-ITIES	LENGTH: (Hrs.);	CONTACT HOURS	TARGET AUDIENCE	(Hrs.);	HOURS	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17-20	21
									PARTICIPATION.										OCCUPATION CODES					
IA	AIDS/HIV INFECTION UPDATE 06/11/89 - I /	15	1	2.0	30.0	IOWADISTRICTEPIDEMIOLOGYCONSULTANTS	11	9	0	0	0	0	0	9	1	0	0	0	0	0	IO	G	2	
IA	13TH ANNUAL IA INFEC. CONTROL SEMIN 06/12/89 - 06/13/89	Al	I O	13.0	1131.0	INFECTION CONTROL NURSES	87	II	0	0	a	0	0	0	0	0	0	0	0	0	0	0	0	0
IN	TEACHING BASICS HIV &INF. CONTROL 04/25/89 - / /	4	0	8.0	32.0	SUPV.& DEV.STAFF/NON-HOSP.HLTH.FACILITIES	2	0	0	0	b	IO	0	IO	0	0	0	G	0	0	0	9		
IN	TEACHING BASICS HIV &INF. CONTROL 04/26/89 - / /	13	G	8.0	104.0	SUP. & OTHER STAFF DEV PERSONNEL IN HOSPS	12	0	9	0	0	0	0	IO	9	0	0	0	0	G	0	G	a	
IN	AIDS TRAINER UPDATE 07/10/89 - / I	51	8	7.0	357.0	CORRECTIONAL STAFF	10	0	0	6	a	9	1	8	2	0	0	0	0	0	0	24	9	
IN	AIDS TRAINING UPDATE 07/13/89 - / /	16	I	7.0	112.0	CORRECTIONAL STAFF	5	0	0	1	0	IO	2	G	0	0	0	0	0	0	0	IO		
IN	AFFECTIVETECH. IN HIV EDUCATION 08/03/89 - / /	8	0	2.0	16.0	SUPERVISORY & STAFF DEV. PERSONNEL	6	0	9	I	O	9	0	9	0	9	0	0	0	0	G	0	IO	
IN	HIV PREV.EDUC.UPDATE FOR SCHOOL RN 08/31/89 - / /	II	a	1.0	77.0	SCHOOL NURSES	la	0	0	0	0	0	0	1	0	0	a	0	0	a	0	0	0	0
IN	PREVENTION AND CARE 10/05/89 - 10/06/89	16	2	6.0	96.0	PSYCHOTHERAPISTS	U	0	0	12	G	9	1	0	9	0	0	9	0	9	G	0	3	0
IN	PRE/POSTTEST COUNSELING FOR HIV 10/10/89 - 10/11/89	If	2	16.0	272.0	CORRECTIONAL NURSES	11	a	0	1	0	3	0	0	0	0	0	a	0	0	0	II	0	
IN	NIV UPDATE:INFECTION CONTROL 10/12/89 - 10/12/89	15	2	1.0	15.0	PROFESSIONAL/PARAPROINPATIENT PSYCH STAFF	4	I	0	>	0	0	0	0	a	0	0	0	a	0	0	0	5	0
IN	AIDS.HIV INFEC & CHEM DEPEN ISSUES 11101189 -11/02/89	40	8	16.0	640.0	ADDICTIONS COUNSELORS	II	0	0	17	G	2	0	2	I	0	0	0	0	0	0	0	I	0
IN	HIV ANTIBODY TESTING & COUNSELING 11/15/89 - 11/17/89	13	9	15.0	195.0	PRISON NURSES	12	9	0	1	0	0	0	0	a	0	0	0	0	0	9	0	0	0
IN	TEACHING THE BASICS ABOUT AIDS/HIV 11/30/89 - I I	8	0	8.0	64.0	NURSES IN SUPERVISORY/STAIF DEVELOPMENT ROLES	5	0	0	0	0	0	a	0	9	0	9	9	0	0	0	0	3	0
IN	DENTAL TREATMENT Of THE HIV PATIENT 02/12/90 - / /	24	4	2.0	48.0	DENTISTS HYGENISTS. DENTAL ASSISTANTS	0	0	5	0	16	0	9	3	b	0	0	0	0	0	0	0	0	0
IN	AIDS TRAINER PROGRAM 04/03/90 - / /	35	0	6.0	210.0	CORRECTIONAL STAFF AIDS EDUCATORS	6	0	0	0	0	2	9	0	IO	0	0	9	1	0	2	23	0	
IN	AIDS TRAINER UPDATE 04/02/90 - / /	14	2	6.9	84.0	CORRECTIONAL STAFF AIDS EDUCATORS	5	9	0	IO	0	9	0	G	0	0	0	0	0	9	0	6	2	
NH	CARING RESPONSE TO PPL W/HIV IN LTC 12/08/89 - / /	18	0	6.9	108.0	NURSES FROM NURSING HOMES	18	9	0	9	0	0	9	a	0	0	9	0	0	0	0	G	0	0
NI	TECHNIQUES FOR AIDS EDUCATION 05/10/89 . / /	5	2	3.0	15.0	NURSES	3	9	U	I	9	G	0	I	o	9	0	0	0	0	0	0	0	G
NI	UNIVERSAL PRECAUTIONS TRNG. PROG. 05/31/89 - / /	9	i	2.0	18.0	AIDS EDUCATION COMMITTEE	9	0	0	0	0	0	9	0	0	a	0	0	0	0	0	0	0	0
NI	SOCIAL WKRS. TRAINING OTHERS 06/15/89 -06/16/89	12	2	16.0	192.0	SOCIAL WORKERS	7	0	0	12	0	0	0	9	0	0	0	0	9	0	0	0	G	9
NI	UNIVERSAL PRECAUTIONS, HIV/HBV 06/19/89 - 06/20/89	38	9	2.9	76.0	PHYSICIANS.NURSES.HOSPITAL STAFF	12	0	0	9	1	0	0	0	2	1	4	8	I	a	0	2	8	a
NI	AIDS BASICS FOR PEER EDUCATORS 09/28/89 - / /	35	7	3.9	105.0	FIRST YEAR MEDICALSTUDENTS	U	3		0	0	0	0	0	0	0	3	9	0	0	0	0	0	0

MATEC SITE	PROGRAM BEGIN - END DATES	TOTAL PARTICIPATIONS	MINOR ACTIVITIES	LENGTH: CONTACT (Hrs.): HOURS		TARGET AUDIENCE	1	2	3	4	5	6	7	8	PARTICIPATION: 9	10	OCCUPATION CODES 11	12	13	14	15	16	17
MI	FACULTY DEVELOPMENT WORKSHOP 11111189 - 11/17/89	12	2	4.0	48.0	MATEC FACULTY MEMBERS/HEALTH EDUCATORS	1	2	0	5	0	0	0	2	1	0	0	0	0	0	1	0	0	0
MI	AIDS EDUCATION STUD TRAIN PROGRAM 11/20/89 - 11/20/89	5	0	3.0	15.0	UIC CAMPUS PEEREDUCATOR	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0
MI	SOMER 02/08/90 - / /	3	2	1.0	3.0	NURSE AND SOCIAL WORK AIDS TRAINERS	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MI	CDOH NHC AIDS TRAINING 02/13/90 - / /	4	4	2.0	8.0	CLINICAL PSYCHOLOGISTS	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2	0
MI	CDOH NHC AIDS TRAINING 03/01/90 - / /	8	1	2.0	16.0	CLINICAL PSYCHOLOGISTS	0	0	0	2	0	0	0	0	4	0	0	0	0	0	0	0	2	0
MI	CH'GO READ NHC TRAIN TRAINER WKRSHP 01115190 - / /	9	0	3.0	21.0	MENTAL HEALTH CENTER PROFESSIONAL STAFF	0	2	0	2	0	0	0	12		0	0	0	0	0	0	0	2	0
SI	AIDS: A PRACTICAL APPROACH 09/21/89 - / /	72	22	8.0	576.0	nos. RNS, HEALTH PROFESSIONALS	29	14	0	6	0	0	2	7	14	0	0	0	0	0	0	0	0	0
SI	AIDS IMPLICATIONS FOR LONG TERM CAR 10/06/89 - / /	26	2	3.0	18.0	RN's	19	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS-TEAM TEACHING: IVDU 10/18/89 - 10/18/89	7	0	2.0	14.0	PHYSCIANS	0	0	5	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
SI	AIDS: A PRACTICAL APPROACH 10/19/89 - 10/19/89	a1	14	1.0	561.0	MD'S, RI'S	32	25	2	5	0	1	1	4	5		10	0	0	0	0	0	5	0
SI	AIDS TEAM TEACHING, III 10/20/89 - 10/20/89	b	0	2.0	12.0	PHYSICIANS	0	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
SI	AIDS/TEA TEAC-OIAS TREATMENT III 10/23/89 - 10/23/89	6	1	2.0	12.0	PHYSICIANS	0	4	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
SI	HIV UPDATE 11109189 - 11/09/89	25	2	3.0	15.0	MED TECHS	0	1	0	0	0	0	0	0	0	0	0	24	0	0	0	0	0	0
SI	HIV/AIDS: A PRACTICAL APPROACH 11/16/89 - 11/16/89	65	5	7.0	455.0	HEALTH CARE PROFESSSIONALS	14	12	7	0	10	2	0	7	5	0	0	2	0	3	3	0	0	0
SI	STD-HIV UPDATE 02/21/90 - / /	59	3	2.0	118.0	MD's	9	41	0	2	0	2	0	0	5	0	0	0	0	0	0	0	0	0
SI	HIV WITH STAPAUREUS SINUSITIS 03/13/90 - / /	12	1	2.0	24.0	PHYSICIANS	U	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS AND CRYPTOMENINGITIS 03/20/90 - / /	12	2	2.0	24.0	PHYSICIANS	0	12	0	0	0	0	0	0	0	u	0	0	0	0	0	0	0	0
SI	RENAL FAILURE IN AIDS PATIENTS 03121190 - / /	55	7	1.0	55.0	PHYSICIANS	6	46	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0
SI	DIAGNOSIS/THERAPY INFECTION HIV PAT 04/10/90 - / /	24	8	2.0	4a.o		1	16	0	1	0	0	0	0	0	0	0	5	0	0	0	0	1	0
EI	NURSING AND THE AIDS EPIDEMIC 03/22/90 - / /	191	25	6.0	1182.0	NURSES, NURSING STUDENTS	182	0	0	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0
SI	CRYPTOCOCCAL MENINGITIS IN AIDS PAT 04/04/90 - / /	17	4	2.0	34.0	MD's	1	15	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SI	AIDS UPDATE 04/03/90 - / /	21	0	1.0	21.0	MD's	0	11	0	u	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EI	AIDS, PERICARDITIS, PULMONARY INFILTR 03/27/90 - / /	15	0	2.0	30.0	MD's	0	15	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
MI	TRANSMISSIBLE DISEASE EDUC. PROJECT 04/07/89 - 04/08/89		0	16.0	112.0	PRACTICING DENTISTS	0	0	7	0	0	0	0	0	L	0	0	J	0	0	0	0	0	0
MI	AIDS/HIV CLINICAL NURSE ED PROG 09/10/89 - 09/10/89	50	4	lb.0	800.0	RN'S IN ADULT CARE, FACULTY FROM NURSE SCHOOL	50	0	4	0	0	0	0	0	9	0	0	i	0	0	9	0	0	0
MI	TRANSMISSIBLE DISEASE ED PROJECT 10/06/89 - 10/07/89	10	0	16.0	160.0	PRACTICING MI DENTISTS	0	0	10			3	3	0	3	0	0	0	0	1	0	0	0	0

MAIL	PROGRAM TITLE	TOTAL MINOR-	LENGTH, CONTACT	TARGET AUDIENCE	PARTICIPATION										OCCUPATI	LOC.
SITE	BEGIN - END DATE)	PART TIES	(Hrs.). HOURS		1	2	3	4	5	6	7	8	9	10		
WI	TRANSMISSIBLE DISEASE ED PROJECT 11/17/89 11/18/89	LO	0 16.0	160.0 PRACTICING WI DENTISTS	0	0	10	0	0	0	0	0	0	0	0	0
WI	CAKING REALOS-PROFESSIONALAPPROAC 02/16/90 - / /	SS	0 5.0	115.0 RN s	54	3	0	1	0	0	0	0	0	0	0	0

TOTAL - TRAIN THE

# of Events	# of Participants	# of Minorities	Total Length	Total Contact Time
51	1377	177	306.0	8946.0

Occupation Totals: (All Programs) (Percentages listed are of those for whom an occupation is known)

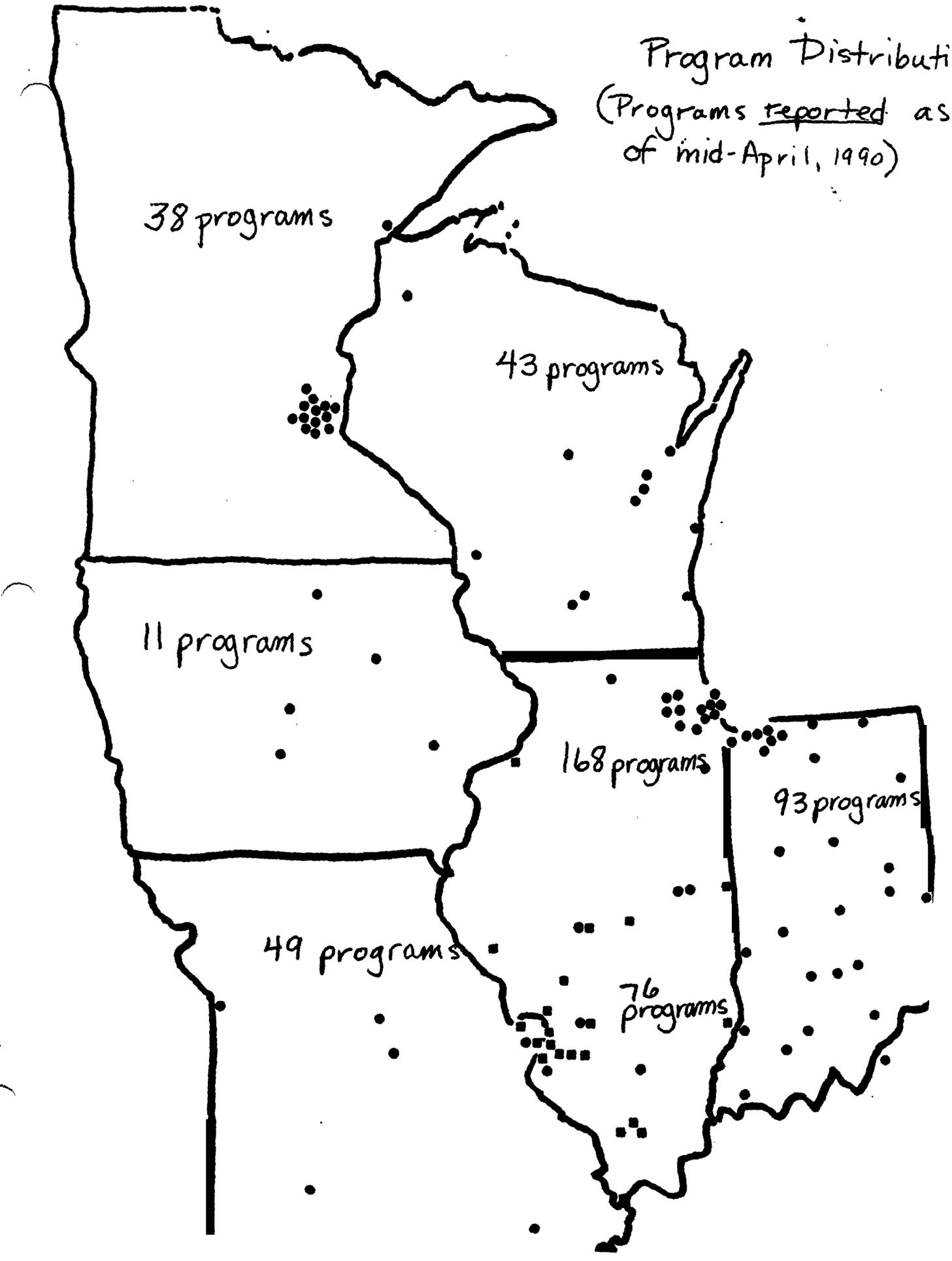
1.)	Registered nurse	645	46.98	10.)	Physical/Occup. Therapist	2	0.15
2.)	Physician	274	19.96	11.)	Housekeeping/Maint.	4	0.29
3.)	Dentist	51	3.71	12.)	Med. Lab. Worker	39	1.84
4.)	Social Worker/Counselor	89	6.48	13.)	Dietician/Nutritionist	1	0.07
5.)	Dental Hygienist/Tech.	26	1.89	14.)	Emerg. Med. Tech.	4	0.29
6.)	LPN/Nurse Aides	22	1.60	15.)	Pharmacist	10	0.73
7.)	Clergy	5	0.36	16.)	Nurse Pract./Phys.Asst.	5	0.36
8.)	Educator	54	3.93	17 - 20.)	Other	95	6.92
9.)	Health Administrator	47	3.41	21.)	Unknown	4	

Percentages based on a total of 1373 people in known occupation listings.

Occupation is Unknown for 4 of 1377 or 0.29 % of all participants

MAFEC Site	# of Events	# of Participants	# of Minorities	Total Length	Total Contact Time
IA	2	102	11	15.0	550.0
IN	15	285	29	115.0	4125.0
MN	1	18	0	6.0	275.0
NJ	11	140	37	41.0	3025.0
SI	17	700	96	54.0	4675.0
WI	5	132	4	69.0	1375.0

14,025


Program Distribution
(Programs reported as of mid-April, 1990)
38 programs
43 programs
11 programs
168 programs
93 programs
49 programs
76 programs

MATEC

YEAR II TRAINING PRODUCTIVITY

SITE	PRIMARY CARE PARTIC.	T.O.T. PARTICI-PANTS	TOTAL PARTICI-PANTS	T.O.T. CONTACT HRS.	DIRECT TRAINING CONT.HRS.	TOTAL CONTACT HRS.	HRS. PER PART. T.O.T.	HRS. PER PART. DIR.TRNG.	TOTAL HRS. PER PART.
IOWA	1,195	102	1,297	550	676	1,226.0	5.4	1.0	0.95
MISSOURI	2,934	0	2,934	0	8.281	8,281	N/A	2.8	2.82
INDIANA	3,764	285	4,049	4125	13,182	10,547	14.5	2.8	2.60
WISCONSIN	3,702	132	3,834	1375	6,422	11,346	10.4	3.1	2.96
s. ILL.	3,404	700	4,104	4675	9,971	14,646	6.7	4.3	3.57
MINNESOTA	1,432	18	1,450	275	6,253	6,528	15.3	4.6	4.50
N. ILL.	4,719	140	4,859	3,025	26,702	29,727	21.6	6.3	6.12
TOTAL	21,150	1,377	22,527	14,025	71,487	82,301.0	10.2	3.9	3.89

SITE	% OF TOTAL PART.	% OF TOTAL CONT.HRS.(DIRECT)	YEAR II BUDGET	% OF TOTAL BUDGET	COST PER PART.	COST PER CONT.HR.	AIDS CASES	% OF AIDS CASES
IOWA	5.76%	1.49%	95,784	11.4%	$73.85	$78.13	174	2.42%
MISSOURI	13.02%	10.06%	122,115	14.6%	$41.62	$14.75	1400	19.43%
INDIANA	17.97%	12.82%	130,626	15.6%	$32.26	$12.39	771	10.70%
WISCONSIN	17.02%	13.79%	128.875	15.4%	$33.61	$11.36	461	6.40%
s. ILL.	18.22%	17.80%	120.215	14.3%	$29.29	$8.21	338	4.69%
MINNESOTA	6.44%	7.93%	98,232	11.7%	567.75	$15.05	670	9.30%
N. ILL.	21.57%	36.12%	141,915	16.9%	329.21	84.77	3390	47.06%
TOTAL	100.00%	100.00%	837,762	100.0%	$37.19	$10.18	7,204	100%

As of 5-1-90

INCREASES (DECREASES) - YR I TO YR 11

CHANGE IN:

SITE	PRIMARY CARE PARTIC.		T.O.T. PARTICI-PANTS		TOTAL PARTICI-PANTS		T.O.T. CONTACT HRS.	
IOWA	464	63.53	(17)	-14.3%	447	52.6%	(887)	-61.7%
MISSOURI	2,637	887.9%	0	N/A	2,637	887.9%	0	N/A
INDIANA	2,602	223.9%	273	2275.0%	2,875	244.9%	4,029	4196.9%
WISCONSIN	2,699	269.1%	123	1366.7%	2,822	278.9%	1,233	868.3%
S.ILL.	190	5.9%	670	2233.3%	860	26.5%	4,450	1977.8%
MINNESOTA	(497)	-25.8%	(22)	-55.0%	(519)	-26.4%	(365)	-57.0%
N.ILL.	247	5.5%	56	66.7%	303	6.7%	2,443	419.8%
TOTAL	8,342	65.1%	1,083	368.4%'	9,425	71.9%	10,903	349.2%

SITE	DIRECT TRAINING CONT.HRS.		TOTAL CONTACT HRS.		% INCR.(DECR.) IN: HRS. PER PART. T.O.T.	HRS. PER PART. DIR.TRNG.	TOTAL HRS. PER PART.	CHANGE IN: % OF TOTAL PART.	% OF TOTAL CONT.HRS.
IOWA	(3,591.5)	-84.2%	(4,479)	-78.5%	-55.3%	-86.9%	-85.9%	-0.7%	-7.4%
MISSOURI	3,351	68.0%	3,351	68.0%	N/A	-83.0%	-83.0%	10.8%	2.4%
INDIANA	10,920	482.8%	14,949	634.0%	80.9%	38.1%	29.7%	9.0%	9.1%
WISCONSIN	2,222	52.9%	3,455	79.6%	-34.0%	-29.2%	-31.0%	9.3%	7.0%
S.ILL.	(5,644)	-36.1%	(1,194)	-7.5%	-11.0%	-12.7%	-26.9%	-6.5%	-6.9%
MINNESOTA	(5,999)	-49.0%	(6,364)	-49.4%	-4.5%	-31.8%	-31.2%	-8.6%	-12.2%
N.ILL.	9,239	52.9%	11,682	64.7%	211.9%	56.1%	54.5%	-13.2%	8.0%
TOTAL	10,498	17.2%	21,400.5	33.4%	-4.1%	-22.3%	-22.3%		

CHANGE IN:

SITE	YEAR I BUDGET (DIRECT)	COST PER PART.		COST PER CONT.HR.	
IOWA	23,231	($11.51)	-13.5%	$65.41	514.3%
MISSOURI	59,826	($168.11)	-80.2%	62.11	16.7%
INDIANA	29,731	($53.68)	-62.5%	($30.40)	-71.1%
WISCONSIN	33,628	($60.50)	-64.3%	($10.58)	-48.2%
S.ILL.	30,332	$1.58	5.7%	$2.53	44.6%
MINNESOTA	26,982	$31.56	87.2%	$9.52	172.3%
N.ILL.	65,915	$12.53	75.1%	$0.56	13.3%
TOTAL	269,645	($6.17)	-14.2%	$1.32	14.9%

MATEC
YEAR I TRAINING PRODUCTIVITY
NOTE: ALL NUMBERS FOR TOT SESSIONS ARE MULTIPLIED BY 2 (WEIGHTED)

SITE	PRIMARY CARE PARTIC.	T.O.T. PARTICI-PANTS	TOTAL PARTICI-PANTS	CONTACT HRS. (WTD.)	HRS. PER PART. (WTD.)	% OF TOTAL PART.	% OF TOTAL CONT.HRS.	YEAR I BUDGET (DIRECT)	COST PER PART.	COST PER CONT. HR.
IOWA	731	119	850	4,467.5	5.26	6.49%	6.92%	72,553	$85.36	$16.24
MISSOURI	297	0	297	4,930	16.60	2.27%	7.64%	62,289	$209.73	$12.63
INDIANA	1,162	12	1,174	2,454	2.09	8.96%	3.80%	100,895	$85.94	$41.11
WISCONSIN	1,003	9	1,012	4,488	4.43	7.72%	6.95%	95,247	$94.12	$21.22
s. ILL.	3,214	30	3,244	16,065	4.95	24.76%	24.88%	89,883	$27.71	$5.59
MINNESOTA	1,929	40	1,969	13,532	6.87	15.03%	20.96%	71,250	$36.19	$5.27
N. ILL.	4,472	84	4,556	18,627	4.09	34.77%	28.85%	76,000	$16.68	$4.08
TOTAL	12,808	294	13,102	64,563.5	5.04	100.00%	100.00%	568,117	$43.36	$8.80

SITE	RN/LPN/PHARM-DENT.HYG. STUD.	ACIST /ASST.	DENTIST	MD/ STUD.	SW/COUNS. STUD.	ADMIN.	LAB/MED TECH	SCHOOL HEALTH	OTHER/ UNKNOWN	TOTAL
IOWA	244	101	56	28	77	71	34	33	17	70	731
MISSOURI		0	0	1						174	297
INDIANA	31:	0	0	1	157 29	47 18	0 0	45 0	8	591	1,162
WISCONSIN	311	9	0	6	428	49	44	32	7	117	1,003
s. ILL.	1,495	52	20	106	898	86	147	7	104	299	3,214
MINNESOTA	436	0	70	0	0	0	44	107	52	1,220	1,929
N. ILL.	605	25	865	954	136	542	119	214	112	900	4,472
	3,487	187	1,011	1,096	1,725	813	388	438	292	3,371	12,808

NORTHERN ILLINOIS MATEC
SUMMARY PROGRAM STATISTICS

Year I	Total Events	Total Participants	Ave. Participants per Event	Contact Hours
Quarter 1	55	721	13	1,647
Quarter 2	18	714	39	1,475
Quarter 3	30	1826	64	11,103
Quarter 4	29	1195	41	3,820
Grand Total	132 •	4656 •	34	18,046

* Includes 60 AIDS Fear Reduction inservices to 683 UIH employees.

Year II	Total Events	Total Participants	Ave. Participants per Event	Contact Hours
Quarter 1	43	1434	33	5,130
Quarter 2	62	1421	23	3,764
Quarter 3	24	1034	43	4,082
Quarter 4				
Grand Total	129 • *	3889 **	30	12,886

** Includes 45 Universal Precautions inservices to 810 UIH employees.

NORTHERN ILLINOIS MATEC
SUMMARY OF PROGRAM LOCATIONS

Number of Events
(including all UIH inservices)

Location	Year I	Year II •	Total
Chicago	113 (84%)	100 (77%)	213 (81%)
Outside Chicago	21 (18%)	29 (23%)	50 (19%)

Number of Events
(including all UIH inservices)

Location	Year I	Year II •	Total
Chicago	54 (72%)	68 (67%)	112 (69%)
Outside Chicago	21 (28%)	29 (33%)	50 (31%)

• Includes all programs through 12-31-89 only.

APPENDIX IV

Project Evaluation-- Preliminary Cost Analysis

PRELIMINARY COST ANALYSIS

MATEC
YEAR I TRAINING PRODUCTIVITY
NOTE: ALL NUMBERS FOR TOT **SESSIONS ARE MULTIPLIED BY 2 (WEIGHTED)**

SITE	PARTICI-PANTS	CONTACT HRS. (WTD.)	HRS, PER PART. (WTD.)	% OF TOTAL PART.	% OF TOTAL CONT.HRS.	YEAR I BUDGET (DIRECT)	COST PER PART.	COST PER CONT.HR.
IOWA	901	4,241.5	4.71	9.14%	8.483	72,553	$80.52	$17.11
MISSOURI	100	990.0	9.90	1.01%	1.98%	62,289	$622.89	$62.92
INDIANA	822	914.0	1.11	8.34%	1.83%	100,895	$122.74	$110.39
WISCONSIN	855	4,138.0	4.84	8.67%	8.27%	95,247	$111.40	$23.02
S.ILL.	2,607	14,378.0	5.52	26.44%	28.74%	89,883	$34.48	$6.25
MINNESOTA	1,157	10,636.0	9.19	11.74%	21.26%	71,250	$61.58	$6.70
N. ILL.	3,417	14,724.0	4.31	34.66%	29.44%	76,000	$22.24	$5.16
TOTAL	9,859	50,021.5	5.07	100.00%	100.00%	566,117	$57.62	$11.36

APPENDIX v

Standardized Evaluation Instruments -- Program Evaluation Instrument

MIDWEST AIDS TRAINING AND EDUCATION CENTER
PROGRAM EVALUATION

Because of the decentralized organizational arrangement of MATEC many of the evaluation efforts are site-specific. Site-specific evaluation activities include formative evaluation of curricular components and training materials, followup of participants in Training-of-Training seminars, and the collection of basic demographic data and participant satisfaction surveys.

Central MATEC is involved in evaluation in three major ways, currently. First, annual site visits are conducted by the Central MATEC administration. At these site visits, Central MATEC staff are provided with updates of current site-specific evaluation activities and discuss with each site their plans for evaluation in the upcoming year.

There are two centralized evaluation activities. One is a Program Data Form that has been designed to collect basic information on all programs sponsored or co-sponsored by all MATEC sites. This, serves as a tool for process evaluation to document the number of people served by MATEC programs by type of programs and with some general demographic information on the participants. The information from the program data form has been completely computerized and routine listings of data are generated to monitor program activities.

The other centralized evaluation component is a short-term impact assessment focusing on attitude change. This is designed as a pre- and post-test measure based on an attitude change scale developed at New York University by Dr. Robert Malgady and associates. Additional items cover global self-assessments of comfort with various aspects of providing care and counseling, a self-assessment of the sufficiency of participants' skills to address the needs of HIV positive clients, and global self-assessments of increases in knowledge and skills, changes in attitudes, and whether personal objectives for the seminar were met. The pre and post-test measures are being used with all sessions 4 or more hours in length.

The current questionnaire is too lengthy and will be shortened, using data from both NYU and our own administration of the current versions of these scales. We will review reliability and factor analyses of the NYU data as soon as the information is sent to us from NYU. We will also do our own analysis of the current instrument when we have collected data from enough programs to do relatively robust factor analyses.

We are discussing what further centralized evaluation should be done, including how and whether to make centralized assessments of behavior change, long-term followup approaches, and whether knowledge change assessments are worthwhile.

MIDWEST AIDS TRAINING AND EDUCATION CENTER

PROGRAM **EVALUATION** COVER SHEET

SITE: _____

PROGRAM: _____

DATE(S): _____

TIME: _____

PROGRAM LENGTH (HOURS): _____

MIDWEST AIDS TRAINING AND EDUCATION CENTER
PRE-PROGRAM QUESTIONNAIRE

Date:_ / / _

To help us evaluate the effectiveness of our program, please complete the following information.

The information provided below will remain anonymous. To help us compare changes over time, we would like the following information to use as a code.

The first two letters of your mother's maiden name: ___

The last four numbers *of your* social security **number:** _____

INFORMATION ABOUT YOURSELF

1. AGE: ___ 2. **GENDER:** _ 1. **Female** 2. Male

3. I am: _ 1. Black/African American _ 4. Native **American/American** Indian

_ 2. **Hispanic/Latino** __ **5. White**

_ 3. Asian _ 6. Other

4. My occupation is: _____

5. How **many** years have you **spent in your present occupation?** ____

6. My primary **worksite** is:

_ 1. Hospital _ 4. Long-term **care facility**

_ 2. Outpatient clinic _ 5. Private office

_ 3. **Home** health care agency __ **6. Other:** _____

7. **Size** of **community** ill which you **work:**

__ **1. Large** city/Urban __ **3. Suburban**

_ 2. Medium city __ **4. Small town/rural**

8. To the **best** of your knowledge have you ever **provided** care to a **person** with either **HIV** infection or AIDS as a part of your job?

Yes (P l e a **answer**

(Please p r o c **to next**

9. How many **people** **infection have** AIDS **_year?**

year d i d **first** u **first known** **infection/AIDS?** _____

YOUROPINIONS

For items 1 to 25 choose one of the following responses and write the number next to the corresponding item number.

1 Strongly agree
2 Agree
3 Don't know or No opinion
4 Disagree
5 Strongly Disagree

___1. I am concerned about contracting AIDS from patients when I am at work.

2 . My family is concerned about the possibility of my working with AIDS patients.

3. My knowledge of AIDS, when compared to that of my co-workers, is greater than most of theirs.

___4. The current scientific knowledge on AIDS is sufficient to protect health care providers.

5 . I am concerned about contracting AIDS from my personal lifestyle.

___6. I feel or would feel uncomfortable working with AIDS patients.

7. AIDS infection control procedures are sufficient to protect health care providera.

a. To control the spread of AIDS, persons with AIDS should be segregated from other people.

9 . I have developed some negative feelings towards homosexuals because of AIDS.

___10. I believe that health care workers should have a choice about whether or not they want to work with persons with AIDS.

___11. To control the spread of AIDS, AIDS information should be incorporated into every health care visit.

___12. I have adequate knowledge to protect myself from getting AIDS from patients.

13. To prevent the spread *of AIDS,* AIDS education should be incorporated into every curriculum of health programs.

___14. I have adequate knowledge to protect myself from getting AIDS through my private life.

___15. Given the choice, I would rather not work with patients with AIDS.

___16. Drug addicts who contract AIDS through shared needles are getting what they deserve.

17. If confronted with a significant number of clients with AIDS, I would look for a job that had minimal contact with persona with AIDS.

___18. Health care facilities should have special areas used only by patients with AIDS.

___19. I have developed negative feelings toward drug addicts with AIDS.

2 0 . Homosexuals who contract AIDS are getting what they deserve.

2 1 . I am comfortable providing care for a person with HIV infection.

2 2 . I feel comfortable counseling my current patients about AIDS/HIV prevention.

2 3 . My current skills are sufficient to address the needs of those who are HIV antibody positive.

2 4 . I am comfortable providing care to persons who are gay or bisexual.

___25. I am comfortable providing care to intravenous drug users.

The options to choose from:

1 Strongly agree
2 Agree
3 Don't know or no opinion
4 Disagree
5 Strongly disagree

___ 14. I have adequate knowledge to protect myself from getting AIDS through my private life.

___ 15. Given the choice, I would rather not work with patients with AIDS.

___ 16. Drug addicts who contract AIDS through shared needles are getting what they deserve.

___ 17. If confronted with a significant number of clients with AIDS, I would Iook for a job that had minimal contact with persons with AIDS.

___ 18. Health care facilities should have special areas used only by patients with AIDS.

___ 19. I have developed negative feelings toward drug addicts with AIDS.

___ 20. Homosexuals who contract AIDS are getting what they deserve.

___ 21. I am comfortable providing care for a person with HIV infection.

___ 22. I feel comfortable counseling my current patients about AIDS/HIV prevention.

___ 23. My current skills are sufficient to address the needs of those who are HIV antibody positive.

___ 24. I am comfortable providing care to persons who are gay or bisexual.

___ 25. I am comfortable providing care to intravenous drug users.

___ 26. I leave this conference with additional knowledge about HIV/AIDS

___ 27. My objectives for attending this conference weft met.

___ 28. I leave this conference with changed views about HIV/AIDS issues.

___ 29. I leave this conference with stronger skills related to my professional practice and HIV/AIDS.

___ 30. I feel prepared to talk with clients who are worried about their AIDS-related risk status.

MIDWEST AIDS TWINING AND EDUCATION CENTER
POST-PROGRAM QUESTIONNAIRE

Date: _ / _ / _

To help us evaluate the effectiveness of our program, please complete the following information.

The information provided below will remain anonymous. To help us compare changes over time, we would like the following information to use as a code.

The first two letters of your mother's maiden name: _

The last four numbers of your social security number: ____

YOUR OPINIONS

For items 1 to 30 choose one of the following responses and write the number next to the corresponding item number.

1 Strongly agree
2 Agree
3 Don't know or No opinion
4 Disagree
5 Strongly disagree

___ 1. I am concerned about contracting AIDS from patients when I am at work.

___ 2. My family is concerned about the possibility of my working with AIDS patients.

___ 3. My knowledge of AIDS, when compared to that of my co-workers, is greater than most of theirs.

___ 4. The current scientific knowledge on AIDS is sufficient to protect health care providers.

___ 5. I am concerned about contracting AIDS from my personal lifestyle.

___ 6. I feel or would feel uncomfortable working with AIDS patients.

___ 7. AIDS infection control procedures are sufficient to protect health are providers.

___ 8. To control the spread of AIDS, persons with AIDS should be segregated from other people.

___ 9. I have developed some negative feelings towards homosexuals because of AIDS.

___ 10. I believe that health care workers should have a choice about whether or not they want to work with persons with AIDS.

___ 11. To control the spread of AIDS, AIDS information should be incorporated into every health care visit.

___ 12. I have adequate knowledge to protect myself from getting AIDS from patients.

___ 13. To prevent the spread of AIDS, AIDS education should be incorporated into every curriculum of health programs.

APPENDIX VI

Evaluations Conducted

1. Evaluation of Training Sessions by Northern Illinois MATEC for Chicago Department of Heath
2. Summary of Data for AIDS Training for Bureau of Mental Health Staff
3. Evaluation Report to US Public Health Service Region V Office AIDS/HIV Continuity of Care Conference
4. Evaluation: MATEC Mini-Residency
5. Summary of Data for Chicago Read Mental Health Center
6. Summary of Data for Central Iowa AIDS Symposium
7. Summary of Data for Nursing's Response to HIV Infection
8. Summary of Data for HIV Infection: Understanding and Caring for the Individual
9. Summary of Data for HIV Update
10. Summary of Data for Working with HIV Infection

EVALUATION OF TRAINING SESSIONS BY

NORTHERN ILLINOIS MIDWEST AIDS TRAINING AND EDUCATION CENTER

for

CHICAGO DEPARTMENT OF HEALTH CDOH

Year I

INTRODUCTION

The Northern Illinois site of the Midwest AIDS Training and Education Center (MATEC) in cooperation with the Chicago Department of Health (CDOH) presented twenty five AIDS educational training sessions for personnel of the CDOH neighborhood clinics. The purpose for these training sessions was to educate staff on the following:

- Disease
  - transmission
  - risk reduction
  - testing
  - risk assessment
- Concerns/fears of Health Care workers
- Occupational Risk Status
- Fatient Psychosocial Concerns
- CDOH Policies and Legal lssues

Sessions were conducted from June 2, 1989 through August 18, 1989 (see Appendix 1). A total of 25 sessions were conducted over this period reaching 808 CDOH employees.

The Midwest AIDS Training and Education Center is one of thirteen regional centers funded by the Health Resources and Services Administration (HRSA) and dedicated to AIDS training and education for health professionals. MATEC is a consortium of academic, professional, and public organization in six states. The primary charge is to help providers deliver competent and effective care to the increasing number of people with HIV infection or AIDS.

Each training session was conducted in the following format:

Introductions
- Speakers
- Purpose
- Objectives

Audience Check - prior AIDS education, contact with HIV infected patients , role in community as AIDS educator.

Brainstorm & response - concerns on general population c concerns of health care workers.

Slides on AIDS

IIIV infected patient panel - discussion of personal experience with family, friends and health professionals.

Conclusion & Evaluation

The above format was used for the clinical and mixed training sessions. For the non-clinical sessions guided fantasy was used in place of the HIV infected patient panel. The guided fantasy consisted of an exercise of progressive loss, similar to the experience of a person with HIV.

The following report is an evaluation of the training conducted by MATEC for the CDOH. The report is meant to provide both MATEC and CDOH information for future planning on AIDS education/training.

II. Program Participants

Eight Hundred and eight individuals received training in either the clinical, non-clinical 'or mixed training sessions, (table II.1).

TABLE II.1

SESSION TYPE	# OF SESSIONS	PARTICIPANT NUMBER	%
Clinical	10	430	53%
Non-Clinical	12	293	36%
Mixed	3	85	11%
TOTAL SESSIONS	25	TOTAL PARTICIPANTS 808	100%

Clinical participants accounted for over half (53%) of the total individuals trained. Non-clinical staff represented 36% and staff trained in the mixed sessions accounted for 11%. Data on number of participants trained was taken from registration sign in sheets. Where sign in sheets were not available, the number of completed evaluation forms was used. Of the 808 participants, only 568 (70%) returned program evaluation forms (Appendix 2), which provided statistics for this evaluation. It is likely that there were more than 808 participants at the 25 sessions, as from 'and registration completion was irregular (table II.2).

TABLE II.2

BREAKDOWN OF PARTICIPANTS, EVALUATIONS, RETURNS BY SESSION

DATE	CATEGORY	# OF PARTICIPANTS	EVALUATIONS RETURNED	QUIZZES RETURNED
6/7	Non-clinical	16	12 (75%)	9 (56%)
6/2	Clinical	26	8 (31%)	9 (35%)
6/14	Non-clinical	10	10 (100%)	9 (90%)
6/14	Non-clinical	8	6 (75%)	6 (75%)
6/14	Clinical	85	17 (20%)	14 (16%)
6/U	Non-clinical	23	24 (96%)	13 (52%)
6/16	Clinical	43	31 (72%)	0 (0%)
6/20	Non-clinical	21	21 (100%)	7 (33.3%)
6/20	Clinical	21	21 (100%)	19 (90%)
6/23	Non-clinical	27	19 (70%)	0 (0%)
6/23	Clinical	36	27 (75%)	18 (50%)
6/29	Non-clinical	31	31 (100%)	0 (0%)
bt 29	Clinical	77	66 (86%)	59 (77%)
6/30	Non-clinical	32	18 (56%)	20 (63%)
6/30	Clinical	27	27 (100%)	15 (56%)
7/12	Non-clinical	13	9 (69%)	0 (0%)
7t 12	Non-clinical	39	19 (49%)	19 (49%)
7/12	Clinical	34	31 (91%)	29 (85%)
7/14	Non-clinical	19	13 (68%)	19 (100%)
7/14	Non-clinical	33	20 (61%)	0 (0%)
7/14	Clinical	75	54 (72%)	52 (69%)
7/28	Clinical	25	11 (44%)	6 (24%)
8/17	Mixed	18	17 (94%)	16 (89%)
8/18	Mixed	29	27 (93%)	27 (93%)
		38	29 (76%)	27 (71%)
TOTAL		808	368 (70%)	376 (47%)

Participant Race

Table II.3 outlines participants race, Overall, there were 30% African American, 3% Native American. 5X Latino, 11% White, 9% Asian, and 12% unknown participants. The survey lost a significant amount of data on race due to participants omission.

TABLE 11.3

RACE	TOTAL	PERCENT
Black	239	30%
Native American	27	3%
Latino	41	5%
White	86	11%
Asian	70	9%
Unknown	345	42%
TOTAL	808	100%

Practice Setting

The majority (57%) of participants responded that they practiced in an outpatient clinic. Thirty nine percent did not answer the question. It can be assumed that the majority of participants practice in an out-patient clinic, since the training was directed to neighborhood clinic staff.

Participant Occupation

Table II.4 provides data on participant occupation. Occupation categories were taken from the program evaluation form. This listing does not reflect categories of occupations at the Chicago Department of Health. When other categories were listed they were incorporated into our current list. As indicated in the table a significant number of nurses (23%) and physicians (9%) received training. CDOH clerks (16%) were the next largest occupation represented. A representation of unknown occupations accounted for 31% of the total participant occupation. This percentage is based on the total number of participants trained.

TABLE II.4

PARTICIPANT OCCUPATION

	Total	Percent
Registered Nurse	130	16%
Physicians	69	9%
Dentist	8	1%
Social Worker	20	2%
Dental Hygenist	9	1%
Licensed Practical Nurse	56	7%
Clergy	0	0%
Educator	5	6%
Health Administrator	9	1%
physical Therapist	2	2%
Housekeeping	0	0%
Medical Labs	46	7%
Dietician/Nutritionist	40	5%
Emergency Medical Technician	0	0%
Pharmacist	10	1%
Nurse Practitioner	4	5%
X-Ray Technician	4	5%
Clerks	133	16%
Speech Therapist	1	1%
Unknown	249	31%
CDCI	10	1%
TOTAL	808	100%

Minority Patient Caseload

According to evaluation forms, forty percent of participants have minority patient loads of fifty percent or more (table II.5). Fifty six percent either didn't know their minority patient load or left the question blank. In general, CDOH clinics predominantly serve communities of people of color.

TADLE II.5

Participant Patient Load Categories:

0 - 10% Minority	19
11 - 25% Minority	3
26 - 50% Minority	8
50% plus	322
Unknown	456
TOTAL	808

Participant Occupation by Race

Table II.6 describes participants occupation according to race. Since race was answered by only 57% of participants, correlations with occupation were based on an even smaller segment of the population receiving education.

TADLE II.6

PARTICIPANT OCCUPATION BY RACE

	African American	Native American	Asian	Latino	Total
Physician	9 (1%)	0 (0%)	30(4%)	2(02%)	41(5%)
Registered Nurse	61 (8%)	3 (03%)	8(09%)	1(01%)	73(9%)
Licensed Practical Nurse	25 (3%)	11 (1%)	1(01%)	3(04%)	40(5%)
Pharmacist	3 (04%)	0 (0%)	1(01%)	1(01%)	5(06%)
Clerk	42 (5%)	4 (05%)	8(09%)	18(2%)	72(9%)
CDCI	4 (05%)	1 (01%)	2(02%)	1(01%)	10(1%)
Medical Lab Worker	11 (1%)	0 (0%)	1(01%)	0(0%)	12(1%)
Nurse Practitioner	3 (04%)	0 (0%)	0(0%)	1(01%)	4(05%)
Dietician	14 (2%)	0 (0%)	5(06%)	2(02%)	2113%)
Social Worker	10 (1%)	0 (0%)	0(0%)	3(04%)	13(2%)
Dentist	0 (0%)	1 (01%)	4(05%)	0(0%)	5(06%)
Speech Therapist	1 (01%)	0 (0%)	0(0%)	0(0%)	1(01%)
Pharmacy Technician	0 (0%)	1 (01%)	0(0%)	0(0%)	1(01%)
Physician Therapist	0 (0%)	0 (0%)	1(01%)	0(0%)	1(01%)
Health Administrator	2 (02%)	0 (0%)	1(01%)	0(0%)	3(04%)
X-Day Technician	3 (04%)	1 (01%)	0(0%)	0(0%)	4(05%)
Educator	2 (02%)	0 (0%)	0(0%)	2(02%)	4(05%)

III Program Evaluation

As previously stated 808 individuals received training over the twenty five training sessions. Of these 808 individuals, 586 returned the program evaluation form, for a 70% response rate. As noted prtviouslv in table 11.2. there was a higher evaluation return rate for clinical sessions (52%) than for non-clinical sessions (34%). For the mixed sessions there was a 13% return rate.

The evaluation form was divided into three sections: A. Program response - questions 1-7; B. Program Learning - questions 8,9,11 &12; C. Instructor Evaluations - question 10. Participants response is described below, A. summary of instructor evaluations will be provided to the 15 training facilitators; it is not included in this report.

A. Program Response

Questions one through seven gather data from program participants on the program content, timing. handouts, answers to questions, instructors' awareness of audience level and instructors knowledge. Overall, participants supported the AIDS education program. This is demonstrated by the high ratings of questions l-7 (table 111.1). Note: All participants did not return the evaluation form(30%), of those returned, some completed

only one or two items in question 1-7.

TOTAL

TABLE 111.1

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical.....	3 (.06%)	1(.01%)	8(2%)	236(46%)	268(52%)
2. There was enough time to cover all the material.....	13(3%)	53 (10%)	81(16%)	250(49%)	114(22%)
3. The handouts and other teaching aids were helpful and adequate.....	4(.09%)	5 (1%)	38(7%)	298(59%)	162(32%)
4. You received satisfactory answers to your questions..	3(.06%)	4(.08%)	19(4%)	289(56%)	199(39%)
5. The instructor seemed aware of your particular skill level, and taught accordingly?.....	5 (1%)	6 (1%)	37(7%)	268(53%)	192(38%)
6. The instructor seemed to have adequate knowledge and skill to teach this workshop.....	4(.08%)	5 (2%)	10(2%)	207(40%)	289(56%)

For all six program evaluation measurements, over 90% agreed that the program met educational objectives. Thirteen percent of the sample found there was insufficient time to cover the materials; this is the only question witb at least 10% or more citing any criticisms.

Question 7 - "Please rake any *general* evaluative comments". Under this general comment question, most wrote that the training was very informative and beneficial to their practice. Responses ranged from very informative to useful.

D. Program *Learning*

An outline of each Question and the most common response is attached (Appendix 3) to provide an understanding of the responses made by participants.

Question 8: "Please writs down one *fact* or idea from the workshop that you learned and that seems important to you".

Responses to this questions mostly fell into categories of new information (i.e. nosquitos do not transmit HIV virus, you cannot get HIV from saliva, tears, etc). It is hoped that participants' misinformation was corrected due to the number of participants listing new, accurate information.

Question 9: "What will you do differently at work as a result of this workshop?"

An overwhelming number of respondents listed the use of universal precautions as the number one change they will undertake in their work environment. Respondents also reported that they were aware *of* the need for universal precautions but now understood' that universal precautiona would reduce their risk of exposure to IIIV.

Question 11: "How could this workshop be improved?"

Most respondents answered that there was not enough time to adequately present materials. The second most frequent suggestion was to increase the number and variety of educational sessions.

Participants felt that there was too much information and too many areas of interest (i.e. AIDS in the work place, counseling, grief, etc.) to cover in one session. Many participants would like to see education/training sessions on specific topics and updates on the latest research findings.

Other specific improvements were suggested by a couple of respondents: slide show was too fast and unclear, need for updated materials, answer questions more clearly.

Question 12: "What are your future AIDS training needs?"

Participants generally incorporated comments from question 11 in to question 12. A large number of participants felt they needed future training sessions on updated information. This question elicited more responses as to what kind of update was needed. Many felt they needed *more* resources i.e. pamphlets, handouts, etc. Some felt that a system should be set up to provide future updates as the information on AIDS changes.

IV Quiz Evaluation

Participants were given a quiz (Appendix 4) to assess their knowledge on AIDS. Of 808 participants receiving AIDS education, 376 returned quizzes for a response rate of 47%. This low response rate was in part due to an instructor error in providing the quiz.

Table IV identifies each question and provides a breakdown of those participants who correctly answered the question. Significant differences noted between session categories are noted with a "*".

The average quiz score was 66%. For participants in clinical sessions the average score was 68%. For non-clinical sessions 57% and for mixed sessions 78%.

TABLE IV

Question 1: "Identify 3 methods of transmission"

261 Correct (71%)

Question 2: "Identify 3 methods of reducing risk of exposure from sexual' contact"

242 Correct (66.6%)

Question 3: "Identify 2 methods of reducing risk of exposure from intravenous drug users"

314 Correct (86%)

Question 4: "Identify 2 possible interpretations of a negative HIV antibody test"

272 Correct (83%)

Question 5: "Explain the iceberg theory as it applies to the clinical spectrum-of HIV"

246 Correct (84%)

Question 6: "Identify 3 psychosocial concerns of people with HIV"

179 Correct (67%)

Question 7: "Identify 3 fears healthcare workers have about HIV Infection"

81 Correct (26%)

Question 8: "Define Universal precautions"

224 Correct (67%)

Question 9: "Identify approximate percentages of Chicago AIDS cases by race"

225 Correct (74%)

PROGRAM ASSESSMENT

The MATEC training of CDOH Neighborhood Clinic personnel was the first organized AIDS educational program for most of the attendees. Staff from the STD clinics had prior information about AIDS, TB clinic staff also indicated some prior training.

Generally, staff information about HIV was at a basic level. There were consistently some attendees who believed that casual contact was a mode of transmission,ie., mosquitos. There were occasional comments about the immorality of homosexuality with religious references to sin. Staff was also inconsistent in supporting confidentiality, thinking that clinic personnel should be informed if a patient was HIV infected or at risk. There were questions about the use of vinyl versus latex gloves for examinations and handling specimens. Universal precautions may not be uniformly practiced or understood. Staff did not seem comfortable with information about risk reduction; they would be unprepared to fully inform and discuss with patients the use of condoms and other sexual practices.

These observations are not so dissimilar to clinical and non-clinical staff from other health care institutions. What is noteworthy however, is the timing. Most health care providers have already instituted this basic level of AIDS education and have progressed in staff development to specific goals and objectives. Most of the CDOH staff are at an introductory level of comfort with and knowledge of HIV. CDOH staff are in need of more specific training and education to enhance skill development. A valuable city resource is not fully capable of being utilized in the fight against the HIV epidemic.

CDOH Neighborhood Clinic staff are an important group of health providers for:

- *early identification of people with HIV infection (case finding)
- *risk assessment and risk reduction counseling
- *reinforcement of risk reduction, behavior change strategies
- *motivated HIV test referrals

We recommend that the AIDS Prevention Office and the Director of Neighborhood Clinics commit to ongoing HIV related training and education for clinical personnel:

- *calendar on an annual basis AIDS updates
  - -improvements in testing procedures
  - -new treatments
  - -epidemiologic updates
- *schedule skill building workshops by site, or staffing level
  - -how to conduct risk assessment interviews
  - -diagnosis or identification of HIV symptoms
  - -substance abuse and HIV counseling
  - -supporting behavior change among women, youth
  - -dental assessment for oral manifestations of HIV
  - -developing a professional role

-coping with terminal illness

Northern Illinois MATEC is available to assist you in planning and implementing any of the above programs.

APPENDIX

APPENDIX ONE

C = Clinical Staff

1st name = social worker
2nd name = nurse or physician

NORTHERN ILLINOIS HATEC
CDOH AIDS - INSERVICE
ALL PROGRAMS 12:30 -4:00 PM

NC = Non - Clinical Staff
Physicians, nurses, laboratory workers

J U N E

M	T	W	TH	F
				2 Lakeview NC - Berman & Jackson C - Winters & Cooksey
5	6	7	8	9
12	13	14 Lower West NC - Ley & Arteaga NC - Rodriguez & Jackson C - Perez & McCully	15	16 Woodlawn NC - Perez & Lovato C - Smith & McCulley
19	20 Westown NC - Ley & Lovato C - Coulson & Berman	21	22	23 Westown NC - Rodriguez & Lovato C - Berman & Cooksey
26	27	28	29 Uptown NC - Rodriguez & Jackson ~~NC - Ley & Arteaga~~ C - Berman & McCulley	30 Near South C - Winters & Cooksey South Lawndale * NC - Perez & Nagel

J U L Y

	12 Holman NC - Rodriguez & Nagel C - Berman & McCulley Grand Blvd.* NC - ~~Ley & Arteaga~~ Smith / Nagel			14 NC - Rodriguez & Jackson NC - ~~Perez~~ C - Winters & ~~Cooksey~~ Nagel

* Clinical Staff from these sites would attend clinical program at another location, same day.

NORTHERN ILLINOIS MATEC
CDOH TRAINING CALENDAR
ALL PROGRAMS 12:30 - 4:00 pm

C = Clinical Staff

NC = Non - Clinical Staff
Physicians, nurses
l&oratory workers

1st name = social worker
2nd name = nurse or physician

JULY

M	T	W	T	F
3	4	5	6	7
10	11	12 Holman NC-Rodriguez and Nagel NC-No.1 and Smith C-Berman and McCulley	13	14 Englewood NC-Rodriguez and Jackson NC-Perez and and Noel C-Winters and Cooksey
17	18	19	20	21
24	25	26	27	28 to-2120 W. Ogden C-McCulley & Berman
31				

NORTHERN ILLINOIS MATEC
CDOH TRAINING CALENDAR
ALL PROGRAMS 12:30 - 4:00 pm

C = Clinical Staff

NC = Non - Clinical Staff
Physicians, nurses
laboratory workers

1st name = social worker
2nd name = nurse or physician

A U G U S T

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16 Englewood C-Coulson & Berman	17 Englewood C-Coulson & Berman	18 Englewood C-Coulson & Berman
21	22	23	24	25
28	29	30	31	

APPENDIX TWO

MIDWEST AIDS TRAINING & EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title _____ Date _____
City and State _____
Instructor(s) _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical.....	1	2	3	4	5
2. There was enough time to cover all the material...	1	2	3	4	5
3. The handouts and other teaching aids were helpful and adequate.....	1	2	3	4	5
4. You received satisfactory answers to your questions.....	1	2	3	4	5
5. The instructor seemed aware of your particular skill level, and taught accordingly?	1	2	3	4	5
6. The instructor seemed to have adequate knowledge and skill to teach this workshop.....	1	2	3	4	5

7. Please make any general evaluative comments here _____

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you: _____

9. What will you do differently at work as a result of this workshop? _____

10. Please evaluate your instructor. How can the instructor do a better job next time?
Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #1 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved? _____

12. What are your future AIDS training needs? _____

(CONTINUED ON REVERSE SIDE) ——>

APPENDIX THREE

Question 8

Detter understandina of AIDS/IIIV
The increase in AIDS over the past five vears
Cannot get disease through saliva
The tip of the iceberg theory
Percentage of IIIV infected people in Chicago
Mosquitos do not transmit virus
Distinction between AIDS and IIIV

Question 9

More receptive to AIDS patients
De more compassionate to those with the disease
Practice universal precautions
Ensure confidentiality
Provide AIDS education to patients/staff
Treat every patient as it' they had AIDS
Discuss risk with patients

Question 11

More sessions
Smaller groups
More time
More literature
Updated statistics

Questions 12

Updates
Follow up workshops
More reading materials and facts
Current research statistics
llow to reach the population at risk
Treatment of patient in hose
Counseling issues

APPENDIX POUR

I A T E C
idwest AIDS Training
Education Center

)RTHERN ILLINOIS SITE
: University of Illinois at Chicago
: S. Wood Street (M/C 779)
icago, Illinois 60612
2) 996-1373

:NTER HEADQUARTERS
: University of Illinois at Chicago
icago, Illinois

:GIONAL SITES
lana University
hool of Medicine
lana Indiana

ssouri Department of Health/
iversity of Missouri
ferson City/Columbia, Missouri

uthern Illinois University
ool, Edwardsville, and Springfield,
nois

: State Medical Society of Wisconsin
dison, Wisconsin

: University of Illinois at Chicago
icago, Illinois

iversity of Iowa
lleges of Medicine
wa City, Iowa

iversity of Minnesota
hool of Public Health
inneapolis, Minnesota

CHICAGO DEPARTMENT OF HEALTH AIDS TRAINING

1. identify 3 methods of transmission of HIV
   a. _____
   b. _____
   c. _____

2. identify 3 methods of reducing risk of exposure from sexual contact
   a. _____
   b. _____
   c. _____

3. identify 2 methods of reducing risk of exposure fot intravenous drug users
   a. _____
   b. _____

4. identify 2 possible interpretations of a negative HIV antibody test
   a. _____
   b. _____

5. explain the iceberg theory as it applies to the clinical spectrum of HIV
   _____
   _____
   _____

6. identify 3 psychosocial concerns of people with HIV infection
   a. _____
   b. _____
   c. _____

7. identify 3 feats healthcare workers have about HIV infection
   a. _____
   b. _____
   c. _____

8. define universal precautions
   _____
   _____
   _____

9. identify approximate percentage of Chicago AIDS cases by race
   _____

MATEC

Midwest AIDS Training
& Education Center

NORTHERN ILLINOIS SITE
The University of Illinois at Chicago
808 S. Wood Street (M/C 779)
Chicago, Illinois 60612
(312) 9964373

CENTER HEADQUARTERS
The University of Illinois at Chicago
Chicago, Illinois

REGIONAL SITES
Indiana University
School of Medicine
Indianapolis, Indiana

Missouri Department of Health/
University of Missouri
Jefferson City/Columbia, Missouri

Southern Illinois University
Alton, Edwardsville, and Springfield,
Illinois

The State Medical Society of Wisconsin
Madison, Wisconsin

The University of Illinois at Chicago
Chicago, Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

April 16, 1990

William Martin,
Interim Director
Office of AIDS Prevention
Chicago Department of Health
50 W. Washington
Chicago, IL. 60602

Reference # 3315A/11/89
Contract # CO10697

Dear Hr. Martin,

Enclosed is a summary of the data on the AIDS Training for Bureau of Mental Health staff from March 8th through March 30, 1990 as per the Contracted Delegate Agency quarterly report.

We suggest that a debriefing session be scheduled at the conclusion of the project for the Mental Realth Bureau Chief, Acting Commissioner of Health and yourself, with the faculty who conducted the training programs and the CDOH AIDS Prevention staff. The purpose of the *meeting* would be to give a candid view of the ability of mental health staff to meet the needs of people with or at risk of HIV infection. The end of May or beginning of June would be a good time for a one hour *meeting.* I believe Tonia Schaffer is looking into the arrangements.

Sincerely,

Caryn Berman, M.A.
Site Coordinator

Year II CDOH

CDOH REPORT
AIDS EDUCATION AND TRAINING
BUREAU OF MENTAL HEALTH

I. Personnel Breakdown

A. Contract is payable on a per session basis and not by staff person.

II. Progress Report

A. Objectives

1. develop specific program format and identify speakers
2. provide no less than 23 inservice training sessions
3. submit outline and hand-outs 2 weeks in advance
4. tabulate evaluation of survey data and share with CDOH

B. Status of Objectives

1. see schedule of training sessions, and program format in Appendix #1 and #2 respectively

2. between March 8 and March 30, 10 sessions were held; another 14 sessions are scheduled between April 1 and May 15, 1990

3. outline and hand-outs were submitted for participants, as evidenced in distribution of hand-outs, see Appendix #3

4. data summary in Appendix #4, contained in section III to follow

III. Statistics to Date

A. Statistics to date

1. number of clients reached
   125 participants

2. number of sessions
   10 sessions;
   *6 two day programs (3 hours each, total 6 hours) for clinical staff
   3/8 and 3/9 25 participants
   3/12 and 3/13 19
   3/19 and 3/23 22
   3/26 and 3/27 14
   *2 one day programs (3 hours each) for non-clinical staff
   3/28 23
   3/30 22

3. number of hours
   30 hours of training

4. number of contact hours
   3750 hours (# hours of training x # people)

B. Demographic data on population served

1. race
   75% Black/African American
   6% Latino/Hispanic
   14% White/Caucasian
   2% Asian
   3% Other

2. age
   data not collected

3. population
   2% Registered Nurse
   54% Social Work/Counselor
   1% Clergy
   1% Physical/Occupational Therapis
   1% Nurse Pract.
   7% Community Health Worker
   4% Psychologist
   32% Clerical Support

IV. AIDS Prevention Office

A. Need to schedule debriefing sessions with trainers, MATEC and appropriate CWH staff

B. CDOH KAB study results should be tabulated and shared with MATEC before or during course of training program; we have no results with which to inform training program delivery.

C. one TV and VCR for the entire training series in the hands of CDOH staff person assigned to the project (Deloris Heard) or funds available to MATEC for special rental would enable program to run more smoothly

APPRNDIX

#1. TRAINING SCHEDULE

112. PROGRAM FORMAT

#3. RAND-OUTS

#4. DATA SUMMARY

Appendix #1

Chicago **Department of Health**
Bureau of **Mental Health**
AIDS **Education** and **Training**
Clinical Staff Training Schedule

CENTER	HIV Panel	DATE	TIME	LOCATION	TRA
Lawndale MHC **Garfield MHC**	E + V	*3/8 & **3/9/90 "	1-4 p.m. "	**Lawndale MHC** 2944 **W.** Polk	**B. Hocker**
Woodlawn MHC **Englewood MHC**	E + N	• 3/12 & **3/13 Session**	9-12 **Noon** "	**Woodlawn MHC** 6337 S. **Woodlawn**	**S. Braine**
Mid-South MHC **Greater Grand MHC**	E + N	*3/19 & • *3/23/90 "	9-12 **Noon** "	Nid-South NW King **Comm.** Ctr. **4314 Cottage Grove** **Class Room #1**	J. **Benitez**
Roseland MHC ***Beverly*** **MHC**	E + V	*3/26 & • *3/27/90 "	9-12 Noon "	Beverly **MHC** 1971 W. 111th St.	T. **Thomas**
Non Clinical Staff "	B + J B + D	28rch • M8rch 30	9-12 *Noon* 9-12 Noon	**Daley Ctr.** LL-155 **Daley Ctr.** LL-155	
Lakeview MHC Northwest **MHC.**	R + E	• 4/2 & • *4/3/90 "	9-12 **Noon** "	**Lakeview MHC** 2047 **N.Clark**	**B. Hocker**
North **River MHC** Northtown **MHC**	E + V	• 4/9 & • *4/10/90 "	9-12 Noon "	North River **MHC** 5601 N. **Pulaski**	**T. Thomas**
Back *of* the Yards **MHC** **Southeast MHC**	E + A	• 4/16 & **4/17/90 "	9-12 Noon 1-4 **p.m.**	**Southeast MHC** 2930 **E.** 89th St.	S. **Thomas**
Greater Lawn MHC	E + J	• 4/24 & • '4/25/90	1-4 **p.m.**	**Greater Lawn MHC** 4150 **W.** 55th St.	J. Benitet
CATC	E + V	*4/30 & **5/1/90	1-4 **p.m.**	**CATC** 3026 S. **California**	B. Booker
Bureau Adm. Staff ***Lower*** North **MHC** **Central MHC**	D + E	*5/7 & **5/8/90 " "	9-12 **Noon** " "	**Daley** *Ctr.* LL-155 50 **W. Washington** "	Y. **Irvin**
Southwest **MHC** **Chatham MHC**	S + E	*5/14 & • *5/15/90 "	9-12 **Noon** "	**Chatham MHC** 110 **E.** 79th	S. **Braine**

• **co-facilitator Eric** Noel
• ***co-facilitator Caryn Berman**

02/09/90

Appendix #2

MATEC

Midwest AIDS Training & Education Center

NORTHERN ILLINOIS SITE
The University of Illinois at Chicago
808 s. wood Street (M/C 779)
Chicago. Illinois 60612
(312) 996-1373

CENTERHEADQUARTERS
The University of Illinois at Chicago
Chicago. Illinois

REGIONAL SITES
Indiana University
School of Medicine
Indianapolis, Indiana

Missouri Department of Health/
University of Missouri
Jefferson City/Columbia, Missouri

Southern Illinois University
Alton, Edwardsville, and Springfield,
Illinois

The State Medical Society of Wisconsin
Madison, Wisconsin

The University of Illinois at Chicago
Chicago. Illinois

University of Iowa
College of Medicine
Iowa City. Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

CDOH Mental Health Centers

AIRS Training Outline

Day I

1. **Introductions 15 minutes**
   a. speakers
   b. participants experience with AIDS
      1) training
      2) people with HIV
      3) community interactions
   c. goals of the training
      1) increase information
      2) decrease fear
      3) increase understanding of psychosocial issues
      4) use information to reduce their personal risk, change their behaviors, talk with family and friends
      5) begin to develop skills for counseling
   d. evaluation forms and registration sheet completion

2. Concerns about AIDS/HIV 20 minutes
   a. brainstorm reasons why people are afraid of the disease
   b. list on flipchart
   c. respond to the content' raised
      1) knowledge or lack of information
      2) attitude or feeling level
      3) lack of skills
   d. clarify how training program will answer some of these issues, and those it will not, need for on-going commitment to topic and learning
   e. respond to issues of belief and disbelief in the information presented

3. Slide Program 1.5 hour with break in middle
   a. AIRS 101
   b. 15 minute break during slides
   c. demonstrate use of condom during section on safer sex

4. HIV Panel 45 minutes
   a. 2 persons, male and female to recount their experience with HIV infection
   b. set it up to be personal, not a soap box, interactive with participants
   c. remind people of next program

MATEC

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& Education Center

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Illinois

The State Medical Society of Wisconsin
Madison, Wisconsin

The University of Illinois at Chicago
Chicago, Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

Day II

1. **Warm-up 15** minutes
   - **a.** ask for response to last session
   - b. questions, clarify

2. Video- Buffer Zone **30** minutes
   - **a.** overview of psychosocial issues
   - b. staff issues re; stress and fear

3. **Patient Simulation** 60 min. total, break in middle
   introduce simulation/role play: could only choose one patient scenario in the **time** available, since there are so many different circumstances and people impacted by the HIV epidemic, see this as only a beginning, to get familiar, comfortable with the counseling issues. Our desire is to return and continue to offer more in-depth training that includes working with the families and significant others. Look over other case scenarios in the hand-outs for self-learning.
   - **a.** patient profile with needs and interventions developed longitudinally
   - b. trainer demonstrates counselling skills with same patient at various interludes
   - c. after each interlude/role modeling, participants asked to discuss what they saw in small groups, with feedback then to large **group,**
   - d. alternate with small groups practicing counselling in role plays using same patient profile
   - e. brainstorm counselor skills during this, as a break from patient simulation
   - f. point out these are **same** skills used in ***general*** practice

   SEE SEPARATE OUTLINE OF **SIMULATION/ROLE** PLAYS

4. Special Needs/Considerations 30 minutes
   have group brainstorm **differences in** issues and interventions of case used in simulation/role play if identified patient fit some of these other characteristics, have characteristics pre-written on flipchart
   - a) **hispanic**
   - **b)** African American
   - **c)** gay/bisexual
   - **d)** women
   - **e)** adolescents
   - **f)** substance abusers

5. psychopharmacology 15 minutes

1) interaction of drugs for mental health on HIV disease
2) impact of HIV disease on mental health symptoms

6. Wrap-up 10 minutes
   a. evaluation8
   b. resources for future needs

MATEC

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The State Medical Society of Wisconsin
Madison, Wisconsin

The University of Illinois at Chicago
Chicago. Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you! 3/9 - 5/30/90

Workshop Title CDOH MHC AIDS Training Workshops Date Quarterly Summary

Instructor(s) _____ City & State _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				56(52) %	52(48) %
2. There was enough time to cover the material		10(9) %	10(9) %	60(57)	26(25)
3. The handouts and other teaching aids were helpful and adequate		1(1)	7(7)	66(61)	34(31)
4. You received satisfactory answers to your questions		2(2)	6(6)	55(51)	44(41)
5. The instructor seemed aware of your particular skill level, and taught accordingly		2(2)	11(10)	53(49)	43(39)
6. The instructor seemed to have adequate knowledge and skill to teach this workshop			1(1)	44(40)	65(59)

7. Please make any general evaluative comments here: _____

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you: _____

9. What will you do differently at work as a result of this workshop? _____

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved? _____

12 What are your future AIDS training needs? _____

(CONTINUED ON REVERSE SIDE)--->

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title _____ Date _____

Instructor(s) _____ City & State _____

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical	1	2	a	4	5
2. There was enough time to cover the material	1	2	3	4	5
3. The handouts and other teaching aids were helpful and adequate	1	2	3	4	5
4. You received satisfactory answers to your questions	1	2	3	4	5
5. The instructor seemed aware of your particular skill level, and taught accordingly	1	2	3	4	5
8. The instructor seemed to have adequate knowledge and skill to teach this workshop	1	2	3	4	5

7. Please make any general evaluative comments here: _____

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

_____

_____

9. What will you do differently at work as a result of this workshop? _____

_____

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

_____

Instructor #2 Name: _____ Comment: _____

_____

Instructor #3 Name: _____ Comment: _____

_____

Instructor #4 Name: _____ Comment: _____

_____

11. In your opinion, how could this workshop be improved? _____

_____

12. What are your future AIDS training needs? _____

_____

(CONTINUED ON REVERSE SIDE)--->

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title OH MRC AIDS Training Workshops Date March 8 & 9, 1990

Instructor(s) Bill Rocker, Eric Noel, Caryn Berman City & State Chicago, IL

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				8 (40)	12 (60)
2. There was enough time to cover the material			1 (5)	9 (45)	8 (40)
3. The handouts and other teaching aids were helpful and adequate				11 (55)	9 (45)
4. You received satisfactory answers to your questions			1 (5)	9 (45)	10 (50)
5. The instructor seemed aware of your particular skill level, and taught accordingly				11 (55)	9 (45)
8. The instructor seemed to have adequate knowledge and skill to teach this workshop				5 (25)	15 (75)

7. Please make any general evaluative comments here: 20 of 25 participants completed evaluations, see attached pages for comments.

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved?

12. What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)--->

Q. 7 **General** • valuetivo commenta.

- Good.
- Learned much.
- Wonderful presentation.
- The workshop was excellent.
- The materials were excellent.
- Well done, but a little long.
- Excellent teaching and techniques.
- Very educational & informative. (5)
- More informative than previous presentations.
- Speakers were direct and informative about topic of discussion.
- The workshop was very well done, and presenters were well prepared.
- He was very attentive and I was able to relate to the information and assimilate it.
- I was given new and informative materials.

Q. 8 Write down one fact or idea from the workshop that seems important to you.

- The true and false things about AIDS.
- Understand transmission and prevention.
- The statistics, high and low risk factors.
- The four different stages of AIDS/HIV disease. (3)
- The statistics regarding AIDS. especially in New York.
- Learned many new concepts that I was not aware of.
- The knowledge of education and facts of AIDS myths.
- Myths and misconceptions regarding infection with HIV.
- Ways of transmitting AIDS were fewer than I thought.
- AIDS can not be contacted via biting, kissing, and mosquito bites.
- AIDS can not be transmitted via general contact with an AIDS victim.
- Information about the HIV virus and how it works and how you get it?
- I am more aware of how the HIV is transmitted not only through needles or sex.
- Mouth condom, to put in mouth to stop semen from going down your throat.
- Overcoming a reluctance to have myself tested.

Q. 8 Whet will you da **differently** at work as a result of this workshop?

- Nothing. (2)
- Be more professional.
- I will have less fears about AIDS. (2)
- Learn more and will follow through.
- Try to educate more people about AIDS.
- My approach to the subject will change.
- Feel more adequate about discussing the subject.
- Be more understanding and knowledgeable.
- I feel more adequate regarding AIDS and working with AIDS clients.
- I am not quite sure except to perhaps be much more sensitive & understanding.
- My consciousness will be more aware and I will be less ignorant and fearful of AIDS.

Q. 10 Please evaluate your Instructor. How can the instructor do a better job next time?

Instructor: Eric Noel

- Good
- Very Good (5)
- Excellent (4)
- Informative
- Well prepared
- Interesting (2)
- Knowledgeable (2)
- Excellent introduction and slide presentation.
- Very knowledgeable and receptive to questions.
- Extremely knowledgeable and able to keep the audience attention.

Instructor: Bill Hocker

- Okay
- Good (2)
- Very good
- Excellent (3)
- Well prepared
- Added so much.
- Good clinical skills.
- Very knowledgeable and invited audience participation.
- Extremely knowledgeable and able to keep the audience attention.
- Good technique to involve group in discussion by eliciting concerns.

Q. 11 In your opinion, how could this workshop be improved?

- Spend more time.
- I can see no way.
- Very good already.
- Have more refreshments.
- Have a microphone available for the speaker.
- The current format is quite acceptable.

0.12 What are your future AIDS training needs?

- Do not know / Not sure. (2)
- More information on the subject.
- to attend additional workshops/seminars. (2)
- Keeping up with knowledge as it becomes available.
- Counseling skills focusing on AIDS with resources.
- Therapy concerning victims and families what are the dynamics.
- Clinical treatment issues of victims/families affected by AIDS.
- To keep myself updated and aware of the changes and techniques of AIDS.

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title CDOH MHC AIDS *Training* Workshop Date March 12 c 13, 1990

Instructor(s) Sandra Braine, Eric Noel, Caryn Berman cay a state Chicago, Il

Please answer all questions thoughtfully. Your careful attention to these questions wilt help your trainer do a better Job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				10(53)	8(42)
2 There was enough time to cover the material		3(16)	4(21)	8(42)	3(16)
3. The handouts and other teaching aids were helpful and adequate		1(5)	3(16)	11(58)	4(21)
4. You received satisfactory answer8 to your questions		1(5)		9(47)	8(42)
5. The instructor seemed aware of your particular skill level, and taught accordingly		1(5)	3(16)	8(42)	7(37)
5. The instructor seemed to have adequate knowledge and skill to teach this workshop				7(37)	12(63)

7. Please make any general evaluative comments here: 19 of 19 participants completed evaluations, see attached pages for comments.

5. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved?

12 What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)--->

a. 7 General evaluative comments.

- Very good. (2)
- Excellent presentation, and presenters. (3)
- The workshop was very informative and useful. (2)
- It's very important that the therapist is not judgmental.
- The quality far exceeded typical City of Chicago workshops/training sessions.
- There should be a continuation of AIDS training so that providers can work effectively with this population
- There was a lack of continuity from the 1st day to the 2nd day.
- More time needed to go over various topics.
- The information was very elementary.

Q. 8 Write down one fact or idea from the workshop that seems Important to you.

- The progress of the virus.
- No one has all of the answers to this problem.
- Most HIV people develop AIDS within 10 years.
- The mental health professional's role working with these clients.
- This is an overwhelming job that will take a great deal of work.
- This is not different from dealing with any other terminally ill disease.
- People are moving towards finding out how to talk with an AIDS victim.
- Treat clients as in any situation. Be sure clients know you are there for them.
- I need to expand my clinical knowledge of human sexuality and grief counseling.
- To work through your own feelings and attitudes about seeing AIDS patients.
- When counseling AIDS clients, techniques can be creative, also explore therapist's feelings about a particular issue as well as the client's.
- Do not label individuals. You can go from the infection stage, bypass ARC and have full blown AIDS.

Q. 9 What will you do differently at work as a result of this workshop?

- Nothing. (2)
- Need more medical input.
- Include psychiatrist and psychologists.
- Be careful not to label, example - are you an IV drug user?
- Talk more about psychosocial issues and how to deal with them.
- Place more emphasis on unconditional positive regard towards client.
- Be more receptive to the concepts involved in AIDS as a disease process.
- Explore more in depth clients behavior that could make him/her at risk for HIV.
- I will make an extra effort to include screening information at point of intake.

Q. 10 Please evaluate your instructor. How oan the instructor do a better job next time?

Instructor: Eric Noel

- Good
- Excellent (2)
- Mr. Noel was extremely knowledgeable. He did an excellent presentation.
- Devote more time to initial presentation and less to question at the beginning.
- Fine job although some information presented was too basic.

Instructor: Sandra Braine

- Good
- Excellent
- Satisfactory
- She refused to speak up although she had been told several times we couldn't hear her.

Instructor: **HIV Panelists**

- **Good (2)**
- Very good
- Excellent (2)
- Panelists were interesting, knowledgeable.
- Enjoyed Novella's portion, she really brought things home.

Instructor: Caryn Berman

- Okay
- Good (3)
- Fine job
- Excellent (2)
- Outstanding presentation.
- Great presentation, very helpful.
- Was able to tie in feedback from the group.
- Knowledgeable, well organized, provided helpful information.
- More time.

Q. 11 In your opinion, how could this workshop be improved?

- **Provide** more 'what to do' information.
- Workshop could offer more referral resources.
- Introduce some information about current research.
- Spread out the information, could not be absorbed.
- Either condense into e whole day, or space the 1/2 day sessions about 1 week apart.
- Spend less time on questions (some people don't know when to shut up).
- Don't bring new people in on 2nd day of training and then discuss reactions to 1 st day.
- Include staff from both centers in both sessions.
- Have two level workshop, basic and advanced.

Q. 12 What are your future AIDS training needs?

- Psychosocial issues
- Focus on death and dying issues.
- More of this same kind of education/information. (3)
- Ongoing education regarding treatment approaches. (3)
- Updates on latest developments in treatment/prognosis.
- To attend other workshops, and need the benefit of having to see a patient.
- I need to expand my clinical knowledge of human sexuality and grief counseling.
- Need information on what decisions are being made about confidentiality, disclosure etc.
- Possibly more personal in that I would like to feel more comfortable about counseling HIV clients. I still feel that I cannot be knowledgeable enough.
- Depends on what new knowledge is developed about the illness.

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title CDOH MHC AIDS Training Workshops Date March 19 & 23

Instructor(s) John Benitez, Eric Noel, Caryn Berman City & State Chicago, Il

Please answer all questions thoughtfully. Your careful attention to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				10(59)	7(41)
2. There was enough time to cover the material		2(12)		12(70)	3(18)
3. The handouts and other teaching aids were helpful and adequate			2(12)	10(59)	5 (29)
4. You received satisfactory answers to your questions		1(6)	1(6)	8(47)	6(35)
5. The instructor seemed aware of your particular skill level, and taught accordingly			3(18)	7(41)	7(41)
9. The instructor seemed to have adequate knowledge and skill to teach this workshop			1(6)	9(53)	7(41)

7. Please make any general evaluative comments here: 17 of 22 participants completed evaluations, see attached pages for comments.

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved?

12. What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)—>

Q. 11 In your opinion, how could this workshop be improved?

- More time.
- More education.
- It waa good as it was presented.
- Quality workshop • presented very well.
- This workshop was okay, however others are needed.
- Hearing about AIDS from a minister's viewpoint
-
- Update AIDS information via workshops, seminars, etc.
- Call in faith healers and people that can offer the HIV victims hope.
- Provide it to Hispanic communities, schools, churches, different organizations.
- Video is boring.

Q. 12 Whet are your future AIDS training needs?

- None.
- Who knows?
- Updated information.
- More clinical knowledge.
- Actual counseling demonstration.
- Interaction between families.
- More about family and community concerns.
- Everything, this is the second session I have attended.

Q. 7 General **evaluative comments.**

- Presentation was good.
- Information was helpful and useful.
- The training session waa informative.
- The two days were beneficial end good.
- I liked the role-playing part of presentation.
- It was educational and informative materials.
- Mr. Noel knew AIDS materia, was very knowledgeable.
- The seminar was quite informative. I have learned more.
- Workshop was informative and issues were addressed directly, professionally.

Q. 8 Write down one fact or idea from the workahop that seems important to you.

- Everyone can get it.
- Establish trust in the client.
- HIV is found in ceils, not body fluids.
- The need to understand the HIV victims.
- About HIV treatment and the coat of the teat.
- The difference between communicable and contagious.'
- I learned in general a more clinical perspective to AIDS.
- That saliva does not have enough ceils to cause a virus infection.
- The widespread need for factual information by all segments of our society.
- Perinatai transmission of AIDS virus and also oral condoms that are now used.
- Becoming aware that AIDS clients should not be treated much different from any other.

Q. 8 What will you do differently at work as a result of this workshop?

- Nothing. (2)
- More group participation.
- Try to be open to HIV clients.
- Non-judgmental approach to AIDS.
- Pray more and being more of a sensitive worker.
- Nothing new, just more resources to help clients.
- Hopefully, I will be more empathic to death or dying.
- Read more information and implement in future for AIDS clients.
- 8e more aware that AIDS issues be asked during social history taking, such as IV use. sexuality, etc.

Q. 10 **Please evaluate your instructor.** How can the instructor do a better job next time?

Instructor: **Eric** Noel

- **Good (4)**
- **Very good (2)**
- Interesting and informative.
- Very informative and educational.
- Excellent presentation of information.
- Did a good job in answering and discussing issues.
- No change.

Instructor: John **Benitez**

- Good **(2)**
- Boring

Instructor: HIV Panelists

- **Good (3)**
- Very good
- Excellent
- Extremely good, panelists were open and honest.
- **It** takes a lot of courage to speak out, self-disclose.
- Commendable for being panelist, adjusting to having AIDS and having spiritually.
- I found panelists inspiring.
- No change.

Instructor: **Caryn** Berman

- Okay
- Good **(3)**
- Very good **(2)**
- Knowledgeable, sensitive.
- Good job **in over all presentation and stimulating groups.**
- Extremely knowledgeable, good speaker, message was received clearly.
- No change.

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title CDOH MHC AIDS Training **Workshop** **Date** **March 28,** 1990

Instructor(s) Eric Noel, PabloHernandez **City & State** Chicago, Il

Please answer **all** questions **thoughtfully.** Your **careful attention** to these **questions will help your trainer** do a **better job. Please don't sign** your **name.**

Circle ons number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful practical				13(68)	6(32)
2. There was enough time to cover ths material		1(5)		13(68)	5(26)
3. The handouts and other teaching aids were helpful snd adequate				12(63)	7(37)
4. You received satisfactory answers to your questions			2(11)	12(63)	5(26)
5. The instructor seemed aware of your particular skill level, and taught accordingly		.1(5)	3(16)	8(42)	7(37)
6. The instructor seemed to have adequate knowledge and skill to teach this workshop				10(53)	9(47)

7. **Please** make any general **evaluative** comments **here:** 19 of 23 **participants** completed evaluations, see attached **pages for** comments.

8. **Please write down one fact or idea from the workshop that you learned, and that seems important to you:**

9. **What will you do differently at work as a result of this workshop?**

10. **Please evaluate your instructor. How can the instructor do a better job next time?**

Instructor #1 Name: _____ **Comment:** _____

Instructor #2 Name: _____ **Comment:** _____

Instructor #3 Name: _____ **Comment:** _____

Instructor #4 Name: _____ **Comment:** _____

11. **In your opinion, how could this workshop be improved?**

12. **What are your future AIDS training needs?**

(CONTINUED ON REVERSE SIDE)—>

Q. 7 **General evaluative** comments.

- **Good** workshop.
- Very interesting, informative on the main body fluids causing AIDS.
- Appreciated the hand-outs and Mr. Noel answering question with authority.
- Could have gotten information from literature only.

Q. 8 Write down one fact or idea from the workshop **that seems** important to you.

- Protection.
- Betty's comments.
- Understand the AIDS.
- Places to go for help.
- M-enforced my knowledge.
- The whole part of the workshop.
- Transmission and treatment of AIDS.
- A greater awareness of disease brought into focus.
- The clarification of how the virus is carried in the body.
- Knew most of facts from own reading and research.

Q. 9 What will you do differently **at** work as a result of this workshop7

- Nothing / No changes. **(3)**
- Wear rubber gloves.
- Looking for sign of AIDS.
- Treat a person as a person.
- Inform other staff about AIDS.
- Be able to talk to people about AIDS.
- Try and be more helpful as much **as I can.**
- Communicate on a knowledgeable basis, use referral sources.

Q. 10 **Please evaluate your instructor. How can the instructor do a better job next time7**

Instructor: Eric Nod

- **Very good (3)**
- Excellent **(2)**
- Well informed.
- Knowledgeable **(2)**
- Very knowledgeable and answered questions.
- This instructor was very knowledgeable, polite and personable.
- Well done workshop, very commendable.
- He was good, when answering questions.
- Speak louder. **(2)**

Instructor: Pablo **Hernandez**

- **Good**
- Excellent (2)
- Informative.
- Wall informed.
- He answered **all** questions.
- Needs help, not sure of material.
- Hesitant.
- Excellent

Instructor: **HIV Panelists**

- Super.
- Excellent **(2)**
- Vary informative.
- Both vary articulate.
- Honest and straight forward.

Q. 11 In your opinion, how could this workshop be improved?

- Could be faster-paced, shorter hours.
- Have more people speak like Betty and John.
- Update slides and materials as soon as information is available.
- Talk with words people can understand on the slides that were showed.

Q. 12 What **are your future** AIDS **training** needs?

- Workshop for patients.
- Six-month follow up review.
- Medication and treatment.
- Ongoing as new information is available.
- Keep up with development and research reports.
- Would like more information and more detailed information.

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title CDOH MHC AIDS Training Workshops Date March 30, 1990

Instructor(s) Eric Noel, Pablo Hernandet City & State Chicago, Il

Please answer all questions thoughtfully. Your careful attentbn to these questions will help your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				10(45)	11(50)
2. There was enough time to cover the material		4(18)	3(14)	11(50)	3(14)
3. The handouts and other teaching aids were helpful and adequate			2(9)	14(64)	4(18)
4. You received satisfactory answers to your questions			2(9)	13(59)	7(32)
5. The instructor seemed aware of your particular skill level, and taught accordingly			1(5)	12(54)	8(36)
6. The instructor seemed to have adequate knowledge and skill to teach this workshop				9(41)	13(59)

7. Please make any general evaluative comments here: 22 of 22 participants completed evaluations, see attached pages for comments.

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved?

12. What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)--,

Q. 7 **General evaluative** comments.

- Good seminar.
- Very enjoyable.
- I learned a lot today.
- Thanks for this presentation.
- It was very helpful in -knowing about AIDS.
- I learned so much about AIDS that I did not know.
- The seminar was very informative and it relieved some certain fears.

Q. 8 Write down one fact or idea from the workshop that seems important to you.

- Treat as human beings.
- How to treat a parson with AIDS.
- How AIDS can be transmitted. (2)
- That AIDS is not easily contracted.
- How to practice safe sex, since I am not giving it up.
- That coughing, sneezing in your face cannot cause AIDS.
- How AIDS is transmitted: blood, semen, vaginal secretions, breast milk.
- The fact that you cannot avoid the facts, but learn how to help understand.
- I am not as fearful of AIDS as I was when I first came to the class.
- Meeting an educator who could answers some question about this well known disease.
- The workshop was what we need more of.

Q. 8 Whet will you do differently et work es a result of this workshop7

- Not sure.
- Get the facts.
- Be very careful.
- Be more sensitive.
- Be more compassionate.
- Be more understanding.
- Be a little more considerate.
- Help teach others the high risk of HIV.
- Be less short in understanding, careful and helpful.
- Not be so scared to offer services to clients who are HIV positive.
- Nothing different for the most psrt. I will treat everyone the same.
- Nothing but be myself and treat people like I want to be treated.
- Nothing. (2)

Q. 10 Please evaluate your instructor. How can the instructor do a better job next time?

Instructor: Erk Noel

- Perfect.
- Very good (6)
- Excellent (2)
- Knowledgeable on the subject of AIDS.
- Keep getting more up to date information
- He's a great speaker and very knowledgeable (3)
- A very good instructor, was able to keep control and attention from everyone.

Instructor: Pablo Hernandez

- Very good (2)
- Excellent

Instructor: HIV Panelists

- Nice.
- Very good (2)
- Enlightening.
- Couldn't do any better.
- Have more people as panelists.
- Explained well the problems of life one can have.
- They told their true story in detail, their life was real.
- They told the wearing experiences they had, both were great.
- Very good and informative, seemed comfortable talking about condition.
- I felt like they are new friends of mind, because they have a way of talking with me.
- He did a good job; but some questions did not get answered because he told us he would get back to these questions.

Q. 11 In your opinion, how could this workshop be improvad?

- Have more workshops.
- Keep up the teaching.
- Give a two-part series.
- Just a little longer time for the workshop. (2)
- Good, willing to answer questions about groups.
- Does not need improvement, just more workshops like this.
- By having more people like David & Betty talking to us like they did.
- Have a program for the hearing and speech impaired.
- More time for to ask panelistsquestions.

Q. 12 Whet **are your future** AIDS training **needs?**

- None.
- Get the facts.
- Keeping up with new data.
- More training sessions. (2)
- Would like to learn more.
- Keep learning facts on AIDS.
- Every time something new is learned, I would like to know.
- Getting more education and wanting to help people in sign language.

EVALUATION REPORT

U. S. Public Health Service
Region V Office
Community/Migrant Health Centers

AIDS/HIV
CONTINUITY-OF-CARE
CONFERENCE

June 26 & 27, 1989

Presented by:

Midwest AIDS Training and Education Center
and
East Central AIDS Education and Training Center

Prepared By:
Patricia Lavanhar,
Program Specialist

July, 1989

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INTRODUCTION

The University of Illinois at Chicago was the site for the June 26 and 27, 1989 AIDS/HIV Continuity-of-Care Conference sponsored by the U.S. Public Health Service, Region V Office and presented by the Midwest AIDS Training and Education Center (MATEC)* and the East Central AIDS Education and Training Center (ECAETC)*. The conference was offered by Region V to meet the AIDS-education needs Of its Community and migrant health-center clinical staff.

There were 47 professionals in attendance at the conference:

10 Social Workers/Counselors	1 Clergy
7 Registered Nurses	1 Dietician
7 LPN's/Nurses AIDS	1 Educational Administrator
7 Health Administrators	1 Medical Lab Worker
4 Health Educators	1 Nurse Practitioner
2 AIDS Specialists	1 Public Health Policy

Twenty-seven (57%) attendees represented Public Health Service outpatient clinics. Although the conference was to focus on the specific, identified needs of community/migrant health centers, the conference was opened to other interested professionals. Eighteen faculty participated in the program.

Of the 47 attendees, 24 (51%) submitted evaluations which reflect the degree to which their individual needs were met. The evaluation report is divided into three parts: the Evaluation Ratings, a Summary Report, and Recommendations. Included in the Appendix are lists of the written comments mad8 on the evaluations by the attendees as well as a copy of the Evaluation Form and the Agenda.

* MATEC and ECAETC are two of thirteen regional centers dedicated to AIDS training and education for health professionals and funded by the U.S. Public Health Service, Health Resource and Services Administration. This conference was made possible by contract with the Public Health Service, Order No. RO-V-1739-88 and No. RO-V-1740-88.

EVALUATION

47 Conference Attendees
24 Evaluation8 Received (51%)

The intent of this evaluation was to determine if attendees' need8 were met. Attendees were requested to evaluate each

the specific quality of the presentation

were **less**

"1" **"5"**
"1" **help**"ting the component was of "little or no
"5"

"1" = **Little or No Help**
"5" = Very Helpful

1. AIDS/EPIDEMIOLOGY **UPDATE** 3.0

- **VIDEO** (3.3)
- **JUDITH COOKSEY. M.D.** (3.8)
- **SMALL GROUPS** (2.51
  - Black **Issues** **(3.0)**
  - **Drug Issues** (1.2)
  - **Gay/Bisexual Issues** (1.0)
  - **Hispanic Issues** **(4.0)**
  - Women and Children **Issues** (3.5)
- **LARGE** GROUP SUMMARY **(2.2)**

EVALUATION

2. SHARING/LAVERN		4.4
3. AIDS PREVENTION		4.0
4. HIV TESTING/COUNSELING		4.2
o VIDEO	(4.0)	
o RONN RUCKER. Ed.D.	(4.3)	
5. CASE MANAGEMENT		3.2
6. COMMUNITY RESOURCES		4.0
o VIDEO	(3.7)	
o SMALL GROUPS	(4.3)	
- Illinois	(3.2)	
- Indiana	(5.0)	
- Michigan/Ohio	(4.2)	
- Minnesota	(4.5)	
- Wisconsin	(4.5)	
7. TRAIN-THE-TRAINER		4.2
8. MANUALS/HANDOUTS		4.7

OVERALL RANK 4.0

SUMMARY

Fifty-on8 percent (24) of the 47 conference attendees submitted program evaluations. Each component of the program was evaluated using a five-point scale, with "5" indicating the component was very helpful and "1" indicating the component was of little or no help to a specific individual.

Overall, the conference received a rating of 4.0. In that 43 percent of the attendees did not represent the professional staff for which the conference was developed, the 4.0 rating suggests a very positive result.

The program manual and handouts recieved the highest rating, 4.7. Other program components receiving 4.0 or greater are: Sharing/Lavern, mother of a deceased HIV positive baby (4.4): HIV Testing and Counseling (4.2); and Community Resources (4.0). No component received a score Of less than 3.0 overall.

Specific comments made by attendees on each component and sub-component of the program can be found in the APPENDIX.

RECOMMENDATIONS

Based on the evaluations, the following recommendations are made:

1. Increase program sponsor's marketing effort for the conference.
2. Increase time for networking, in total and by individual states.
3. Provide the opportunity to rotate through a number of small groups rather than limiting selection to one small group.
4. Add to faculty, a registered nurse who is working with AIDS patients.
5. Shorten segment on case management.
6. Increase length of time for train-the-trainer or have optional section for those desiring additional help in this area.
7. Continue to utilize a person with AIDS as a part of the faculty.
8. Continue to provide manuals.

Most of the above recommendations would require a greater time commitment for the conference. Two days, rather than one and one-half days, should provide adequate time for implementing the recommendations given.

APPENDIX

COMMENTS

1. AIDS/EPIDEMIOLOGY UPDATE

o VIDEO

- Helpful
- No new information
- Too much inaccurate information
- Big numbers/Big deal
- I've seen better and I've seen worse
- Physician is very homophobic, misinformed. Blames homosexuals for the spread of AIDS. Otherwise, technically accurate and acceptable.
- No new information
- Knowledgeable prior to conference

o JUDITH CDOKSEY. M.D.

- Informative
- Needed additional time for questions
- Interesting statistics
- Good communicator
- Very effective

o SMALL GROUPS

WOMEN AND CHILDREN' ISSUES

- Good speaker/good information
- Leader shared experiences not encountered by me

COMMENTS

WOMEN AND CHILDREN ISSUES (Continued)

- Incomplete information
- No information on children - minimal information on women
- No indepth coverage
- Great

DRUG ISSUES

- Needed more examples Of risk-reduction education among IVDUs
- Not enough people in session to make it useful, but a good idea
- Not wel 1 organized
- Not much information on AIDS

SLACK ISSUES

- Content good
- Time-frame deplorable, missed next session
- Talked too long
- Leader not Willing to discuss any issues but her own
- More than 30 minutes over allotted time and terribly insensitive to time limitation, which I perceive as "very poor"
- Excellent presenter
- Great audience participation

COMMENTS

o LARGE GROUP

- Too informal - not much information exchanged
- Missed this session due to overtime on Black Issues
- Poorly organized session
- Not too informative
- No designated reporters to summarize
- More constructive comments needed

COMMENTS

2. SHARING/LAVERN

- Impressive individual
- It's always helpful to get this kind of input
- Good presenter, good information
- She's "O.K."! Valuable insights!
- Good to hear her personal experience
- A very courageous presentation
- Identify with her feelings! Great!
- Short, concise (just right)
- A new experience to hear it
- Had prior "sharing" with 5 PWA's,

-here, but I didn't learn much

-

COMMENTS

3. AIDS PREVENTION

- An excellent review
- Excellent presentation - point was made
- Good speaker - excellent for uninformed listeners
- Knowledgeable prior to conference
- Well informed - good delivery
- Useful, clear, direct
- I've heard most of this
- Good example of effective and frank public speaking
- Ruben Blades' video good. Nothing new but well organized and presented.
- Video (condoms), excellent with Ruben Blades

COMMENTS

4. HIV TESTING/COUNSELING

o VIDEO

- **Straight up! To the point!**
- **Technically helpful**
- **Succinct and to the point**
- Very basic video
- **Great** material
- Prior training
- Physician is very **homophobic** and misinformed. He indicates that **HIV positive** persons are very likely to commit suicide which is not accurate. Otherwise, acceptable.

o **RONN RUCKER. Ed.D.**

- **Good discussion leader**
- Most of this, I've heard **before**
- **Excellent** presenter
- Material was very good
- Prior training
- **Good speaker**
- Straight forward, very enlightening

COMMENTS

5. CASE MANAGEMENT

- Handouts were excellent and I will use them
- This particular talk was not helpful to me as I supervise a prenatal program
- We already have a system in place
- Speaker was boring
- Good materials
- Material was excellent but could have been presented in one-third the time
- Good combination of handouts and A-V screen
- Good handouts, however, talk too redundant
- Excellent basic information on case management. Needed more emphasis on actual management and problems related to AIDS cases. Excellent handout material
- Good material - boring delivery
- Good handouts - lifeless presentation
- I've heard most of this before
- Much too long and wordy - handout would have been sufficient
- Excellent handouts - presentation duplicated handouts

COMMENTS

6. COMMUNITY RESOURCES

o VIDEO

- A very informative film
- Excellent video
- Good general information
- Torture - beautifully done but inappropriate for me, my area of expertise
- I have the video
- Appropriate link between Care Management and Community Resources
- Good for comparison
- Nice production
- What about State Health Department or residences for HIV/homeless individuals?

o SMALL GROUPS BY STATE

ILLINOIS

- Not much information presented - pleasant
- Need list of centers that offer services

INDIANA

- Great
- Poor turnout/attendance
- Fun to network

COMMENTS

o **SMALL GROUPS BY STATE (Continued)**

OHIO/MICHIGAN

- **Excellent for networking - needed much more time**
- **More time for networking - ways of identifying and accessing existing resources**

WISCONSIN

- **Good to be able to share information**

COMMENTS

7. TRAIN-THE-TRAINER

- Had prior training in this area
- Handout very good
- I've no previous training experience – very good
- Good handout/talk
- More time!
- Could be a workshop by itself
- Great information
- Very Good

COMMENTS

8. MANUALS/HANDOUTS

- Very thorough
- Very comprehensive
- Excel lent variety
- Nice production - good information
- Looks good
- Will be extremely helpful to me!
- Good

AOOITIONAL COMMENTS

- I was very pleased with the conference and the participants.
- Most of the information was read by the presenters - no personal input - rather dry.
- Uncomfortable seating
- Friendly, accommodating registration area
- Much good information in manuals and handouts!
- Much information can be generalized to other settings. Thank you.
- Need a faculty sheet with small biographical sketches.
- A breakout group for Community health centers alone would have been helpful to me.
- Thank you
- I could have used more time, perhaps in a workshop format, to discuss problems I encounter and to share with people in a more personal way. Such things as access to resources and identifying resources are my concerns. The manuals Will be helpful. Thank you.
- Temperature/humidity very uncomfortable which detracted from learning.
- Supply pads of paper for notetaking.
- I wanted to attend ALL of the small group discussions and found it frustrating not to be able to rotate through each session.
- This evaluation form is an excellently "laid out" form...easily read and completed.
- Rows of tables preferable to auditorium-style seating.
- Would have liked an RN working with AIDS patients to present a session.

ADDITIONAL COMMENTS

- Small group leaders for the "Responses to AIDS Update" were not in touch with needs of participants.
- Should include a clinical-base session for non-clinical attendees.

EVALUATION

AIDS/HIV
CONTINUITY-OF-CARE
CONFERENCE

June 26 & 27, 1989

We hope you have found thls program helpful. to assist us In the evaluation pnd revision of the program, we would appreciate your comments.

Please rank the Items below, with "5' being very helpful and '1' being of little or no help. Please comment on why any segment of the program was not particularly helpful to you. (e.g., Knowledgeable about topic prior to the conference.)

	5 4 3 2 1	COMMENTS
1. **AIDS Epidemiology Update**		
Video		
Judith Cooksey, M.D.		
small Group _____ (Identify)		
Large Croup Summary		
2. **Sharing/LaVern**		
3. **AIDS Prevention**		
4. **HIV Testing/Counseling**		
Vldeo		
Ronn Rucker, Ed.D.		
5. **Case Management**		
8. **Community** Resources		
Video		
Small Group_____ (Give State)		
7. **Train-the-Trainer**		
Manual/Handouts		
9. **Additional Comments (Use other side)**		

- THANK YOU -

MATEC

Midwest AIDS Training & Education Center

AND

ECAETC AIDS

AGENDA

U.S. Public Health **Service**
Region V Office

COMMUNITY/MIGRANT HEALTH **CENTERS**
AIDS/HIV CONTINUITY-OF-CARE CONFERENCE

presented by

Midwest AIDS **Training** and Education Center
and
East Central AIDS Education and **Training** Center

June **26-27,** 1989

MONDAY, JUNE 26: 1989

12:45 p.m.	**REGISTRATION**	Cathy **Mays**
1:15 p.m.	**Opening** Remarks	**Nathan Linsk, PhD** **Norris** Lewis, **MD** James A. **Pearsol**
1:30 p.m.	**AIDS/Epidemiology Update (Video)**	**James** A. **Pearsol** **Judith** Cooksey, **MD**
2:10 p.m.	**Responses** to AIM **Update**	
	* Black Issues **(206A)**	**Melody** Jackson, **PhD**
	* **Drug** Issues **(206B)**	**Wendell Johnson**
	* Gay/Bisexual Issues **(213A)**	**Caryn Berman, ACSW**
	* **Hispanic** Issues **(213B)**	**Jorge Arteaga**
	* **Women** and Children Issues **(Chicago "A")**	**Marcia Harris, RN,MS**
2:45 p.m.	**BREAK**	
3:00 p.m.	**Summary: Responses** to AIDS Update	Nathan **Linsk, PhD**
3:20 p.m.	**Sharing**	**LaVern**
3:So **p.m.**	AIDS Preventlon	**Ronn Rucker, EdD**
4:30 p.m.	Closing **Comments/Evaluation**	**James** A. **Pearsol**
4:45 p.m.	**ADJOURN**	

MATEC

Midwest AIDS Training & Education Center

AND

ECAETC AIDS

AGENDA

U.S. Public Health Service
Region V Office

COMMUNITY/MIGRANT HEALTH CENTER9
AIDS/HIV CONTINUITY-OF-CARE CONFERENCE

presented by

Midwest AIDS Training and **Education** Center
and
East Central **AIDS** Education and **Training** Center

June 26-27, 1989

TUESDAY, JUNE 27, **1989**

8:30 a.m.	COFFEE PLUS	
9:00 a.m.	**HIV** Testing **&** Counseling **(Video)**	**Ronn** Rucker, **EdD**
9:45 a.m.	Case **Management-Part I**	Douglas R. **Morton, PhD**
10:30 a.m.	BREAK	
10:45 a.m.	Case Management-Part **II**	Douglas R. Morton, **PhD**
11:30 a.m.	**Community** Resources **(Video)**	**James** A. Pears01
12:15 p.m.	**Community** Resources by **State**	
	* **Illinois** (Chicago "A")	**David Ley, MSW**
	* Indlana **(216)**	Anne **Farringer**
	* **Michigan** (Chicago "B")	James A. **Pearsol**
	* **Minnesota** **(Chicago "A")**	Frances **Smith**
	* Ohio **(SRH 218)**	Ronn Rucker, **EdD**
	* Wisconsin **(SRH 219)**	Mary **Brown, RN**
12:45 p.m.	LUNCH **(On own -** U of I Hospital **Cafeteria** or Centennial **Room)**	
1:45 p.m.	federal Resources	**John Krzemian**
2:30 p.m.	Train-the-Trainer: Part I	**Ann Crowe, MSSW**
3:15 p.m.	**BREAK**	
3:30 p.m.	**Train-the-Trainer:** Part II	**Ann Crowe, MSSW**
4:oo **p.m.**	**Closing Comments/Evaluations**	Nathan **Linsk, PhD**
4:15 p.m.	**ADJOURN**	

EVALUATION

MIDWEST AIDS TRAINING & EDUCATION CENTER

MINI-RESIDENCY

Community-Based Care of HIV-Infected/AIDS Patients
U.S. Public Health Service Region V
Chicago, Illinois

November 30, 1989

December 8-7, 1989

Prepared by:
Patricia Lavanhar, M.H.P. Ed.
Program Specialist

January, 1990

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INTRODUCTION

The University of Illinois at Chicago was the site for the November 30, December 6 and 7, 1969 pilot AIDS Mini-Residency Program, sponsored by the U.S. Public Health Service, Region V Office and presented by the Midwest AIDS Training and Education Center (MATEC)* in collaboration with the Cook County Hospital AIDS Prevention Service (CCHAPS). The Mini-Residency Program was offered in Chicago by Region V to meet the AIDS educational needs of physician-nurse teams from three community health centers, two in Illinois and one In Wisconsin. Similar programs were offered by Region V to professional teams at sites In Minnesota and Indiana.

Three community health centers were registered for the Mini-Residency Program. However, Wisconsin was not able to find clinical staff that felt the need for AIDS education at this time, and Chicago's Claretion Health Center's physician-nurse team did not show at the program. To replace Wisconsin, a few days prior to the program, Cook County Department of Health was offered the opportunity to participate. One physican was able to attend, but only on the first program day.

Four healthcare professionals were present at the program: a physician-nurse team from Erie/Humboldt Park Family Health Centers: a physician from Cook County Department of Health - Bureau of Community Health; and, Donald Dennis , M.D., Medical Director for Region V.

Of the four program attendees, the three who attended all three days submitted written evaluations of the program, two physicians and one nurse. The same three professionals provided oral evaluations at the end of the third day. The oral comments were combined with the written evaluation comments and are included in the evaluation data.

This evaluation report is divided into three parts: Part I: Evaluation Data, Part II: Summary of Evaluation Data; and Part III: Recommendations for Future Programs. The Recommendations include suggestions offered by the program developers and faculty at a December 18, 1989 program follow-up meeting. Included In the Appendix are copies of the evaluation Instruments and the program agenda

*MATEC is one of 13 regional centers dedicated to AIDS training and education for health professionals and funded by the U.S. Public Health Service, Health Resource and Service Administration. This program was made possible by contract with the Public Health Service, Order No. Ro-V-1740-88.

PART I:

EVALUATION DATA

EVALUATION

MIDWEST AIDS TWINING & EDUCATION CENTER

MINI-RESIDENCY

Community-Based Care **HIV-Infected/AIDS Patients**
U.S. **Public Health Service,** Region V

3 Attendes
3 Evaluations Received

November 30, 1989

Please rank the items below, with **"5"** being very **helpful** and **"1"** being of little or no help.

1) IMPACT OF HIV-RELATED **ATTITUDES &** EMOTIONS ON **HEALTH-CARE** DELIVERY **(4.0)**

Comment

- Help us to **warm** up. look at our own issues, practices, and feelings.

2) TAKING A SEXUALJDRUG-USE HISTORY **(4.7)**

Comment

- This would be an excellent **inservice** for Community Health **Center Personnel.**

3) STANDARDIZED PATIENT **ENCOUNTER: "SEXUAL/DRUG-USE HISTORY"** **(4.3)**

4) PATHOPHYSIOLOGY & EPIDEMIOLOGY OF HIV/AIDS **(4.0)**

Comments

- Excellent Background.
- **Too detailed. May be confusing for some.**
- Immunology at too high a **level...Briefer or delete.**

5) SOCIAL & COMMUNITY SUPPORT FOR **HIV-INFECTED** CLIENT **(3.7)**

Comments

- Would like to know what the **needs** of these patients are as regards finances, housing, food, etc.

- PWA could be eliminated.

6) AIDS PREVENTION (33)

Comments

- Would like covered more **indepth,** including sexual alternatives.

7) CULTURAL, ETHNIC, GENDER, SEXUAL ORIENTATION, **I-V** DRUG ISSUES **(3.0)**

Comments

- would be good to have this covered **more indepth.**

- Need to focus more on the issue.

8) ADDITIONAL COMMENTS

Comments

- This day was too long. The afternoon could have been **significantly reduced.**

- I feel the material **covered** today could be condensed to **less** than 10 hours.

- **I feel this MATEC program is very beneficial to all of us since aids affects all our lives one way or another.**

- **I appreciate the opportunity given to attend this program. It has helped me deal with a lot of feelings I have regarding aids, and will help me be able to answer questions others may have regarding this epidemic (especially at our clinic setting...patients and employees).**

EVALUATION

MIDWEST AIDS TRAINING & EDUCATION CENTER

MINI-RESIDENCY

Community-Based Care of **HIV-Infected** AIDS Patients
U.S. Public Health Service, Region V

DECEMBER 6.1989

Please rank the items below, with "5" being very helpful and "1" being of little or no help.

1) HIV ANTIBODY TESTING/COUNSELING **(4.7)**

Comments

- Would be nice to role play before actually doing pre/post test counseling.
- Mom time would be helpful.
- Excellent,

2) STANDARDIZED PATIENT ENCOUNTER: **"PRE/POST** TEST COUNSELING." **(4.3)**

Comments

- Very helpful.
- I enjoyed the standardized patient encounters even though they had a tendency to make me feel uncomfortable. You get a sense of how you interact with patients. It made me more aware of how and what I had to focus on regarding questions, how to get patients to be more open with their answers, and what I need to explore as far as their lifestyles.

3) CASE **CONFERENCE: PRE/POST** TEST COUNSELING **(3.7)**

4) UNIVERSAL PRECAUTIONS IN MEDICAL OFFICE (VIDEO) (3.7)

Comment

- Good video - adequate coverage of this topic

5) DIAGNOSIS/MEDICAL MANAGEMENT OF HIV/AIDS AND RELATEDPROBLEMS (4.7)

Comment

- Include discussion of DNR status.

6) PROPHYLACTIC/THERAPEUTIC DRUG REGIMENS FOR HIV-RELATED AND OPPORTUNISTIC INFESTION (4.3)

Comment

- Excellent

7) HIV NEUROPSYCHIATRIC ISSUES (2.0)

Comment

- Need explained in more simple terms and to include mom of how it affects aids.

Physicians Only

8) STANDARDIZED PATIENT ENCOUNTER: "DIANOSTIC TREATMENT OF SYMPTOMATIC HIV + MALE" (4.5)

COMMENT

- This is not as helpful as Sexual history and Pre/Post Test Counseling.

Nurses Only

9) VIDEOS, ETC. N/A

COMMENT

- Not covered, but would like to see and to get more R.N's invloved with this project to get more input on nurse's role with HIV/AIDS patients.

EVALUATION

Midwest AIDS Training & Education Center

MINI-RESIDENCY
Community-Based Care of HIV-Infected/AIDS Patients
U.S. Public Health Service, Region V
November 30.1989

We hope you have found this mini-residency helpful. To assist us in the evaluation and revision of the program, we would appreciate your comments.

Please rank the items below, with "5" being very helpful and "1" being of little or no help. Please comment on why any segment of the program was not particularly helpful (e.g., Knowledge about topic prior to the conference.)

							COMMENTS
1.)	IMPACT OF HIV-RELATED ATTITUDES & EMOTIONS ON HEALTH-CARE DELIVERY	5	4	3	2	1	_____
2.)	TAKING A SEXUAL/DRUG-USE HISTORY	5	4	3	2	1	_____
3.)	STANDARDIZED PATIENT ENCOUNTER: "SEXUAL/DRUG-USE HISTORY"	5	4	3	2	1	_____
4.)	PATHOPHYSIOLOGY & EPIDEMIOLOGY OF HIV/AIDS	5	4	3	2	1	_____
5.)	SOCIAL & COMMUNITY SUPPORT FOR HIV-INFECTED CLIENT	5	4	3	2	1	_____
6.)	AIDS PREVENTION	5	4	3	2	1	_____
7.)	CULTURAL, ETHNIC, GENDER, SEXUAL-ORIENTATION, I-V DRUG ISSUES	5	4	3	2	1	_____
8.)	ADDITIONAL COMMENTS						

• THANK YOU •

EVALUATION

Midwest AIDS Training & Education Center

MINI-RESIDENCY
Community-Based Care of HIV-Infected/AIDS Patients
U.S. Public Health Service, Region V
December 6, 1989

We hope you have found this mini-residency helpful. To assist us in the evaluation and revision of the program, we would appreciate your comments.

Please rank the items below, with "5" being very helpful and "1" being of little or no help. Please comment on why any segment of the program was not particularly helpful to you. Knowledge about topic prior to the conference.)

							COMMENTS
1.)	HIV ANTIBODY TESTING/COUNSELING	5	4	3	2	1	
2.)	STANDARDIZED PATIENT ENCOUNTER: "PRE/POSTTEST COUNSELING"	5	4	3	2	1	
3.)	CASE CONFERENCE: PRE/POSTTEST COUNSELING	5	4	3	2	1	
	UNIVERSAL PRECAUTIONS IN MEDICAL OFFICE (VIDEO)	5	4	3	2	1	
5.)	DIAGNOSIS/MEDICAL MANAGEMENT OF HIV/AIDS & RELATED PROBLEMS	5	4	3	2	1	
6.)	PROPHYLACTIC/THERAPEUTIC DRUG REGIMENS FOR HIV-RELATED & OPPORTUNISTIC INFECTIONS	5	4	3	2	1	
7.)	HIV NEUROPSYCHIATRIC ISSUES	5	4	3	2	1	
	Physicians only						
8.)	STANDARDIZED PATIENT ENCOUNTER: "DIAGNOSTIC TREATMENT OF SYMPTOMATIC HIV+ MALE"	5	4	3	2	1	
	Nurses only						
9.)	VIDEOS, ETC.	5	4	3	2	1	
10.)	MULTIDISCIPLINARY HIV-TEAM DEVELOPMENT	5	4	3	2	1	

11.) ADDITIONAL COMMENTS (Use other side)

• THANK YOU •

PL/11.89

EVALUATION

Midwest AIDS Raining & Education Center

MINI-RESIDENCY
Community-Based Care of HIV-Infected/AIDS Patients
U.S. Public Health Service, Region V
December 7, 1989

We hope you have found this mini-residency helpful. To assist us in the evaluation and revision of the program, we would appreciate your comments.

Please rank the items **below,** with **"5" being very helpful and** "1" **being of little or no** help. **Please** comment o **why any segment** of the program **was** not **particularly helpful to you. Knowledge** about topic **prior** to the **conference.)**

						COMMENTS
1.)	MULTIDISCIPLINARY TEAM CONFERENCE	5	4	3	2	1 _____
2.)	CASE MANAGEMENT OBSERVATION	5	4	3	2	1 _____
3.)	CLINICAL OBSERVATION	5	4	3	2	1 _____
4.)	CLINICAL/CASE MANAGEMENT DISCUSSION	5	4	3	2	1 _____
5.)	MINI-RESIDENCY MANUAL	5	4	3	2	1 _____
6.)	ADDITIONAL COMMENTS					

. THANK YOU .

PL/11.89

EVALUATION

MIDWEST AIDS TRAINING & EDUCATION CENTER

MINI-RESIDENCY

Community-Based of HIV-Infected/AIDS Patients
U.S. Public Health Service+ Region V

DECEMBER 7.1989

Please rank the items below, with "5" being very helpful and "1" being of little or no help.

1) MULTIDISCIPLINARY-TEAM CONFERENCE **(3.0)**

Comment

- Not very organized. Could be covered briefly during clinical observation prior to having interaction with patient.

2) CASE MANAGEMENT OBSERVATION **(4.3)**

3) CLINICAL OBSERVATION **(4.3)**

4) **CLINICAL/CASE** MANAGEMENT DISCUSSION **(3.5)**

5) MINI-RESIDENCY MANUAL **(4.0)**

Comments

- **Have not evaluated.**
- Beneficial. **Need** to look **at it more.**
- **Will be good reference for work setting.**

6) ADDITIONAL COMMENTS

- Suggest **adding** component on **death** and **dying.**

PART II:

SUMMARY

OF

EVALUATION DATA

SUMMARY

OF

EVALUATION DATA

This data cannot be considered reflective of physicians/nurses at all Region V, U.S. Public Health Service Community Health Centers because, only three professionals, two physicians and one nurse, attended the total three-day Mini-Residency Program and completed evaluations. However, the data generated should be considered in revising the curriculum for future programs.

Overall, the Mini-Residency Program received a rating of 3.9 on a scale of 1 to 5 with 5 indicating "very helpful." Of the 20 program components, 12 (60%) received ratings of 4.0 or greater. The four areas receiving the highest ratings, 4.5 to 4.7, were: '"Taking a Sexual/Drug-Use History", "HIV Antibody Testing/Counseling", "Diagnosis/Medical Management of HIV/AIDS and Related Problems", and "Standardized Patient Encounter: Diagnostic Treatment of Symptomatic HIV+ Male". The only component of the program receiving less than 3.0 was "HIV Neuropsychiatric Issues" which received a 2.0 with the comment, "Need to explain in more simple terms and to include more of how it affects AIDS.'

Additional comments induded: "The first day was too long; suggest adding a Death & Dying component; and, appreciation for the opportunity to attend the program.

Recommendations for further consideration follow.

PAR7 III:

RECOMMENDATIONS

FOR

FUTURE PROGRAMS

RECOMMENDATIONS

FOR

FUTURE PROGRAMS

The following recommendations are based upon the orai and written evaluation comments received from the three program attendees, two physidans and one nurse, and from suggestions made by the program faculty and developers present at the December 18, 1989 Mini-Residency Program follow-up meeting.

it is recommended that the following be considered for future programs:

1) Change program title from "Mini Residency" to "Mini Fellowship", to reflect a more appropriate status of the participating health professionals.

2) Shorten days to 8 to 8 1/2 hours maximium and extend program to four days, to maintain and add program content while shortening number of required hours per day.

3) If out-of-state participants are to be included, re-evaluate how the three or four days are set up, to make program attendance realistic.

4) Provide a one-half to full-day program at each center, for ail center staff, prior to the physician-nurse team's attendance at the Mini-Residency, to develop interest in and support for AIDS education.

5) Based on the experience of the pilot program, re-evaluate manual contents before next program and make appropriate deletions/additions.

6) Provide program registrants with the program manual prior to the program to facilitate perusal of lts contents before attendance at program.

7) Keep affective component first on program as it helps participants identify wlth persons with AIDS (PWA'S) and their own personal issues related to AIDS/HIV thus, stimulatlng an increased appreciation for the "right" versus "wrong" way to work with PWA'S.

8) Eliminate PWA from program and replace with more indepth coverage of social and community services for PWA'S.

9) Provide more indepth coverage of prevention, including sexual-alternatives.

10) Provide more indepth coverage of cultural, ethnic, gender, sexual-orientation and IV-drug issues.

11) Role play pre and post test counseling prior to standardized patient encounter.

12) Add standardized patient encounter, pre & post test counseling of IVDU.

13) Keep pathophysioiogy and epidemiology of HIV/AIDS to minimum.

14) Limit universal precautions to video shown (TRIAD-Ambuiatqry Care Setting).

15) Have Diagnostic/ Medical Management presenters coordinate their presentations, so as not to duplicate information provided.

16) include discussion of DNR status.

17) Relate neuropsychiatric component to effect on AIDS patients and make explanation less technical.

18) Delete Muitidispiinary Team Conference, unless better organized.

19) Include additional clinical observation, if time permits.

20) Add additional standardized patient encounters (if time permits) as, based on partidpants evaluations, excellent learning results.

21) Add component on death and dying.

22) Provide affective and sexual/drug-use history as inservices for all community health centers professional staff.

APPENDIX

MATEC

Midwest AIDS Training
& Education Center

NORTHERN ILLINOIS SITE
The University of Illinois at Chicago
808 s. Wood street (M/C 779)
Chicago, Illinois 60612
(312) 996-1373

CENTER HEADQUARTERS
The University of Illinois at Chicago
Chicago, Illinois

REGIONAL SITES
Indiana University
School of Medicine
napolis, Indiana

Missouri Department of Health/
University of Missouri
Jefferson City/Columbia. Missouri

Southern Illinois University
Alton, Edwardsville. and Springfield.
Illinois

The State Medical Society of Wisconsin
Madison. Wisconsin

The University of Illinois at Chicago
Chicago, Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

CHICAGO-READ MENTAL HEALTH CENTER

AIDS TRAINING WORKSHOP AGENDA

9:00	Introductions Objectives
9:10	Staff Concerns and Issues
9:20	Medical Aspects of HIV/AIDS
10:30	Break
10:45	Loss Exercise
11:00	Psychosocial and Treatment Issues for Clients & Caregivers
11:50	Closing / Evaluation

The Midwest AIDS Training and Educatbn Center (MATEC) is funded by the U.S. Public Health Service, Health Resources and Services Administration, Educatbn and Training Center Program, Grant #HHS BRT 000033-01-0.

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Madison, Wisconsin

The University of Illinois at Chicago
Chicago, Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

CHICAGO-READ MENTAL HEALTH CENTER AIDS TRAINING

PRESENTER OUTLINE

Introductions & Objectives (10 minutes)	**Facilitators introduce themselves and explain the goals of training:** **1) increase knowledge and awareness** **2) decrease fear and misconceptions** **3) increase understanding of psychosocial issuas** **4) reduce personal risk, change behavior, share the information with others**
Staff Concerns About HIV/AIDS (10 minutes)	**Ask the audience about their previous experience with AIDS (training, persons with HIV, family, community). Brainstorm concerns or fears they may have about the disease and list on flipchart. Identify those issues that will be addressed in training and those that will not.**
Medical Aspects (70 minutes)	**Present videotape & review epidemiology, transmission, immunology, testing, course/stages, symptoms, prevention, treatment, & basic infection control procedures.**
Loss Exercise (15 minutes)	**Guide audience through loss visualization exercise and then relate their experience to that of people with HIV or AIDS. Use the exercise to help the audience understand AIDS from the client's point of view.**
Psychosocial and Treatment Issues Clients/Staff (50 minutes)	**Segue from loss exercise into a discussion of typical emotional reactions and psychological & social changes typically for experienced by PWA's, families, friends, & caregivers. Also address specific ways to treat or deal with issues that arise, both for clients and for staff.**
Closing & Evaluation (10 minutes)	**Answer any remaining questions and ask the audience to complete an evaluation form.**

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Madison. Wisconsin

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Chicago, Illinois

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College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

EXPERIENTIAL EXERCISE

1. **Take out sheet of paper. Write down the following things: (No one but you will every see what is written on the sheet)**

   a. **your favorite possession, something you own that is very important to you.**

   b. **your favorite part of your body, the aspect of your physical self that you are proud of and admire most.**

   C. **your favorite activity, the one thing you like to do more than anything else.**

   d. **a secret about yourself, something you keep hidden and never reveal to others.**

   e. **the most important person in your life.**

2. **Now concentrate and imagine that someone has stolen your favorite possession. (Pause)**

   Imagine that you have had an accident that has damaged or destroyed the favorite part of your body. (Pause)

   . . . And as a result of this accident, you can no longer do your favorite activity. (Pause)

   . . . And your secret has been revealed to everyone. (Pause)

   . . . And the most important person in your life has left you.

3. **How do you feel? What are your feelings? (Discussion)**

4. **You can have everything back now. None of these things have happened, but now you should have a better understanding of what it might feel like to be a person with AIDS/HIV.**

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of our participants. You can help us by completing this form. Thank you.

workshop Title _____ Date _____

Instructor(s) _____ City & State _____

Please answer all the questions thoughtfully. Your careful attention to these questions will help us do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical.	1	2	3	4	5
2. There was enough time to cover the material.	1	2	3	4	5
3. The handouts and other teaching aids were helpful and adequate.	1	2	3	4	5
4. You received satisfactory answers to your questions.	1	2	3	4	5
5. The instructor seemed aware of your particular skill level, and taught accordingly.	1	2	3	4	5
6. The Instruotor seemed to have adequate knowledge and skill to teach this workshop.	1	2	3	4	5

7. Please make any general evaluative comments here: _____

_____

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

_____

_____

9. What will you do differently at work as a result of this workshop? _____

_____

10. Please evaluate your Instruotor. How can the instructor do a better job next time?

Instruotor #1 Name: _____ comment: _____

_____

Instructor #2 Name: _____ comment: _____

_____

Instructor #3 Name: _____ comment: _____

_____

Instructor #4 Name: _____ comment: _____

_____

11. In your opinion, how could this workshop be improved? _____

_____

12. What are your future AIDS training needs? _____

_____

(CONTINUED ON REVERSE SIDE) -->

(CONTINUED FROM REVERSE SIDE)

13. Professional Group — Please identify the professbnal group of which you are a member. Mark a P if you are a practicing professbnal or an S if you are a student in this field. *Choose one category only.*

P or S		P or S	
_____	1. Registered Nurse	_____	10. Physkal I Occup. / Resp. Therapist
_____	2. Physician/MD/DO	_____	Housekeeping/ Maintenance Worker
_____	3. Dentist	_____	Medkai Lab Worker
_____	4. Social Worker	_____	Dietklan / Nutritbnist
_____	5. Dental Auxiliary	_____	14. EMT/ First Responder
_____	6. LPN/Nurse Aide / CNA	_____	15. Pharmacist
_____	7. Chemical Dependence Counsebr	_____	16. Nurse Pract. / Physician Asst.
_____	8. Health Educator	_____	17. Psychologist / Mental Heaith Worker
_____	9. Administrator / Manager	_____	18. Other (please list) ·

_____

14. Race / Ethnkity — Check the appropriate category.

_____	Black / African	_____	4. Indian / Native American
_____	Hispanic / Latino	_____	5. White / Caucasian
_____		_____	6. Other

15. Please estimate the percentage of your patient bad that Is minority.

_____ **%** (mark NA if you do not provide direct services)

16. Practice Setting — Check your current *primary* work setting.

_____	1. Hospital	_____	7. Chemical Dependence Treatment Facility
_____	2. Community Health Clink	_____	8. Community Mental Health Center
_____	3. Home Health Care Agency	_____	9. Public Health Department
_____	4. Long Term Care Facility	_____	10. Correctbnai Facility
_____	5. Private Office	_____	11. Student Health Service
_____	6. Health Care Training Program	_____	12. Other (please describe)

_____

THANK YOU FOR YOUR ASSISTANCE11

NORTHERN ILLINOIS SITE: MIDWEST AIDS TRAINING AND EDUCATION CENTER
PARTICIPANT INFORMATION AND EVALUATION FORM

The following Informatbn is requested by our funding source and will help us talbr our programs to the specific needs of the participants. You can help by completing this form. Thank youl

Workshop Title Chicaso-Read MHC AIDS Training Workshop **Date** February 7, 1990

Instructor(s) Eric Noel, Armand Cerbone **Ctty & State** Chicago, Il

Please answer all auestbns thoughtfully. Your careful attention to these auestbns will help your trainer do a better job. Please don't sign your name.

Circle one number for each questbn:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. Tho content was useful and practical			1 (4%)	5(23%)	16(73%)
2. There was enough time to cover the material		3(13%)	3(13%)	11(50%)	5(23%)
3. The handouts and other teaching aids were helpful and adequate			1 (4%)	12(55%)	9(41%)
4. You received satisfactory answers to your questions				6(27%)	16(73%)
5. The instructor seemed aware of your particular skill level, and taught accordingly		1(4%)	1(4%)	8(36%)	12(55%)
8. The instructor seemed to have adequate knowledge and skill to teach this workshop				5(23%)	17(77%)

7. Please make any general evaluative comments here: See attached pages

8. Please write down one fact or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your instructor. Row can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be Improved?

12. What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)-->

4.7 Please make any general evaluative comment8 here.

- Excellent.
- Very Good (2).
- Too short.
- Very adequate.
- Good and informative (2).
- Well planned and presented.
- The presenters were flexible.
- Good balance between presenters.
- This training should be -available to all employees.
- The presenters used candid, easy to understand language.
- Gave me ideas on how to proceed with issues of anger, etc.'

- I appreciate the first-person examples usedbythe instructors, it made the information more realistic.

- The videotape was excellent at showing the range of people who could get AIDS.

Q.8 Please write one fact or idea from the workshop that you learned, and that seems important to you.

- Learning the four stages of the disease (2).
- That HIV can only be transmitted by four body fluids.
- The psychological reactions of AIDS patients.
- How to address the emotional/psych issues of patients (2)
- Feelings regarding loss of control with the disease.
- The need for candidness and empathy with AIDS patients.
- That the origin of AIDS is still unknown to scientists.

- I began to understand why patients with AIDS behave differently from other groups of patients with terminal illnesses.

- The distinction between a communicable disease like AIDS and a contagious disease like flu.

- The clinical aspects of HIV+ vs. AIDS patients and what to think about.

- The information seems to be more updated than previous AIDS training I have participated in.

Q.9 **What** will you do differently **as** a **result** of **this workshop?**

- Nothing **(2).**
- I don't know yet.
- Will be very careful.
- Be more candid with patients.
- Be less concerned about contagion.
- Demonstrate greater empathy and understanding (2).
- Emphasize effects vs. intent of patients' actions in therapy.
- Inform staff when they have questions about AIDS.
- My sensitivity to **PWA's** experiences has been heightened.

- Take extensive precautions in the workplace (i.e., frequent handwashing, etc.)

- Continue to increase the education of my staff, demand education for all staff and patients.

- I have more basic knowledge to deal with staff and patients when issues regarding AIDS arise.

Q.10 Please evaluate your instructor. **How can** the **instructor** do a better job next time?

Instructor Name: *Eric* Noel

- Excellent (5)
- Great job.
- Very good (3)
- Well prepared and knowledgeable (3).
- Very informed on the subject matter (2).
- Presented well, very clear. Good speaking voice.
- You were both great, knowledgeable, invested in your topic, and complemented each other well.

Instructor Name: **Armand Cerbone**

- Excellent (5)
- Great job.
- Very Good (4)
- Well informed.
- Well prepared and knowledgeable.
- Interesting material, well presented.
- Extensive knowledge of AIDS complexities. Excellent insight.
- Very good at giving empathy needed to deal with **PWA's.**

Q.11 In your opinion, how could this workshop be improved?

- Serve coffee.
- Allow more time (2).
- Good as an introductory workshop.
- Presentation was the best I have attended.
- Don't change content or presentation.
- More workshops to be frequently scheduled.
- Expanded to train all employees, direct service staff.

- Make it more practical for unit management rather than individual therapy.

- More time needs to be spent on the actual facts. People think because they hear the word AIDS on TV they know all about it.

4.12 What are your future AIDS training needs?

- Updates.
- More detailed information.
- Interviews with AIDS patients.
- How to handle PWA's in the hospital setting.
- How to deal with line staff working with AIDS patients.
- Two hours every 6 months on current aspects.
- Emphasis on unit/group patient procedures.
- This workshop seemed to cover my needs.
- Don't know yet.

NORTHERN ILLINOIS SITE: **MIDWEST AIDS TRAINING AND EDUCATION CENTER**
PARTICIPANT INFORMATION AND EVALUATION FORM

The following information is requested by our funding source and will help us tailor our programs to the specific needs of the participants. You can help by completing this form. Thank you!

Workshop Title Chicago-Read MHC AIDS Training Workshop **Date** February 14, 1990

Instructor(s) Eric Noel, Armand *Cerbone* **City & State** Chicago, Il

Please answer all questions thoughtfully. Your careful attention to these questions will heb your trainer do a better job. Please don't sign your name.

Circle one number for each question:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The content was useful and practical				4 (27%)	11 (73%)
2. There was enough time to cover the material		2 (13%)	4 (27%)	8 (53%)	1 (7%)
3. The hancbuts and other teaching aids were helpful and adequate			5 (33%)	7 (47%)	3 (20%)
4. You received satisfactory answers to your questions				6 (40%)	9 (60%)
5. The instructor seemed aware of your particular skill level, and taught accordingly		2 (13%)		6 (40%)	7 (47%)
6. The instructor seemed to have adequate knowledge and skill to teach this workshop				4 (27%)	11 (73%)

7. Please make any general evaluative comments here: See Attached Pages

8. Please write down one fad or idea from the workshop that you learned, and that seems important to you:

9. What will you do differently at work as a result of this workshop?

10. Please evaluate your Instructor. How can the instructor do a better job next time?

Instructor #1 Name: _____ Comment: _____

Instructor #2 Name: _____ Comment: _____

Instructor #3 Name: _____ Comment: _____

Instructor #4 Name: _____ Comment: _____

11. In your opinion, how could this workshop be improved?

12 What are your future AIDS training needs?

(CONTINUED ON REVERSE SIDE)--,

Q.7 Please make my general evaluative comments here.

- Good presentation.
- Pertinent and helpful.
- Excellent presentation overall.
- Very good informative presentation (3)
- Should be available to all levels of staff.
- The seminar was great, both presenters knew the material.
- This was the most informative and satisfying workshop I have attended for many years.

- The instructors appeared knowledgeable, compassionate, and supportive.

- Content for at least some participants was redundant. For a general audience I believe it could be very useful.

Q.8 Please write down one fact or idea from the workshop that you learned, and that seems important to you.

- Educate, educate, educate.
- A clearer definition of the stages.
- The four progressive stage of the illness (2)
- HIV is communicable but not contagious.
- Ways AIDS is transmitted vs. ways it is not (2)
- AIDS is not caught through simple day to day behavior.
- The risk factors are not what the general public thinks.
- That AIDS is a very, very dangerous communicable disease.
- We must deal with possibility of AIDS on several levels - medical, legal, social.

- The concept of medical isolation is reversed to protect the AIDS patients from infections from other patients.

Q.9 What will you do differently as a result of this workshop?

- Not sure at this point (2)
- Eliminate biases against AIDS patients.
- Be extremely cautious with all patients.
- Not feel guilty or anxious about patients with AIDS.
- Try to clarify miseducation and ignorance.
- Work to educate staff and patients more (2)
- Help educate staff & patients of the safety aspect on an equal term.

Q.10 Please evaluate your instructor. How can the instructor do a better job next time?

Instructor #1 Name: Eric Noel

- Excellent (6)
- Very Good (2)
- Interesting, well organized presentation (2)
- Professional, knowledgeable, easy to listen to.
- Good knowledge and ability to relate the material.
- Be within given time while presenting the seminar.
- Well informed and obviously cared about material presented,

Instructor #2 Name: **Armand**

- Excellent (2)
- Very Good (4)
- Talk more on grief and loss.
- Gave relevant and'appropriate disclosure.
- Professional, knowledgeable, easy to listen to.
- More difficult material, but he did well with it.
- Gave many ideas to deal with patients on clinical level.
-
-
-

- Appeared loose, even on acknowledgement that topic was more subjective.

Q.11 In your opinion, how could this workshop be improved?

- Make it longer, allow more time (3)
- Increase the amount of time and provide a follow-up.
- Need to focus more on the universal precautions to take.
- More structured presentation of clinical consultation.
- More explanation of psychological & life-adjustment issues.
- Give more information on confidentiality, legal issues, and specific precautions, especially issues related to minors.

Q.12 What *are* your future AIDS training needs?

- More education.
- More diverse clinical training.
- To be kept updated on the disease (3)
- Latest breakthrough in curing AIDS.

CENTRAL IOWA AIDS SYMPOSIUM FOR HEALTH PROFESSIONALS

June 2, 1989

EVALUATION QUESTIONNAIRE

	Very Satisfied		Moderately Satisfied		Dissatisfied	
1. **The information presented** was intellectually stimulating to me.	1	2	3	4	5	6
2. **The program** objectives **were** met.	1	2	3	4	5	6
3. Practical and useful information was presented,	1	2	3	4	5	6
4. This program **helped** me become more receptive **to points** of **view** of other health **disciplines.**	1	2	3	4	5	6
5. **Well chosen** examples **were** *used* by **the** speakers to 'clarify points.	1	2	3	4	5	6

How **satisfied were you with** the **following?**

	Very Satisfied		Modera tely Satisfied		Dissatisfied	
1. **Conference** format	1	2	3	4	5	6
2. **Conference** administration	1	2	3	4	5	6
3. Quality of instruction	1	2	3	4	5	6
4. Opportunity for **questions**	1	2	3	4	5	6
5. Meeting facilities	1	2	3	4	5	6
6. Audiovisuals	1	2	3	4	5	6

Note: If you indicated dissatisfaction with any of the above, please give us your specific recommendations for improvement.
(Continue on reverse side if you so desire.)

COMMENTS:

What topics would you suggest for future **programs?**
(Continue on reverse side if you so desire.)

Additional comments **and/or recommendations:**
(Continue oh **reverse side** it you **so desire.)**

CENTRAL IOWA AID SYMPOSIUM FOR HEALTH PROFESSIONALS
JUNE 2, 1989
EVALUATION SUMMARY

	Very Satisfied		Moderately Satisfied		Dissatisfied		%
	1	2	3	4	5	6	
1 The information presented was intellectually stimulating to me.	33%	40%	23%	4%	0%	0%	100%
2 The program objectives were met.	41%	36%	16%	7%	0%	0%	100%
3 Practical and useful information was presented.	47%	27%	19%	6%	1%	0%	100%
4 This program helped me become more receptive to points of view of other health disciplines.	35%	43%	19%	4%	0%	0%	100%
5 Well chosen examples were used by the speakers to clarify points.	44%	37%	15%	2%	1%	0%	100%
Averages	40%	37%	18%	5%	0%	0%	100%
Totals		77%		23%		0%	100%

	Very Satisfied		Moderately Satisfied		Dissatisfied		%
1 Conference format	44%	37%	14%	1%	4%	0%	100%
2 Conference administration	52%	32%	14%	2%	0%	0%	100%
3 Quality of instruction	49%	33%	14%	4%	0%	0%	100%
4 Opportunity for questions	38%	28%	19%	6%	9%	0%	100%
5 Meeting Facilities	48%	30%	9%	10%	1%	2%	109%
6 Audiovisuals	51%	37%	9%	4%	0%	8%	100%
Averages	47%	33%	13%	5%	2%	a%	100%
Totals		80%		17%		3%	100%

COMMENTS:
EXCELLENT/VERY GOOD
Not enough time for questions
Rooms too cold

University of Wisconsin-Madison School of Nursing
Continuing Education In Nursing

Summary

NURSING'S RESPONSE TO HIV INVECTION:
An Emerging Spectrum of Care
April 17, 1990

Total = 130

APR 2 6 1990

EVALUATION

Your assistance In completing this evaluation will help us to plan future continuing education conferences.

A. Content

Select the number from the scale which best indicates the degree to which these objectives were achieved:

	Not at all				Well Done
SCALE	1	2	3	4	5

This conference will enable the participant to:

1. Utilize nursing diagnoses of functional health patterns for persons with HIV infections. — 3.46
2. Explore the latest knowledge on the HIV epidemic. — 3.75
3. Identify the Investigational dtugs'and their implications for nursing practice. — 3.59
4. Assess the scope of HIV-related chronic care needs and the nursing implicatons. — 4.13
5. leach and counsel individuals and groups with a focus on safer sex and 'safer IV drug use. — 3.62
6. Apply effective nursing approaches to support coping and self-perception patterns in persons with HIV infection. — 3.61
7. Employ nursing Interventions to support cognitive-perceptual functions.
8. Understand nursing approaches to meeting nutritional and metabolic needs, — 4.22

B. faculty

Please rate the presenters for this conference In the following two areas, using the scale of 1 to 5; 1=none to S-excellent:

NAME	KNOWLEDGE OF CONTENT	EFFECTIVENESS OF DELIVERY
Beth Zwickl	4.46	4.28
Bill Barrick	4.59	3.64
Laura Govoni	4.14	4.10
Panelists:	5.00	4.81

(over)

c. General Reaction

Using the scale of 1 to 5 where 1=negative to 5=positive, please respond to these questions:

1. What is your overall impression of this conference? 3.83
2. Old the information presented relate to the conference objectives? 4.09
3. Was the subject matter adequately covered within the allotted time? 3.48
4. Did you get the information you sought? 3.38
5. Will thls knowledge be of practical value to you? 3.71
6. Were the handouts relevant? 4.07
7. Old the audiovisuals augment your learning? 3.53
8. Was the conference setting conducive to your learnlng? 4.09

Additional comments:

1. What was the most helpful part of the conference?

2. What was the least helpful part of the conference?

3. How do you plan to use information from this conference in your practice setting?

4. Suggestions/Recommendations for:

   a. Faculty:

   b. Conference Coordinator:

RL:cp
4/90
6201q

INFORMATION ABOUT PARTICIPANTS **(144 Responded)**

AGE: **average age** is 41 GENDER: 134 1. Female 9 2. Male 1 **3.No** response

1. I am:

2 1. African **American/Black**
1 2. **Latino/Hispanic**
0 3. Asian
137 5. **Whitee American**
1 6. Other
2 7. No response

My **occupation** is:

1 Asst. **Researcher**
1 gcncfit Analyst
3 Case Analyst
1 Clinical Research Coord.
3 Dircotors of Nursing
2 Health Educators/Instructors
1 Health Service Unit Hancgcr
2 **Infection** Control **Nurses**
2 LPN
1 **Medical** Assistant
3 Nurse Clinician II
1 Nurse **Consultant**
1 Nurse **Practitioner**
1 Nursing Assistant
1 Nursing **Coordinator**
1 Oocupctional Nurse
2 **Public** Health Nurses
109 **R.N.s,** staff nurses, etc.
5 **Students**
3 No responses

How many years have you spent in your **present occupation?** average is 12 **years**

My primary **worksite** is:

40 1. Hospital
10 2. Outpatient clinic
8 3. **Home** health care **agency**
27 4. **Long-term** care facility
5 5. Private office
54 6. Other: _____

Other Sites:
1 AIDS Service Organization
1 **BCHS**
9 **Blood** Collection **Agency**
2 Schools
5 **Colleges/Tech.** Hospice
1 **Industry**
4 Insurance **Company**
2 **Multi-Specialty** Clinic
1 **Occupational** Health
21 **Prison/Corrections**
1 **V/R - QA**
5 **Indicated** Other Site but did not **expand**

Size of **community** in which you work:

45 1. Large city/Urban
45 2. **Medium** city
5 3. **Suburban**
44 4. **Small town/Rural**
5 No response

To the **best** of your knowledge have you **ever provided** care to a **person** with either HIV infcotion or AIDS as a part of your job?

86 1. **Yes** (Please answer **nexttwo questions)**
55 2. No (Please **proceed** to **next section)**
33. Norcspomc

How many **people** with HIV infcotion or AIDS **have** you **cared** for in the **past year?** average of 16 patients

In what year did **you** first **care** for **your** first **known person** with HIV **infection/AIDS?**

2 1983
3 1984
11 **1985**
14 **1986**
16 **1987**
21 **1988**
15 1989
1 1990
3 Gave no year

MIDWEST AIDS TRAINING AND EDUCATION CENTER
PRE-PROGRAM QUESTIONNAIRE
April 17, 1990

OPINIONS (144 Responded)

A Strongly agree
B Agree
C Don't know or No opinion
D Disagree
E Strongly disagree
F No response

		A%	B%	C%	D%	E%	F%
1.	I am concerned about contracting AIDS from patients when I am at work.	15.3	30.6	6.3	35.4	12.5	
2.	My family is concerned about the possibility of my working with AIDS patients.	11.1	31.3	24.3	25.7	7.6	
3.	My knowledge of AIDS, when compared to that of my co-workers, is greater than most of theirs.	20.8	21.5	30.6	22.2	4.2	.7
4.	I am concernad about contracting AIDS from my personal lifestyle.		1.4	1.4	17.4	79.2	.7
5.	I feel or would feel uncomfortable working with AIDS pstients.	5.6	13.9	18.1	34.0	28.5	
6.	AIDS infection control procedures are sufficient to protect health care providers.	4.9	38.2	29.2	19.4	7.6	.7
7.	To control the spread of AIDS, persons with AIDS should be segregated from other people.	2.1	7.6	8.3	43.8	37.5	.7
8.	I have developed sane negative feelings toward homosexuals because of AIDS.	2.1	18.8	0.3	33.3	36.8	.7
9.	I believe that health care workers should have a choice about whether or not they want to work with persons with AIDS.	11.8	41.0	12.5	21.5	12.5	.7
10.	To control the spread of AIDS, AIDS information should be incorporated into every health care visit.	25.0	36.1	16.0	19.4	2.1	1.4
11.	I have adequate knowledge to protect myself from getting AIDS from patients.	23.6	43.8	16.0	12.5	2.8	1.4
12.	To prevent the spread of AIDS, AIDS education should ba incorporated into every curriculum of health program.	56.3	34.7	2.1	4.2	1.4	1.4
13.	I have adequate knowledge to protect myself from getting AIDS through my private life.	54.2	37.5	2.8	3.5	.7	1.4
14.	Given the choice, I would rather not work with patients with AIDS.	9.7	15.3	22.9	31.3	18.8	2.1
15.	Drug addicts who contract AIDS through shared needles are getting what they &serve.	1.4	6.3	16.7	37.5	36.1	2.1
16.	If confronted with a significant number of clients with AIDS, I would look for a job that had minimal contact with persons with AIDS.	5.6	14.6	37.5	24.3	16.7	1.4
17.	Health care facilities should have special areas used only by patients with AIDS.	4.2	17.4	23.6	34.0	17.4	3.5
18.	I have developed negative feelings toward drug addicts with AIDS.	2.0	13.9	16.7	44.4	20.8	1.4
19.	Homosexuals who contract AIDS are getting what they deserve.	.7	4.9	13.9	41.0	37.5	2.1
20.	I am comfortable providing care for a person with HIV infection.	11.8	41.0	25.7	16.7	2.8	2.1
21.	I feel comfortable counseling my current patients about AIDS/ HIV prevention.	18.1	43.8	18.8	15.3	1.4	2.8
22.	My current skills are sufficient to address the needs of those who are HIV antibody positive.	9.7	29.2	19.4	35.4	3.5	2.8
23.	I am comfortable providing care to parsons who are gay or bisexual.	18.8	47.2	20.0	7.6	2.8	2.8
24.	I am comfortable providing care to intravenous drug users.	11.1	43.1	27.8	12.5	2.8	2.8

MIDWEST AIDS TRAINING AND EDUCATION CENTER
POST-PROGRAM QUESTIONNAIRE
April 17, 1990

OPINIONS (116 Responded)

A strongly agree
B Agree
C Don't know or No opinion
D Disagree
E Strongly disagree
F No response

		A%	B%	C%	D%	E%	F%
1.	I am concerned about contracting AIDS from patients when 1 am at work.	6.0	15.5	13.8	39.7	25.0	
2.	My family is concerned about the possibility of my working with AIDS patients.	6.0	29.3	29.3	20.7	14.7	
3.	My knowledge of AIDS, when compared to that of my co-workers, is Greater than most of theirs.	20.7	37.9	18.1	1.7	1.7	
4.	Iam concerned about contracting AIDS from my personal lifestyle.		1.7	1.7	26.7	69.8	
5.	I feel or would feel uncomfortable working with AIDS patients.	2.6	10.3	19.8	43.1	24.1	
6.	AIDS infection control procedures are sufficient to protect health care providers.	46.6	11.2	18.1	14.7	7.8	1.7
7.	To control the spread of AIDS, persons with AIDS should be segregated from other people.	.9	.9	7.8	45.7	44.8	
a.	1 have developed some negative feelings toward homosexuals because of AIDS.	1.7	6.0	8.6	44.0	39.7	
9.	I believe that health care workers should have a choice about whether or not they want to work with persons with AIDS.	12.9	44.8	12.9	21.6	7.8	
10.	To control the spread of AIDS, AIDS information should be incorporated into wery health care visit.	29.3	44.0	10.3	12.1	3.4	.9
11.	I have adequate knowledge to protect myself from getting AIDs from patients.	30.2	55.2	9.5	2.6	2.6	
12.	To prevent the spread of AIDS, AIDS education should be incorporated into every curriculum of health program.	58.6	34.5	1.7	2.6	2.6	
13.	I have adequate knowledge to protect myself from getting AIDS through my private life.	62.1	34.5	1.7		1.7	
14.	Given the choice, I would rather not work with pstients with AIDS.	6.9	9.5	26.7	33.6	23.3	
15.	Drug addicts who contract AIDS through shared needles are getting what they deserve.	3.4	5.2	14.7	40.5	36.2	
16.	If confronted with a significant number of clients with AIDS, I would look for a job that had minimal contact with persons with AIDS.	4.3	10.3	32.8	32.8	19.8	
17.	Health care facilities should heve special areas used only by patients with AIDS.	4.3	7.8	18.1	44.8	22.4	2.6
18.	I have developed negative feelings toward drug addict8 with AIDS.	2.6	10.3	19.0	45.7	22.4	
19.	Hanosexuals who contract AIDS are getting what they deserve.	1.7	3.4	10.3	40.5	44.0	
20.	I am comfortable providing care for a person with HIV infection.	18.1	40.5	29.3	9.5	2.6	
21.	I feel comfortable counseling my current patients about AIDS/HIV prevention.	23.3	45.7	24.1	6.0	.9	
22.	My current skills are sufficient to address the needs of those who are HIV antibody positive.	14.7	43.1	24.1	15.5	.9	1.7
23.	1 am comfortable providing care to persona who are gay or bisexual.	25.9	49.1	16.4	7.8	.9	
24.	I am comfortable providing care to intravenous drug users.	13.8	46.3	25.7	11.2	.9	
25.	1 leave this conference with additional knowledge about HIV/AIDS.	35.3	53.4	7.8	2.6	.9	
26.	My objectives for attending this conference were mat.	21.6	52.6	12.9	11.2	.9	.9
27.	I leave this conference with changed views about HIV/AIDS issues.	11.2	33.6	18.1	32.8	4.3	
28.	I leave this conference with stronger skills related to my professional practice and HIV/AIDS.	12.9	68.1	11.2	6.0	.9	.9
29.	I feel prepared to talk with clients who are worried about their AIDS-related risk status.	17.2	62.1	14.7	5.2	.9	

PROGRAM EVALUATION

HIV Infection: Understanding and Caring for the Individual
Larry Von Behren, M.D. and Terry King, M.A., Course Directors
December 14, 1989

Please take a *few* minutes to complete this evaluation. It will help us in planning future programs.

1. In general, how do you rate the course?

   Excellent = 28 Very Good = 28 Good = 4 Fair = 0 Poor = 0

2. What did you find to be the strongest feature?

   -- Dr. Von Behren (12)
   -- Afternoon small groups (10)
   -- Direct discussion with patients (21)
   -- Comfort, questions and answers
   -- Homosexuality
   -- Let you know many different outlooks on the virus
   -- Very informative
   -- Overview and personal sharing
   -- Openness
   -- Learning the people themselves talk about aids
   -- IV drugs
   -- Gene Brodland
   -- The overview and description of what AIDS is
   -- The gay couple and HIV infection
   -- Eric Noel's frankness on homosexuality
   -- Very-organized, well run conference
   -- That gay men are human too
   -- Information on IVDU - chance to network
   -- Issues surrounding homosexuality - An *overview* of HIV Infection and issues surrounding the IV drug user
   -- Variety of topics presented
   -- Clear and to the point

3. What did you find to be the weakest feature?

   -- Dr. Spencer's slides, lunch, small conference *room*
   -- "The couple talk" I felt they were somewhat uncomfortable
   -- Listening to the doctors
   -- Needed 1 1/2 hours for lunch
   -- Drug usage in the community
   -- I didn't know some of the terms used by the doctors(2)
   -- The waiting in line for lunch, otherwise no weaknesses
   -- Eric Noel
   -- Need to have a non-gay HIV+ person on the panel
   -- issues surrounding aids
   -- Too much time hearing from patients - While it was very valuable, three sessions was too much (sessions 5-7)
   -- XV drug user (5)
   -- Issues surrounding the IV drug user
   -- Difinitive information/correlation with XV Drug abuse & AIDS & current public policies/programs
   -- David Spencer (4)

-- Development of HIV+ fnto AIDS
-- Issues surrounding the drug user - this wasstilla good topic but not all beneficial to me
-- Time constraints (3)
-- I needed to hear more' solutions to Gene's problems
-- 1:00 questions with couple in large group
-- Not enough time for Eric to speak
-- Finding auditorium - need map of building
-- Would have liked more time devoted to the disease, treatment, etc.
-- Nothing - it was great
-- Information on the IV drug user seemed to be conflicting material
-- IV drug use presentation - but that is consistent of the fact the Springfield HIV+ population is mostly gay men?
-- Speaker's handouts could be added

4. To what extent did the content presented meet your objectives in attending?

Completely = 18 to a large extent = 29 Partially = 0 Not at all = 0

Please comment:
-- You stuck to the format as out lined
-- I was interested in infants and children with HIV
-- It was broad based, reached a variety of audiences
-- Need more handouts with updated statistics/data.
-- The program hit directly issues that I was not well informed
-- I learned a lot that I didn't know
-- I wanted a little more information on counseling issues - i.e. how to deal with patient denial (3)
-- Gave a good overview and touched psychosocial issues
-- I still need to learn more about the scientific or medical cause and Working of AIDS - I'mstill not sure of the differences between HIV+, ARC and AIDS
-- Much more effective than I anticipated
-- I didn't read the program, I didn't think the gay people would be there but I appreciated it
-- I thought we would have more educational material to give to staff we work with
-- I wanted a more indept understanding of what the gay community felt about AIDS and being HIV+
-- Even though nutrition is not on the program
-- I came with the intention of learning about AIDS and the issues that deal with it and I did learn about the various issues
-- I just wanted to know the facts and symptoms of HIV
-- I personally need an entire conference just on IVDU issues
-- I would like to attend more programs
-- My main interest is HIV infection: transmission
-- I better understand the "Gay Lifestyle"
-- I understand some issues from the gay perspective now
-- Need to experience patient comments
-- Would have liked more time devoted to disease, treatment, etc.
-- Exceeded my expectations
-- A true understanding of AIDS from the HIV victim
-- further educated me with my concerns .
-- Helped me to understand feelings among the infected
-- Update on the present studies
-- Every speaker was clear about their thoughts_

- What have you learned today that will be immediately useful in your practice?

-- More about homosexuality (2)
-- Treat everybody like human beings and not catagorize people (3)
-- Greater appreciation for HIV+ persons as 'regular folks" (2)
-- Communication in counseling, especially listening (5)
-- Homosexual issues and that men really-feel this is something they are at birth --II've learned a new understanding of their behavior
-- You can start AZT when T4 is 200 or under
-- There are no like situations
--Having time to devote my day completely to AIDS and other distractions helps me to become more used to dealing with AIDS and hopefully to accepting it
-- Not to be afraid of the patients (2)
-- AZT
-- Compassion
-- To consider and help AIDS people
-- Increased sensitivity to psychosocial needs
-- Some of what Dr. Von Behren discussed
-- Deal with HIV and the patient with HIV (5)
-- Good overview for teaching
-- Better understanding of IVDU personality
-- Stages of incorporating AIDS into our lives by C. Wolfy
-- Since I am a student, it would be valuable to me in the future
-- Since I am still a student, I am learning everyday about AIDS
--How to relate to homosexuals
-- 10-15% of population is gay - misconceptions
-- Understanding gay people and how to help them dealing with AIDS
-- My main interest is HIV infection transmission
-- Helps eliminate fear of unknown..acceptance of gays
-- Fear of the unknown of how AIDS will affect someone keeps then from being tested
-- Updated information
-- What individuals with HIV go through
-- Use gloves when dealing with blood
-- Local resources
-- How to be comfortable with different or unknown

6. What topics have been discussed here that you will investigate further?

-- IV Drug Abuse (7)
-- Support groups - they play such a large part in this (5)
-- I will read the book (And the Band Played On) and will read more on homosexuality (2)
-- Help adolescents appreciate HIV risks
-- HIV testing (I would like to know more on *the* subject)
-- HIV Virus, (3) AIDS (3) and how they effect the human
-- If given time, I would like to investigate causes and treatment and how T4 actually works
-- AZT to health care workers ____ sticks
-- Trying to convert others thinking to compassion
-- Education of community
-- Buddy Plan and counselling of patients and HIV families (4)
-- Issues surrounding the IVDU
-- Stages of incorporating AIDS into our lives
-- I would like to investigate all the topics for more information
-- Homosexuality - learning *more* about lives of others
-- The treatments *for* HIV and AIDS
-- Political support
--Everything
-- Issue of gay from birth vs alcoholic *or* substance addictive tendency from birth
-- Addiction - HIV ongoing research

-- Resources
-- Public Aid benefits to pay for AZT
-- Precautions *to* take against HIV+ patient
-- Conference with Eric
--

7. What would you like to have heard/learned here that was not covered?

-- Reaction of health care workers to dealing with AIDS (more of their roles in support groups)
-- Children with HIV - Research, testing in children and mothers who use drugs
-- Now to get involved with helping with support groups
-- HIV Dementia
-- Legal aspects, universal precautions
-- The intravenous drug users view on AIDS
-- What the major difference between the HIV and AIDS
-- More about AZT and the HIV virus
-- Experimental treatments and physiological mechanisms of these treatments
-- Pregnancy in the HIV+ mother - risk of child
-- Another topic - Homosexuality - Eric was great - I need a day with a workshop on him to help me deal with my feelings and learn more about gays and the "nurse - patient relationship"
-- Outline of general treatment options
-- How to more openly discuss diagnosis of HIV
-- Nutritional care for the AIDS patient (2)
-- Can't think of anything
-- A little more dealing with sexuality, religion
-- More on the IVDU and AIDS relationship, etc.
-- A71 the topics I wanted to hear ware covered plus more (2)
-- Counselling, strategies,, theories re: IVDU
-- Universal practice (precautions)
-- Philosophy about conception in life, death, in permanence
-- Psychological aspects of being gay with HIV virus
-- More about testing procedures, new drugs that are out, etc.
-- Recent research with developmentally delayed HIV patients
-- Advice from significant others
-- Would like to have heard from family members, their reactions, fears, concerns'
-- I'm not sure to 'relevance in Springfield, but HIV and the-pediatric population? Also HIV patients who do not have homosexual history - it tends to set the tone for the discussion and preoccupy your thoughts and questions. Finally, more help in dealing with homosexuality would help
-- Lesbian to be involved on female HIV

8. In general, how do you rate the level of this course?

Too complex = 1 About right = 59 Too elementary = 2

9. Were your questions adequately answered, directly or otherwise? Yes = 50
-- No - 0

10. What courses/ topics would be of value to you *in* the future?
-- Psychiatry for the non-psychiatrist; Addiction workshop .
-- Hospice care of terminal phase/Symptom control - Management of complicating primary and secondary infections
-- The one on one with patients and not so much "Doctors' lectures*
-- Syphillis, Gonorrhea, some of the other diseases (2)
-- Psychological aspects/ Sexual activity of HIV+/PWA
-- AIDS, usage of drugs, HIV pregnancies
-- Dealing with HIV and AIDS patients and helping others realize and understand more about them (2)

-- Specific cause and t4 of AIDS and Eric
-- Contfnued updates on new drugs and research (6)
-- AIDS and community involvement
-- HIV+ - treatment options
-- Nutrition and AIDS patients
-- Support Groups/Facilitator Pointers
-- Minorities - Black and AIDS -- Women/Infants and AIDS -- In depth physiology and treatment of the disease, the opportunistic infections, drugs
-- How do we he?p others deal with homophobia and dea? (treat with respect) people who are HIV+
-- All the topics, since I want to go into radiology after I finish my schooling in administrative assistant program
-- Al? of the courses were of value to me since I am going to further my education
-- Counseling (3), strategies, theories re: IVDU
-- Treatments and tips for preparing children to relate to HIV and AIDS
-- Universal practice (precautions)
-- HIV disease - legal issues, Public Aid & Social Security, Housing issues
-- HIV and the health care professional
-- Patient, social, parential, SW, Dr. relationship
-- Understanding the racial standing in *our* community
-- HomosexuaI i ty, counsel ing needs (3)
-- More talks with individuals who have HIV
-- More information on hygiene when dealing with HIV patients
-- Again, HIV and Pediatrics (I'm going into a pediatric residency) if applicable to a geographic area
-- Cancer; stroke; hypertension; arthritis; diabetes

11. Where would *you* like such courses to be offered?

Springfield = 44 Your Community = 15

/our position: Practicing physician = 4 Resident = 1 Student = 10 Nurse = 17
-- Other = 25

Specialty

-- emergency physician'
-- Family Practice (2)
-- School nursing
-- Medical dental administrative assistant
-- Child psychology
-- STD counselor
-- Student-Robert Morris College (2)
-- AIDS Program coordinator - Counselor/Physiology
-- Child abuse counselor
-- Clergy (2)
-- Medical Social Worker
-- Surgery
-- OB/GYN
-- Emp Health
-- Nurse Supervisor
-- Social worker
-- Drug Rehabilitation
-- Respiratory Therapy,
-- School nurse for the handicapped
-- Alcohol/Drug Abuse
-- Respitory Care
-- x-ray technologist & paralegal
-- Dietetic intern (2)

-- AIDS Resource and Referral Agency
-- Nurse
-- HIV antibody counseling and testing/education
-- Chemical dependency
-- Counseling
-- MT
-- Social worker (3)
-- Chemistry; medical technologist
-- Internal Medicine
-- Public Health(2)
-- School Nurse
-- School Administrator
-- Severe/Profound Mentally Retarded
-- Radiology technologist
-- Interviewing in pediatrics
--

Please rate each topic and speaker.

1) HIV Infection: An Overview - Larry Von Behren, M.D.

Content: Excellent = 44 Very Good = 13 Good =1 Fair Poor = 1
Presentation: Excellent = 45 Very Good = 8 Good = 0 Fair =0 Poor =0

Comments:

-- A wonderful brilliant speaker
-- Excellent slides
-- Talked in *circles,* too boring
-- Complex terms
-- Excellent, good 'approach
-- The camcorder guy distracted a lot.' I would have had better'attention without him
-- Very articulate
-- Clear
-- Too basic for me at this tine
-- Excellent, as always
-- Always organized. If there is one thing you can say about Von Behren ...he can talk
-- entertaining
-- Very informative (3)
--

2) Issues Surrounding Homosexuality - Eric Noel, B.A.

Content: Excellent = 33 Very Good = 14 Good = JO Fair =1 Poor =0
'Presentation: Excellent = 33 Very Good = 18 Good = 3 Fair =0 Poor =0

Comments:

-- Open (5), a little bit elitist - some excellent suggestions to help deal with the gay person
-- Very relaxed
-- made me want to learn more
-- Honest
-- Excellent
-- He was very open and it is very rare for people to have the chance to discuss homosexuality with a homosexua? person without feeling it was a personal issue (as with a patient)
-- Wanted more content -- too openended format
-- His honesty was appreciated (2)
-- Delightful young man
-- Eric is such *a* comfortable and warm speaker - you automatically like him
-- Good speaker
-- The gentleman is perfect for making the public aware of the gay community and showing them they are not like the stereotype
-- He should be commended for his courage in addressing his sexual preference and helping others learn to deal with it
-- Thought he could have expanded if he'd had more time allotted (4)
-- Interesting - he made me feel like its my problem that I can't accept him instead of his problem being gay. I think this is a problem, though -- he's ready *to* take the defense on so many issues that Its hard to listen to him
--

3) Issues Surrounding the IV Drug User - David L. Spencer, M.D.

Content: Excellent = 11 Very Good = 16 Good = 22 Fair =9 Poor =1
Presentation: Excellent = 11 Very Good = 15 Good = 18 Fair =8 Poor =3

-- Boring slides
-- Talked in circles, too boring
-- Difficult to bear
-- Information good but not presented in organized format, Difficult to follow
-- I fee7 he is an expert on Drug(IV) and drug abuse. I felt, however, confused on the topic of drug abuse and AIDS as a topic
-- I learned one thing about drug personality but lost where the relationship to AIDS
-- Dr. Spencer painted a very accurate picture of an IV drug user
-- More!
-- Could have had tfghter presentation -- a lot of rambling but gave some new points to the group I think
-- Conflicting data given
-- He *took too* long with extraneous information before getting around to his main point
--

4) Special Counseling Needs of the HIV-Infected Individua? - Gene A. Broadland, MSW; ACSW

Content: Excel lent = 22 Very Good = 23 Good = 9 Fair =5 Poor =1
Presentation: Excellent = 76 Very Good = 23 'Good =12 Fair =4 Poor =1
Comments:
-- Very feeling, empathetic, a good lecture
-- Talked in circles, too boring
-- Confusing
-- No enthusiasm
-- Very informatfve and dealt more with my profession
-- Covered the basics, didn't learn anything new
-- Didn't give enough in terms of actions to take and things to say. Good insight into what concerns are, not enough solutions
-- Not a lot of organization, lots of rambling
-- I felt Gene covered necessary counseling needs and support centers
-- Covered a lot of issues in 'limited time

5) The Gay Couple and HIV Infection - Carl and Steve'

Content: Exce llent = 30 Very Good = 20 Good = 9 Fair =1 Poor =0
Presentation: Excellent = 29 Very Good =17 Good = 9 Fair =1 Poor =0
Comments:
-- Steve relaxed/Carl nervous
-- Open and helped me learn a lot I didn't know
-- Terrific sharing
-- These guys are great. They need to be highly commended
-- Every couple may be different. I admit it was interesting to get a chance to hear their *point* of view, however the questions-asked sometimes seemed "nosey" and intended to pry
-- Thanks, it was great to meet you
-- I wish to thank them for thefr envolvement in making me aware of AIDS
-- Steve's openness helped facilitate #'s 6 & 7. He made me more comfortable asking questions
-- Informative
--

6) HIV Infection from the Patient Perspective - Small Graups

Content: Excellent = 37 Very Good = 13 Good = 2 Fair =0 Poor =0
Presentation: Excellent = 33 Very Good = 12 -Good = 2 Fair =0. Poor =0
Comments:
-- [illegible] what I paid for. Learned a lot. Information very

-- Great idea (3)
-- Steve- excellent
-- Too much - one small group along with Carl and Steve was plenty
-- Very admirable that Carl wanted to ___ awareness et help
-- Good to talk to Carl again
-- Please tell the members of the HIV support group that they' made the conference
-- Open and Honest. (3) I admire their positive outlook
--

7; HIV Infection from the Patient Perspective - Small Groups

Content: Excellent = 32 Very Good = 11 Good = 5 Fair =0 Poor =0
Presentation: Excellent = 28 Very Good = 72 Good = 2 Fair =0 Poor =0
Comments:
-- I felt like I got what I paid for. learned a lot. Information very open, rel axed
-- Wonderful, open forum
-- Too much, one small group along with Carl and Steve was plenty
-- Steve was very open and again, I admire his participation to draw awareness
-- Paul is so helpful and sincere
-- Would have appreciated hearing *more* from patient instead of co-ordinator
-- Please tell the members of the HIV support group that they made the conference
-- Great
-- Patient (Gary) was very open
--

8) Community Services - Terry King, M.A.

Content: Excellent = 16 Very Good = 17 Good = 4 Fair =1 Poor =0
Presentation: Excellent = 14 Very Good = 15 Good = 4 Fair =1 Poor =0
Comments :
-- Poised, relaxed
-- Not enough information, boring, not really worth $25 worthless conference except for the couple and small groups
-- Very knowledgable
--

Thank you.

Terrill A. Mast, PhD
Assistant Dean for Continuing Education
SIU School of Medicine

Application for Enrollment

HIV Update

May 13, 1989
Springfield, Missouri
Fee: $35

Social Security Number | Name for Nametag

Last Name | First Name | Middle Name

Street Address

City | State | Zip

Business Phone | Home Phone

Graduate of

Degree(s) | Year | Board Certified? Yes No Eligible

Specialty

I will pay by: __Check (Payable to University of Missouri) Visa__MasterCard

For Credit Card Payment:

Check One: MasterCard | Expiration Date

Signature

Mail completed application and payment to: HIV Update, Office of Continuing Education, MA21 5 Health Sciences Center, Columbia, MO 65212.

You may also register by calling 314/882-4105 and charging the fee to your Visa or Mastercard, or by FAXing your application to 314/882-5666.

EEO INFORMATION: __Male __Female __White __Black
Asian or Pacific Islander American Indian or Alaskan Native __Other
Equal Employment Opportunity information is optional and is used only for the purpose of statistical analysis.

CONFERENCE NAME HIV Update

LOCATION Sheraton Inn-Springfield, MO DATE 5/13/89

UNIVERSITY EXTENSION, SCHOOL OF MEDICINE
UNIVERSITY OF MISSOURI-COLUMBIA
CONFERENCE EVALUATION

This Questionnaire is designed to help us improve the quality of our educational program. Please answer all questions frankly. All your answers will be carefully considered. There is no need to sign your name. Thank you.

1. How were you informed about this conference: (Please mark all that apply.)

- ○ Individual mailing received
- ○ Campus Communication
- ○ Friend
- ○ Other - Please specify _____

2. Please mark the degree to which:

	Excellent	Good	Average	Below Average	Poor
a. you gained what you want from the program.	○	○	○	○	○
b. the program was able to maintain your interest.	○	○	○	○	○
c. the program was organized.	○	○	○	○	○
3. How would you rate the meeting facility and their services?	○	○	○	○	○

Your present status:

- ○ Social Worker
- ○ RN
- ○ Dietitian
- ○ Speech Therapist
- ○ EMT-P
- ○ LPN
- ○ Radiologic Technologist
- ○ Other
- ○ MEMT
- ○ Aide
- ○ Medical Technologist
- ○ EMT-A
- ○ Health Services Administrator
- ○ Student
- ○ Physician
- ○ Physical Therapist
- ○ Respiratory Therapist
- ○ House Officer
- ○ Pharmacist
- ○ Occupational Therapist

Please rate individual courses and subjects.

Title & Speaker Anti-Viral Therapy and AZT-Dr. Bryant

Instructor & Presentation Code

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

	Excellent	Good	Average	Below Average	Poor
a. Sufficient time was provided for participation and questions.	0	0	0	0	0
b. The length of the session was sufficient to cover the subject.	0	0	0	0	0
c. Rate the instructor's knowledge of the subject.	0	0	0	0	0
d. Rate the overall performance of the instructor.	0	0	0	0	0

e. Please add any additional comments you may have on this subject and speaker.

Title & Speaker Office Management of the HIV Positive Patient-Dr. Gerecht

Instructor & Presentation Code

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

	Excellent	Good	Average	Below Average	Poor
a. Sufficient time was provided for participation and questions.	0	0	0	0	0
b. The length of the session was sufficient to cover the subject.	0	0	0	0	0
c. Rate the instructor's knowledge of the subject.	0	0	0	0	0
d. Rate the overall performance of the instructor.	0	0	0	0	0

e. Please add any additional comments you may have on this subject and speaker.

Title & Speaker Care Coordination for AIDS Patients: The Missouri Approach-Graessle R.N.C & Wrnkelman K.N.

Instructor & Presentation Code

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

	Excellent	Good	Average	Below Average
a. Sufficient time was provided for participation and questions,	0	0	0	0
b. The length of the session was sufficient to cover the subject.	0	0	0	0
c. Rate the instructor's knowledge of the subject.	0	0	0	0
d. Rate the overall performance of the instructor.	0	0	0	0

e. Please add any additional comments you may have on this subject and speaker.

CONFERENCE NAME HIV Update

LOCATION Sheraton Inn-Springfield, MO DATE 5/13/89

UNIVERSITY EXTENSION, SCHOOL OF MEDICINE
UNIVERSITY OF MISSOURI-COLUMBIA
CONFERENCE EVALUATION

This Questionnaire is designed to help us improve the quality of our educational program. Please answer all questions frankly. All your answers will be carefully considered. There is no need to sign your name. Thank you,

1. How were you informed about this conference: (Please mark all that apply.)

46 ○ Individual mailing received

4 ○ Campus Communication

2 ○ Friend

3 ○ Other - Please specify _____

2. Please mark the degree to which:

	Excellent	Good	Average	Below Average	Poor
a. you gained what you want from the program.	22 ○	28 ○	7 ○	0	0
b. the program was able to maintain your interest.	15 ○	35 ○	9 ○	0	0
c. the program was organized.	26 ○	26 ○	4 ○	1 ○	
3. How would you rate the meeting facility and their services?	25 ○	25 ○	7 ○	1 ○	0

Your present status:

- ○ Social Worker
- ○ EMT-P
- ○ MEMT
- ○ EMT-A
- 0 Physician
- ○ House Officer
- ○ RN
- ○ LPN
- ○ Aide
- ○ Health Services Administrator
- ○ Physical Therapist
- ○ Pharmacist
- 0 Dietitian
- ○ Radiologic Technologist
- ○ Medical Technologist
- ○ Student
- 0 Respiratory Therapist
- ○ Occupational Therapist
- ○ Speech Therapist
- ○ Other

Please rate individual courses and subjects.

Title & Speaker Anti-Viral Therapy and AZT-Dr. Bryant

Instructor & Presentation Code

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

	Excellent	Good	Average	Below Average	Poor
a. Sufficient time was provided for participation and questions.	17	36	6	1	0
b. The length of the session was sufficient to cover the subject.	15	35	8	1	0
C. Rate the instructor's knowledge of the subject.	28	28	5	0	0
d. Rate the overall performance of the instructor.	13	30	11	3	0

e. Please add any additional comments you may have on this subject and speaker.

Title & Speaker Office Management of the HIV Positive Patient-Dr. Gerecht

Instructor & Presentation Code

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

	Excellent	Good	Average	Below Average	Poor
a. Sufficient time was provided for participation and questions.	40	15	3	0	0
b. The length of the session was Sufficient to cover the subject.	39	15	4	0	0
c. Rate the instructor's knowledge of the subject.	52	5	1	0	0
d. Rate the overall Performance of the instructor.	49	8	1	0	0

e. Please add any additional comments you may have on this subject and speaker.

Title & Speaker Care Coordination for AIDS Patients: The Missouri Approach-Graessle R.N.C & Winkelman R.N.

Instructor & Presentation Code

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

	Excellent	Good	Average	Below Average	Poor
a. Sufficient time was provided for participation and questions.	20	33	6	0	0
b. The length of the session was sufficient to cover the subject.	19	27	8	0	0
C. Rate the instructor's knowledge of the subject.	22	27	6	1	0
d. Rate the overall performance of the instructor.	18	30	5	0	0

e. Please add any additional comments you may have on this subject and speaker.

HIV Update
Springfield, MO
5/13/89

The Conference Could Be Improved By:

- Mid morning lavatory break included.
- Periodic breaks (mid morning and mid afternoon)
- Very good as is.
- Need 10-15 min bathroom, stretch break.
- Too much basic science-not enough practical information including-psychology, sociology, screening, law and counseling. This was covered in the afternoon. All of above more important to physicians than details of clinical trials of experimental drugs.
- 1. Shortening program
  2. Having participants leave their beepers outside the room & have some one take their phone calls.
- 3. Reduce paperwork-limit handouts.
- Short break in the AM, less overlapping of info- ie. Winkelman, Hbggard and pamphlet.
- Very good.
- Breaks!
- Less discussion of medications of little value.
- No comments.
- Shorten all sessions except Dr. Gerechts, and expand the ethics issues.
- Be as practical as possible but give info of what is being done with treatment.
- Start 30 minutes earlier so there is time for a short break in between several speakers.
- Everything was fine in my opinion.
- Break in morning session.
- Only by picking up tab for lodging, thanks it was great.

The best part of this conference was:

- Office Management-Wolfe Gerecht.
- Office Management of the HIV Positive Patient-Dr. Gerecht.
- Thought all presentations went well.
- Concise summary of current status of the MO Aids Clinical Trial Group, Summary of MO Public Health, Clinical Management of HIV-Dr. Gerecht.
- Generally and informally excellent.
- Dr. Gerecht and Mr. Meekers talks.
- Excellent integration and coverage of all aspect of subject.
- Dr. Gerecht who was excellent.
- Intelligent out of town speakers.
- Office management of HIV positive pt.-Dr. Gerecht.
- Talk by Dr. Ratner and Dr. Gerecht.
- Lunch, Tobias Meeker.
- Wolfe Gerecht, and Mr. Meeker.
- The entire program was exceptional. Speakers were very knowledgeable about HIV subject. Afternoon program was more interesting. Thank you for lunch.

The **best part of this conference (cont.)**

- Whole conference has been very good, addressed every aspect of HIV.
- The practical clinical information.
- Lighting, screen, sound, PM lunch and refreshments.
- All aspects of HIV covered very well.
- Clinical application of current knowledge.
- This was a well conceived conference, future conferences on subjects of general interest would be welcomed.

What suggestions do you have for future topics?

Discuss protection of Dr. and office personnel.

- Labs, EMT's, office Nurses- handling and protecting ourselves from AIDS while working with blood.
- Antibiotic management in two settings, office and hospital.
- Annual or biannual update 1/2 day session.
  Very much the same.
- Continue trying.
- Program on office management of HIV/AIDS just after and full year operation of Care/Coordination and its success or failure.
- Possible conference on mental health issues involving HIV/AIDS.
- Would think an annual update conference would be indicated in this disease that is increasing in frequency and where research is changing almost daily.
- Morning conference only using afternoon speakers.
  COPD, RAD employ some rehabilitation.
- Lawyer on panel to define legal aspect of AIDS re confidentiality, legai weapons, etc.
  Periodic update on new treatment and knowledge about HIV infections as it comes out.
- The hearing impaired will have difficulty interpreting and understanding the rapid-fire lectures. (Slower speech is better).
  Refer to past lecturers as Cleveland Clinic, NY Univ., Boston Univ, Dartmouth, Univ of Vermont and Albany Medical College.
- AIDS in pregnancy.

MATEC

Midwest AIDS Paining & Education Center

INDIANA SITE

Indiana University
School of Medicine
Wishard Memorial Hospital
WOP 312
Indianapolis, Indiana 46202
(317) 630-8521 or 630-7133

CENTER HEADQUARTERS

The University of Illinois at Chicago
Chicago, Illinois

REGIONAL SITES

Indiana University
School of Medicine
Indianapolis, Indiana

Missouri Department of Health/
University of Missouri
Jefferson City/Columbia, Missouri

Southern Illinois University
Alton, Edwardsville, and Springfield,
Illinois

The State Medical Society of Wisconsin
Madison, Wisconsin

The University of Illinois at Chicago
Chicago, Illinois

University of Iowa
College of Medicine
Iowa City, Iowa

University of Minnesota
School of Public Health
Minneapolis, Minnesota

WORKING WITH HIV INFECTION

ST, VINCENT STRESS CENTER
MAY 24, 1909
May 31, 1989
1:00 - 3:00 pm

AGENDA

1:00 Overview of HIV Infection and AIDS
(Kathryn M. Connell, M.P.H.)

- Epidemiology
- Transmission
- Prevention
- Treatment/Prognosis

2:00 Psychosocial / Affective Issues
(Kathryn M. Connell)

- Emotional Impact of HIV/AIDS
- Housing, Discrimination, Employment
- Exploring Personal Feelings
- Affective Exercise

Participant Feedback

Please take a few moments to give us some feedback on the session just completed. This will assist us in improving our work.

1. How much new information did you obtain (circle one) ?

A lot Some A little None

2. What would you like to learn more about?

3. Do you feel that your *work* activities put you at risk of XIV infection?

High risk
Some risk
Very little risk
No risk

4. Did the session change your feelings about personal risk on the job? YES NO

5. If your feelings are unchanged, what concerns were not successfully addressed in the session?

6. Do you feel you understand how to protect yourself from HIV infection off the job? YES NO If no, please comment:

7, Please comment on the speaker:

8. Please comment on the audioviaual aids (blackboard, slides, videotapes):

9. Generally, how could today's session have been improved?

Thank you.

St. Vincent's Stress Center
5/24, 31/89

Participant Feedback

Please take a few moments to give us some feedback on the session just completed. This will assist us in improving our work.

1. How much new information did you obtain (circle one) ?

A lot	some	A little	None
26	14	1	0

(31 respondents)

2. What would you like to learn more about?

3. Do you feel that your work activities put you at risk of HIV infection?

2 High risk
&Some risk
20 Very little risk
7 No risk

(39 respondents)

4. Did the session change your feelings about personal risk on the job? YES NO

10 30

(40 respondents)

5. If your feelings are unchanged, what concerns were not successfully addressed in the session?

See responses, attached

6. Do you feel you understand how to protect yourself from HIV infection off the job? YES NO If no, please comment:

40 0

(40 respondents)

7. Please comment on t&e speaker:

See comments, attached

8. Please comment on the audiovisual aids (blackboard, slides, videotapes):

See comments, attached

9. Generally, how could today's session have been improved?

See responses, attached

Thank you.

2. What would you like to learn more about?

How to address the psychosocial aspects of this disease with our patients

Psychosocial aspects

Psychosocial impact

Mutation

New information updates as they are available

Bow to counsel patients with HIV positive and/or AIDS

Psychosocial information for mental health professionals

Repeat session

Neuropsychiatric manifestations

Current research

Psychiatric/behavioral symptoms

Effects on brain and behavior

Psychological

Origin: role of WHO; use of virus on ethnic groups? Is true? Why Africa?

Have friend whose daughter died at age 34 from AIDS last year, Have read quite a bit but Kathy did a great job in reinforcing what I read.

5. If your feelings are unchanged, what concerns were not successfully addressed in the session?

I have no problem working with AIDS patients

None

None

They were addressed but the fear is a gut reaction

None

All were addressed

None

It was not that concerns were not addressed

Next session could be helpful

Chances are the same as getting hit by a truck

None--I *knew* it was not airborne

None- I've already been educated about a lot of topics

All concerns addressed

None

I believe I understood the personal risk before the inservice

It just validated my feelings and thoughts

None

All concerns addressed

7. Please comment on the speaker:

Very well organized, information well presented

Well organized, understandable, excellent

Excellent--considerate of participants

Thorough, good explanation

Energetic, interesting, informative

Excellent

Excellent

Well-informed, easy to listen to, good comfortable rapport

Good command of language, sound knowledge base, casual manner of presentation made a great, presentation, Frank and honest presentation1

Great, very knoweldgeable, wonderful presentation

Very open and frank and relaxed and honest--extremely helpful

Very good

Handled *very* personal subjects very well--excellent presenter

very informative/hone&/open

Wonderful--non-blaming, empathetic, understanding. Clear w/good understanding of AIDS

Excellent. Clear, good vocabulary

Very informative--funny

Personable and well informed

Enjoyable

Excellent--informed--positive interaction with participants

She appeared both knowledgeable and comfortable in presenting controversial subject

Good presentation technique

Excellent--knowledgeable . Good presentation--easy to understand--interesting to listen to and to follow

Excellent, articulate, concise

Interest. Caring. Very knowledgeable, I believe what she says.

Excellent, direct, no nonsense, succinct, good sense of humor

Absolutely excellent!! Low key, matter of fact, confident, engaging, non-alarmist, organized, clear

Good but voice fades out a little at end of sentence; could use microphone

Very good, very good knowledge and command of subject; enthusiastic

Enjoyed her--lots of facts on my level

Excellent

Fine

Very good

Clear and precise

Very informative

Knowledgeable

Very good

Very interesting and informative

SVSC--5/24

8. Please comment on the audiovisual aids (blackboard, slides, videotapes) NB: only blackboard used on 5/24

Adequate, handouts helpful

Good, well used

O.x. --readable!

O.K. (7 respondent@

Adequate

Good, graphic and succinct!

Good

Appreciative

Blackboard use *reinforced* her talk

Good diagraming

Fine

Good use

Adequate to good

Blackboard used appropriately

Adequate

Well illustrated

Helpful, clarified points

seeing thing8 in writing--glad she used the board

Vary good

Good

Wrote small at times

A little confusing blackboard. Great handouts

SVSC --5/24

9. Generally, how could today's session have been improved?

No necessary improvements. Very well presented

None needed

Good as is

Thought it was great!

Good presentation

Enough packets for all

More info. on how to counsel HIV positive and AIDS patients

I wouldn't-but the topic was uncomfortable

More info on psychological/ social effect8 of AIDS and forma of treatment for PWA's

Repeat

More available pamphlets--I did not get one (NB additional packets provided at 5/31 session)

Fine

Have our doctors present

Handout packets available for all attending

Presentation was *great the* way it was!

Slides perhaps, e.g. Kaposi's sarcoma, statistics

10 minute break *in* between hours

Microphone

More theory on origin and explanation on *why* animals do not "have" AIDS; why on humans?

Very good; no suggestion8

VIII

MOUNTAIN-PLAINS AIDS EDUCATION AND TRAINING CENTER

EVALUATION REVIEW

I. OVERVIEW

The Mountain-Plains AIDS Education and Training Center (MPAETC) is based at the SEARCH-AHEC Program of the University of Colorado Health Sciences Center in Denver. The MPAETC region includes the states of Colorado, Kansas, Nebraska, New Mexico, North Dakota, South Dakota, Utah and Wyoming.

MPAETC is a highly decentralized organization, consisting of a regional administrative and coordinating arm and eight individual statewide ETCs, each of which tailors their programs to fit local needs and resources. For the most part, the state ETCs are university-based and lodged in the medical school/medical center; the Colorado ETC is a partnership between the medical school and state health department, and its programs are implemented through local AHECs and the state community health center association. Each state ETC has its own set of objectives and state implementation plan.

The Train-the-Trainers program is the pivotal component of the regional ETC's training program, enabling it to develop a cadre of trainers around the region, thus achieving maximum decentralization while maintaining internal consistency. It is a two-tiered system: first generation trainers from each state are trained centrally by MPAETC; second generation trainers are trained by the first generation trainers through the state ETC. Training of caregivers, done by either first generation trainers or second generation trainers, is referred to as "outreach training." Multidisciplinary clinical training, called "mini-sabbaticals," is coordinated by the MPAETC headquarters; additional clinical training opportunities are available through several of the state ETCs.

The ETC's evaluation plan covers a number of aspects of its program, including organizational development and curriculum. For the most part, evaluation of training activities focuses on participant demographics and participant assessment of elements of program quality. A standard data collection instrument, which can be modified to include knowledge, attitude, belief and behavior data, is used to collect data for all education and training events regardless of program objective or length. Analysis is facilitated by using a mark-sense response sheet which can be optically scanned. Evaluation of MPAETC's impact, in terms of changes in training practice, is in the planning stage.

II. ADMINISTRATION OF THE EVALUATION PROCESS

A. The Evaluation Plan

1. The Plan as Proposed

The Mountain-Plains ETC presented an evaluation plan in its initial proposal, consisting of both process and impact evaluation applied to each of its five goals. As proposed, the process evaluation component was designed to assess the delivery of the program so that ongoing improvements and refinements could be made systematically. As described in the proposal, the impact evaluation was designed to assess the effectiveness of the project, i.e. how well the goals and objectives are met, and to generate the data to ascertain the cost effectiveness of the program.

Process Evaluation

As would be expected, the various components of the ETC's proposed process evaluation are highly qualitative:

- o Ascertain the extent to which regional activities are effectively coordinated on an ongoing basis.

  The process of coordination was to be assessed by asking management team members to complete a short survey instrument designed with input from the management team to assure that the expectations of each representative institution was reflected.

- o Determine the extent to which the target disciplines of health provider groups are represented among first and second generation faculty trainers.

  This was to be accomplished by having the regional ETC project staff monitor the process of trainee recruitment with an emphasis on appropriateness of discipline representation.

- o Assess the appropriateness and relevance of each state's decentralized AIDS education plan.

  The regional ETC project staff were to conduct this aspect of the evaluation as well. Criteria for this assessment were to include: involvement and utilization of existing AHEC educational networks, the degree to which other existing community-based networks are being utilized in each state, the extent to which the planned activities are likely to provide statewide coverage.

- o Monitor the content, provider target population, and location of the training programs conducted in each state by the first and second generation faculty.

  The regional ETC evaluation staff were to compile a database containing attendees by discipline using program logs of registrations.

- Assess the content of the training curriculum of the faculty development conferences, as well as the educational methodology being modeled and presented.

  In Year 01, the first ETC-wide faculty development conference was to be assessed. Each first generation faculty trainer was to be asked to provide feedback regarding the relevance, effectiveness, thoroughness, clarity, utility, and value of the instruction. In addition, they were to be asked to evaluate the quality of teaching during the conference and to identify those elements they would model in their own teaching of the content. This information was to be reported to each Statewide ETC in order to guide first generation faculty as they structure state level AIDS programs.

  In Year 02, the state level faculty development conferences were to be included in the evaluation. The same types of data regarding relevance of content and quality of teaching were to be collected, along with more specific information about the potential usefulness and applicability of the AIDS training to their practice or workplace.

  Also in Year 02, the regional ETC evaluation staff were to observe randomly selected training programs, at which time the quality of teaching and content were to be evaluated according to previously agreed upon criteria. It was expected that summary feedback would help state project coordinators to determine the effectiveness of the teaching efforts.

- Assess state-specific curriculum content.

  Before use, both the content and objectives of the core and discipline-specific curricula were to be submitted to the project curriculum planning group for review and comment. Appropriate task forces of target providers, minority AIDS action groups, as well as previously funded AIDS ETC projects were to be asked to critique the curriculum as well. This feedback was to be used to make modifications before the curriculum was used for the first time.

- Monitor the utilization of existing resources in developing curricular components.

  A review of the curriculum development process was to be carried out by the project management team through regular meetings.

Impact Evaluation

- Establish the success of the project in establishing linkages to existing AIDS activities.

  A roster of AIDS activities by state was to be developed in the first year of the project. At the end of the three-year project period, documentation regarding the extent of both intra and inter state linkages is to be provided through ETC summary records.

- Ascertain the extent of provider accessibility to AIDS educational offerings in each state.

  The number and geographic distribution of programs was to be determined on a county by county basis for each state. Distances that health care providers travel from their practices/jobs to obtain training was to be assessed in Year 02 and 03. To assess the ETC impact, a baseline for training accessibility was to have been established by asking trainees, prior to ETC training, whether they had desired to attend previous AIDS training but could not for reasons of time and/or distance.

- Assess the dissemination pattern of AIDS educational resources (first and second generation faculty), by geographical location and specialty, at the end of the three-year project period.

  No methodology was given.

- Assess the dissemination pattern of participants in the AIDS educational programming at the end of the three-year project period.

  No methodology was given.

- Assess the extent to which participants in AIDS training report changes of an interdisciplinary nature following the training.

  Pre/post training questionnaires, and follow-up questionnaires were to be designed to elicit information from trainees about their practices in the use of interdisciplinary health care resources, such as referrals to counseling at the local level.

- Assess changes in providers' knowledge of AIDS, skills and techniques for the care of AIDS patients, and attitudes about AIDS.

  Using an adaptation of an existing AIDS survey, participants' level of knowledge, skills and attitudes prior to, and immediately following each training event was to be assessed. Items on the questionnaire were to be rated on a five-point scale. Participants were to have the option of responding anonymously.

  Stability of changes was to be assessed three months after each training event. The ETC regional evaluation staff were to mail out the same questionnaire to participants listed on the registration mailing lists. At the same time, the ETC was to collect self-reports of changes in practice strategies.

- Assess the extent of dissemination into health professions curricula of the AIDS educational materials.

  This effect was to be addressed by ascertaining the number of health professional undergraduate and graduate programs that incorporate some or all of the educational material about AIDS into the curricula of each health professions institution by the Statewide AIDS ETC project staff.

Cost Efficiency/Cost Effectiveness

o Costs for personnel devoted to the project, travel, educational materials and other training expenses will be compiled and used to calculate a cost per trainee.

o Other indicators of cost efficiency were also identified:

--How often course materials or training aids must be replaced because they were outdated, as compared to consumed

--Number of agencies with whom linkages have been formed as part of the networking process

2. Implementation of the Plan

Most of the components of the evaluation plan have been initiated and a considerable amount of evaluation activity has taken place. Toward the end of the first year, the evaluation protocol, which documents those activities in the evaluation plan that relate to the evaluation of education and training offerings conducted by the state ETCs, was refined. Currently, trainers under the auspices of the AIDS ETC are expected to evaluate their training programs using the Mountain-Plains Regional AIDS ETC mark sense evaluation form that has been preprinted with demographic information and items asking for participant evaluation of various aspects of the course. In addition, trainers are expected to provide a list of the objectives for the training. Measurement of knowledge, attitudes, beliefs and behaviors of participants--the true measure of program effectiveness--is collected at the option of the trainer.

Several of the other components of the evaluation plan have been found to be unworkable and have either been abandoned or postponed:

. Observation of training of trainers participants as they train others has not proved workable on a regional level, although some observation has been done at the level of the state ETC.

. The assessment of state-specific curriculum content by the region has never been implemented, due to the highly autonomous nature of the state ETCs coupled with the fact that most state modifications of the MPAETC's "Curriculum for Trainers" vary presentation by presentation.

. Little attention has been paid to ascertaining the extent of provider accessibility to AIDS educational offerings in each state; baseline data about accessibility of prior AIDS training is tracked only in terms of the number of previous AIDS trainings attended by participants in the ETCs' offerings.

. There are no mechanisms in place to assess, in any substantial way, the dissemination pattern of participants

in the AIDS educational programming at the end of the three-year project period.

. There are currently no formal plans for assessing the extent to which participants in AIDS training report changes of an interdisciplinary nature following the training, although this may be incorporated into the trainee follow-up currently under design.

. No progress was reported on the cost efficiency/cost effectiveness activity.

B. Locus of Responsibility

1. Staff

Carol P. Vojir, a Ph.D. evaluator specializing in psychometrics and data analysis, serves as the ETC's regional evaluator at 10% time. She has been the evaluator and statistician for the University of Colorado SEARCH/AHEC program since 1986 and continues in that capacity. She also serves as the evaluator for MPAETC's NIMH grant. She currently holds an appointment as Assistant Research Professor in the School of Dentistry and is on the graduate faculty of the School of Nursing. In addition to her teaching responsibilities, she provides statistical and program evaluation consultation to her colleagues.

2. Sub-Contractors

There are no staff specifically designated for evaluation at the state ETC level. However, various staff of the state ETCs have participated in evaluation activities. In the development of a knowledge, attitudes, beliefs and behavior (KABB) instrument, the project evaluator was assisted by Donna Anderson (Colorado), Lucy Bradley-Springer (New Mexico), Jim Cooney (Kansas), Lanyce Keel (Nebraska), and Neal Whitman (Utah). Neal Whitman was the originator of the Educational Intervention Grid referred to throughout this review.

C. Coordination of Evaluation Activities

Dr. Vojir is responsible for coordinating data collection and reporting from the state ETCs.

Management team meetings are the primary mechanism for coordinating all of the ETC's activities, including evaluation. Site visits, scheduled for Year 02, are a potential mechanism for further coordination.

D. Reporting of Findings

1. Evaluation Reports of Program Activities at the State Level

Each of the State **ETCs** reports to the regional program on a semi-annual basis. Evaluation activities conducted during the reporting period are supposed to be included in those reports. While these reports include information on training outputs, they have not reported on other evaluation activities.

2. Evaluation Reports of Training Activities

Evaluation forms for each training event are submitted by the trainers to the state ETC which, in turn, forwards them to the regional evaluator. The data are analyzed at the regional level and reports prepared. The reports are sent to the state **ETCs** where they are reviewed and passed on to the appropriate trainers.

3. Regional Evaluation Reports

The Regional ETC reports its evaluation activities, in relation to its plan, in its semiannual reports to HRSA.

III. APPROACHES TO PROJECT EVALUATION

A. Project **Monitoring**

The **ETC's** formal statement of goals and objectives provides it with a broad structure within which to monitor its major project activities and under which to report its progress systematically in its semi-annual progress reports. However, for the most part, the goals and objectives include ongoing activities with no target dates for completion, rendering their use for monitoring purposes rather limited.

A great deal of what is described in the **ETC's** evaluation plan as process evaluation, particularly efforts to assess networking and coordination, falls within the purview of project monitoring for purposes of this evaluation review. In particular, the effectiveness of coordination is monitored in terms of the satisfaction of the management team with management team meetings. Management team members have completed a feedback form for their June, August and December 1988 and July 1989 management team meetings and the August 1988 curriculum development meeting. The results are summarized in Appendix I. The fact that **MPAETC** has chosen to monitor the effectiveness of regional coordination underscores the emphasis that this ETC has placed on its regional efforts. The positive results obtained through this aspect of the **ETC's** evaluation are consistent with the picture of MPAETC as a strong regional organization as portrayed in the Case Study.

B. Output Evaluation

The major thrust of **MPAETC's** evaluation effort is aimed at creating profiles of its education and training activities. While these profiles contain the traditional output measures--number of courses, number of participants, disciplines represented, minority participation, etc.--they go beyond these measures to give a somewhat broader picture of the **ETC's** program.

1. Profile of Training Outputs and Outcomes

One set of profiles summarizes the quantity and quality of its education and training events, and the number and select characteristics of those attending these events. These profiles are generated at two levels:

. Regional Summary by State

. State Summary by State

Data upon which these profiles are based are collected by the-state **ETCs** via several mechanisms, but the MPAETC Evaluation form serves **as the** primary source document. The profiles themselves are compiled by the regional evaluator. Each of these regional and state summaries are presented on one page in tabular form as illustrated in Appendix II. Both profiles contain the same information. The unit of analysis for the regional summary is the state while the unit of analysis for the state summary is the individual ***course*** offering. The items covered in the profiles are as follows:

Number of Courses Evaluated. This item is found on the Regional Summary only. A listing of MPAETC courses is kept, by state, in chronological order and includes the date and course title. Information for this course listing is provided to MPAETC by each of the state **ETCs** via the Presenter's Form (see Appendix V).

Number of Participants. This item represents only the number of **participants completing the** MPAETC Evaluation form (See Appendix IV) and therefore, is an underrepresentation of participants actually attending MPAETC offerings. There is provision for documenting the actual number of participants through an item on the Presenter's Form but this item is not consistently and uniformly completed by the presenters. Relatively accurate counts of the actual numbers of participants are available for Nebraska and New Mexico offerings.

By the end of the first year of the project, 22,849 people were reached by educational presentations in the region, although far fewer are documented in the profiles.

Number of Ethnic Minori ties. Data on ethnicity is collected primarily via the MPAETC Evaluation Form; ethnicity was added as a data item as of July 1989. In addition, presenters are asked to estimate the number of participants by ethnic group and record the data on the Presenter's Form.

As of March 1990, 1,369 participants or approximately 17% of the participants for whom data were available identified themselves as ethnic

minorities. New Mexico accounted for the highest concentration of minority trainees, with over 35% of the participants identifying themselves as belonging to an ethnic minority.

Discipline. Data on the participants' discipline is collected on the MPAETC Evaluation form. This data item has been collected from the inception.

An analysis of 2,380 participants reveal that the majority of the participants have been doctors, nurses and a variety of individuals in health care professions not originally targeted by the ETC.

Overall Evaluation. One item on the MPAETC Evaluation form asks participants to rate the offering overall (excellent, good, fair or poor). This data item has been collected from the inception.

Average Percentage of Main Points Listed. Early in the project, speakers were asked to list the main points they would try to make during their presentation on their Presenter Form. The first version of the MPAETC Evaluation form contained a corresponding item, the Educational Intervention Grid, asking participants to list the main points that the speaker made (see Section **V.D).** The speaker's lists and the participant's lists were compared and an average calculated which represented the speaker's success in conveying his or her main points. Because this approach was phased out as of July 1989, the profile describes only those offerings held at the beginning of the program.

Overall Points Well-Made. In addition to asking participants to list the speakers ' main points on the MPAETC Evaluation form, they were asked whether or not the points were well-made. The profile reflects the responses to this i tern, However, like the above item, this question was phased out as of July 1989.

Overall Change. This item on the profile summarizes the responses to the question on the MPAETC form **"Will** you use the information acquired in this program to change your approach to HIV infection at work?" On the first version of the form, phased out around July 1989, the question was asked in relation to each of the main points speakers made; in the two subsequent versions of the form, the question was asked in relation to the program as a whole.

Number of Usable Social Security Numbers. This item reflects the **ETC's** ability to match pre, post and follow-up data.

Percent Providing Services to HIV+ Patients. This information was collected via the MPAETC Evaluation as of July 1989 and enables the ETC to track the degree to which they are training actual HIV/AIDS caregivers.

2. Profile of Geographic Distribution of Training

A second set of profiles seeks to describe the geographic distribution of training across the region. This set of profiles is displayed in the form of pin maps, a sample of which are included as Appendix III. Through these maps,

progress in reaching areas throughout the eight-state region can be evaluated at a glance. To date, the geographic profiles have included only those courses which have been evaluated. States that have had considerable evaluated training activity since late 1988 (Colorado and New Mexico, for example) have made good progress in taking training activities outside the major metropolitan areas. While the location data on these profiles correspond to the quantitative and qualitative data on the regional and state profiles described above, it may be incomplete.

In Year 03, the geographic profiles will be expanded to include the distribution of both trainers and trainees. The geographic profile of first and second generation trainers will be used to determine the dissemination pattern of AIDS educational resources, while the geographic profile of the trainees will be used to ascertain the dissemination pattern of participants in the AIDS educational programming.

C. Cost Efficiency and Cost Effectiveness

Although the evaluation of cost efficiency and cost effectiveness was part of MPAETC's original evaluation plan, no cost analysis has been reported.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

MPAETC has not engaged in a great deal of development of education and training products, its widely disseminated curriculum being the notable exception. No formative evaluation was undertaken in conjunction with the development of this curriculum.

V. APPROACHES TO RVALUATING INDIVIDUAL EDUCATION AND TRAINING OFFERINGS

Together with the creation of regional and state profiles, the evaluation of individual education and training offerings has been the primary thrust of MPAETC's evaluation efforts to dater These evaluations have-been predominately formative in nature, focusing on the appropriateness of the content and the quality of the training and trainers.

A. Standardization of Evaluation RTC-Wide

MPAETC has developed a standard "protocol" for evaluating all of its offerings, be they train-the-trainers or "outreach" training. The format includes three separate components: formative evaluation of the structure and process of the offering via feedback from participants; presenter's training summary; and an outcome-oriented evaluation based on a knowledge, attitude, belief and behavior (KABB) test for participants which combines objective and subjective items. The participant and presenter components are required for all MPAETC offerings. The KABB testing, administered either before and after training or after training only, is currently optional.

The standard methodology for evaluating MPAETC's education and training offerings has evolved over the first two years of the project.

1. Data Collection Instruments

As initially proposed, a comprehensive **pre/post** test was to be the major instrumentation for **MPAETC's** evaluation. The items used in the instrument were to be drawn from a variety of existing sources: a University of Nebraska evaluation document, CDC evaluation documents, University of Arizona evaluation document used by the UCD AIDS ETC, and an evaluation survey instrument reported in Public Health Reports, May-June, 1987. Items assessing behavioral intentions as the percent of certainty for accomplishing the behavior were also to be included.

Development of the standard instrument(s) began at the first management team meeting. It was hoped that, from the available items, a consensus would be achieved on which items to include in the MPAETC instrument. While full consensus was not reached at the meeting, the regional evaluator received enough input to prepare a draft document which was completed in the first half of Year 01.

By mid-year, it was determined that a single, fairly lengthy instrument to evaluate all types of presentations was unworkable, such a comprehensive document being particularly inappropriate for the short presentations which were typical the state **ETCs'** early offerings. While it was agreed that certain demographic data needed to be collected uniformly throughout the ETC, the state **ETCs** were encouraged to adapt the **KABB** portion of the draft instrument for their own purposes. Particular attention was paid to developing an instrument that would be accepted when courses were submitted for continuing education accreditation. Also in the first year, drawing on the evaluation expertise from the Utah site, the Educational Intervention Grid approach was introduced and offered to the other state **ETCs** for their use.

The first complete set of ETC-wide instrumentation was fielded in January 1989. The core of the instrumentation was the MPAETC Evaluation form, described below, which was printed two-sided in mark-sense format to facilitate the data entry process. The front of the form collected a single demographic characteristic--participant's discipline--and a single, overall assessment of the offering, along with an adaptation of the Educational Intervention Grid which attempted to identify not only whether the presenters'-main points were recognized and well-made, but also their educational impact on the participant's intention to change their approach to HIV infection. The reverse side of the evaluation form was simply a mark-sense answer sheet that could be used in connection with **KABB** items should the ETC chose to exercise this option.

After a short test period, the mark-sense form was considerably revised to increase the usefulness and clarity of information obtained. In particular, demographic information was added, as was information on the nature of the participant's practice. The Educational Intervention Grid was eliminated and replaced by a presenter assessment grid on which the trainee could rate individual presenters. The format of side-two, on which **KABB** data is collected, was revised. In the revised format, instead of being simply an answer sheet, the **KABB** items could actual be photocopied onto a blank area on the mark-sense form, transforming side-two into a self-contained test. This second version was introduced in July 1989.

The third and current version was introduced in February 1990. The impetus for this revision was to enable MPAETC to make their ETC evaluation consistent with the evaluation of their newly awarded NIMH grant. The revision included reordering of questions, minor modifications in wording or clarification of questions, expanded response choices to standard questions, deletion of a few items about practice setting, and modification of questions on previous AIDS training. The most noteable change was the addition of a space reserved for MPAETC regional use that would allow the regional evaluator to more readily link participant data to course data.

MPAETC Evaluation Form. MPAETC collects both demographic and work-related data on its participants. Participant data is included on the Mountain-Plains Regional AIDS ETC Evaluation form which has been through three iterations as described above. Each new iteration has incorporated feedback from the field as well as being responsive to HRSA priorities: adding items, rewording questions, expanding response choices. The most recent version of the form, instituted in February 1990, is included as Appendix IV. Currently, the following information is collected for each participant:

Demographic Data

- Sex
- Age group
- Ethnic identification
- State of residence
- Educational level
- Profession
- Years in the profession
- Previous AIDS training

Work-Related Data

- Type of work setting
- Size of community in which work setting is located
- Practice profile with regard to at-risk groups and ethnic groups
- Fulltime/parttime employment status
- Participation in direct client service (yes/no)
- Extent of experience with HIV+ clients

Additional questions soliciting information for the formative evaluation of the course are included and are discussed in Section V.B. below.

MPAETC is aware that making periodic modifications in the data items collected limits the comparability of their data over time, and is making plans to convert the data from previous iterations to the most comparable form possible.

Presenter Form. Program data were initially collected via a Presenter's Form (see Appendix V). The Presenter Form includes:

- Overview of the Presentation (Course Title; Course Date(s); Course Location; Length of Presentation; Contact Hours)

. Major Points (To include up to five specific pieces of knowledge or behaviors participants should have gained from the presentation)

. Overview of the Participants (Estimate of total number of participants; estimate of number of participants by discipline and type of professional; estimate by ethnic group)

KABB Testing. KABB testing has been the evaluation component which has engendered the least agreement among management team members and trainers alike, probably because it is logistically the most difficult component to implement.

KABB testing is an optional part of standard evaluation. For those who chose to exercise this option, a "pool' of KABB questions has been developed. The pool has been revised several times. It currently includes 33 knowledge and belief items, 13 attitude and opinion items, and 21 behavioral items. A copy of the current items in the pool is included in Appendix VI. In tailoring the evaluation of a given offering to the specific content and focus, the **ETCs** are encouraged to draw on items from this pool as appropriate. This allows for flexibility for evaluating individual offerings while at the same time ensuring consistency of data among various offerings.

o Knowledge and Belief Items

The "knowledge and **belief"** section includes items about the pathology and transmission of HIV infection about which there are common misconceptions. The items are written as statements; participants are asked to respond whether they agree (A), disagree (B) or are unsure (C).

o Attitudes and Opinion Items

The "attitude and opinion" section is designed to identify participants' biases and sensitivities toward **PWAs,** fears of risk of contracting AIDS from a work exposure, views on the rights of the patient vs. the rights of the public in exercising control measures, and appraisal of their co-workers' ability to care for AIDS patients. The items are presented as statements, both positively and negatively phrased, with responses to be made on a **4-point** scale ranging from strongly agree to strongly disagree, with an additional response choice of **"unsure."**

o Behavioral Items

The "behavior" section includes items designed to identify participants' confidence in their own ability to carry out AIDS **care-**related tasks on the job. Items are presented in the form of a question beginning with **"How** sure are you that **you...?"** There are 7 response choices representing degree of certainty including a **"not** applicable" choice for participants whose responsibility does not include the task. The certainty choices include "very sure could," **"most** likely could, **"** "probably could, **"** "probably could not, **" "most**

likely could not,""very sure could never. " A final question asks "Does your job prevent you in any way from performing the activities mentioned in the preceding items?"

The use of before and after training KABB testing in the evaluation of training effectiveness is discussed below in Sections V.C.l. and VI.D.

2. Analysis of Data

Analysis of the data is performed by the regional evaluator.

Data Entry. Data entry of information from the mark sense forms is accomplished using an HE1 360 reflexive scanner, creating a participant file consisting of 124 characters per record. As of spring of 1990, the file included 3-4,000 records.

Data Clean-Up. The data is put through an SPSS screen to identify multiple or missing responses. Any data found to be defective is cleaned up manually by the regional evaluator. The clean data from the participant file is linked with data from the course file, creating an SPSS system file.

Data Analysis. Statistical analysis then is performed on the data in the system file using SPSS/PC+. In addition to the regional and state profiles described in Section III.B above, a report for each training activity is generated.

Data Aggregation. Following these analyses, the SPSS data are converted into ASCII so that raw data can be further aggregated. The data are kept in eight files, one for each state. From the ASCII, a d-Base III file is created and used to produce the Course Report. In addition, the ASCII data are electronically transferred to the University's Vax computer in Boulder for use in large scale analyses.

3. **Reporting the Results**

Currently, three levels of reports are being generated from evaluation data: (1) a profile summarizing the data for the regional ETC over all states and all training activities, (2) a profile for each state summarizing the data over all state training activities, and (3) a report for each training activity. The regional and state profiles have been discussed in Section III.B.l and samples are included in Appendix II. The analysis of an AIDS Educator Workshop held in New Mexico is included in Appendix VII as an example of a report at the level of the individual training offering.

Some 175 individual offerings, reaching approximately 4000 individuals, have been evaluated to date. The first 2,380 of these have been analyzed; the records of nearly 2,000 additional participants are currently undergoing analysis. Of the records analyzed, over 95% rated the training offering as 'Good'

B. Approaches to the Formative Evaluation of Training Events

Formative evaluation questions are built into the MPAETC Evaluation form described above. They include a rating of the program overall on a 4-point scale; as well as ratings for each of the individual presenters or panels. The presenters and panels are rated on four dimensions: relevance; clarity; educational skills; and knowledge.

C. Approaches to Evaluating Training Outcomes

In Year 02 of the project, the revised evaluation protocol included an outline of a design by which all outcome evaluation specified in the original evaluation plan was to be accomplished. Outcome evaluation, either of program effectiveness or program impact, offers MPAETC an opportunity to move from their current focus on formative evaluation to a more summative approach.

1. Evaluation of Program Effectiveness

MPAETC uses two methodologies to measure effectiveness of its education and training offerings:

- post-training self-reporting
- pre and post-training testing

Post-Training Self-Reporting. The "intention to change behavior" question on the MPAETC Evaluation form asks participants to subjectively assess whether the training will have an effect on their future behavior. The question is currently phrased: "will you use information acquired in this program to change your approach to HIV infection at work?" Early application of this methodology asked the participants to tie specific information obtained in training to intention to change their work-related behavior.

While the raw data are available, no formal analysis of these data have been undertaken.

Pre and Post-Training Testing. MPAETC uses pre and post-training KABB testing to evaluate an offering's immediate effectiveness in changing knowledge, attitudes, beliefs and intended behavior. The KABB methodology is described in detail in Section V.A.l.

2. Evaluation of Program Impact

Initial plans called for the impact evaluation to be carried out in Year 03. Planning is now in the early conceptualization stage. The design of this aspect of MPAETC's evaluation is expected to be undertaken in earnest in late spring 1990, with data collection commencing the following fall.

Evaluation of impact will be conducted on the first generation train-the-trainers program, second generation train-the-trainers activities, and "outreach" training conducted by both first and second generation trainers. As originally envisioned, all participants were to be surveyed three months

after training to ascertain the degree to which they have utilized information from MPAETC courses. It is now anticipated that a sample of participants who received training will be followed up.

A mailed-survey questionnaire will be developed. First and foremost, it will attempt to assess the applicability of the information/skills imparted at the workshop to the participant's job. A small subset of the sample may be asked to respond to some general KABB items. Consideration is being given to trying to relate the participant's on-the-job behavior at the time of the survey with the behavioral objectives of the workshop attended. Space on the questionnaire will be provided to allow for the respondent's free-form comments and qualitative amplification of coded responses. Telephone follow-up may also be incorporated into the design.

D. Unique and Interesting Evaluation Techniques

1. The Educational Grid Methodology

The Educational Intervention Grid methodology, introduced by Neal Whitman of the Utah ETC and described in Section III.B.l "Average Percentage of Main Points Listed", is a unique methodology for objectively evaluating whether trainers were effective in getting across their main points. Presenters list, on the Presenters Form, the five main points they intended to make. On the post-training evaluation form, participants then list the main points they have gleaned from the presentation. The presenter's and the participants' main points are compared qualitatively to determine how well the main points were actually conveyed.

This methodology is a difficult one to implement, as the MPAETC discovered. The ETC made several attempts at implementing this methodology, incorporating it into the first two iterations of its Evaluation Form and Presenter Form but found it unworkable and has abandoned its use.

2. Graphical Analysis of Pre and Post-Training Test Items

The MPAETC evaluator analyzed the common items on pre and post-training tests of selected courses conducted by the New Mexico and Wyoming ETCs. This analysis is described in Section VI.D. below. In addition to the standard statistical analysis, a graphical analysis format was used. For each test item, the modal range of responses was represented by a horizontal bar, with the pre-training range and the post-training range juxtaposed on the graph. Juxtaposition of the pre and post ranges clearly displays group shifts for each item.

A sample of the graphic display of data is included in Appendix X.

VI. EVALUATION CONDUCTED

All of the state ETCs report that they are using the regional evaluation format regularly, although 'evaluation is less likely to be carried out for events less than two hours in duration. Those ETCs collecting KABB data

generally do so only on events that are at least a half-day in length. Several states report difficulty in having the form used in co-sponsored events, as most of their co-sponsors have evaluation formats of their own to adhere to.

New Mexico and Wyoming add supplemental questions to the regional evaluation form, from time to time, to tailor the evaluation to the specific objectives of the training event.

A. First Generation Train-the-Trainers

The first generation train-the-trainer program was held November 30–December 2, 1988. Participant feedback was formally solicited and reviewed at the end of each day. A modified version of the standard form, in use at that time, was used and is included in Appendix VIII. The front of the form listed the presentation topics and presenters by name and solicited information on 1) clarity of the presentation, 2) educational skills of the trainer, 3) overall quality of the presentation, 4) the utility of the information to both participant's role as a trainer and to their normal work activities. The back of the form solicited feedback on the relevance, utility and quality of the overall conference.

Because of the varied backgrounds and personal expectations for the program, feedback was mixed. Some wanted more AIDS content; others wanted more teaching skills.

B. Second Generation Train-the-Trainers Activities

First generation trainers, in turn, conducted second generation train-the-trainers activities within their own state. The format and content of the second generation training activities were left to the discretion of the state ETC. Evaluation of these activities, most of which took place in Year 02, was by means of the MPAETC Evaluation form. Analysis of these activities has been by individual event rather than in the aggregate owing to the uniqueness of each of the events.

The original evaluation plan called for the evaluation of the impact of train-the-trainers activities on the quality of training through observation of selected training events by the regional staff. While this aspect of the evaluation has been for all intents and purposes abandoned, follow-up of second generation trainers is occurring selectively and informally at the state ETC level. In Nebraska, for example, follow-up telephone interviews and/or meetings with co-sponsors and agencies have been used to evaluate the on-the-job performance of second generation trainers. In addition, Nebraska's use of the mentoring approach provides an opportunity for first generation trainers to observe second generation trainers in action and give their impressions of the quality of their training.

C. Evaluation of Mini-Sabbatical Activities

To date, evaluation activities with regard to MPAETC's mini-sabbatical experiences have been formative in nature, geared to improving the structure and substance of the program.

At the regional level, an instrument was developed to collect data for the formative evaluation of the mini-sabbatical program. This instrument contains much of the same questions as the standard MPAETC Evaluation form but its questions tend to be more open-ended. It asks the participant to rate the usefulness of each of the specific components of the mini-sabbatical experience that s/he attended. The form also elicits the participant's personal goals in attending the mini-sabbatical and the degree to which these goals were met. In addition, the form taps the most useful and least useful parts of the experience as well as the applicability of the experience to the participant's work. The Program Coordinator routinely reviews the forms and uses the information for management of this component of the program. In addition, at the end of their experience, participants debrief with the MPAETC Program Coordinator who then writes up her impressions informally.

The Nebraska ETC uses the same format as the regional form, substituting the specific clinical experiences available as part of that program.

The New Mexico ETC has developed its own instrument to evaluate the mini-sabbatical experience that they sponsor. New Mexico's evaluation is also formative in nature and attempts to ascertain the value of the mini-sabbatical to the participant. The data from the instrument are compiled by the state ETC and forwarded to the region.

No comprehensive, formal evaluation report on the mini-sabbatical experiences has yet been generated. It is anticipated that the MPAETC Annual Report for Year 02 will summarize the data from all of the mini-sabbatical activities to date.

A copy of each of these mini-sabbatical evaluation forms is included in Appendix IX.

D. Evaluation of Effectiveness

ETCs (New Mexico, Nebraska, and Wyoming) have experimented with pre and post testing of knowledge, attitudes, beliefs and behavior; however, only New Mexico and Wyoming have actually incorporated pre/post tests into their evaluation strategies. KABB

However,

of aggregate data is underway. In January, 1990, a special analysis was begun on changes in KABB following training. Nine offerings have been included in the analysis to date, seven from New Mexico and two from Wyoming. A special train-the-trainers course given by MPAETC's site coordinator for the Wisconsin site of MATEC was also included in the analysis. These courses had little in common other than all were at least 1/2 day in length and that their KABB pre/posttests included common items. 27 common items were identified from pre/post instruments of the courses including 10 knowledge items, 7 attitude/belief items and 10 behavior items. Behavioral items were available only from the New Mexico courses.

Analyses were conducted for each state separately, and for the special train-the-trainers course. In all cases, t-tests were used with an alpha equal to .05 and directional hypotheses (posttest scores "better" than pretest scores). In addition, a graphical analysis format was used to display the data. This technique was described in Section V.D.2. above.

For the most part, shifts in knowledge were in the desired direction, except for a shift, that was not statistically significant, to less strong agreement that HIV can be transmitted heterosexually. In Wyoming, the aggregate data showed that trainees from both programs changed their opinion significantly that AIDS could be transmitted by eating utensils and mosquito bites, and that they were significantly less personally threatened by AIDS in general. The aggregate analysis from New Mexico showed significant improvement in the understanding that protective garments should be worn for all contact with HIV+ patients, as well as significant increase in comfort in touching an HIV+ individual and decrease in fear of becoming infected with HIV on the job. The most notable finding was that the item "I have sufficient knowledge to protect myself from HIV infection" showed statistically significant improvement in the New Mexico aggregate analysis, the Wyoming aggregate analysis, and the analysis of the special train-the-trainer session. These findings suggest that the MPAETC's trainings have been effective in giving participants appropriate and sufficient information about AIDS, its spread and precautions to take to alleviate personal fears about contracting HIV infection on the job.

The KABB items analyzed and a sample of the graphical analysis methodology can be found in Appendix X.

VII. ISSUES AND CHALLENGES FOR THE FUTURE

The Mountain-Plains AIDS ETC has made a significant commitment to evaluation, particularly to the evaluation of its education and training offerings. The path by which the ETC has come to its current approaches to evaluation has not been an entirely straight one. There has been a need for occasional backtracking and some blind alleys have been encountered along the way. The ETC has not been afraid to try some unusual approaches, such as the **Educational Intervention Grid.**

It was MPAETC's intention to use a relatively flexible approach to evaluation, once common information was agreed upon, so that each state ETC could incorporate the unique aspects of its program into the evaluation

process. In developing a regional approach to evaluation, MPAETC reports that the most serious of the problems encountered to date has been the difficulty in developing an evaluation strategy that would work well across state ETCs. Three factors reportedly contributed to this problem: lack of knowledge about evaluation and its purposes on the part of the trainers; perceived encumbrance of pre-posttesting for many training situations; and, the inability of the regional evaluator to find a way to convey, concretely, abstract evaluation concepts to the appropriate individuals.

The current standard evaluation format has been developed through the collaborative efforts of the regional evaluator and the state ETCs. The state ETCs are committed to using mandatory components which provide output data as well as formative evaluation data about the quality of the event. State ETCs have voiced concerns over the burden of data collection. As a result, MPAETC has pulled back from some of their efforts to assess program effectiveness. The KABB pre/posttesting methodology has been made optional and only two state ETCs have incorporated this approach into their training strategies. The results from New Mexico's pre and post KABB testing have yielded some interesting preliminary data on the effectiveness of these activities.

Pre and post-training KABB testing has been and will continue to be the basis for MPAETC's evaluation of effectiveness of its education and training offerings. The KABB is a standard tool and, as such, does not relate directly to the content of the training it is intended to evaluate. With its standardized curriculum and a commitment from all trainers to use it, the ETC is poised to establish a truly meaningful evaluation system. By keying each item in the KABB pool of questions to its corresponding curriculum item, trainers could easily assemble a customized pre/posttest that specifically addresses their planned presentation. It is even conceivable that the this process could be computerized to lessen the burden on the trainer.

It appears that the evaluation of training effectiveness has been directed primarily to the "outreach" training provided at the state level. The ETC's more intensive training efforts have not been subjected to evaluation of effectiveness.

For example, the November/December 1988 first generation train-the-trainers program would have been an appropriate unit of analysis for the evaluation of program effectiveness. While extensive evaluation was conducted for this program, the evaluation was essentially formative. The lack of summative evaluation of program effectiveness represents an opportunity missed.

As the mini-sabbatical program is one of the more intensive, with a relatively high cost per participant as well as higher expectations for impacting on clinical practice, it would be of great benefit to both MPAETC and HRSA to undertake a more outcome-oriented evaluation of this component of the ETC's program. The follow-up study which is planned for Year 03, intended to gauge impact on the trainees' on-the-job behavior, is a good start.

Being conscientious about evaluation, MPAETC regrets the excessive turn-around time for the evaluation reports. It currently takes the regional evaluator about three months to produce reports from evaluation data, which is

too long for useful feedback to trainers. Attempts to shorten this interval are currently under way. In some cases, data is available but the aggregate analysis has not yet been done. This is the case for the series of programs entitled **"AIDS** in the Health Care Setting, an Integrated Approach" put on by the Nebraska ETC. The ETC could clearly benefit from an expanded time commitment from its regional evaluator or from an assistant under her supervision.

APPENDIX I

Honitoring Management Team Satisfaction

MOUNTAIN-PLAINS REGIONAL AIDS ETC
MANAGEMENT TEAM MEETING
June, 1988

Satisfaction Evaluation
SUMMARY

1. Did the information presented at this meeting help you to better understand the goals and objectives of the regional AIDS ETC?

100% yes ___ no COMMENT:

2. Did the information presented at this meeting help you to better understand how the regional AIDS project will accomplish its goals and objectives?

100% yes ___ no COMMENT:

3. Did the information presented at this meeting help you to better understand how your state ETC functions within the regional ETC?

93% yes 7% no COMMENT:

4. Are you satisfied with the accomplishments of this meeting?

100% yes ___ no COMMENT:

5. Are you satisfied with the structure of the management team?

93% yes 7% no COMMENT: not clear about role of management team -1

6. What were the strengths of this meeting?
ability to interact with personnel from other states - 5
organization of meeting - 4
flexibility, clear communication, time for discussion, time management

7. How could the meeting have been improved?
better meeting facilities - 5
better preparation by participants, slightly faster pace, more time

8. Please comment on any other issues that would be useful for future meetings or the overall functioning of the project.
supplying agenda and materials before meeting so that participants could prepare
end meeting with plan of action for states to be accomplished before next meeting

MOUNTAIN-PLAINS AIDS ETC
MANAGEMENT TEAM MEETING
August, 1988

Satisfaction Evaluation Summary
(n = 16)

1. Are you satisfied -with the accomplishments of this meeting?

   100% yes ___ no

2. Are you satisfied with the shortened time frame for this meeting?

   100% yes ___ no

   COMMENT: could have been shorter yet if discussions kept focussed

3. Are you satisfied with the composition of the management team?

   100% yes ___ no

4. Was information useful to you provided at this meeting?

   94% yes 6% no

   COMMENT: nothing new presented

5. Are you satisfied with the overall progress of the project?

   100% yes ___ no

6. What were the strengths of this meeting?

   organization and preliminary work, followup from first meeting
   staying with agenda (12%)
   communication (75%)

7. How could the meeting have been improved?

   even earlier pre-meeting transmission of materials
   probably should have been held after curriculum development meeting
   keeping discussion to issue, acoustics (12%)

8. Please comment on any other issues that would be useful for future meetings or the overall functioning of the project.

   further discussion on desired knowledge base for first generation faculty
   educate management team about types of evaluation
   written progress reports from all states
   evaluation proposal needs further discussion (12%)

MOUNTAIN-PLAINS REGIONAL AIDS ETC
MANAGEMENT TEAM MEETING
December 3, 1988

Satisfaction Evaluation
(n = 11)

1. Are you satisfied with the accomplishments of this meeting?

   100% yes ___ no COMMENT:

2. Was useful information provided to you at this meeting?

   100% yes ___ no COMMENT:

3. Are you satisfied with the overall progress of the project?

   100% yes ___ no COMMENT:

4. What were the strengths of this meeting?

   Adequate and open discussion of important issues; organization: interaction among state ETCs; helpful suggestions; openness and sensitivity of regional personnel; updating issues and facts

5. How could the meeting have been improved?

   Agenda or list of issues in advance of meeting; less discussion on minisabbaticals; briefer, since it followed an intense 3 day conference: omit state oral reports, make written reports mandatory (possibly using standard format and including standard topics)

6. Please comment on any other issues related to the meetings or the overall functioning of the project.

   Helpful for networking, information, and materials; less paperwork connected with unrelated reports; keep ETC separate from other AIDS work in the eight states

MOUNTAIN-PLAINS REGIONAL AIDS ETC
MANAGEMENT TEAM MEETING
July 20, 1989

Satisfaction Evaluation Summary
(n = 13)

1. Are you satisfied with the leadership transition process?

   100% yes no

2. Do you understand how carryforward monies, if approved, will be used?

   83% **yes** 17% no

3. Do you understand the procedure to be used for the regional site visits (the site visit protocol)?

   91% yes 9% no

4. Do you understand hoc; the required parts of the evaluation plan are now to be carried out in your state?

   85% yes 15% no COMMENT:

5. Was useful information provided to you at this meeting?

   100% yes no

6. Are you satisfied with the overall progress of the project?

   100% yes no

7. What were the strengths of this meeting?

   communication of information
   one day format

8. How could the meeting have been improved?

   better amplification system

9. Please comment on any other issues related to the meeting or the overall functioning of the project.

   good meeting

MOUNTAIN-PLAINS AIDS ETC
CURRICULUM DEVELOPMENT MEETING
August, 1988

satisfaction Evaluation Summary
(n = 25)

1. Are you satisfied with the accomplishments of this meeting?

   92% yes 8% no COMMENT: had hoped to be further along
   a lot of work

2. Are you satisfied with the way the curriculum currently is outlined?

   86% yes 14% no COMMENT: needs more work; reservations about CNA; too much in core?; needs more clinical teaching

3. Are you satisfied with the followup activities as they were discussed?

   87% yes 13% no COMMENT: may be problems with coordination
   concerned about time and manpower
   a lot of work: not enough shared out

4. Was the information provided at this meeting useful to you?

   96% yes 4% no COMMENT: enjoyed getting to know others
   should have curriculum developed by now; CNA presentation too shallow

5. Are you satisfied with the overall progress of the project?

   92% yes 8% no COMMENT: need general brochure soon
   had hoped to be further along by now

6. What were the strengths of this meeting?

   discipline-specific plans: participants; organization; strong leadership; communication and sharing; realistic agenda: using CHA to help people clarify ideas and preferences

7. How could the meeting have been improved?

   to be further along in development as a starting point: of disciplines not good: advance education about task and discipline-specific issues; action on logo; specific assignments for participants: CNA not well utilized

8. Please comment on any other issues that would be useful for future meetings or the overall functioning of the project.

   should have considered meeting again before Nov/Dec meeting
   need evaluation process clarified by TTT/ trainers' commitment to evaluation essential

APPENDIX II

Output Evaluation -- Training and Trainee Profiles

MOUNTAIN-PLAINS REGIONAL **AIDS BTC**
EVALUATION REPORT

Regional summary by state
September, 1988 to March, 1990

	CO	KS	NE	NM	ND	SD	UT	WY	TOTAL*
NO COURSES EVALUATED	113	5	24	97	22	6	17	66	351
NUMBER PARTICIPANTS	2,299	344	826	1,921	462	123	501	1,367	7,892
NUMBER ETHNIC MINORITIES IDENTIFIED	379	52	120	679	19	4	19	93	1,369
DISCIPLINE:									
DENTISTRY	1.4%	17.8%	4.0%	10.0%	19.7%	4.2%	16.4%	5.6%	7.5%
EMS	5.6	0.9	7.3	10.5	4.2	16.0	1.0	11.2	7.5
MEDICINE	15.8	12.5	22.1	9.7	8.4	1.7	28.0	9.1	13.6
NURSING	25.7	36.2	18.5	33.4	32.1	45.4	26.0	28.8	29.1
PA	2.5	1.8	9.5	0.7	1.6		3.3	1.0	2.4
PUBLIC HEALTH	2.1	1.2	4.6	4.5	1.8	8.4	5.1	3.1	3.4
MENTAL HEALTH	2.5	1.8	9.35	2.2	0.4	0.8		1.0	1.2
SOCIAL WORK	43.4	18.7	24.2	24.9	4.2	28.3 3.5	16.0 7.6	14.5 5.7	36.1 4.2	5.0
OTHER		9.3							30.4
	(1998)	(343)	(766)	(1833)	(452)	(119)	(489)	(1331)	(7379)
OVERALL EVALUATION:									
EXCELLENT	52.6%	59.4%	56.4%	55.9%	51.3%	47.5%	45.6%	50.4%	53.2%
GOOD	41.6	37.1	41.5	39.5	45.5	50.0	47.1	44.6	42.0
FAIR	5.2	3.2	2.0	4.2				4.6	4.4
POOR	0.7	0.3	0.1	0.4	3.2	2.5	0.4	0.4	0.4
	(2015)	(313)	(692)	(1689)	(431)	(122)	(471)	(1241)	(7020)
AVERAGE PCT POINTS LISTED	84.2% (595)	-	90.8% (57)	62.7% (238)			57.5% (120)	51.3% (231)	71.7% (1241)
OVERALL YES	98.2%	-	98.2%	99.3%	-		99.5%	95.3%	97.9%
POINTS NO	1.8		1.8	0.7			0.5	4.7	2.1
WELL MADE:	(619)		(489)	(213)			(93)	(283)	(1697)
OVERALL YES	79.1%	81.5%	71.4%	81.6%	80.0%	84.6%	76.5%	81.0%	79.4%
CBANGE: NO	19.4	18.5	22.9	17.7	20.0	15.4	21.3	18.4	19.2
NA	1.4		5.7	0.6			2.2	0.5	1.4
	(1743)	(324)	(739)	(1623)	(430)	(117)	(408)	(1100)	(6529)
NUMBER USABLE SS NUMBERS	1,358	-	564	1534	417	102	295	898	5,217
PCT PROVIDING SERVICES TO HIV+ PATIENTS	24.5 (1866)	43.7 (339)	37.3 (284)	40.3 (1654)	46.3 (449)	32.2 (121)	60.0 (355)	15.3 (979)	33.2 (6095)

* Includes one activity taught by regional personnel outside the eight state region

MOUNTAIN-PLAINS REGIONAL AIDS ETC
COLORADO AIDS ETC
EVALUATION REPORT

State summary by course
December, 1988 to January, 1990

	1 12-88	2 1-89	3 1-89	4 1-89	5 2-89	6 2-89	7 2-89	8 2-89	9 3-89	10 4-89	11 4-89	12 4-89	13 4-89	14 4-89	15 4-89
NUMBER EVALUATIONS	7	29	21	58	30	20	17	17	60	16	7	46	16	21	9
NUMBER ID MINORITIES		3	1		2		4	2		2			4	4	2
DISCIPLINE:															
DENTISTRY								93.3%							
EMS										100%					
MEDICINE		93.1%	81.0%						96.7%						
HNTL HEALTH															
NURSING	57.1%		9.5		96.3%		66.7%						40.0%	12.5%	50.0%
PA									3.3				40.0		
PUBL HEALTH							6.7								
SOCIAL WORK		3.4	4.8		3.7		6.7						6.7	12.5	
OTHER	42.9	3.4	4.8			100%	20.0	6.7					13.3	75.0	50.0
	(7)	(29)	(21)		(27)	(20)	(15)	(15)	(60)	(16)			(15)	(8)	(6)
OVERALL EVALUATION:															
EXCELLENT	50.0%	89.3%	85.0%	62.1%	59.3%	44.4%	38.5%	50.0%	30.8%	62.5%	85.7%	67.4%	75.0%	81.3%	85.7%
GOOD	50.0	10.7	15.0	22.4	37.0	55.6	61.5	42.9	44.2	37.5	14.3	28.3	25.0	18.8	14.3
FAIR				12.1	3.7			7.1	23.1			4.3			
POOR				3.4					1.9						
	(6)	(28)	(20)	(58)	(27)	(9)	(13)	(14)	(52)	(16)	(7)	(46)	(16)	(16)	(7)
AVC PCT POINTS LISTED	100% (7)	--	--		84.1% (23)	100% (20)	80.0% (5)	93.8% (4)	85.5% (57)	100% (16)	71.4% (7)		77.1% (14)	100% (20)	43.3% (6)
OVERALL POINTS WELL MADE:															
YES	100%	100%	100%		100%	97.0%	100%	93.8%	83.1%	100%	100%		100%	100%	100%
NO						3.0		6.2	16.9						
	(7)	(29)	(20)		(17)	(20)	(3)	(4)	(9)	(16)	(5)		(13)	(20)	(6)
OVERALL CHANGE:															
YES	100%	86.1%	81.2%		95.2%	83.2%	100%	93.8%	63.5%	87.0%	90.0%		75.8%	84.7%	95.8%
NO		7.7			3.2	7.0			25.3	10.9	10.0		19.7		
NA		6.2	18.8		1.6	9.8		6.2	11.2	2.1			4.5	15.3	4.2
	(6)	(27)	(16)		(21)	(20)	(4)	(4)	(49)	(16)	(6)		(11)	(18)	(6)
NUMBER **SS** NUMBERS		19	14		5		3	2	22	13			5	7	3
PCT PROVDG SVCS TO HIV+ **PTS**		45.4 (22)	66.7 (15)		10.6 (19)		53.3 (15)	12.5 (16)		0.0 (13)			87.5 (16)	11.1 (18)	87.5 (18)

MOUNTAIN-PLAINS REGIONAL AIDS ETC
COLORADO AIDS ETC
EVALUATION REPORT - PAGE 2

State' summary by course
December, 1988 to January, 1990

	16 4-89	17 5-89	18 5-89	19 5-89	20 5-89	21 5-89	22 5-89	23 5-89	24 5-89	25 5-89	26 5-89	27 6-89	28 5-89	29 5-89	30 5-89
NUMBER EVALUATIONS	15	18	95	18	12	6	38	40	61	17	14	47	12	17	33
NUMBER ID MINORITIES	2		5	4	1	3	6	5	3	3	1	7	0	9	2
DISCIPLINE:															
DENTISTRY												2.3%			
EMS							2.6%								10.0%
MEDICINE			61.1%												
MNTL HEALTH															
NURSING			15.8	26.7%	8.3%	40.0%	42.1	17.5%	34.4%	52.9%	64.3%	44.2		6.7%	10.0
PA			20.0		75.0							2.3			
PUBL HEALTH	23.1%			6.7	8.3				1.6			2.3			
SOCIAL WORK			1.1	6.7		20.0		2.5	1.6			9.3			
OTHER	76.9	100%	2.1	60.0	8.3	40.0	55.3	80.0	62.3	47.1	35.7	39.5	100%	93.3	80.0
	(13)	(18)	(95)	(15)	(12)	(5)	(38)	(40)	(61)	(17)	(14)	(43)	(8)	(15)	(30)
OVERALL EVALUATION:															
EXCELLENT	75.0%	72.2%	34.1%	46.7%	88.9%	50.0%	89.2%	82.5%	77.4%	82.4%	11.1%	41.2%	100%	83.3%	56.0%
GDDD	25.0	27.8	59.8	53.3	11.1	50.0	10.8	17.5	22.6	11.8	88.9	55.9		16.7	40.0
FAIR			6.1							5.9					4.0
POOR												2.9			
	(12)	(18)	(82)	(15)	(9)	(6)	(37)	(40)	(53)	(17)	(9)	(34)	(11)	(6)	(25)
AVG PCT POINTS LISTED	53.3%	94.4%	--	91.7%	66.7%	--	100%	97.3%	99.6%	100%	--	--	73.3	25.7	99.1
	(12)	(18)		(4)	(3)		(37)	(37)	(56)	(17)			(9)	(7)	(22)
OVERALL POINTS WELL MADE:															
YES	100%	100%	--	100%	100%	100%	100%	100%	99.4%	100%	95.2%	90.7%	100%	91.7%	100%
NO									5.6		4.8	9.3		8.3	
	(11)	(17)		(4)	(3)	(6)	(37)	(34)	(52)	(16)	(14)	(33)	(9)	(6)	(22)
OVERALL CHANGE:															
YES	97.0%	66.7%	--	77.1%	100%	100%	72.1%	93.9%	79.2%	96.4%	88.5%	67.8%	42.9%	90.0%	96.1%
NO	3.0	4.8		6.2			15.5	3.0	10.7	1.8	7.7	19.4	14.3		
NA		28.6		16.7			12.4	3.0	10.1	1.8	3.8	12.8	42.9	10.0	3.9
	(11)	(14)		(4)	(3)	(6)	(37)	(33)	(42)	(14)	(13)	(32)	(7)	(5)	(21)
NUMBER SS NUMBERS	5		6	1	4		12	3	17	4	1	23	2	3	22
PCT PROVDG SVCS TO HIV+ PTS	20.0		55.0	50.0	55.5	60.0	10.8	5.6	15.0	23.5	38.5	58.3	0	0	3.0
	(15)		(40)	(18)	(11)	(5)	(37)	(36)	(60)	(17)	(13)	(36)	(11)	(17)	(33)

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COLORADO AIDS ETC
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State summary by course
December; 1988 to January, 1990

	31 6-89	32 6-89	33 6-89	34 6-89	35 6-89	36 7-89	37 7-89	38 7-89	39 7-89	40 7-89	41 8-89	42 8-89	43 8-89	44 8-89	45 8-89
NUMBER EVALUATIONS	13	7	10	9	13	10	34	12	32	13	13	30	13	6	7
NUMBER ID MINORITIES	3		2	2	1		3	0	2	1	0	0	0	5	3
DISCIPLINE:															
DENTISTRY					7.7%										
EMS						100%									
MEDICINE			11.1%							92.3%	84.6%	73.3%			
MNTL HEALTH															
NURSING	27.3%		11.1				8.8%		14.8%			10.0	100%		16.7%
PA	9.1		22.2							7.7	7.7	3.3			
PUBL HEALTH			22.2					62.5%						16.7%	33.3
SOCIAL UORK								12.5	3.7					50.0	16.7
OTHER	63.6	100%	33.3		92.3		91.2	25.0	81.5		7.7	13.3		33.3	33.3
	(11)	(7)	(9)		(13)	(10)	(34)	(8)	(27)	(13)	(13)	(30)	(13)	(6)	(6)
OVERALL EVALUATION:															
EXCELLENT	75.0%	25.0%			76.9%	33.3%	85.3%	75.0%	52.4%	76.9%	30.8%	46.4%	46.2%	100%	40.0%
GOOD	25.0	75.0	50.0%		23.1	66.7	14.7	25.0	47.6	23.1	61.5	53.6	53.8		60.0
FAIR			37.5								7.7				
POOR			12.5												
	(12)	(4)	(8)		(13)	(9)	(34)	(8)	(21)	(13)	(13)	(28)	(13)	(1)	(5)
AVG PCT POINTS LISTED	100	100	--	--	69.2	100	40.0	57.1	96.4	20.0					
	(13)	(7)			(13)	(9)	(34)	(7)	(28)	(7)					
OVERALL POINTS WELL MADE:															
YES	98.1%	96.4%	80.0%		100%	100%	100%	96.4%	97.4%	100%					
NO	1.4	3.6	20.0					3.6	2.6						
	(13)	(7)	(5)		(13)	(9)	(34)	(7)	(19)	(4)					
OVERALL CHANGE:															
YES	63.1%	91.7%	57.1%		87.8%	91.7%	95.1%	95.8%	86.8%	100%	75.0%	78.6%	84.6%	66.7%	60.0%
NO	10.8		42.9		2.6	2.8	2.9		2.9		25.0	21.4	15.4	33.3	40.0
NA	26.2	8.3			9.6	5.6	2.0	4.2	10.3						
	(13)	(7)	(7)		(13)	(9)	(34)	(6)	(17)	(4)	(12)	(28)	(13)	(3)	(5)
NUMBER SS NUMBERS	5		1		12		8	4	8	5	12	27	8	2	7
PCT PROVDG SVCS TO HIV+ PTS	23.1		44.4	37.5	23.1		5.9	0	4.2	50.0	46.2	53.4	30.8	0	14.3
	(13)		(9)	(8)	(13)		(34)	(12)	(24)	(8)	(13)	(30)	(13)	(6)	(7)

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COLORADO AIDS ETC
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State summary by course
December, 1988 to Januarv. 1990

	46 8-89	8-89 47	8-89 48	8-89 49	8-89 50	9-89 51	9-89 52	53 9-89	9-89 54	9-89 55	9-89 56	9-89 57	9-89 58	9-89 59	60 9-89
NUMBER EVALUATIONS	42	18	11	8	5	14	11	113	12	38	5	11	16	18	17
NUMBER ID MINORITIES	6	0	1	0	0	1	0	28	1	4	0	2	0	2	4
DISCIPLINE:															
DENTISTRY	7.1%									5.4%					
EMS	4.8	82.2%		100%			45.5%						6.3%		
MEDICINE	11.9		100%						33.3%					11.1%	
HNTL HEALTH										8.1					17.6%
NURSING	5:::				100%			38.8%	8.3	5.4	100%		56.3		17.6
PA															
PUBL HEALTH	7.1							4.1							
SOCIAL WORK	4.8							3.1		2.7					41.2
OTHER	4.8	11.8				100%	54.5	54.1	58.3	78.4		100%	37.5	88.9	23.5
	(42)	(17)	(11)	(8)	(5)	(14)	(11)	(98)	(12)	(37)	(5)	(11)	(16)	(18)	(17)
OVERALL EVALUATION:															
EXCELLENT	61.5%	35.3%	63.6%	50.0%	80.0%	14.3%	54.5%	47.5%	16.7%	32.4%	60.0%	36.4%	57.1%	52.9%	9.1%
GOOD	38.5	64.7	36.4	50.0	20.0	71.4	45.5	48.5	66.7	62.2	40."				
FALR						14.3		4.0	16.7	5.4					
POOR															9.1
	(26)	(17)	(11)	(8)	(5)	(14)	(11)	(101)	(12)	(37)	(5)	(11)	(14)	(17)	(11)
AVG PCT POINTS LISTED															
OVERALL POINTS WELL MADE:															
YES															
NO															
OVERALL CHANGE:															
YES	78.8%	94.4%	72.7%	100%	100%	53.8%	100%	86.5%	63.6%	86.5%	80.0%	81.8%	66.7%	82.4%	64.3%
NO	21.2	5.6	27.3			46.2		13.5	36.4	13.5	20.0	18.2	33.3	17.6	35.7
NA															
	(33)	(18)	(11)	(8)	(5)	(13)	(10)	(104)	(11)	(37)	(5)	(11)	(15)	(17)	(14)
NUMBER SS NUMBERS	41	18	11	8	4	10	11	84	9	36	4	8	13	17	16
PCT PROVDG SVCS TO HIV+ PTS	61.9	5.6	36.4	0	40.0	28.5	20.0	4.7	45.5	8.3	40.0	0	6.3	27.8	17.6
	(42)	(18)	(11)	(8)	(5)	(14)	(10)	(107)	(11)	(36)	(5)	(11)	(16)	(18)	(17)

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COLORADO AIDS ETC
EVALUATION REPORT -- PAGE 5

State summary by course
December, 1988 to January, 1990

	61 8-89	62 8-89	63 8-89	64 8-89	65 8-89	66 8-89	67 9-89	68 9-89	69 10-89	70 8-89	71 9-89	72 9-89	73 8-89	74 10-89	75 10-89
NUMBER EVALUATIONS	8	11	9	35	26	15	14	36	9	13	21	6	13	4	71
NUMBER ID MINORITIES	1		1	14	5	3	3	5	2	9	7	1	4	2	14
DISCIPLINE:															
DENTISTRY				4.3%											
EMS	75.0%	100%													
MEDICINE			100%			6.7%		2.8%			14.3%				
MNTL HEALTH												20.0%			
NURSING	12.5				10.0%	80.0		91.7						75.0%	61.5%
PA															
PUBL HEALTH															
SOCIAL WORK									11.1%						3.1
OTHER	12.5			95.7%	90.0	13.3	100%	5.6	88.9	100%	85.7	80.0	100%	25.9	35.4
	(8)	(11)	(9)	(23)	(10)	(15)	(13)	(36)	(9)	(12)	(21)	(5)	(7)	(4)	(65)
OVERALL EVALUATION:															
EXCELLENT	100%	72.7%	75.0%	48.3%	63.2%	25.0%	72.7%	50.0%	66.7%	46.2%	66.7%	83.3%	66.7%	25.0%	10.3%
GOOD		27.3	25.0	41.4	36.8	66.7	27.3	47.2	33.3	46.2	33.3	16.7	33.3	75.0	62.1
FAIR				6.9		8.3		2.8		7.7					25.9
POOR				3.4											1.7
	(8)	(11)	(8)	(29)	(19)	(12)	(11)	(36)	(9)	(13)	(21)	(6)	(9)	(4)	(58)
AVG PCT POINTS LISTED													35.0 (4)		
OVERALL POINTS WELL MADE:															
YES													100%		
NO															
													(4)		
OVERALL CHANGE:															
YES	100%	72.2%	80.0%	71.5%	54.3%	93.3%	92.3%	86.1%	77.8%	53.8%	76.2%	100%	100%	100%	74.2%
NO		18.2	14.3	19.6	27.1	6.7	7.7	13.9	22.2	46.2	23.8				25.8
NA		9.1	5.7	8.9	18.6										
	(8)	(11)	(7)	(22)	(14)	(15)	(13)	(36)	(9)	(13)	(21)	(6)	(4)	(4)	(62)
NUMBER SS NUMBERS	8	5	4	18	8	14	14	35	9	13	21	6	9	4	60
PCT PROVDG SVCS TO HIV+ PTS	62.5 (8)	72.7 (11)	44.4 (9)	17.6 (34)	4.3 (23)	40.0 (15)	0 (14)	16.7 (36)	22.2 (9)	0 (13)	0 (19)	20.0 (5)	30.0 (10)	75.0 (4)	6.3 (63)

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State **summary by** course
December, 1988 to January, 1990

	76 10-89	78 10-89	79 10-89	80 10-89	81 10-89	82 lo-89	83 10-89	84 10-89	85 10-89	86 11-89	87 10-89	88 10-89	89 10-89	90 10-89
NUMBER EVALUATIONS	16	13	33	14	5	43	19	31	15	9	4	8	13	18
NUMBER ID MINORITIES	0	0	6	1	3	8	2	6	0	1	2	1	0	5
DISCIPLINE:														
DENTISTRY						2.5%		6.7%			100%			
EMS		45.5%						3.3					23.1%	11.1%
MEDICINE	100%	9.1				80.0				100%			7.7	
MNTL HEALTH							5.9%							
NURSING		9.1	97.0%	42.9%			23.5		7.1%					33.3
PA								6.7				14.3%		
PUBL HEALTH				57.1								28.6		
SOCIAL WORK							17.6							
OTHER		36.4	3.0		100%	17.5	52.9	83.3	92.9			57.1	69.2	55.6
	(16)	(11)	(33)	(14)	(4)	(40)	(17)	(30)	(14)	(8)	(4)	(7)	(13)	(9)
OVERALL EVALUATION:														
EXCELLENT	81.3%	76.9%	14.8%	55.6%	80.0%	11.6%	23.5%	73.3%	50.0%	14.3%		25.0%	46.2%	31.3%
GOOD	18.8	23-1	77.8	44.4	20.0	51.2	64.7	26.7	28.6	57.1	100%	75.0	53.8	62.5
FAIR			7.4			32.6	11.8		14.3	28.6				6.3
POOR						4.7			7.1					
	(16)	(13)	(27)	(9)	(5)	(43)	(17)	(30)	(14)	(7)	(4)	(8)	(13)	(16)
AVG PCT POINTS LISTED														
OVERALL POINTS WELL MADE:														
YES														
NO														
OVERALL CHANGE:														
YES	81.3%	92.3%	93.1%	70.0%	80.0%	58.5%	94.4%	80.0%	73.3%	85.7%	75.0%	75.0%	61.5%	85.7%
NO	18.8	7.7	6.9	30.0	20.0	41.5	5.6	20.0	26.7	14.3	25.0	25.0	38.5	14.3
NA														
	(16)	(13)	(29)	(10)	(5)	(41)	(18)	(30)	(15)	(7)	(4)	(8)	(13)	(14)
NUMBER SS NUMBERS	15	12	30	-14	4	39	18	28	12	6	4	2	13	15
PCT PROVDG SVCS TO HIV+ PTS	68.8	0	40.0	14.2	0	16.2	31.6	13.0	0	88.9	25.0	12.5	0	0
	(16)	(13)	(30)	(14)	(4)	(37)	(19)	(31)	(15)	(9)	(4)	(8)	(13)	(10)

MOUNTAIN-PLAINS REGIONAL AIDS ETC
COLORADO AIDS ETC
EVALUATION REPORT - PAGE 7

State summary by course
December, 1988 to January, 1990

	91 IO-89	92 11-89	93 11-89	94 11-89	95 II-89	96 11-89	97 11-89	98 II-89	99 IO-89	100 II-89	101 11-89	102 11-89	103 11-89	104 II-89	105 12-89
NUMBER EVALUATIONS	8	4	16	16	22	15	11	5	26	12	23	9	22	17	22
NUMBER ID MINORITIES	0	0	0	1	0	0	4	3	4	0	5	0	0	2	4
DISCIPLINE:															
DENTISTRY															
EMS							9.1%		12.5%		10.0%		14.3%		7.1%
MEDICINE				6.3%					4.0						
HNTL HEALTH	37.5%				4.5%				4.0		10.0				7.1
NURSING		100%	60.0%	56.3		100%			56.0		45.0	88.9%	57.1		
PA															
PUBL HEALTH					4.5			60.0%							
SOCIAL WORK	50.0							40.0			5.0		4.8		
OTHER	12.5		40.0	37.5	90.9		90.9		24.0	100%	30.0	11.1	23.8	100%	85.7
	(8)	(4)	(15)	(16)	(22)	(15)	(11)	(5)	(25)	(9)	(20)	(9)	(21)	(15)	(14)
OVERALL EVALUATION:															
EXCELLENT	37.5%	25.0%	50.0%	50.0%	52.9%	23.1%	30.0%	100%	25.0%	41.7%	23.1%	44.4%	72.7%	6.3%	45.5%
GOOD	62.5	75.0	50.0	50.0	47.1	76.9	70.0		65.0	58.3	76.9	55.6	22.7	68.8	45.5
FAIR									5.0				4.5	18.8	9.1
POOR									5.0					6.3	
	(8)	(4)	(16)	(16)	(17)	(13)	(10)	(5)	(20)	(12)	(13)	(9)	(22)	(16)	(22)
AVG PCT POINTS LISTED															
OVERALL POINTS YELL MADE:															
YES															
NO															
OVERALL CHANGE:															
YES	100%	100%	93.8%	87.5%	61.1%	92.9%	100%	60.0%	75.0%	66.7%	66.7%	77.8%	90.9%	82.4%	68.4%
NO			6.3	12.5	38.9	7.1		40.0	25.0	33.3	33.3	22.2	9.1	17.6	31.6
WA															
	(8)	(4)	(16)	(16)	(18)	(14)	(9)	(5)	(20)	(12)	(15)	(9)	(22)	(17)	(19)
NUMBER SS NUMBERS	7	4	11	13	16	15	11	5	24	12	22	9	22	14	20
PCT PROVDG SVCS TO HIV+ PTS	37.5	50.0	6.7	12.5	47.7	46.7	'18.2.	20.0	4.0	0	26.3	0	n.2	17.6	5.6
	(8)	(4)	(15)	(16)	(21)	(15)	(11)	(5)	(25)	(10)	(19)	(9)	(22)	(17)	(18)

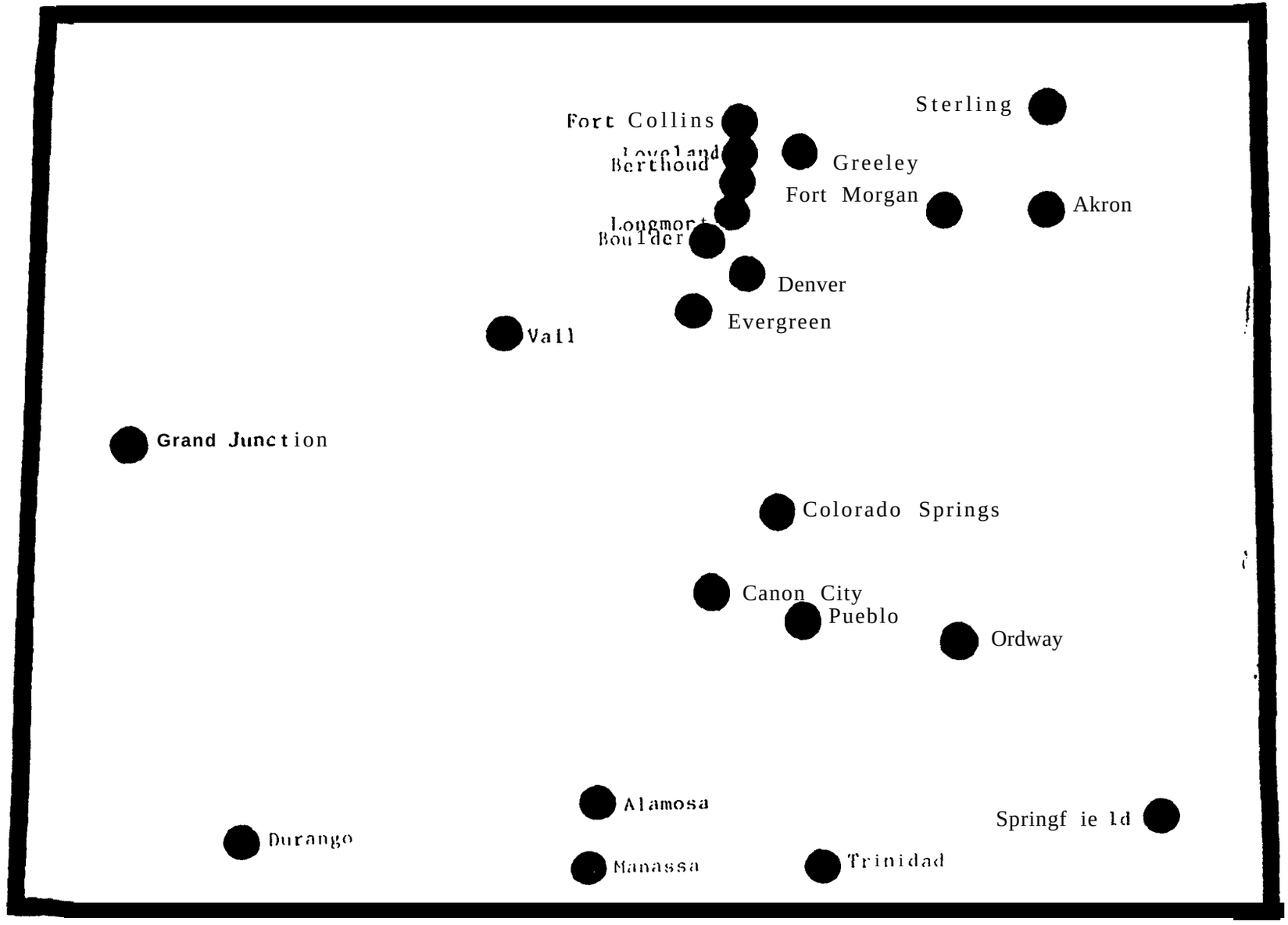
MOUNTAIN-PLAINS REGIONAL AIDS ETC
COLORADO AIDS ETC
EVALUATION REPORT – PAGE 8

State summary by course
December, 1988 to January, 1990

	12-89 106	12-89 107	12-89 108	11-89 109	11-89 110	11-89 111	12-89 112	113 1-90	114 1-90	TOTAL
NUMBER EVALUATIONS	12	9	13	31	3	31	8	18	36	2,299
NUMBER IO MINORITIES	0	0	0	25	2	7	5	3	8	379
DISCIPLINE:										
DENTISTRY										1.5%
EMS	91.7%				4.2%	4.2%			3.6%	5.6
MEDICINE	8.3	77.8%							17.9	15.8
HNTL HEALTH					8.3	8.3		5.9%		1.0
NURSING		11.1	6.7%				87.5%	70.6	3.6	25.7
PA									14.3	2.5
PUBL HEALTH								5.9	7.1	2.1
SOCIAL WORK			6.7		4.2	4.2				2.5
OTHER		11.1	86.7	100%	83.3	83.3	12.5	17.6	53.6	43.4
	(12)	(9)	(15)	(3)	(24)	(24)	(8)	(17)	(28)	(1998)
OVERALL EVALUATION:										
EXCELLENT	66.7%		33.3%	72.0%	100%	55.2%	50.0%	66.7%	79.3%	52.6%
GOOD	25.0	100%	58.3	20.0		41.4	50.0	33.3	17.2	41.6
FAIR	8.3		8.3	4.0		3.4			3.4	5.2
POOR				4.0						0.7
	(12)	(9)	(12)	(25)	(3)	(29)	(8)	(18)	(29)	(2015)
AVG PCT POINTS LISTED										84.2% (595)
OVERALL POINTS YELL MADE:										
YES										98.2%
NO										1.8
										(619)
OVERALL CHANGE:										
YES	83.3%	62.5%	61.5%	90.5%	100%	86.7%	87.5%	94.4%	100%	79.1%
NO	16.7	37.5	38.5	9.5		13.3	12.5	5.6		19.4
WA										1.4
	(12)	(8)	(13)	(21)	(3)	(30)	(8)	(18)	(28)	(1743)
NUMBER SS NUMBERS	11	5	3	24	3	29	7	15	31	1,358
PCT PROVDG SVCS TO HIV+ PTS	58.4 (12)	77.8 (9)	84.6 (13)	0 (24)	0 (3)	13.3 (30)	12.5 (8)	5.6 (18)	0 (28)	24.5% (1866)

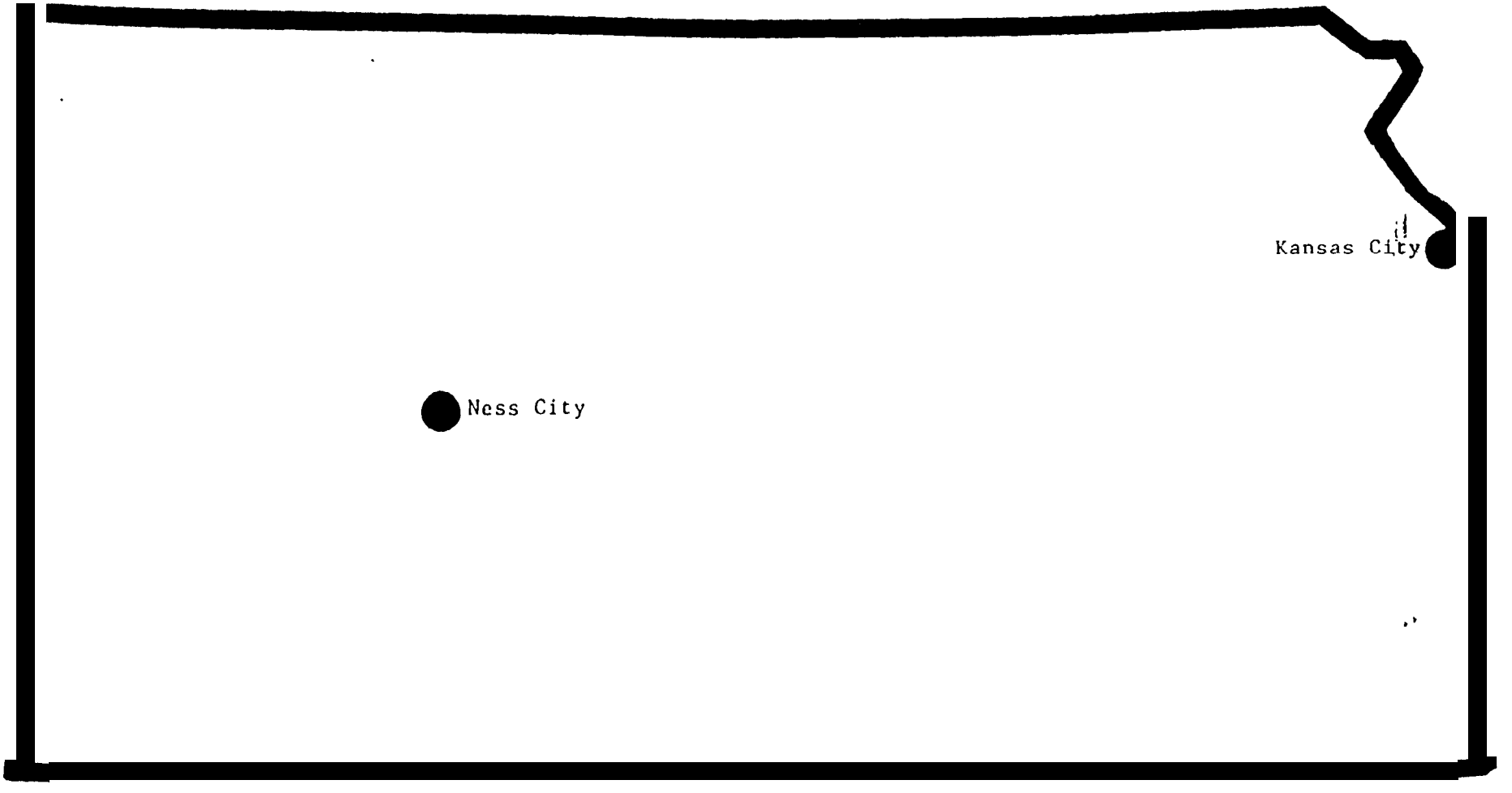
APPENDIX III

Output Evaluation -- Profile of Geographic Distribution of Trainings



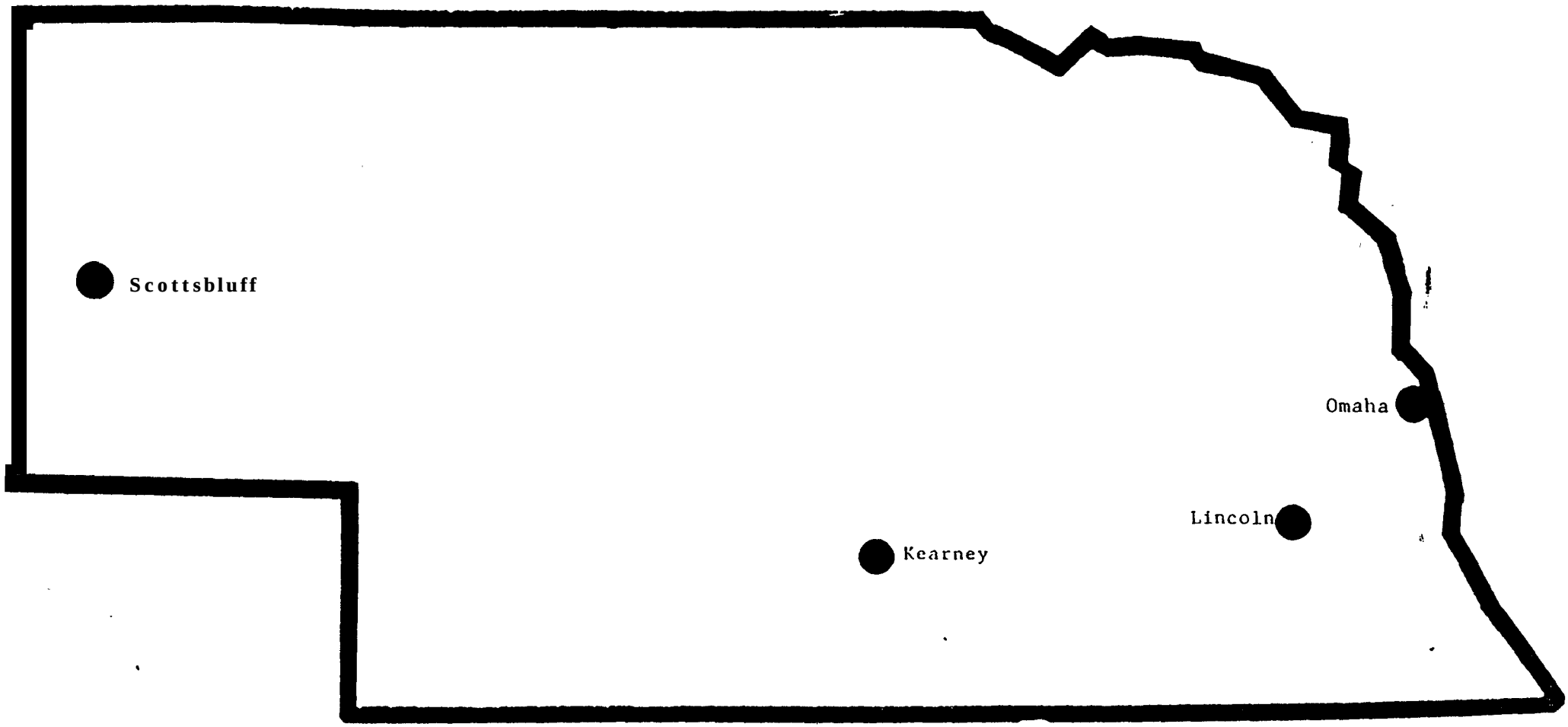
COLORADO AIDS ETC

LOCATIONS OF EVALUATED COURSES



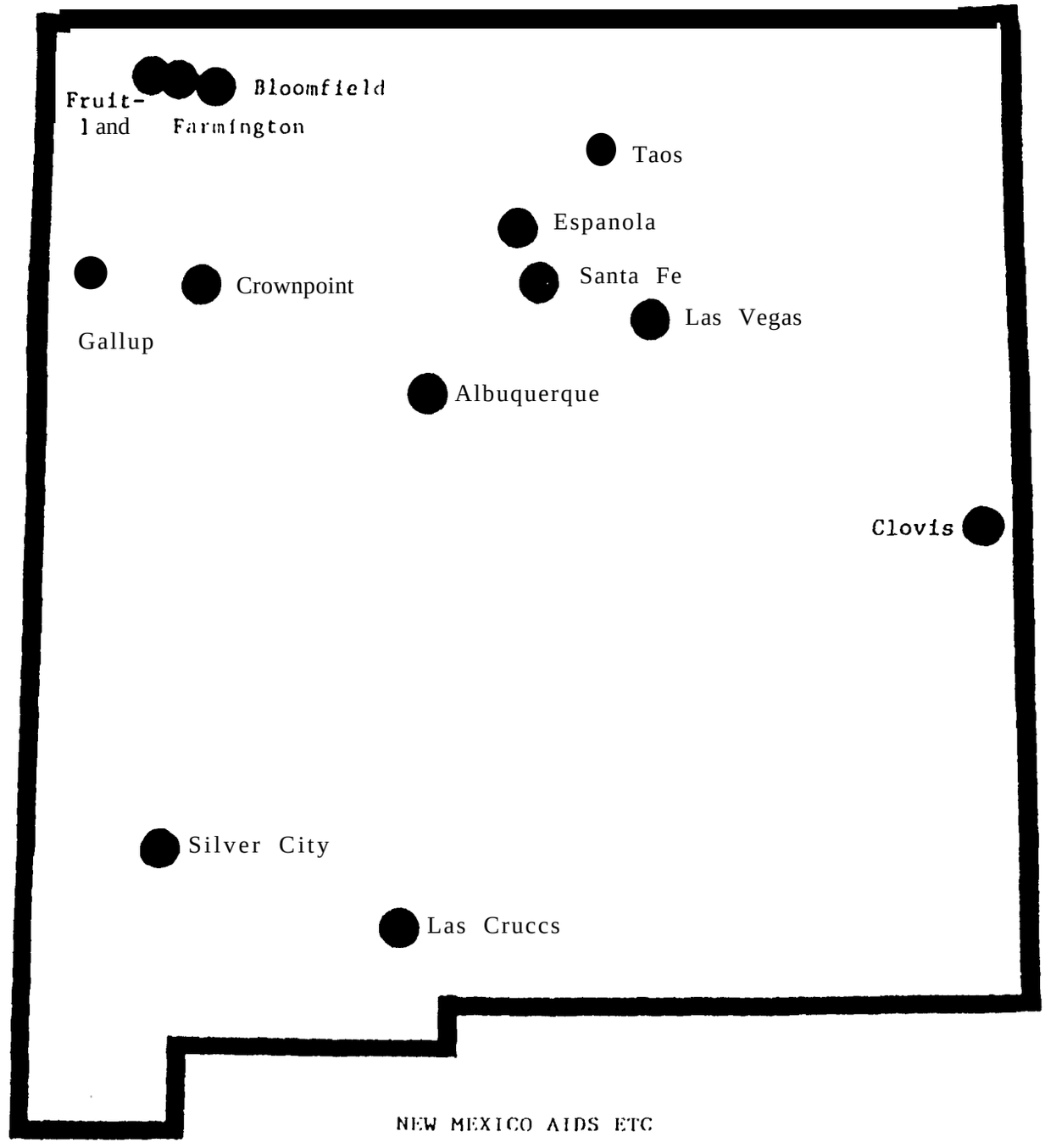
KANSAS AIDSETC

LOCATIONS OF EVALUATED COURSES



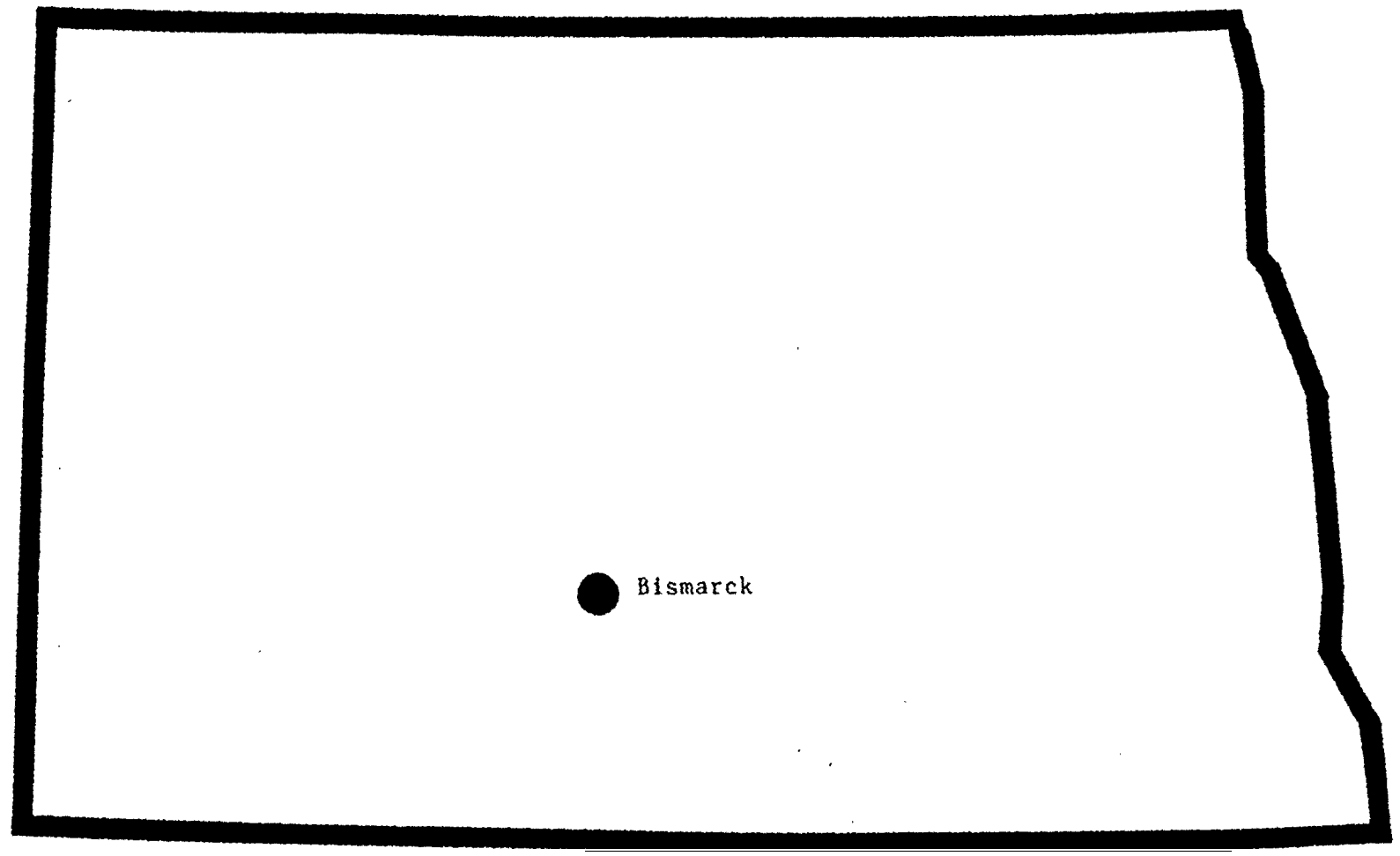
NEBRASKA AIDS ETC

LOCATIONS OF EVALUATED COURSES



NEW MEXICO AIDS ETC

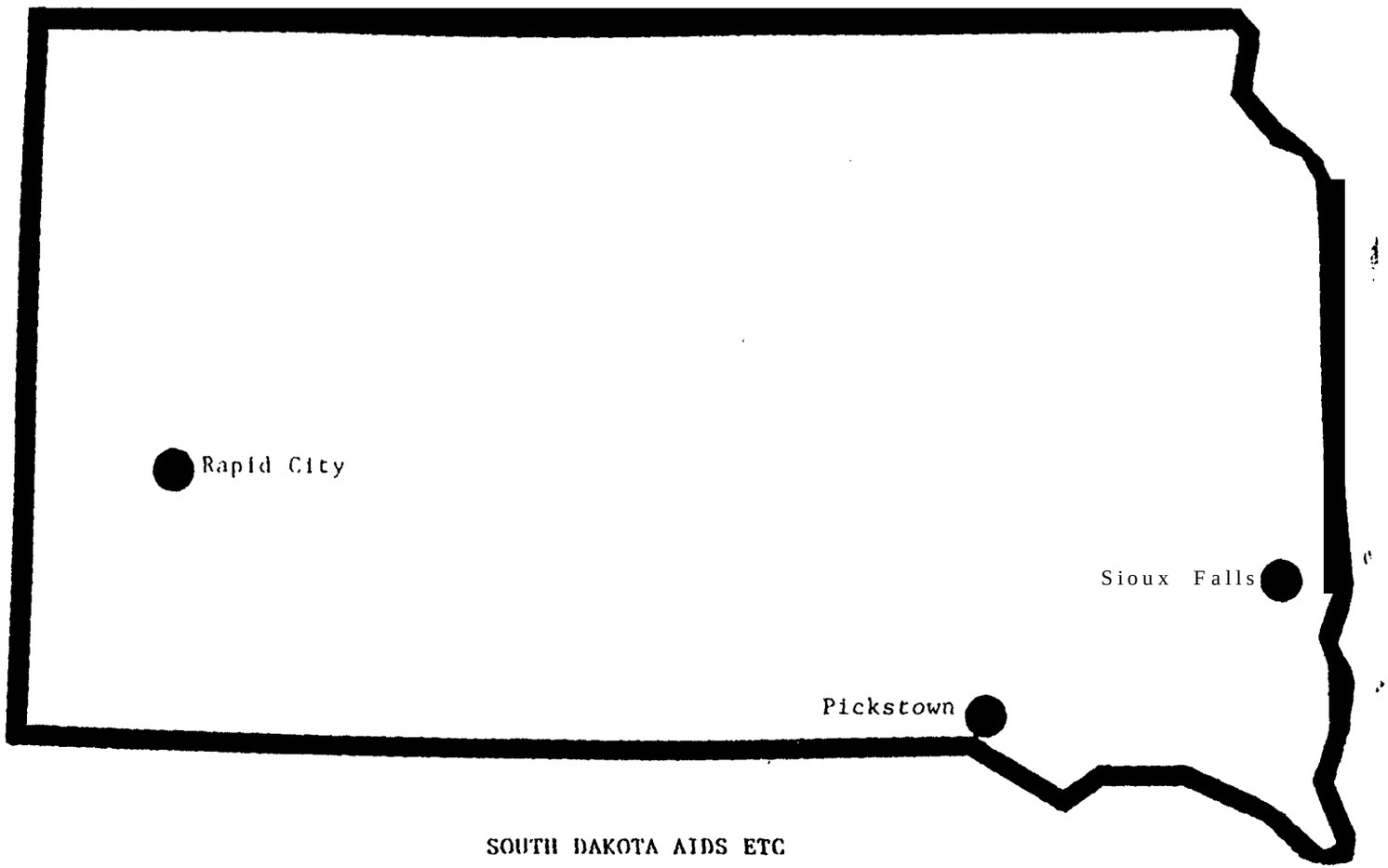
LOCATIONS OF EVALUATED COURSES



NORTH DAKOTA AI DS ETC

LOCATIONSOF EVALUATED COURSES

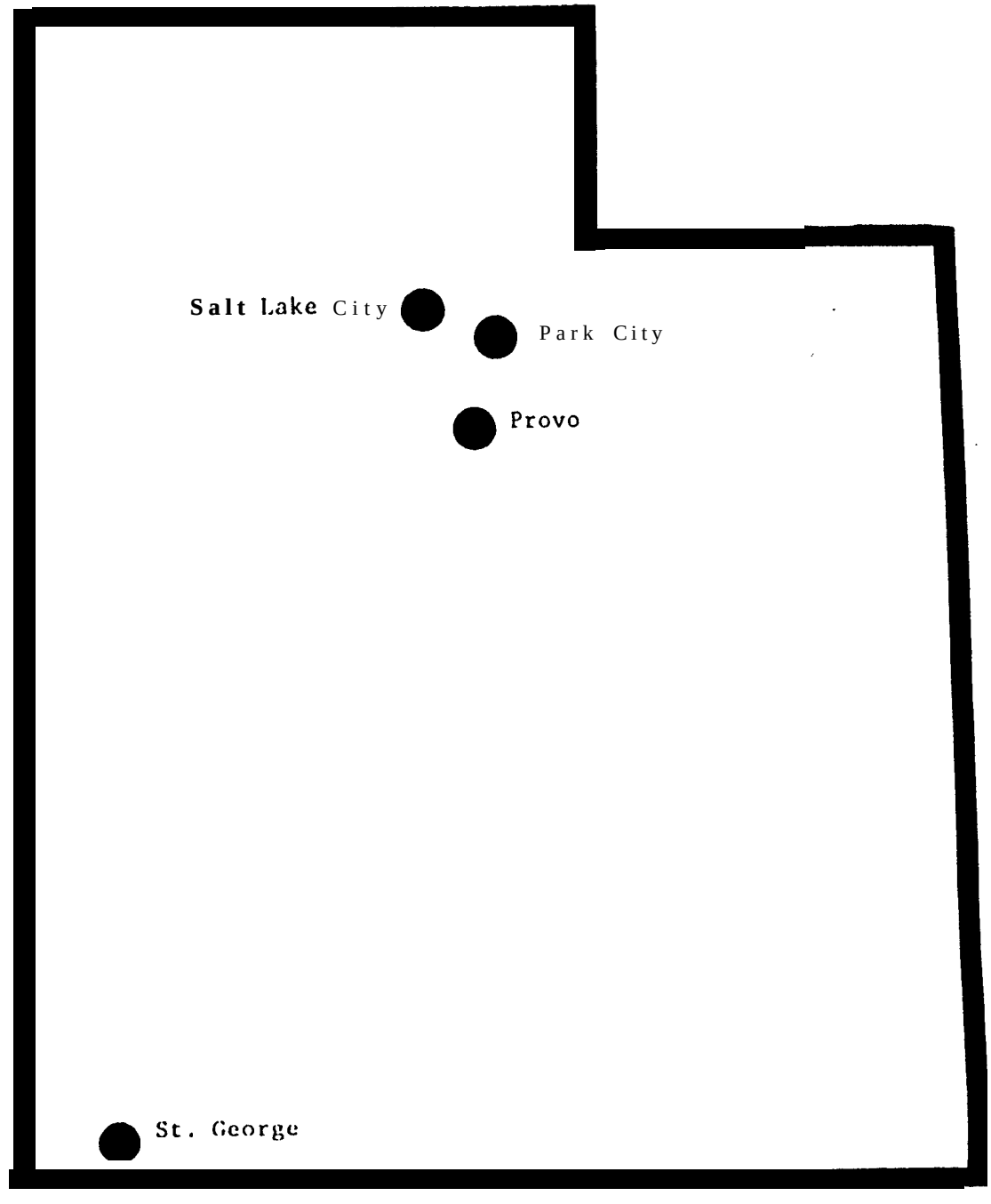
88 - 89



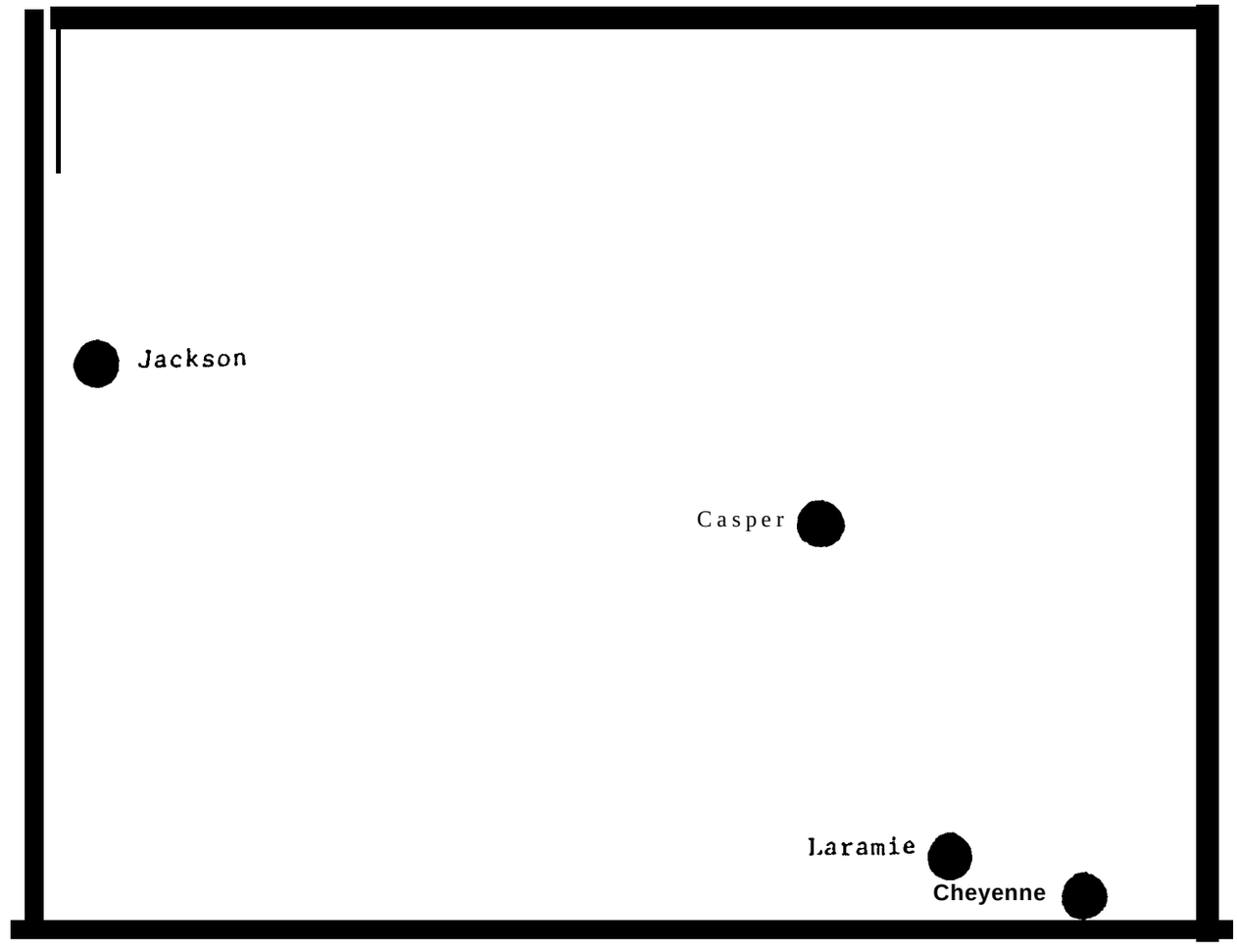
SOUTH DAKOTA AIDS ETC

LOCATIONS OF EVALUATED COURSES

88 - 89



UTAH AIDS ETC
LOCATIONS OF EVALUATED COURSES
88 . 89



WYOMING AIDSETC

LOCATIONS OF EVALUATED COURSES

88 - 89

APPENDIX IV

Standard Evaluation Format -- MPAETC's Evaluation Form

Printed in U.S.A. NCS Mark Reflex® MP82124-321 A2306

MOUNTAIN-PLAINS REGIONAL AIDS ETC EVALUATION

USING A NO. 2 PENCIL, COMPLETELY DARKEN A SINGLE OVAL FOR EACH QUESTION BELOW UNLESS INSTRUCTED TO DO OTHERWISE.

SOCIAL SECURITY NUMBER
ast six digits only)

Mark one digit in each box and fill in the oval representing the same digit in the column below the box.

YOUR OVERALL EVALUATION OF THIS **PROGRAM** IS: ○ Excellentt ○ Fair ○ Good ○ Poor

WILL YOU USE INFORMATION ACQUIRED IN THIS PROGRAM TO CHANGE YOUR APPROACH TO HIV INFECTION AT WORK?
0 Yes ○ Nc 0 Not applicable

DID THIS PROGRAM MEET ITS STATED **OBJECTIVES?**
○ Completely ○ Partially ○ Not at all ○ Objectives not stated

DID THIS PROGRAM MEET YOUR PERSONAL OBJECTIVES?
0 Completely ○ Partially ○ Not at all

SEX ○ Female ○ Male

AGE 0 26-35 35 ○ 36-45 ○ under 21 ○ 21-25 0 66-70 0 over 70 ○ 46-55 ○ 56-65

WITH WHAT ETHNIC GROUP DO YOU PRIMARILY IDENTIFY?
0 Asian ○ White, non-Hispanic ○ Native American (Indian)
0 Hispanic ○ Black ○

WHERE DO YOU LIVE?
○ CO ON D O N M O U T ○ Other
○ KS O N E ○ SD ○ WY

HOW MANY HOURS PER WEEK DO YOU WORK AT YOUR **JOB?**
○ less than 40 ○ 40 or more

DO YOU PROVIDE HEALTH CARE SERVICES DIRECTLY TO CLIENTS?
0 Yes 0 No

WHICH ONE OF THE FOLLOWING DISCIPLINES **BEST DESCRIBES** YOUR CURRENT OR MOST RECENT PROFESSIONAL ACTIVITY?

DENTAL
○ Dentist
○ Dental hygienist
○ Dental assistant
○ Student

GENERAL AND MENTAL HEALTH CARE
○ Counselor
○ EMT/Paramedic
○ Nurse
○ Physician assistant
○ Physician (specialty

○ Advanced Certification in Nursing
○ Psychologist
○ Social worker
0 Student

OTHER
○ Health administrator
○ Health educator
○ Lay volunteer
○ Other health
○ Non-health

HOW **MANY PEOPLE LIVE IN THE CITY/TOWN IN WHICH YOU WORK?**
○ under 10,000 **0** 10,000 to **35.000 0 35,000** to 70,000
0 70,000- 100.000 0 over 100.000

WHAT IS YOUR HIGHEST COMPLETED LEVEL OF EDUCATION?
, 0 High school diploma ○ Baccalaureate degree (eg, EA. BS)
0 Vocational/certificate program Cl Master's degree
0 Associate degree 0 Doctoral degree

WHICH OF THE FOLLOWING BEST DESCRIBES THE AREA IN WHICH YOU PRIMARILY WORK? (Select only one)
○ Mental health care
○ General acute care medicine
○ Long-term care/rehabilitation
○ General out-patient care
○ Public health agency
○ Ambulance service/fire dept.
○ AIDS service organization
○ Alcohol/drug sbuse program
○ Education
○ Home health
○ Hospice
○ Other health care
○ Non-health care (SKIP TO GRID AT BOTTOM OF FORM)

HOW MANY YEARS HAVE YOU BEEN WORKING IN YOUR CURRENT PROFESSION?
○ 1-5 0 11-15 ○ 21-25 ○ over 30
○ 6-10 ○ 16-20 0 26-30

TO THE BEST OF YOUR KNOWLEDGE, HOW MANY TIMES IN THE LAST AVE YOU PROVIDED PROFESSIONAL SERVICES TO HIV+ CLIENTS?
00 ○ 6- 15 times ○ over 25 times
0 I-5 times 0 16-25 times ○ Don't know

ESTIMATE THE NUMBER OF AIDS EDUCATION AND TRAINING COURSES YOU HAVE PREVIOUSLY ATTENDED.
None 06-10 0 16-20 ○ over 25
○ 1-5 0 1 1 - 1 5 0 21-25

ESTIMATE WHAT PERCENTAGE OF THE FOLLOWING GROUPS YOU CURRENTLY SERVE?

	PERCENTAGE					
	NONE	1-25	26-50	51-75	76-99	100
Adolescents	0	0	0	0	0	0
Hemophiliacs	0	0	0	0	0	0
Homosexuals/bisexuals	0	0	0	0	0	0
Substance abusers	0	0	0	0	0	0
Asians	0	0	0	0	0	0
Blacks	0	0	0	0	0	0
Hispanics	0	0	0	0	0	0
Native Americans (Indians)	0	0	0	0	0	0

RESERVED FOR REGIONAL OFFICE USE

! ! WRITE PRESENTERS **IN PRESENTING ORDER !!**

	RELEVANCE	CLARITY	EDUCATIONAL SKILLS	KNOWLEDGE
	EXCGO FR PR	EXCGD FR PR	EXCGD FR PR	EXC GD FR PR
PRESENTER/PANEL #1	0 0 0 0	0 0 0 0	0 0 0 0	○○○○
PRESENTER/PANEL #2	0 0 0 0	0 0 0 0	0 0 0 0	○○
PRESENTER/PANEL #3	0 0 0 0	0 0 0 0	○○○○	o - c
:SENTER/PANEL #4	0 0 0 0	0 0 0 0	0 0 0 0	
RESENTER/PANEL #5	0 0 0 0	0 0 0 0	0 0 0 0	○○○○

MOUNTAIN-PLAINS REGIONAL AIDS ETC
EVALUATION

APPENDIX v

Standard Evaluation Format -- Presenter's Form

MOUNTAIN-PLAINS REGIONAL AIDS ETC
PRESENTER'S FORM

PRESENTER NAME _____

DATE OF PRESENTATION _____

TITLE OF PRESENTATION _____

LOCATION OF PRESENTATION _____

LENGTH OF PRESENTATION _____ CONTACT HOURS _____

A. Please list ALL MAJOR POINTS/OBJECTIVES for your presentation. (These should be the specific knowledge or behaviors that you want the participants to gain from your presentation.) DO THIS PART AS YOU PLAN YOUR PRESENTATION.

1.

2.

3.

4.

5.

B. Please ESTIMATE the following WHILE PARTICIPANTS ARE FILLING OUT THE EVALUATION FORM:

1. Total number of participants: _____

2. Number of participants in:

Dentistry _____ (type of professional _____)
EMS _____
Medicine _____ (type of professional _____)
Mental health ___ (type of professional _____)
Nursing _____ (type of professional _____)
Social work _____
Other _____ (type of professional _____)

3. Number of participants that are:

Asian _____ Hispanic _____
Black _____ Native American _____
Caucasian, non-Hispanic _____ Other _____

APPENDIX VI

Standard Evaluation Format -- **"Pool"** of KABB Items

MOUNTAIN-PLAINS REGIONAL AIDS ETC
OPTIONAL EVALUATION ITEMS

KNOWLEDGE AND BELIEFS ITEMS

Please use the following scale for items 1 through 33:

Agree	Disagree	Unsure
(A)	(D)	(U)
A	B	C

		A	D	U
1.	The Human Immunodeficiency Virus (HIV) is the causative organism in Acquired ImmunoDeficiency Syndrome (AIDS) and AIDS-Related Complex (ARC).	A	B	C
	There is evidence that HIV may be transmitted from an infected person to an uninfected person by:			
2.	heterosexual intercourse.	A	B	C
3.	being sneezed on.	A	B	C
4.	receiving a blood transfusion.	A	B	C
5.	using the same drinking glass.	A	B	C
6.	using the same eating utensils.	A	B	C
7.	shaking hands.	A	B	C
8.	using the same toilet seat.	A	B	C
9.	mosquito bites.	A	B	C
10.	unprotected mouth-to-mouth CPR.	A	B	C
11.	donating blood.	A	B	C
12.	sexual contact with a prostitute.	A	B	C
13.	Masks, gowns, and gloves should be worn during all contact with HIV+ patients.	A	B	C
14.	A person infected with HIV may have no symptoms but will be able to transmit the virus to others.	A	B	C
15.	After a person develops antibodies to HIV, he or she is no longer infectious to others.	A	B	C
16.	The only way to control the spread of AIDS is to prevent the transmission of HIV.	A	B	C
17.	A health care worker who is accidently pricked with a needle containing traces of blood from an HIV+ patient is at minimal risk of acquiring the HIV virus.	A	B	C
18.	All patients who are seropositive for HIV have-AIDS.	A	B	C
19.	Currently, all blood donated for transfusion is tested for the HIV antibody.	A	B	C
20.	Using a condom during sex is recommended because it may prevent transmission of HIV.	A	B	C
21.	It is not known whether all persons infected with HIV will develop AIDS.	A	B	C

MOUNTAIN-PLAINS REGIONAL AIDS ETC
OPTIONAL EVALUATION ITEMS

KNOWLEDGE AND BELIEFS ITEMS

		A	D	U
22.	Zidovudine (Retrovir, AZT) is a drug that can cure AIDS.	A	B	C
23.	Women who are infected with HIV can transmit the virus to their unborn children during pregnancy.	A	**B**	C
24	Specimens, tissue, and blood samples from all patients should be handled with the same precautions as those used for Hepatitis B patients.	A	**B**	C
25.	Ten percent of AIDS patients present with neuro-psychiatric changes rather than PCP or Kaposi's.	A	B	C
26.	HIV primarily affects red blood cells.	A	**B**	C
27.	HIV has been isolated from blood, saliva, semen, and vaginal secretions.	A	**B**	C
28.	The incubation period for AIDS may be up to six years.	A	B	C
29.	Homosexual and bisexual men are at risk of contracting HIV.	A	**B**	C
30.	Heterosexual contacts of hemophiliacs and intra-venous drug users are at risk for AIDS.	A	**B**	C
31.	Ethnic background is not an issue in the care of HIV+ patients.	A	**B**	C
32.	Health care professionals who care for patients have an ethical obligation not to abandon an established patient if he or she **becomes** HIV+.	A	**B**	C

33. The following statements regarding sputum examination in AIDS patients with pneumonia are true except:

a. it is an inexpensive and noninvasive diagnostic procedure
b. it is less sensitive than bronchoscopy
c. it has a poor yield for infectious causes of pneumonia other than PCP (i.e., tuberculosis)

MOUNTAIN-PLAINS REGIONAL AIDS ETC
OPTIONAL EVALUATION ITEMS

ATTITUDE AND OPINION ITEMS

Please use the following scale for these items:

Strongly Agree (SA)	Agree (A)	Disagree (D)	Strongly Disagree (SD)	Unsure (U)
A	B	C	D	E

1.	People who get AIDS deserve it because of their behavior.	SA A A B CD E
2.	People diagnosed with AIDS should be reported to protect the public health.	A-B C D
3.	All patients should be placed on universal precautions.	A B C D E
4.	I am fearful that I may become HIV+ while performing my job duties.	A B CD E
5.	I am comfortable with my co-workers' clinical skills when we are caring for an HIV+ patient.	'A B CD E
6.	I do not intend to work with persons who are HIV+.	A'B C D B
7.	I do not feel personally threatened by AIDS.	A B C D E
8.	I have sufficient knowledge to protect me from HIV infection.	A B CD E
9.	If I had a choice, I would choose to work with HIV+ people.	A B C D E
10.	People who are HIV seropositive should be reported to protect the public health.	A B C D E
11.	I feel comfortable touching an HIV+ patient.	A B CD E
12.	HIV testing for health care professionals who directly care for HIV+ patients should be mandatory.	A B C D E
13.	Health care professionals should be able to choose whether or not to care for an AIDS patient.	A B C D E

MOUNTAIN-PLAINS REGIONAL AIDS ETC
OPTIONAL EVALUATION ITEMS

BEHAVIORAL ITEMS

Please select a single response to the following items using the following scale:

I am very sure I COULD DO this.	I most likely COULD DO this.	I probably COULD DO this.	I probably COULD NOT DO this.	I most likely COULD NOT DO this.	I am very sure I could NEVER DO this.	NOT APPLICABLE
1	2	3	4	5	6	7

How sure are you that you could:

1.	provide support to the significant other(s) of a person with HIV infection?	1	2	3	4	5	6	7
2.	wear gloves when drawing blood?	1	2	3	4	5	6	7
3.	ask a male patient if he had sex with another man?	1	2	3	4	5	6	7
4.	protect yourself from HIV infection in your work situation?	1	2	3	4	5	6	7
5.	properly dispose of used needles without sticking yourself?	1	2	3	4	5	6	7
6.	clean up human blood spills appropriately?	1	2	3	4	5	6	7
7.	wear gloves when coming into contact with potentially infectious materials?	1	2	3	4	5	6	7
8.	ask IV drug users about their habits without being judgmental?	1	2	3	4	5	6	7
9.	interact with an HIV+ patient the same as with any other patient?	1	2	3	4	5	6	7
10.	protect yourself from HIV infection in your everyday life outside of work?	1	2	3	4	5	6	7
11.	wear gloves when inserting a needle or catheter for IV infusion?	1	2	3	4	5	6	7
12.	start CPR on an HIV+ patient?	1	2	3	4	5	6	7
13.	maintain the confidentiality of an HIV+ patient?	1	2	3	4	5	6	7
14.	be comfortable discussing relationship problems with a homosexual couple?	1	2	3	4	5	6	7
15.	protect yourself from injury when dealing with a patient with HIV dementia?	1	2	3	4	5	6	7

MOUNTAIN-PLAINS REGIONAL AIDS ETC
OPTIONAL EVALUATION ITEMS

BEHAVIORAL ITEMS

I am very sure I COULD Do this.	I most likely COULD DO this.	I probably COULD Do this.	I probably COULD NOT DO this.	I most likely COULD NOT DO this.	I am very sure I could NEVER Do this.	NOT APPLICABLE
1	2	3	4	5	6	7

How sure are you that you could:

16. arrange home care and social services for an HIV+ patient? 1 2 3 4 5 6 7

17. teach professionals how to take a sexual history? 1 2 3 4 5 6 7

18. teach people about AIDS as it relates to working with IV drug users? 1 2 3 4 5 6 7

19. teach people about the transmission of HIV? 1 2 3 4 5 6 7

20. teach someone how to counsel individuals regarding safer sex practices? 1 2 3 4 5 6 7

21. Does your job prevent you in any way from performing the activities mentioned in the preceding items? A. Yes B. No

If so, please specify what aspect of your job causes the difficulty?

APPENDIX VII

Standard Evaluation Format -- Sample Event Report

New Mexico "AIDS Educator Workshop" (April 6, July'1989)

MOUNTAIN-PLAINS REGIONAL AIDS ETC
EVALUATION REPORT

NEW MEXICO AIDS ETC

AIDS Educator Workshop
Lucy Bradley-Springer and Pat C. Hays
Albuquerque, New Mexico
April 6, 1989
(n=16)

DISCIPLINE:	
Dentistry	6.3%
Nurse	51.3
Physician	6.2
Social Worker	6.3

OVERALL EVALUATION OF THIS PRESENTATION:			
Excellent	Good	Fair	Poor
68.8%	31.3		

WHAT WERE THE SPEAKER'S MAIN POINTS IN THIS PRESENTATION?

MAIN POINT	WAS THE POINT WELL MADE?	WILL YOU USE THIS INFORMATION TO CHANGE YOUR APPROACH TO HIV INFECTION?	PERCENT LISTING POINT
1. Education Principles (Pat Hays)	YES 100% NO	YES 73.3% NO 26.7 NA	62.5
2. Curriculum (Lucy Bradley-Springer)	YES 100% NO	YES 90.9% NO NA 9.1	62.5
3. Teaching methods for AIDS Education	YES 100% NO	YES 100% NO NA	56.2
4. Program Evaluation (LucyBradley-Springer)	YES 100% NO	YES 91.7% NO NA 8.3%	62.5

13. HOW MANY HOURS PER WEEK DO YOU PRACTICE OR WORK AT YOUR PRIMARY JOB?

6.3%, Less than 20 6.3, 20-30 37.5, 31-40 37.5, 41-50 6.3, 51-60 6.3, 61-70

14. DO YOU PROVIDE SERVICES DIRECTLY TO CLIENTS?

66.7%, Yes 33.3, No

15. TO THE BEST OF YOUR KNOWLEDGE, HOW MANY TIMES IN THE LAST YEAR HAVE YOU PROVIDED SERVICES FOR HIV+ CLIENTS AS PART OF YOUR JOB?

18.8%, 0 37.5, 1-5 times 18.8, 6-15 times 18.8, more than 25 times 6.3, Don't know

16. IF YOU ARE ASSOCIATED WITH AN IN-PATIENT FACILITY, DOES IT HAVE INFECTION CONTROL POLICIES FOR THE CARE OF HIV+ PATIENTS?

87.5%, Yes 12.5, Not associated with in-patient facility

17. DO YOU HAVE ANY RESPONSIBILITY AT WORK FOR DETERMINING POLICIES RELATED TO THE CARE OF HIV+ CLIENTS?

87.5%, Yes 12.5, No

18. HAVE YOU ATTENDED ANY PREVIOUS AIDS EDUCATION OR TRAINING COURSES?

93.8%, Yes 6.3, No

19. IF YOU ANSWERED NO TO QUESTION 18, HAVE YOU HAD ANY EARLIER OPPORTUNITIES TO ATTEND AIDS EDUCATION OR TRAINING COURSES?

66.7%, Yes 33.3, No

20. IF YOU ANSWERED YES TO QUESTION 19 BUT DID NOT ATTEND AIDS EDUCATION OR TRAINING COURSES, WAS IT FOR ANY OF THE FOLLOWING REASONS?

[illegible]%, Didn't have time 33.3, Distance and expense 50.0, None of these

21. WHAT IS YOUR STATE OF RESIDENCE?

100%, NM

22. WHAT IS THE SIZE OF THE CITY/TOWN IN WHICH YOU WORK OR PRACTICE?

26.7%, 10,000 - 35,000 33.3, 35,000 - 70,000 40.0, > 100,000

23. Adult learners tend to have all of the following characteristics EXCEPT:

6.3%, They are self-directed and self-motivated.
6.3, They are motivated by a perceived need.
87.5, They do not mind being told what they need to know.

APPENDIX VIII

Instrument for Evaluating First Generation Training-of-Trainers

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
November 30, 1968

NSTRUCTIONS: Please circle the responses that correspond to your opinion about the content and quality of oday's presentations. Use the following scale, **EXCELLENT** (BX or **1), GOOD (GD** or **2),** FAIR *(FR* or **3),** POOR (PR or), except where indicated otherwise. Completed evaluations should be placed in the box by the door that is arked @EVALUATIONS'. Your-feedback is appreciated.

TOPIC	CLARITY OF PRESENTATION	EDUCATIONAL SKILLS OF PRESENTER(S)	OVERALL QUALITY OF PRESENTATION	DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER?	AT WORK?
	BX **GD** *FR* **PR**	BX **GD** FR **PR**	BX **GD** *FR* PR	YBS **NO**	**YES** **NO** **NA**
HOW TO EVALUATE TEACHING (N. Whitman)	**1** **2** **3** **4**	**1** **2** **3** **4**	12 3 4	Y **N**	Y N N A
EPIDEMIOLOGY/PREVENTION (R. Hoffman)	12 3 4	12 3 4	12 3 4	Y **N**	Y **N** **NA**
IMMUNOLOGY/VIROLOGY (J. Vennes)	12 3 4	12 3 4	12 3 4	**Y** **N**	Y **N** NA
TREATMENT /CL. RANIFESTATIONS (G. **Mertz)**	12 3 4	12 3 4	12 3 4	Y **N**	Y N NA
KEYNOTE SPEECH (J. Arradondo)	12 3 4	1 **2** **3** 4	12 3 4	**Y** N	**Y** **N** **NA**
PSYCHOSOCIAL ISSUES (panel)	12 3 4	1 '2 3 4	12 3 4	**Y** N	**Y** **N** **NA**
ETHICS/LEGAL/POLICY ISSUES (panel)	12 3 4	12 3 4	12 3 4	**Y** **N**	Y N **NA**
WHAT PROVIDERS NEED TO **KNOW** (panel)	12 3 4	12 3 4	12 3 4	**Y** **N**	Y **N** NA

PLEASE TURN THIS PAGE OVER AND CONPLBTB **THE ITEMS** ON **THE** OTHER SIDE.

GENERAL	EXC	GD	FR	PR
1. Relevance of conference so far:	1	2	3	4
2. Usefulness of conference so far:	1	2	3	4
3. Overall quality of conference so far:	1	2	3	4

4. COMMENTS AND/OR SUGGESTIONS:

WOUNTAIN-PLAINS REGIONAL AIDS RTC
Train-the-Trainer Conference
December 1, 1988

INSTRUCTIONS: Please **circle** the responses that correspond to your opinion about the content and **quality** of today's presentations. Use the following scale, **EXCELLENT** (BX *or* **1), GOOD (GD** or **2), FAIR (FR** or **3), POOR** (PR or **4),** except where indicated otherwise. Completed evaluations should be placed in the box by the door that is marked 'EVALUATIONS'. Your feedback is appreciated.

TOPIC	CLARITY OF PRESENTATION				EDUCATIONAL SKILLS OF PRESENTER(S)				OVERALL QUALITY OF PRESENTATION				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER?		AT WORK?		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
INTRODUCTION TO ADULT LEARNING	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
CLIMATE SETTING	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
SELF-ASSESSMENT	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
CULTURAL/ATTDNL FACTORS	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
USE OF VIDEOTAPES	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
VALUES CLARIFICATION	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
LOSS EXERCISE	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
CASE STUDIES/ROLE PLAYS	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
ADULT LEARNING PRINCIPLES	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
PROBLEM LEARNERS	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
THE CNA EXPERIENCE	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA

PLEASE TURN THIS PAGE OVER AND COMPLETE THE ITEMS ON THE OTHER SIDE.

GENERAL	EXC	GD	FR	PR
1. Relevance of conference so far:	1	2	3	4
2. Usefulness of conference so far:	1	2	3	4
3. Overall quality of conference so far:	1	2	3	4

4. COMMENTS AND/OR SUGGESTIONS:

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 2,. 1988

INSTRUCTIONS: Please circle the responses that correspond to your opinion about the content and quality of today's presentations. Use the following scale, **EXCELLENT (EX** or **1), GOOD (GD** or **2),** FAIR **(FR** or **3),** POOR **(PR** or **4),** except where indicated otherwise. Completed evaluations should be placed in the box by the door that is marked 'EVALUATIONS'. Your feedback is appreciated.

TOPIC	CLARITY OF PRESENTATION				EDUCATIONAL SKILLS OF PRESENTER(S)				OVERALL QUALITY OF PRESENTATION				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER?		AT WORK?		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
EDUCATION AS A CHANGE PROCESS (R. Saylor)	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
DESIGNING TO MEET LOCAL NEEDS (N. Whitman)	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA
DISCIPLINE-SPECIFIC SESSION YOU ATTENDED: _____ (Your discipline: _____)	1	2	3	4	1	2	3	4	1	2	3	4	Y	N	Y	N	NA

PLEASE TURN THIS PAQB **OVER AND COMPLETE THE ITEMS** ON THE **OTHER SIDE.**

1. In your opinion, has anything been OMITTED from this curriculum that is NECESSARY for your discipline? __ yes __ no __ not applicable COMMENT

2. In your opinion, has anything been INCLUDED in this curriculum that is UNNECESSARY for your discipline? __ yes _ no _ not applicable COMMENT

3. Does the curriculum for your discipline read clearly? __ yes __ no __ not applicable COMMENT

4. In your opinion, does the curriculum make a useful contribution to discipline? __ yes __ no __ not applicable COMMENT

5. From the evaluation presentation, was it clear that every training event involving this curriculum, no matter how short, must be evaluated? __ yes __ no COMMENT

6. From the evaluation presentation, was it clear what evaluation tasks are required of you in your role as an AIDS trainer? __ yes __ no __ not applicable COMMENT

7. Did you get all the information you needed at the conference in order to teach this curriculum:

   a. to others in your discipline? __yes __no __ not applicable COMMENT

   b. to other health professionals? __ yes' __ no __ not applicable COMMENT

8. Do you think that you need clinical experience with AIDS patients BEFORE you can teach this curriculum to others?
   __ yes (Please identify yourself so that we can talk further with you about this: _____)
   __ no __ not applicable COMMENT

9. Please rate the following:

	EXC	GOOD	FAIR	POOR
a. overall relevance of the conference	1	2	3	4
b. overall usefulness of the conference	1	2 .	3	4
c. facilities at the conference	1	2	3	4
d. amenities (e.g., refreshments)	1	2	3	4
e. length of the conference	1	2	3	4
g. overall quality of the conference	1	2	3	4

10. COMMENTS ON ANY AND ALL ISSUES RELATED TO THE CONFERENCE, THE CURRICULUM, OR THE PRESENTERS.

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
November 30, 1988

EVALUATION SUMMARY (n = 99)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTER(S) PERCENT				OVERALL QUALITY OF PRESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
CONNOISSEURSHIP (N. Whitman)	30	54	16		35	51	14		27	53	18	2	82	18	69	23	9
EPIDEMIOLOGY (R. Hoffman)	22	57	19	2	30	43	22	4	19	55	20	6	87	13	77	12	11
IMMUNOLOGY/VIROLOGY (J. Vennes)	29	55	16		43	42	16		27	54	19		84	16	68	20	12
TREATMENT/CL. MANIFESTATIONS (G. Hertz)	23	64	12	1	33	45	21	1	19	62	20		90	10	78	12	11
KEYNOTE SPEECH (J. Arradondo)	70	25	5		76	19	4	1	73	20	7		89	11	74	16	10
PSYCHOSOCIAL ISSUES (panel)	40	42	17	2	29	54	16	1	29	50	19	2	88	12	78	15	7
ETHICS/LEGAL/POLICY ISSUES (panel)	65	31	3	1	67	29	3	1	66	30	3	1	94	6	94	4	2
AIDS PATIENT/PARENTS (panel)	89	11			75	24	1		88	12			99	1	93	6	

EXC (excellent), CD (good), FR (fair), PR (poor)

GENERAL	PERCENT EXC	GD	FR	PR
1. Relevance of conference so far:	44	49	6	1
2. Usefulness of conference so far:	39	48	13	
3. Overall quality of conference so far:	37	60	3	

4. COMMENTS AND/OR SUGGESTIONS:

GENERAL COMMENTS

- The *conference* and curriculum represented a lot of work, for which participants were appreciative. Some feeling for less "sit" time vas expressed.
- The panels were excellent and helpful. Stefan, Mike and June especially were praised for their openness.
- Some participants commented that more information on the teaching of curriculum content was necessary. Others commented that more detailed information on content was necessary.
- The facilities generally were praised. However, several participants felt that more space per person would have been nice.

SELECTED SPECIFIC COMMENTS

- The immunology/virology presentation was at too high a level for many participants. Some also thought that the immunology/virology material in the curriculum is too detailed for use in the core.
- Afternoon topics were not as vell related to the curriculum as the morning topics.

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 1, 1988

OVERALL EVALUATION SUMMARY (n = 91)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTERS PERCENT				OVERALL QUALITY OF PRESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
INTRODUCTION TO ADULT LEARNING	49	41	10		60	32	8		48	42	9		95	5	81	9	10
CLIMATE SETTING	52	39	8		61	33	6		51	40	8		96	4	82	8	10
SELF-ASSESSMENT	52	39	9		59	36	5		49	42	8		95	5	84	9	8
CULTURAL/ATTDNL FACTORS	45	38	17		57	34	10		46	39	13	1	88	12	80	9	10
USE OF VIDEOTAPES	48	39	12		60	31	9		50	39	11		97	3	80	8	$2
VALUES CLARIFICATION	58	33	9		66	27	7		57	33	8	1	94	6	83	7	10
LOSS EXERCISE	57	26	13	5	63	28	8	1	54	31	12	4	87	13	76	13	11
CASE STUDIES/ROLE PLAYS	40	41	18	1	44	47	8	1	36	44	20		87	13	73	16	11
ADULT LEARNING PRINCIPLES	50	36	14		57	33	10		48	38	14		92	8	82	7	11
PROBLEM LEARNERS	54	30	16		61	32	7		53	36	11		94	6	86	8	5
'THE CNA EXPERIENCE	57	33	8	2	67	27	7		57	33	10		95	5	84	7	10

EXC (Excellent), CD (Good), FR (Fair), PR (Poor)

GENERAL	PERCENT EXC	GD	FR	PR
1. Relevance of conference so far:	52	47	1	
2. Usefulness of conference so far:	52	46	2	
3. Overall quality of conference so far:	52	47	1	

4. COMMENTS AND/OR SUGGESTIONS:

GENERAL COMMENTS:

- This day was extremely useful. Most participants commented that they learned valuable teaching strategies for use in the future. A few suggested that this material precede that presented on Day 1.
- It might have been helpful to preview videos during the evening or at mealtimes. A book sale would also be valuable for those from rural areas.

SELECTED SPECIFIC COMMENTS:

- The three presenters were repeatedly praised for their expertise, style, and level of involvement.
- Several participants in Zoe-Ann's group commented that case studies went too long.
- Experience sharing among participants was helpful.

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 1, 1988

EVALUATION SUMMARY FOR PAT McCARTHY (n = 30)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTER PERCENT				OVERALL QUALITY OF PRESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
INTRODUCTION TO ADULT LEARNING	48	38	14		59	34	7		46	43	11		96	4	76	3	21
CLIMATE SETTING	57	30	13		67	27	7		50	37	13		97	3	77	7	17
SELF-ASSESSMENT	57	30	13		63	33	3		53	33	13		97	3	80	3	17
CULTURAL/ATTDNL FACTORS	50	32	18		68	29	4		50	36	14		96	4	76	3	21
USE OF VIDEOTAPES	57	33	10		67	27	7		50	37	13		97	3	77	3	20
VALUES CLARIFICATION	64	32	4		76	24			64	29	7		93	7	79	4	18
LOSS EXERCISE	69	23	8		67	30	4		63	26	11		96	4	74		26
CASE STUDIES/ROLE PLAYS	50	27	20	3	53	33	10	3	43	33	23		87	13	72	10	17
ADULT LEARNING PRINCIPLES	56	33	11		63	33	4		56	33	11		96	4	74	4	22
PROBLEM LEARNERS	68	14	18		68	29	4		64	25	11		96	4	82	4	14
THE CNA EXPERIENCE	70	15	15		76	19	5		65	20	15		95	5	29	5	19

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 1, 1988

EVALUATION SUMMARY FOR ZOE-ANN FITZHUGH (n = 30)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTER PERCENT				OVERALL QUALITY OF PR ESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
INTRODUCTION TO ADULT LEARNING	54	39	7		62	31	7		57	36	7		100		96	4	
CLIMATE SETTING	56	41	4		61	36	4		63	33	4		100		88	4	8
SELF-ASSESSMENT	55	41	3		61	36	4		54	43	4		100		96	4	
CULTURAL/ATTDNL FACTORS	50	36	14		61	29	11		52	37	7	4	93	7	88	8	4
USE OF VIDEOTAPES	43	46	11		65	31	4		52	41	7		96	4	81	19	
VALUES CLARIFICATION	62	31	7		70	22	7		62	31	8		100		96	4	
LOSS EXERCISE	60	20	17	3	72	17	7	3	59	28	10	3	86	14	79	21	
CASE STUDIES/ROLE PLAYS	31	48	21		39	54	7		31	45	24		96	4	81	15	4
ADULT LEARNING PRINCIPLES	45	45	10		52	43	5		42	53	5		100		90	5	5
PROBLEM LEARNERS	39	48	13		52	39	9		43	48	10		96	4	90	10	
THE CNA EXPERIENCE	48	48		5	60	35	5		50	45	5		95	5	90	5	5

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 1, 1988

EVALUATION SUMMARY FOR HELEN MIRAMONTES (n = 31)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTER PERCENT				OVERALL QUALITY OF PRESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	GD			NO	
	55	45	10		59	31	10		41	40	10		89	11	72	20	8
CLIMATE SETTING	44	48	7		56	37	7		41	52	7		92	8	83	12	4
SELF-ASSESSMENT	42	46	12		52	41	7		41	52	7		88	12	75	21	4
CULTURAL/ATTDNL FACTORS	35	46	19		41	44	15		37	44	18		72	28	78	17	4
USE OF VIDEOTAPES	45	39	16		48	36	16		40	39	13		97	3	82	4	15
VALUES CLARIFICATION	40	35	17		50	36	14		46	39	11	4	88	12	75	12	12
LOSS EXERCISE	43	33	13	10	50	37	13		40	40	13	7	79	21	75	18	7
CASE STUDIES/ROLE PLAYS	39	48	13		39	55	6		32	55	13		80	20	67	23	10
ADULT LEARNING PRINCIPLES	48	32	20		54	25	21		44	32	24		81	19	85	12	4
PROBLEM LEARNERS	52	32	16		62	29	8		50	38	12		88	12	88	12	
THE CNA EXPERIENCE	53	37	10		63	26	10		56	33	11		95	5	85	10	5

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Train-the-Trainer Conference
December 2, 1988

EVALUATION SUMMARY (n = 82)

EX (Excellent), GD (Good), FR (Fair), PR (Poor)

TOPIC	CLARITY OF PRESENTATION PERCENT				EDUCATIONAL SKILLS OF PRESENTER PERCENT				OVERALL QUALITY OF PRESENTATION PERCENT				DID YOU RECEIVE INFORMATION THAT WILL BE USEFUL TO YOU: AS AN AIDS TRAINER? PERCENT		AT WORK? PERCENT		
	EX	GD	FR	PR	EX	GD	FR	PR	EX	GD	FR	PR	YES	NO	YES	NO	NA
EDUCATION AS A CHANGE PROCESS (R. Saylor)	40	41	19		54	34	10	1	31	52	17		85	15	72	25	3
EDUCATION TO MEET LOCAL NEEDS (N. Whitman)	70	26	4		82	17	1		70	25	5		99	1	90	9	1
DISCIPLINE-SPECIFIC SESSION OVERALL RATING	31	47	18	4	48	39	10	3	33	51	14	1	92	8	87	13	
Dentistry (n = 10)	80	20			80	20			90	10			100		100		
EMT (n = 10)	40	60			50	30	20		40	50	10		100		100		
Nursing (n = 23)	22	61	13	4	56	39	4		27	64	9		87	13	87	13	
Physician/PA (n = 19)	16	53	26	5	26	53	10	10	16	53	26	5	94	6	84	16	
Social work (n = 8)	35	38	25	12	62	38			25	50	25		100		75	25	

1. In your opinion, has anything been OMITTED from this curriculum that is NECESSARY for your discipline? 32% yes 60% no 8% NA

   COMMENT: General summary lecture: burnout and stress: teambuilding; crisis theory: death, dying, grieving: health care workers psychosocial issues; overcoming irrational fear that interferes with quality care; public health information: names of discipline-specific journals for updates; DDS, treatment and sp. precautions

2. In your opinion, has anything been INCLUDED in this curriculum that is UNNECESSARY for your discipline? 19% yes 75% no 6% NA

3. Does the curriculum for your discipline read clearly?
   92% yes 3% no 6% NA

4. In your opinion, does the curriculum make a useful contribution to your discipline? 94% yes 3% no 4% *NA*

5. *From* the evaluation presentation, was it clear that every training event involving this curriculum, no matter how short, must be evaluated? 88% yes 12% no

6. From the evaluation presentation, was it clear what evaluation tasks are required of you in your role as an AIDS *trainer?*
   88% *yes* 10% *no* 3% *NA*

7. Did you get all the information YOU needed at the conference in order to teach this curriculum:

   a. to others in your discipline? 80% yes 16% *no* 4% *NA*

      COMMENT: not sure yet; not sure what role is: need state-specific data: need slides: need more "how to" practical learning experience

   b. to other health professionals? 76% yes 16% no 8% NA

      COMMENT: not sure yet: not sure what role is: need state-specific data: need more "how to" practical learning experience

8. Do you think that you need clinical experience with AIDS patients BEFORE you can teach this curriculum to others?
   27% yes 64% no 10% NA

9. Please rate the following:	PERCENT EXC	GOOD	FAIR	POOR
a. overall relevance of the conference	60	39	1	
b. overall usefulness of the conference	48	48	5	
c. facilities at the conference	89	11		
d. amenities (e.g., refreshments)	75	25		
e. length of the conference	31	52	17	
g. overall quality of the conference	52	45	2	

10. GENERAL COMMENTS:

- Generally, quite complimentary about conference and curriculum.
- Neal Whitman specifically and repeatedly praised.
- Requests for more breaks, a public health breakout session, more small groups, and *more* time for individual state team planning

APPENDIX IX

Instruments for Evaluating Mini-Sabbaticals

1. Regional Instrument
2. Nebraska Modification of the Regional Instrument
3. New Mexico Instrument

MOUNTAIN-PLAINS REGIONAL AIDS ETC
Mini-Sabbatical Evaluation

Please give us your thoughtful and complete evaluation of your mini-sabbatical experience. This information will be used to structure the experience for others as well as to provide an overall assessment of the educational enhancement that a clinical learning experience such as this can provide for health professionals.

If you would like to make a personal comment about your mini-sabbatical experience, please call Lorraine Adams, M.S.W., at 355-1501 or Richard Call, D.M.D. at 270-5885.

NAME _____

DISCIPLINE AND SPECIALTY _____

DATES OF MINI-SABBATICAL EXPERIENCE _____

What were your primary goals for the mini-sabbatical experience?

_____

_____

What is your overall assessment of the quality of the mini-sabbatical experience?

__ Excellent __ Good __ Fair __ Poor

What is your assessment of the usefulness of the following components of the mini-sabbatical experience for meeting your personal goals?

Colorado AIDS Project __ Excellent __ Good __ Fair __ Poor __ NA
__ Wed PM
__ Support Group (Tues, Thurs)
__ Resource Group (Wed night)

Counseling and Testing site (UH) __ Excellent __ Good __ Fair __ Poor __ NA

Denver Nursing Project for Human Caring __ Excellent __ Good __ Fair __ Poor __ NA

Hemophilia clinic (UH) __ Excellent __ Good __ Fair __ Poor __ NA

Hospice of St. John __ Excellent __ Good __ Fair __ Poor __ NA

ID clinic at DGH __ Excellent __ Good __ Fair __ Poor __ NA
__ Tues PM
__ Wed AM

ID clinic at UH (Fri PM) __ Excellent __ Good __ Fair __ Poor __ NA

continued

ID clinic at VA (Fri AM) __ Excellent __ Good __ Fair __ Poor __ NA

ID rounds: __ Excellent __ Good __ Fair __ Poor __ NA
__ DG
__ UH
__ VA

Infection control __ Excellent __ Good __ Fair __ Poor __ NA
__ UH
__ VA

Kaiser Case Management __ Excellent __ Good __ Fair __ Poor __ NA

Laboratory (CO. Dept. of Health) Excellent __ Good __ Fair __ Poor __ NA

Visiting Nurses Association __ Excellent __ Good __ Fair __ Poor __ NA
__ Discussion
__ Home Visit

Other _____ (specify) __ Excellent __ Good __ Fair __ Poor __ NA

Other _____ (specify) __ Excellent __ Good __ Fair __ Poor __ NA

Other _____ (specify) __ Excellent __ Good __ Fair __ Poor __ NA

Comments _____

_____

_____

Was the length of the mini-sabbatical experience long enoush for you to meet your goals? __ yes __ no

Comments _____

_____

_____

Were your personal goals for the mini-sabbatical experience met?

__ **yes** __ no Comments _____

_____

_____

What was the most useful part of your mini-sabbatical experience?

What was the least useful part of your mini-sabbatical experience?

Did you gain skills and/or knowledge from the mini-sabbatical that you can use in your work or practice? __ yes __ no

Comments

What suggestions can you offer to improve the mini-sabbatical experience for others?

General comments or suggestions

Thank you very much for your help. Please return this form to Lorraine Adams in person or mail it to: Mountain-Plains AIDS ETC, 4100 E. 9th Avenue, Box A-096, UCHSC, Denver, CO. 80262

MOUNTAIN-PLAINS REGIONAL AIDS ETC NEBRASKA

Mini-Sabbatical Evaluation

Please give us your thoughtful and complete evaluation of your mini-sabbatical experience. This information will be used to structure the experience for others as well as to provide an overall assessment of the educational enhancement that a clinical learning experience such as this can provide for health professionals.

If you would like to make a personal comment about your mini-sabbatical experience, please call Lanyce Keel at 559-6681.

NAME _____

DISCIPLINE AND SPECIALTY _____

DATES OF MINI-SABBATICAL _____

What were your primary goals for the mini-sabbatical experience?

_____

_____

What is your overall assessment of the quality of the mini-sabbatical experience?

Excellent Good _____ Fair Poor

What is your assessment of the usefulness of the following components of the mini-sabbatical experience for meeting your personal goals?

VS Clinic at UNMC	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Rounds at UNMC	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Dental Clinic at UNMC	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Immunology Lab	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Hemophilia Clinic at UNMC	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Counseling/Testing	_ Excellent	_ Good	_ Fair	_ Poor	_ NA
Research Labs	_ Excellent	_ Good	_ Fair	_ Poor	_ NA

Comments _____

_____

_____

Was the length of the mini-sabbatical experience long enough for you to meet your goals? _ yes __ no

Comments _____

_____

Were your personal goals for the mini-sabbatical experience met? __ yes _ no

Comments _____

_____

What was the most useful part of your mini-sabbatical experience?

_____

_____

_____

What was the least useful part of your mini-sabbatical experience?

_____

_____

_____

Did you gain skills and/or knowledge from the mini-sabbatical that you can use in your work or practice? _ yes _ no

Comments _____

_____

What suggestions can you offer to improve the mini-sabbatical experience for others?

_____

_____

General comments or suggestions

_____

_____

_____

_____

Thank you very much for your help. Please return this form to Lanyce Keel in person or mail it to: Nebraska AIDS ETC, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68105-5130.

1/19/90

New Mexico AIDS Education & Training Center
Minisabbatical Evaluation

Name: _____ Dates: _____

A. How did you learn about the program?

B. Logistics
1. Were you adequately informed regarding your schedule and locations for various activities?

2. Were there any specific logistical problems?

C. Education
1. Was your experience tailored to your level of expertise?

2. Did the pr'ogram meet your expectations? Explain.

3. Were your educational objectives met?

4. What were the most valuable aspects of the program?

5. What were the least valuable aspects of the experience?

D. What suggestions do you have for the minisabbatical program?

APPENDIX x

Evaluation of Effectiveness -- KABB Aggregate Analysis

KNOWLEDGE ITEMS (NM AND WY)
PRETEST AND POSTEST EVALUATION

1. The Human Immunodeficiency Virus (HIV) is the causative organism in Acquired **ImmunoDeficiency** Syndrome (AIDS) and AIDS-Related Complex (ARC).

   There is evidence that HIV may be transmitted from an infected person to an uninfected person by:

2. heterosexual intercourse

3. donating blood

4. mosquito bites

5. A person infected with HIV may have no symptoms but will be able to transmit the virus to others.

6. After a person develops antibodies to HIV, he/she will not develop the disease and is no longer infectious to others.

7. Women who are infected with HIV can transmit the virus to their fetuses during pregnancy.

8. All patients who are HIV seropositive have AIDS.

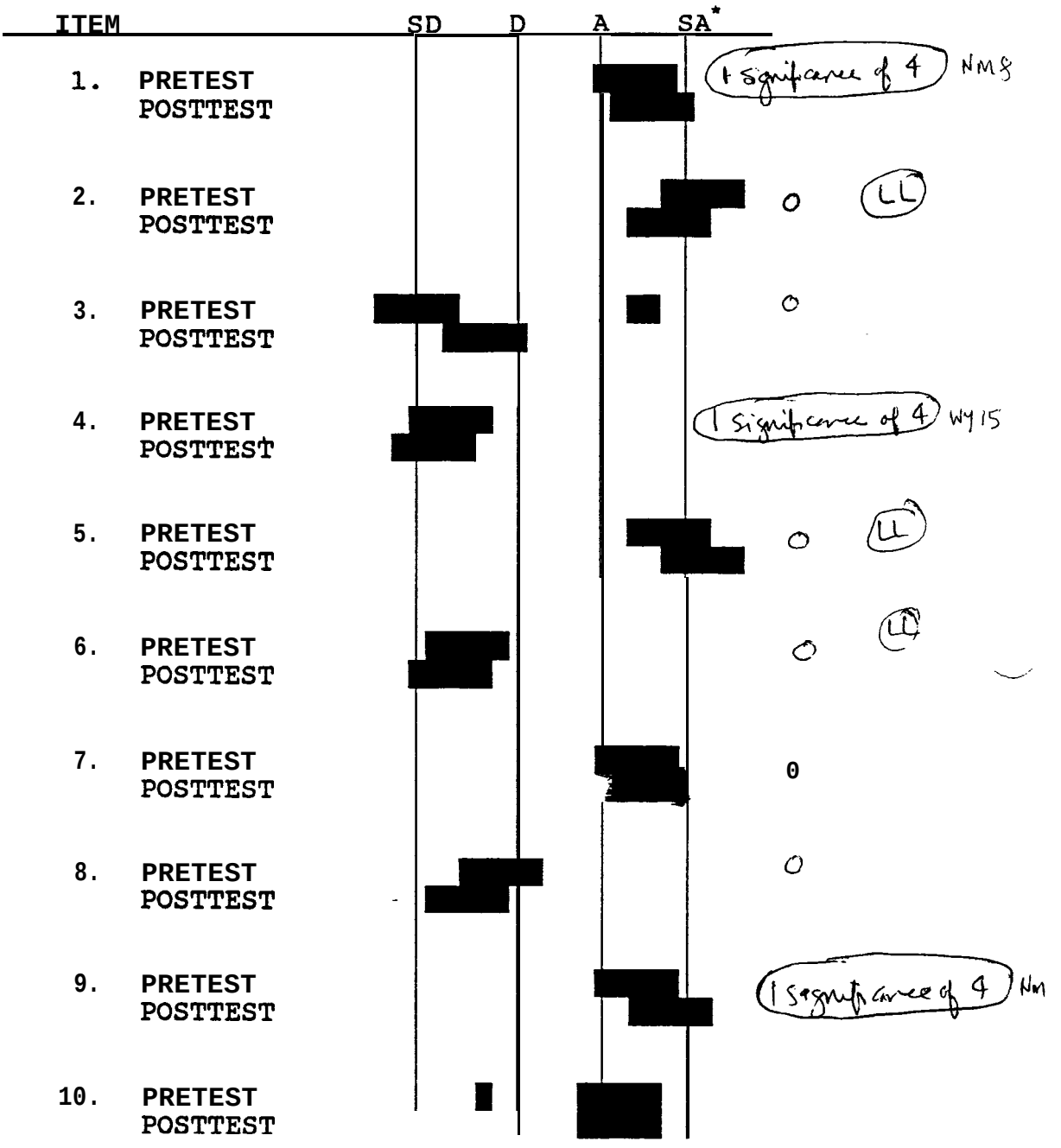
9. Specimens, tissue, and blood samples from all patients should be handled with the same precautions as those used for Hepatitis B patients.

10. A health care worker who is accidently pricked with ~~a~~ needle containing traces of blood from an HIV+ client is at minimal risk of acquiring the HIV virus.

ns 69 } NM
14 }
10 } WY
29 }
122

1/90

KNOWLEDGE **ITEMS (NM and WY)**
PRETEST-POSTTEST RESULTS

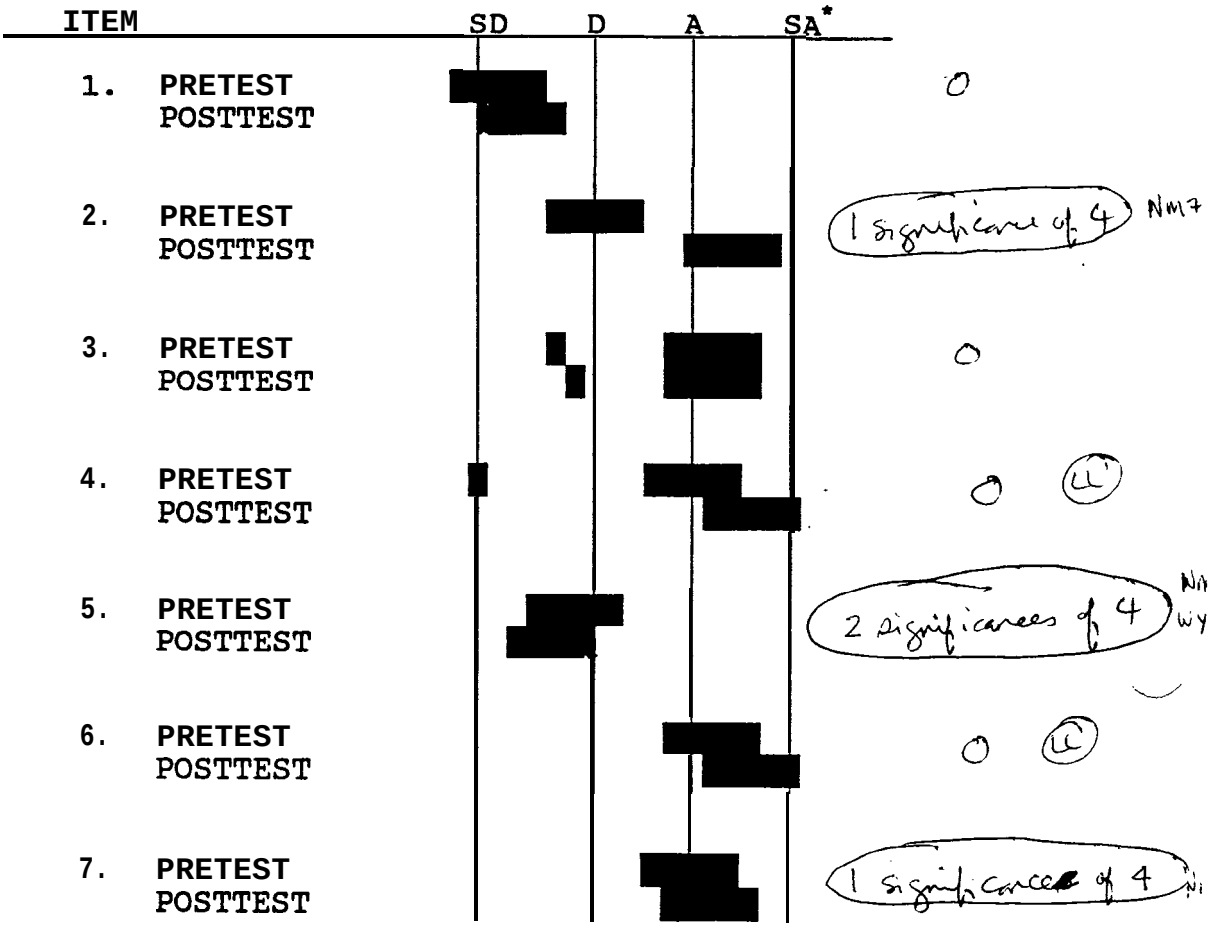


. SD, STRONGLY DISAGREE; D, DISAGREE; A, AGREE; SA, STRONGLY AGREE

ATTITUDES/BELIEFS ITEMS (NM AND WY)
PRETEST AND POSTEST EVALUATION

1. Most people who get AIDS deserve it because of their behavior.
2. If I had a choice, I would choose to work with HIV+ people.
3. People who are HIV seropositive should be reported to protect the public health.
4. All patients should be placed on universal precautions.
5. Masks, gowns, and gloves should be worn during all contact with HIV+ patients.
6. I have sufficient knowledge to protect myself from HIV.
7. I feel comfortable touching an HIV+ patient.

ATTITUDE/BELIEF ITEMS (NM and WY)
PRETEST-POSTTEST RESULTS



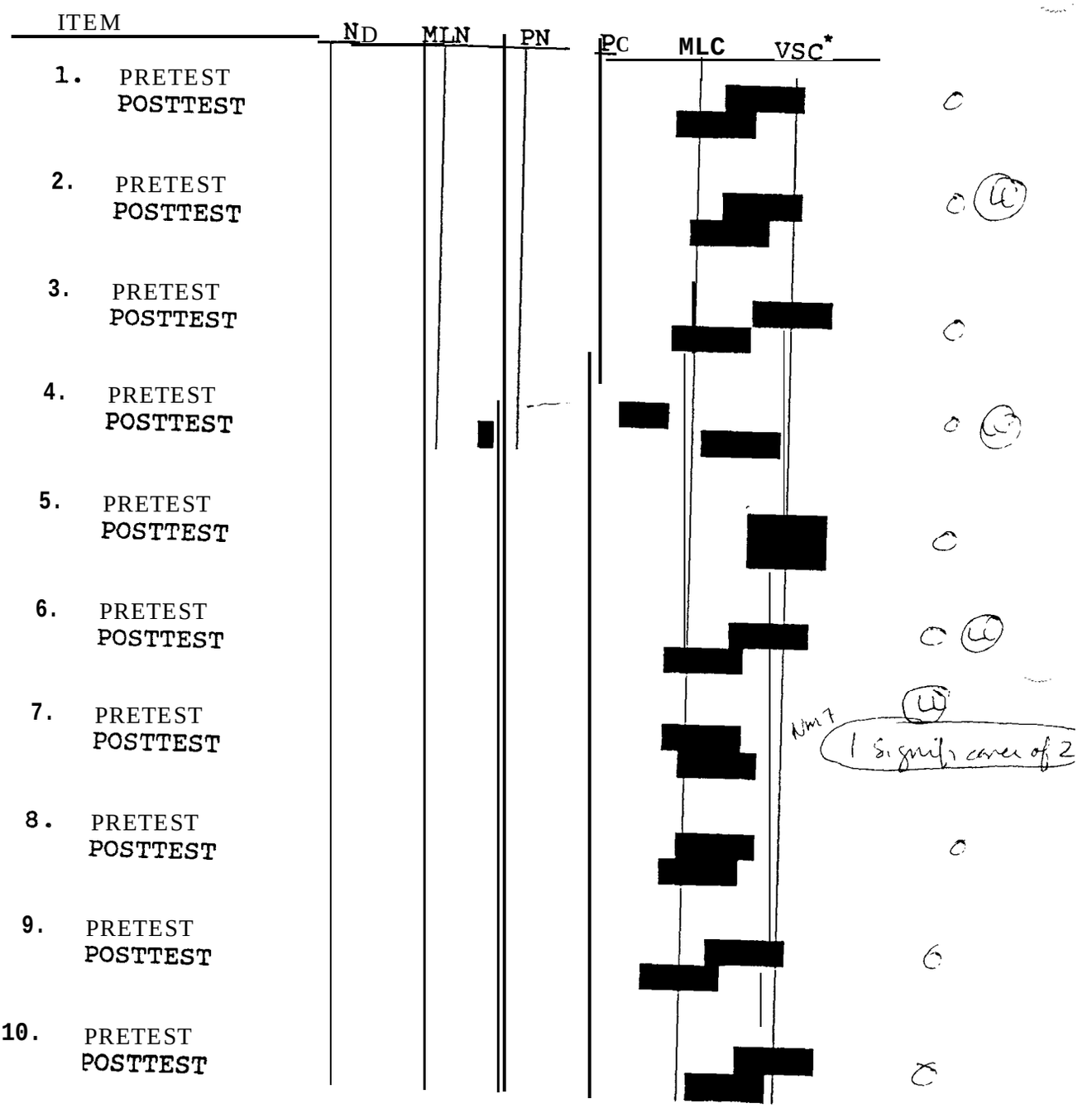
* SD, STRONGLY DISAGREE: D, DISAGREE: A, AGREE: SA, STRONGLY AGREE

BEHAVIOR ITEMS (NM)
PRETEST AND POSTEST EVALUATION

How sure are you that you could:

1. provide support to the significant other(s) of an HIV positive patient?
2. protect yourself from HIV infection in a work situation?
3. wear gloves when coming into contact with potentially infectious materials?
4. start CPR on an HIV positive patient?
5. maintain the confidentiality of an HIV positive patient?
6. ask a male client if he ever had sex with another man?
7. clean up human blood spills appropriately?
8. interact with an HIV infected client the same as with any other client?
9. be comfortable discussing relationship problems with a homosexual couple?
10. ask IV drug users about their habits without being judgmental?

BEHAVIOR ITEMS (NM)
PRETEST-POSTTEST RESULTS



. ND, NEVER DO; MLN, MOST LIXELY NOT: PN . PROBABLY NOT; PC, PROBABLY COULD; MLC, MOST LIKELY COULD; VSC, VERY SURE COULD

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MOUNTAIN-PLAINS REGIONAL AIDS ETC EVALUATION

USING A NO. 2 PENCIL, COMPLETELY DARKEN A SINGLE OVAL FOR EACH QUESTION BELOW UNLESS INSTRUCTED TO DO OTHERWISE.

SOCIAL SECURITY NUMBER
(last six digits only)

Mark one digit in each box and fill in the oval representing the same digit in the column below the box.

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

YOUR OVERALL EVALUATION OF THIS PROGRAM IS: ○ Excellent ○ Fair ○ Good ○ Poor

WILL YOU USE INFORMATION ACQUIRED IN THIS PROGRAM TO CHANGE YOUR APPROACH TO HIV INFECTION AT WORK?
○ Yes **0 No** **0** Not applicable

DID THIS PROGRAM MEET **ITS STATED OBJECTIVES?**
○ Completely ○ Partially ○ Not at all ○ Objectives not stated

DID THIS PROGRAM MEET YOUR PERSONAL OBJECTIVES?
○ Completely ○ Partially ○ Not at all

SEX ○ Female ○ Male

AGE ○ under 21 ○ 21-25 0 **26-35** **0 36-45** ○ **46-55** ○ **56-65** **0 66-70** **0** over **70**

WITH WHAT ETHNIC GROUP DO YOU PRIMARILY IDENTIFY?
○ Asian ○ White, non-Hispanic ○ Native American (Indian) ○ Hispanic ○ Black

WHERE DO YOU LIVE?
○ CO ○ ND ○ NM O U T ○ Other ○ KS O N E ○ SD ○ WY

HOW MANY HOURS PER WEEK DO YOU WORK AT YOUR JOB?
○ less than 40 ○ 40 or more

DO YOU PROVIDE HEALTH CARE SERVICES DIRECTLY TO CLIENTS?
○ Yes **0 No**

WHICH ONE OF THE FOLLOWING DISCIPLINES BEST DESCRIBES YOUR CURRENT OR MOST RECENT PROFESSIONAL ACTIVITY?

DENTAL
○ Dentist
○ Dental hygrenist
0 Dental assistant
0 Student

GENERAL AND MENTAL HEALTH CARE
0 Counselor
○ EMT/Paramedic
0 Nurse
0 Physician assistant
○ Physician (specialty

○ **Advanced** Certification in Nursing
○ Psychologist
○ Social worker
○ Student

OTHER
○ Health administrator
○ Health educator
0 Lay volunteer
○ Other health
○ Non-health

HOW MANY PEOPLE LIVE IN THE CITY/TOWN IN WHICH YOU WORK?
0 under 10,000 0 10,000 to 35,000 0 35.000 to 70,000 ○ 70,000- 100,000 ○ over 100,000

WHAT IS YOUR HIGHEST COMPLETED LEVEL OF EDUCATION?
0 High school diploma 0 Baccalaureate degree (eg. BA. BS) ○ Vocational/certificate program ○ Master's degree 0 Associate degree ○ Doctoral degree

WHICH OF THE FOLLOWING BEST DESCRIBES THE AREA IN WHICH YOU PRIMARILY WORK? (Select only one)
○ Mental health care
○ General acute care medicine
○ Long-term care/rehabilitation
○ General out-patient care
○ Public health agency
○ Ambulance service/fire dept.
○ **AIDS** service organization
○ Alcohol/drug abuse program
○ Education
○ Home health
○ Hospice
○ Other health care _____
○ Non-health care (SKIP TO GRID AT BOTTOM OF FORM)

HOW MANY YEARS HAVE YOU BEEN WORKING IN YOUR CURRENT PROFESSION?
0 1-5 0 11-15 ○ 21-25 ○ over 30
0 6-10 0 16-20 ○ 26-30

TO THE BEST OF YOUR KNOWLEDGE, HOW **MANY TIMES IN THE LAST YEAR HAVE YOU PROVIDED PROFESSIONAL SERVICES TO HIV+ CLIENTS?**
○ 0 ○ 6- 15 times ○ over 25 times
0 l-5 times 0 16-25 times ○ Don't know

ESTIMATE THE NUMBER OF AIDS EDUCATION AND TRAINING COURSES YOU HAVE PREVIOUSLY ATTENDED.
0 None 06-10 0 16-20 ○ over 25
0 1-5 ○ '1-15 ○ 2-l-25

ESTIMATE WHAT PERCENTAGE OF THE FOLLOWING GROUPS YOU CURRENTLY SERVE?

	PERCENTAGE					
	NONE	l-25	26-50	51-75	76-99	100
Adolescents	0	0	0	0	0	0
Hemophiliacs	0	0	0	0	0	0
Homosexuals/bisexuals	○	○	○	○	○	○
Substance abusers	○	○	○	○	○	○
Asians	○	○	○	○	○	○
Blacks	0	0	0	0	0	0
Hispanics	0	0	0	0	0	0
Native Americans (Indians)	0	0	0	0	0	0

RESERVED FOR REGIONAL OFFICE USE

○	○	○		○	○	○	○	○	○
○	○	○		○	○	○	○	○	○
○	○	○		○	○	○	○	○	○
0	○	○		○	○	**0**	○	○	○
○	○	○		○	○	○	○	○	○
○	○	○		○	○	○	○	○	○
○	○	○		○	○	○	○	○	○
○	○	○		○	○	**0**	○	○	○
○	○	○		○	○	○	○	○	○

!! WRITE PRESENTERS IN PRESENTING ORDER !!

	RELEVANCE				CLARITY				EDUCATIONAL SKILLS				KNOWLEDGE			
	EXC	GD	FR	PR	EXC	GD	FR	PR	EXC	GD	FR	PR	EXC	GD	FR	PR
PRESENTER/PANEL # 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PRESENTER/PANEL #2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PRESENTER/PANEL #3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PRESENTER/PANEL #4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PRESENTER/PANEL #5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

NEW ENGLAND AIDS EDUCATION AND TRAINING CENTER

EVALUATION REVIEW

I. OVERVIEW

The New England AIDS Education and Training Center (NEAETC) is based at the Statewide AHEC Office at the University of Massachusetts Medical School in Worcester, Massachusetts. As initially funded, the ETC covered the states of Massachusetts, Rhode Island, Maine, New Hampshire and Vermont. In the second year of the project, the region was expanded to include Connecticut. The three northern states (Maine, New Hampshire and Vermont) are served through a subcontract with the Maine Consortium for Health Professions Education.

Programs offered include faculty development, train-the-trainers, mini-residencies, regional conferences and programs targeting providers of care to minority populations. The program also focuses on impacting students in professional schools and residents.

The core of the NEAETC's evaluation is the collection of output data; subcontractors are required to provide specified output data on all courses. The NEAETC staff evaluate its faculty development programs and coordinate follow-up evaluation of its own faculty development programs as well as the mini-residencies of its subcontractors. Subcontractors are responsible for evaluating the programs they present with the format and intensity left to their discretion. Most do formative evaluation of the events; some use pre/post or post-only questionnaires to measure program effectiveness.

II. ADMINISTRATION OF THE EVALUATION PROCESS

A. The Evaluation Plan

The NEAETC's evaluation plan emphasized both formative and summative evaluation.

Formative Evaluation. Formative evaluation was planned to provide information to ETC staff to assist them in the process of developing effective programming.

Summative Evaluation. Summative evaluation was planned to provide information to the national AIDS ETC office, to help document use of federal dollars as well as the effectiveness of various approaches.

The ETC's evaluation was to be aimed at answering five basic evaluation questions:

What is being done?

Data aimed at answering this question included:

- structure and function of various steering committees created for planning and coordination of ETC efforts

- number of programs offered, by type of program, length, content and location for each program component
- number of participants for each type of training, by discipline, and type of practice, or type of resident or student
- changes in curriculum
- description of various teaching materials or resources developed with ETC funds and their use

Is the program effective?

Evaluation methods aimed at answering this question included:

- Short Programs. Post-training participant evaluation, via questionnaire, of speakers, the importance or value of program emphasis, with suggestions for future programs.
- Mini-Residencies/Faculty Development Programs. Pre-post tests were to be utilized to assess changes in attitude or information retained. To the extent possible, the ETC intended to use instruments, scales or questionnaires obtained from the literature or through the ETC network, particularly in the attitudinal domain.

  Three to six months after the completion of the above programs, participants were to be followed up. Faculty development programs were to be assessed in terms of the new teaching programs participants have implemented, the ETC curriculum suggestions that have been adopted, or the teaching materials that have been utilized. Mini-residencies were to be assessed in terms of the impact on care provided for the AIDS patients of program participants, the referral patterns of participants, and the participant's use of community resources.

Is the program cost-effective?

Evaluation data aimed at answering this question included:

- Cost per participant. Cost data was to be analyzed for each program component with the recognition that this ratio would vary depending on length, intensity of training, purpose of the program, etc.

Has the ETC contributed productively to the ongoing efforts of the various organizations/facilities collaborating in the project?

Evaluation methods aimed at assessing collaboration included:

- Qualitative assessment, via periodic interviews, to obtain information on the contribution made by the ETC to the ongoing education efforts of its subcontractors were to be conducted through the three-year project period.

Has the ETC made a contribution to the development of multi-disciplinary, community-based care for AIDS patients in communities throughout the region?

Evaluation methods aimed at answering this question included:

- o Qualitative assessment which was to attempt to correlate training outputs with measures of changes in service, particularly progress on the development of regional systems for care of AIDS patients and changes in referral patterns. Information-gathering for this assessment was to include interviews with individuals responsible for the provision and planning of health care for individuals with HIV infection. These assessments were to be made periodically throughout the program.

For the most part, the evaluation plan with regard to education and training activities has been implemented as initially conceived. cost analysis has been minimal and the qualitative evaluations of the collaboration process and the degree to which training has contributed to multi-disciplinary systems of care have not yet been undertaken in a formal way.

B. Locus of Responsibility

1. Staff Responsibility

Oversight of evaluation activities of the ETC is provided by the Program Administrator, Alan Chuman, M.P.H. Mr. Chuman spends 40% of his time on ETC activities, of which evaluation is only one of his responsibilities. He concurrently serves as Associate Director of the Massachusetts Statewide AHEC Program and has been responsible for evaluating data management and manpower studies for the AHEC program since its inception.

Mr. Chuman is responsible for conducting six-month follow-up evaluations of programs such as faculty development workshops and mini-residencies to assess the utility of the program and the degree to which it resulted in additional training programs being conducted by the participants.

2. Contractor Responsibility

Each subcontractor is responsible for conducting an evaluation of each of its own programs. While subcontractors are required to do some type of evaluation, only the nature of the output data is specified. The format of any additional evaluation is negotiable, and varies according to the level of intensity of the training offering.

C. Coordination of Evaluation Activities

Coordination of evaluation activities across the ETC is rather informal. The NEAETC Program Administrator has sent some of the subcontractors copies of evaluation tools used by the AHECs and others to serve as examples. The NEAETC staff make themselves available to assist subcontractors in developing evaluations should they request it. In addition, the Program Administrator assists some of the contractors by tabulating and interpreting their evaluation results.

The primary forum for formal coordination of evaluation activities is the semi-annual meeting attended by all subcontractors as part of the management function. During this meeting, the discussion is said to frequently turn to evaluation issues. Minutes of these meetings confirm this.

The NEAETC maintains quality control over the subcontractors activities by ensuring that an ETC staff member or an AHEC representative attend most of the offerings. The Program Coordinator most frequently serves the quality control function.

D. Reporting of Findings

The NEAETC Program Administrator prepares a report on each of the follow-up evaluations he conducts. These reports include an aggregation of the data; the extent of analysis varies somewhat depending on the number of respondents. In addition, he attaches a cover letter interpreting the findings; interpretations have become more and more substantive over time.

Subcontractors are expected to prepare evaluation reports on each training they conduct and submit these as a component of the final report. However, those subcontractors involved in the more intensive training efforts such as mini-residencies and faculty development workshops have tended to submit summary reports of their trainings more frequently, generally semiannually.

In the first six-month progress reports to HRSA, the NEAETC has included a summary of its evaluation activities. In more recent progress reports, descriptions of evaluation activities and findings have been lacking.

III. APPROACHES TO PROJECT EVALUATION

A. Project Monitoring

The ETC's goals and objectives in its original grant proposal are defined in terms of the activities it intended to carry out. These include:

- establish a mechanism for inter-institution collaboration
- provide faculty development and mini-residency training programs
- provide training on the prevention, diagnosis and treatment of HIV infection to practicing health professionals
- provide for development of curriculum and training opportunities for professional school students and residents
- provide for special focus training for health professionals serving minorities
- provide for coordination of ETC activities

- provide plan for continuation beyond project period

While the ETC generally prepares its reports according to the above-listed activities, the lack of specific targets and timeframes prevents the ETC from using the statement of goals as a framework for truly meaningful project monitoring.

Given the collaborative nature of the NEAETC, a great deal of monitoring of subcontractor activities occurs informally via ongoing and frequent contacts between the staff--particularly the Program Coordinator, the Health Educator, and the Program Administrator--and NEAETC subcontractors.

B. **Output Evaluation**

The analysis of output data serves as the core of the NEAETC's evaluation.

At the outset, the ETC has established targets for each of its training programs, for each of the three program years. These targets provide a frame of reference against which the ETC can measure actual level of activity. These targets are included in Appendix I.

In the first year, the ETC exceeded its overall target number of trainees by nearly 75%, reaching 7,606 individuals rather than the targeted 4,366. Targets were exceeded in all categories of training including the mini-residencies where 115 providers were trained rather than the 84 targeted.

Data is maintained on all programs sponsored or co-sponsored by the ETC, including program title, location, date, target population, number of participants by discipline, and co-sponsor. These data are collected via the Program Report and the Attendance Report forms developed by the NEAETC. The Program Report gathers data by offering, be it one hour, one day, two days or multiple sessions. Data gathered on the Program Report form include:

Program title
Coordinator's name
Sponsoring agency(s)
Date(s)
Location
- Number of contact hours
Number of sessions
- Type of program (faculty development, mini-residency, in-service, train-the-trainer, conference)
Format (lecture, panel, grand rounds, consultation clinic, clinical practicum, audiovisual, workshop, small group)
Registration fee (yes/no)
CEUs (yes/no)
- Evaluation methods used

The Attendance Report form enumerates the attendees by crossing "provider type" (medical resident, physician, dentist, nurse, nurse practitioner, physician assistant, social worker, dental hygienist, other) with "practice setting" (hospital, private practice, community health center, educational

institution, other). A sample of the Program Report form and the Attendance Report form are included in Appendix II.

Subcontractors are required to complete these forms for all offerings and are asked to submit them to the NEAETC headquarters within a month of the offering's completion. More typically, the reports are batched and submitted semiannually. Most subcontractors prepare an analysis summary and submit it along with their progress reports. The Program Administrator reviews all reports. Depending on the results, he may follow-up with the Program Coordinator.

The ETC estimates that, realistically, it has hard numbers on about 80% of the programs under its sponsorship. For the most part, rather than determining actual counts of minority participants, estimates are made. However, evaluation forms for some events ask for this data directly. This information was gathered in one instance, for example, by phrasing the question "To fulfill Federal funding requirements the following optional information is requested."

No automated training database is maintained. Hard copy files are maintained at the NEAETC headquarters. It is estimated that approximately two days per year are required to make hand tabulations of the data required for reporting project outputs to HRSA.

C. Cost Efficiency and Cost Effectiveness

Across the board cost analyses have not yet been done; those analyses that have been performed have been done more for management purposes related to issues of budget and equity than for evaluative purposes. Analyses have been conducted for the faculty development and the conference components of the program. In the latter case, the unit of analysis has been the cost per "training day" which is defined as 5-6 contact hours rather than on cost per participant.

The NEAETC will undertake more extensive evaluative cost analysis when requested to do so by HRSA and when more definition is given to the purpose that such a cost analysis is meant to serve.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

The products developed by NEAETC have been primarily produced in the form of print media. The major audiovisual product produced under NEAETC auspices has been the videdtape "Haitians and HIV Infection," which has been subjected to extensive external expert review but no other form of formative evaluation.

V. APPROACHES TO EVALUATING INDIVIDUAL EDUCATION AND TRAINING INTERVENTIONS

A. Standardization of Evaluation ETC-Wide

The only truly standardized evaluation component ETC-wide is that for collecting output data as described in Section III.B. However, a relatively standard approach to the formative evaluation of training events and the

evaluation of training outcomes are evolving, although subcontractors are not required to follow this approach.

Informal NEAETC guidelines suggest that, for shorter programs, formative evaluation of the event be conducted along with a simple assessment of effectiveness. Standard approaches to formative evaluation are described in Section B below along with other approaches used by individual subcontractors.

Intensive programs tend to include both a formative evaluation of the event, along with a two-stage assessment of training outcomes (effectiveness and impact). The approaches to evaluating effectiveness and impact are described in Section C below.

B. Approaches to the Formative Evaluation of Training Events

The NEAETC uses the dual concepts of "educational quality" and "usefulness" as the focus of its approach to formative evaluation. Participants are asked to rate both the overall event as well as individual components on these two dimensions, generally using a 4 or 5-point rating scale. NEAETC formative evaluation instruments often contain open-ended questions, asking participants to identify the most useful and the least useful aspects of the event.

More focused formative evaluations are conducted on specific events, usually the more intensive ones. The faculty development program for primary care providers is one example of a program which conducts a more extensive formative evaluation. The methodology is described below in Section VI.B.

The format for the formative evaluation of individual events may deviate from the standard from time to time, particularly when the event is co-sponsored with other organizations. One example is the evaluation of workshops included in the "Creating AIDS Care Partnerships: The Clinical and Community Response to Mental Health Professionals." A copy of this instrument is included as Appendix III.

The Massachusetts Hospital Association uses its own format for formative evaluation. It considers seven questions:

- does the content fulfill the behavior objectives?;
- was the content presented in a logical and orderly progression?;
- was the content appropriate to the participants learning needs?;
- were the teaching methods used effective?;
- was the speaker well-prepared in quality and delivery of information?;
- was the time allotted for each presentation adequate?; and

- were the physical facilities adequate?.

The MHA's program evaluation instrument presents these questions as positive statements, asking whether participants agree or disagree along a 4-point scale. In addition, participants are asked the extent to which the information is new or repetitious. A copy of this instrument is included as Appendix IV.

C. Approaches to Evaluating Training Outcomes

Outcomes examined in NEAETC evaluations include effectiveness in conveying knowledge, effectiveness in increasing confidence in skill levels, impact in terms of changes in behavior and tasks, particularly training others, actually executed.

1. Evaluation of Program Effectiveness

The evaluation plan called for pre/post-training testing for mini-residencies and faculty development programs. This is actually done in one of two ways:

- pre and post-training testing; and
- post-training self-reporting.

Pre and Post-Training Testing. Pre/post-training testing is done by subcontractors according to their individual level of interest. The NEAETC does not push it. Two of the ETC's programs serve as examples of the use of pre and post testing for evaluating training effectiveness. Both examine the effectiveness of the program in the cognitive domain, i.e. the degree to which participants' knowledge increases as a result of the training.

The three-day faculty development program for primary care providers on substance abuse, developed jointly by the NEAETC staff and the Yale subcontractor, includes a fairly extensive evaluation of program effectiveness based on 88-item multiple choice test administered both at the beginning and the end of the training. The test is entirely knowledge-based and heavily clinical in nature. A copy of the test is included in Appendix V.

The Massachusetts Hospital Association's "AIDS: Train the Trainer Program" includes a pretest/posttest containing 15 fill-in questions, each keyed to one of the program's learning objectives. While this instrument is still used in conjunction with the course, the subcontractor questions whether the ability to memorize facts is a true measure of effectiveness. Therefore, the data are reviewed but not tabulated and no conclusions are drawn. A copy of this instrument is included in Appendix VI for purposes of documentation.

Post-Training Self-Reporting. For its more intensive courses, the NEAETC attempts to assess a course's effectiveness in terms of increasing participants' confidence in their own knowledge level or skill proficiency. At the end of the course, participants are asked to recall and rate their confidence level prior to the course, and then rate it as it is at the close of the course. The knowledge and skills examined correspond to those which are the focus of the course, and therefore vary from course to course.

Ratings are generally done on a 5-point scale. Section VI illustrates several applications of this methodology.

2. Evaluation of Program Impact

To evaluate the impact of the faculty development programs and the mini-residencies, a follow-up evaluation is scheduled to be conducted six months subsequent to the program. Questionnaires are mailed to participants from the NEAETC headquarters with a cover letter signed by the trainer. A month later, a blind reminder with a second copy of the questionnaire is sent to all participants to give those who have not yet responded a second chance to do so. As a result, the response rate has been very high.

Impact is measured in one or more of the following ways:

- participants' general assessment, in retrospect, of the utility of the course after having had an opportunity to return to work and try to apply what was learned;

- participants' more specific assessment, in retrospect, of aspects of the course that have been most useful as they have pursued their role 1) as an educator for residents, students or colleagues, and 2) as a provider of health care for persons with AIDS;

- identification of specific things that participants do differently as a result of having taken the course; and

- identification of new educational programs on HIV infection/AIDS that the participants have developed, coordinated or served as an instructor which can in some way be attributed to participation in the NEAETC course.

The results of the follow-up are summarized by the Program Administrator. Summaries along with a cover letter containing feedback are returned to the subcontractor.

D. Unique and Interesting Techniques Used

1. Self-Evaluation Testing

Under subcontract with NEAETC, the Somerville Portuguese American League developed a self-study manual for Portuguese-speaking health care professionals. Included in the manual is a self-evaluation questionnaire which focuses on misconceptions about a multiplicity of possible workplace risks and infection control precautions. The questionnaire and the answer sheet, which are included in Appendix VII, like the rest of the manual are in Portuguese.

2. Case Conference Debriefing

At the Rhode Island Hospital mini-residency site, informal assessment of effectiveness is built into the clinical experience. At this site, formal case conferences are held. Following the case conference, participants debrief with the trainers, providing feedback to the trainers on what the participants have learned.

3. Standardized Patients

The Standardized Patient methodology makes use of "actors" trained to respond as patients according to a specific protocol. The NEAETC has used this methodology with fourth year medical students and internal medicine residents to train them to educate and gather data from patients, and to evaluate their performance in doing so.

Two standardized cases were developed for fourth year medical students. 226 students at the University of Massachusetts, Brown University, University of Connecticut and Albany Medical School each spent 15 minutes with one standardized patient. They were asked to obtain a focused and relevant history, perform a relevant physical exam, develop a differential diagnosis, communicate their impressions and provide patient counseling.' The students were given written feedback on their performance. The use of the standardized patient methodology is ongoing for medical students in their third year internal clerkship at UMass.

Two standardized patients were also developed for use with the internal medicine residents. 221 internal medicine residents at 19 training programs in Massachusetts, Rhode Island, Connecticut and New York participated and were given written feedback on their performance.

VI. EVALUATIONS CONDUCTED

A significant amount of evaluation has been carried out by the NEAETC and its subcontractors, much of which was initiated at the outset of the project. Evaluation of some programs, such as the UMass Mini-Residency Program, did not begin in a substantial way until the second year. However, currently, evaluation is an integral part of all programs. For the most part, formal evaluation reports are prepared in each case. The evaluations conducted on the ETC's more intensive programs are described below.

A. Family Medicine Preceptor Conference

On September 16, 1988, NEAETC co-sponsored with the UMMC Department of Family and Community Medicine a one-day workshop on HIV infection for private practice physicians and others who serve as preceptors to third-year medical students at the UMass Medical School. The workshop, attended by 33 family physicians and pediatricians, included a didactic component covering epidemiology, testing and counseling, and clinical manifestations, a panel including foster parents of children with AIDS, and small group/role play sessions emphasizing counseling techniques.

The formative component of the workshop's evaluation indicated a positive response to the session; the evaluation of its effectiveness indicated

increased confidence on the part of participants in their knowledge of the primary care management of patients with HIV infection.

B. Faculty Development Program

The NEAETC faculty development program, "AIDS for the Primary Provider," is targeted toward faculty with responsibility for teaching medical students and/or residents. This two and a half day program has been held annually and has accommodated 19 participants in each round, the majority of whom were physicians.

The program is evaluated formatively, in terms of the quality of the educational experience, for its effectiveness in enhancing specific skill areas, and for its impact on improving the quality of AIDS teaching.

A pre-workshop questionnaire focuses on the congruence between the workshop objectives and the participant's personal objectives for attending the course. Thirteen knowledge and skill areas are identified:

- taking a sexual history
- counseling a patient worried about AIDS
- explaining the pros and cons of AIDS testing to patients
- giving a patient the results of an AIDS test
- advising a reluctant resident or colleague about the care of a patient with AIDS
- dealing with the first major illness of a patient with AIDS
- discussing advanced directives and preferences for terminal care for a patient with AIDS
- being aware of issues unique to minority patients
- being aware of issues unique to women and children
- counseling an IV drug user about AIDS
- dealing with significant others of a patient with AIDS
- understanding ethical issues
- understanding burnout

A major focus of the post-workshop questionnaire is to gain formative information on the structure, content and process of the workshop. The questionnaire includes:

- overall impressions of the educational quality of the program and its usefulness on a 5-point rating scale;

- assessment of the educational quality and usefulness of each of the eleven content modules on a 5-point scale;

- assessment of the value of the workshop's primary instructional methods (lectures, interviewing work groups, self-awareness groups,

written material) via both overall rating and specific rating of two of the methods in terms of educational quality of the experience, the usefulness of the experience, and the way the experience was or was not helpful in achieving the participant's own learning objectives;

- assessment of the individual facilitators, specifically what each did to help participants achieve their goals, and what each did that was least helpful;

- assessment of the educational "climate," defined in terms of the clarity, relevance and attainability of the educational objectives, degree to which the process is teacher or learner-centered, the flexibility and pace of the process, and the complexity and interest of the content; and

- open-end questions on the most useful and least useful aspects of the course;

The questionnaire taps the dimension of effectiveness by asking participants to rate their knowledge or proficiency in each of the same thirteen areas covered on the pre-training questionnaire both prior to training and after completing the workshop via a 5-point scale.

Aggregated post-training data from the first annual faculty development conference held in November 1988 indicated that the overall quality of the workshop was excellent and that the course was perceived as extremely useful. The interviewing workgroups, particularly the role play exercises, were considered the most valuable portions of the program. The lectures were considered least valuable, and were said to have been more technical than needed for primary care providers. All of the modules were rated similarly in terms of educational quality, with "Medical Aspects of Screening and Testing," "Medical Aspects of Infection Control," and "Intravenous Drug Use and AIDS" rated slightly higher in educational quality, and "intravenous Drug Use and AIDS" rated highest in usefulness. According to the participants self-assessment, the faculty development program was most effective in increasing their ability to counsel an IV drug user about AIDS and increase their awareness of issues unique to minority patients, improvement measuring 40% in each of these areas. Interestingly, participants registered a decline in their ability to explain the pros and cons of AIDS testing to patients after the workshop, perhaps because they were more sensitized to the complexities.

A follow-up questionnaire was mailed to the 19 participants by the NEAETC headquarters in June 1989. A reminder was mailed two months later. 18 participants responded for a response rate of 95%. The results indicate that their initial interest, measured at the end of the workshop, in using skill-building teaching methods such as case studies and role play in their teaching persisted. Another residual effect of the training was a more client-oriented view with regard to their clinical practice.

The primary impact of the workshop was measured by the degree to which participants actually engaged training activities utilizing information or

skills gained at the workshop. In the six-month period since the training, these 19 physicians had gone on to develop or conduct 18 programs for more than 600 participants.

The evaluation reports for the first annual faculty development workshop are included as Appendix VIII. A similar evaluation has been conducted for the second annual workshop but neither the post-training data nor the follow-up data were reviewed.

C. Brown University Hini-Residencies

Two mini-residencies are conducted under a subcontract with Brown University. Each includes a didactic component and a clinical component. The clinical experiences are provided through the Rhode Island Hospital and Meriam Hospital. The mini-residencies are targeted at primary care physicians, most of whom have had little experience with AIDS patients.

Formative evaluations of the didactic component of the first mini-residency suggested additional emphasis on the practical patient management and treatment issues for the primary care physician. Evaluation of effectiveness of the didactic component indicated increased confidence in providing various aspects of care for AIDS patients. Findings of more recent formative evaluations were not reviewed.

The immediate post-training evaluation of the didactic sessions held in October 1988 and March 1989 showed consistent results. In both cases, the didactic sessions were rated moderately to very useful overall, the most useful components being opportunistic infections and to a somewhat lesser extent, antiviral therapies. Psychosocial issues/community resources also ranked highly in the first course while infection control was identified as very useful in the second. Pediatric AIDS was seen as least useful in the October session while testing and legal issues were rated lowest in the March course.

The effectiveness of the mini-residency was judged by the participants' self-assessment of their confidence in their ability to perform in six specific skill areas:

- answering patients' questions about AIDS;
- screening patients for HIV history;
- practicing effective infection control for yourself and your staff;
- counseling patients with HIV infection;
- providing.primary care management for patients with AIDS; and
- utilizing appropriate community resources and referral networks.

Participants reported significant increased confidence in their ability to perform all of these skills. In both cases, their confidence in their ability

to utilize community resources was reported as lowest prior to the sessions and highest after- training, with an improvement of over 80%. Confidence in providing primary care management showed the next most improvement in both cases. Copy of the subcontractor's post-training evaluation reports are included in Appendix IX.

The practical component of the mini-residency is evaluated according to the standard follow-up methodology. Follow-up evaluations have been conducted on all mini-residencies held in the first and second years. Because the numbers for each mini-residency were so small, data were not aggregated. Individual completed questionnaires were returned to the subcontractor along with comments from the NEAETC Program Administrator.

D. Beth Israel Nurse Hini-Residency

The Beth Israel Mini-Residency Program is targeted to clinical nurses. It consists of a didactic portion accommodating 20 nurses followed by a 2-day (initially 4-day) practical experience accommodating five cycles of four nurses at a time. The practical experience is designed to acquaint nurses with the full spectrum of AIDS care--inpatient, ambulatory and home care. Graduates are also expected to become the AIDS resource person in their home institution.

An extensive evaluation is conducted of the program. At the end of the mini-residency, participants are asked to fill out a lengthy evaluation questionnaire which includes, among other things:

- a formative evaluation of the offering (appraisal of each of the faculty, appraisal of the workshop as a learning experience, assessment of the best and worst features of the offering, suggestions for improving the experience);
- an assessment of the effectiveness of the experience in conveying specific nursing task-related information (gathered via open-ended questions);
- an assessment of insights gained ("As a result of this mini-residency, I discovered .... I realized...)
- an assessment of effectiveness in stimulating participant's intention to change the way they provide nursing care to people with AIDS.

Review of the aggregated responses of the 20 participants who attended the mini-residencies in the fall of 1988 and winter of 1989 indicated that the experience was very positive overall and that faculty were well-informed and able teachers. Results of the open-ended knowledge test indicated that discrete information was communicated and understood. The responses to questions on intended behavioral changes and insights gained were extremely varied and pointed to the richness that this experience provides.

Interestingly, many felt that their care wouldn't change but that they had better information with which to carry out their duties.

The follow-up evaluation for these mini-residency experiences was conducted by the NEAETC Program Administrator in June 1989. The 20 participants who had been through the mini-residency program during the previous 3 to 8 months were sent the one-page follow-up questionnaire; 19 responded for a response rate of 95%. It is worth noting that while the participants were primarily clinical nurses and the content of the mini-residency was heavily clinical in nature, the primary impact of these mini-residencies has been in preparing the nurses for roles as educators and resource people rather than on improvement in their clinical abilities. In the time period since attending their mini-residency, these nurses had collectively done 17 training events for health care professionals, three public education sessions and two resource books attributable to their mini-residency experience, and had transferred knowledge acquired in the mini-residency to more than 1,300 individuals.

A copy of these evaluation reports is included as Appendix X.

E. Massachusetts Hospital Association Training of Trainers Program

The Massachusetts Hospital Association Training of Trainers Program targets individuals who have training responsibility in community hospitals. The objective of the program is to prepare these individuals to conduct elementary AIDS training within their own institutions. Five courses are offered each year encompassing 25 hospitals and 125 individuals. The program began as a two-day event, but has been expanded to three days in order to include a unit on substance abuse.

As a subcontractor of the NEAETC, the Massachusetts Hospital Association completes the required Program Report and Attendance Report. The Program Evaluation, as it calls its formative evaluation form, (described in Section V.B) and the pre/posttesting (described in Section V.C.l) are of their own design.

The Program Evaluation focused on sub-sections of the Train-the-Trainers Program. Each section contained seven statements with which the participants could agree or disagree. A four-point forced choice scale was used for the evaluation. Results of the Program Evaluation for the five training programs given between September 1988 and April 1989 are included in Appendix XI. From the data, MHA concluded that, in this preliminary analysis, the majority of the participants agreed or strongly agreed that the content fulfilled the objectives; was presented logically; and was appropriate to learning needs. It also concluded that the majority of participants considered the teaching methods to be effective, the speakers to be well prepared, and the time allowance and physical facilities to be adequate. The final report, to be rendered at the conclusion of the subcontract, will integrate the results from all of the courses and offer a more comprehensive discussion of the results obtained.

The Massachusetts Hospital Association plans to evaluate the impact of the Training of Trainers program by surveying all participants who have taken part in the program over the three-year period to determine what they have done in the way of training since completing the Train-the-Trainers program.

VII. SUMMARY AND CHALLENGES FOR THE FUTURE

The NEAETC has made a significant commitment to evaluation, although in their eyes, they have taken a minimalist view. Output data are routinely collected for all events, both those sponsored by the ETC and those conducted by subcontractors. Reports are hand-tabulated as needed. Quantitative data is estimated to be reliable for about 80% of the past events.

Additional evaluation beyond collecting output data is at the option of the subcontractor. Most do at least some formative evaluation of the events they sponsor.

Evaluations of program outcomes, while not entirely standardized, are conducted routinely on all intensive courses. Data are aggregated and interpreted, and written reports are prepared. Reports prepared by subcontractors are submitted to the NEAETC headquarters to keep them apprised of activities; reports prepared by the NEAETC headquarters are sent to subcontractors to provide them with feedback. Reports appear to have become more and more substantive.

In one case, the evaluation process actually serves an instructional purpose. The post-training evaluation questionnaire used in the faculty development workshop for primary care providers requests participant feedback on detailed aspects of the structure and process of the workshop, highlighting and reinforcing the qualities of a workshop considered important.

The NEAETC is conducting a number of creative training programs, particularly in the area of faculty development and mini-residencies, which may well be models for the national ETC program. However, as a prerequisite to become a model, more rigorous evaluation of the outcomes produced would be required to confirm the effectiveness of the training design and the impact of the overall experience. The ETC is in somewhat of a quandary over this issue. They fully understand and appreciate the value of sound research, but recognize the difficulty in conducting such research in an environment where the primary goal is getting the job of training done. They also recognize that to commit additional resources to the evaluation effort would mean a reduction of resources in the training effort. In the short term, there are some relatively simple things that can be done to improve the quality of the current follow-up studies, such as focusing more on specific changes that have been made in practice than on simply asking what aspects of the training contributed most to specified roles. In the longer term, the larger ETC program would be well-served by a more intensive level of evaluation on programs with high impact potential.

APPENDIX1

NEAETC's Trainee Targets by Type of Intervention

NEAETC's Trainee Targets by Type of Intervention

	Year 01	Year 02	Year 03
Faculty Development and Train-the-Trainers Programs			
Special Workshop for Residency Faculty, Dentists, Nurses	20-25	20-25	20-25
Faculty in Schools of Nursing and and Allied Health	100	200	200
Workshop for Primary Care Preceptors	50	50	50
Hospital Trainers	100	150	150
Subtotal	275	425	425
"Primary" and "Secondary" Training of Health Care Providers			
"Primary" or **"Basic"** AIDS Training for Practicing Health Professionals	2100	3300	3300
"Secondary" AIDS Training in **Mini-** Residency Format	84	96	96
Subtotal	2184	3396	3396
Student and Resident Training			
Mini-Grant	300	300	300
Second Year Symposium	100	100	100
Third Year Family Medicine Preceptorship	100	100	100
First Year Community Medicine Course and Summer Assistantships	7	7	7
Standardized Patient Methodology	460	460	460
Subtotal	967	967	967

Programs Focusing on Providers of Care to Minority Populations			
Community Health Center Site Presentations	300	300	300
Regional and State Association Workshops	200	250	250
Minority Provider Workshops	240	300	300
AHEC HealthNET	200	300	300
Subtotal	940	1150	1150
TOTAL	4366	**5938**	**5938**

APPENDIX II

Output Evaluation -- Data Collection Forms

1. Program Report Form
2. Attendance Report Form

ATTENDANCE REPORT

Program Title: _____

Date: _____ **Location:** _____

Contact parson: _____ **Telephone:** _____

PROVIDER **PRACTICE SETTING**

	Hospital	Private Practice	Comm. Hlth. Cntr.	Educational Institution	Other	Don't Know	TOTAL
Medical Resident							
Physician							
Dentist							
Nurse							
Nurse Practitioner							
Physician Assistant							
Social Worker							
Dental Hygenist							
Other (specify)							
TOTALS							

Please return form within one month of completion of program to:

Alan Chuman
AHEC Program
55 Lake Ave. No.
Worcester, MA 01655
(508) 856-3255

NEW ENGLAND AIDS EDUCATION & TRAINING CENTER

PROGRAM REPORT

Program Title : _____

Coordinator: _____

Sponsor **(s):** _____

Dote(s): _____

Location: _____

_____

Number of Hours: _____ Number of **Sessions:** _____

Type of **Program:**
___ Faculty **Development** ___ Train-the-Trainer
___ Mini-Residency ___ Conference
___ **In-Service** ___ Other _____

Format: (check all that apply)
___ Lecture ___ Consultation Clinic ___ Workshop
___ Panel ___ Clinical Practicum ___ Small Group
___ Grand **Rounds** ___ Audiovisual ___ Other

Registration Fee: $_____ **CEUs: Y e s** ___No

Evaluation: ___**Yes** ___**No** If Yes, briefly specify method.

_____

_____

PLEASE ATTACH A COPY OF BROCHURE OR AGENDA INCLUDING DESCRIPTION OF PROGRAM AND SPEAKERS.

Note: Please complete a form for each program. A program for this purpose is defined as an offering, be it one hour, one day, two days, or multiple sessions, which is provided for a particular group of attendees. The same program offered to two different populations on different days would be defined as two programs, and should have two forms completed. **A series** of related sessions which are attended by different audiences should also be defined as separate programs.

APPENDIX III

Formative Evaluation of Training Events

Sample Instrument for a Co-Sponsored Event

WORKSHOP EVALUATION

Title of Workrhop:_____

Facilitator:_____

Please complete the first question before the workshop begins:

1. What are your personal objectives for this workshop?

_____

_____

_____

_____

Please complete the remaining questions after the workshop is over (Circle your response):

2. To what extent did the workshop presentation/activities meet your personal objectives?

Poorly 1 2 3 4 5 6 7 Extremely Well

3. How well do you feel that the objectives of the workshop facilitator(s) matched your own objectives?

Poorly 1 2 3 4 5 6 7 Extremely Well

4. In your opinion, what was the overall quality of the workshop?

Poor 1 2 3 4 5 6 7 Excellent

5. How helpful was the w&shop for your professional activities?

Poor 1 2 3 4 5 6 7 Excellent

6. How effective was this workshop in adding to or expanding your knowledge?

Poor 1 2 3 4 5 6 7 Excellent

7. How effective was this workshop in adding to or expanding your skills?

Poor 1 2 3 4 5 6 7 Excellent

8. How effective was the workshop facilitator in encouraging and supporting active participation of all the workshop attendees?

Poor 1 2 3 4 5 6 7 Excellent

APPENDIX IV

Formative **Evaluation** of Training Events

Sample Subcontractor Instrument

Massachusetts Hospital Association

MASSACHUSETTS HOSPITAL ASSOCIATION
and
DEPARTMENT OF PUBLIC HEALTH

AIDS: Train the Trainer Program

Program Evaluation

Title: _____

Speaker : _____ Total: _____

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Responsa
1. The content fulfilled the behavioral objectives,					
2. The content was presented in a logical and orderly progression.					
3. The content was appropriate to your learning needs.					
4. The teaching methods utilieed were effective.					
5. The speaker was well preparad in quality and delivery of information.					
6. The time alloted for each presentation was adequate.					
7. Physical facilities were adequate.					

8. Was the information:

____all new information ___ partially new information ____no response

____a worthwhile reviaw ___ repititious old information

5 New England Executive Park, Burlington, MA 01803, (617) 272-8000/FAX (617) 272-0468

APPENDIX v

Evaluation of Program Effectiveness

Pre/Posttest Used to Evaluate

"Substance Abuse and AIDS: A Faculty Development Program for Primary Care Providers"

SUBSTANCE ABUSE KNOWLEDGE SURVEY
FOR MEDICAL STUDENTS AND PHYSICIANS

Part 1

Select the one best answer or completion:

1. The patient with delirium tremens typically shows all of the following except

   A. normal physical examination.
   B. disorientation for time and place.
   C. short attention span.
   D. increased motor activity.
   E. marked inability to sleep.

2. Immediately following each of the event listed below, the number of opioid addicts increased significantly except

   A. use of patent medicines in the second half of the 19th century.
   B. treatment of Civil War veterans with injectable morphine.
   C. passage of the constitutional amendment establishing Prohibition.
   D. importation of Chinese laborers to the West Coast between 1852 & 1870.
   E. return of veterans of the Vietnam War.

3. The ratio of alcoholics and problem drinkers to the total drinking population in the united States is estimated to be

   A. 1 in 5.
   B. 2 in 15.
   C. 1 in 10.
   D. 1 in 26.
   E. 1 in 50.

4. Among teenagers the three most widely abused chemical substances are

   A. alcohol, tobacco, marijuana.
   B. marijuana, barbiturates, cocaine.
   C. heroin, solvents, cough syrup.
   D. hallucinogens, opiates, depressants.
   E. barbiturates, herion, alcohol.

5. The inhalation of volatile solvents for purposes of intoxication may result in death due most often to

A. pulmonary edema.
B. convulsions.
C. cardiac arrest.
D. cerebral hemorrhage.
E. acute bilateral pneumothorax.

6. Wikler and many behavior theorists have postulated that opioid addiction results primarily from

A. peer pressure.
B. conditioning.
C. abnormal reward systems during the first three years of life.
D. economic deprivation.
E. efforts to control chronic depression.

7. All of the following are in the DEA Schedule 1 classification except

A. Methadone.
B. Tetrahydrocannabinols.
C. 4-methyl-2,5-dimethoxyamphetamine (ST?).
D. Heroin.
E. Mescaline.

3. Historically, the United States had at one time legally sanctioned maintenance clinics for addicts of

A. cocaine.
B. morphine.
C. barbiturates.
D. amphetamine.
E. bromide.

9. The analgesic effects of morghine are due to

A. alteration of the threshold of peripheral nerve endings.
B. alteration of the responsivity of peripheral nerve endings.
C. impairment of conduction in peripheral nerves.
D. actions on the central nervous system.
E. decreased metabolic rate in peripheral nerve cells.

10. All of the following statements about ethyl and alcohol are true **except**

A. absorption occurs directly into the blood stream from the stomach.
B. ingestion of water before ingesting alcohol decreases rate of absorption.
C. ingestion of carbonated liquids before or with alcohol increases rate of absorption.
D. ingestion of food before ingesting alcohol decreases rate of absorption.
E. increased secretion of stomach mucus decreases rate of absorption of alcohol.

11. All of the following comments about fruit-flavored "pop" wines are true except

A. the alcohol content is half that of beer.
B. the sweet flavor disguises the alcohol content.
C. they are especially appealing to teenagers.
D. they are inexpensive in comparison to liquor.
E. they make the transition from soda pop to alcohol an easy step.

12. Physical dependence and an abstinence syndrome can occur in all of the following except

A. Chloral hydrate.
B. Ethchlorvynol (Placidyl).
C. Phenytoin (Dilantin).
D. Propoxyphene (Darvon).
E. Meprobamate (Equanil).

13. which of the following is pharmacologically most similar to alcohol?

A. LSD
B. marijuana
C. cocaine
D. amphetamines
E. barbiturates

14. An opioid antagonist which has no clinically relevant agonfstic action is

A. levallorphan. (Lorfan)
B. calorphine. (Nalline)
C. naloxone. (Narcan)
D. cyclazocine.
E. disulfiram. (Antabuse)

15. 100 micrograms of which of the following drugs will produce clinical affects?

A. Naloxone.
3. Phencyclidine.
c. Delta 9 Tetrahydrocannabinol.
D. Lysergic Acid Diethylamide.
E. Propoxyphene.

16. The peculiar type of sedation, "going on the nod", refers to

A. egisodes of prolonged sleep in barbiturate addicts.
3. breakthrough episodes of sudden sleep in amphetamine abusers.
C. a state of semisomnolence from which arousal is easily obtaiced in narcotic addicts.
3. rspatitive up and down movements of the head in patients with tardive dyskinesia.
E. use of barbiturates to overcome the chronic insomnia of amphetamine abusers.

17. After single doses of morphine intravenousley in therapeutic dosage, all of the following might be expected except

A. pupillary constriction.
3. flushing and itching of the skin.
c. lowering of body temperature.
D. depression of respiratory rate.
E. relaxation of smooth muscle sphincters.

18. Overdose with pure heroin is characterized by all of the following except

A. unresponsiveness.
3. slow respiratory rate.
C. hypotension.
D. convulsions.
E. hypothermia.

19. In typical amphetamine psychosis all of the following are frequent except

A, visual hallucinations.
3. irritability
c. delusions of persecution.
D. disorientation.
E. violent behavior.

20. In patients taking 900 mg per day of pentobarbital for 6 months

A. abrupt cessation will probably cause convulsions.
B. the patient will probably appear sedated.
C. physical dependence is not present.
D. opioids would relieve withdrawal symptoms if pentobarbital is discontinued.
E. there is cross tolerance to opioids.

21. All of the following are frequently seen in the barbiturate withdrawal syndrome except

A. tremors.
B. hallucinations.
C. vomiting.
D. insomnia.
E. convulsions.

22. Alcohol abuse can cause all of the following except

A. impaired body utilization of vitamins.
B. low resistance to bacterial infection.
C. gastritis.
D. impotence.
E. cross tolerance to amphetamines.

23. All of the following statements about pathological intoxication with alcohol use are true except

A. it occurs after intake of even small amounts of alcohol.
B. onset is gradula over a period of 12 to 24 hours.
C. disorientation occurs.
D. delusions occur.
E. hallucinations occur.

24. Delirium tremens in alcoholics is frequently preceded by all of the following except

A. restlessness.
B. tremulousness.
C. ego non-intact hallucinations
D. aversion to food and alcohol.
E. disturbed sleep with terrifying dreams.

25. A patient is admitted for surgery to take place the next day. He is sedated that night and has his operation without incident. Two days gost-og, after he is no longer sedated, he is frightened and is seeing bugs and snakes. There is no evidence of fever or infection.

What is the most likely diagnosis?

A. Korsakov's psychosis.
B. alcohol paranoid state.
C. delirium- tremens.
D. pathological intoxication.
E. alcohol hallucinosis.

26. Which of the following is an organic brain syndrome of transient duration following minimal alcohol ingestion?

A. Korsakov's psychosis.
B. alcohol paranoid state.
C. delirium tremens.
D. pathological intoxication.
E. alcoholic hallucinosis.

27. A chronic organic brain syndrome associated with peripheral neuropathy and confabulation suggests

A. Korsakov's psychosis.
B. alcohol paranoid state.
C. delirium tremens.
D. pathological intoxication.
E. other alcoholic hallucinosis.

28. which is the most likely effect of a blood alcohol level of 200 mg % to 300 mg % in the non-alcoholic individual?

A. death.
B. mental impairment and ataxia.
C. euphoria.
D. improved sexual potency.
E. improved interpersonal relationships.

29. "Talking down" is a commonly accepted form of treatment for a person with acute intoxication from

A. amphetamine.
B. heroin.
C. LSD.
D. barbiturate.
E. alcohol.

30. Physical dependence and withdrawal syndrome may occur with all of the following except

A. Memprobamate. (Miltown)
B. Methadualone. (Quaalude)
C. Diazepam. (Valium)
D. Methyprylone. (Noludar)
E. Nortriptyline. (Aventyl)

31. All of the following statements about disulfiram-alcohol reaction are true except

A. symptoms begins to 10 minutes after ingestion.
B. pallor of the face and upper extremities occurs.
C. there is coughing and bronchospasm.
D. labored breathing occurs.
E. nausea and vomiting occurs.

32. The term "Psychedelic" is most accurately defined as

A. pertaining to drugs that cause hallucinations.
B. pertaining to drugs that are said to cause expansion or heightening of consciousness.
C. pertaining to drugs that cause illusions.
D. pertaining to drugs that cause delusions.
E. pertaining to drugs that cause distortion of time sense.

33. All of the following substances are typically found in analysis by DEA laboratories of THC peddled on the street except

A. synthetic tetrahydrocannavinol.
B. PCP (p-chlorophenylalaine).
C. LSD.
D. methaqualone.
E. marijuana.

34. In detoxification of a patient with barbiturate addiction the total dosage optimally should be reduced each day by no more than

A. 1% of the established daily intake.
B. 3% of the established daily intake.
C. 10% of the established daily intake.
D. 20% of the-established daily intake.
E. 33% if the established daily intake.

35. A 23 year old male homosexual is admitted by commitment to the psychiatric ward after attemping suicide by hanging. He was brought in by his roommate who had discovered him comatose but in time to resuscitate him. The roommate says the patient has been taking "barbs" for at least 6 months. The patient denies any use of drugs or any suicidal ideation. He demands to be released. The patient dismissed his suicide attempt as an impulsive gesture of anger at. his roommate. The most reliable way to determine the level of barbiturate which he has been taking would be

A. measurement of urine level of barbiturates.
B. observation of the effects on the patient of a test dose of pentobarbital.
C. measurement of **blood** level of barbiturate.
D. analysis of barbi turate content of capsules brought by the roommate.
E. confrontation of the patient with the information obtained from the roommate,

35. The withdrawal syndrome normally seen in meprobamate users most resembles the withdrawal syndrome of

A. methadone.
3. cocaine.
C. heroin.
D. barbiturates.
E. alcohol.

37. The withdrawal syndrome With chlordiazepoxide can show all of the following except

A. insomnia.
3. convulsions.
C. agitation.
D. increased appetite.
E. sweating.

33. In chronic alcoholism, the earliest symptom of withdrawal typically is

A. tremors of hands.
B. nystagmus.
c. diarrhea.
D. convulsions.
E. hallucinations.

33. Which of the following is most likely to cause convulsions with high doses?

A. Morphine.
3. Methadone.
C. Heroin.
D. Demerol.
E. Dilaudid.

40. Heroin maintenance is

A. a synonym for "chipping".
3. a system of support involving provision for nutritional needs, emotional support and vocational counseling for heroin addicts.
C. a procedure in which addicts are regularly given heroin under medical supervision.
D. a procedure of surveillance of sources of opium production to maintain production at a level sufficient for medical but not illicit use.
E. a term used to refer to the network of criminal activities which insure regular delivery of heroin to addicts.

41. A 33 year old man who is a barbiturate addict is being detoxified uneventfully when his clinical signs began to vary in an unusual way. At times he is uncooperative, garrulous, overtly friendly, and slightly ataxic. At other times he seems his usual quiet cooperative self. The first course of action for his physician should be to order

A. thyroid function studies.
3. blood cultures, frequent vital signs.
C. 6 hour glucose tolerance test.
D. search of the patient's belongings for barbiturates.
E. EEG, repeated neurologic exams.

42. Detoxification from a substantial dependency on barbiturates requires

A. a gradual withdrawal of the sedative medication - *over* days or weeks.

3. the administration of insulin and IV glucose to prevent coma.
C. the immediate withdrawal of all medication to clarify the clinical picture.
D. gastric lavage to wash out residual amounts of the hypnosedative.
E. administration of a stimulant drug.

43. In the presence of liver disease, which of the following would be the safest barbiturate?

A. Secobarbital
B. Amobarbital
C. Phenobarbital
D. Pentobarbital
E. Hexobarbital

44. All of these statements about Alcoholics Anoymous are generally true except

A. there are no dues.
B. anyone can become a member who considers himself an alcoholic..
C. no one can contribute more than $300 per year.
D. current research has shown this approach to be ineffective.
E. members help each other instead of using professional therapists.

45. If a patient presents to you in the ER with coma and smelling strongly of alcohol, which would be the most important next step?

A. blood sugar level
B. complete blood count
C. VDRL
D. CSF protein level
E. EEG

46. All of the following statements about detoxification from physical dependence on alcohol are true **except**

A. traditionally one of the primary sites for detoxification was jail.
B. in mild cases outpatients detoxification may be medically currect.
C. sedative or tranquilizing agents are sometimes indicated.
D. non-medical detoxification programs have been proven to be ineffective.

47. Alcohol patients in psychotherapy can be expected to do all of the following except

A. anticipate rejection from the therapist.
B. deny the severityof their alcoholism.
C. readily establish a strong positive relationship with the therapist.
D. test the treatment relationship with provocative behavior.
E. experience depression when dependency needs are not met.

48. Al-Anon is

A. an organization for teenage children of alcoholics.
B. a political lobby group of Alcoholics Anonymous.
C. an organization chart for AA.
D. an organization for women alcoholics.
E. an organization for spouses (and significant others) of alcoholics.

49. Which is the most correct statement?

A. Individual counseling is superior to group therapy in alcoholism treatment.
B. Detoxification drug of choice in alcoholism is a sedative or minor tranquilizer.
C. Chlorpromazine should be given I.M. to an alcoholic who is violent or having seizures.
D. Vitamin B_1 is contraindicated in the presence of neurological complications of alcoholism.
E. Treatment of alcoholism is not a proper use of medical facilities.

50. A patient who by history was taken both Heroin and Seconal is brought to the emergency clinic comatose. Which of the following drugs would be most appropriate?

A. naloxone
B. methamphetamine
C. nalorphine
D. cyclazocine
E. naltrexone

51. Talking down" may be defined best as

A. direct verbal remarks in which the patient is given repeated assurance that frightening hallucinations are a drug effect.
B. direct form of criticism given to a member of a therapeutic community by the other members when there has been a serious breach of rules.
C. a method of teaching through behavior modification a new set of contingencies for drug-seeking behavior.
D. one aspect of transactional analysis in which parent, child, and adult behavior are related to problems of drug dependence.
E. a form of marathon group therapy in which drug dependent patients meet continuously for 43 to 72 hours to break through defenses related to drug-seeking. behavior.

52. Impending delirium tremens could be managed by administration of all of the following except

A. barbiturates.
B. whiskey.
C. diazepam.
D. imipramine.
E. paraldehyde.

53. Addiction to minor tranquilizers has been reported. Appropriate detoxification from these substances includes titrated doses of which of the following.

A. propoxyphene.
B. chlorpromazine.
C. secobarbital.
D. diphenylhydantoin.
E. pentazocine.

54. Disulfiram is usually given

A. once daily.
B. twice daily.
C. three times daily.
D. four times daily.
E. every four hours.

55. There has been reported a sharp decrease in the number of registered heroin addicts between the ages of 33 and 40 years. All of the following are plausible reasons for this except

A. early death.
B. prolonged incraceration.
C. more effective skills at evading the law.
D. faster metabolism of heroin with increased age.
E. psychological maturation.

56. All of the following statements about methadone maintenance are true except

A. methadone produces constipation.
B. methadone has a longer duration of action than heroin.
C. methadone products physical dependence.
D. intravenous methadone is used for maintenance.
E. the dosage of methadone used is generally kept in the range of 10 mg to 80 mg/day.

57. The most common first source of illicit drugs for young people is

A. a physician.
B. a friend.
C. an adult pusher.
D. a teenage pusher.
E. a pharmacist.

58. Among teenagers the most widely abused chemical substance is

A. cocaine.
B. heroin.
C. alcohol.
D. marijuana.
E. hallucinogens.

59. In monetary terms, the most expensive street drug for maintenance of a "daily habit" is

A. heroin.
B. barbiturate.
C. LSD.
D. amphetamines.
E. cocaine.

60. All of the following are at high risk for alcoholism except

A. American males between the ages of 21-2:.
B. abstainers who begin drinking later in life.
C. medical doctors in primary care and specialty practice.
D. drinkers who life in "dry" regions or those exposed to strong temperance orientations in their culture.
E. members of the Jewish religion where alcohol is an integral part 0f religious ceremonies.

61. All of the following statements are true except

A. Peyote is in Schedule I of the federal list of controlled substances.
a. Peyote may be used by some research laboratories.
C. Peyote may be legally prescribed by any licensed M.D. for terminal cancer patients.
D. Peyote may be legally used in religious ceremonies by the Native American Church.
E. i?eyote is obtained from a cactus which grows in the southwestern part of the United States.

Part 2

Answers.

(A) only 1,2, and 3 are correct
(B) only 1 and 3 are correct
(C) only 2 and 4 are correct
(D) only 4 is torract
(E) all are correct

62. Alterations of life style seen in heavy users of amphetamines frequently include

1. intensification of the emotion of anger.
3. increased suspiciousness.
3. increased "grooming behavior". (examining, rubbing, and picking at the skin)
4. episodes of great involvement in repetitive tasks.

63. Common psychological effects of hallucinogenic drugs include

1. aggressiva and violent behavior.
2. synesthesias such as "seeing" music in color and "hearing" a painting as music.
3. measurable increase in intellectual ability.
4. mystical or "insightful" experience.

64. Among the behaviors most indicative of alcoholism is/are

1. the patient's deep-rooted insistence that he can control his drinking.
2. repeated geriods of self-imposed abstinence.
3. avoidance of food when drinking.
4. use of alcohol with religious rituals or family customs.

65. Drugs which often release violent and aggressive behavior include

1. barbiturates.
2. alcohol.
3. amphetamines.
4. cannabis.

66. Recent research regarding the possible medical utility of cannabinoids (marijuana) suggests it might be useful in

1. suppressing nausea.
2. stimulating appetite.
3. decreasing intraccular pressure.
4. stimulating testosterone production.

A

67. Studies on the genetics of alcoholism.

1. suggest alcoholism is more likely to occur among those whose
2. have evaluated children born to alcoholics but raised by non-alcoholic parents. 4
3. indicate an association with bipolar depression illness in women.
4. suggest it is a sex-linked trait accounting for the 3:1 male famale ratio of alcoholics.

68. With regard to methadone maintenance programs,

1. methadone must be kept stored in a separate safe within a secure area.
2. annual approval is required by federal agencies.
3. maintenance is defined as any regimen which prescribes methadone for over 21 consecutive days.
4. a hospital with a Methadone Maintenance program is thereby approved for using Methadone for analgesia.

A

63. Excessive uss of caffeine through beverages such as coffee, tea, cola drinks, and cocoa can lead to

1. mild delirium.
2. sensory distrubances such as flashes of light and ringing in ears.
3. diuresis.
4. gout.

E

70. The general public has ready access to stimulant drugs through the use of

1. coffee.
2. cola drinks.
3. tea.
4. cocoa.

E

76. Important factors in the recognition of the alcoholic include

1. irregularity and unstable work history.
2. falls with contusions, fractures and other trauma.
3. social, marital, and legal economic difficulties.
4. denial of an alcohol problem on confrontation.

77. Factors determining the severity of alcohol withdrawal include

1. abruptness of abstinence.
2. amount and concentration of alcohol beverage.
3. pattern of consumption.
4. age of onset of problem drinking.

73. A blood alcohol level of 200 mg percent is often associated with which of the following in non-alcoholic individuals?

1. increased reaction tine.
2. dysarthria.
3. ataxia.
4. coma.

79. Correct statements concerning the female alcoholic include

1. the ratio of female to male alcoholic persons in 2 to 1.
2. a history of depression is present more often than in males.
3. the age of onset of alcoholism is earlier than in males.
4. more women than men seek treatment for their problems with alcoholism.

80. Sensations described by users as akin to *orgasm* are often reported after use of

1. cocaine.
2. heroin.
3. amphetamine.
4. marijuana or THC.

71. Incases of physical deqtndence, abrupt withdrawal from which of the drug(s) below may cause death.

1. barbiturates.
2. morphine.
3. alcohol.
4. chlordiazepoxide.

10

72. The following drugs produce cross tolerance to heroin:

1. Morphine.
2. Secobarbital.
3. Codeine.
4. THC.

10

73. Which of the following is/are frequent presenting complaints of an alcoholic to the primary care physician?

1. injuries due to accidents or falls.
2. gastrointestinal distress.
3. various complications arising from malnutrition.
4. inability to handle or control drinking.

A

74. Life threatening conditions commonly associated with alcohol withdrawal include

1. delirium tremens.
2. hepatic coma.
3. esoohageal varices.
4. acute renal failure.

77

75. Correct statements regarding the alcoholic include

1. In withdrawal, if the person has consumed more than 1/5th of 50% distilled spirits ger day, seizures occur in nearly all cases.
2. Alcoholism now ranks as the leading cause of death in persons over 35 years of age in the U.S.
3. Acute hallucinosis in withdrawal can not occur earlier than 48 hours after discontinuation of alcohol.
4. The symptoms of withdrawal frequently include an acute brain syndrome.

D

81. Of the following drugs, which is/are capable of producing a true physical withdrawal syndrome?

1. LSD.
2. cocaine.
3. imipramine.
4. alcohol.

82. The "causes" of drug and alcohol addiction are complex and controversial, though generally thought to include

1. socioeconomic factors.
2. personality factors.
3. pharmacological factors.
4. genetic factor.

93. Abusers of certain drugs typically develop an "action-reaction" cycle with the action phase associated with hallucinosis, paranoia and often violence and the reaction phase associated with exhaustion depression and tendency to use sedative or narcotic drugs. Drugs which show this cycle include

1. cocaine.
2. LSD.
3. amphetamine.
4. phencyclidine.

84. Amphetamines are considered appropriate treatment for

1. minimal brain dysfunction.
2. chronic fatigue states.
3. narcolepsy.
4. barbiturate overdosage.

85. In telephone crisis intervention with parents of children involved in drug-seeking behavior, good procedures include

1. avoid inducing guilt in parents or child.
2. ask the child why he is seeking drugs.
3. remember the person on drugs is super-suggestible.
4. talk to the child about your own drug experiences.

86. The chronic alcohol abuser is especially prone to

1. infections.
2. opiate addiction.
3. suicide.
4. leukemia.

87. Alcoholism is associated with

1. depression as a correlated affective state.
2. adaptive impairment.
3. organic disease complications.
4. an established preexisting personality type.

88. Research on the relationship of drugs. to crime indicates that

1. alcohol use is strongly associated with violent crime.
2. the incidence of violent crimes by heroin addicts is less than one-half that of the general population.
3. heroin use is associated primarily with crimes of acquisition such as shoplifting and burglary.
4. marijuana use is directly associated with violent crime.

APPENDIX VI

Evaluation of Program Effectiveness

Pre/Posttest Used to Evaluate Massachusetts's Hospital Association's "AIDS: Train the Trainer Program"

MASSACHUSETTS HOSPITAL ASSOCIATION,
DEPARTMENT OF PUBLIC HEALTH, and
NEW ENGLAND AIDS EDUCATION AND TRAINING CENTER
AIDS: Train the Trainer Program

Pretest/Posttest

1. What are the three major fears/phobias associated with the initial phase of the caring for the patient with AIDS?

   1. _____
   2. _____
   3. _____

2. After experience in caring for patients with AIDS, the two major issues caregivers need support with are:

   1. _____
   2. _____

3. The two primary supports to provide caregivers are:

   1. _____
   2. _____

4. The HIV virus primarily attacks the _____ cells of the _____ system thereby destroying the body's ability to fight _____.

5 New England Executive Park, Burlington, MA 01803, (617) 272-8000/FAX (617) 272-0466

5. Four major symptoms of AIDS/ARC are:

   1. _____
   2. _____
   _____
   4. _____

6. Two common opportunistic illnesses associated with AIDS are:

   1. _____
   2. _____

7. The only four body fluids known to transmit HIV, the AIDS virus are:

   1. _____
   2. _____
   3. _____
   4. _____

8. List two of each; safe, possibly safe and unsafe sexual activities.

   Safe 1. _____
   2. _____
   Possibly Safe 1. _____
   2. _____
   Unsafe 1. _____
   2. _____

9. Describe why needle sharing is considered high risk.

   _____
   _____
   _____
   _____

10. The risk of HIV infection from occupational exposure is _____ _____ as compared to Hepatitis which is _____.

11. Use of universal precautions means:

_____

_____

_____

12. The three critical elements of HIV testing are:

_____

_____

_____

13. Identify three common concerns of persons with AIDS.

_____

_____

_____

14. The four critical assumptions about adult learning which should be incorporated into educational programs are:

1. _____
2. _____
3. _____
4. _____

15. The five major components of AIDS 101 are:

1. _____
2. _____
3. _____
4. _____
5. _____

APPENDIX VII

Unique and Interesting Evaluation Techniques

Self-Evaluation Questionnaire Accompanying "AIDS: **Manual** de **Treino"**

1.2 AUTO-AVALIAÇÃO.

0 seguinte questionário serve para testar os seus conhecimentos sobre a doença AIDS. Sii-se a vontade em marcar no espaço apropriado, a resposta que pensa ser a mais correcta. A chave das respostas é a seguinte:

V (= Verdadeiro); F (Falso); NS (Não Sabe); HIV (= Virus da Imunodeficiência Humana, do inglês "Human Immunodeficiency Virus); AIDS (= síndrome da Imunodeficiencia Adquirida, do inglês "Acquired Immunodeficiency Syndrome"); DST = Doença Sexualmente Transmissível); PCA (= Pessoa Corn AIDS).

l- Ao beijar uma pessoa corn AIDS, o risco de ficar infectado é muito grande.

V—— F—— NS——

2- AIDS é uma preocupação nas fábricas, onde muitas pessoas podem transmitir 0 virus a utros, sem 0 saber.

V - F - N &

3- Os medicos são os que mais dinctamente podem apanhar AIDS, quando examinam os doentes, principalmente se estes já t&m a doença.

V—— F—— NS——

4- Os enfermeiros, porque não receitam medicamentos aos doentes, estão livres de apanhar a AIDS.

V—— F—— NS——

5- É um êrro muito grave classificar AIDS como sendo uma DST.

V—— F—— NS——

6- Gonorreia e Sifilis são exemplos de DST, mas não AIDS.

V—— F—— NS——

7- Uma assistente social deve sempre usar luvas e mascaras ao aproximar-se de um doente com AIDS.

V—— F—— NS——

8- Os técnicos de laboratório não correm risco de apanhar AIDS, porque todos os materiais usados na manipulação diagnóstica são automaticos.

V - F - N N C

9- Os bancos de sangue são os locais onde existe a maior percentagem de contaminação pela AIDS.

V - F - N %

10- 0 acupuncturista, ao inserir a agulha numa pessoa, pode infecta-la corn 0 virus e a si próprio também.

V—— F—— NS——

11- Entre um dentista e um técnico de laboratório, o primeiro tern maior probabilidade de ficar infectado.

V—— F——NS——

12- É impossivel apanhar-se AIDS nas prisões.

V - F - N +

13- Devia haver uma lei que banisse por completo as casas e agencias funerárias. 0 virus HIV pode permanecer aí como um reservatório para futuras infecções.

V - F - N &

14- Os maqueiros das ambulancias deviam perguntar sempre se a pessoa que vai usufruir dos serviços tem AIDS ou não. Se tiver, não deveria usar tal meio de transporte.

V - F - N N C

15- Se vai viajar para fora do país não precisa preocupar-se sobre AIDS. 0 problema só existe nos EUA.

V—— F—— NS——

15. RESPOSTAS AO TESTE DA SECÇÃO AUTO-AVALIAÇÃO.

01 -Falso

02-Falso

03-Falso

04-Falso

05-Falso

06-Falso

07-Falso

07-Falso

08-Falso

09-Falso

10-Falso

11-Falso

12-Falso

13-Falso

14-Falso

15-Falso

APPENDIX VIII

Evaluation Reports

"AIDS for the Primary Care Physician--A Faculty Development Course"

NEW ENGLAND AIDS EDUCATION AND TRAINING CENTER

AIDS FOR PRIMARY CARE PHYSICIANS AND OTHER CARE GIVERS

A Faculty Development Course

November 17 - 19, 1988

prepared by

The AIDS Task Force
of
The Society of General Internal Medicine

In collaboration with
Members of The Task Force
on Medical Interview of
The Society of General Internal Medicine

Harvey J. Makadon, M.D., Project Director
Penny Williamson, Sc.D., Project Director

Supported by a grant
from
The American Foundation for AIDS Research

EVALUATION SUMMARY

PRE-WORKSHOP QUESTIONNAIRE

PURPOSE: The purpose of this workshop is to improve your teaching skills on" the subject of AIDS. To evaluate how well the workshop meets this purpose and to identify its most effective components, we need to know your individual proficiencies and objectives. At the end of the workshop, we will ask you whether or not your objectives were met.

DIRECTIONS: In the column to the right of each item please indicate the extent to which an increase in your ability to understand and discuss the material in the area is an objective of yours for the workshop, using the following scale:

Not applicable	Not at all				Very much so
NA	1	2	3	4	5

A. AREA OF KNOWLEDGE OR SKILLS:

		Objectives of Yours For this Course?				
1) Taking a sexual history	NA	1	2	3	4	5
		1	3	6	2	**5***
2) Counseling a patient worried about AIDS	NA	1	2	3	4	5
		1	2	4	6	**4***
3) Explaining the pros and cons of AIDS testing to patients	NA	1	2	3	4	5
		1	2	4	6	**4***
4) Giving a patient the results of an AIDS test	NA	1	2	3	4	5
		1	1	4	4	**8***
5) Advising a reluctant resident or colleague about the care of a patient with AIDS	NA	1	2	3	4	5
			1	2	5	**9***
6) Dealing with the first major illness of a patient with AIDS	NA	1	2	3	4	5
		1		9	4	**5***
7) Discussing advanced directives and preferences for terminal care for a patient with AIDS	NA	1	2	3	4	5
				3	10	**4***
8) Being aware of issues unique to minority patients	NA	1	2	3	4	5
		1	1	5	5	**5***

* denotes evaluation responses

9)	Being aware of issues unique to women and children	NA	1	2 2	3 5	4 4	5 6*
10)	Counseling an IV drug user about AIDS	NA	1	2	3 7	4 5	5 5*
11)	Dealing with significant others of a patient with AIDS	NA	1	2 2	3 5	4 6	5 5*
12)	Understanding ethical issues	NA	1	2	3 2	4 7	5 9*
13)	Understanding burnout	NA	1	2 1	3 3	4 2	5 10*

14) Please add other objectives you would like to pursue during the course

_____

_____

_____

B. 1. Describe briefly a difficult professional encounter that you or a colleague have had with an AIDS patient, a patient's family, or significant others. Describe some of the things that you said or did to be most helpful. Describe any mistakes that you feel you may have made.

2. Based on this experience, what are you most interested in learning from this course? Try to identify skills, knowledge, or attitudes that specifically interest you.

POST-WORKSHOP QUESTIONNAIRE

PURPOSE: The purpose of this questionnaire is to see how well the workshop improved your ability to understand and discuss the following. To do this we would like you to rate your skill levels as they were before the course, and as they are now after it.

DIRECTIONS: In the column to the right of each item please indicate your assessment of your PRE-COURSE LEVEL OF KNOWLEDGE OR PROFICIENCY using the following scale:

Not applicable	Not at all				Very much so
NA	1	2	3	4	5

AREA OF KNOWLEDGE OR SKILLS:

	RATE YOURSELF BEFORE THE COURSE						RATE YOURSELF AFTER THE COURSE					
1) Taking a sexual history	NA	1	2	3	4	5	NA	1	2	3	4	5
			3	9	3	2			1	5	9	2*
2) Counseling a patient worried about AIDS	NA	1	2	3	4	5	NA	1	2	3	4	5
			2	8	5	2				3	11	5*
3) Explaining the pros and cons of AIDS testing to patients	NA	1	2	3	4	5	NA	1	2	3	4	5
			1	5	6	5			4	7	6*	
4) Giving a patient the results of an AIDS test	NA	1	2	3	4	5	NA	1	2	3	4	5
		1	1	7	4	4				3	7	6*
5) Advising a reluctant resident or colleague about the care of a patient with AIDS	NA	1	2	3	4	5	NA	1	2	3	4	5
			3	11	2	1				7	7	4*
6) Dealing with the first major illness of a patient with AIDS	NA	1	2	3	4	5	NA	1	2	3	4	5
		1		7	7	2				5	8	5*
7) Discussing advanced directives and preferences for terminal care for a patient with AIDS	NA	1	2	3	4	5	NA	1	2	3	4	5
				8	6	2				3	9	5*

8)Being aware of issues unique to minority patients	NA 1 2 3 4 5 2 5 7 2 1	NA 1 2 3 4 5 1 2 12 **1***
9) Being aware of issues unique to women and children	NA 1 2 3 4 5 1 1 4 8 2	N A 1 2 3 4 5 1 4 5 **6***
10)Counseling an IV drug user about AIDS	NA 1 2 3 4 5 2 5 10	NA 1 2 3 4 5 3 3 **8** **1***
11)Dealing with the significant others of a patient with AIDS	NA 1 2 3 4 5 2 9 23	N A 1 2 3 4 5 5 7 **5***
12)Understanding ethical issues	NA 1 2 3 4 5 3 8 41	NA12 3 4 5 12 **3***
13)Understanding burnout	NA 1 2 3 4 5 2 2 **10** **3**	N A 1 2 3 4 5 2 4 4 **7***

A. <u>OVERALL EVALUATION</u>

First we would like a global rating and gestalt impression from you.

1. Please rate the overall educational quality of the course.

POOR				EXCELLENT
1	2	3	4	5
		2	2	**9***

2. How useful was the course to you?

NOT AT ALL USEFUL				EXTREMELY USEFUL
1	2	3	4	5
		2	2	**9***

3. In your own words, what was the greatest strength or most helpful aspect of the course?

A. A method for discovering ourselves and our interviewing skills
B. Meeting people, using role play techniques
C. The sharing of concerns & issues among HCP the sharing of information and frustration and improvement in techniques.
D. Small group role plays and especially the chance in them to focus on IVDA issues.
E. Role play, Esp. regarding pts. with which I have little contact, Lectures esp. **Schooley.**
F. **Becoming aware of the powerful role of role playing as a basis for discussion of a great** range of issues.
G. **The small groups provided a great amount of knowledge and** interaction.

H. Meeting with colleagues who care for AIDS pt's around the issues of AIDS - knowledge, interview skills and personal experience.
I. The chance to work with the others in the small groups.
J. Role playing getting to know other people.
K. Small groups with role playing.
L. Increasing my personal awareness of the issues. I need to deal with in caring with patients and colleagues .
M. 'Excellent selection of attendees. Excellent selection, for the most part, of faculty.
N. The close - small groups especially the workgroups by the enhancement of the small group be lecture were essential.
0. Formal talks, especially AIDS and minorities, Meeting with others in the same work
Q.

4. What was the greatest weakness or least helpful aspect?

A. I would have enjoyed and benefitted from a couple of hours spent asking Mr. Wizard;" to compare and contrast DX, resources use etc.
B. Medical lectures way beyond primary care
C. I would have preffered more nuts and bolts talk on taking a sexual history. A short lecture on "burnout" signs/symptoms and prevention. Also would have liked everyone to do a role play where they became the person in less control and power.
E.
G. Fact oriented lecturers were hard to intergrate and continually atteni to.
I. Not enough time for the PA groups to develop. The groups themselves added positively to the concerns. Not enough real patient contact in the interviewing groups.
J. Lectures especial medical group.
K. Too many talks. I would have allowed more time such as longer lunches for us to get to know each other.
L. PWA came to group with his own agenda and it became the groups agenda. To oriented toward personal issues for gay. Lecture on testing and talking to health care providers.
M. Rooms
N. Long program (not a major weakness!)
Q. Very limited direction. Goal was unclear and needed more focus.

5. With regard to your learning objectives for the course, please RATE EACH OF THE COURSE COMPONENTS ON A SCALE FROM 1 TO 6. 1 BEING THE LEAST VALUABLE:

	Least Valuable				Most Valuable
Lectures	12	3	4	5	6
	12	1	7	5	1*
Interviewing work groups	12	3	4	5	6
		2	2	3	12*
Self-awareness groups	1 2	3	4	5	6
	1	2	4	6	2*

	1	2	3	4	5	6
Syllabus, reading materials			3	1	4	1*

FACILITATORS

1. INTERVIEW WORE GROUP FACILITATOR

Who was your Interview Work Group Facilitator_____

What did he/she do that helped you achieve your goals?

A. Nudge here and there
B. Superb facilitator, supportive
C. Define and explore feelings
D. Allowed us to continuely set our own goals for each session
E. Role play encouraged
F. She is a very good listener. Sensitive able to reflect back feeling and content that me comfortable
H. Identified goals/organized us. Brought in Rohrs to work with us.
J. Listened well. Steered the group very gently, taught about teaching.
K. Allowed us to use play whatever we wanted - didn't always stick to the program. Very good facilitator. I learned alot.
L. Made each person set agenda for learing.
M. Listened, corrected, supported, and organized.
N. Enabled us to develope our own interests.
O. Perception about how to teach role playing

What was least helpful?

C. At times felt that the group rambled off into areas that were not revelant to what we were trying to accomplish
D. Reticence to use expertise/experience and prod group forward to work.
E. More Direction
F. I urged her to push the role play and not let us avoid a stressfuil, but valuable situation.
G. Some rambling but it was ok
H. Focus on role playing per se my not be as useful as it is with the general SGIM interview groups. In some sense we needed just to talk more but pushing us was helpful.
M. Did not introduce Richard Kahn.
N. The negotiation of what to do with the time.
0. To much emphasis on process. Too frequent interruptions in the midst of discussions which groups were enjoying.

2. SELF-AWARENESS GROUP FACILITATORS

Who were your Self-Awareness Group facilitators?

_____ and _____

What did they do that helped you achieve your goals?

A. Nudge here and there
B. Helped focus groups
C. Felt this group did not meet any of my goals not was there a clear sense of goals. the group was probably to large.
D. Set ground rules and occasionally helpful comments
E. Encouraged discussion of personal experiences in care of patients/
F. Both were very good at facilitating rather than controlling the discussions. It is very special skill to have.
G. Did not direct let happen
H. They just left us alone to talk about our issues.
K. Allowed us to vent
L. I think groups did this.
L. Allowed group to run self.

What was least helpful?

A. They could have also shared their own feelings a bit more - as leader participant more than leader
D. Let some dominate a bit much
K. Could have pulled more of the quiet people into the group. A few tended to dominate.
M. The facilitators did not help the "quiet ones" to speak.
Q. Limited focus

3. OTHER PEOPLE

Please comment on any other people who influenced your experience in any significant way.

A. Charlie Rohrs was absolutely wonderful as a lecturer and group participant. The idea of having an expert join the group was excellent.
B. Participants in small groups were outstanding

C. Thank you John for sharing so much what a cleansing process
D. Charlie Rohrs excellent, Mark, Chip, and Mike excellent
F. Harvey M. was very upbeat, positive; friendly. He set a nice tune for the conference.
G. PA's were very helpful.' Other participants were wonderful teachers.
H. Lectures, the low keyness of the organization: especially the smaller work groups and the relationships engendered there.
I. The people that care for the AIDS patients are very unique. It was a priviledge to be able to work with them.
K. Everyone was a unique gift to me. I enjoyed mostly hearing the others experieinces and getting their feedback and different situations.
L. Participation in my small groups.
Q. Ken Mayer talks were useful for a variety of reasons.

C. GROUPS

1. Interview Work Group

a. Please rate the quality of your Interview Work Group.

POOR		MODERATE		EXCELLENT
1	2	3	4	5
			4	**13***

b. How useful was the Interview Work Group for your learning?

POOR		MODERATE		EXCELLENT
1	2	3	4	5
		1	4	**11***

c. How effective was the role play technique in contributing to your learning?

POOR		MODERATE		EXCELLENT
1	2	3	4	5
		1	5	**11***

d. In what ways did you find the Interview Work Group helpful in achieving your goals?

In what ways not helpful?

2. Self-Awareness Group

a. Please rate the educational quality of your Self-Awareness Group.

POOR		MODERATE		EXCELLENT
1	2	3	4	5
		10	7	**2***

b. How useful was the Self-Awareness group for your learning?

NOT AT ALL USEFUL		MODERATELY USEFUL		EXTREMELY USEFUL
1	2	3	4	5
		7	**8**	**3***

C. In what ways did you find the Self-Awareness Group helpful in achieving your goals?

In what ways not helpful?

D. RATINGS OF INDIVIDUAL MODULES

Lease rate each of the eleven written modules on **two** dimensions: the

educational quality of the materials and their usefulness for your teaching and clinical practice. Use the following scale for both dimensions:

POOR 1 2 MODERATE 3 4 EXCELLENT 5

MODULE	YOUR RATING FOR EDUCATIONAL QUALITY					YOUR RATING FOR USEFULNESS				
1. The Need for Primary Care Givers	1	2	3 3	4 5	5	1	2	3 3	4 **5***	5
2. Overcoming Reluctance to Care for HIV Infected Individuals	**1**	2 1	3 3	4 3	5 1	1	2	3 1	4 6	5 **1***
3. The Sexual History in the Context of a Medical Interview	1	2 **1**	3 3	4 3	5 **1**	1	2	3 2	4 3	5 **3***
4. Counseling People who are Seropositive	1	2	3 2	4 5	5 **1**	1	2	3	4 6	5 **1***
5. Intravenous Drug Use and AIDS	1	2 1	3 **1**	4 3	5 3	1	2	3	4 3	5 **5***
6. Caring for Minority Population	1	2 1	3 3	4 2	5 2	1	2	3 3	4 2	5 **3***
7. Women and Children with HIV Infection	1	2 **1**	3 2	4 4	5 1	1	2	3 3	4 2	5 **2***
8. Medical Aspects of Screening & Testing	1	2	3 **1**	4 4	5 3	1	2	3 1	4 3	5 **4***
9. Medical Aspects of HIV Infection	1	2	3 **2**	4 3	5 **3**	1	2	3 3	4 3	5 **2***
10. Ethical Concerns	1 1	2	3 2	4 4	5 1	1	2	3 3	4 3	5 **3***
11. Avoiding Burnout	1 1	2	3 2	4 **4**	5 1	1	2	3 3	4 3	5 **3***

E. Learning Climate

Please rate the following aspects of the climate for learning provided in this course.

1. Educational Objectives

INCOHERENT				CLEARLY STATED
1	2	3	4	5
	1	**4**	7	**3***

NOT AT ALL RELEVANT				HIGHLY RELEVANT
1	2	3	4	5
		2	4	**9***

UNREALISTIC NOT ATTAINABLE				REALISTIC ATTAINABLE
1	2	3	4	5
		2	6	**7***

2. Teaching and Learning Process

TEACHER DIRECTED				LEARNER DIRECTED
1	2	3	4	5
		2	**11**	**3***

INFLEXIBLE, RIGID				FLEXIBLE RESPONSIVE
1	2	3	4	5
			8	**8***

PACE TOO SLOW		APPROPRIATE PACE		PACE TOO FAST
1	2	3	4	5
	1	**11**	**3***	

TREATMENT WAS TOO SIMPLE		APPROPRIATE LEVEL OF COMPLEXITY		TREATMENT WAS TOO COMPLEX
1	2	3	4	5
	5	**9***		

CONTENT WAS **OF LITTLE INTEREST**				**CONTENT WAS EXCEPTIONALLY INTERESTING**
1	**2**	**3**	**4**	**5**

2 a 6*

DISCOURAGED ACTIVE PARTICIPATION				ENCOURAGED ACTIVE PARTICIPATION
1	2	3	4	5

13*

3. What changes in course content or process would improve the learning climate?

G. FUTURE PLANS

List a few personal goals, activities, and collaborative arrangements that you would be interested in pursuing during the next six months as a result of your participation in the course.

	PERSONAL GOALS	ACTIVITIES & PROJECTS	COLLABORATION & LINKAGES
A.	Bring it home		Look forward to linkage. Resources, mail, etc.
E.	Develop closer contact with other providers	Monthly Quarterly support/information Exchange meetings	

F. Establish on going education programs for family practice residents in our program and for medical students. Improve our department links with AIDs resources in RI both the medical and community. Establish AIDS education for foriegn students who come to Brown (many of whom will be come leaders in their home medical communities). Specifically prepare a series of sessions for a period in the next year or so when I hope to be a guest faculty person in East Germany.

G. More active coherence - hopefully with some of the people who participated

H. Establishing a support group at work with outher AIDS providers. Just supported and "bouyed "up enough to keep going in this very difficult work.

I. To be a better facilitator. Would like to follow through again as a facilatator for this gourp it the opportunity arose.

K. Refined my interview and dealing with people in crisis. Take much of the teaching material from here and give to others.

L. Establish group of socially responsible physicians who can set an agenda make a plan of action for addressing social issues related to AIDS.

N. I need more knowledge of AIDs. Implement a short series in our residency. Focus on seriousness of role play.

0. Use of role playing in teaching. Further work with AHEC possible mini-

grant applications.

P. Teaching **teacheres** how to better **teach.** Patient care models. Establish a data base of epidemiologic studies.

Q. House Officers identifies of HIV dx and emotional feelings. Role plays didactic situations, exposure to **PWA's** and apply for mini-grant. Support grousp for patients and families and better sharing of emotion feelings. It was a worthwhile **experieince** if for no other reason than hearing similar problems and feelings elsewhere.

AIDS For Primary Caregivers: A Faculty Development Course

November 17-19, 1988

Follow-up Evaluation

Method

Follow-up one-page questionnaire mailed in late June, 1989, uith reminder mailed in August. Responses uere obtained from 18 out of 19 participants, a response rate of 95 percent.

1. In retrospect, please note the overall educational quality of the course (Scale of 1-5, uith 1 being poor, 5 being excellent)

	Rating	Number of responses
Poor	1	0
	2	0
	3	5
	4	7
Excel lent	5	6

Mean = 4.06

2. How useful has the course been to you? (Scale of 1-5, uith 1 not useful, 5 being very useful)

	Rating	Number of reswnses
Not useful	1	0
	2	0
	3	11
	4	5
Very useful	5	2

Mean = 3.50

3A. Since the Aids for Primary Caregivers course in November, 1988, what has been the most important contribution the course has made to you in terms of your role as an educator for residents, students or colleagues?

getter able to discuss issues related to counseling uith residents/students.

Wrote and got approval on an H.H.S. grant to organize a course on AIDS.

Increase in my confidence in counseling skills.
Initiated patient centered approach in counseling discussions.
Practical and valuable knowledge that facilitated discussions with residents uho care for HIV+ patients in the outpatient setting.

Better role model.

Gained better understanding of issues of AIDS in minorities and a knowledge of role playing technique.

Greater knouledge about availabe resources and an increased awareness in the netuork of colleagues to consult with on issues.

Exposure to these issues broadened and deepened understanding of problems which enhanced effectiveness in teaching residents.

Given several lectures to AHEC and non AHEC groups on HIV issues.

More in touch with issues of "burn-out" and need to develop supportive group of other healthcare providers.

Provided materials for teaching.

Use of role plays has been incorporated into educational activities.

Case method teaching knouledge has provent to be an important tool in teaching.

More insight into role playing.

Resources available to HIV+ people.

38. Since the Aids for Primary Caregivers course in November, 1988, whet has been the most important contribution the course has made to you in terms of your role as a provider of health care for persons with HIV?

HIV counseling uith specific emphasis on who should be tested, why they uant to be tested and what happens to results.

More comfortable dealing with PWAs.

Recognized need for emotional support in physicians as well as patients.

Recognized the need to slow dom and listen to the patient.

Gained knowledge of resources in area.

More indepth perceptions of the problems faced by gays and IVDU.

Increased awereness of their point of view.

HIV counseling on who should be tested, why they want it and what happens to results.

More comfortable interacting uith PWAs.

Resources available to HIV+ people.

4. Please provide a list or description of new educational programs on HIV infection/AIDS uhich you have developed, coordinated or for which you served as an instructor since November. Please include only those activities for uhich you feel the course made a contribution in terms of ideas, knowledge, methodologies or faculty participation.

Program	Target Group	Approximate Number of Participants
Commonwealth Provider Ed.	Physicians	30
Core curriculum for management of HIV related problems in primary care setting.	Residents - 3 core experiences provided monthly for first yeer residents.	12 per year
Second ETC faculty development course	MDs/RNs	20
Maine AHEC course	RNs - cont. ed.	25
Residents Lecture series	Interns/Residents	80
Videotape of patients, New lecture material	students	45

Development of a hospital-uide program for managers which will resemble format of November program.	N/A	N/A
Multi-disciplinary AIDS Program at hospital.	Providers in AIDS clinic	N/A
In-service	Pastoral students	10
in-service	Kidney Foundation	20
HIV case mgmt meetings 1 -4x/mo	Medical students, Interns, residents attendings, SWs, nutritimalists	10 ea. session
FP Uorkshop	FP residents	20
Monthly clinical case conference	FP residents	8-10
RI Hospital HIV Clinic	Residents, PC physicians	80 residents 12 PC Mds
Lecture	2nd yr. medical students	70
AIDS seminars (monthly)	PC physicians	5-6 per month
Video tape of HIV+ pt. to examine pscho-social sessions, MD/patient relationships.	2nd yr. medical students	43
AIDS: A Caring Response	Healthcare Providers	125

APPENDIX IX

Evaluation Reports

Brown Mini-Residency Program

massachusetts

Area Health Education Center
U/Mass Medical Center
5 lake Avenue. North
Worcester, Massachusetts 01655

area
health
education
centers

a
ahec

statewide program
(508) 656-3255

November 10, 1988

Kenneth Mayer, M.D., Chief
Infectious Disease Division
Memorial Hospital
Prospect Street
Pawtucket, Rhode Island 02860

Dear Ken,

I've enclosed a summary of the eleven evaluation forms completed by participants in the October 5 and 12 workshops.

In general the evaluations are positive. Participants reported increased confidence in'the various skills we inquired about. As we've already discussed, several participants suggested more emphasis on specific patient management issues in the outpatient setting.

I'd also like to follow up with people subsequent to the clinic sessions. I'll send you a copy of a draft questionnaire.

Talk to you soon.

Sincerely,

Alan Chuman, Associate Director
Massachusetts Statewide AHEC Program

/js
Encl.

an equal opportunity employer

Evaluation Summary

AIDS For Primary Providers

Pawtucket, Rhode Island

October 5 and 12. 1988

Resuondents		Number of HIV or AIDS patients seen	
Internists	8	0-5	5
Other M.D.	2	6-10	5
Nurse Practitioner	1	20+	1

Overall Usefulness of Conference

Very useful	4
Useful	4
Somewhat useful	1

Mean response for usefulness of each component (Scale of 1-4)

Natural history (Carpenter)	3.2
HIV testing (Wachtel)	2.7
Opportunistic Infections (Fisher)	3.4
Pediatric AIDS (Smith)	2.4
Antiviral Therapy (Mayer)	3.0
Infection Control (Boyce)	3.2
Psychosocial Issues/Community Resources (Smith/Fish)	3.3

Before and After Mean Scores of Confidence in Specific Skills (Scale of 1-4)

		Before	After
a)	Answering patients' questions about AIDS	2.4	3 . 1
b)	Screening patients for HIV history	2.6	3.3
c)	Practicing effective infection control for yourself and staff	2.5	3.2
d)	Counseling patients with HIV infection	2.2	2.8
e)	Providing primary care management for patients-with AIDS	2.0	2.7
f)	Utilizing appropriate community resources and referral networks	1.7	3.1

What components were most useful?

Opportunistic infections	4
Antiviral Therapy	4
Infection Control	2
Psychosocial	2
Testing	2
History	2
All	1

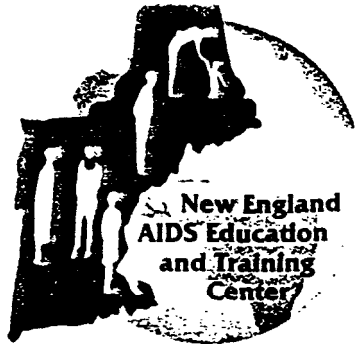
Least Useful?

Pediatric	2
Antiviral Therapy	2
Infection Control	1
Testing	1

Other issues or tonics?

Practical aspects of therapeutics,
More on outpatient management and initial workup for HIV patients in outpatient settings.
Specific recommendations for AZT use.
More time for questions/discussions, perhaps by holding three sessions.

WORCESTER
Statewide AHEC Office
UMASS Medical Center



55 Lake Avenue ***North***
Worcester, MA 01655
(506) 6563255

June 6, 1989

Kenneth Mayer, M.D., Chief
Infectious Disease Division
Memorial Hospital
Prospect Street
Pawtucket, Rhode Island 02860

Dear Ken,

I've enclosed a summary evaluation for the AIDS Primary Providers Course held on March 22 and 29. Sorry its taken me awhile to compile it.

It's clear from the evaluations that the program was well received. Each speaker's talk was evaluated as being "useful" by the participants, although the legal update 'took it on the chin.

Participants *also* reported increased levels of confidence in various aspects of caring for HIV+ patients. Interestingly, the area in which they reported the least initial confidence, and the. greatest increase in confidence, was in "utilizing appropriate community resources and referral networks".

The open-ended comments on the most useful and least useful aspects are the usualmixedbag. The material on opportunistic infections and antiretroviral therapy got lots of kudos.

The request for additional suggestions once again yielded requests from several participants for more concrete information regarding patient management issues for primary care physicians. Perhaps you and-your colleagues could put your heads together again on this to see if there is another way to address this.

As you know, we recently conducted a follow-up evaluation of the first group of providers to go through the clinic sessions. We received six out of

(Cont'd. - Page two)

BOSTON
Beth Israel Hospital Libby 314
330 Brookline Avenue, Boston, MA 02215 (508) 735-2328

NORTHERN **NEW ENGLAND**
Maine Consortium for Health Professions
150 Capital Street, Augusta, ME 04330 (207) 623-2531

nine responses. They're brief, so rather than summarize them I've made copies and included them in the package. They are positive, and obviously people feel good about the program. The principal problem people had was the small number of patients seen and discussed in the clinic sessions.

I hope this information is helpful. Talk to you soon.

Sincerely,

Alan Chuman, Project Administrator
New England AIDS Education and
Training Center

/js
Encl.

AIDS For Primary Providers

March 22 and 29, 1989

Pawtucket, Rhode Island

Evaluation Summary

Approximate number of HIV+ patients seen	
0 - 5	14
6 - 10	4
11 - 20	2
21+	2
Total	22

Specialty	
Family Medicine	4
Internal Medicine	8
OB/GYN	1
Nurse Practitioner	4
Physician Assistant	1
R.N.	4

Overall Usefulness of Conference

Very useful	7
Useful	8
Somewhat useful	3
Not useful	0

Usefulness of each component (Scale of 1 to 4, 4 = very useful)

		Very Useful	Useful	Somewhat Useful	Not Useful	Mean Score
A.	Natural History (Mayer)	9	10	2	0	3.3
B.	HIV Testing (Wachtel)	4	12	3	2	2.9
C.	Opportunistic Infections (Fisher)	13	6	2	0	3.5
D.	Legal Update (Fine)	1	a	9	2	2.4
E.	Antiretroviral Therapy (Carpenter)	13	7	0	2	3.4
F.	Infection Control (Boyce)	9	9	3	1	3.2
G.	Community Resources (Silvia)	6	10	4	0	3.1
H.	Psychosocial Issues (Smith)	6	9	3	2	2.9

Confidence of participants before and after sessions (Scale of 1-4, 4 = very confident, 1 = not confident)-

	Mean Score	
	Before	After
A. Answering patients' questions about AIDS	2.7	3.2
B. Screening patients for HIV testing	2.9	3.3
C. Practicing effective infection control for yourself and staff	3.1	3.5
D. Counseling patients with HIV infection	2.5	3.0
E. Providing primary care management for patients with HIV infection	2.1	2.8
F. Utilizing appropriate community resources and referral networks	1.8	3.4

Most useful part of the program

- Opportunistic Infections (4)
- Infection Control (4)
- Antiretroviral Therapy (3)
- Psychosocial Lecture (2)
- Community Resources (2)
- Testing (1)
- Natural History (1)

Least helpful part of the program

- Testing (4)
- Legal Issues (4)
- Infection Control (2)
- Psychosocial Issues (2)
- Community Resources (1)
- Opportunistic Infections (1)

Natural History (1)

All but antiretroviral therapy (1)

- Other issues that should be covered

- More concrete recommendations for work-up for suspected PCP, etc

- Would like to see course offered on yearly basis

- More information on how to suspect/diagnose during physical examination

- Wanted to hear more detail about managing patients. These issues were covered fairly quickly. Drs. Fisher's and Carpenter's talks were most useful. I'd rather see an emphasis on this rather than **legal/social** issues

- Nice program

- Overall sessions were very good. They should not be allowed to run until 9:00 PM.....**assimilation** of material is impaired when it runs so late. Have you considered 3 sessions?

- Different research projects - directly available to our patients or non-traditional (underground).

- Strategies for maintaining health in relatively healthy HIV infected patients; i.e. immunization, nutrition, exercise, etc.

  It would be useful to have a printed summary of names and numbers of who's available for referrals and connections

- None, other than to hold it during one day, not at night

APPENDIX X

Evaluation Reports

Beth Israel "AIDS Mini-Residency Program for Clinical Nurses"

Beth Israel Hospital
Nursing Services

AIDS MINI-RESIDENCY PROGRAM FOR CLINICAL NURSES

EVALUATION

Date: _____

I. As a result of participating in this residency, please rate the extent to which you are able to:

	To a great extent	Somewhat	No, unable to
1. Explore the role of the nurse practitioner in an ambulatory setting in the care of the person with AIDS.	11	6	2
2. Identify the role responsibilities of the members of the inter-disciplinary team in caring for people with AIDS-related illness.	17	2	
3. Explore the role of the nurse in the care of people uith AIDS in the home.	14	4	
4. Describe the nursing care considerations associated uith the care of people with AIDS-related illnesses in the inpatient setting.	17	3	

II. Please appraise Faculty/Preceptor effectiveness (in presenting, discussion, and/or clinical teaching) in the following areas by designating your rating using this scale. (Write numbers below.)

Poor 1 2 3 4 5 Excellent

Names of Faculty/Preceptors	Teaching Ability	General Knowledge of Subject	Depth Coverage
Warren Goff	4.10	4.7	4.40
Mary Gorman	4.96	5	4.46
Sheila Hussey	4.72	4.8	4.70
Vickie Griffen	4.49	5	4.41
Jean Chaisson	4.5	4.95	4.68
John (PWA)	5	5	5
Carol London	4.21	4.63	4.63
Betty Morgan	4.33	4.33	4.33
Sal Tassone	4.33	4.67	4.17
Mary Ellen Ricardi	4.8	4.8	4.7
Bonnie Titelman	4.7	4.9	4.6
Gail Pearlstein	4.25	4.8	4.5
Anita Backestose	3.75	4.25	3.75
Linda Schmidt	4.33	4.6	4.33
Ros Avila	4	4	4
Amy Paul	3	5	4.5
David Hannaberry	5	5	5
Marcia Maurer	5	5	5
Laura Curtian	4		
Andrea Dercolia	5	5	5
Karen Dick	5	5	4
Lauren Wood	3	3	3

Glen Kimball 4
Elten Kitchen 5

III. Please respond to the following statements:

	Yes	Somewhat	No
1. Attending the workshop "Caring for people uith AIDS" enhanced my learning.	18	1	
2. The content was relevant to the objectives.	20		
3. The envircment was conducive to my Learning.	18	2	
4. My personal objectives for attending this *residency* were met.	13	5	

Comnents:

IV. Please complete the following questions:

Included for cmtact hour purposes. Participants were able to answere questions correctly, indicating that descrete information on renewed within didatic and clinical practicum sessions was communicated and understood.

1. List the major components of nursing assessment for a parson admitted with HIV-related illness.

2. List two major side effects of the drug Pentamadine.

3. List 3 major considerations in discharge planning of people with AIDS-related illness.

4. Describe 3 essential elements to be incorporated in health teaching for newly diagnosed people with AIDS.

5. List 3 community resources that you learned about this during residency and describe how you might utilize them on behalf of people uith AIDS.

6. As a result of participating in the residency, will your nursing care of people with AIDS change? Hou?

Besides knowing resources to contact, I think I may be more "holistic" in my assessment and ask questions to patients that might not have been asked before. I think that I'm more prepared to hear their answers.

My nursing care will not change, but I have a more well-rounded view of resources which are available to patients on the outside. What I can do now is pass all the info. on that I have learned and accumulated, to my colleagues. Therefore, we will all be able to care for the AIDS patient in more holistic manner.

I feel that my nursing care will change in that I feel a lot more knowledgeable about support services, medications and treatment, diagnostic procedures, and nursing diagnosis, and assessment. Since my position involves Nursing Education I will be imparting this information to my colleagues at a nursing forum.

I am more aware of opportunistic infections that occur and the physical assessments needed for early detection. Also aware of research protocols patient can become involved in.

Better approach.

I will be able to utilize the resources I have obtained.

My care will not change, but this *course* has allowed me to deepen my commitment to my patients.

The program helped me re-think my thinking and approach to the I.V. Drug population-- in particular to issues of pain control, limit setting, and my own role in providing care.

7. As a result of participating in the residency, I changed: (Check all that apply):

A.	My thinking about AIDS	10
B.	My attitude about people with AIDS	5
C.	My beliefs about people uith AIDS	2

COMMENTS:

I don't feel that I really changed my attitudes towards PWA's, but I feel I was able to learn a lot about coping with IVDA's which was a big issue for me.

I became more aware of the anormity of the problem.

I have learned much about the other people with AIDS (children, IVDA, and women) as opposed to just the gay man population.

Greater Understanding of how really i 11 people with AIDS can become; especially with fever spikes and diarrhea.

My knowledge of what it is really like to have AIDS , books and reading can only do so much. An advanced awareness of uhat BI is doing and certainly an appreciation for the fine job nursing is doing for all patients with AIDS.

I think I see AIDS more as a major public health problem that effects all segments of society not just high risk groups or behaviors. There are no typical patients of situations • all are individual.

Increased empathy and awareness of their plight.

I did not change my thinking, but rather looked at this as an update. I obtained a lot of information in greater detail in regards to IV drug abuse., HIV testing, inpatient care of an AIDS pt. etc.

8. As a result of participating in the residency,

I learned:

Hou difficult the research studies are, how involved taking care of an educated gay man, and AIDS (very sensitive to health care system) and a little bit about a better approach to the IV drug abuse, who's usually such a management problem.

About the many community services available to AIDS patients and their families from counseling nursing care.

I learned that the state of Massachusetts allows up to 100 mg q.d. of methadone a day.

The complex system of care providers necessary to deal with HIV positive patients and persons uith AIDS.

I expanded my knouledge about epidemiology of the disease, more risk factors.

More about drugs used in treatment.

Caring for AIDS patients is one of the greatest challenges for nursing.

More about the different populations affected with AIDS.

Hou extensive the netuork of AIDS related information and people is.

How extensive the Shattuck program is.

I discovered:

Hou to manage complicated terminally ill patients.

The problem of insufficient home health aids and the barriers to care for minorities.

The enormity of the epidemic and the huge and varied populations that it affects.

That the AIDS virus effects the eyes, GI, and resp tract system.

Many resources available to people with AIDS

I had some pre-conceived judgments that needed to be reevaluated.

A uonderful group of highly skilled nurses uho have rekindled my love of nursing.

The extent nursing must go to bridge the void in nursing AIDS research. Hou centered approach to nursing changes all the hospital roles and attitudes especially if all believe that is focus. It can uork. I have my own prejudices I have to deal with in treating AIDS patients more effectively.

That patients can administer their pentamidine therapy at home.

The vacuum in services needed for home care. The increasing demands on all people for discharge planning.

The Boston AIDS Consortium

Just hou much the AAC does offer and unfortunately hou scarce AAC are; i.e. Cape Cd area - none are

available.

I realized:

My issues with IVDA's can be broken down and dealt with as I deal uith other types of paitents.

State and Federal financial constraints limit extent of services available.

Education is the key to the whole AIDS issue.

What a wonderful support nurses can be for each other.

How difficult it is for AIDS patients to deal with insurance and jobs etc.

There is so much ue don't know.

The public's greet fear of AIDS.

That not all people uith AIDS are male or gay or IVDA. Women uith AIDS have much more complex issues of family, etc.

That drug abusing people be put in charge of their own lives.

That nursing care is the key to quality of life for PWA's. AIDS paitents challenge every nursing skill we have.

How quickly the population of AIDS patients is increasing.

There can be some reward for taking care of IVDA's.

I re-Learned:

The contrast betueen the teaching institution and special attention to staff and the state institution.

The devastation of the disease!

Side effects of medications. i.e. pentamidine, AZT, ribiviran, bactrim.

What the inpatient setting is like nou. It is all different my past clinical experience.

About the pathophysiology of AIDS and hou it affects other organs.

Modes of transmission testing, basic physiology of the immune system.

Some nursing problems never change.

AIDS patients are people and the loss of one effects us all.

The importance of caring holistically. AIDS patients have so many needs that need to be met physically and mentally.

The lou socio-economic class of IVDA's is going to be the most challenging to educate.

9. When I return to my work setting, the first thing I will share with my colleagues is:

My impressions and drug information.

Professionalism of nursing care at BI.

I have been able to complete a Resource Manual for my unit.

New drugs under investigation.

Risks of opportunistc infections that can set in after diagnosis.

Refining our universal precaution procedure.

How to best approach the subjects of sexuality and addiction with patients.

In hospital "contact" or "resource" people to seek out information needed.

10. The best part of this program uas:
Sharing of information among small groups; lots of room to ask questions or talk about uhatever interested me.

Spending time with several different nurses uho are experts in their fields and being able to question them in person among a small group.

Discussing patients with their primary care nurse and seeing hou much they actually kneu impressed me.

The opportunity to netuork and learn from such a broad scope of health care professionals dealing with PWA's.

Meeting uith Sheila Hussey and Gail Pearlstein's discussion about the studies and research they are doing now.

Attending didactic session with Mary and clinical session with Sheila Hussey and the psychiatrist that lectured at the all day program.

People we met uith and uho shared their real Life experiences uith us. Seeing and speaking uith patients who have AIDS. Visits uith home care and AIDS patients in home or IV care.

Home visit and anonymous testing.

The varied range of experiences that uere offered to us. The high quality of speakers and preceptors.

Time spent uith Mary Ellen.

11. The worst part of this program uas:

Not being able to go on clinical rounds or visit a pedi site.

Too much focus on inpatient nursing and discharge planning from the perspective of the staff nurse on the second day.

Second day immersion in HIV related issues. Feelings of being overwhelmed with the extent of the problem.

Sitting so long in one place the first morning.

Not having Vickie available for ambulatory care conference.

Needing more time with one area and had too much time in another.

Not long enough (4days) for individual to have clinical experience in all areas; just really touched the surfaces of many areas.

Inpatient time uas too non structured.

The cost of parking.

Trips to the Boston VNA which did not work out.

Clinical session needs to ba more structured with a nurse specialist in AIDS who is oriented to teaching. Also being given an opportunity to observe a physical assessment of a PWA and going over his/her drug regimen in detail i.e. common doses, side effects.

Spending too much time with a patient who needed rest and privacy.

A lot of learning contact in a relatively short amount of time.

Some lack of structure from such a broad scope of health professionals dealing with AIDS.

12. What uould improve the experience?

Really can't emphasize hou informative these last two days have been for me, I enjoyed the privelege of small group participation among the 3-4 of us.

Time spent uith clinical nurse was non-structured. Supplemental therapies discussions.

Getting a patient uith AIDS to share his experiences uith us. Audio visual of the program i.e skin lesion or kaposi sarcoma.

Observing particular procedures that I am not familiar with i.e. aerosal ized pentamadine, giving drugs through portacath, mixing and preparing of experimental drugs i.e. DHPG, etc.

Visiting and hearing from more patients.

More patient contact with nurse practitioner. Availabilty to talk with nurse practitioner.

More concrete types of treatment plans such as:
Physical assessment
Drugs used end S/E and uses of these medications.

Interest group was saneuhat repatious of mutual information in Workshop in November.

Maybe people who were at the workshop uho do not have contact with AIDS patients could benefit from spending a day uith a nurse who is in care of an AIDS patient.

The parking and traffic issues uere horrible and made things difficult. Spending time with an in-patient who was willing to open up to me.

Having case studies presented on the second day.

Asking 4 day residents before they arrive if they wanted a particular experience.

ADDITIONAL COMMENTS:

Everybody was so nice.

I particularly enjoyed seeing the various supports in place to encourage professional development of clinical nursing. I think the netuork lists will be valuable in the future.

The best program I have ever attended and I really appreciate the opportunity.

Would have liked to spend time at Shattuck on AIDS uards. Packet of information uas very helpful.

If possible schedule a public health clinic when there are appointments for HIV testing. Carol London while counseling was very informative.

Discharge planning uas very important for staff nurse.

Disdain for the human being is the worst of all evils. You have presented a timely, professionally astute uorkshop uith reaffirms my hope that ue are not just treating the HIV, the disease, but encompassing the body, mind and spirit as our responsibility to each other.

I would have liked more information before to decide which workshop I uanted to attend.

I think it is very difficult to design a program to meet the diverse needs of RNS in very different practice setting and on the whole the program succeded.

AIDS Mini-Resickncv Program for Clinical Nurses

Follow-up Evaluation

Method

A one page follow-up questionnaire was mailed to all participants in late June 1989, 3-8 months subsequent to the 2-4 day course which was offered on a staggered basis between November and March. A reminder uas mailed in August. Responses were obtained from 15 out of 20 participants, a response rate of 75 percent.

1. In retrospect, please note the overall educational quality of the course. (Scale of 1-5, with 1 being poor, 5 king excellent)

	Rating	Number of reswnses
Poor	1	0
	2	1
	3	1
	4	7
Excel lent	5	6

Mean = 4.2

2. Hou useful has the course been to you? (Scale of 1-5, with 1 not useful, 5 being very useful)

	Rating	Number of Responses
Not useful	1	0
	2	2
	3	2
	4	8
Very useful	5	3

Mean = 3.8

3A. What has been the most important contribution the mini-residency has made to you as an educator for students or colleagues?

Able to dismiss fears and myths on a one-to-one basis with young people.

Able to complete a resource manual for colleagues and serve as a resource nurse on unit.

Source of information to supervisors/managers both verbally and with written materials.

Broadened perspective and expansion of nursing role in the care of these patients.

Promoting HIV treatment with ambulatory care at health center.

More confident about teaching abilities.

Able to update the staff uith new facts on AIDS.

More comfortable as a resource person and educator on AIDS and HIV infection.

Direct experience with PWAs was informative learning experience.

Bibliography and presentations were useful in AIDS 101 class that I teach.

Able to pinpoint "weak spots" in colleague's knowledge base regarding AIDS and plan inservices addressing these issues.

3B. What has been the most important contribution the mini-residency has made to you as a provider of health care for persons with HIV?

Resource person to those who need information.

Care of patients has been enhanced because I can offer them greater information and resources on inpatient and outpatient basis.

More of an educator/facilitator than direct-care provider.

Enhanced knowledge of drug use for HIV patients and increased use of nursing diagnosis.

More understanding of sane of the symptoms of HIV patients and able to provide information on support systems.

Can better educate the patient/family about the illness and available resources.

Increased knowledge base, more sensitivity to psychosocial issues, and more confidence with persons uith HIV in the community.

4. Please provide a list or description of neu educational programs on HIV infection/AIDS which you have developed, coordinated *or* for which you *served as an* instructor since November. Please include only those activities for which you feel the course made a contribution in terms of ideas, knowledge, methodologies or faculty participation.

Program	Target Group	Approximate Number of Participants
Aids Comprehensive Health & Informational Sessions (5)	Home Health Aides	16 - 18
IV medications used on HIV pts	Nurses in IV program	5
Inservice uorking with AIDS pts	Homemaker/HHAs	25 - 50
AIDS 101- epidemiology, transmission, drug use, safer sexual practices	All health care uorkers	250
AIDS nursing care: Utilize the standard of care developed after the course	All nursing service orientees	63
AIDS 101 - High school sessions	High school seniors	250
STDs/HIV	High school students	30
STDs/HIV	Adolescent therapy group	6
In-service	Staff nurses	5 - 6
Resource	Staff nurses	20 - 30
Resource book	Staff nurses	20 - 30
Public education, minorities	Tenant housing	8 - 10
Dvervieu on AIDS	Nursing staff	10 - 20
HIV transmission & risk factors	High School seniors	25
Unprotected exposure for pre-hospital care providers	Firemen, EMTs, police officers	70
Universal precautions & Infection control practices	Hospi tat personnel	200+

AIDS 101	Nursing students	100
AIDS 101	Nurse Aides	50
AIDS in the Workplace	Company health programs	30
AIDS	High school students	70
AIDS interest group	Nurses, social workers	30
Update of AIDS	Home Health Aides	15 - 20

5. Have you undertaken a new or expanded role as a resource person regarding HIV infection in your facility? If yes, please explain.

Considered AIDS information resource person by colleagues.

Enhanced role as an AIDS resource nurse on unit. Increased knowledge enabled completion of a resource manual on the care of the AIDS patient for use by my colleagues.

Increased role in policy setting/input into training and greater access to other offices that haven't had much contact with HIV patients.

Nursing care resource and a resource to all employees for services in community.

Role as HIV resource person has developed over the year and has added depth to preparation and contacts.

Regard4 as resource nurse on the floor. More involved uith HIV pts as a primary or assoc. nurse.

Although role has not expanded it is more well-rounded.

Expanded rote as Infection Control Coordinator with a resource library of articles. Consult with nursing staff and staff education and to clients/businesses outside the hospital.

Nou participating in AIDS interest group as a speaker.

Course gave me more credibility and recognition as a nurse uith special expertise. Sought out for questions by the other nurses and I sea many HIV infected persons at the supervisor's request.

APPENDIX XI

Evaluation Report

Massachusetts Hospital Association's "AIDS: Train the Trainers Program"

Table 1: Average Percentage of Responses Within ***Program*** **Evaluation Scale.**

	S A	A	D	S D
A. Support for the Caregiver				
1. Content fulf **illed objectives.**	11%	79%	7%	4%
2. Content presented logically.	7%	75%	19%	
3. Content was appropriate to learning needs.	7%	75%	16%	3%
4. The teaching methods ware effective.	19%	58%	19%	3%
5. The speaker was well prepared.	39%	54%	7%	
6. Time allowance *was* adequate.	33%	55%	9%	3%
7. Physical **facilities** were adequate.	23%	70%	7%	

KEY: SA = Strongly Agree, A **= Agree,** D **= Disagree,** SD **=** Strongly Disagree.

	S A	*b*	D	SD
B. Clinical ***Information;*** **"Beyond** Feet"				
1. Content fulfilled objectives.	26%	74%		
2. Content presented **logically.**	55%	42%	3%	
3. Content was appropriate ***to*** learning needs.	*28%*	*63%*	9%	
4. The teaching methods were **effective.**	*42%*	*51%*		*7%*
5. The speaker was well prepared.	*53%*	*47%*		
6. Time allowance **was adequate.**	38%	59%	3%	
7. Physical facilities were ***adequete.***	*41%*	*57%*	*3%*	

	SA	*b*	D	SD
C. HIV Testing				
1. Content fulfilled objectives.	52%	48%		
2. Content presented logically.	47%	49%	3%	
3. Content war appropriate to learning needs.	48%	45%	7%	
4. The teaching methods were effective.	35%	61%	4%	
5. The rpeaker **was** well **prepared,**	55%	45%		
6. Time allowance was adequate.	46%	51%	3%	
7. Physical facilities **were** adequate.	40%	55%	4%	

D. Personal Transmission

	SA	A	D	SD
1. Content fulfilled objectives.	33%	52%	7%	7%
2. Content presented logically.	44%	45%	11%	
3. Content was appropriate to learning needs.	34%	51%	11%	4%
4. The teaching methods were effective.	31%	57%	3%	9%
5. The speaker was well prepared.	39%	53%	9%	
6. Time allowance was adequate.	33%	61%	7%	
7. Physical facilities were adequate.	29%	59%	11%	

E. Occupational Risks

	SA	A	D	SD
1. Content fulfilled objectives.	37%	63%		
2. Content presented logically.	43%	53%		3%
3. Content was appropriate to learning needs.	38%	51%	7%	3%
4. The teaching methods were effective.	33%	60%	3%	3%
5. The speaker was well prepared.	50%	47%		3%
6. Time allowance was adequate.	33%	65%	3%	
7. Physical facilities were adequate.	17%	63%	21%	

F. Psychosocial Issue8

	SA	A	D	SD
1. Content fulfilled objectives.	45%	55%		
2. Content presented logically.	45%	55%		
3. Content was appropriate to learning needs.	45%	55%		
4. The teaching methods were effective.	46%	50%	4%	
5. The speaker was well prepared.	59%	41%		
6. Time allowance was adequate.	44%	56%		
7. Physical facilities were adequate.	33%	55%	13%	

G. Educating Adults About **HIV**

	SA	A	D	SD
1. Content fulfilled objectives.	**31%**	**57%**	**13%**	
2. Content presented logically.	29%	71%		
3. Content was appropriate to learning **needr.**	23%	65%	13%	
4. The teaching methods ware effective.	21%	67%	13%	
5. The speaker was well prepared.	**30%**	**67%**	**3%**	
6. Time allowance was adequate.	**21%**	**73%**	**3%**	**3%**
7. Physical facilities **were adequate.**	**23%**	**73%**	**3%**	

H. **AIDS 101 Overview**

	SA	A	D	SD
1. Content fulfilled **objectivea.**	13%	**83%**	**3%**	
2. Contant presented **logically.**	16%	84%		
3. Content was appropriate **to** learning needs.	13%	**87%**		
4. The teaching methods **were *effective.***	17%	78%	5%	
***5. The* speaker was** well prepared.	**21%**	**79%**		
6. Time ● llowanca was **adequate.**	**13%**	**74%**	**9%**	**4%**
7. Physical facilities were adequate.	**13%**	**77%**	**9%**	

I. **Small Group** Presentation

	SA	A	D	SD
1. Contant fulfilled objectives.	61%	39%		
2. Content presented **logically.**	**51%**	49%		
3. Content was appropriate to learning needs.	49%	41%	7%	4%
4. The teaching methods were effective.	**59%**	**38%**	**3%**	
5. The speaker was well prepared.	**52%**	**48%**		
6. **Time** allowance was adequate.	**50%**	**46%**	**4%**	
7. Physical facilities were adequate.	**43%**	**57%**		

NEW YORK-CARIBE AIDS/SIDA EDUCATION AND TRAINING CENTER

BVALUATION REVIEW

I. Overview

The New York-Caribe AIDS/SIDA Education and Training Center (NYU AIDS ETC), after some rearrangement of its region, currently serves the areas of metropolitan New York City, New Jersey, Puerto Rico, and the Virgin Islands. Activities in Puerto Rico have been subcontracted to the University of Puerto Rico; teleconference activities, previously under subcontract as well, have been discontinued.

Like the NYU program itself, the ETC's evaluation activities are highly centralized. The NYU ETC program consists of three broad components: education and training programs for medical providers, dental providers and other health professionals; trainer/faculty development; and telephone support for practicing providers. The ETC evaluates all of its program components to some extent, including short- and/or medium-term impact of a number of the components. Formative evaluation is conducted informally on many of the ETC's "products".

A description of the evaluation activities of the University of Puerto Rico subcontractor, to the extent that they differ from those of the rest of the ETC, were not available at the time that this review was prepared.

II. The Evaluation Process

A. Evaluation Plan

1. Evaluation Plan as Proposed

According to NYU's initial grant proposal, the ETC's evaluation procedures were to address each of its three components. The first component, training programs for primary care givers, dentists and other health care professionals, was to be evaluated using the following methods:

- o trainee assessment (examinations, attitude scales and inventory assessments - these assessment tools were to be translated into Spanish to be used in Puerto Rico);
- o cost efficiency and cost effectiveness.

The second component, trainer/faculty development, consists of two separate programs: the Train-the-Trainer Institute and the Faculty Institute. The approach to evaluating this component was to be primarily descriptive. The measures to be used to evaluate the Train-the-Trainer Institutes were as follows:

- o assessment of participants' perception of the training;
- o documentation of the number of regional trainees reached by each trainer.

The Faculty Institutes were to be evaluated based on:

- o revision of curriculum based on information received in the training.

The cost efficiency and cost effectiveness of each of these institutes was also to be assessed.

The evaluation of the third program component, the AIDS Warm Line, was to be descriptive as well. It was to be evaluated using the following methods:

- o documentation of the frequency and nature of incoming calls;
- o sampling callers, at a future date, to determine whether the information received proved helpful.

The planned timeframe for the evaluation was as follows.

Year 01

At the end of the first year, the Year 01 offerings were to be evaluated by the Director of Evaluation for the project. The initial plan did not indicate exactly what the scope of this evaluation was to be. In addition, the Educational Program Committee (EPC) was to evaluate the teaching modules intended to be used in structuring the training program for "other health care professionals". The AIDS Warm Line activity reports were to be developed during the first year, as well.

Year 02

An evaluation report of the Year 01 offerings of the Train-the-Trainers Institute was be completed early in Year 02. Also, the Year 02 training offerings for providers were to be evaluated.

Year 03

In Year 03, all program components were to be evaluated.

2. Implementation of the Evaluation Plan

A review of NYU's evaluation to date, measured against its plan, indicates the following:

a. Evaluation of Training Programs for Health Care Providers

- o trainee assessments are ongoing, but variables examined have been changed and refined over time; in particular content tests have been eliminated and attitude items have been defined and refined through ongoing analysis; the primary emphasis in evaluation of programs has been of participant satisfaction;

- o the Evaluation Program Committee members were primarily responsible for developing rather than evaluating the teaching modules, although they do participate informally in formative evaluation;

- o the assessment of cost-efficiency was carried out in the third year through a rudimentary calculation of cost per trainee (about $125) and cost per contact hour (about $21); an assessment of cost effectiveness has not been possible.

b. Evaluation of Train-the-Trainers Institutes

- o evaluation of participant satisfaction was carried out as planned;

- o number of trainees trained by train-the-trainers graduates are being tracked through the required 50 second generation trainees as a condition of certification;

- o second year graduates conducted evaluations of their training programs consisting of knowledge change and participant satisfaction;

- o the assessment of cost-efficiency and cost-effectiveness have not been carried out in any formal way.

c. **Evaluation of Faculty Institute** (activity to be carried out in Year 03)

- o a needs assessment providing baseline data has been conducted.

d. Bvaluation of the Warm Line

- o a Warm Line log is being kept;

- o a sample of Warm Line callers have been followed up.

B. Locus of Responsibility

1. Staff Responsibility

Professor Robert Malgady has been designated as the Director of Evaluation for NYU's ETC project. Dr. Malgady is a Professor in the Department of Mathematics, Science and Statistics Education with experience in statistical and psychometric research and program evaluation. Dr. **Malgady's** responsibilities in the project include analyzing and interpreting pre/posttest data, revising instruments as necessary, and designing additional evaluation activities, as indicated. Dr. Malgady is also responsible for coordinating the evaluation activities of the University of Puerto Rico site with those of the rest of the ETC. While he has committed only 10 percent of his time as Director of Evaluation of the ETC project, his involvement is enhanced by the fact that he devotes an

additional 10 percent time to the NIMH project's evaluation activities which are closely related.

Bill Sakolsky, the Project Administrator, attends all of the ETC's offerings in the New York Metropolitan area. He is responsible for seeing to it that evaluation instruments are used and that participants complete them. Following the session, he reviews written evaluation comments and shares them with the trainers.

The ETC has several graduate assistants to assist in the evaluation effort, particularly in the analysis of the participant satisfaction data.

2. **Advisory Responsibility**

At one point, it was anticipated that the Educational Program Committee would be responsible for the formative evaluation of each training module. As the program unfolded, they became the actual curriculum developers. Their role in formative evaluation was limited to seeking the input of clinical experts on AIDS as the curricula developed. Initially, as well, the EPC faculty members were to work with the Evaluation Coordinator in preparing questions for evaluating knowledge gains derived from the discipline-specific modules. This portion of the evaluation has since been discontinued because it proved logistically difficult to keep the content items up to date and tailored to the curricula.

The Council for Professional and Health-Related Organizations (CoPHRO) was also to have a role in the evaluation process. However, because of uncertainties about the ETC's geographical region and, therefore, membership in the CoPHRO, this group has not been able to carry out the evaluative function initially assigned to it.

3. **Subcontractors**

Each of the State Coordinators is responsible for distributing and collecting evaluation questionnaires at the training events that they conduct and for transmitting the completed questionnaires to the ETC office.

The University of Puerto Rico subcontractor is responsible for conducting its own evaluation. These efforts are coordinated by Gilda Padilla Rodriguez, MPH, MEd. The subcontractor uses a variant of the ETC's standard instrument (described in Section III.D.l.) which has been translated into Spanish, using back translation methods to assure that the original meaning of the items was retained.

The teleconference portion of the provider training program was subcontracted to Hospital Satellite Network which was supposed to provide estimates of the number of providers reached. Concern on the part of the ETC that it was not getting accurate data on the number of providers reached and the inability to gauge the effectiveness of the programs was one of the reasons that the ETC terminated the teleconference component of their program.

c. Coordination of Evaluation Activities

Evaluation activities of the NYU ETC are centralized and, consequently, coordination of these activities appears to be rather straightforward. Instrumentation is developed centrally and used for all programs under the ETC's auspices whether they are conducted by the ETC staff and faculty or by subcontractors. Analysis, too, is done centrally, except for programs conducted by the University of Puerto Rico, making efficient use of the ETC's Evaluation Coordinator.

D. Reporting of Findings

Annual evaluation reports are planned for the Training Programs, the Train-the-Trainers Institute and the Faculty Institute. For the AIDS Warm Line, the frequency of calls and the nature of the calls are reported every six months.

The evaluation reports for each year of training programs conducted for "other health care professionals" as well as for Warm Line activities have been completed.

III. Program Evaluation

A. Project Monitoring

The NYU ETC has specified its goal and objectives, and has developed a task-specific table which establishes a timeframe for accomplishment and identifies the party responsible for each particular task. Although the ETC does not identify project monitoring as an evaluation objective, it does use this goal/objective structure for much of its reporting.

B. Project Outputs

NYU's program outputs are summarized in the case study.

Data on participants of NYU's training programs are collected by means of a supplementary sheet attached to its pretest instrument. This sheet, included as Appendix I, collects information on sex of the trainee; professional level of the trainee (professional, support, faculty, graduate student, undergraduate); profession; highest degree earned; and ethnic origin (optional).

Evaluation data on the Warm Line is collected using a log to document the number of calls, types of callers, and the nature of the incoming calls.

Graduates of the ETC's Train-the-Trainer Institutes are required to train 50 others as a condition of certification. No attempt is made to track second generation trainees beyond the required 50.

C. Cost Efficiency and Cost Effectiveness

The initial project proposal called for a computation of the cost efficiency and cost effectiveness of the program. The efficiency ratios as originally projected based on budgeted figures and projected trainees, are as follows:

Year	Physician Tele-conferences	Dental Tele-conferences	Workshops	Train the Trainers	Faculty Institute	Warm Line
01	$35	$38	$77	$33	--	$3.89
02	63	38	46	36	--	3.89
03	63	38	47	--	50	3.89

As mentioned, an assessment of cost efficiency was carried out for the overall program in the third year and estimated cost per trainee at about $125 or cost per contact hour of $21. Assessment of specific components or of cost effectiveness has not been done.

D. Evaluation of Impact

1. Short-Term Impact

The NYU ETC assesses the changes produced by its provider training programs on a routine basis, thus providing data for the assessment of short-term impact.

Initially, the NYU ETC planned a rather elaborate evaluation of its training programs for primary care givers, dentists and other health care professionals. The ETC's approach has been modified in light of experience in the early months of the project. It was found that extensive testing significantly cut down on the time available for training and that participants did not respond well to having to fill out numerous forms.

a. Evaluation Design

The following is a comparison of the initial and current designs. The way in which the ETC has had to modify its design in response to practical considerations is instructive.

o Format

Initial. The evaluation format was to be based on pre- and post-testing of trainees. Additionally, a six month follow-up was included to measure the persistence of gains recorded immediately after training.

Current. Attitudes are measured both before and after the offering. Satisfaction with the training program is measured after the offering only. The six-month follow-up is no longer planned, although the ETC may conduct follow-up for specific programs or events in the future.

o Variables

Initial. Variables were to include cognitive change (knowledge gained); affective change (decreased anxiety; decreased phobia and increased positive attitudes); and behavioral change (quality and quantity of interactions with patients).

Current. Preliminary evaluation activities focused on both cognitive and a variety of affective variables. Because of complaints of overtesting by participants and other reasons discussed below, knowledge variables have been dropped from the design. Anxiety was initially measured but shown to be relatively low, particularly among sophisticated city providers. "Posi tivi ty" of attitudes remains the dominant variable.

0 Controls

Initial. Since there was no natural control group against which to compare trainees' change, control was to be created by staggering the entry of participants into the training programs. For example, half the dentists were to have been randomly assigned to early training sessions and half to a "waiting list" control group. Both groups were to have been pre- and post-tested before and after the experimental group's training. Following testing, the control group would have been eligible to receive training.

Current. Because of the logistic difficulty of this approach, the idea of a control group has more or less been dropped. However, recently the ETC has begun thinking about a small controlled study, drawing on a group of 40 graduate students, divided into two groups, following the design described above.

0 Instruments

Initial. The cognitive change evaluation was to consist of content examinations on each module. Those tests were to have been developed by the project evaluator after receiving proposed questions from the EPC faculty member responsible for the module. The question format was to be multiple choice.

The evaluation of affective change was to be based on available instrumentation in the field (e.g. the Gaines and Michal AIDS Inventory) and on the adaptation of standardized scales to be AIDS-specific in content.

Current. The content pre/posttests are no longer to be used for assessing the provider training programs. Their use has been discontinued for several reasons. Curriculum developers were asked to submit 25 multiple choice questions that would discriminate between those who had successfully mastered the informational aspects of the training and those who had not. Typically, ten relatively transparent true-false questions were submitted instead. It was found that, even when questions with face validity were submitted, content changed so quickly that instrumentation could not be kept current. Content pre/posttest were developed, but are now used only in the Train-the-Trainers Institutes and by graduates of the train-the-trainer program to assess their own trainees.

Rather than using an existing instrument, a new "attitude scale" instrument was developed by Barbara Hummel Rossi, the evaluator for the NYU NIMH AIDS Training Program in its first year. Scale items were taken from several existing scales, supplemented by questions developed by Ms. Rossi. The instrument has since been revised considerably by Dr. Malgady upon experience with using it and based on analysis of the items to develop subscales. The instrument is also used to evaluate NIMH training activities in order to assure consistency between the activities of the two projects. It is a non-specific scale intended to measure the "positiveness of the provider's attitudes toward people with AIDS" and, by inference, a "predisposition" to do AIDS-related work. The instrument consists of 20 items which are rated on a 5-point scale. The instrument is included as Appendix II.

In addition, the ETC measures participant satisfaction. The instrument used to measure this satisfaction is a modification of the "CSQ8" (Client Satisfaction Questionnaire 8) found in the psychiatric literature. This instrument consists of 8 items, each with four alternative responses. The instrument is included as Appendix III.

As mentioned in Section III.B, demographic information is also collected: sex; professional status; discipline; and, ethnicity.

o Validation of Instruments

Initial. The items composing all of the tests and scales were to have been submitted to content specialists at NYU and elsewhere to establish both face and content validity.

Since some of the instrumentation was to be newly developed, the psychometric properties of the scales for the population of trainees would have had to have been established, requiring a preliminary pilot analysis. The pilot version of the scales were to have been administered to the trainees as pretests prior to the onset of training, and an item analysis and internal consistency and reliability estimates calculated. Based on the results, the measures would be revised for subsequent use.

Instruments that were translated into Spanish were to have been "back translated" to assure the validity of the translation.

Current. As discussed above, content variables are no longer being consideredand therefore, this aspect of instrument validation is no longer relevant.

Internal consistency is measured, i.e. reliability, is measured via alpha coefficient of the pre- and post-workshop attitude scales. The attitude scale has been shown to be highly internally consistent, with most alphas in the range of .85-9. Item analyses are also carried out, with mean scores in the range of .45-.50. Rather than validating the instrument through a pilot test, the ETC does internal consistency checks and item analyses on an ongoing basis.

Back translation was used to validate the Spanish version of the attitude scale and remains an important means of assuring the validity of translations.

0 Analysis

Initial. The analysis was to have consisted of an analysis of covariance. Because of the problems with unreliability of difference scores, residualized **posttest** scores (pretest = covariance) was to be used in the statistical analysis. Separate data analyses were to have been conducted for each of the three professional programs on a state by state basis.

Current. When the control group design was tabled, analysis of **covariance was** no longer appropriate. Under the current design, mean attitude change is reported. A dependent t-test is used to assess the significance of the change. The effect size (standardized mean difference) is reported as an indication of the meaningfulness of the attitude change with .25 SD-unit change = weak, .50 SD-unit change = moderate, .75 SD-unit change = strong effect).

Satisfaction levels for each of the eight items as well as an overall satisfaction level are analyzed and converted to a **4-point** scale.

b. Data Collection

The ETC evaluation instruments are widely used. However, a number of the host institutions that request on-site ETC training insist on using their own evaluative tests.

c. Findings

The ETC has analyzed the data by the degree to which the site was actually involved with AIDS work. Interesting findings emerged. Sites at which most of the attendees were academically-oriented showed high positivity on the pretest; these trainees showed modest gains in positivity and expressed only moderate satisfaction with the training. Trainees at sites in the front line of health care with significant chance of contact with **PWA's** (predominantly those in city settings) showed only moderate positivity on pretest; they, too, showed modest gains in positivity and were only moderately satisfied with the ETC training. Trainees at more remote sites with less chance of contact with **PWA's** began the training with a low positivity towards people with AIDS but showed significant increase in positivity on posttest; these trainees expressed high satisfaction with the ETC training.

As a result of these finding, the ETC will try to develop a modified program as an alternative to better meet the needs of the more **AIDS-**sophisticated trainee groups.

2. Hid-Range Impact

a. Provider Training Programs

The **ETC's** original evaluation plan included an assessment of the medium range impact of its provider training program component in terms of assessing whether knowledge gained and improvement in attitudes towards AIDS patients was translated into practice. The evaluation was to make

use of an inventory designed to assess the quality and quantity of interactions with AIDS patients.

Ideally, the design of such a study was to include direct observation both before and after a provider attended training. While a candidate who could carry out such a study has been identified, this aspect of the evaluation has not been implemented due to budgetary constraints.

Dr. Malgady feels strongly that this aspect of the evaluation should be pursued for the evaluation to yield truly insightful information on the effects of the ETC's programs. As a less costly alternative, the ETC is considering a telephone follow-up survey in which training participants would be asked to self-report any job-related behavioral changes they have experienced and attribute to the training program.

b. Train-the-Trainers

The objective of the Train-the-Trainer Institute is for the trainers to reach and train as many health care providers in their region as possible. The impact of the Train-the-Trainers Institutes in the mid-term is measured in terms of the number of second generation trainees trained by ETC train-the-trainers graduates. Thus, the evaluation focuses on documenting the number of regional trainees reached by each trainer and on documenting the specific training goals achieved.

Currently, documentation of second generation trainees is limited to the first fifty individuals trained by each graduate. Presumably, these trainers will go on to train additional health care workers. Therefore, NYU is probably understating the impact of this aspect of their program.

Graduates of the second Train-the-Trainers Institute, held in June 1989, have agreed to evaluate the training that they subsequently do. Using the ETC's standard questionnaire, they will assess the satisfaction of participants in the training they provide. Further, using the knowledge pre/posttests initially developed by the ETC and later abandoned for use in their own provider training programs, these train-the-trainers graduates will assess knowledge changes of their own trainees. The results of these assessments will be shared with the ETC staff.

c. Faculty Institute

The ETC has conducted an extensive needs assessment for the Faculty Institute planned for December 1989. An extensive questionnaire (see Appendix IV) was mailed to faculty involved in curriculum planning in 18 health professions schools throughout the NYU region, including Puerto Rico and the Virgin Islands. A similar but less extensive questionnaire was sent to administrators of the schools. The comprehensive survey covers the nature and amount of HIV/AIDS content in the current course offerings, barriers encountered in including HIV/AIDS content in curriculum, expectations and plans for expanding HIV/AIDS curriculum content in the future, practicum policies, student attitudes and opportunities for working with AIDS patients/clients, the availability and need for various types of resource materials on AIDS, as well as logistical consideration for planning the institute.

In all, 268 questionnaires were sent out; 150 responses were received. The ETC is currently in the process of analyzing this baseline data.

A six month follow-up of the Faculty Institute will be conducted. A questionnaire will be sent to participants to determine whether information gained in the workshop has been incorporated into the educator's own teaching or curriculum.

d. AIDS Warm Line

A sample of Warm Line callers is taken from those who give their voluntary consent to participating in a follow-up survey. This sample is called back by a graduate student within two to three weeks to determine whether the information the caller had received from the Warm Line proved helpful in resolving the caller's problem.

IV. Evaluation of Specific Education and Training Interventions

NYU's specific education and training interventions have been identified and described in Section IV.B.l of the case study.

A. Evaluation Designs for Specific Interventions

1. Teleconferences

The Healthcare Information Network was to have gathered post-program survey data within four weeks of each broadcast. While some surveying was done, the report submitted by the Bealthcare Information Network was unsatisfactory, in part leading to the ETC's decision to discontinue this aspect of their program.

2. **Videotapes for Physicians and Dentists**

In the second year of the project, videotaped panel presentations replaced interactive teleconferences as NYU's primary strategy for reaching large numbers of physicians and dentists. The videotapes for each of these disciplines are in the final stages of production.

The current strategy calls for a mass mailing of the videotapes to area physicians and dentists through professional associations and health care institutions as well as directly to providers in zip codes containing significant minority populations. A knowledge-based posttest has been or will be developed for each videotape and will be included to enable the viewer to obtain continuing education credit. This test will also serve as the ETC's evaluation instrument for this program component.

3. Training Programs for Other Health Professionals

As described in Section II.A.1., evaluation of training programs for "other health professionals" is a major focus of the ETC's evaluation activities. Apart from and preliminary to the evaluation of impact described in the previous section, the data collected via attitude scales and participant satisfaction questions is used to analyze individual offerings.

In its evaluation report of April 1989, the ETC presented the findings of the evaluations of ten selected programs presented between October 1988 and April 1989. Those findings found to be statistically significant are summarized below:

Site	Major Target	Response Rate	Positivity at Pretest	Attitude Change	Participant Satisfaction
NYU Medical Center	Medical Students	77% (n=43)	70.64/100	Moderate	Mod.- High
Kings County Hospital	Multidisc. Staff	98% (n-106)	57.12/100	Moderate	High
Brooklyn NYSNA	Nurses & Others	93% (n=145)	63.401100	Moderate	High
Goldwater Hospital	Multidisc. Staff	64.5% (n=124)	60.98/100	Moderate	High
Riverhead, LI	Nurses & Therapists	84% (n=110)	69.74/100	Mod.-Large	High
Creedmore Psych Center	PAs & Therapists	84% (n-95)	58.711100	Moderate	High
Norwich Hosp. (CT)	Nurses	64% (n=44)	71.02/100	Very Large	Very High
New York University	Nurses & Therapists	46.5% (n-129)	70.291100	Moderate	High
CCNY School of Nursing	Faculty & Students	50% (n=26)		Not Signi-ficant	High
St. Thomas, VI	Nurses & Therapists	43% (n=185)	64.961100	Large	High

4. **Train-the-Trainers**

The Train-the-Trainers Institutes are evaluated using the ETC's standard participant satisfaction questionnaire. In addition, knowledge gains of the participants are assessed using the content tests initially developed for use in evaluating the provider training programs but latter discontinued for this purpose.

5. **Faculty Institute**

The Faculty Institute assessed participants' perceptions of the quality of the three-day workshop by means of the same participant satisfaction questionnaire as is used to assess satisfaction in the ETC's provider training workshops.

6. Warm Line

Warm Line activities are analyzed descriptively every six months from data collected on the log. During the period October 1988 through February 1989, the number of calls per month increased from 12 to 36. Analysis of the log data showed that the Warm Line was used by a broad spectrum of health care disciplines, with a large increase in requests from health educators and social workers. Questions tend to be about available research, counseling and, to some extent, legal issues with a large increase in inquiries about educational opportunities. The Warm Line does not seem to **be used as a** source of referral information. Questions of a professional, rather than personal nature, were the focus.

V. **Formative** Evaluation of Products Developed

The NYU ETC does not engage in what they consider formal formative evaluation. They do conduct formative evaluation of curriculum modules in the sense that they undertake "expert reviews" as part of the development process. The EPC faculty member responsible for developing a discipline-specific module is required to obtain input from a clinician in their discipline actively working with AIDS patients. In addition to providing input during the planning stage, the clinical experts do content reviews of the draft materials as well.

Videos are being or have been developed to support the discipline-specific curricula. Videos for therapeutic recreation, nutrition, nursing,. social work occupational therapy and physical therapy are being developed by the EPC faculty and produced by the NYU Center for Media Services. Four videos, three for physicians and one for dentists, are being produced through a subcontract to Telesource. The physician videos are being produced under the direction of Conrad Rosenberg, M.D., the ETC Medical Director while dentists' video is being prepared under the Direction of Harriet Goldman, D.D.S. The videos, too, undergo "expert reviews."

VI. Recommendations

1. The ETC invested a considerable amount of time and effort in developing its attitude questionnaire. By their own **description,** it is a non-specific scale of "positivity" of attitud**es. The** usefulness of this tool might be enhanced by subjecting it to a factor analysis, thereby identifying sub-scales. Before and after comparisons of sub-scale changes or lack thereof would be helpful in identifying attitudinal areas which are not responding to ETC inputs, thereby pinpointing areas for course improvement. The ETC might benefit from a review of the evaluation work done in this area by the Arizona site of the UCD ETC.

2. Most of the products the ETC plans to produce have been completed or are nearing completion. They have been produced professionally, but have not been subjected to formal formative evaluation. Should the ETC produce more products in the future, it is recommended that they go that one little step further, building in a pilot testing step before the final production step.

APPENDIX1

NYU's Instrument for Collecting Demographic Characteristics of its Training Participants

I.D. Number _____

NEW YORK UNIVERSITY AIDS EDUCATION PROJECTS

****

PLEASE CIRCLE ONE

FEMALE MALE

****

PLEASE CIRCLE ONE

1. Health Care Professional
2. Support Staff
3. Faculty
4. Graduate Student
5. Undergraduate Student

****

PLEASE CIRCLE ONE

CLERGY	COUNSELOR - DRUG	COUNSELOR - HIV
COUNSELOR - OTHER	COUNSELOR - REHAB	DENTAL HYGIENIST
DENTIST	HEALTH EDUCATOR	NURSE [LPN]
NURSE [RN]	NUTRITIONIST/ DIETICIAN	OCCUPATIONAL THERAPIST
PHYSICAL THERAPIST	PHYSICIAN	PHYSICIAN'S ASSISTANT
PSYCHIATRIST	PSYCHOLOGIST	RECREATION THERAPIST
RESPIRATORY THERAPIST	SOCIAL WORKER	OTHER: _____

HIGHEST DEGREE EARNED: _____

****

YOUR ETHNIC/RACIAL ORIGIN (OPTIONAL) PLEASE CIRCLE ONE

ASIAN	BLACK	CAUCASIAN	HISPANIC	NATIVE AMERICAN	OTHER

****

PLEASE ESTIMATE WHAT PERCENTAGE OF YOUR CLIENT LOAD IS:

ASIAN	BLACK	CAUCASIAN	HISPANIC	NATIVE AMERICAN	OTHER
_____	_____	_____	_____	_____	_____

(Numbers across should total 100%)

over...

APPENDIX II

NYU's Attitude Scale (Pre/Posttest Instrument)

New York University
A private university in the public service

NYU AIDS Education Projects
Post - Evaluation

I.D. Number _____ Profession _____

NYU HIV/AIDS ATTITUDE QUESTIONNAIRE: Health Care Providers

Instructions: The following statements refer to your feelings about various aspects of caring for patients or clients with AIDS/HIV infection in your role as a health care provider. Read each of the following statements and choose the response option that best corresponds to your feeling about each statement. Indicate the extent of your agreement or disagreement with each statement by choosing one of the following options (write the letter corresponding to your choice in the space next to each statement):

A. Agree Strongly
B. Agree Somewhat
C. Neutral/No Opinion
D. Disagree Somewhat
E. Disagree Strongly

---- 1. I often worry about contracting HIV because I do not always follow universal precautions at work.

---- 2. I often worry abut co-workers contracting HIV because of their high risk personal behavior.

---- 3. Health care providers should not be obligated to care for patients/clients with HIV/AIDS.

---- 4. Current knowledge abut HIV transmission is effective in protecting health care providers who work with PWAs.

---- 5. I sometimes worry that it is possible to contract HIV from patients/clients at work even without contact with their body fluids.

---- 6. Working with patients/clients with HIV/AIDS is no more dangerous than working with others with communicable illnesses.

---- 7. I prefer not to care for patients/clients who have acquired HIV/AIDS through homosexual or bisexual experiences.

---- 8. Infection control procedures at work are sufficient to protect health care providers from increased risk of contracting HIV from patients/clients.

---- 9. Sufficient information about all aspects of HIV/AIDS is being provided in educational programs for health care providers.

---- 10. The spread of HIV infection has not made ma resentful of homosexual patients/clients at work.

---- 11. I rarely worry about contracting HIV from patients/clients with whom I work.

---- 12. I often worry that my own knowledge about transmission of HIV is insufficient to protect me from infection at work.

---- 13. Ethnic and cultural sensitivity are very important in relation to the care of patients/clients with HIV/AIDS.

---- 14. I prefer not to care for drug users who have acquired HIV/AIDS through sharing needles.

---- 15. My family and friends will disassociate themselves from me if they know that I care for HIV/AIDS patient/clients at work.

---- 16. A pregnant HIV-infected patient/client should have an abortion.

---- 17. Health care providers should be able to accept and support non-traditional families, same sex partners, and friends of patients/clients with HIV/AIDS.

---- 18. I would prefer not to have direct contact with HIV/AIDS patients/clients at work.

---- 19. I sometimes find myself trying to avoid treating patients/clients with HIV/AIDS.

---- 20. The spread of HIV infection has instilled feelings of resentment in me towards patients/clients at work who are known IV drug users.

APPENDIX III

Participant Satisfaction Questionnaire (Posttest Instrument)

I.D. _____

NEW YORK UNIVERSITY AIDS EDUCATION PROJECTS

SATISFACTION QUESTIONNAIRE
(Post-Evaluation)

CIRCLE YOUR ANSWERS

1. How would you rate the quality of training you received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind *of* training you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has *our* program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a co-worker/colleague were in need of similar help, would you recommend this program to him/her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied *are you* with the amount of information you received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satified

6. Has the training you received helped you to deal more effectively with your work with PWA's?

4	3	2	1
Yes, Helped a great deal	Yes, Helped somewhat	No, Really didn't help	No, seemed to make things worse

over . . .

CIRCLE YOUR ANSWER

7. In an overall, general sense, how satisfied are you with training you received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No, definitely not	No, I *don't* think so	*Yes,* I think so	Yes, definitely

WRITE **COMMENTS** BELOW:

THE FOLLOWING SECTION IS FOR **NURSES** ONLY
TO MEET NEW **YORK** STATE NURSES ASSOCIATION **REQUIREMENTS**

Please rank the following questions	LOW				HIGH
Relevance of presentation's content to the program objectives	1	2	3	4	5
Appropriateness of the physical facility for training	1	2	3	4	5
Achievement of personal objectives by the learner	1	2	3	4	5
Attainment of program objectives	1	2	3	4	5
Teaching effectiveness of presenter					
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

APPENDIX IV

Needs Assessment and Baseline Data Collection Instrument for NYU's Faculty Institute

New York University
A private university in the public service

School of Education, Health, Nursing, and Arts Professions
N.Y.U. AIDS Regional Education and Training Center

429 Shimkin Hall
Washington Square
New York, N.Y. 10003
Telephone: (212) 998-5332, 5330
FAX: (212) 995-3143

NEW YORK UNIVERSITY
Regional
AIDS
Education and Training Center

SURVEY OF HIV/AIDS CONTENT IN THE CURRICULUM

THIS QUESTIONNAIRE FOCUSES ON HIV/AIDS CONTENT IN COURSES YOU TEACH. IF YOU TEACH IN MORE THAN ONE LEVEL OF YOUR CURRICULUM (E.G. BACCALAUREATE AND MASTER'S) PLEASE FILL OUT A SEPARATE QUESTIONNAIRE FOR EACH OF THE LEVELS. PLEASE ANSWER THE QUESTIONS. AS FULLY AS POSSIBLE.

NAME OF DEPARTMENT OR PROGRAM (Please specify which)

II. A. PRESENT PLACE OF HIV/AIDS IN THE CURRICULUM

1. What percent of your curriculum is related to HIV/AIDS content?

2. Please list the courses you teach which have content relating to HIV/AIDS?

3. In the-past year the amount of HIV/AIDS information in your courses has:
   1. increased
   2. decreased
   3. not changed

4. Referring to question 3, in what area has this change (if any) taken place? (Circle all that apply)
   1. cognitive
   2. attitudes
   3. clinical

5. Which one of the following **terms** best describes your view of the amount of HIV/AIDS content in your curriculum?
   1. Poor
   2 Fair
   3. Adequate
   4. Excellent

6. If instructional hours have not been devoted to HIV/AIDS, please check **all** the reasons that explain why.

   ___1. AIDS isn't at all relevant to courses
   2. There hasn't been time to revise course syllabi to include AIDS
   3. Couldn't find handouts or readings related to AIDS that are appropriate for courses
   ___4. Very few of the students are interested in AIDS
   ___5. Most of the students will get instruction on AIDS related topics elsewhere
   6. Faculty are not interested
   7. Faculty do not believe it necessary

7. Which of the following best describes the expectations for including HIV/AIDS content in the curriculum for the remainder of this academic year and the next academic year (1989-90)

   1. Plan to increase coverage of HIV/AIDS specific content
   2. Plan to decrease coverage of HIV/AIDS specific content (because_____)
   3. Won't be making any changes in HIV/AIDS specific content
   4. Need more information before making a decision

8. How is HIV/AIDS information presented in your current curriculum? (Circle all that apply)
   1. integrated into courses
   2. **separate** elective course
   3. separate required theory course
   4. separate required clinical course

9. Do you foresee this presentation changing in the near future
   1. no, keep as is
   2. keep as integrated course
   3. change to separate elective course
   4. change to separate required theory course
   5. change to separate required clinical course
   6. change to integrated course

10. What teaching methods are used to relate HIV/AIDS specific content? (Please circle all that apply)
    1. seminars
    2. lectures
    3. symposia
    4. guest speakers
    5. field trips
    6. other (please list) _____

B. SPECIFIC CONTENT RELATED TO AIDS

1. Do you have separate clinical/theoretical objectives related to HIV/AIDS
    1. yes, both clinical and theoretical objectives
    2. only theoretical objectives
    3. only clinical objectives
    4. no objectives specifically related to HIV/AIDS

2. The following is a list of HIV/AIDS related topics. In the first column check those aspects relevent to your discipline which are presently included in your curriculum content specifically related to HIV/AIDS. In the second columnn please indicate those topics you would like to see included in the curriculum.

PRESENTLY INCLUDED	LIKE TO SEE INCLUDED	
		HIV INFECTION
1.___	2.	a. CDC definitions/diagnoses
1.___	2.	b. immune system
1.___	2.	c. pathophysiology
1.___	2.	d. geographics
1.___	2.	e. epidemiology/virology of HIV
1.___	2.	f. demographics
1.___	2.	g. counseling/testing
		INFECTION CONTROL
1.___	2.___	a. CDC guidelines
1.___	2.	b. aseptic practices/techniques
1.___	2.	c. occupational risks
1.___	2.	d. transmission of HIV
1.___	2.___	e. blood banks

PRESENTLY INCLUDED	LIKE TO SEE INCLUDED	
		RESOURCES/ENTITLEMENTS
1. -	2. -	a. community
1. -	2. -	county
1. -	2. -	c. state
___	___	d. national
1.___	2.___	e. federal/governmental
		CARE OF PATIENTS
1.___	2.___	a. patient care
1.___	2.	b. case management
1.___	2. -	c. current research findings
1.___	2. -	d. nutrition
1.___	2. -	e. drug management
1.___	2. -	f. activities of daily living
1.___	2. -	g. opportunistic infections
1.___	2. -	h. neuropsychiatric complications
1.___	2. -	i. resources/entitlements
1.___	2. -	j. social/community support
1.___	2. -	k. spiritual support
1.___	2. 1	1. psychosocial seguelae
		LEGAL/ETHICAL/SOCIAL ISSUES AND HIV
1.___	2.	a. legal issues
1.___	2. -	b. politics of AIDS care/ legislation/prevention
1.___	2.	c. ethical issues
1.	2.___	d. politics of AIDS testing
1. -	2.	e. community networks
1. -	2. -	f. confidentiality
1. -	2. -	g. effects of mass media
1. -	2. -	h. change strategies
1.___	2. =	i. politics *of* health care (relating to HIV/AIDS)
1.___	2.___	j. politics of poverty (relating to HIV/AIDS
		HEALTH CARE PROVIDER ISSUES
1.___	2.___	a. coping with death and dying, of the young
1.___	2.	b. patient/family/lover **counselling**
1.___	2. -	c. values clarification
1.___	2. -	d. coping with fears of transmission
1.___	2.___	e. stress reduction techniques for above issues

PRESENTLY INCLUDED	LIKE TO SEE INCLUDED	
		GROUPS/AT RISK BEHAVIORS
1.___	2.	a. homo/bisexuals
1.___	2 . -	b. hemophiliacs/blood product recipients
1.___	2 . -	c. substance users/abusers
1.___	2 . -	d. women
1.___	2 . -	a. infants, children
1.___	2 . -	f. heterosexuals
1.___	2 . -	g. racial/ethnic minorities

		AFFECTIVE COMPONENTS FOR PATIENTS SIGNIFICANT OTHERS/FAMILIES
1.___	2.	a. fear and anxiety
1.___	2 . -	b. death and dying
1.___	2 . -	c. communication
1.___	2.___	d. acceptance of alternative life styles

c. STUDENT ISSUES

1. Which statement best describes your policies for students caring for AIDS patients/clients?

   1. Students are assigned to and required to care for patients/clients with HIV/AIDS when appropriate
   2. Student preferences are taken into consideration when assignments are made
   3. All students are required to have cared for at least one HIV/AIDS patient/client during their schooling
   4. Faculty do not usually assign students to care for HIV/AIDS patients/clients
   5. Have not addressed this issue

2. What percentage of your students have cared for an AIDS patient/client?

   1. 0-252
   2. 25-502
   3. 50-75%
   4. 75 - 100%

3. How would you describe your average student's attitude toward caring for an AIDS patient/client
   1. readily provides direct care
   2. reluctantly provides direct care
   3. chooses to have no contact wiith AIDS patients/clients
   4. don't know

4. What actions take place if student refuses to care for a patient/client with AIDS?

D. INSTRUCTIONAL RESOURCES

The following is a list of teaching aids and instructional resources. Please indicate:
   a. resources you know you can easily obtain
   b. the degree to which you have used that resource
      1 - never used **5** - always use

RESOURCE	OBTAINABLE	USE
1. Student Reference lists	1. Yes 2. No	1 2 3 4 5 never always

I would like to have references on:

RESOURCE	OBTAINABLE	USE
2. Faculty Reference lists	1. Yes 2. No	**1** 2 3 **4** **5** (1 never, 5 always)

I would like to have references **on:**

3. Audiovisual Material	1. Yes 2. No	1 2 3 4 5

I would like audiovisual material on:

4. Lecture material	1. Yes 2. No	1 2 3 4 5

I would like lecture material on:

5. Guest Speakers	1. Yes 2. No	1 2 3 4 **5**

I would be interested in guest speakers on:

6. Workshops	1. **Yes** 2. No	1 2 3 4 5

I would be interested in workshops **on:**

D. FUTURE DIRECTIONS

1. would you be interested in attending a curriculum workshop on HIV/AIDS for your discipline?
   1. yes
   2. no
   3. undecided

2. Please look at the following list of HIV/AIDS related topics. Mark in order of preference those topics you would included in a curriculum workshop.
   1 = most preferred 10 = Least Preferred

___a. HIV/AIDS Infection
___b. Infection control
___c. Resources/Entitlements
___d. Care of patients/clients with AIDS
___e. Political/social issues
___f. Legal/ethical issues
___g. Health care provider issues
___h. Groups/Behaviors at risk
___j. Affective components for patients/significant others/families

3. Other topics you would like included (please specify)

4. Please circle the day(s) most convenient for you to attend such a workshop
   1. Monday
   2. Tuesday
   3. Wednesday
   4. Thursday
   5. Friday
   6. Saturday
   7. Sunday

5. I would be willing to attend a workshop for:
   1. one day
   2. two days
   3. three days
   4. four days
   5. five days

6. Best time of year
   1. Fall
   2. Winter
   3. Spring
   4. Summer

7. Comments/Suggestions

Please return this form by March 27, 1989

to:

Patricia M. Hurley, Ph.D. R.N.
NYU AIDS Project
532 Shimkin Hall
Washingon Square
New York, New York 10003

Yes, I've participated in the HIV/AIDS CONTENT IN THE CURRICULUM survey and would like a copy of the results.

Name_____

Position_____

ADDRESS_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

WAMI-0 AIDS EDUCATION AND TRAINING CENTER

EVALUATION REVIEW

I. Overview

The WAMI-0 AIDS Education and Training Center Program (WAMI-0) identified as its mission the integration of existing resources and delivery of multidisciplinary education and training to primary care practitioners and allied health and support professionals in the Northwest and Alaska.

The WAMI-0 AIDS ETC Program offers a train-the-trainer program, a series of clinical updates, and other special courses and activities identified as regional needs. It is also intending to create multidisciplinary "centers of competence" or "resource cities" around the region (Washington, Oregon, Montana, Idaho and Alaska) to serve as the foci of education and HIV clinical care at the local level. Additionally, WAMI-0 plans to assist area professional schools in expanding-the HIV/AIDS content in their curricula.

The WAMI-0 program is closely associated with the NIMH project in the region. Consequently, much of the training curricula and most of the evaluation approach is either borrowed directly or adapted from the NIMH program. The ETC's evaluation activities address each of the above activities, with a major focus on the evaluation of its train-the-trainers program. There has been heavy emphasis on assessing multiple dimensions of any given program, particularly mid-range impact.

II. The Evaluation Process

A. Evaluation Plan

WAMI-0 formulated a general evaluation plan in the early stages of the project. Subsequent plans which are more specific have been prepared. The most recent, prepared in March 1989, presents current evaluation priorities and delineates the specific activities to be undertaken and the kinds of data to be collected.

1. Initial Broad Plan

WAMI-0's evaluation plan, as set forth in its original statement of goals and objectives is as follows:

- o Create criteria for competence/standards of practice for the care and prevention of AIDS, ARC and HIV infection
- o Develop and implement evaluation of the train-the-trainer program to be used by the AIDS ETC
- o Develop and implement quantitative measurements to evaluate the effectiveness of training provided by the centers of competence.

o Develop and implement quantitative measurements to evaluate clinical updates (on-site and in Seattle)

o Research response to AIDS training in urban and rural communities of the Northwest and Alaska.

Time frames are given only for establishing the criteria for competence, to be begun and completed in the second half of Year One, and for analyzing data from the outcome evaluation, to be begun and completed in Year Three.

2. **Implementation of the Evaluation Plan**

Midway into the second year, WAMI-0 AIDS ETC had developed instruments to evaluate several programs and has completed analysis for both pre/post test measures and follow-up questionnaires for two of its training programs and two train-the-trainer programs. The broader evaluation goals have not yet, of course, been accomplished. A review of WAMI-0 AIDS ETC's evaluation measured against its plan revealed the following:

(1) Criteria for Competence/Standards of Practice:

o Criteria for Competence/Standards of Practice have not yet been formulated

As was noted in the Case Study Report, achieving consensus on appropriate standards and devising a method of measurement are problematic tasks. Furthermore, legislative action prompted immediate attention to training activities and this activity has not received great attention to date. The ETC will be addressing this issue indirectly by working closely with another group at the University of Washington School of Medicine that have recently received a grant to pursue development of competency criteria.

(2) Evaluation of Train-the-Trainer Program:

o extensive instrumentation is in place for the train-the-trainers program

(3) Evaluation of the Effectiveness of Centers of Competence Programs:

o Centers of Competence concept is not yet in place, although a modified version, "Resource Cities", has been initiated

The project is continuing toward the development of the capabilities of a regional network of important foci of medical care. The resource cities concept differs somewhat from the centers of competence concept in that there is more of an emphasis on development of local caregiving resources in the former than local edcuation and training capabilities, although the two are obviously related. Since the the concept is just getting underway, there has been no effort, to date, to evaluate

progress or effectiveness, although evaluation of both is planned.

(4) Evaluation of Clinical Updates:

o needs/demands assessments are being done prior to most offerings

o offerings are routinely evaluated via participant feedback questionnaires

(5) Research Response to Training in Urban and Rural Communities:

o no activity has yet been recorded in this area

B. Locus of Responsibility

In an administrative sense, the Project Director, Dr. David Johnson has the final responsibility for evaluating the project's progress, while the Deputy Project Director, Ms. Ann Downer, is responsible for the evaluation of the multicomponent and multidisciplinary programs.

Initially, Dr. Lewayne Gilchrist was designated as the Program Evaluator with responsibility for implementing evaluation activities. Dr. Gilchrist, who is the principle investigator for the NIMH AIDS Training Program, began by integrating many of the NIMH evaluation tools into the ETC program. In the second year of the project, Lynn Mandel, **PhD,** took over the responsibility for coordinating evaluation efforts: developing evaluation designs; developing and revising evaluation tools; and, implementing evaluation activities. Dr. Gilchrist is still officially listed as the ETC Program Evaluator, but is now involved only as an internal evaluation consultant. In the third year of the program, again a new individual, Bernadette LaLonde, **PhD,** took over the role of program evaluator. The ETC staff feel that Dr. LaLonde brings excellent capabilities to the program and will be very instrumental in improving the intensity and utility of evaluation activities for the ETC. She has spent much of her time initially attempting to clean and analyse the data previously collected. She is also beginning to develop evaluation plans for the **ETC's** future programs.

C. **Coordination of Evaluation Activities**

In the first year and a half of the project, little in the way of coordination of evaluation activities had taken place. The project evaluator was to have visited each AHEC to assist in implementation of evaluation methods developed for each state. Travel costs apparently proved too high to allow any of the ETC project staff to travel to the sites for coordination purposes.

D. Reporting

General reporting of subcontractor outputs and evaluation activities to the ETC coincides with the preparation of the semiannual progress report to HRSA. The ETC is considering requesting these reports on a quarterly basis.

To date, evaluation activities have concentrated on the train-the-trainer course on which the ETC issues periodic, indepth evaluation reports on select courses. To date, two such reports have been published, each covering two train-the-trainers courses.

III. Program Evaluation

The current WAMI-0 ETC AIDS Training Project Evaluation Plan (March, 1989) delineates four priority areas of evaluation: implementation, process, impact/outcome, and costs.

- o Implementation is to be evaluated through a case study description of the program which will include an articulation of goals and objectives, documentation of the development process, description of structure, as well as a case description of a program from planning stage to evaluation.

- o Documentation of program processes will include information about training outputs as well as a description of program planning and evaluation processes. While data will be aggregated, thereby rendering this a form of program evaluation, the primary unit of analysis appears to be the training offering; this aspect of the evaluation will therefore be described in Section IV of this report which is devoted to the evaluation of specific training offerings.

- o The impact/outcome evaluation for the Train-the-Trainer (T3) will include outputs; pre/post measures of training plans, attitudes, and practice; quality control or certification of trainees; observations; as well as second generation trainee assessments of the T3 trainers. The impact/outcome evaluation for Training Direct Service Providers will include measures of change in knowledge, attitudes, and practice.

- o The evaluation of products and other outcomes will include descriptions, reviews, and related trainings.

- o Cost analysis will examine costs per T3 trainee, direct service eider, and materials.

A. Evaluative Case Study

Case Studies will offer a description of the overall ETC program including statements of goals and objectives, descriptions of the program's development, its organizational and management structure, and operational activities. The ETC had intended to use case studies to document the rationale for program changes, description of activities and each stage of program design and implementation. Finally, case studies were to provide a description of external relationships. To date, no specific activity toward case study development has taken place.

B. Impact/Outcome Evaluation

WAMI-0 has identified impact assessment as a component of its evaluation since the outset. Preliminary designs appeared in the **ETC's** early documentation. The current plan, which was produced in the second year of the project, is a more well-defined version of earlier documents. The **ETC's** plans for implementing the evaluation, while still evolving, call for extensive follow-up of all of its trainees, via mailed questionnaires, telephone interviews and, where feasible, direct observation. It is an extremely ambitious plan which will require intensive staff input over the duration of the project. However, the potential payoff is great.

WAMI-0 will examine the impact/outcomes of two categories of courses. The first group of courses are those whose primary focus is to prepare its participants as trainers. Courses in this category include **train-the-**trainers programs (AIDS Intensive + Instructor) and courses that prepare trainers in specialty areas to deal with AIDS issues (such as trainers of drug abuse counselors). The second category includes courses which are primarily aimed at preparing direct service providers to deal with AIDS issues in their areas of professional practice, but also prepares them to teach should they be called upon to do so.

1. Train-the-Trainers (including Trainers in Specialty Areas)

The design and instrumentation (some of which also provides data for the impact analysis) for evaluating individual train-the-trainers courses is discussed in Section IV. This section presents the outcome variables that will be examined in the aggregate to assess the impact of **WAMI-0's** overall train-the-trainers efforts.

As part of its evaluation of its train-the-trainers efforts, the ETC will examine the relationship between the job held by its graduates and (1) the number and types of trainings they subsequently do and (2) the numbers and types of health care professionals they ultimately reach.

Another measure of the program's impact is how well graduates are able to carry out their planned training activities. This will be evaluated by comparing the graduates intentions to do training, as evidenced by the training they prepare during the course, and what they are actually able to accomplish 4 to 6 months later (as determined through telephone follow-up).

Specific variables that will be examined as part of this ongoing study of impact include:

- Persistence of knowledge (measure by testing immediately **post-** training and at 3-month follow-up)
- Change in attitudes toward training and confidence in their own ability to train (pre-training and 3-month post-training follow-up questionnaire)
- Training ability (as assessed by the graduate's trainees, and as observed by WAMI-0 staff)
- Networking skills (measured by follow-up questionnaire)
- Change in professional practice (still under discussion: probably to be implemented via self-report during telephone interview)

One related area of training where follow-up has occurred in this manner is for the training of trainers courses held in the third year focusing on substance abuse issues. The courses included segments on effecting organizational development and behavior with specific ideas for changing or improving intake procedures to be more attuned to substance abuse. Trainees were asked to both hold trainings in their home institutions and to implement appropriate systemic or procedural changes. Trainees were being followed-up by the ETC staff to assess factors contributing to organizational successes and barriers. Results of this evaluation should be available by the end of the third year.

2. Training for Direct Service Providers

As part of the evaluation of its programs for direct service providers, the ETC will examine the effectiveness of various approaches to recruit providers, especially physicians, into these programs.

Variables that will be examined in assessing the impact of WAMI-O's training programs for direct service providers are similar to those used to assess the train-the-trainers program except that they focus more on the trainees* preparedness to serve people with AIDS (i.e. their attitudes/ confidence in caring for people with AIDS) than on their preparedness and accomplishments as trainers (only self-reports of their activities in this area will be sought).

c. Bvaluation of Products and Other Services

Products and other services will be evaluated as follows:

- o Descriptive analysis of products and how they are being used
- o Feedback about products received via review questionnaires enclosed with the product and a telephone survey of a sample of recipients
- o Qualitative analysis of the utilization of **WAMI-0's** Speakers' Bureau

D. Effort Evaluation (Cost Analysis)

WAMI-0 has established as its cost target **"less** than $250 per trainee." Initially, a simple cost per trainee for each session was to be calculated. More recent plans indicate a more elaborate cost analysis is to be conducted, including:

- o cost per train-the-trainer graduate by site
- o cost per direct service provider that train-the-trainers graduates train
- o cost per direct service provider trained directly by the ETC
- o costs for materials development, production and dissemination
- o value of donated materials, services, personnel time, in-kind contributions, etc.

Cost analyses of several events have been performed, but aggregate cost assessments have not been issued as yet.

E. Evaluation of Program Outputs

WAMI-0's program outputs are summarized in the case study. In terms of number of participants, the ETC has already exceeded the 7,900 health care workers it had projected for training by the end of the three-year grant period.

WAMI-0 uses a Training Report Form to collect output data. Variables collected include:

Reach

0 Location of training
o Ethnic background of population served (estimate of **%)**

Participants/Trainees

o Number of participants by professional category
o Ethnic background of participants (estimate of %)

Education/Training Intervention

o Number of contact hours
o Topics presented
o Training methods used

A copy of the Training Report Form is included as Appendix I.

F. Project Honitoring

While WAMI-0 does not specifically identify project monitoring as an evaluation activity, it does note progress toward its various goals in progress reports.

Project monitoring of complex goals, such as the establishment of local resource cities for the care and management of AIDS, through documentation in a case study analysis and other evaluative efforts would be very helpful.

IV. Evaluation of Specific Education and Training Interventions

WAMI-O's specific education and training interventions have been identified and described in the Case Study. The overall evaluation design and numerous instruments to assess training interventions are used by both the WAMI-0 AIDS ETC and the NIMH Training Program.

A. Generic Design For Evaluating Trainees

1. Definition of Competence

An important component of the overall evaluation design is the creation of a definition of competence for AIDS practitioners. The ETC will be working with a group in the School of Medicine at the University of Washington to create competency criteria for health care professionals. Ultimately, it was intended for the evaluation of all components of the ETC to involve these standards for practice. The goal is to have the successful participants of the AIDS ETC train-the-trainers and clinical training programs model the standards.

2. Evaluating Changes in Trainee Competences

WAMI-0's original grant application proposed a generic methodology for evaluating changes in trainee competence resulting from any of their trainings. This generic methodology is described below:

o Design Format

Pre/post design with the training as the independent variable. Trainees are asked to complete a pretest and posttest for each session.

o Variables and Measures

Variables related to specific training objectives are noted for each training. Categories of dependent variables include:

--Knowledge gain (tested)
--Changes in cognitive competence (tested)
--Attitude change (tested)
--Changes in levels of comfort and confidence (self-report)
--Skill-level (self-report)

Data on the following independent variables are to be collected post-training:

--Specific sessions attended
--Prior AIDS training

o Controls--Consistency of Data in the Time Series

To assure anonymity for trainees and yet allow the evaluator to match and compare each trainee's pre-training and post-training responses, trainees are asked to mark their questionnaires with a code constructed from their mother's and father's initials and their own birth date. This procedure protects the confidentiality of trainees' responses and typically results in a loss of fewer than 10% of subjects due to inability to match pre- and posttest codes.

0 Sampling

Presumably, 100% of trainees participating in the course will be sought .

0 Instruments

A paper-and-pencil test is used. The available instrument, to date, consists of scales for attitude, comfort, confidence and skill level. A draft of knowledge/attitude assessment is currently available.

o Analysis

The analyses will employ standard parametric and nonparametric tests to compare trainees' pre- and post-training responses to document increases in knowledge, professional confidence and subjective comfort.

3. Process Evaluation

The design of the process evaluation has evolved considerably over time. Initially, it was conceptualized in terms of the evaluation activities that were to be carried out. The data items, which were not specified, were to have been summarized by training site and professional discipline.

This approach was extremely labor-intensive:

o Training team members were to complete a form after each session asking them to rate each element of the program.

o Staff and faculty for the program were to directly observe randomly selected training sessions, rating training team members on their adherence to protocol, clarity, and other teaching skills.

o When training at that site was finished, the administrators at each site (if identified) were to have been asked to complete a short form summarizing any problems, complaints, or other feedback they may have about the training program, and any behavioral or procedural changes in care related to AIDS that may have occurred in their agency/setting during or after training.

o Trainees were to complete participant satisfaction forms asking them to rate the utility, clarity, and value of the training they received. Trainees were to have been asked to suggest additions and deletions to the program, how much they would make use of the skills and information stressed by the training program to colleagues.

The process evaluation has now been redesigned, focusing more on the variables to be examined. As currently conceived, it will consist of two components as follows:

<u>outputs</u>

-- Level of ETC involvement
-- Training location
-- Number of participants
-- Demographics of the participants
-- Content of the program

<u>Program Planning/Evaluation</u>

-- How target groups/populations were chosen
-- Logistical considerations in reaching each group
-- How needs assessments were used in program planning

-- How speakers were chosen
-- Participant reaction at the end of training
-- Results of debriefing of facilitators
-- How results will be used to revise future sessions

B. Evaluation of the Train-the-Trainers Courses

1. Evaluation Design

WAMI-0 evaluates its Train-the-Trainers Program from many different perspectives: specific training needs perceived; pre-training self-perceptions of training competence; trainees evaluation of the train-the-trainers course; evaluation of performance in practice as perceived by the trainee's audience; utility, in practice, of techniques taught in the course, etc. The overall design for the evaluation was described as evolving.

2. Evaluation Instruments

Workshop Planning Survey: A needs/demand assessment instrument has been designed to use in conjunction with both the ETC and NIMH train-the-trainers program. It polls respondents about the topic areas they would find most useful. It is sent out to potential participants along with theiracceptance letter for the train-the-trainers course and is used to tailor the offering to the audience.

Community Assessment Sheet: This form is sent to the trainees along with their acceptance to the train-the-trainers program. It requires the trainee to think about the types of training needed, training already provided and the training role s/he will play in the community.

Trainee Pretest: The trainee pretest, used in conjunction with the train-the-trainers program, asks the trainees to rate their own level of confidence in their knowledge base and teaching ability in a long list of AIDS-related topics. It also tests their knowledge/perceptions on the transmissibility of the HIV virus.

Training Plan: This form encourages the trainers to plan and schedule their training activities and asks them to detail their plans. The purpose is threefold: 1) to provide trainees with a practical blueprint for planning, 2) to force a consideration of practical aspects of training in a setting where participants can seek help from the facilitator or from other trainees, 3) as a baseline for the impact/outcome evaluation as discussed in Section III. It was intended to use these plans to assess what each trainee has accomplished six months after the course.

Course Bvaluation Form: The Course Evaluation form asks the participant to rate each item on a list of topics on a scale of l-4 as to the clarity of the presentation and the usefulness of the session. Open-ended questions solicit information on the most

and least useful aspects of the course. Participants also **self-** report their confidence in planning and delivering programs of various lengths and formats as well as their confidence in handling difficult training problems.

Participant Evaluation Questionnaire: In order to evaluate how well the train-the-trainer graduates perform as trainers, they are asked to have their own trainees evaluate their performance. The results of these evaluations are passed on to the ETC. The ETC has developed a simple, mark-sense form for this purpose. A supplementary form collects demographic information on the second generation trainee doing the evaluation.

Training Report Form: The primary purpose of the Training Report Form is to provide information on training outputs. However, since the form is used to report training activities conducted by the instructors, it provides a forum-for these trainers to provide feedback on which training techniques were or were not successful. This approach provides data for an ongoing formative evaluation of the train-the-trainers curriculum if WAMI-0 chooses to use it in this manner.

Train-the-Trainers Telephone Follow-up: The Train-the-Trainers Telephone Follow-up form is used to structure the telephone follow-up survey. Along with some demographics, it solicits information on what aspects of the training and the training manual the graduate found most useful. It also asks about the training they have done since completing their own training: number of sessions, number and types of trainees, topics covered, and barriers encountered. Finally, it asks the extent to which the graduate feels s/he can now meet his/her agency's critical training needs.

Appendix II contains all of the above instruments with the exception of the Training Report Form which has already been cited as Appendix I.

3. Findings from Train-the-Trainer Evaluations

Two courses held in September/October 1988 were reported on in **"A** Summary of Results of Two Trainings: From Needs Assessment to Follow-up." The following are illustrative of the type of findings that result from the evaluations.

The September course**,** presented jointly with the NIMH AIDS Training Program focused on advanced psychosocial issues. It was three days in length. Trainees were primarily nurses but included social workers, counselors, health educators and others, numbering 27 participants in all. Most had already had experience teaching about AIDS. As a result of the needs assessment, the curriculum was modified to focus on improving presentation skills. Pretest showed the group to be most confident in their knowledge and skills to teach about HIV transmission and their lowest confidence in areas of living with an AIDS diagnosis, issues related to communities of color, and dealing with deteriorating mental state. Course evaluations showed that the most useful aspect of the course was the

training manual, dealing with resistance, participant practice and feedback, and psychosocial issues. Least useful was the biomedical content. The course was rated excellent overall. Follow-up forms were mailed out four months after training (63% return rate). Pre and post test comparisons yielded a statistically significant difference for self-assessments of knowledge and skills to teach about various subjects and planning ability. All but one respondent reported doing at least one training of approximately one to two hours in length, with a focus on psychosocial aspects of AIDS, AIDS 101, or testing and counseling. The average number of second generation trainees per train-the-trainer graduate was 154.

The October training was more general in nature, with one of its five days devoted to psychosocial issues presented jointly with the NIMH AIDS Training Program staff. The audience of 22 were mainly nurses, social workers and educators. On pretest, the trainees expressed the greatest confidence in their knowledge and skills to teach about transmission, safer sex, and the decision to be tested for the HIV antibody. They were least confident in their ability to teach about IV drug use, living with AIDS diagnosis, care in rural communities, people of color and dementia. They expressed confidence in planning a two-hour presentation but less confidence in actually doing it. Confidence decreased as the length of the program increased. The course evaluation showed that the most useful areas were addiction, homophobia and training issues related to psychosocial content. The lowest rate areas were adult learning theory, neurospychiatric aspects, cultural issues, and women and AIDS. October trainees were likewise followed up approximately four months later (response rate of 64%). Pre and post test comparisons yielded improvement regarding self-assessments of knowledge and skills to teach about a variety of topics as well as for planning ability for presentations and workshops. All respondents reported offering at least one presentation of approximately one to two hours in length, with a focus on licensure training, psychosocial aspects, epidemiology or infection control. The total number of second generation trainees trained by the 18 graduates was 690.

C. Evaluating the Bureau of Substance Abuse (BASA)/WAMI-0 AIDS Courses

1. Substance Abuse Counselor Course

Evaluation is built into the BASA/WAMI "AIDS Curriculum for Substance Abuse Counselors." The primary means of evaluating these courses is via a participant feedback questionnaire completed at the end of the 7-hour course. The questionnaire solicits participant reaction to the content, the presentation of material, and the responsiveness of the instructor. Among other things, it asks participants to identify the most important thing that they learned from the course and what they would do differently in their work as a result of the course.

In addition to the official evaluation instrument, the curriculum contains several other tools that could be used for evaluations purposes. The first is a 20-item knowledge survey to establish the trainee's baseline knowledge of HIV/AIDS. Another instrument soliciting personal reactions to HIV/AIDS is included with the lesson on "managing personal fear and resistance. "

These instruments are included as Appendix III.

2. Train-the-Trainers Course

An extensive evaluation tool has been developed to evaluate **WAMI-0's** train-the-trainers offerings directly aimed at preparing substance abuse professionals to train others in the field using the **BASA/WAMI** "AIDS Curriculum for Substance Abuse Counselors.,,

This pretest **instrument·queries** current level of HIV/AIDS related professional activity, self-assessment of confidence regarding knowledge and skills, comfort level for dealing with training related issues, as well as participant assessments of various training program components. This tool is included as Appendix IV. The end-of-course questionnaire and follow-up instruments are under development.

V. Formative Evaluation of Products Developed

WAMI-0 had not planned to begin the development of new products in earnest until the second and third year of its project. However, the ETC was presented with an opportunity it could not pass up when the Omnibus AIDS Bill was passed. In 1988, in response to this bill, WAMI-0 worked in conjunction with the **Novela** Health Foundation, the Department of Licensing, the Washington Community College System, and the State AIDS office toward the production of a videotape series. WAMI-0 was commissioned to provide technical assistance in the design and development of the videos and, in so doing, served as some of the "expert reviewers,, in the formative evaluation. No other formal formative evaluation is planned.

VI. Recommendations

1. One of the major objectives of the WAMI-0 AIDS ETC program is to influence curriculum and the quality of AIDS teaching in professional schools around the country. A great deal of attention has been paid to the collection of baseline data on curriculum status. It would be very useful to develop an evaluative case study which documents the project's efforts in the area of curriculum and the resultant outcomes.

2. The establishment of locally-based multidisciplinary centers was one of the highlights of the WAMI-0 AIDS ETC Project. Attention to this effort had been diverted because of other demands but now that WAMI-0 is refocusing its efforts on the establishment of such centers in **"resource** ci ties,, **,** a more structured evaluation plan for this complex

process would be beneficial. A case study process or a form of project monitoring through articulation of the specific steps involved in the development of such centers and a reporting mechanism to document attempts/ successes would enable WAMI-0 to showcase and evaluate these activities.

3. The utilization of self-assessments of knowledge and skills follows principles of adult learning. For train-the-trainer programs, however, some objective assessments of trainee knowledge, skills, and attitudes seem necessary. Paper and pencil measures of posttest knowledge and attitudes augmented by observations of trainees during role play assignments within the course of the training program would offer stronger measures of participant accomplishments. Some consideration might be given to the policy and process of rejecting a trainee as a sanctioned trainer when and if a certain level of competency is not achieved.

4. Extensive and commendable evaluations are in place for training activities that are under the direct supervision of the ETC center in Seattle. However, very little evaluation is taking place outside of Washington State. As a regional program, the evaluation expertise of the ETC should be shared with the other state programs.

APPENDIX1

Training Report Form

WAMI AIDS EDUCATION AND TRAINING CENTER PROGRAM

TRAINING REPORT FORM

The following information is needed as part of the report to our grantors the Health Services and Resources Administration. Please take the time to fill out this form and **include a copy of your training agenda** whenever you complete a training on AIDS and send to:

Lynn Chapman
WAMI AIDS Education and Training Center Program
820 NE 45th, Suite 1
Seattle, WA 98105

Information on trainer/training coordinator
(The person who was trained by the WAMI AIDS ETC Program.)

Name _____

Address _____

_____

When were you trained by our program?
Month _____ Year _____

Employer _____

Work address (if it differs from above)

_____ Work phone _____

_____

Information on training (s)

1. Location of training _____
2. Sponsoring facility/organization _____
3. Dates of training (s) _____
4. Number of hours of training specific to AIDS _____

Types of Health Providers Trained

1. Please indicate the approximate numbers of each group that you trained in this session.

_____Physicians
_____Physician Assistants
_____Nurse Practitioners
_____Nurses
_____Social Workers
_____Other (please list) _____

_____Counselors
_____Dentists
_____Medical Technologists
_____EMT's/Paramedics

2. Approximately what percent of these were: (optional - for reporting purposes only)

American Indian/Eskimo/Aleut_____ Asian_____ Black_____
Caucasian (white)_____ Hispanic/Latino_____
Other (specify)_____ (note: numbers must equal 100%)

3. Training Methods (please check all those used)
Lecture_____ Discussion_____ Role-play_____ Vignettes_____
Other experiential exercises_____
(Please specify)_____

_____

4. Topics presented_____

_____

5. Who requested/initiated the training?_____

6. Did you use any of the training techniques taught in the course?_____

7. Which techniques worked best?_____

_____

a. Which techniques did not work well?_____

_____

9. What kind of problems (if any) did you encounter in your training?

_____

APPENDIX II

Instruments for Evaluating the Train-the-Trainers Course

NIMH AIDS TRAINING PROJECT
University of Washington
Seattle, Washington

WAMI AIDS EDUCATION
AND TRAINING CENTER PROGRAM
University of Washington
School of Medicine

MAY WORKSHOP PLANNING SURVEY

Name _____

1. What is your professional position (e.g. nurse, social worker, physician, administrator) _____

2. What is the main setting in which you work?

_____Health department
_____Home health agency
_____Community health facility
_____Long-term care facility
_____Other (specify) _____
_____Hospital
_____Office, private practice
_____Mental health facility
_____Other community agency

3. Your highest degree _____

4. What is your most important reason for taking this course?

_____Need to provide training as part of my job
_____Other job-related requirements
_____Washington State licensing requirements
_____Other (specify) _____

5. Approximately how many HIV-infected clients/patients have you dealt with in the past year? _____

6. In general, how would you characterize your involvement with HIV-infected individuals?

_____ low involvement
_____ moderate involvement
_____ high involvement

7. How experienced do you feel you are in teaching people about AIDS?

_____ not at all experienced
_____ somewhat experienced
_____ experienced
_____ very experienced

If you have teaching experience, what groups do you usually address? Check all that apply.

_____Physicians
_____Nurses/nurse practitioners/physician's assistants
_____Social workers, counselors, mental health professionals
_____Dentists
_____Dental hygienists/assistants
_____Administrators
_____Medical technologists, physical/occupational therapists, other allied health professionals
_____General public--e.g. community groups, school groups
_____Other (specify) _____

What size audience do you usually address? Check all that apply.

_____<10 _____11-30 _____31-50
_____51-100 _____>100 _____Other (specify) _____

What topics do you usually cover? _____

_____

Have you had any problems with the groups you have addressed regarding AIDS? Please be as specific as possible _____

_____

8. Are you currently counseling clients regarding HIV testing?

_____Yes _____No

9. The legal issues and testing and counseling each encompass many topics. Since we cannot cover them all, please rate each potential topic using the following scale:

1 Very interested
2 Moderately interested
3 Slightly interested
4 Not at all interested

a. Legal issues

_____Overview of Omnibus bill
_____Confidentiality
_____Mandated vs. voluntary testing and counseling
_____Public health penalties--e.g. detention, quarantine
_____Penalties for providers who do not follow directives of the Omnibus bill
_____Education mandate--for health professions licensure
_____Rule-making process on the state level
_____Background about the State Board of Health
_____Federal guidelines regarding HIV/AIDS
_____Washington State human rights guidelines
_____Other (specify) _____

b. Testing and counseling

_____ **Available** testing technologies
_____ Test accuracy
_____ Pretest counseling protocol
_____ **Posttest** counseling protocol
_____ Washington State Omnibus law requirements
_____ Psychosocial issues
_____ Suicide risk
_____ Behavioral changes associated with testing
_____ Mandatory testing
_____ Confidentiality requirements
_____ Other (specify) _____

9. What other areas would you like this workshop to address?

_____

lo. What would you like to know or be able to do at the end of this workshop that you cannot do now? _____

_____

_____

Please return in the envelope provided to:

AIDS Training Programs
820 N.E. **45th**, Suite 1
Seattle, WA 98105

Thank you very much.

MAYNEED1.DOC
4/17/89

COMMUNITY ASSESSMENT TO BE SEN
WITH ALLEGIANCE TO
TRAINEES

NIMH AIDS TRAINING PROJECT
University of Washington
Seattle, Washington

WAMI AIDS EDUCATION
AND TRAINING CENTER PROGRAM
University of Washington
School of Medicine

COMMUNITY ASSESSMENT SHEET

Please complete this form before you attend the workshop. The information you collect will be helpful for planning AIDS education programs for your community.

Your name_____ Your agency_____

Your position at agency_____

1. Please indicate what, if any, training you have had in AIDS or AIDS related areas. Check all that apply.

_____ In-service lectures or short presentations (1-4 hours)

_____ Short courses (full day to one week)

_____ Extended courses (one week or more)

_____ Coursework as part of professional training (AIDS course at a university)

_____ Another train the trainer course

_____ CDC testing and counseling course

2. What state and county does your agency or facility serve?

_____

3. What is the ethnic composition of the population your county or facility serves? Indicate the approximate percentages.

White_____ American Indian_____ Black_____ Asian_____
Hispanic_____ Other, please specify_____

3. a. How many cases of AIDS has your county had to date?_____
How many are still living?_____

How many AIDS cases were diagnosed during 1988 in your county?_____

b. If applicable, how many cases of AIDS has your facility seen?_____

4. What are the attitudes of your community (where you work) and your agency's staff in dealing with AIDS in the areas listed below? Please use the scale below and write in the number that represents your best guess.

intolerant/not accepting 1 2 3 4 5 tolerant/accepting

	Community	Staff
a. attitudes toward homosexuality	_____	_____
b. attitudes toward drug users	_____	_____
c. attitudes toward **HIV+/PWAs/PWARCs**	_____	_____
d. attitudes toward ethnic minorities	_____	_____

Do you have additional comments about your community and staff?

_____

_____

_____

5. Communities also demonstrate their attitudes by their actions. Please check which of the following your community has done or is planning to do and indicate when the service was (or will be) started.

	Month/year Started
_____ Education in the public schools	_____
_____ Outreach to the gay community	_____
_____ Outreach to IV drug users	_____
_____ Outreach to ethnic minorities	_____
_____ *An* ongoing AIDS task force	_____
_____ Support groups for **HIV+/PWAs/PWARCs**	_____
_____ Case management services	_____
_____ Media campaigns	_____
_____ Making condoms available	_____
Anonymous testing and counseling	_____

6. What is the total number of physicians in Your **community** who see AIDS patients? _____

7. What AIDS education have the health professionals that you will be training already had? Please indicate whether you are referring to your facility or community or both.

Check all that apply: Facility _____ Community _____

Please list the types of topics the following health professionals have had in their training (if any). Examples of topics include: **"AIDS 101"** (basics of transmission, prevention); infection control; psychosocial aspects: biomedical aspects; legal/ethical issues; HIV testing and counseling.

Nurses _____

_____

Social workers _____

_____

Physicians _____

_____

Other (specify) _____

_____

8. What additional information or skills do the health professionals in your community need to care appropriately for AIDS patients? You might want to consider their attitudes toward caring for people with AIDS and the attitudes of those who live in your community.

9. Can you identify any barriers that exist in your community or facility that would prevent you from meeting the existing training needs of your target population? (e.g. cultural, language, status, socio-economic, educational level)

10. What training resources are available in your community or local area? (e.g. existing programs, services, educational materials, speakers/trainers, space to conduct training, equipment)

11. Can you identify any gaps in training resources in your community?

Thank you very much for taking the time to collect this information.

Your ID_____

AIDS TRAINING PROGRAMS
University of Washington
Seattle, WA' 98195

Pretest

1. Geographical location: ____West WA ____East WA ____Other

2. Community: ____U r b a n Suburban ____Rural

3. Professional position (e.g. nurse, social worker, physician, administrator) _____

4. Your highest degree_____

5. How many years of post-degree professional practice experience do you have? _____

6. What percent of your time is allotted for the following:
   a. direct patient care_____
   b. administration and policy making_____
   c. supervision of clinical staff_____
   d. community education_____

7. Approximately how many people do you provide health care services to in a l-month period?_____

a. Approximately how many **seropositive/AIDS/ARC** patients have you provided service to in the past 6 months?_____

_____Not applicable (I don't provide direct patient care).

9. Approximately how many people with AIDS has your **facility/agency** provided service to in the past year?_____

10. In general, how would you characterize your involvement with people with ARC/AIDS?

_____ low involvement (occasionally)

_____ moderate involvement (frequently)

_____ high involvement (almost exclusively)

_____Check here if you are not presently involved

For each of the following questions please circle the response which best represents your confidence level in: 1. your knowledcm about the subject area, and 2. your skill in teaching others about the subject area.

11. How confident are you with your knowledge and skill in teaching professionals how to take a sexual history?

Knowledae of necessary content:

quite confident						not at all confident
1	2	3	4	**5**	6	7

Skill in teaching others how to take a sexual history:

quite confident						not at all confident
1	2	3	4	5	6	7

12. In general, how confident are you with your **ability** to teach people about AIDS as it relates to working with IV-drug users?

Knowledae of necessary content:

quit confidtnt						not at all confident
1	2	3	4	**5**	6	7

skill in teaching others how to work with IV drug users:

quite confident						not at all confident
1	2	3	4	5	6	7

13. How comfortable are you with your ability to teach about the transmission of the HIV virus?

Knowledue of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about transmission:

quite confident						not at all confident
1	**2**	**3**	**4**	**5**	**6**	**7**

14. How confident are you that you have sufficient skills and knowledge to teach someone how to counsel individuals regarding safer sex practices?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	**7**

Skill in teaching others how to counsel individuals about safe sex practices:

quite confident 1 2 3 4 5 6 7 not at all confident

15. How confident are you with your ability to teach people how to identify the early symptoms of AIDS?

Knowledge of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in teaching others how to identify early symptoms of AIDS:

quite confident 1 2 3 4 5 6 7 not at all confident

16. How confident are you that you have sufficient knowledge to teach effectively the issues regarding the decision to be tested for the HIV virus?

Knowledge of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in teaching others how to counsel individuals about the descision to be tested (pre-test counseling):

quite confident 1 2 3 4 5 6 7 not at all confident

17. How confident are you that you have sufficient knowledge to teach effectively the issues regarding a person's psychological reaction to testing positive for the HIV antibody?

Knowledge of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in teaching others the issues regarding a person's psychological reaction to testing positive for the HIV antibody:

quite confident 1 2 3 4 5 6 7 not at all confident

18. How confident are you that you have sufficient skills and knowledge to teach ways to counsel someone who tests positive for the AIDS antibody (post-test counseling)?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others how to counsel individuals who test positive:

quite confident						not at all confident
1	2	3	4	5	6	7

19. How confident are you that you have sufficient skills and knowledge to teach what the experience of living with an AIDS diagnosis is like?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others what the experience of living with an AIDS diagnosis is like:

quite confident						not at all confident
1	2	3	4	5	6	7

20. How confident are you that you have sufficient skills and knowledge to teach about the stress of providing care for a person with AIDS (for family caregivers and professionals)?

Knowledge of necessary Content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about the stress of providing care for a person with AIDS (for family caregivers and professionals):

quite confident						not at all confident
1	2	3	4	5	6	7

21. How confident are you that you have sufficient skills and knowledge to teach about loss and grief issues for the caregivers of persons with AIDS (for family caregivers and professionals)?

Knowledge of necessary content:

quite confident						not at all confident
1	2	3	4	5	6	7

Skill in teaching others about loss and grief issues for the caregivers of persons with AIDS (for family caregivers and professionals):

quite confident 1 2 3 4 5 6 7 not at all confident

22. How confident are you that you have sufficient knowledge and skill to identify the AIDS health care issues particular to communities of color?

Rnowledae of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill, in teaching others how to identify the AIDS health care issues particular to communities of color:

quite confident 1 2 3 4 5 6 7 not at all confident

23. How confident are you that you have sufficient knowledge and skill to identify the special problems related to care of AIDS patients in a rural community?

Knowledae of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in teaching others how to deal with the special problems related to care of AIDS patients in rural communities:

quite confident 1 2 3 4 5 6 7 not at all confident

24. How confident are you that you have sufficient knowledge to teach ways to effectively deal with deteriorating mental status/dementia due to AIDS related infections?

Knowledge of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in teaching others how to deal with deteriorating mental status/dementia due to AIDS related infections:

quite confident 1 2 3 4 5 6 7 not at all confident

25. How confident are you that you have the knowledge and skills to provide referral sources for someone who is HIV positive and in need of financial and social assistance?

Knowledue of necessary content:

quite confident 1 2 3 4 5 **6** 7 not at all confident

Skill in teaching others how to access referral sources:

quite confident 1 2 3 4 **5** **6** 7 not at all confident

26. How confident are you that you have sufficient knowledge and skills to provide community education regarding infection control?

Knowledue of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in providing community education regarding infection control:

quite confident **1** 2 3 4 **5** 6 7 not at all confident

27. How confident are you that you have sufficient knowledge to provide community education regarding the care of someone with AIDS?

Knowledae of necessary content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in providing community education regarding care of someone with AIDS:

quite confident 1 2 **3** 4 5 6 7 not at all confident

28. How confident are you that you have sufficient knowledge and skills to educate health care professionals regarding the legal and ethical aspects of caring for someone with AIDS?

Knowledge of necessary Content:

quite confident 1 2 3 4 5 6 7 not at all confident

Skill in providing education regarding legal/ethical aspects of care of someone with AIDS:

quite confident						not at all confident
1	2	3	4	5	6	7

29. How confident are you with your ability to tailor your presentation to meet the needs of diverse audiences?

quite confident						not at all confident
1	2	3	4	5	6	7

30. How confident are you that you have sufficient knowledge to (1) plan/organize, and (2) deliver the following types of training formats:

	PLAN/ORGANIZE very confident				not at all confident	DELIVER very confident				not at all confident
a. two hour lecture	1	2	3	4	5	1	2	3	4	5
b. four hour (half day)	1	2	3	4	5	1	2	3	4	5
c. one day workshop	1	2	3	4	5	1	2	3	4	5
d. two day workshop	1	2	3	4	5	1	2	3	4	5

31. Please rate your comfort level in dealing with the following training related issues.

	very comfortable						not at all comfortable
a. hostile audiences	1	2	3	4	5	6	7
b. homophobic audiences	1	2	3	4	5	6	7
c. large audiences (+50)	1	2	3	4	5	6	7
d. responding to questions	1	2	3	4	5	6	7
e. adjusting presentation to sponsoring agency's time limits	1	2	3	4	5	6	7
f. using audiovisual materials	1	2	3	4	5	6	7

32. To what extent do you believe that each of the following can transmit the HIV infection?

	Definitely Can	Probably Can	Probably Cannot	Definitely Cannot
a. needlestick with an infected needle	4	3	2	1
b. mouth-to-mouth CPR	4	3	2	1
c. sharing coffee cups	4	3	2	1
d. shaking hands	4	3	2	1
e. touching equipment	4	3	2	1
f. being in the same room	4	3	2	1

g.	working with specimens of blood/urine	4	3	2	1
h.	cleaning vomitus	4	3	2	1
i.	toilet seats	4	3	2	1
j.	bedsheets	4	3	2	1
k.	assisting at autopsy	4	3	2	1
1.	emptying bedpans	4	3	2	1
m.	being sneezed or coughed on	4	3	2	1
n.	donating blood (risk to donor)	4	3	2	1

33. Do you know of any health care providers in your community where you could refer a patient/client who exhibited symptoms of ARC or AIDS?

_____No
_____Yes

34. If you do not know of any treatment resources in your community, do you know where the nearest treatment resources are located?

_____No
_____Yes

35. As a health professional, how much do you worry that you will be infected with HIV in the course of your professional activities?

_____ _____ _____ _____
not at all a little a moderate amount a lot

36. How much do you worry that you will infect a member of your family (including significant other) with HIV?

_____ _____ _____ _____
not at all a little a moderate amount a lot

Thank you very much.

PRETEST2.DOC
1/19/89

Name _____

AIDS TRAINING PROGRAMS
University of Washington

TRAINING PLAN

1. How many trainings do you plan to conduct in the next six months? _____

2. Where do you plan to conduct your trainings? _____

_____

3. Approximately how many people will attend each training? _____

4. What length of time will each training take? _____

5. What type of group(s) will you be working with? What types of individuals will be in this group?

6. If you have identified any training barriers on the community assessment you completed before this course (e.g. cultural, language, educational level, community resistance), what are your plans for overcoming these barriers?

7. Identify specific people who can help you plan or conduct the training.

8. If you identified any gaps in training resources when you completed the community assessment form, how can you fill those gaps?

9. How do you plan to **"market"** your trainings?

lo. How do you plan to **evaluate** the **"success"** of your trainings? What are your criteria for **"success"?**

11. Do you anticipate any problems in planning, implementing or evaluating your trainings?

12. How do you plan to address these problems?

13. Choose 3 ideas, exercises or training methods that you have learn&-in this training and explain how you could incorporate them into one of your own trainings.

14. Diagram a tentative timeline for planning and implementing your plan for conducting training in your community. Start by selecting a program or series of programs you plan to conduct in your community and then set a target date. Work backwards when filling in your timeline, starting with the target date. Include when you plan to assess your communities needs, design the program(s), gather the resources, market and conduct the training(s). Consider how long you will need to promote the program, line up speakers, etc.

Program Title _____ Target Date _____

Action	Feb	Mar	Apr	June	July	Aug

Your ID_____

AIDS TRAINING PROGRAMS
University of Washington
Course Evaluation

Please take a few minutes to give us an overall evaluation of the AIDS training workshop you just attended.

1. Using the rating scales below, please indicate how clearly each of the following **sections** or aspects of the workshop was presented and how **helpful or useful** each was to **you.**

Presentation		Usefulness	
4	Very clearly presented	4	Very helpful/useful
3	Clearly presented	3	Helpful/useful
2	Somewhat clearly presented	2	Somewhat helpful/useful
1	Not at all clearly presented	1	Not at all helpful/useful

Presentation		Usefulness
aNA	. the community assessment worksheet	_____
_____	b. epidemiology of AIDS	_____
_____	c. psychosocial issues--1st wave (e.g. gay white males, homophobia/discrimination, family issues, grief, loss, caregiver fears)	_____
_____	d. psychosocial issues--2nd wave (e.g. people of color, access to care, women/children, funding **prevention/tx,** impact of drugs on care	_____
_____	**e.** sexuality issues	_____
_____	f. training issues re: psychosocial content	_____
_____	**g.** self-care/burnout prevention	_____
_____	**h.** testing and counseling	_____
_____	**i.** medical assessment	____
_____	**j.** case management	_____
_____	k. dealing with resistance	_____
_____	1. presentation skills	_____
_____	**m.** addiction and AIDS	_____
_____	n. training issues for diverse communities	_____
_____	0. curriculum design/instructional design	_____
_____	**p.** participant practice/feedback	_____
_____	**q.** ethical issues	_____
_____	r. legal issues	_____

_____	s.	chance to network w/ other professionals	_____
_____	t.	interacting w/ facilitators and speakers	_____
uNA		the training workplan	_____
vNA		the AIDS training manual	_____
_____	w.	_____	_____
_____	x.	_____	_____
_____	y.	_____	_____

2. How confident are you that you have sufficient knowledge to (1) plan/organize, and (2) deliver the following types of training formats? Use the scale below:

very confident 1 2 3 4 5 not at all confident

	PLAN/ORGANIZE	DELIVER
a.	5	1 2 3 4 5
b. two four hour hou(half day)	12 1 2 33 44 5	1 2 3 4 5
c. one day workshop	1 2 3 4 5	1 2 3 4 5
d. two day workshop	1 2 3 4 5	1 2 3 4 5

3. Please rate your comfort level in dealing with the following training related issues. Use the scale below:

very comfortable 1 2 3 4 5 6 7 not at all comfortable

a. hostile audiences	1	2	3	4	5	6	7
b. homophobic audiences	12		3	4	5	6	7
c. large audiences (+50)	1 2	2	3	4	5	6	7
d. responding to questions	1	2	3	4	5	6	7
e. adjusting presentation to sponsoring agency's time limits	12		3	4	5	6	7
f. using audiovisual materials	1	2	3	4	5	6	7

4. Overall, the workshop facilitators were:

_____ excellent _____ good _____ fair _____ poor

Comments _____

_____

5. What part(s) of this workshop was most useful to you?

_____

_____

6. What part(s) was least useful to you? _____

_____

_____

7. Did the workshop meet your expectations? _____Yes - N o

Please explain as specifically as possible _____

_____

_____

a. Name one skill that you have acquired or improved as a result of attending this workshop? _____

_____

_____

9. If we held a one-day **"booster"** session in 3-6 months, would you attend?

_____**Yes** _____No

10. What would you like a **"booster"** workshop to cover? _____

_____

11. Is there anything else you would like to tell us about this workshop? _____

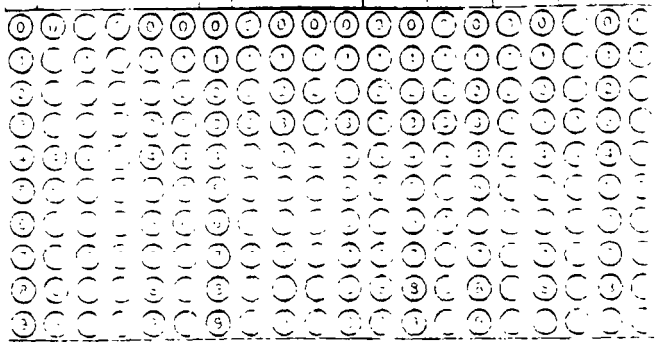
_____

_____

Thank you very much.

JANEVAL. DOC
1/4/89

ID NUMBER	SPECIAL CODES
	A B C D E F G H I J



PARTICIPANT EVALUATION QUESTIONNAIRE

STRONGLY DISAGREE

DISAGREE

NEUTRAL

AGREE

STRONGLY AGREE

GENERAL PURPOSE DATA SHEET II
form no. 70921

USE NO 2 PENCIL ONLY

PRESENTATION/SPEAKER sl: Name _____

1. Presentation was well-organized:-------->
2. The material was **clearly** presented:--------*
3. Material is useful to me **now** in my professional practice:-------->
4. Material will be useful to me in future for my **prof.** practice:-------->
5. Speaker had a good command of material:-------->
6. Speaker's voice was audible **and** clear:-------->
7. Speaker made good eye contact:-------->
8. Speaker made major points clear to me:-------->
9. Speaker was able to answer questions well:-------->
10. The speaker geared the presentation to my **level:-------->**
10. Enough time was allocated for this presentation:-------->
12. Audiovisual materials were useful to me:-------+
13. The handouts were useful to **me:-------->**
14. As a result of this presentation, I plan to do something differently in my professional practice:--------*
15. I would recommend this presentation for my colleagues:-------->

PRESENTATION/SPEAKER #2: Name _____

21. Presentation was well-organized:-------->
    The material was **clearly** presented:-------->
3. Material is useful to me **now** in my professional practice:--------+
4. Material will be useful to me in future for my **prof.** practice:-------->
5. Speaker had a good command **of** material:-------->
6. Speaker's voice was audible and clear:-------->
7. Speaker made good eye con tact:-------->
8. Speaker made major points clear to me:-------->
9. Speaker was able to answer questions well:-------->
10. The speaker geared the presentation to my **level:-------->**
10. Enough time was allocated for this presentation:-------->
12. Audiovisual materials were useful to me:-------->
13. The handouts were useful to me:-------->
14. As a result of this presentation, I plan to **do something differently in my professional practice:-------->**
15. I would recommend this presentation for my colleagues:-**-------->**

(OVER)

Printed in USA

WRITE-IN AREA 1

What topics/areas in the presentation(s) did you find most useful for your professional practice?

WRITE-IN AREA 2

What topics/areas were least useful? What is the **one** most important aspect you would change in the presentation(s)?

WRITE-IN AREA 3

What **skills** have you acquired as a result of today's presentation(s)? What **changes** do you anticipate making in your professional practice as a result of what you learned today?

1 A B C D E

2 A B C D E

3 A B C D E

AIDS TRAINING PROJECTS
University of Washington

The answers to questions A.-J. should be put in the "Special Codes" section in the upper left of your answer sheet. Fill in only one answer for each question.

A. Your professional position:

0 Nurse/nurse practitioner/physician's assistant
1 Physician
2 Dentist
3 Dental hygienist *or* assistant
4 social worker or other mental health professional
5 Health educator/educator
6 Paramedic/EMT
7 Administrator
8 Med. tech., P.T., O.T. or other allied health professional
9 Other

B. Your main work setting:

0 Health department
1 Hospital
2 Office, private practice
3 Community health facility
4 Community mental health agency
5 Community-based organization
6 Home health agency/hospice
7 Nursing home or other long-term care facility
8 Drug/alcohol treatment facility
9 Other

C. Your highest educational level or degree:

0 Less than high school graduate
1 High school graduate
2 High school graduate plus some technical training
3 Some college
4 Associate degree
5 Bachelor's degree
6 Master's degree
7 Doctoral degree
8 Other

D. What is the geographical location of your professional activities *(choose* one answer only):

0 Western Washington
1 Eastern Washington
2 All of Washington state
3 Idaho
4 Montana
5 Alaska
6 Oregon
7 California
8 Washington plus other states in the region
9 Other

E. Your most important reason for taking this course:

0 To meet Washington State Licensing requirements
1 other employment-related requirements
2 Clinical update
3 Personal interest in the topics
4 To accompany a friend who is taking the course
5 Other

F. Approximately how many HIV-infected clients or patients have you dealt with in the past year:

0 None
1 1-10
2 11-25
3 26-50
4 51-75
5 76-100
6 101-500
7 more than 500

G. In general, how would you characterize your current professional involvement with HIV-infected people:

0 No involvement
1 Low involvement
2 Moderate involvement
3 High involvement

H. How would you characterize your anticipated professional involvement with HIV-infected people in the coming year:

0 No involvement
1 Low involvement
2 Moderate involvement
3 High involvement

I. Age:

0 less than 20
1 20-30
2 31-40
3 41-50
4 51-60
5 61-70
6 more than 70

J. Your personal racial/ethnic group (optional):

0 Asian/Pacific Islander
1 Black/African American
2 Hispanic/Latino
3 Native American (Indian, Eskimo, Aleut)
4 White/Caucasian
5 Other

AIDS TRAINING PROJECTS
University of Washington

Train-the-Trainer Telephone Follow-Up

Name_____ Date Trained_____

Date_____ Time_____ Phone_____

Call attempt #: 1 2 3

Hello, my name is _____ and I am working with the AIDS Training Projects at the University of Washington. According to our records, you took our train-the-trainer course in Seattle in [month]. I would like to ask you a few questions about the trainings you have been doing. This interview will take approximately ten minutes. Is this a good time to speak with you? (If no, ask when it would be convenient for you to call back].

First, I would just like 'to ask you a few questions about yourself and your work.

1. What is your profession?_____

2. How would you describe the setting in which you work?

_____Health department _____Hospital
_____Home health agency _____Office, private practice
_____Community health facility _____Mental health facility
_____Substance abuse facility _____Other community agency
_____Other (specify)_____

Training Follow-Up

1. What knowledge and/or skills/techniques that you learned in your training have you found most useful in your professional practice? Please explain._____

_____

_____

_____

2. What changes have you made in your professional practice as a result of your participation in the training? Please be as specific as possible. _____

_____

_____

_____

3. Have you worked cooperatively with any other participants from your training?

_____Yes _____No

If yes, which of the following have you done (indicate all that apply):

planning and/or delivering a joint training

_____speaking at one of their trainings or vice versa

_____giving or receiving informal advice

_____getting together socially

_____other (please pecify)_____

4. Have you used your AIDS training manual since the course?

_____Yes _____No If yes:

a. What materials or information have you used (e.g. topic outlines, resource section, training section?_____

_____

b. Have you used any of the articles?

_____Yes _____No

If yes, which ones_____

_____

5. Because the manual is so big, we are considering reducing the number of articles that we give trainees. Do you think we should:

_____Keep # as is (@40) _____Reduce number _____Eliminate

Trainina Follow-up

1. How many trainings or presentations have you conducted since your own training? _____

2. Approximately how many people total would you say you have trained? _____

3. What types of groups or individuals have you trained--e.g. physicians, nurses, social workers, high school teachers, substance abuse counselors, etc.)? _____

4. What topics have you covered? _____

5. What were the problems you had in implementing your training plan? _____

6. What barriers have you identified--e.g. funds; time; lack of administrative support; staff resistance; patient/family resistance? _____

7. How can you (or'have you already) overcome these barriers?

Critical Needs

1. What is the most critical training need at your agency?

_____

2. To what extent do you feel that you have met this need as a result of your training?

_____ _____ _____ _____

not at all a little a lot almost entirely

Please explain_____

_____

3. Is there anything else you want to tell us about your training or what you have done since then?_____

_____

_____

One last thing. We are required by our granting agencies to collect information about the trainings that **you** conduct. We would really appreciate if you could hand out evaluation forms to the participants in your next **two** trainings. All you have to do is to give them the forms, explain briefly what to do, and collect them. We will give you two preaddressed stamped envelopes so you can return them to us for computer scoring.

We will send summaries back to you plus, if there are not too many forms, copies of the comments on the back of the form.

Since they are mark-sense forms, people should use number 2 pencils. If you do not have enough, we can send you some small pencils along with the forms.

When are your next two trainings scheduled?_____

_____

How many trainees do you expect in both?_____

Do you need number 2 pencils?_____

Thank you very much for taking the time to answer these questions.

FOLTEL2.DOC
4/3/89

APPENDIX III

Instruments for Evaluating

AIDS Training for Substance Abuse Counselors

HIV/AIDS AND SUBSTANCE ABUSE TRAINING EVALUATION

workshop Title _____

Date _____ Location _____

Instructor(s) _____

Please answer the following questions by entering one of the following codes:

1	2	3	4	5
Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree

1. Was the content **useful and practical?**

   Circle one: **1** 2 3 **4** **5**

2. Was the material **well organized** (followed a logical sequence)?

   Circle one: **1** 2 3 **4** **5**

3. Did the instructor seem *to* **have adequate knowledge and** skill to teach the material?

   Circle one: **1** 2 3 **4** **5**

4. Were the handouts and other teaching aids **helpful** and **adequate?**

   Circle **one:** 1 **2** **3** 4 **5**

5. Did the instructor seem **aware** of your **particular** skill level and **teach** accordingly?

   Circle one: **1** 2 3 **4** **5**

6. Did you **receive satisfactory answers** to your questions?

   Circle one: 1 2 3 4 **5**

7. Did your **instructor provide opportunities for everyone to** participate without letting any one individual dominate the discussion?

   Circle **one:** 1 2 3 4 3

8. Did the instructor hold your interest.

Circle one: 1 2 3 4 5

9. Did your instructor make it a point to identify and respond your training needs and goals?

Circle one: 1 2 3 4 5

Please write done one fact or idea from the training that you learned, and that seems important to you.

What will you do differently at work as a result of this training?

Please evaluate your instructor. If there were two or more instructors, be sure to mention each by name.

In your opinion, how could this workshop be improved.

What are your future HIV/AIDS training needs.

HIV/AIDS KNOWLEDGE SURVEY

The purpose of this survey is to identify your training needs, Please don't be concerned if you don't know the answer to any particular question. Not all the questions have just one right answer.

1. Circle the letter in front of the statement that best describes Acquired Immune Deficiency Syndrome (AIDS).

   a. People who have AIDS may not experience any symptoms of illness.
   b. People have AIDS when they test positive for antibodies to the virus that causes AIDS.
   c. People who have AIDS lose their resistance to infections and cancers that would not ordinarily affect people with healthy immune systems.

2. Name the virus that causes AIDS. _____

3. As of January 1989 approximately how many cases of AIDS have been identified in this country?

   ___ 50,000 or more
   ___ 100,000 or more
   ___ 500,000 or more
   ___ over 1million

4. About how many people in this country are estimated to have the virus that causes AIDS?

   50,000 or more
   100,000 or more
   -500,000 or more
   ___ over 1 million

5. Most people with AIDS are homosexual men. True ___False

6. One out of every three diagnosed cases of AIDS in 1988 was an IV drug abuser. ___True ___False

7. Which of the following groups are mostly Black and Hispanic?

   ___ IV Drug Abusers with AIDS
   ___ Heterosexuals with AIDS
   ___ Homosexual men with AIDS
   ___ Women with AIDS
   ___ Children with AIDS

HIV/AIDS KNOWLEDGE SURVEY

a. By themselves, which of the following substances have been known to carry infectious doses of HIV (the AIDS virus)?

___blood
___sweat
___feces
___urine
___tears
___saliva
semen
-vaginal fluids
-breast milk

9. Name three behaviors or conditions that have been known to transmit the AIDS virus.

1. _____

2. _____

3. _____

10. Name one thing that all acts known to transmit HIV have *in* common.

_____

11. Name two ways that substance abuse increases a person's risk for getting AIDS.

1. _____

2. _____

12. Name two ways that people can reduce their risk of HIV infection.

1. _____

2. _____

13. **Name two reasons why somebody might be unable or unwilling** to lower their risks for contracting the AIDS virus.

1. _____

2. _____

14. Name two things that can increase a person's willingness and ability to use risk reduction methods.

1. _____

2. _____

15. Identify one benefit of HIV antibody testing.

_____

16. Identify one disadvantage of HIV antibody testing.

_____

17. When someone is experiencing a severe life crisis, like finding out that they have HIV infection, the best counseling approach is to:

___ avoid confronting denial regarding HIV infection -- let the denial run its course, unless it presents a danger to the client or others.

___ break through any denial the client may have over his/her HIV status so s/he can begin to deal with the problem.

avoid discussing HIV issues since they can be used by the -client to divert attention from his/her substance abusing behaviors.

18. Name two significant losses that may be experienced by someone with HIV infection.

1. _____

2. _____

19. When might it be appropriate to break confidentiality requirements against revealing a client's HIV status?

____when the client continues to engage in high risk behavior.

____when it is necessary for someone to handle the bodily fluids of an HIV infected client.

____when there is a specific reason to believe that the client intends to transmit the virus to a specific individual.

20. Employers may take action against staff who refuse to perform their duties involving clients who are HIV infected, unless the employee can provide clinical justification for his or her actions. ____True ____False

PERSONAL REACTIONS TO HIV/AIDS

Sometimes what we know and how we feel are very different. Please read the following statements and circle the number that most closely corresponds with what you know about risk. Then circle the number that most closely describes your feelings.

1. Sitting in a car next to someone who has HIV.

Very Low Risk				Very High Risk
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

2. Shaking hands with some who has HIV.

Very Low Risk				Very High Risk
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

3. Handling a specimen jar containing the urine of an HIV positive client.

Very Low Risk				Very High Risk
a.	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

PERSONAL REACTION8 TO HIV/AIDS

4. Using the same bathroom facilities used by someone with HIV.

Very Low Risk				Very High Risk
1	2	3	4	4

Quite. Comfortable				Extremely Uncomfortable
1	2	3		S

5. Using the same kitchaa facilities (utensils, plates, dishwater, etc.) as someone with HIV.

Very Low Risk				Very High Risk
1	2		4	5

Quite comfortable				Extremely Uncomfortable
1	2	3	4	5

6. Cleaning up blood *or* urine spillr (wearing gloves) of an HIV infected person.

Very Low Risk				Very High Risk
1	2	3	4	5

Quite comfortable				Extremely Uncomfortable
1	2	3	4	5

PERSONAL REACTIONS TO HIV/AIDS

There may also be a big difference between what we think we should do and how comfortable are doing it. Please read the following statements and circle the number that most closely corresponds with how important you think each is. Then circle the number that most closely corresponds with how you feel about doing it.

1. Doscribing high risk sexual behaviors to a client.

Very Important				Not At All Important.
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

2. **Describing correct condom use** to **a client.**

Very Important				Not At All Important
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1		3	4	5

3. Doing **couples counseling** with • **client and** his **homosexual partner.**

Very Important				Not At All Important
1	2	3	4	5

Quite comfortable				Extremely Uncomfortable
1	2	3	4	5

PERSONAL REACTIONS TO HIV/AIDS

4. Showing a client how to correctly clean needles.

Very Important				Not At All Important
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

5. Helping a client decide whether *or not to* get tested for HIV antibodies.

Very Important				Not At All Important
1	2	3	4	5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

6. Counseling a client who has had a positive tort result.

Very Important				Not At All Important
1	2	3	4	5

Quit8 Comfortable				Extremely Uncomfortable
1	2	3	4	5

PERSONAL REACTIONS TO HIV/AIDS

7. Talking to health care providers about the needs of an HIV infected client.

Very Important				Not At All Important
1				5

Quite Comfortable				Extremely Uncomfortable
1	2	3	4	5

8. Talking to a client with AIDS about death.

Very Important				Not At All Important
1	2	3	4	5

Quite comfortable				Extremely Uncomfortable
1	2	3	4	5

APPENDIX IV

Pretest for Evaluating

Train-the-Trainers for the **BASA/WAMI** Curriculum for Substance Abuse Counselors

BASA/WAMI AIDS TRAINING PROJECT

1. Date_____

2. Location: ____West WA E a s t W AOther

3. Professional position (e.g. counselor, social worker, nurse, clinical supervisor, etc.) _____

4. Highest academic degree _____

5. Other professional credentials, certification, etc. _____

Current Level of HIV/AIDS Related Activity

6. What percent of your time is allotted for the following:

   a. direct client services_____

   b. supervision of clinical staff_____

   c. administration and policy making_____

   d. community education_____

7. Approximately how many people do you provide direct or indirect substance abuse services to in a on8 month **period?**_____

a. Approximately how many of the clients that you have serviced **over the past** 12 months fall into any of the following categories:

   a. diagnosed with AIDS_____

   b. HIV positive_____

   c. IV drug user_____

   d. sexual partner in a high prevalence group (IV drug user, homosexual/bisexual male, hemophiliac)

   8. Other risk behavior (specify) _____

9. Approximately how many of the clients serviced by your facility/agency over the past 12 months fall into any of the following categories:

   a. diagnosed with AIDS_____

   b. HIV positive_____

   c. IV drug user_____

   d. sexual partner in a high prevalence group (IV drug user, homosexual/bisexual male, homosexual/bisexual male, hemophiliac)

   e. Other risk behavior/circumstances (specify) _____

   _____

10. In general, how would you characterize your involvement with the following groups:

People known to have AIDS

not at all occasionally frequently exclusively

People known to be HIV positive (HIV infection)

not at all occasionally frequently exclusively

People known to be IV drug users

not at all occasionally frequently exclusively

People known to have sexual partner/s in a high prevalence group (IV drug user, homosexual/bisexual male, hemophiliac)

not at all occasionally frequently exclusively

People known to be involved **in** other high risk behaviors **(specify)**

_____

not at all occasionally frequently exclusively

BASA/WAMI AIDS **TRAINING PROJECT**

For each of the following **questions** please circle the response which best represents your confidence level in: 1) your **knowledge** about the subject area, and 2) your **skill** in teaching others about the subject area. Please circle only **"before"** responses prior to the training, you will be asked to circle the **"after"** responses following the training.

11. How confident are you with your knowledge and skill to familiarize others with the various stages of HIV infection?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

12. How confident are you with your ability to teach others to recognize major epidemiological trends and relate these to their client populations?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	**5**	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	**6**
after:	1	2	3	4	5	**6**

13. How confident are you in your ability to teach others how HIV transmission occurs and to identify co-factors that influence the likelihood that infection with occur?

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	**4**	5	6
after:	1	2	3	**4**	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

14. How confident are you in your ability to teach others how to identify and respond to inappropriate reactions to people with HIV/AIDS?

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

15. How confident are you in your ability to teach others to identify various relationships between drug **ab/use** and increased risks for HIV infection?

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	**5**	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

16. How confident are you in your ability to teach others to use a strategic approach (versus a uniform approach) to risk reduction?

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	**5**	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	**5**	6

17. **How** confident are you in your ability to teach others to identify principles of behavioral change?

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	**6**

18. **How** confident are you in your ability to teach others to identify barriers to positive behavioral change, particularly among substance abusing **populations?**

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

19. How confident are you in your ability to teach others how to assist clients to assess their own risk for HIV exposure and infection?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	**4**	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	**1**	2	3	4	5	6
after:	**1**	2	3	4	5	6

20. How confident are you in your ability to teach others to assess general client risk without relying on client **self-** disclosure or invasive questioning?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	**6**

21. How confident are you in your ability to teach others to effectively communicate with clients around issues sexuality and drug use?

Knowledge of necessary content-:

	quite confident				not at all confident
before:	**1**	2	3	4	**5** 6
after:	**1**	2	3	4	**5** 6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5 6
after:	1	2	3	4	5' 6

22. How confident are you in your ability to teach others how to motivate clients towards risk reducing behaviors?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5 6
after:	1	2	3	4	5 6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5 6
after:	1	2	3	4	5 6

23. How confident are you in your ability to teach others how to help clients develop risk reduction skills.

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	**4**	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

24. How confident are you in your ability to familiarize others with HIV antibody testing including test procedures, accuracy, and predictive value?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

25. How confident are you in your ability to teach others to identify and respond effectively to the special needs of the person with HIV infection?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	**5**	6

26. How confident are you in your ability to teach others to make appropriate legal and ethical decisions with regarding HIV positive and high risk individuals?

Knowledge of necessary content:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	**5**	6

Skill in teaching others:

	quite confident				not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

27. How confident are you in your ability to identify and respond to the special needs of culturally diverse audiences.

Knowledge of necessary content:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

Skill in teaching others:

	quite confident					not at all confident
before:	1	2	3	4	5	6
after:	1	2	3	4	5	6

28. Please rate your comfort level in dealing with the following training related issues:

BEFORE

	very comfortable				not at all comfortable
a. hostile audience	1	2	3	4	5
b. homophobic audience	1	2	3	4	5
c. large audience (+50)	1	2	3	4	5
d. answering questions	1	2	3	4	5
e. working within set time frames	1	2	3	4	5
f. using audiovisuals	1	2	3	4	5

AFTER

	very comfortable				not at all comfortable
a. hostile audience	1	2	3	4	5
b. homophobic audience	1	2	3	4	5
c. large audience (+50)	1	2	3	4	5
d. answering questions	1	2	3	4	5
e. working within set time frames	1	2	3	4	5
f. using audiovisuals	1	'2	3	4	5

29. As a service provider, how much do you worry that you will be infected with HIV in the course of your professional activities?

before: not at all a little a moderate amount a lot

after: not at all a little a moderate amount a lot

30. What do you believe are your own chances of contracting HIV from your professional activities?

before: **very high** high moderate low very low

after: very high high moderate low very low

31. How much do you worry that you will infect a member of your family (including sexual partner/s) with HIV?

before: not at all a little a moderate amount a lot

after: not at all a little a moderate amount a lot

32. Have you ever provided services for a person with HIV/AIDS?

_____Yes _____No

33. How comfortable are you in providing care for a person with HIV/AIDS?

before: very comfortable 1 2 3 4 5 very uncomfortable

after: very comfortable 1 2 3 4 5 very uncomfortable

34. What would make you more comfortable in providing such care?

BEFORE

_____

_____

_____

AFTER

_____

_____

_____

Thank you very much.

eval.doc

WESTERN AIDS RDUCATION AND TRAINING CENTER

RVALUATION REVIEW

I. OVERVIEW

The organizational structure of the Western AIDS Education and Training Center (Western AIDS ETC) is described fully in the Case Study. Several of its components are particularly relevant to the understanding of its evaluation activities. The Western AIDS ETC follows a decentralized program model. The regional ETC office is the administering arm and has oversight responsibility. The regional ETC also is responsible for carrying out faculty development activities regionwide and other, selected programs such as miniresidencies. The area AIDS education centers (AA ETCs) are subcontractors, located around the region, and have responsibility for carrying out the other four of the ETC's five levels of training in their catchment area. All of the AA ETCs are affiliated with a local teaching hospital which serves as the site for its clinical training.

Implementation of evaluation was slow to start. For the first two years of the project, the ETC was without a regional evaluation specialist. Although a number of extensive and interesting evaluation activities were planned, few were implemented. Initially, a number of tools were distributed to the AA ETCs; the conduct of the evaluation been left to their discretion. While a few of the sites have been notably active in evaluation, most sites have concentrated on program delivery with very limited evaluation+ Arizona, for instance, had a strong evaluation component which it developed in conjunction with its NIMH AIDS Training Program. In the third year, an evaluation specialist was added to the regional management team and the expertise of evaluators at the sites were tapped for the benefit of the regional program. One article about this ETC program has been published in The Journal of Continuing Education in the Health Professions. A more comprehensive evaluation of the program's effectiveness and impact is now under way.

II. THE ADNINISTRATION OF THE EVALUATION PROCRSS

A. Evaluation Plan

During the third year of the program, the Western ETC management adopted a formal evaluation policy. The policy includes: Policy Considerations, Western AIDS ETC Plan Outline, and Evaluation Markers for the Western AIDS ETC. Evaluation activities will fit within this policy framework (see Appendix I).

B. Locus of Responsibility

1. Staff Responsibility

For the first two years of the project, responsibility for evaluation was included among the many responsibilities of the Assistant Program

Director/AIDS Program Coordinator, Barbara Marquez. Following personnel changes and an administrative reorganization, Maria D. Canfield, M.S. took on evaluation responsibility in February 1990. Ms. Canfield divides her time as evaluator for the ETC (50%) and for the AHEC (50%). As the ETC evaluator, Ms. Canfield is responsible for developing the evaluation plan, coordinating evaluation activities ETC-wide, collecting data on education and training outputs, developing evaluation methodologies, and compiling the evaluation sections of ETC reports. Dr. Michael Reyes, the Assistant Medical Director, assists in monitoring activities while Lynette Jordan, the Resource Center Director, is responsible for overseeing the evaluation, of Resource Center activities.

2. Sub-Contractors

The directors of each of the AA ETCs are responsible for conducting evaluations of the trainings offered by their center. Current guidelines require the AA ETCs to do pre/post-training testing of fifty percent of their programs--the selection of the events to be included and the tools to be used are left up to the discretion of the individual AA ETC.

Drawing on the services and structure provided by an NIMH-funded evaluation specialist, Janet Senf, Ph.D., evaluation activities of the Arizona site have been relatively comprehensive from the outset. Evaluation activities at the Arizona site are currently coordinated by a psychologist, Jim Allender, Ph.D. The evaluation instruments and activities have been developed and implemented independently of the evaluation program of the regional ETC.

Tom Ficarrotto, Ph.D., also a psychologist, is responsible for evaluation of the NIMH-sponsored faculty development training. He joined the evaluation staff when NIMH grant funding was added to the HRSA funding of the AA ETCs. Dr. Ficarrotto has been focusing on evaluation of the faculty development training for the core faculty members. This evaluation has consisted of pre- and post-testing after the training sessions, and six-month follow-ups measuring changes in knowledge, attitudes, risk perception and satisfaction with the training. (The report is discussed in greater detail in section VI.) He will also be working on development of a new standardized questionnaire for use by the AA ETCs that will assess AIDS knowledge, attitudes, beliefs, risk perceptions, and AIDS-related skills. The new questionnaire will be implemented in the fourth year of the project.

C. Coordination of Evaluation Activities

The regional ETC office assumed a strong coordinating role when the project began. Along with its official acceptance of UCLA's NIMH education and training modules as its own, it adopted the accompanying evaluation instruments as well. The modules and evaluation instruments were distributed to the AA ETCs with the expectation that they would be used on a routine basis. Early on, the ETC staff recognized the practical limitations of the instruments and planned to modify them to make them more useful to the AA ETCs. They developed several instruments of their own and disseminated them to the AA ETCs.

Because of the decentralized structure of the ETC, combined with the independence of the AA **ETCs,** the modules and evaluation instruments were not used as frequently as had originally been hoped. By the second year of the project, the ETC revised its policy, encouraging the use of these materials rather than expecting it.

With the restructuring of the regional ETC management, there has been a reawakening of regional coordination. The regional evaluator undertakes quarterly telephone monitoring of AA ETC activities. Annual site visits are made to each of the AA **ETCs** and their evaluation activities are reviewed and critiqued at that time. At the request of the AA **ETCs,** the regional ETC is developing new evaluation tools, particularly attitude scales, to test program effectiveness. Several approaches to evaluating program impact were developed and piloted by the regional ETC, and are being extended by the AA **ETCs.**

D. Reporting

The AA **ETCs** report, on a quarterly basis, progress towards achieving their scopes of work, their aggregate program outputs as well as their forthcoming events. These reports are made verbally via telephone and in writing (forthcoming events) as described in Section **III.A.** below. In addition, the AA **ETCs** submit formal annual progress reports, a sample of which is included in Appendix II. Sign-in sheets for each training event, containing individual participant data, are attached to these progress reports. The individual progress reports are aggregated into a project-wide report by the ETC project office. Reporting of the overall achievement of the project goals coincides with the twice annual submission of reports to HRSA.

In the third project year, evaluation reports of individual training events have been prepared under the **ETCs** auspices. The most notable was a comprehensive report prepared for the 1990 faculty development conference sponsored jointly by the regional ETC and the San Francisco site.

III. APPROACHBS TO PROJECT BVALUATION

A. Monitoring

The tasks set forth in the scope of work of each subcontract provide a baseline against which progress can be measured. Annual site visits, ranging from 1/2 day to 2 days each, are generally conducted by two members of the management team (except in the case of Hawaii, where only one member of the ETC staff conducted the site visit). A formal site visit protocol (included in Appendix III) is used and written feedback is provided.

Quarterly monitoring via telephone is routinely conducted by the evaluator. A Telephone Reporting Worksheet, also included in Appendix II, is used to structure the data collection discussion.

B. Output Evaluation

The Western AIDS ETC calls its evaluation of program outputs an 'analysis of the overall breadth or 'reach' of the project." To document this, it collects the following types of information:

- o number of AIDS education programs provided through the AA ETCs
- o number of health professionals attending the AA ETC-sponsored AIDS educational programs
- o average length of participation of health professionals in AA ETC-sponsored programs

Western AIDS ETC recognizes that all outputs are not the same and has developed a system for categorizing its outputs according to the intensity of the input and the degree of involvement of the AA ETC staff. It collects and analyzes its data to distinguish between "contact hours" which are part of integrated planned programs, and those which result from quick orientations. With regard to training content, Western AIDS ETC categorizes its training according to its five major intervention strategies which it refers to as its "five levels of training," (refer to case study) all of which are being implemented to some degree by each of the participating AA ETCs. If any of the NIMH curriculum modules were used in the training, they are identified. Data on trainees include identification by ethnic group, work setting, and other special requirements.

Data are collected by the AA ETCs via a sign-in sheet developed by the ETC. In the third year, this sign in sheet/activity log was expanded in anticipation of the implementation of a common data set among ETCs nationwide. A copy of this sign-in sheet is included as Appendix IV.

Output data reported to the regional ETC office by the AA ETCs are currently entered into a Lotus spreadsheet which can accommodate simple sorting analyses. Other analyses are done manually from the spreadsheet data. The individual training event is the unit of measure of the database.

The ETC is in the process of developing a more flexible database, initially using dBase. When this system is operational, quarterly data for the first three quarters will continue to be kept in Lotus for "quick and dirty" analyses throughout the year. Annual data will be kept in the database for more complete and definitive analysis for reporting purposes.

C. Cost Efficiency and Cost Effectiveness

No cost analysis has been reported.

IV. FORMATIVE EVALUATION OF PRODUCTS DEVELOPED

The audiovisual products developed by the Western ETC are listed in the Case Study. Formative evaluation of these products has been limited to "expert review" by members of the Program Steering Committee.

The Western AIDS ETC has used a core of modules developed by the University of California, Los Angeles NIMH project and adapted for use in the ETC, supplemented by materials developed by the California Nurses Association and the California AHEC System. In addition, the resource center aggressively monitors agencies and distributes other curricula materials from nationwide sources. The decentralized sites further modify and adopt materials to local needs. The development of a new mental health module is planned for the 1990 faculty development retreat. In conjunction with that development process, a comprehensive evaluation is planned including a pilot test and more summative evaluation of effectiveness in general use.

A number of special studies addressing access to care and quality of care are to be completed in 1991 and 1992. These studies are being conducted by ETC central staff and AA ETC faculty members and include: "The Effect of ETC Training on the Number of Physicians Providing Care," "Measuring the Fear of Infection and the Knowledge of Working Nurses Before and After Training, " and "Impact of Mental Health Curriculum on the Knowledge, Skill and Behavior of AIDS-related Faculty Teams." The results of these studies may be both interesting and beneficial to other ETCs as well. Progress towards completion of these special studies should be communicated and disseminated.

V. APPROACHES TO EVALUATING EDUCATION AND TRAINING OFFERINGS

A. Standardization of Evaluation ETC-Wide

Because of its decentralized structure, there has been virtually no standardization of evaluation ETC-wide, to date. AA ETCs are required to do pre/post-training KAP testing on fifty percent of the events they sponsor. The choice of instrumentation and the selection of the events to be evaluated are at the option of the AA ETC.

At the beginning of the project, the ETC developed three standard knowledge questionnaires that were provided to all of the AA ETCs. One was meant for use with lay audiences, the second for health professionals not currently caring for HIV-infected patients, and the third for use with more experienced providers. The use of these tools was left to the discretion of each AA ETC. As the AA ETCs moved beyond "AIDS 101"-type presentation, they have tended to develop their own instruments which focus more on the content of their training. The early standardized tests have essentially been outgrown.

As part of the ongoing development of evaluation instruments within the ETC, Dr. Ficarrotto, under the direction of the central staff, is developing a standardized attitude scale for use by the AA ETCs. The scale is a component of the standardized questionnaire mentioned in section B.2. above.

B. Approaches to the Formative Evaluation of Training Events

Formative evaluation of Level 2, 3, 4 and 5 training events are conducted at the option of the AA ETCs; most sites are doing some type of formative evaluation.

Faculty development activities (Level 1 training) are the responsibility of the regional ETC as is their evaluation. Formative evaluation of the 1990 Asilomar seminar, which the ETC called "Program Evaluation," was included in the comprehensive evaluation of the event. The formative aspect of the comprehensive evaluation included aspects of program process, structure and content. In addition to an overall assessment of the retreat and the participant's level of satisfaction with it, participants were asked to indicate the degree to which the retreat process allowed them to express their feelings, provided opportunities to have questions answered, and provided opportunities to interact with other participants. Five-point rating scales were provided to enable participants to assess individual speakers and sessions. Finally, open-ended questions solicited an assessment of the most valuable parts of the retreat in question, suggestions for improving future retreats, and suggestions for specific topics to be covered at the next retreat.

C. Approaches to Evaluating Training Outcomes

1. Evaluation of Effectiveness

The Western AIDS ETC uses both the pre/post-training testing approach and the post-training self-reporting approach to evaluating the effectiveness of its training programs.

Pre/Post-Training Testing. The AA ETCs are required to do pre/post-training testing on fifty percent of the events that they sponsor. Typically, this takes the form of knowledge testing with specific questions keyed into the technical content covered by the presentations. Sample instruments are included in Appendix Q.

Several sites have developed instruments for assessing the effectiveness of training in changing attitudes and beliefs. The Arizona site uses a 33-item pre/post attitude test covering a wide variety of issues. Items are worded as statements and participants are asked to rate their agreement-disagreement on a 7-point scale. A sample of this test is included as Appendix VI.

The San Francisco site of the Western ETC is in the final stages of validating a pre/post-training attitude assessment instrument. This instrument includes scales measuring situation-based perception of risk, fear of contagion, emotions towards AIDS patients, and professional resistance. This preliminary instrument is included in Appendix VII.

Post-Training Self-Reporting. Both the regional ETC and several of the individual AA ETCs have included post-training self-reporting as part of event evaluation forms. In the evaluation of the 1990 Asilomar faculty retreat, the following self-efficacy type questions were included on the post-test:

- To what extent has participation in the retreat increased your knowledge about AIDS?

- To what extent has your participation in the retreat changed your own personal fears of contracting HIV infection?

The East Bay AA ETC uses a standard form to evaluate its "HIV Knowledge for Caring" training for nurses. This post-training questionnaire, which is included in Appendix VIII, asks: "What can you do now that you couldn't do before?

2. Evaluation of Impact

The Western ETC has implemented two unique approaches to evaluating program impact. The first measures the impact of a specific type of program (Level 2 clinical training programs for residents) on specific behaviors (sexual history taking/risk assessment and risk prevention counseling). The second approach measures the collective impact of an AA ETC on increasing the accessibility of providers willing and able to treat HIV+ individuals.

The approach to the evaluation of the clinical training program is based on chart reviews of patients of residents that have participated in one of its clinical training programs. The chart reviews focus on the degree to which participants routinely do risk assessment and risk reduction counseling. A form was used for abstracting the information documented in the patient charts. This abstracting form is included as Appendix IX.

The second approach, a study of the impact of its training in increasing the number of physicians willing to see HIV+ patients, uses a "key informant" approach. A number of the AA ETC sites have identified, by name, the physicians and dentists in their communities who treat AIDS patients. This list, which the ETC reports has been surprisingly easy to compile, serves as a baseline for the assessment of impact. Repeat rounds will document any increase, New names on the list can be compared with training rosters to determine whether or not new entries to AIDS practice have previously been ETC training participants.

VI. EVALUATIONS CONDUCTED

A. Evaluation of Faculty Development Programs

The faculty development activities, being the primary direct training activity undertaken by the regional ETC staff, have been a major focus of the ETC's evaluation activities. The evaluations have become increasingly more focused and comprehensive. The reports of two of the ETC's 1990 faculty development activities serve as examples.

The first report covers the evaluation of the dental faculty development program, "Dental AIDS Faculty Refresher Course," held March 2-3, 1990 in conjunction with the Sacramento AA ETC. A pre/post-training

test included a three-item knowledge test and seven attitude and behavioral measures. The post-training questionnaire also included a formative evaluation of the program. Since only seven participants completed both the pre and post-training tests, with additional pre-training data from five participants and post-training data from two participants, the data were simply aggregated and no interpretation of the findings made. In the formative evaluation of the event, all aspects of the program were rated "Very Good" or "Outstanding." There was a change in a positive direction on all attitude and behavior items: feeling of competency to develop educational programs; comfort in the role of an AIDS educator; use of the training in providing educational programs; and interest in incorporating more audiovisual materials into training. On post-test, participants strongly expressed the intention to use material from the training in their future program, a feeling of comfort and competency to provide HIV information to dental colleagues, and to be involved in office infection control evaluations in the future.

In a comprehensive evaluation of its 1990 faculty development seminar focusing on mental health issues, the Western ETC included pre/post-training testing of knowledge, attitudes and risk perceptions. Attitudes and risk perception were measured by means of 6-point Likert-type scales while knowledge was measured via multiple choice questions. Baseline ratings and change scores were examined as a function of participants' gender, race, occupational status, geographical location, as well as their previous clinical and personal contact with HIV-AIDS patients. Pre-training findings showed a positive skew in the attitudes and perceptions of risk among participants in this faculty development program. Probably because of this high baseline, overall increases in positivity were not statistically significant. One item, perception of risk from accidental needlesticks, showed a significant change in the desired direction, indicating that the program had been successful in reducing this concern.

Both of these evaluation reports are included in Appendix X.

B. Evaluation of Clinical Training Programs

To assess the impact of its clinical training for family practice residents to see whether they were incorporating risk assessment and risk reduction counseling into their day-to-day practice, the Western ETC study focused on chart reviews. Planning for this study took place over an extended period with modification made as logistical problems were encountered. What began as an extensive study scheduled for the spring of 1989 evolved into a pilot study to begin in the fall of that year.

The charts of 50 patients aged 12-50 who were seen for routine care (periodic health maintenance including Pap smears and annual physicals; new obstetrical patients; preoperative history and physical employment or sports physical) in a family planning outpatient setting (Valley Medical Center) were sampled. The chart reviews were undertaken by David Kunz, then a fourth year Family Practice resident at the Valley Medical Center who served as the physician member of that AA ETC's training team. The charts were reviewed for evidence of sexual history-taking; evidence of STD history-taking; evidence of substance abuse history-taking and evidence of

risk reduction counseling (including counseling on condom use, other specific risk reduction strategies, and/or distribution of patient education materials). This study is scheduled for completion in January 1991.

C. Evaluation of the Effectiveness of the Arizona AA ETC's Training Efforts

The Arizona AA ETC developed and has incorporated pre/posttesting of knowledge and attitude into its training event of four or more contact hours. The tests were developed by the site's evaluation specialist in conjunction with the project team according to specified training objectives. Some items were drawn from validated tests of other NIMH AIDS training projects. As previously noted, Arizona's evaluation instrument is included as Appendix VI.

After the first year of experience, individual attitude items were validated through analysis of the accumulated data for change and frequency distribution. A second level of instrument validation was performed through factor analysis. Some items were dropped and others added to reflect new areas of training content and emphasis. · Items that loaded on factors associated with fear of AIDS or with homophobia were further analyzed for pre-test, post-test change by occupation and by respondents' frequency of contact with people with AIDS. Copies of some of the results are included as Appendix XI.

Direct feedback on training events is solicited through a participant satisfaction instrument. An interesting element of this instrument is a 7-point scale asking how much of the material was new to the respondent. Responses to this item have then been cross-tabulated with the data on changes in knowledge and attitudes. The results from this analysis have assisted the program to tailor training content to the needs of different audiences.

Pre- and follow-up practice tests are also incorporated in trainings for practicing clinicians, although performing follow-up tests has proved logistically difficult. The evaluator is considering asking for trainees to volunteer at the time of the training event for participation in a follow-up evaluation exercise.

D. Evaluation of the Hawaii AA ETC's 1989 Conference

The Hawaii AA ETC conducted an evaluation of its November 1989 conference, "Building Skills, Building Knowledge." Participants were asked to rate each of the presenters/sessions in terms of the degree to which the specific session objectives were met, the effectiveness of the speaker's teaching style, the relevance of the session, the clarity of the content, the appropriateness of the physical facilities to the particular session, and the degree to which the participant's personal objectives were met. Participants also indicated the most useful aspects of each session, ways the session could be improved, and ways in which the session would change the way they would perform their job. These data were aggregated and means calculated. In terms of the degree to which the session objectives were met, overall 94% of the responses were 3 or better on a scale of l-4 (4

being excellent). All presentations were rated highly; only one out of thirteen was rated noticeably lower than the others, and even this one received an overall favorable rating. In response to ways in which the conference would change the way participants do their job, the most common responses were about increasing sensitivity (awareness and compassion). However, a significant minority stated that there would be no change. (The evaluation report notes that "it is difficult to know whether this is a resistance, a statement of powerlessness, or simple reality.") These aggregated findings, along with a brief summary interpretation, are contained in the report included in Appendix XII.

APPENDIX1

Western AIDS BTC Evaluation Policy

EVALUATION POLICY CONSIDERATIONS

1. Evaluation is "management information" for someone.

2. The evaluation spectrum *ranges* from simple monitoring to published, scholarly studies.

3. It is costly to overevaluate and costly to underevaluate. Sam questions to help determine how much evaluation to do, of what kind:

   a. What will the information be used *for?*

      (1) Assure contract/grant compliance and maintain an audit trail.
      (2) Intrrnal decision-making?
      (3) Fulfill administration requirements?
      (4) Justify the program?
      (5) Measure impact?

   b. What does the nation61 ETC office consider to be success?

   C. What do the ETC projects and their medical schools consider to be success?

   d. What does Congress want to know?

      (1) 16 there "evidence" of success(studies, especially published studies)?
      (2) Do "authorities" support the program (deans, medical societies, AAMC, major AIDS coalitions)?
      (3) Do constituents support the program(community-based organizations [CBOs], AIDS providers)?
      (4) Does it atiract other money?
      (5) Does it attract bipartisan support?
      (6) What are the numbers (of trainees, etc.)?

WESTERN AIDS ETC PLAN OUTLINE

A. PROJECT GOAL(S) PURPOSES:

1. **Improved prevention through** provider involvement.
2. **Better access to care.**
3. **Better quality of care.**
4. **Regional/state system development and the' diminution of thr federal role.**

B. METHODS:

1. **Establish a** regional network of competent grantees.

2. **Allocate funds Lo grantees** according to:
   - **Needs (AIDS cases, number of potential trainees, geographical**
   - Quality of plans.
   - Results achieved.

3. Through **training, get provider8** to identify **and** counsel high-risk persons **(PREVENTION)**.

4. **Through** training, recruitment and outreach servicea, increase the **number** of **AIDS** providers **(BETTER ACCESS TO CARE),**

5. Through education **and training, prepare residents and students to** provide high-quality **care (QUALITY OF CARE).**

6. **Through** outreach support **services, develop** and maintain **"AIDS Provider Network" (ACCESS** AND **QUALITY)** .

7. Through intensive training, **prepare faculty to train practitioners and students** (PREVENTION, ACCESS, QUALITY).

8. Develop networks of **agencies** to carry out educational and support services **within each** BTC **(SYSTEM DEVELOPMENT).**

9. Require the **development** of **supplementary/replacement funding (SYSTEM).**

10. Evaluate/obtain **reauthorization and appropriation;** reallocate as **needed.**

    Monitor progress/problems.
    b. Develop **annual** budget/program **requests.**
    c. Respond **to** internal demands **(advisory committee,** higher headquarters).
    d. Respond **to Congress.**
    e. Exercise **leadership.**
    f. Measure impact.

11, **Solve or reduce the** problem and **minimize fedora1 program involvement.**

C. PLAN:

1. Cover the Major Population Clusters and the major political jurisdictions, taking into account current needs and trendr.

2. Establish Decentralized **Network.**
   - **4** states.
   - 7 medical schools.
   - 13 area AIDS ETCs.

3. **Five** Levels.

   a. Faculty teams at teaching hospitals or medical schools: 15 teams, LOO faculty.
   b. Residencies--26.
   c. Hospital-based physicians, nurses, dentists, allied health workers.
   d. Community providorn.
   e. Community leaders.
   (Good teams in place? Conducting training? Training good? Curriculum in placed-training ongoing? Established identity? Number of students?)

4. Three Phases (overlapping).

   a. Subcontractor and faculty team development.
   b. AIDS Provider Network development and central services.
   c. Development of greater cost sharing and diminution of federal role.

5. Central Services.

   a. Information services.
   b. Evaluation.
   c. Needs identification and long-range planning.
   d. AIDS Provider Network.
   e. AIDS Protocol Council.
   f. Professional AIDS Consultation Service.
   g. Rural AIDS Center.
   h. Key Physician Development Program.
   i. Miniresidencies.

6. Revise **Plan** in Three-Year Intervals *(or* sooner if needed).

7. System Development .

   a. State support.
   b. University support.
   c. Hospital support.
   d. Professional society support.
   e. Institutional identity.

8. Solve Problems ninth year?

EVALUATION MARKERS FOR THE WESTERN ETCS

FOR THE PROJECTS

1. Did you fulfill your scope of work?
2. Is your process valid?
   - Transfer knowledge?
   - Change attitude?
   - Present training in an acceptable way?
3. Did you improve prevention services?
4. Did you improve quality of care?
   - Change behavior?
   - Improve patient satisfaction, mortality, morbidity?
5. Did you improve access to core?
6. Did you establish an enduring educational system?

APPENDIX II

Sample AA ETC Annual Progress Report

S A M P L E

AIDS EDUCATION AND TRAINING CENTER
CALIFORNIA AREA HEALTH EDUCATION CENTER SYSTEM
PROGRESS REPORT

Reporting Period: 4/1/89 to 6/30/89

Subcontractor:	Modoc General Hospital Family Practice Residency Training Program 100 Main Street Alturas, CA 96101
Submitted by:	Lois Middle, M.P.H.
Title:	Modoc AAETC Director
Date:	July 15, 1989

I. MODOC AREA AIDS EDUCATION AND TRAINING CENTER

A. ADMINISTRATION AND OPERATIONS

1. By February 1, 1989, enter into a written agreement with the University of California at Davis School of Medicine.

   RESPONSE: We entered into a written agreement with the University of California at Davis School of Medicine on January 21, 1989.

2. By February 1, 1989, identify a program director who will be responsible for the performance of all aspects of this agreement.

   RESPONSE: Lois Middle, M.P.H., was approved as the Modoc AAETC director on January 4, 1989.

etc.

6. Use the forms contained in Appendix K to request contract changes.

   RESPONSE: A written agreement revision request for both budget and scope of work changes was submitted on February 15, 1989, and subsequently was approved by the AIDS Education and Training Center office.

7. Submit quarterly billings to the AIDS Education and Training Center, using the form(s) contained in Appendix E, as follows:

   a. Due May 16, 1989, for the quarter ending March 31, 1989.

   b. Due August 15, 1989, for the quarter ending June 30, 1989.

   c. Due October 17, 1989, for the quarter ending August 31, 1989.

   RESPONSE: First quarter billing submitted May 31, 1989.

8. Submit reports to the AIDS Education and Training Center as follows:

   a. Submit a progress report listing each item of the scope of work followed by a description of progress or problems encountered, if appropriate, and giving specific responses to each quantified objective, using the forms contained in Appendix N, as follows:

      (1) Due March 15, 1989

      (2) Due July 15, 1989.

      RESPONSE: This document serves as our progress report due July 15, 1989.

   b. Submit data collection forms due with each progress report, using the form(s) contained in Appendix 0.

      RESPONSE: Attached to this progress report are the completed summary report forms and accompanying sign-in sheets for all educational programs conducted during this reporting period.

B. TRAINING

1. Level 1 Training

   a. By February 1, 1989, identify at least one primary care physician, one nurse, and one dentist to serve as principal faculty for the educational programs described herein. In addition, a dental hygienist may be identified for participation in b.(2) below.

RESPONSE: Ricardo Familia, M.D., Patience Chart, R.N., Joseph Toothacher, D.D.S., and Maria Dientes, R.D.H., have been identified as the Modoc AAETC project.

b. Arrange for the faculty identified in 1.a. above to participate in the faculty development experiences provided by the AIDS Education and Training Center as follows:

(1) By February 12, 1989, physicians and nurses will complete a five-day clinical training course conducted by the AIDS Education and Training Center.

RESPONSE: Dr. Familia and Ms. Chart attended the five-day clinical training course conducted in San Diego on February 8-12, 1989.

(2) By April 11, 1989, dentists will complete a five-day clinical training course conducted by the AIDS Education and Training Center.

RESPONSE: Dr. Toothacher and Ms. Dientes attended the five-day clinical training course conducted at the University of California at San Francisco School of Dentistry on April 3-7, 1989.

(3) By April 30, 1989, physicians, nurses and dentists will complete a three-day faculty development course in the use of AIDS educational modules conducted by the AIDS Education and Training Center.

RESPONSE: All four of the Modoc AAETC faculty attended the three-day faculty development retreat in Santa Cruz on in May 1989.

c. Assure that all educational materials provided by the AIDS Education and Training Center are updated and maintained throughout the duration of this agreement.

RESPONSE: An education "kit" was received in February, and is being maintained at the Modoc AAETC office

etc.

4. Level 4 Training

a. By August 31, 1989, provide one **or more** hours of training for at least 40 physicians, 40 nurses and 40 dentists from the community in which the teaching hospital identified in A.#. operates.

RESPONSE: During this reporting period, the Modoc AAETC project has conducted 15 educational programs. The programs conducted are as follows:

Date: April 15, 1989--2 hours
Title: Infection Control and Dentistry
AAETC Faculty: Dr. Toothacher and Ms. Dientes
Trainees: 10 private practice D.D.S; 5 R.D.H.
Comments: Two units of continuing education units offered. Sununary report attached. Overall evaluation of program was excellent. Presenters were invited back for follow-up sessions.

Date: May 1, 1989--1 hour
Title: Psych-social aspects of AIDS
AAETC Faculty: Ms. Chart and Ms. Middleton
Trainees: 2 M.D.; 4 P.A.; 1 F.N.P.; 1 M.S.W.; 5 nursing assistants; 2 dental
Comments: Staff of a community health center. This session was a follow-up session to an AIDS 101 presentation offered earlier in the year.

Date: **May** 5, 1989--1.5 hour
Title: Diagnosis and Treatment Issues
AAETC Faculty: Dr. Familia
Trainees: 60 family practice physicians
Comments: Dr. Familia's presentation was part of a larger two-day continuing education conference entitled "Annual Family Practice Refresher Course."

Date: June 1, 1989--2 hours
Title: Sexual History Taking
AA ETC Faculty: Dr. Familia
Trainees: 64 physicians
Comments: Ongoing study group. Utilized interactive exercise (role playing).

etc.

Other activities conducted by the AAETC office during this reporting period include:

AAETC director surveyed the community health clinics in the surrounding area to determine their interest and need for staff training. As a result, three additional clinic sites identified for further training programs to be conducted during the next quarter. The most requested training topics are infection control, diagnosis/treatment and referral issues.

Ms. Middleton and Dr. Toothacher are working with the local dental society to coordinate a large dental program, tentatively scheduled for September 15, 1989. A needs assessment survey was mailed in the dental society newsletter. A further report on this conference will be included in the next progress report.

APPENDIX III

1. Site Visit Protocol
2. Telephone Reporting Vork Sheet

HEALTH RESOURCES AND SERVICES ADHINISTRATION (HRSA)
NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
OFFICE OF AIDS (CEPP)
SITE VISIT PROTOCOLS

This protocol addresses the documents needed to conduct the site visit, the topics that should be addressed during the visit, and the contents of the Site Visit Report (prepared after the site visit by the team leader, with input from the other team's members).

I. **REFERENCE DOCUMENTS NEEDED**

A. Current Scope(s) of Work (contracts)
B. Any Budget Revision (BRRs) or Language Revision (LRRs) Requests
C. Up-to-date List of Deliverables with due dates
D. Quarterly Reporting Format Form(s)
E. Relevant correspondence, including central office Contact Report(s)
F. Central Office List of Faculty Team Members, with titles and address/telephone numbers, and attendance at Faculty Development Training sessions
G. Central Office's need for "key personnel" resumes/CVs/bio-sketches
H. Knowledge regarding billings submitted or due
I. Knowledge regarding use of attribution(s) on promotional materials, etc.
J. Information on Western AIDS ETC's future plans (HRSA Application)
K. Special projects information: NIMH FDT follow-up materials; knowledge, attitude, behavior, etc., survey; research questionnaires
L. Resource Center Brochure, Core Curricula List, Videotape Library List

II. TOPICS TO BE COVERED (sample questions)

A. Administrative control issues--Do the personnel situation and management situation match our understanding? Have the contracts been signed? Does the staff understand how to submit billings, BRRs and LRRs? Are they up-to-date on the deliverables? Are they having any problems and how can we help? If at all possible, the site visit team should meet the administrative staff. In most cases, it will be necessary to review the Scope(s) of Work with the program's administrative staff. Discuss long-term viability.

B. Education Program--Are all the team members on board, contributing, going to be around for awhile? Are they successfully carrying out their Scope of Work? The site visit team should observe the team in action, but if this is not possible, it is important to talk with them. If there are new members, the names, clinical training background/experience, and faculty affiliation status must be collected for each team member. Which team members attended the FDTs (how trained is the faculty)? If there are vacancies, how they occurred and how they are being addressed, must be determined. Allow time for team members to relate their experiences and to offer "lessons learned". Discuss long-term viability.

C. Evaluation--Are they conducting the evaluation components that are their responsibility, including using the sign-in sheet? What are the evaluation tools they are using (get copies)? If they are having trouble, what can we do to help? Solicit impact evaluation ideas.

D. Problems--Ask the director and team members to identify problems and discuss solutions.

E. Future Plans--Time should be spent briefing the AA ETC on the Western AIDS ETC's plans for the future (eg. the AIDS Provider Network) and. their role in program development and implementation. The views of the team should be solicited and suggestions for change recorded. There should also be time for them to give us feedback on their unmet needs, future plans, suggestions regarding solutions to existing problems, etc.

F. Special Considerations--With each site visit, there-will be a different set of information to be collected, for example, some of the AA ETC faculty teams will be participating in the NIMH post-FDT follow-up activities.

III. SITE VISIT REPORT

The Site Visit Report should be written by the team leader with input from the team's members, as appropriate. The following is a suggested outline/format for the report. Feel free to append any documentation supplied by the AA ETC. This information will not be entered into a database, so please include all that may be required in "all versions of future need".

A. Identification/Introductory Information
- Subcontractor
- Project Director
- Site Visit Date(s)
- Site Visit Team Members
- List of Individuals Interviewed, (including title and relationship to program)

B. Review of Scope of Work (discuss strengthens, weaknesses and comments, as relevant)

C. Review of Administrative and Fiscal Issues (discuss strengthens, weaknesses and comments, as relevant)

D. Review of Education Program (discuss strengthens, weaknesses and comments, as relevant)

E. Review of Evaluation (discuss strengthens, weaknesses and comments, as relevant)

F. Review of Problems not discussed above (discuss strengthens, weaknesses and comments, as relevant)

G. Review of Future Plans (discuss strengthens, weaknesses and comments, as relevant)

H. Review of Special Considerations (discuss strengthens, weaknesses and comments, as relevant)

I. Conclusions (recommendations on timing, etc., of next site visit, and anything else for the record)

J. Follow-up Needed (feedback need by the AA ETC staff and team members, include staff member assignments, etc.)

MC/mdc/mjr/2/23/90

California Area Health Education Center System
Western AIDS ETC
5110 East Clinton Way, Suite 115
Fresno, California 93727-2098
(209) 252-2851

TELEPHONE REPORTING **WORK SHEET**
April 1, 1990, through June 30, 1990

INTRODUCTION

The following work sheet has been developed to enable you to prepare for the telephone report for the period April 1 through June 30, 1990. In addition to this information, we are requesting that you send us copies of any sign-in sheets not yet forwarded for programs conducted through June 30, 1990.

The work sheet lists the items to be covered during the reporting call in the order in which they will be addressed. It also suggests the documents you may wish to have on hand and the tabulations you will need to have completed before the telephone call. The reporting covers five areas: IDENTIFYING INFORMATION, SCOPE OF WORE REVIEW, MANAGEMENT REVIEW, REPORT ON PROGRAMS CONDUCTED, CALENDAR OF FUTURE EVENTS, and a SPECIAL QUESTION. These areas will be covered, as appropriate, for each source of funds: HRSA, NIMH, or AHEC SPECIAL INITIATIVE. (Note:. Report on Programs Conducted, Calendar of Future Events, and the Special Question do not apply to AHEC Special Initiative funding.)

IDENTIFYING INFORMATION--You will be asked for the following information:

- Reporting Period is April 1, 1990 through June 30, 1990
- Source of Funds
- Subcontractor Name
- Name and Position of Person Answering.Questions
- Date
- Contact Phone Number
- Confirmation Address
- Whether or not you plan to send us any information in writing

SCOPE OF WORE REVIEW--It will be necessary for you to have your Scope of Work, and any revisions handy. Since you will be asked item-by-item for a response, there may be some calculations you will need to complete prior to the telephone call. Both the Administration and Operations, and the Programmatic Activities sections will be reviewed. In general, you will be asked the status of the objective, and will need to be able to give us a verbal statement about any problems that you have encountered. If you have encountered problems, you should let us know what strategies you are using to overcome them. Of special importance are the following:

- Number of Programs Conducted
- Number and Types of Participants
- Dates the Programs Were Conducted
- Titles of the Programs
- Use of the Sign-in Sheets and Other Forms

MANAGEMENT REVIEW--There are five additional topic areas that are really questions, as follows:

1. Are you doing pre- and/or post-testing? What evaluation forms are you using? Do we have copies of them?

2. Have you developed any promotional materials/publications? If yes, do we have copies of them? Are you using the correct acknowledgement? If applicable, do you use letterhead identifying the program as an ETC?

3. Have there been any significant changes to your organization or AIDS education program since the last site visit or quarterly report? If these haven't been discussed yet, summarize them.

4. Are you having any problems we don't know about? If yes, what strategies are you using to overcome them?

5. IS there anything else you would like to mention for the record?

REPORT ON PROGRAMS CONDUCTED--This is not relevant to Special Initiative funding. We need to know the number of trainees by Level and Type that have gone through your programs. This information'should be obtained from the sign-in sheets for the three-month period April 1, 1990 through June 30, 1990. As a reminder, the levels and types of trainees are as follows:

INFORMATION ON PROGRAMS CONDUCTED NUMBER OF TRAINEES APRIL THROUGH JUNE 1990		
LEVEL		NUMBER OF TRAINEES
Level 2	PHYSICIANS	
Level 3	PHYSICIANS	
	NURSES	
	MEDICAL STUDENTS	
	ALLIED HEALTH"	
Level 4	PHYSICIANS	
	NURSES	
	DENTISTS	
	ALLIED HEALTH*	
Level 5	COMMUNITY LEADERS	
	HEALTH PROFESSIONALS	
	ADMINISTRATORS	
	TOTAL	

*NOTE: Includes dental auxiliaries, mental health counseling providers, first responders, human service workers, health educators, etc.

TELEPHONE REPORTING WORK SHEET

CALENDAR OF FUTURE EVENTS--This is not relevant to Special Initiative funding. We need to know the title, location, target audience(s) and date for the programs you are planning, including those events which are still in the preliminary stage. Please note all programs which are tentatively scheduled with the symbol (T). The Levels have different projected time lines, as follows:

Level 2	Schedule for next 12 months
Level 3	Schedule for next 12 months
Level 4 and Level 5	Schedule for next 12 months

LEVEL	TITLE	LOCATION	TARGET AUDIENCE	DATE

SPECIAL QUESTION: This question does not apply to AHEC Special Initiative funding. In preparation for the federal government's site visit in August, the central office is collecting information on non-federal funding for AIDS education. What we need to know is the amount of any award, the awarding agency or type of funds, and the recipient (awardee). This information would be most useful if we could have it for both fiscal year 1989 and fiscal year 1990.

	AMOUNT OF FUNDS		
Recipient (Awardee)	1988-89	1989-90	Source/Type of Funds

If you have any questions, please call me at (209) 252-2851. Thank you very much for your help.

Maria Canfield

MC/mjr/7/17/90

APPENDIX IV

Draft Sign-In Sheet

ACTIVITY LOG (SIGN-IN SHEET)

Area AIDS Education and Training Center

Title/Topic of Program: _____

Source(s) of Funds: _____

DRAFT

Presenter(s): _____ Date: _____

Location: _____ Duration: _____ Hours/Days/Months
(institution/city)

Number of contact hours: CEU _____ or CME _____ or, Other _____

NAME - Please print	DEGREE HELD OR SOUGHT	TRAINEE STATUS: STUDENT OR RESIDENT PHYSICIAN: Please specify type of program or major	INSTITUTIONAL AFFILIATION or DEPARTMENT: Please print name and indicate if private or public sector	O P T I O N A L Please state your: Ethnicity)	Gender
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

LEVEL OF TRAINING	TYPE OF TRAINEE	NUMBER OF TRAINEES
Level 1 Faculty Team Members	Physicians Nurses Dentists Mental Health Professionals	
Level 2 Teaching Hospital	Primary Care Residents Other Resident Physicians Medical Students	
Level 3 Community Teaching Hospital	Physicians Nurses Allied Health* Other (please specify)	
Level 4 Community-Based Health Professionals	Physicians Nurses Dentists Allied Health* Other (please specify)	
Level 5 Community	Community Leaders Health Professionals Administrators Others	
	TOTAL	

*Includes dental auxiliaries, mental health counseling providers, first responders, human service workers, health educators, etc.

TYPE OF TRAINING ACTIVITY (please check only one):

Lecture (< 2 hrs) Tutorial (skill transfer 1-to-1) Teaching HIV Curriculum Chart Review
Half-Day Conference (2-4 hrs) Miniresidency Brief Informational Encounter Teleconference
_____ Full Day(s) Conference (4+ hrs) _____ Teaching Rounds (Informal Case Consultation Other, please &scribe _____

EDUCATIONAL MATERIALS USED (indicate which, if any, Western AIDS ETC modular materials were utilized):

_____ #1 _____
_____ #2 Sexual History
_____ #3 Sexual Counseling
_____ #4 Attitudes & Sexual Counseling
_____ #5 Ethical Dilemmas
_____ #6 Coping
_____ #7 Stress/Burnout
_____ #8 Neuropsychiatry
_____ #9 Nursing Issues
_____ #10 HIV Babies/Children
_____ #11 Latino Community
_____ #12 _____
_____ #13 AIDS Primer
_____ #14 Latinos
_____ #15 Retroviruses
#16 Global Perspectives
#17 AIDS in ths Work Place
#18 Oral Manifestations
#19 _____
_____ #20 _____
_____ #99 UNKNOWN

ETHNIC BACKGROUND OF PROGRAM PARTICIPANTS (please enter the number of participants in each category):

Asian/Pacific Islander _____ Caucasian (Non-Hispanic) _____ Native American _____ Other Hispanic _____
Black (Non-Hispanic) _____ Mexican/American _____ Puerto Rican _____ Other _____
Unknown _____

GENDER OF PARTICIPANTS (please list the number of individuals attending the session):

Male _____ Female _____ Unknown _____

INSTITUTIONAL AFFILIATION (please complete the breakdown of the types of institutions where the participants have the majority of their patient contact by entering the number employed in each setting):

Academic Institutions _____ Community Migrant Health Centers _____ Public Agencies _____ Substance Abuse/Mental
Community-Based Organizations _____ Hospitals _____ Long-Term Care _____ Health Treatment Centers _____
Other (please specify number(s) and type(s) _____ Unknown _____

Private Pra ce _____

APPENDIX V

Sample Pre-Post-Training Knowledge Tests

University of California, San Francisco
and
University of California, Davis
Western AIDS ETC

Saturday, May 12, 1990
"HIV INFECTION AND THE PRIMARY CARE PRACTITIONER"

PRE-TEST

The following questionnaire is intended to allow us to assess the efficacy of this program in educating health care providers about AIDS. We will be asking you to complete this questionnaire both prior to and at the end of the session. The information you give us will help us develop optimal HIV-AIDS educational programs in the future. Please be as candid as possible. All of your responses will remain strictly confidential.

Please circle as many answers as you wish; *more than one* item may be correct for each multiple choice question.

1. The human immunodeficiency virus (HIV) primarily invades which of the following cells:

   a. sperm cells b. red blood cells
   c. suppressor T cells (CD8 lymphocytes) d. macrophages
   e. helper T cells (CD4 lymphocytes) f. epithelial cells

2. The human immunodeficiency virus is found in sufficient quantity to be infectious in which of the following body fluids:

   a. saliva b. blood c. urine d. semen
   e. vaginal secretions

3. A person who has no symptoms or signs of AIDS **is not** infectious.

   True False

4. The total number of AIDS cases reported in the United States is:

   a. 10,000 - 99,999 b. 100,000 - 199,999 c. 200,000 - 500,000

5. The median time from infection to the development of clinical AIDS is:

   a. 1 - 2 years b. 3 - 5 years c. 6 - 8 years
   d. 8 - 11 years

6. The most reliable laboratory indicator for following the course of HIV infection isr

   a. total lymphocyte count b. P 24 antigen
   c. absolute number of T "helper" cells (CD4 lymphocytes)
   d. total leukocyte count e. sed rate

7. AZT (zidovudine, retrovir) should be offered to all persons who test positive for HIV.

   True False

8. Which of the following tests should be done initially in asymptomatic, HIV-positive patients:

   a. PPD skin test b. chest x-ray c. RPR d. CBC
   e. sed rate f. CD4 lymphocyte count g. toxoplasma titer

9. Which of the following conditions establish the diagnosis of AIDS by themselves in a patient who is not on immunosuppressive therapy:

   a. disseminated tuberculosis b. disseminated coccidioidomycosis
   c. candida esophagitis d. oral thrush e. Kaposi's Sarcoma
   f. cryptosporidiosis g. pneumocystis pneumonia

10. I presently have a patient(s) with known HIV infection in my practice.

    Yes No

11. I regularly take a historyfor HIV risk factors in my patients.

    yes No

12. On a scale of 1 - 10, I feel the following level of comfort in caring for HIV-positive patients:

    (10 BEING COMPLETELY COMFORTABLE)
    1 2 3 4 5 6 7 8 9 10 .

MC/mjr

University of California, San Francisco
and
University of California, Davis
Western AIDS ETC

Saturday, May 12, 1990
"HIV INFECTION AND THE PRIMARY CARE PRACTITIONER"

POST-TEST

Thank you for participating in today's course. We are asking participants to complete this questionnaire a second time to allow us to assess the efficacy of this program in educating health care providers about AIDS. This questionnaire also includes an evaluation section which will provide you with the opportunity to give us feedback on the course. Please be as candid as possible. All of your responses will remain strictly confidential.

Please circle as many answers as you wish; more than one item may be correct for each multiple choice question.

1. The human immunodeficiency virus (HIV) primarily invades which of the following cells:

   a. sperm cells b. red blood cells
   c. suppressor T cells (CD8 lymphocytes) d. macrophages
   e. helper T cells (CD4 lymphocytes) f. epithelial cells

2. The human immunodeficiency virus is found in sufficient quantity to be infectious in which of the following body fluids:

   a. saliva b. blood c. urine d. semen
   e. vaginal secretions

3. A person who has no symptoms or signs of AIDS is not infectious.

   True False

4. The total number of AIDS cases reported in the United States is:

   a. 10,000 - 99,999 b. 100,000 - 199,999 c. 200,000 - 500,000

5. The median time from infection to the'development of clinical AIDS is:

   a. 1 - 2 years b. 3 - 5 years c. 6 - 0 years
   d. 8 - 10 years

6. The most reliable laboratory indicator for following the course of HIV infection is:

   a. total lymphocyte count b. P 24 antigen
   c. absolute number of T "helper" cells (CD4 lymphocytes)
   d. total leukocyte count e. sed rate

7. AZT (zidovudine, retrovir) should be offered to all persons who test positive for HIV.

   True False

a. Which of the following tests should be done initially in asymptomatic, HIV-positive patients:

   a. PPD skin test b. chest x-ray c. RPR d. CBC
   e. sed rate f. CD4 lymphocyte count g. toxoplasma titer

9. Which of the following conditions establish the diagnosis of AIDS by themselves in a patient who is not on immunosuppressive therapy:

   a. disseminated tuberculosis b. disseminated coccidioidomycosis
   c. candida esophagitis d. oral thrush e. Kaposi's Sarcoma
   f. cryptosporidiosis g. pneumocystis pneumonia

10. I presently have a patient(s) with known HIV infection in my practice.

    Yes No

11. I regularly take a history for HIV risk factors in my patients.

    Yes No

12. On a scale of 1 - 10, I feel the following level of comfort in caring for HIV-positive patients:

    (10 BEING **COMPLETELY** COMFORTABLE)

    1 2 3 4 5 6 7 a 9 10.

13. Of all of the postgraduate conferences I have attended, I would rank this one:

    (10 = BEST)

    1 2 3 4 5 6 7 8 9 10

14. I had the following questions which were not answered by this **conference:**

_____

_____

_____

_____

_____

Last 4 digits of social security #: _ _ _ _

San Diego Area AIDS Education and Training Center (SD AAETC)
and
University of California, Davis
Western AIDS Education and Training Center (AIDS ETC)
California Area Health Education Center (AHEC)
October 22-24, 1990

Post-Test

Please circle correct answer(s).

I. What is the risk of becoming infected with HIV after puncture-type exposure to the blood of an HIV infected person?

a. 1 in 2
b. 1 in 20
c. 1 in 200
d. 1 in 2000

2. After exposure to HIV, when is antibody to HIV usually first detected in the recipient?

a. 4 - 6 weeks
b. 3 - 6 months
c. 1 - 5 years
d. 5 - 10 years

3. Choose the most correct statement regarding women and HIV.

a. Women account for 5% of reported AIDS cases.
b. Approximately 50% of HIV+ women are of child bearing age.
c. Of heterosexuaily transmitted AIDS cases, 75% have occurred in women.
d. Of women with ADS, 10% were infected heterosexually.
e. All of the above.

4. Choose the most correct statement regarding HIV+ women and cervical dysplasia.

a. The incidence of cervical dysplasia is increased among HIV+ women.
b. Cervical dysplasia among HIV+ women appears to present with advanced and multi-focal lesions.
c. Progression to cancer appears to be more common.
d. HIV+ women should have at least yearly PAP smears.
e. All of the above.

5. Which of the following statements about ddI (2',3'-dideoxyinosine) is incorrect?

a. ddI is associated with pancreatitis.
b. ddI is associated with peripheral neuropathy.
c. ddI has anti-retroviral activity.
d. ddI shares cross resistance to AZT.
e. ddI is currently being evaluated in combination therapy regimens.

6. Which of the following drug regimens when compared to standard treatment has resulted in reduced mortality in patients with moderately severe *Pneumocystis carinii* pneumonia?

a. Trimethoprim Sulfa + steroids.
b. Trimethoprim Sulfa + Pentamidine.
c. Trimethoprim - Dapsone.
d. Aerosol Pentamidine.

7. What proportion of drug injectors are likely to try to protect themselves from AIDS?

a. 0%
b. Less than 10%
c. About half
d. More than two thirds.
e. All

3. HIV seroprevalence among drug injectors is a function of which of the following?

a. City
b. Drug injection frequency
c. Race/ethnicity
d. Year
e. Sharing injection equipment
f. All the above

9. Which of the following have been reported to lead to risk reduction by drug injectors?

a. Methadone maintenance programs
b. Exchanging sterile syringes
c. AIDS education
d. Organizing users against AIDS
e. Outreach by ex-users
f. All the above

IO. The data on racial and gender variation of AIDS cases, HIV infection, and *risk* behaviors indicated that:

a. Mexican Americans have been the group of drug injectors most affected by the epidemic.
b. Perinatal transmission is primarily a problem for white drug injectors and their partners.
c. Puerto Rican and Black drug injectors have been *most* likely to get AIDS.
d. Female sexual partners of white and Black drug injectors 'have been at exceptionally high risk.
e. Risk behaviors by Mexican American, Black, white, and Puerto Rican drug injectors indicate that they all are at risk.
f. Both 'c' and 'e' are true

11. The most common cause of central nervous system mass lesions in patients with HIV infection is:

a. *Mycobacterium tuberculosis*
b. CMV
c. *Cryptococcus neoformans*
d. *Toxoplasma gondii*
e. Lymphoma

12. The most common cause of meningitis in patients with HIV infection is:

a. *Toxoplasma gondii*
b. *Cryptococcus neoformans*
c. *Mycobacterium tuberculosis*
d. Herpes simplex virus
e. CMV

13. Xl1 of the following statements correctly characterize the risk of transmission *of HIV* from an infected patient to a health care worker **except:**

a. There is an approximately 0.4 percent risk of **seroconversion** for hospital employees after needlestick or other sharp injury *exposure* to the blood of HIV infected patients.
b. The risk of transmission of HIV is approximately the same as the risk of hepatitis B virus.
c. The risk of HIV infection is **extremely low** after a health care worker is exposed to blood that does not involve penetrating injuries.
d. A negative HIV antibody test 3 months after a needlestick injury does not rule out all possibility **of HIV** infection.

14. X11 of the following statements correctly characterize the body substance isolation policy for prevention of the spread of HIV infection **except:**

a. Health care workers should wear gloves when contacting patient's blood.
b. Patients with AIDS do not routinely need private rooms.
c. Needles should be capped immediately after blood is drawn.
d. Gloves should be worn for examination of all patients' mouths.
e. Laboratory specimens from all patients should be handled in the same manner.

13. All of the following statements correctly describe psychosocial issues related to the diagnosis of ARC except:

a. Patients with ARC may undergo depression.
b. Patients with ARC are keenly interested in their doctors' opinions of ways to prevent progression to AIDS.
c. Patients with ARC experience lower levels of emotional distress than patients with full-blown AIDS.
d. Patients with ARC are at risk for developing neuropsychiatric problems such as cognitive dysfunction.

16. X11 of the following are correct statements about the care of an asymptomatic individual who is seropositive for HIV infection **except:**

a. An initial biomedical evaluation should be performed to determine whether a patient truly lacks symptoms or signs and to gather baseline information.
b. Ongoing screening for disease progression and opportunistic infections should be planned.
c. No prophylactic measures are indicated initially.
d. Education concerning prevention of HIV transmission in important.
e. Identification and strengthening of psychological and social supports are important components of care.

17. Which of the following components of the physical examination should be repeated frequently (e.g., at least every 6 months) in patients who are asymptomatic but HIV seropositive?

a. Fundoscopic examination
b. Examination for lymphadenopathy
c. Oral examination
d. Detailed skin examination
e. All of the above

18. All of the following are true statements about beta-:! microglobulin except:

a. Beta-2 microglobulin is a protein that is part of the major histocompatibility complex.
b. Serum levels of beta-2 microglobulin are thought to reflect lymphocyte turnover.
c. Cohort studies show that increased levels of beta-2 microglobulin correlate with increased risk of progressing to AIDS.
d. Increased levels of beta-2 microglobulin do not correlate with increased risk of progressing to AIDS independent of CD4 lymphocyte counts.
e. Beta-2 microglobulin is used in other settings for evaluation of immune function and is generally available.

19. An otherwise asymptomatic, HIV-seropositive patient presents with new onset of coughing, rhinitis. and mild general malaise for the past 2 davs. The patient has recent T-lymphocyte studies that showed that his CD4 ceil count was 800. There are no abnormalities on physical examination, and the patient is afebrile, with' a normal respiratory rate. Which of the following approaches would you use for this patient?

a. Gallium scan
b. Chest x-ray
c. Arterial blood gas measurement
d. Hospitalization
e. Careful follow-up of the patient without initial tests

20. Reported side effects of ridovudine include all of the following except:

a. **Anemia**
b. Neutropnia
c. Nausea
d. Confusion
e. Increased opportunistic infections

21. All of the following are true statements about the ELISX HIV antibody test except:

a. The positive predictive value of the ELISA (the likelihood that a positive ELISX actually represents true HIV infection) is dependent on the prior probability of HIV infection in an individual (presence of risk factors)
b. The strength of ELISA reactivity (strongly versus borderline reactive) affects the predictive value of the test
c. For individuals with no known risk of HIV infection, the probability that a positive ELISX reflects true HIV infection is approximately 20 percent
d. The HIV ELISA test is highly sensitive (at least 99 percent) and highly specific (99 percent)
e. Most laboratories will report positive ELISA results without confirmatory test results

22. All of the following are true statements about the Western blot *test* except:

a. Indeterminate Western blot *results can be* reported in both low- and high-risk persons in as many as 25 percent of ELISA-reactive specimens
b. False-negative Western blot tests never occur in individuals at high risk for HTV infection
c. False-positive Western blot tests are almost never found in persons who are at high risk for HIV infection
d. The Western blot test detects antibodies to specific viral antigens
e. The Western blot test is time-consuming and subjective, with some interlaboratory variability in technique and interpretation

23. All of the following statements are true about HIV antibody tests except:

a. Indeterminate HIV Western blots are due to early seroconversion, autoantibodies, and possible cross-reactivity with antibodies to other viruses
b. A confirmatory test is not necessary if the HIV ELISA is positive
c. A low-risk individual with an indeterminate Western blot should be followed for 6 months with repeat Western blots and should be counseled that he or she is unlikely to be infected with HIV if a Western blot is negative or indeterminate after 6 months of follow-up
d. False-negative antibody tests have been reported in high-risk individuals with evidence of HIV infection by culture in 3 years of foilow-up
e. The likelihood (i.e., positive predictive value) that an individual is infected with HIV as determined by a reactive ELISA followed by a positive Western blot is 99 percent in high-risk individuals and 93-99 percent in low risk individuals

24. In taking a history from a new male patient concerning the possible risk of HIV infection, a clinician should:

a. Ask open-ended questions in a nonjudgmental fashion
b. Ask about previous STDs
c. Ask questions in the appropriate vernacular about drug use
d. Ask 'have you had sex with men, or women, or both?"
e. All of the above

25. In providing counseling after an HIV test has been performed, a clinician should do all of the following except:

a. Meet in person with patients who are at risk for HIV infection
b. Delay presenting the result of the HIV test until the end of the counseling session, when the patient fully understands the implications
c. Interpret the meaning of a positive or indeterminate result
d. Discuss plans for medical or psychological services for newly diagnosed, HIV-seropositive patients
e. Discuss the importance of safer sex and drug practices

26. Which of the following have been documented as modes of transmission of HIV?

a. Bites by mosquitos or other arthropods
b. Contamination of mucous membranes with saliva
c. Sharing eating utensils
d. All of the above
e. None of the above

27. Which of the following most accurately **represents** the **relative efficiencies of HIV transmission?**

a. Transfusion>receptive intercourse>insertive intercourse
b. Receptive **intercourse>transfusion>insertive** intercourse
c. **Transfusion>insertive** intercoursexeceptive intercourse
d. Receptive **intercourse>insertive intercourse>transfusion**
e. **Insertive** intercoursexeceptive **intercourse>transfusion**

Suppose that you were to engage in the following **behaviors. Please estimate your** consequent risk (chance) of becoming infected with the AIDS virus, using **a scale** of 1 - 6.

28. Entering the room of an AIDS patient without wearing a gown **or mask.**

1. No risk
2. **Very low** risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

29. Mouth-to-mouth resuscitation on a person with AIDS.

1. No risk
2. Very low risk
3. Low risk
4. 'Moderate risk
5. High risk
6. Very high risk

30. Recapping a needle used on an AIDS patient using a two-handed technique.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

31. Holding a patient with AIDS.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

32. While wearing gloves, performing an anal exam on an AIDS patient.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

33. Xccidently sticking myself with a needle that has been used on a person with AIDS.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

3-L French kissing (deep mouth-to-mouth) with a person with AIDS.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

35. Receiving a root canal from a dentist who is HIV+.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

36. Emptying the bedpan of an AIDS patient without wearing gloves.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

37. Engaging in anal intercourse with a person with AIDS using a condom

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

38. Engaging in genital intercourse with a person with AIDS using a condom

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

39. Having the blood of a patient with AIDS splashed on my skin.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

40. Performing a physical exam on an AIDS patient without wearing gloves (excluding anal exam).

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

41. Sharing a drinking glass with a person who is infected with the AIDS virus.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

42. Receiving a blood transfusion during surgery.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

43. Being sneezed upon by an AIDS patient.

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

44. Being bitten by a person with AIDS.

1. No risk
2. Verylowrisk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

45. Performing a cut-down on an HIV+ infant

1. No risk
2. Very low risk
3. Low risk
4. Moderate risk
5. High risk
6. Very high risk

46. Which of the following are modes of HIV transmission to infants and children?

A. Pregnancy/birth
B. Breast feeding
C. Sharing toys
D. Transfusion with infect& blood/blood produas
E. Sexual abuse

1. A, D
2. B, C, E
3. All but C
4. All of the above

47. Which of the following laboratory and/or clinical findings indicate HIV infection in children less than 15 months old?

a. Positive ELISA, negative Western Blot
b. Positive ELISA, positive Western Blot
c. Positive ELISA, positive HIV culture
d. Generalized lymphadenopathy

48. Which ACTG clinical trial will be available to HIV infected children who have demonstrated AZT intolerance or disease progression while taking AZT?

a. ACTG 051 (AZT ± IVIG)
b. ACTG 134 (rCD4 -IgG)
c. ACTG 128 (High versus low dose AZT)
d. ACTG 138 oral ddC

49. Which of the following are important issues to be considered when testing children and adolescents for HIV?

A. Availability of pre- and past test counseling
B. Referral network for adolescent health care, even if results are negative
C Disclosure of parental IDU, bisexuality, sexual abuse as source of child's HIV infection
D. Child's/adolescent's school performance and future goals

1. All but D
2. A,C,D
3. B, D
4. Doniy

50. Which *of the* following are factors that support the rationale for the establishment of a maternal-child clinic?

A. HIV+ mothers often put their own health care needs last.
B. It has proven to be more cost-effective than more traditional approaches.
C. HIV+ child's well-being depends on a responsible, healthy care-giver.
D. Multiple family stressors make it difficult for HIV+ women and children to access health care.

1. A,C,D
2. B and C
3. A only
4. A, B, D

APPENDIX VI

Arizona Pre/Post-Training Attitude Test

AIDS EDUCATION: PRETEST QUESTIONNAIRE

DATE: _____

ID: _____
Last Six Digits of Social Security Number
(To match pre- and post-tests)

DEMOGRAPHY: **Age**_____

Sex **F**__ **M**__

Occupation (If student, be specific) _____

Highest Level of Education_____

Do you have children? Yes_ No_

How often do you have contact with a person with AIDS?

Never Rarely Sometimes Frequently Very Frequently

ATTITUDES

Please indicate your level of agreement with each of the following statements:

		Strongly Agree						Strongly Disagree
1.	I would feel comfortable working with a colleague who is HIV+.	**1**	2	3	4	**5**	6	7
2.	Health care professionals should be able to choose whether or not to care for a person with AIDS.	**1**	2	3	4	5	6	7
3.	I am at high risk for contracting the HIV infection if I care for people with AIDS.	**1**	2	3	4	5	6	7
4.	I would choose not to be a member of any organization which had any homosexuals in its membership.	**1**	2	3	4	5	6	7
5.	HIV+ health care providers should find work in non-health care fields.	**1**	2	3	4	5	6	7
6.	Most patients with AIDS deserve the disease because of their own behavior.	**1**	2	3	4	5	6	7
7.	I would be upset to find I was alone with a homosexual of my same sex.	**1**	2	3	4	5	6	7
8.	I would not send my child to school with children who have AIDS.	**1**	2	3	4	5	6	7
9.	IV-drug users should be protected against discrimination just like any other group.	**1**	2	3	4	5	6	7
10.	It makes me uncomfortable when people use street language in describing sexual activities.	1	2	3	4	5	6	7

		Strongly Agree						Strongly Disagree
11.	Homosexuals should not be allowed to hold government positions that have access to classified **information.**	1	2	3	4	5	6	7
12.	I would be afraid for my child to have a person with AIDS as a school teacher.	1	2	3	4	5	6	7
13.	I would be suddenly uncomfortable if I found the patient I was working with had AIDS.	1	2	3	4	5	6	7
14.	I find the thought of gay ***or*** lesbian sexual acts disgusting.	1	2	3	4	5	6	7
15.	I would be afraid for a child of mine to have a gay or lesbian school teacher.	1	2	3	4	5	6	7
16.	Nearly all homosexuals are promiscuous.	1	2	3	4	5	6	7
17.	Telling IV-drug users how to clean their needles and syringes to avoid AIDS encourages people to stay on drugs.	1	2	3	4	5	6	7
18.	I would be embarrassed to demonstrate proper condom use to a client/patient.	1	2	3	4	5	6	7
19.	For their own protection, health and mental-health workers have a need to know the HIV status of their clients/patients.	1	2	3	4	5	6	7
20.	I do not mind talking about specific sexual practices with clients/patients.	1	2	3	4	5	6	7
21.	I think pre-hospital admission testing should include HIV testing.	1	2	3	4	5	6	7
22.	I think pre-marital blood testing should include testing for HIV.	1	2	3	4	5	6	7
23.	The gay male is unassertive, and usually a passive person.	1	2	3	4	5	6	7
24.	I would prefer not to care for AIDS patients.	1	2	3	4	5	6	7
25.	I would not mind if my child had a close friend with AIDS.	1	2	3	4	5	6	7
26.	It is important that new cases of AIDS be reported to the Health Department so sexual partners can be located.	1	2	3	4	5	6	7
27.	Homosexuals are anxious to bring young teens into their lifestyle.	1	2	3	4	5	6	7

	Strongly Agree						Strongly Disagree
28. Even **with precautions,** I **am** at **increased** risk of getting AIDS if I care for AIDS patients.	1	**2**	**3**	**4**	**5**	**6**	**7**
29. I would hire a person with AIDS as a babysitter for my children.	1	**2**	**3**	**4**	**5**	**6**	**7**
30. IV-drug users have special needs that must be addressed with sensitivity and compassion.	1	**2**	**3**	**4**	**5**	**6**	**7**
31. Using sexually explicit videotapes to educate clients/patients about safer sex would make me uncomfortable.	1	**2**	**3**	**4**	**5**	**6**	**7**
32. Insurance companies should be able to test people for HIV before writing new policies.	1	**2**	**3**	**4**	**5**	**6**	**7**
33. Gay men become gay because they hate women.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

INFORMATION

Please indicate whether you think the following questions are true or false:

	Definitely True	Probably True	Probably False	**Definitely False**
1. Individuals who test positive for HIV antibody are capable of infecting other people with their virus.	**1**	2	3	4
2. Individuals who test positive for HIV antibody have a high probability of developing ARC or AIDS.	1	2	3	4
3. Modes of transmission for HIV include:				
a. Blood or blood products	1	2	3	4
b. Saliva	1	2	3	4
c. Feces	1	2	3	4
d. Urine	1	2	3	4
e. Heterosexual sexual intercourse	1	2	3	4
f. Homosexual sexual intercourse	1	2	3	4
g. Sharing eating utensils	1	2	3	4
h. Insects	1	2	3	4
i. Mother to fetus	1	2	3	4
4. Minorities in Arizona have a greater chance of getting AIDS than anglos do.	1	2	3	4

	Definitely True	Probably True	Probably False	Definitely False
5. Minorities in the United States have a greater chance of getting AIDS than anglos do.,	1	2	3	4
6. Drawing blood from any patient requires (under universal precautions or Body Substances Isolation) use of gloves, gown, mask and goggles.	1	2	3	4
7. Condoms are 100% effective in protecting against getting AIDS from sexual intercourse.	1	2	3	4
8. In Arizona, a patient with a positive HIV antibody test is required to be reported by name to the State Department of Health Services.	1	2	3	4
9. Ten percent of AIDS patients present with neuropsychiatric changes rather than PCP or Kaposi's.	1	2	3	4
10. The more expensive "natural' condoms offer better protection against the AIDS virus than the cheaper "rubber' or latex condoms do.	1	2	3	4
11. If an HIV+ male has a vasectomy, he can no longer transmit the AIDS virus.	1	2	3	4
12. The lubricant/spermicide non-oxynol 9 is also effective in killing the AIDS virus.	1		3	4

APPENDIX VII

San Francisco Pre/Post-Training Attitude Scales

SUPPOSE THAT YOU WERE TO ENGAGE IN THE FOLLOWING BEHAVIORS. PLEASE **ESTIMATE** YOUR CONSEQUENT RISK (CHANCE) OF BECOMING INFECTED WITH THE AIDS VIRUS, USING A SCALE OF 1 • 5:

No Risk	Very Low Risk	Low Risk	Moderate Risk	High Risk	Very High Risk
1 ----------	2 -	3 -	4 -	5 -	6 - -

___ 1. Entering the room of an AIDS patient without wearing a gown or mask.

___ 2. Having the blood of a patient with AIDS splashed on my skin.

___ 3. Holding a patient with AIDS.

___ 4. Emptying the bedpan **of an AIDS** patient without wearing gloves.

___ 5. Receiving a blood transfusion during surgery.

___ 6. Being bitten by a person with AIDS.

___ 7. Sharing a drinking glass with a person who is infected with the AIDS virus.

___ 8. Accidentally sticking myself with a needle that has been used on a person with AIDS.

___ 9. Being sneezed upon by an AIDS patient.

___ 10. Performing the full physical exam on an AIDS patient without wearing gloves.

___ 11. French kissing (deep mouth-to-mouth) with **a** person with AIDS.

THE ITEMS BELOW ARE STATEMENTS ABOUT HEALTH CONCERNS'- ESPECIALLY OPINIONS AND CONCERNS ABOUT AIDS -- **AND** PERSONAL **ATTITUDES** AND TRAITS GERMANE TO HEALTH CARE. PLEASE **MARK THE** EXTENT TO WHICH YOU PERSONALLY AGREE **OR** DISAGREE WITH THEM, **USING A SCALE OF 1 - 6:**

Strongly Disagree	**Moderately Disagree**	**Slightly DIsagree**	**Slightly Agree**	**Moderately Agree**	**Strongly Agree**
1 ------	**2 -**	**3 -**	**4 ------**	**5 ------**	**6 ------**

___ 1. I would prefer to refer persons with AIDS to my professional colleagues.

___ **2.** I sometimes find it hard to be sympathetic towards AIDS patients.

___ **3.** I would consider changing my professional specialty/position, however interesting, if it became necessary to work with AIDS patients.

___ 4. I feel angry about the risk of AIDS which homosexuals have imposed upon the straight community.

___ **5.** I often have tender, concerned feelings for people with AIDS.

___ 6. AIDS makes my job a high risk occupation.

___ 7. It is best to train a few specialists who would be responsible for the treatment of AIDS patients.

___ a. I would rather work with a better class of people than AIDS patients.

___ 9. I don't want persons at higher risk for AIDS, such as IV drug users and homosexuals as patients.

___ 10. I would be willing to eat in a restaurant where I knew the chef had AICS.

___ 11. Despite all I know about how AIDS is transmitted, I am still afraid of catching it.

___ 12. I would not want my child to go to school with a child with AIDS.

___ 13. Even were I to follow strict infection control measures, it is likely that I would become infected with HIV if I were working with AIDS patients over a long period of time.

___ 14. Given a choice, I would prefer not to work with AIDS patients.

___ 15. I would feel resentful if AIDS patients accounted for a significant pan of my case load.

APPENDIX VIII

Sample AA ETC Self-Bfficacy Instrument for Evaluating Effectiveness

(This standard form was used to evaluate the "HIV Knowledge for Caring" Course. Response was 51% overall. It is difficult to tabulate results. Instructors were given copies for review.)

HIGHLAND GENERAL HOSPITAL NURSING EDUCATION DEPARTMENT

COURSE EVALUATION

Name of Course/Class_____ Date_____

1. What can you do now that you couldn't do before?

2. What new concept(s) did you learn?

3. Which part of the course did you find least useful?

4. Which part of the course did you find most useful?

5. Was the information presented useful? __YES __NO __SOMETIMES

6. Was the presentation effective? __YES __NO __SOMETIMES

7. Was the content covered adequately? __YES __NO __SOMETIMES

8. Comments:

APPENDIX IX

Impact Evaluation--Abstracting Form for Chart Reviews

Chart Review/Risk Assessment Reviewer: _____
Charts: ___ to ___ of 50

CHART INFORMATION:

chart	___	___	___	___	___
age					
sex					
type of visit					

HISTORY NOTED, CHECK IF PRESENT(✓), LEAVE BLANK IF ABSENT, STAR IF A FORM IS USED(✱), AND CIRCLE THE STAR IF THE SPECIFIC INFORMATION BEING ASSESSED IS ASKED FOR ON FORM(✱):

sexual history					
type activity					
preference					
practices					
partners					
partners' risk					
STD					
specific type					
HIV					
substance use					
alcohol					
IVDU					
other substance					
frequency					
setting					
risk red.couns.					
condoms					
other suggest.					
pt.ed.materials					

APPENDIX x

Evaluation Reports--Faculty Development Activities

ACD
Sacramento AAETC

DENTAL AIDS FACULTY REFRESHER COURSE
March 2 - 3, 1990

COMPARISON OF PRE- AND POST- 'TEST RESULTS

Number of Tests Completed:

# of participants who completed both tests:	7
# who completed only pre-tests:	5
# who completed only post-tests:	2

The following results are for those **seven** *participants who completed both the* ***pre-*** *and post-tests..*

True and False Questions: (testing knowledge)

# who answered all three questions correctly:	3
# who answered two of the three correctly:	4
# treating HIV+ patients in their practices:	7

Questions measuring attitudes or behavioral changes: (each question ranked on a scale of 1 - 5, with 1 = strongly agree and 5 = strongly disagree.)

Questions	Pre-Test	Post-test
1. I feel competent to develop a variety of educational programs *on* HIV for dental professionals:	*3.0*	*2.14*
2. I am comfortable with my role as an AIDS educator in spite of the negative attitudes of many of my colleagues towards AIDS patients.	*2.86*	*2.0*
3. I am currently using my training as an AIDS educator to provide educational programs.	*3.57*	*2.66*
4. I am interested in incorporating the use of more audiovisual materials into my AIDS education programs.	*2.14*	*1.66*
5. I plan on using many of the written and audiovisual materials that I learned about in this training in my future educational programs.	N.A.	1.16
6. I feel more **knowledgeable** and competent to provide HIV information to dental audiences as a result of this training.	N.A.	1.5
7. I plan on either doing or training other dentists to do office infection control evaluations.	N.A.	1.66

Results of 5 Pre-tests only:

True and False Questions:

who answered all three questions correctly: 2
who answered 2 of the 3 questions correctly: 3

3 are currently treating HIV+ patients in their practices, 2 are not.

Attitude Questions:

1. I feel competent to develop a variety **of** educational programs on HIV for dental professionals: *2.4*

2. I am comfortable with my role as an AIDS educator in spite of the negative attitudes of many of my colleagues towards AIDS patients. *2.2*

3. I am currently using my training as an AIDS educator to provide education programs. *1.6*

4. I am interested in incorporating the use of more audio-visual materials into my AIDS education programs. 1.4

Results of 2 Post-tests only:

True and False Questions;

2 participants *got* all three questions correct.
The question re: treating HIV+ patients was not asked on the post-test.

Attitude Questions:

1. I feel competent to develop a variety of educational programs on HIV for dental professionals: 1.5

2. I am comfortable with my role as an AIDS educator in spite of the negative attitudes of many of my colleagues towards AIDS patients. 1.5

3. I am currently using my training as an AIDS educator to provide education programs. 1.5

4. I am interested in incorporating the use of more audio-visual materials into my AIDS education programs. 2.5

5. I plan on using many of the written and audiovisual materials that I learned about in this training in my future educational programs. *2.5*

6. I feel more knowledgeable and competent to provide HIV information to dental audiences as a result of this training. *2.0*

7. I plan on either doing or training other dentists to do dental office infection control evaluations. 1.0

UNIVERSITY OF CALIFORNIA, DAVIS
AIDS EDUCATION AND TRAINING CENTER

DENTAL FACULTY REFRESHER COURSE

EVALUATION - DAY ONE

Please rate each of the following on a scale of 1 to 5, with 1 = Outstanding and 5 = Poor

		1	2	3	4	5
1.	Problem Areas - **Maxwell**					
	Presentation Content 1.75		3	4	1	
	Faculty 1.625		3	5		
2.	Motivating Attendees - von Friederichs-Fitzwater					
	Presentation Content 1.5		4	4		
	Faculty 1.5		5	2	1	
3.	Rural Programs					
	Presentation Content 1.75		4	2	2	
	Faculty-Dillenberg 1.75		3	4	1	
	Faculty - Toepke 1.75		2	3	2	
4.	Resource Materials					
	Presentation Content 2.125			4	3	
	Faculty - Torgerson 2.25		1	4	3	
	Faculty - Jordan 1.875		1	4	2	
5.	Office I.C. Evaluation					
	Content - Overview 1.75		2	3	2	
	Content - **Demonstration** 1.875		2	5	1	
	Content - Preparing report 1.875		3	3	2	

EVALUATION - DAY ONE

PAGE TWO

		1	2	3	4	5
5.	Office I.C. Evaluation					
	Faculty - Maxwell 1.75	2	3	2		
	Faculty - Torgerson 2.125	1	5	2		
6.	Teaching Experiences Discussion 2.125	3	1	4		
7.	Luncheon 1.75	1	5	1		
a.	Hand Out **Materials** 1.125. **Great!**	7	1			

Comments:

Verv good day -I learned a lot.

Bravo!

UNIVERSITY OF CALIFORNIA DAVIS
AIDS EDUCATION AND TRAINING CENTER

DENTAL FACULTY REFRESHER COURSE

EVALUATION - DAY TWO

Please rate each of the following on a scale of 1 to 5, with 1 = Outstanding and 5 = Poor

		1	2	3	4	5
1.	Transmission Variables Avg					
	Routes and Resistance 2.0	3	5	3		
	Saliva Studies 1.8	5	3	3		
	Dental Office Risks 1.9	5	2	4		
	Infection Control 1.7	5	4	2		
	Faculty - Maxwell 1.5	6	4	1		
2.	Oral Lesions					
	"Deferred" = 1 response					
	Patient Communication 1.7	4	5	1		
	Referrals 2.0	3	4	3		
	Updating Protocols 1.7	4	5	1		
	Faculty - Gall 1.6	5	4	1		
3.	Legal Issues					
	Videotape 2.0	4	3	4		
	Discussion 1.9	4	4	3		
4.	CDA Viewpoint					
	Presentation Content 2.3	3	3	4	1	
	Faculty - Nakata 2.4	3	3	3	2	

EVALUATION - DAY TWO
PAGE TWO

5.	OSHA Requirements					
	Videotape	1.9	5	4	1	1
	Discussion	1.9	4	5	1	1
6.	Closing Discussion	2.1	4	4	2	1
7.	Luncheon	1.7	5	4	2	
a.	Hand Out Materials	1.5	7	2	2	

Comments:

This was a wonderful update. Please strongly consider another faculty update next vear.

Thank vou, good organization. I enjoyed the conference of only dentists because it directly relates to the interest.

Prefer sep. training - more issue specific, better use of time.

Extremely important information is exchanged to enhance our competence as educators. Constant updating is vital to provide information to our colleagues that will valuable, believable and forward looking (sic).

UNIVERSITY OF CALIFORNIA, DAVIS
AIDS EDUCATION AND TRAINING CENTER

DENTAL FACULTY REFRESHER COURSE

COURSE EVALUATION

1. Approximately how many conferences on AIDS-related issues have you attended in the last 12 months?

   3 (3 respondents), 1 (3 respondents), 5 (1 respondent), 6-8 (1 respondent)

   _____ Conferences
   (number)

   "this one only" (1 respondent)

2. How would you characterize the overall organization of the seminar you attended?

5	Outstanding	COMMENTS:
4	Very Good	Dr. Maxwell did a great job!
1	Satisfactory	
	Not Very Good	
	Poor	

3. To what extent has your participation in the seminar increased your knowledge about AIDS?

Increased	GREATLY
5	Increased it SOMEWHAT
	Increased it a LITTLE
1	NO increase AT ALL

4. To what extent has your participation in the seminar changed your own personal fears of contracting HIV infection?

REDUCED	my fears GREATLY
REDUCED	my fears SOMEWHAT
has NOT	CHANGED my fears at all "(had none)", "not feared"
	INCREASED my fears SOMEWHAT
	INCREASED my fears GREATLY

COURSE EVALUATION
PAGE TWO

5. To what extent did the retreat allow youto express your thoughts or feelings about the AIDS-related issues that were under discussion?

6	Greatly	COMMENTS:
3	Somewhat	I am new to this group.
	Not very much	
	Not at all	

6. How would you describe opportunities to have your questions answered by the various speakers and presenters at the seminar?

5	Extremely adequate	COMMENTS:
3	Very adequate	
1	Somewhat adequate	
	Not very adequate	
	Not at all adequate	

7. How would you describe your opportunities to meet and socialize with the other professionals who were attending the seminar?

	Extremely adequate	COMMENTS:
5	Very adequate	
1	Somewhat adequate	
	Not very adequate	
	Not at all adeqaute	

8. What is your overall level of satisfaction with the seminar?

4	Extremely satisfied	COMMENTS:
4	Very satisfied	Very helpful update - Small group facilitated discussion of issues raised. This would be an appropriate annual event.
1	Somewhat satisfied	
	Not very satisfied	
	Not at all satisfied	

APPENDIX B

PROGRAM EVALUATION OF THE WESTERN AIDS EDUCATION AND TRAINING CENTER'S FACULTY DEVELOPMENT TRAINING (FDT) SEMINAR 'AIDS AND MENTAL HEALTH.'

REPORT PREPARED BY THOMAS J. FICARROTTO, PHD.

SEMINAR CONDUCTED JANUARY 30TH - FEBRUARY 2ND, 1990,
IN PACIFIC GROVE. CALIFORNIA

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This report presents results from an evaluation of the Western AIDS Education and Training Center's Faculty Development Training (FDT) Seminar entltled 'AIDS and Mental Health.' The seminar was conducted with the purpose of educating health care professionals about the mental health implications of HIV-AIDS. The seminar was conducted over a four day period, January 30 - February 2nd at the Asilomar Conference Center in Pacific Grove, California.

The primary purposes of this report are to: 1) provide information regarding the impact of the seminar upon participants: and 2) provide formative evaluations of the seminar's success on the basis of participants' self reponed evaluations. With respect to the former, the immediate impact of the FDT was assessed with regard to: 1) reducing health fears of occupational risk: 2) improving attitudes about working with HIV-AIDS patients: and 3) increasing health care professionals! knowledge regarding the mental health aspects of HIV infection.

Changes in risk perceptions, attitudes, and knowledge are examined as a function of participants' gender, race, occupational status, geographical location, as well as participants' professional and personal contact with HIV-AIDS patients, A summary of evaluations from the post-test feedback questionnaires (i.e., organization of retreat, clarity of presentations, etc.), and a summary and comparison of ratings of lecture presentations and 'break-out' (discussion) groups are likewise included. In addition, the methodology of pre/post test evaluations, and the sample characteristics of the health-care workers participating in the FDT are presented.

Review of the Literature

AS the number of Americans infected with HIV increases, health-care providers who never expected to treat persons with HIV-AIDS will be forced to play a pivotal role with respect to its early detection, diagnosis, and prevention. Yet evidence from surveys suggests that among health-care providers medical knowledge about HIV-AIDS is often limited and/or inaccurate. (l-5). Results from surveys similarly indicate a resistance on the part of many health care professionals in working with HIV-AIDS patients (l-5).

As the health care needs of HIV-AIDS patients increase, so will the demands upon the health system. It is imperative that we, as health professionals and educators, develop effective educational programs, as well as effective means of evaluating educational programs targeted at increasing health-care workers' knowledge base about HIV-AIDS, and in overcoming resistance on the pan of health-care providers in working with HIV-AIDS patients.

Several published studies document the efficacy of educational programs in improving attitudes, reducing fears, and increasing knowledge about HIV-AIDS among health-care workers. O'Donnell and colleagues surveyed over 200 Massachusetts hospital workers in 1985 and in 1986 after the institution of in-service training programs.6 The programs provided information pertaining to the biology and epidemiology of AIDS, its clinical course and treatment, and infection control. The study found that in-service training was associated with reductions in workers' reported stress, perceived risks, and negative attitudes, with improvements in both knowledge and professional satisfaction.

Wertz and colleagues found significant improvements in accuracy of knowledge about modes of HIV transmission, and in attitudes about caring for HIV patients amon[3]. health care providers working in Massachusetts immediately following 90-minute in-service trainings. The training consisted of traditional lecture-format presentations by health-educators with follow-up question and answer sessions. One session included a person with AIDS, thus providing a format for more personal and experiential learning. A 1-month followup of 159 of the original 1,247 providers revealed that postprogram changes. in knowledge and attitudes were largely retained.

Gerbert and colleagues tested the efficacy of a multi-modal educational format in changing dentists' knowledge, attitudes, and behaviors related to AIDS.[8] A total of 101 dentists in the San Francisco Bay Area were randomly assigned to either an educational intervention group (n=35) or a control group (n-66) not receiving the intervention. The intervention consisted of three formats: 1) computerized feedback comparing participants' AIDS-related knowledge, attitudes, and behaviors

with that Of fellow participants, and with the ideal; 2) periodic informational bulletins on HIV-AIDS and dentistry, and 3) telephone conference calls about HIV-AIDS with experts in the field of dentistry.

A 6-month follow-up indicated that the group receiving the educational package had better scores than the control group on: 1) willingness to treat persons with AIDS; 2) identification of HIV lesions: 3) knowledge about AIDS; and 4) completeness of conducting intraoral and extraoral examinations. Unfortunately, the intervention group received all three educational formats, making it impossible to determine the differential effect of these interventions in effecting outcome measures.

Not all studies have found significant changes in outcome variables for groups receiving educational interventions in comparison to control groups. Lewis and colleagues tested the efficacy of three different treatment groups receiving the same materials about AIDS either in printed, audiocassette, or videocassette formats.[9] Over 200 primary care physicians in Los Angeles County were targeted for interviews prior to the intervention and during a 5 month follow-up period.

Follow-up interviews revealed significant increases in competency in caring for HIV infected patients across all groups, including a control group not receiving any intervention. The investigators attributed increases in learning to the enormous amount of AIDS-related material presented in the mass media between pre and post testing, and not to the treatment interventions.

Method

Participants

The participants of this conference represented a total of 15 Educational and Training Centers (ETCs) across 4 diierent states, including Arizona, California, Hawaii, and Nevada. Of 77 seminar participants, a total of 46 participants completed either the pre-test only (n=7), the post-test only (n=4), Or completed both pre-test and post-test assessments (n=35).

Table 1 gives the number of faculty registered for the conference, in comparison to the percentage completing the pre-post test assessments from each of the 15 sites. As can be seen from Table 1, Salinas/Monterey, San Francisco, and Tuscon had the highest rate of survey participation, whereas Sacramento had the lowest rate of participation.

Figure 1 gives the breakdown of participants by state of residence. Approximately 68% (n-30) of the participants were from California, 14% (n-6) were from Arizona, 9% (n=4) were from Hawaii, and 9% (n=4) were from Nevada The mean age of the respondents was 39.70 (sd-6.67). There was a total of 33 women and 13 men. All participants were American citizens, with the exception of one.

Figure 2 gives the demographic breakdown of the 46 participants by occupation. Thirty-Six percent (n-15) of the participants were nurses, 29% (n=12) physicians, 26% (n-1 1) represented their ETC as mental health care professionals, 5% (n=2) were dentists, and 5% (n-2) identified themselves in some "other" category.

Figure 3 gives the demographic breakdown of the 46 participants by race/ethnicity. The overwhe'ming majority (78%; n=36) was Caucasian, whereas only approximately 21% (n=10) of participants represented non-white groups.

Figure 4 presents a breakdown of the number of AIDS patients with whom participants indicated having had professional contact. As can be seen from Figure 4, most participants have had professional experience working with AIDS patients. The majority (57%; n=26) indicated having professional contact with more than 20 AIDS patients; only 11% (n=5) indicated having no professional contact with AIDS patients.

Figure 5 presents a breakdown of the number of persons with AIDS known personally outside of the work setting. As can be seen from Figure 5, a large proportion (41%; n=19) of participants did not personally know anyone with AIDS outside of the work setting; fifty-nine percent (n=27) of participants, however, indicated that they personally knew persons with AIDS outside of the work setting.

Chi-square analyses revealed no significant relationship between age, race, gender, or occupation in regard to the amount of professional or personal contact with AIDS patients.

Procedure

The Western AIDS Education and Training Center's Faculty Development Training (FDT) Seminar entitled 'AIDS and Mental Health' was conducted over a four day period, January 30 - February 2nd, 1990, in Monterey, California. A copy of the working agenda is given in Appendix A.

The seminar included a total of 7 lecture presentations, as Well as 7 different sessions where participants had the choice of attending one of several 'break-out' (discussion) groups on topics Of interest (see Appendix A), The latter format provided participants' the opportunity to engage in more informal and experiential types of learning in comparison to the lecture presentations.

The pre-test was administered on the morning of the first full day of the conference. Participants were instructed to complete all items on the questionnaire and to 'be as honest and candid' as they liked. Participants were also informed that their responses would remain strictly confidential. The post-test was administered two days later, on the morning of the last full day of the conference.

Instruments

A copy of the pre-post test assessment instrument is given in Appendix B. The AIDS Attitude Scale for Heatth Professionals (AAS) measured participants' attitudes and beliefs about HIV-AIDS.[10] This 15-item scale asks participants to indicate the extent to which they agree with statements on a 6-point Likert-type scale, ranging from 1 =Strongly Disagree to 6=Strongly Agree.

Confirmatory factor analyses on the MS has revealed a total of 3 subscale components: (1) Professional Resistance (PR) measures unwillingness to work with AIDS patients (i.e., 'I would consider changing my professional specialty/position, however interesting, if it became necessary to work with AIDS patients.'); (2) Negative Emotions (NE) measures respondents' endorsement of negative affective responses in regard to persons with AIDS (i.e., 'I sometimes find it hard to be sympathetic toward AIDS patients.'); (3) Fear of Contagion (FC) measures the degree to which the respondent is concerned about contracting the illness (i.e., 'Even were I to follow strict infection control measures it is likely that I would become infected with HIV if I were working with AIDS patients over a long period of time.').

The AAS was originally standardized on a sample of medical and nursing students, and is currently being used in several locations around the country in assessing health-care professionals' attitudes toward AIDS. Alpha coefficients calculated for the three subscales and a summary AAS score range from .65 to .86 (Fear of Contagion- .65; Negative Emotions- .70; Professional Resistance-.75; Total- .86).

AIDS knowledge was assessed by an 8-item multiple-choice exam. Items were constructed by asking each of the lecturers to submit at least two muftiplechoice items corresponding to the content of their presentation. Only 4 of the 7 lecturers submitted items in time to be included as pan of the scale. Two presenters did not submit items because they fett that their topics contended with material that did not lend itself to factual multiple-choice items.

A total of 11 items from the Risk Perception Scale (RPS) was employed to assess participants' estimates of their consequent risk of becoming infected with HIV in a variety of occupational settings (i.e., 'Entering the room of an AIDS patient without wearing a gown or mask.').[10] Items were completed on a J-point Liken-type scale ranging from 'No Risk' to 'Very High Risk'. The original RPS has an alpha coefficient of .86, revealing high internal consistency.

Previous clinical experience with AIDS patients was assessed by participants indicating the approximate number of AIDS patients with whom they have had professional contact. The number of persons with AIDS known to participants personally outside of the work setting was also assessed in the same manner.

Demographic information, including age, gender, race, citizenship, occupation, state Of residence, and the ETC each participant represented was also assessed.

Results

Program Evaluation

This section examines the resutts from the participants' self reported ratings of the seminar, ratings of lecture presentations, and ratings of individual 'break-out' groups. Results from the overall Program evaluation in response to items #1 through #8 of the post-test questionnaire are presented in Figure 6. Written comments in response to items #11, #12, and #13 of the post-test questionnaire, in addition to any additional comments are given in Appendix C.

The majority of respondents indicated that they attended other conferences on AIDS-related issues in the 12 months prior to the 'AIDS and Mental Health" seminar. The mean number of other conferences attended in the past 12 months was 2.97 (sd=1.94) (see Figure 6, item #1).

Results from the overall program evaluation indicate that participants evaluated the seminar quite favorably. The majority (71.8%; n-28) of respondents rated the overall organization of this conference as "Very Good.' Only 1 respondent rated the organization of the conference as 'Not Very Good' (see Figure 6, item #2). The majority of respondents rated their 'opportunities to have questions answered by various speakers and presenters,' and "to meet and socialize with other professionals who were attending the retreat' as either "Extremely Adequate' or 'Very Adequate' (79.5%, n=31; 82.1%, n=32, respectively) (see Figure 6, items #6 and #7).

In response to item #5 ("To what extent did the retreat allow you to express your thoughts or feelings about the AIDS-related issues that were under discussion*) approximately 56.4% (n=22) of the respondents indicated Greatly: Approximately 41% (n=16), however, indicated "Somewhat" (see Figure 6, item #5).

me overall level of satisfaction with the conference was high. Approximately 23% (n=9) of the respondents indicated that they were *Extremely Satisfied,' approximately 54% (n=21) indicated that they were 'Very Satisfied,' and approximately 21% (n=8) indicated that they were 'Somewhat Satisfied.' Only 1 respondent indicated dissatisfaction with the conference (see Figure 6, item #8).

Only 8% (n=3) of the respondents, however, reponed that the conference 'Greatly* increased their knowledge about AIDS. Approximately 56% (n=22) indicated that their knowledge increased 'Somewhat,' and approximatety 31% (n=12) indicated that their knowledge increased only 'A Little.' A total of 2 respondents (5%) reported that their knowledge about AIDS did not increase at all after attending the conference (see Figure 6, item # 3).

The latter findings may be accounted for by the fact that our faculty represent a select group of health-professionals who have chosen to work professionally within the area of AIDS care. It is likely that our faculty already have a high ceiling of knowledge about AIDS. This issue will be contended with further when examining pre-post test change scores for HIV-AIDS knowledge and attitudes.

interestingly, approximately 85% (n-33) of respondents reported that their personal fears of contracting HIV infection did not change as a result of attending the conference (see Figure #6, item #4). Similar findings have been obtained in work conducted at the UCSF AIDS Education Project with incoming medical and nursing students, and will also be discussed in further detail at the conclusion of this report.

Ratinas of Speakers and 'Break-Out' Groups

Participants were asked to rate each of the speakers on a 5-point Likert-type scale (1 -Excellent; 2=Very Good; 3=Satisfactory; 4=Not Very Good; 5=Poor). The overall mean rating across all 7 speakers was 1.99 (sd=.48). The highest rated presentation was by Dr. Sandra Bertman on 'Death and Dying' (mean rating=1.26, sd=.50). The lowest rated presentation was by Dr. George Solomon on 'The Psychoneuroimmunology of HIV Infection' (mean rating=2.74, sd=.98).

Participants were also asked to rate each of the 'break-out' sessions they attended on the same 5-point Liken-type scale. The overall mean rating collapsed across the 19 different sessions was 2.15

(sd=.47). The mean ratings rank ordered for each of the sessions are given in Table 2.

Typically, the lecture presentations and the 'break-our sessions represented two different types Of educational experiences. Wiih the exception of Dr. Bertman's presentation on 'Death and Dying,' the lectures contended primarily with basic factual information that lend themselves to traditional didactic types of presentations. The 'break-out' groups, on the other hand, provided opportunity for more personal, interactive, and experiential types of learning. Independent sample t-tests, however, did not reveal significant mean differences between participants' ratings of the lecture presentations in comparison to their ratings of the 'break-out' groups.

Dr. Bertman's presentation on 'Death and Dying' might be considered distinct in comparison to the other 6 lecture presentations. This presentation employed use of split screen still photography. It also included a short film documenting one family's real fife attempt to cope with the emotional devastation of AIDS, as a young gay man returns home in the final days of his life to reconcile past conflicts with his Morman father surrounding his homosexuality.

Dr. Bertman's presentation had a strong emotional impact on conference attendees. For instance, one attendee commented, 'I think the 'Death and Dying' lecture was excellent, but intense and we really needed a break . . . small discussion groups to help process. Many people took 'breaks' individually that day really pointing our how hard it was to process.' Another attendee commented on the back of the questionnaire, 'Please, a little more time after 'Death and Dying' to diffuse emotions.'

Fortunately, the 'break-out' groups scheduled immediatety following the 'Death and Dying' presentation lent themselves to topics that apparently provided attending participants with the opportunity to process their emotions with colleagues. In fact, independent sample t-tests revealed that the mean rating of the 4 'break-out* sessions immediately following the 'Death and Dying' presentation was significantly higher than the mean ratings of all other 'break-out' sessions. The mean rating for the 4 sessions following 'Death and Dying' was 1.69 (sd=.20). The mean rating for all other 'break-out' groups was 2.28 (sd=.44) [t(17)=2.58, p<.05].

Outcome Evaluation

This section examines baseline ratings, as well as changes in HIV-AIDS knowledge, attitudes, and risk perceptions immediately preceding and following the conference. Baseline ratings and change scores are examined as a function of participants' gender, race, occupational status, geographical location, as well as their previous clinical and personal contact with HIV-AIDS patients.

Baseline ratings

Mean baseline ratings for Risk Perception Scale (RPS) items rank ordered from lowest to highest ratings of consequent risk of becoming infected with the AIDS virus are given in Table 3. 'Entering the room of an AIDS patient without wearing a gown or mask' was rated as lowest risk; 'Accidentally sticking myself with a needle that has been used on a person with AIDS was rated as highest risk.

Each of the RPS items were summed in deriving an overall composite RPS score for each participant. The possible range for the RPS is 11 (lowest risk) to 66 (highest risk). The obtained range was 13 to 46. The overall mean RPS score was 24.06 (sd=8.00).

The distribution of RPS scores was clearly skewed in a positive direction, indicating that participants had a tendency to rate items toward the lower end of the scale continuum. Nevertheless, several items that might be thought to entail no risk of infection were rated by respondents as entailing at least some risk of occupational infection.

Mean baseline ratings for each of the items from the AIDS Attitude Scale for Health Professionals (AAS) are given in Table 4. Each of the AAS items were summed in deriving an overall composite AAS score. Positiiely stated items were reverse scored so that higher scores reflected more negative attitudes. Subscaie scores were summed in the same manner in deriving a Professional Resistance subscale score (PR), a Fear of Contagion subscale score (FC), and a Negative Emotions (NE) subscale score.

The possible range for the overall AAS is 15 (most positive attitudes) to 90 (most negative attitudes). The obtained range was 15 to 37. The mean overall AAS score was 23.43 (sd=6.33). The possible range for the PR scale is 6 (least resistance) to 36 (most resistance). The obtained range was 6 to 13. The mean PR score was 7.9 (sd=2.48). The possible range for the FC scale is 5 (low fear of contagion) to 30 (high fear of contagion). The obtained range was 5 to 20. The mean FC score was 9.8 (sd=3.78). Finally, the possible range for the NE scale is 4 (most positive emotions) to 24 (most negative emotions). The obtained range was 4 to 11. The mean NE score was 5.76 (sd=2.21).

The distributions of AAS scores and subscale scores were also skewed in a positive direction, indicating a tendency on the part of our faculty to have generally more favorable attitudes toward AIDS patients than would be expected given a normal distribution. As can be seen by examining measures of skewness in Table 4, however, variability was found in response to particular attitudinal items, such as: "AIDS makes my job a high risk occupation,' 'I would be willing to eat in a restaurant where I knew the chef had AIDS,' and 'Despite all I know about how AIDS is transmitted, I am still afraid of catching it."

Table 5 presents the percentage of correct and incorrect responses to the 8 multiple-choice items assessing AIDS knowledge at baseline. Items in which a large percentage of respondents scored incorrectly at baseline included items #2, #6, and #7. Participants were given 1 point for each correct item, and the 8 items were summed in deriving an overall AIDS Knowledge score for each participant. The obtained baseline scores ranged from 2 to 7 correct items, with a mean Of 3.81 (sd=1.43) items correct. AIDS Knowledge scores were normally distributed.

Oneway analysis of variance on AIDS Knowledge scores revealed that physicians scored significantly higher on knowledge about AIDS at baseline (mean number correct=4.8, sd= 1.32) than did mental health care workers (mean number correct=3.20, sd=1.32), and nurses (mean number correct-3.31, sd=1.11) [$F(2,30)=5.41$, $p<.01$] (Newman Keul's, $p<.05$). No baseline differences were found in overall RPS scores, overall AAS scores, nor AAS subscale scores as a function of gender,

age, occupation, state of residence, nor amount of professional and personal contact with AIDS patients.

Changes between pre/post test assessment

Because RPS scores and overall AAS scores and AAS subscale scores were positively skewed, non-parametric tests were employed to examine changes in these variables between pre/post-test assessments. Parametric tests were employed in assessing changes in knowledge over time, since AIDS Knowledge scores were normally distributed.

Dependent sample t-tests revealed significant increases in the mean number of correct AIDS Knowledge items from the pre-test to the post-test assessment (mean number of correct items at pre-test was 3.67, sd=1.40; mean number of correct items at post-test was 5.23, sd=1.31) [t(29)=8.00, p<.002]. Wilcoxon's matched pairs signed rank test, however, did not reveal significant changes in risk estimates, overall AIDS attitudes, professional resistance, fear of contagion, nor negative emotions between pre/post test assessments.

Changes in dependent variables were also examined as a function of demographic variables. Change scores were calculated by subtracting each participant's post-test score from their pre-test score on all dependent measures. Oneway analysis of variance on AIDS Knowledge change scores revealed a significant main effect for age [F(2,27)=3.65, p<.05]. Participants between 3640 years of age showed significantly greater increases in knowledge between pre/post test assessments in comparison to participants between the ages of 3035, and those 41 or older (mean change for 36-40 year old group was 2.43, sd=.98; mean change for 30-35 year old group was 1 .18, sd=1.08; mean change for 41 or older group was 1.42, sd=.90) (Newman Keul's, p<.05).

Changes in risk estimates, AIDS attitudes, professional resistance, fear of contagion, and negative emotions did not vary as a function of gender, age, occupation, state of residence, nor amount of professional and personal contact with AIDS patients. Changes in knowledge also did not vary as a function of gender, occupation, state of residence, nor amount of professional and personal contact with AIDS patients.

Single item analyses were also conducted on individual RPS and AAS items. Wilcoxon's signed rank tests revealed only one significant finding. There was a significant reduction in the proportion of respondents who rated RPS item #8 ('accidentally sticking myself with a needle that has been used on a person with AIDS') as entailing high occupational risk before the seminar, in comparison to immediately following the seminar (Z=-2.83, p<.01).

Discussion

Results indicate that our faculty generally score on the low end of the continuum when estimating occupational risk, and on the high end of the continuum in regard to reporting positive attitudes toward working with AIDS patients. Nevertheless, many items that might be thought to entail no risk of infection were rated by respondents as entailing at least some risk of occupational infection. Variability was also found in response to particular attitudinal items, such as: 'AIDS makes my job a high risk occupation,' 'I would be willing to eat in a restaurant where I knew the chef had AIDS,' and 'Despite all I know about how AIDS is transmitted, I am still afraid of catching it.'

Results from outcome evaluations indicate that the FDT seminar 'AIDS and Mental Health' was successful in increasing faculty's knowledge about AIDS, at least as measured by the 8 multiple-choice items. Similar changes, however, were not observed between pre/post test assessments for overall risk perceptions, nor AIDS attitudes.

Lack of change in attitudinal items is most likely accounted for by the high ceiling of positive attitudes at baseline. It is difficult to conclude that the FDT was not successful in effecting changes in AIDS attitudes when the majority of faculty scored at such an extreme at baseline. It is likely that the instrument employed to measure attitudes was not successful in detecting more 'subtle' indices of negative attitudes toward working with HIV-AIDS patients among this select group of health professionals.

In regard to risk perceptions, outcome evaluations clearly indicated that the FDT was successful in reducing estimates of risk concerning accidental needlesticks. Although overall risk estimates were quite low at baseline, there was sufficient variability in the distribution of scores to detect changes in assessing program efficacy. Results from the outcome evaluation indicated, however, no change is overall risk estimates between pre/post test assessments. These findings were corroborated by participants' lack of self-reported change in personal fears as a result of attending the conference.

Similar findings have been obtained in work conducted at the UCSF AIDS Education Project.[1] The latter study employed a nonequivalent control group design in examining changes in risk estimates, attitudes, and knowledge about AIDS among incoming medical and nursing students. Results indicated that students who completed an AIDS-elective course during their first year of study, showed significantly more favorable changes in AIDS attitudes, and marginally greater increases in AIDS knowledge over time in comparison to students who chose not to take the course. Risk estimates, however, did not change over time as a function of whether or not students completed the AIDS-elective course.

These findings, in addition to findings obtained from the current program evaluation, point to the importance of continuing educational efforts in effectively addressing health-care workers' anxieties and fears of occupational contagion when working with HIV-AIDS patients.

Changes in outcome measures generally did not vary as a function of demographic characteristics (with the exception of the relationship found between age and changes in knowledge). This may be an artifact of a small sample size, since previous research has documented significant relationships between demographic characteristics, such as age, race, and education, in explaining resistance to working with HIV-AIDS patients among health-care workers.[12,13]

Results from program evaluations clearly indicate that participants were satisfied with the overall organization and content of this conference, in addition to opportunities provided to meet and socialize with other health professionals. Several participants commented on the ideal location of the retreat, and requested more free time. A substantial proportion of participants voiced the need for greater opportunity to express their 'thoughts and feelings' about AIDS-related issues under discussion. This was especially true following presentation of sensitive materials, such as Dr. Bertman's presentation on 'Death and Dying.'

Suggestions and Recommendations

On the basis Of the results from this evaluation, the following suggestions are recommended in the planning of future retreats:

1). First, there is a need for HIV-AIDS education programs to provide accurate information about risk. It is imponant that heatth-care workers team to differentiate between their warranted and unwarranted fears when working with HIV-AIDS patients. Effective educational interventions would help free workers from their irrational fears, and help them deal more effectively with their rational ones.

2). Second, health-care workers' emotional reactions to HIV-AIDS, and working with the HIV infected patient must be addressed. Of importance is not only attendance to biomedical findings and fact but perceptions which may preclude assimilation and application of such knowledge. Faculty must provide a forum where health-care workers can feel free to ask questions and share their fears regarding HIV-AIDS in a non-judgmental environment. Interaction with peers, faculty, and individual counseling when necessary must be considered integral components of the educational experience.

3). Educational programs must continue to expand health-care workers' knowledge base regarding basic factual information about HIV-AIDS, its transmission, virology, diagnosis, prevention, treatment, epidemiology, infection control precautions, and psychosocial issues concerning the care of HIV-AIDS patients. Although our strategy in assessing HIV-AIDS knowledge is appropriate, and should be continued in assessing knowledge at future retreats, more than 8 multiple-choice items need to be contributed by speakers in developing a valid and reliable scale.

4). There is a clear need for greater participation of traditional ethnic/racial minorities on our faculty teams. Although there is a disproportionate representation of traditional racial/ethnic minorities among the HIV infected population that faculty serve, only 21% (n=lO) of our faculty members represented these groups at the conference.

5). There should also be an effort to include more dentists on faculty teams. Only 5% (n=2) of participants identified themselves as dentists at this seminar.

6). Items measuring additional demographic characteristics of participants, including their sexual orientation, religious denomination, and a measure of religiosity might be included on future pre/post test evaluation instruments. Demographic characteristics of the patient population being served by our faculty might also be assessed.

7). It would be helpful if during the next retreat that only faculty team members are requested to complete the pre/post test evaluations. Several administrators completed the evaluation component of this seminar, and had to be eliminated from the analyses only after the data were collected. Also, it would be helpful to the program evaluators if we can have a complete updated list of identified faculty team members representing each ETC, as well as an updated list of registered faculty immediately prior to each retreat.

8). Finally, attempts should be made in determining whether changes in risk estimates, attitudes, and knowledge have been extended, or maintained months following the original FDT seminars. Periodic assessments of outcome measures following completion of each of the FDTs are currently in planning stages

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Table 1 **Number of Faculty Registered for the Conference In Comparison to the Percentage Completing the Pre/Post Test Assessment from each of the ETC Sites**

Site	# of Faculty Reaistered	# of Faculty Completing Pre/Post Test	Percentage of Faculty Completing Pre/Post Test
San Jose	4	2	50%
Tuscon	4	3	75%
Sacramento	4	1	25%
San Diego	7	4	57%
F resno	7	4	57%
Salinas/Montery	4	3	75%
Martinez	7	2	29%
Oakland	7	3	43%
Modesto/Stockton	4	2	50%
Honolulu	7	4	57%
Santa Rosa	7	4	57%
Phoenix	4	2	50%
Las Vegas	3	1	33%
Reno/Carson City	4	2	50%
San Francisco	4	3	75%
Total	77	40	52%*

* A total of 6 participants completed questionnaires, but failed to indicate the ETC site they represented. Thus total return fate is actually 46/77 or approximately 60%.

Table 2 **Mean Ratings of "Break-out" Groups**
Rank 'ordered from Highest to Lowest **Rated Groups***,+

		Rating	S.D.	Sample Size
1.	Rational Verses Reactive Suicide,	1.50	.67	12
2.	Limit Setting In The Clinical Practice with the HIV Infected: Taking Care of the Clinician.	1.50	.71	2
3.	Talking About Death with the HIV Infected Patient.	1.54	.69	11
4.	Working with the Individual who has Suffered Multiple Losses	1.80	.92	10
5.	Engendering Concern for and by Panners of the HIV Positive	1.80	.45	5
6.	Antibody Testing and Treatment Choices: What is the Clinician's Role in Facilitating Decisions?	1.88	.99	8
7.	Working with the Couple and Family System Affected by HIV	1.90	.57	10
8.	Experiential Workshop: Stress Management for AIDS Providers	2.0	.67	19
9.	Medications and HIV: The Psychological Effects of Medical and Psychiatric Treatments	2.0	1.0	11
10.	Nurturing Yourself: Strategies for Survival	2.11	1.17	9
11.	Talking About Sex with Patients: Techniques and Topics	2.13	.74	15
12.	Biased Assumptions Among Health Care Workers About the Behaviors and Beliefs of Cultural Minorities	2.21	.70	14
13.	Homonegativisim Among Health Care Workers as it Preceeds and is Prompted by the Care of Gay Men and Lesbian Women	2.31	1.03	13
14.	Transference and Countertransference: Dealing With All the Feelings	2.40	1.67	5

		Rating	S.D.	Sample Size
15.	Dealing with Violent, Homicidal or Acting Out Patients	2.50	.71	10
16.	Recognition and Management of HIV-Related Dementia	2.55	.82	11
17.	Common Misconceptions about IVDUs	2.67	.87	9
18.	Interactions with the Actively Using Client	2.83	.75	6
19.	Disscussion of Faculty Team Operations of HIV Treatment and Teaching Programs	3.25	.87	12

* Break-out groups were rated on a S-point Likart-type scale (1 = Excellent, 2 = Very Good, 3 = Satisfactory, 4 = Not very good, 5 = Poor)

+ 'The Challenge of Working with Women at Risk, and the Very Challenge of Perceiving Women as at Risk' was not rated by any of the respondents.

Table 3 **Mean Baseline Ratings for Risk Perception Scale (RPS) Items Rank Ordered from Lowest to Highest Rating of Consequent Risk of Becoming Infected With the AIDS Virus***

		Mean	S.D.
1.	Entering the room of an AIDS patient without wearing a gown or mask.	1.07	.34
2.	Holding a patient with AIDS.	1.10	.37
3.	Sharing a drinking glass with a person who is infected with the AIDS virus.	1.45	.83
4.	Being sneezed upon by and AIDS patient.	1.55	.86
5.	Emptying the bedpan of an AIDS patient without wearing gloves.	2.31	1.14
6.	Performing the full physical exam on an AIDS patient without wearing gloves.	2.43	1.38
7.	Receiving a blood transfusion during surgery	2.69	.95
8.	Having the blood of a patient with AIDS splashed on my skin.	2.71	1.15
9.	Being bitten by a person with AIDS.	2.63	1.25
10.	French kissing (deep mouth-to-mouth) with a person with AIDS.	2.88	1.25
11.	Accidentally sticking myself with a needle that has been used on a person with AIDS.	4.0	1.25

* Items were rated on a 6-point Liken-type Scale (1 = No Risk, 2 = Very Low Risk, 3 = Low Risk, 4 = Moderate Risk, 5 = High Risk, 6 = Very High). Total sample size n = 42.

Table 4 **Mean Baseline Ratings of the AIDS Attitudes Scale (AAS)***

Item	Mean	S.D.	Sample Size	Skewness
Fear of Contagion				
1. I would not want my child to go to school with a child with AIDS.	1.25	.63	40	2.99
2. I would be willing to eat in a restaurant where I knew the chef had AIDS.	4.73	1.77	40	1.17
3. AIDS makes my job a high risk occupation.	234	1.79	40	1.00
4. Despite all I know about how AIDS is transmitted, I am still afraid of catching it.	2.61	1.56	41	.24
5. Even following strict infection control measures, it is likely that I would become infected with **HIV if** I were working with **AIDS** patients over a long period of time.	1.23	.72	40	3.95
Emotions				
6. I **would feel resentful if** AIDS patients accounted for a significant pan of my case load.	1.70	1.02	40	1.90
7. I feel angry about the risk **of AIDS** which homosexuals have imposed on the straight community.	1.24	.72	41	2.94
8. I often have tender, concerned feelings for people with **AIDS.**	5.63	1.03	40	3.32
9. I sometimes find it hard to be sympathetic toward AIDS patients.	1.38	.77	40	2.36
Professional Resistance				
10. Given a choice, I would prefer not to work with AIDS patients.	1.34	1.02	41	3.37
11. It is best to train a few specialists who would be responsible for the treatment of AIDS patients.	1.46	.81	40	2.17
12. I would prefer to refer persons with **AIDS** to my professional colleagues.	1.80	1.65	40	1.95
13. I would consider changing my professional specialty/position if it became necessary to work with AIDS patients.	1.08	.35	40	4.98
14. I would rather work with a better **class** of people than AIDS patients.	1.18	.55	40	3.03
15. I don't want persons at higher risk for AIDS, such as IV drug users and homosexuals as patients.	1.20	.52	40	2.63

* Items were rated on a 6-point Likert-type scale (1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree)

Table 5 Percentage of Correct **and incorrect Responses to** AIDS-Knowledge Multiple **Choice Items**[*,+]

1. AIDS dementia:

19% (n=8) A. results from neuronal death because of viral invasion of the neuron through the CD8 receptor:
14% (n=6) B. is of the conical type.
43% (n=18) C. **may first be manifested as paranoia.**
7% (n=3) D. is not helped by zidovudine (AZT) because the drug does not pass the blood/brain barrier.
12% (n=5) E. results in cognitive impairment that is not influenced by degree of psychological distress.

2. Psychoneuroimmunologic research to date has clearly demonstrated:

12% (n=5) A. that emotional distress hastens death from AIDS.
38% (n=16) B. that emotions have similar correlations with immunologic measures in patients with AIDS and ARC.
10% (n=4) C. that long survivors with AIDS use denial mechanisms effectively.
21% (n=9) D. **that depressed mood** In asymptomatlc HIV seropositlve persons is **associated** with a pattern of Immune changes predictive of the development of **AIDS.**
14% (n=6) E. that stress definitely activates HIV from a latent to **a** rapidly replicating state.

3. A significant increased risk for HIV positivity is associated with which of the following:

5% (n=2) **A.** history of recent transfusion (since 1988).
18% (n=32) **B. history of hepatitis B virus.**
0% (n=0) **C.** history of a mutually monogamous gay male relationship for the last 13 years.
2% (n=1) D. history of marijuana use.
2% (n=1) E. all of the above.

4. In taking a risk-factor history of HIV, an often overlooked factor is:

0% (n=0) **A.** IV drug use.
2% (n=1) B. male-male sexual activity.
2% (n=1) C. history of gonorrhea.
86% (n=36) **D. IV drug use in the partner of the person being seen.**
10% (n=4) E. history of syphilis.

5. Select the best answer regarding tuberculosis prevention in HIV infected patients:

24% (n-10) **A. A** skin test for tuberculosis (PPD) should be administered to ail HIV infected patients as early as possible.
5% (n=2) B. A twelve month course of isoniazid (INH) should be prescribed for ail patients with a positive skin test (PPD) for tuberculosis.
2% (n=1) C. A positive skin test (PPD) is defined as induration exceeding greater 5 mm.
0% (n=0) D. Pyridoxine 25 mg. daily should be given along with isoniazid (INH).
69% (n=24) E. **all of the above.**

6. Choose the best statement regarding pneumocystis pneumonia (PCP) prophylaxis:

31% (n=13) **A.** PCP prophylaxis is indicated for all patients with T4 helper cells less than 500.
2% (n=1) **B. 100 mg./day** is effective.
10% (n=4) C. septra 1 double strength tablet daily is effective.
19% (n=5) **D. possible occupational hazards to health care workers should be considered when administering aerosolized pentamldine.**
29% (n-12) E. septra and aerosolized pentamidine have been demonstrated to be equally effective.

7. Which of the following statements are true?

0% (n=O) **A.** Providers who are particularly caring and idealistic in their intents tend to be better protected from AIDS-related burnout.
29% (n=12) **B.** Professionals who are active as clinicians and called upon to function as administrators, educators, and researchers are more prone to bum-out.
14% (n=6) **C. Providers who spend** more hours per week **involved in in-patient** care **are more vulnerable to depression, but experience their AIDS-related work as more** intellectually stimulating.
26% (n=11) D. Burn-out has been correlated with the number of years spent with AIDS patients.
29% (n=12) E. All of the above

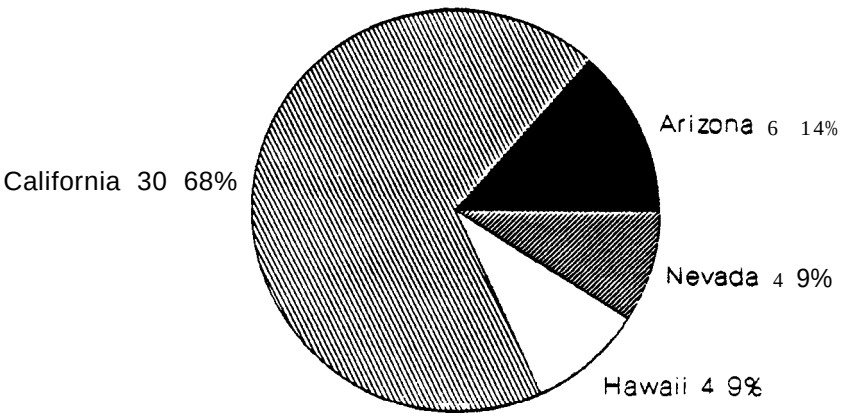
8. The percent of professionals in AIDS care who acknowledge being or having been frankly depressed is:

5% (n=2) A. Less than 5%
5% (n=2) B. 510%
31% (n=13) **C. 15-30%**
38% (n=16) **D. Approximately 50%**
21% (n=9) E. Greater than 75%

• Correct Answers are in boldface type.

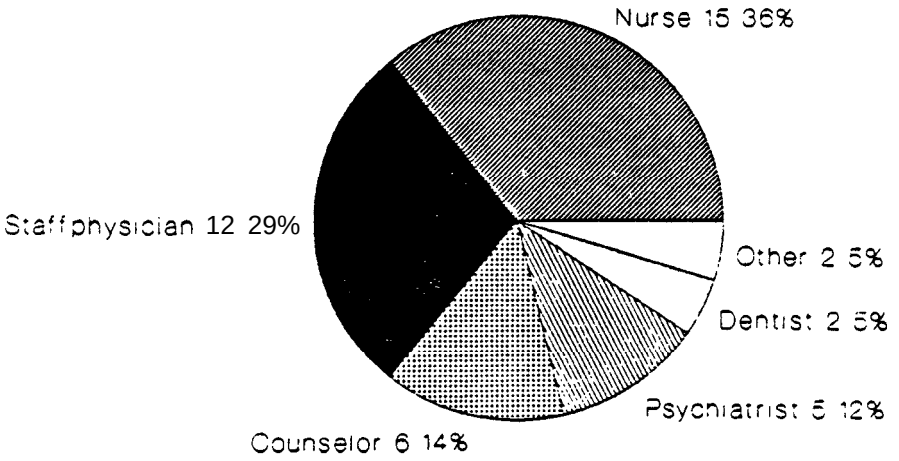
+ Percentages do not always add to 100 because of rounding errors and because of missing data for particular items.

Figure 1: State of Residence
Asilomar Conference Participants



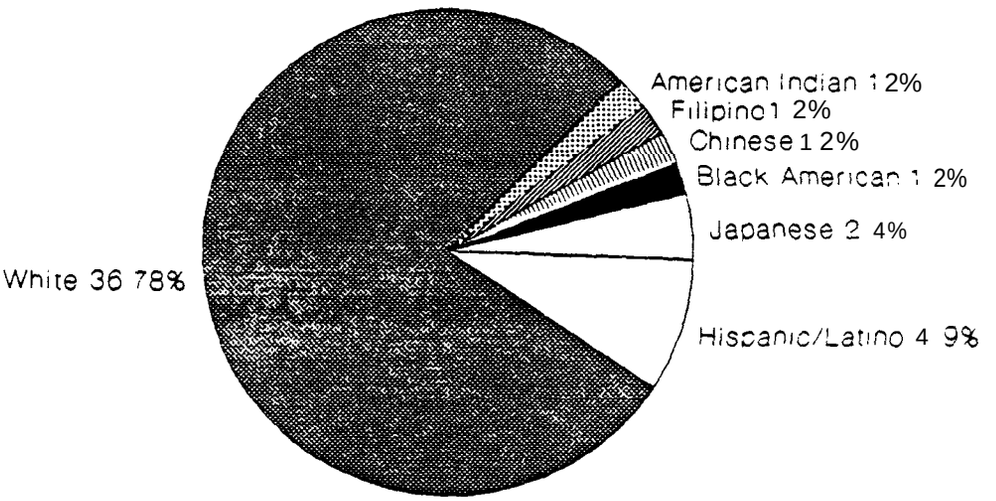
* Total does not sum to n=46 because of missing data.

Figure 2: Occupation
Asilomar Conference Participants



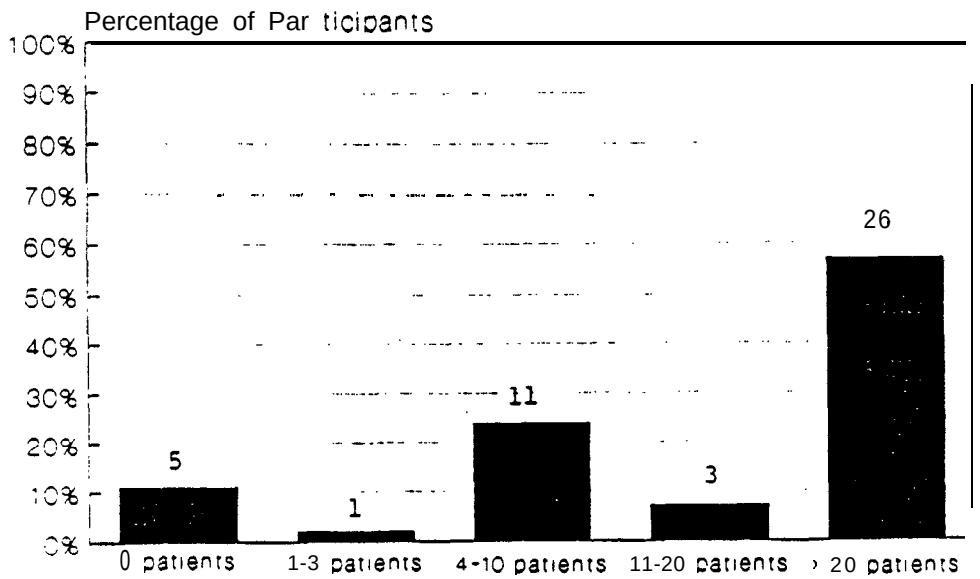
* Total does not sum to n=46 because of missing data. Percentages to not sum to 100 because of rounding errors

Figure 3: Ethnicity
Asilomar Conference Participants



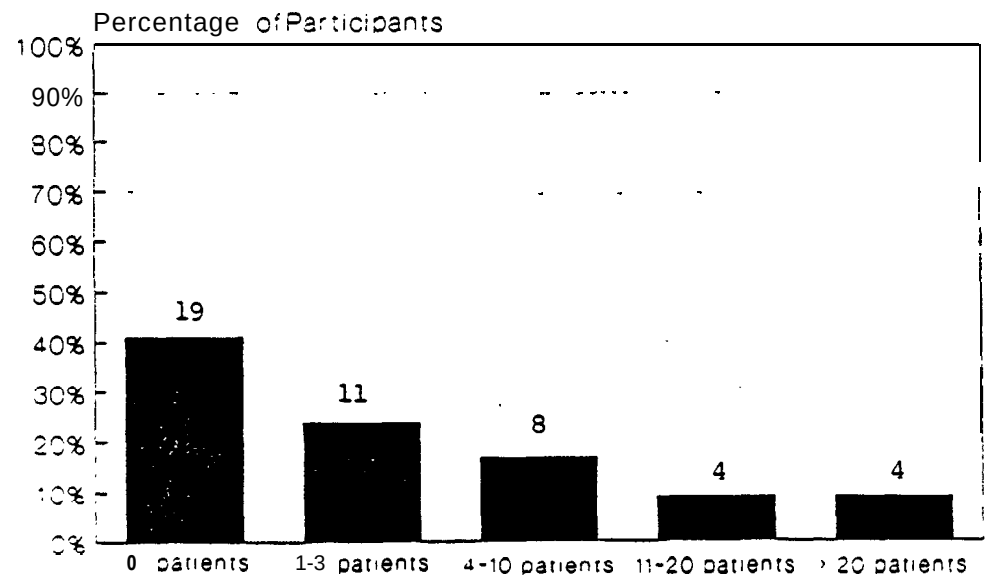
* Total n = 46. Percentages do nor sum to 100 because of rounding errors

Figure 4:
AIDS Patients - Professional Contact



* Total n = 46. Percentages 00 not add up to 100 because oi rounding errors

Figure 5:
AIDS Patients - Known Personally

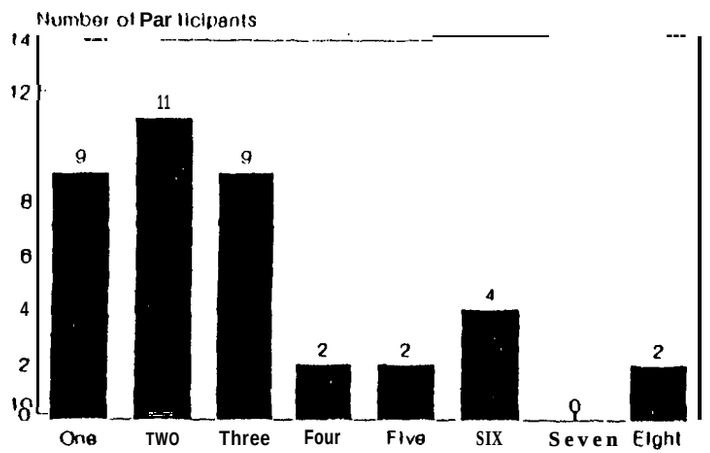


. Total n = 46. Percentages do not sac up to 100 because of rounding errors

FIGURE 6 : ITEMS 1-4

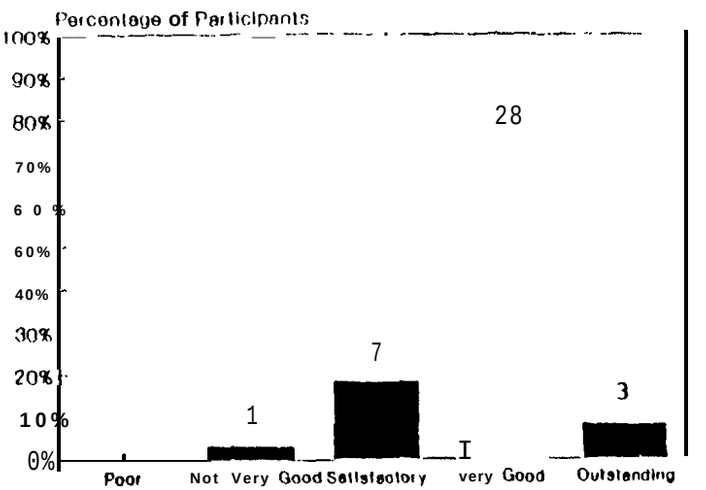
Item 1

Number of Conferences
Attended in the Last Year



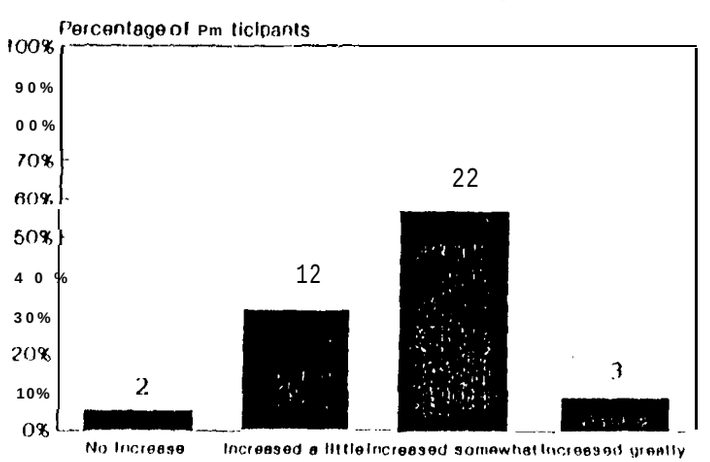
Item 2

Overall Organization of Conference



Item 3

Increase in **Knowledge**
Self Reported



Item 4

Change in Fears
Self Reported

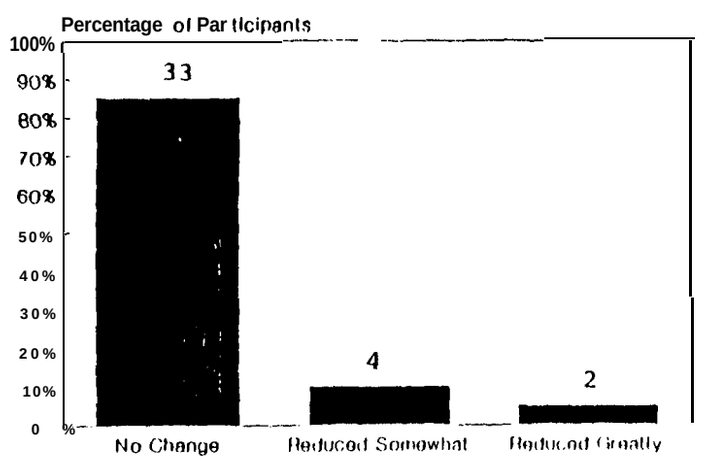
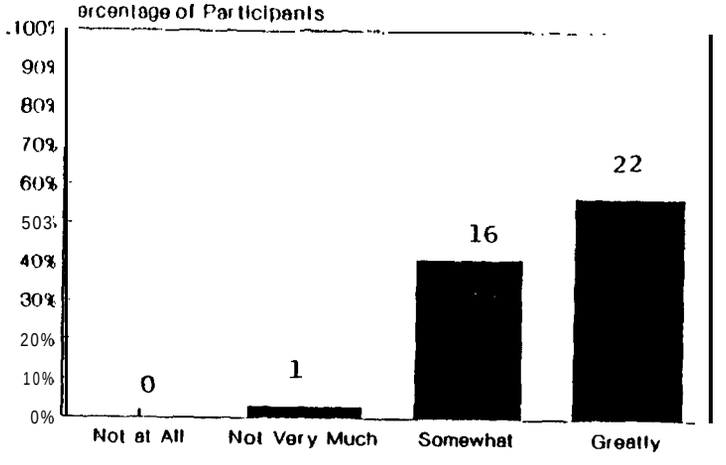


FIGURE 6; ITEMS 5-8

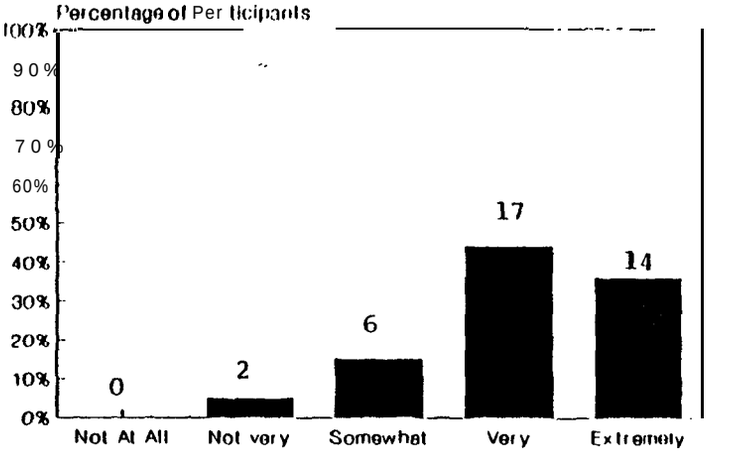
Item 5

Opportunity to Express
Thoughts and Feelings



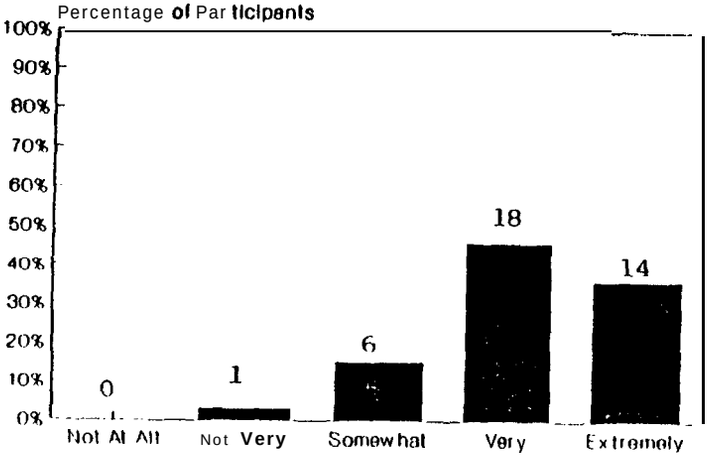
Item 6

Adequate Opportunity
To have Questions Answered



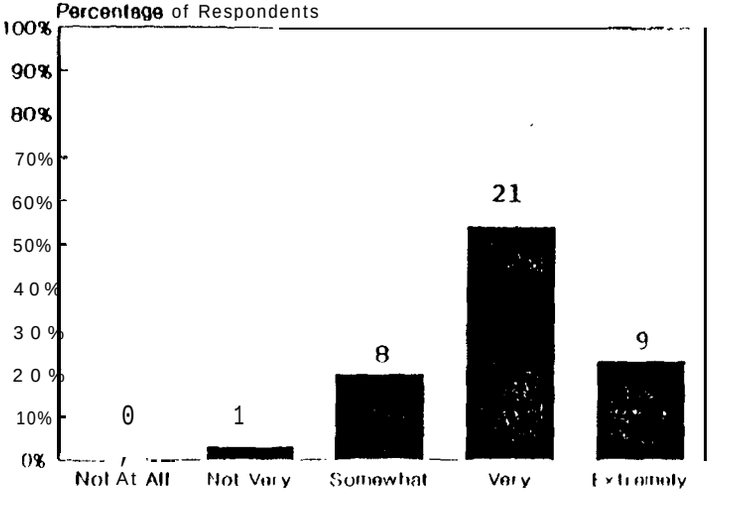
Item 7

Adequate Opportunity
To Meet and Socialize with Others



Item 8

Overall Satisfaction



Appendix C

Asilomar content evaluation questions 11, 12, 13, and any additional comments on the back.

The following are the three evaluations questions asked on the Post-Test at the Asilomar Conference:

11. Please give any comments (positive or negative) that you think might be helpful to the planning of future retreats:

12. What topics of information would you like to have covered at the next retreat ('Preparing for the Second Epidemic IVDUs, Women, and Children')

13. What pan of the retreat did you find most valuable?

Of the 39 Post-test respondents, a total of 4 left questions 11 and 12 blank, a total of 3 left questions 12 and 13 blank, a total of 4 left only question 11 blank, a total of 4 left only question 12 blank, and a total of 2 left only question 13 blank. A total of 4 respondents did not complete questions 11, 12, or 13.

Subject 02:

11. An afternoon break of l-2 hours e.g. 3-5 would be great for R&R.
12. Knowledge, attitudes, belief and behaviors of women at risk for HIV. Epidemiology of AIDS among ethnic groups.

Subject 03:

13. Overall presentation followed by discussion groups in same subject area

Subject 04:

12. Children with AIDS and medication for them.
13. Both the speakers and discussion groups and the socialization.

Subject 05:

12. Effect of HIV on hemophiliacs and their relationship to family, etc. Update on transfusion of blood products.

Subject 06:

11. More time for workshops (1 1/2 hours). Plenary speakers need an hour and must be kept on schedule so workshops aren't cheated. Unfairly cheated workshops of time. Could repeat workshops and offer fewer.
12. Talking to partners. Separating IVDU from HIV in given pt.
13. Faculty exchange. Good plenary speakers.
BACK: Should give free time early or late afternoon and replace with a session in the evening

especially on Wed. In Asilomar, need beach day time but less to do **in evenings. Need more time for** exchange between sites and with central office people.
Subject 07:

11. Groups for sharing educational successes, hang-ups, techniques, etc. for specific professions. Nurse to nurse - Dr. to Dr. etc.
12. Nothing specific at this time. Maybe Hispanic women's issues?
13 All of it!

Subject 08:

11. Use the great brain of George Solomon more effectively by allowing his free-thinking on the biologic to take off. I'd like to appreciate the courage and human kindness which many of the conferees express in their work patients who have HIV in light of the struggles these care givers have. Some of them care for family members with grave disabilities and illnesses. Some have HIV themselves
BACK: Thanks, great work.

Subject 09:

11. The **only Holistic realm of the conference** not conveyed was the spiritual aspect which is extremely important as well.
12. Medical updates
13. Lecture.

Subject 10:

11. This facility location was excellent. The meals could be improved. If they want to have cafeteria style food why not have it like the hospital cafeteria - where you have many more choices. Also Asilomar needs to get a fiiness/work-out center. Its very relaxing being here; at the same time its important to maintain ones activity level - kind of hard to do with all the sitting around during the lectures.
12. Women with HIV. Children with HIV. More information on the psychological aspects of AIDS-i.e. intervention techniques, i.e. use of laughter therapy; more of cognitive/behavioral therapies etc.
13. Getting away to a beautiful environment which is very relaxing - great stress reducers! Getting reinvigorated just by being with people who are so gung-ho/passionate about their cause. Meeting other nurses who are experiencing similar problems. GREAT! GREAT! GREAT!

Subject 12:

11. More easily visible nametags. i-2 hour break during daylight hours - would be willing to compensate for that by an evening session.
12. Effective ways of reaching people at risk through prevention.
13. Death and **Dying. Talking about sex and patients - techniques.**

Subject 13:

11. More structure to workshops would improve effectiveness.

Subject 14:

13. Sharing what is working on problem areas in other projects.

Subject *15:*

11. Begin the seminar with a basic lecture on AIDS. Teach basic statistics, safe sex practices, time duration of the onset of the virus, danger in transfusion.
12. Specific techniques that are helpful for counseling HIV.
13. Death Dying lecture.

Subject 16:

13. Lectures.

Subject 17:

11. Perhaps it is my medical background, but I found the focus of the conference to be a bit fuzzy. Not much information was communicated, more feeling tones and problem stating than problem solving.
12. How to reach IVDU and women for prevention education. Especially teenage girls! Both techniques and teaching materials/brochures.
13. Small group discussions were helpful for ventilation and discussion of personal frustrations.

Subject 18:

11. Could it be compressed into a shorter time, i.e., be a little more intensive.
12. How to handle IVDU's - what behavior to expect - why is it there - what to do about it - how to balance the wish to Rx the disease vs. the selfdestructive nature of the patient.

Subject 19:

11. Admonish speakers to stick to the time limits - it caused workshops to be shortened. Frustrating for leaders and participants.
12. Attitudes toward IVDU's
13. Connecting with other AIDS professionals. George Solomon's talk.

Subject 20:

11. I would have liked more hard-core didactic and factual information, on the other hand, the acknowledgement that we are all exploring new territory and can't be too dogmatic about the 'right answers' was realistic and reassuring.
13. Social interaction. Rejuvenating atmosphere.

Subject 22:

11. Why were 'experts* imported from out of our region? Although Dr Bertman was excellent, I'm sure there is someone in our area who is as well prepared/experienced on the topic of Death & Dying.
12. Minorities and HIV, blacks, hispanics, especially illegal Mexicans.
13. Death and Dying/Dr Bertman. Anita Gerhard on anything. Location: the West! Socialization/networking.

Subject *23:*

11. I think the Death and Dying lecture was excellent but intense and we really needed a break - then small discussion groups to help process. Many people took 'breaks' individually that day really pointing to how hard it was to process. Suggest: *3045* min break: don't turn lights on!; regroup with meditation followed by discussion in small (10 or less) groups. I would also like to see a group led meditation or visualization as options at the beginning and end of the day. The visualization might be an empowering type - validating us, our work - sending us 'back home' with new energy and good feelings. A lot of this did happen through networking but it would be fun to have as a formal (optional) pan of the conference.
12. I'll think more about this on topic I discussed with a fellow colleague here regarding our dual roles as parents (moms) and educators to other parents/community/schools - identification with patients (esp children and women).
13. Networking with others. support from others for my work (validation). Role playing as means of understanding or exploring topics in small groups.

Subject 24:

11. Need more organized sharing of ideas, innovations between centers.
12 Empowering women. Financial concerns of providing care. Impacting prostitute/IVDU's-effective outreach programs. Adolescent AIDS-crack use, runaways.
13. Yvette Flores-Ortiz really was a bright spot in identifying and personalizing difficulties of AIDS providers.

Subject 25:

11. Very good retreat, death and dying was a good presentation, it struck me because I deal a lot with this with my dying AIDS patients.

Subject 26:

12. Skill building to work with IVDU's. More on clinical diseases, Dx and Rx. More on Nsg and role clarification - who does what.
13. Networking.

Subject 27:

11. Tables to write on. Chairs in half circle.
12. Long term studies done on HIV positive infants raised in New York City. Especially hospital wards where infants end up living out their lives.
13. Interacting with other Health educators. Dr. Zegans lecture. S. Bertman and film.
BACK: A little more time after Death and Dying to diffuse emotions.

Subject 29:

12. Review of legal ramifications re: confidentiality, testing, public health issues. Practical and common psycho/social interventions. Section on multiple case presentations.
13. Talking with other health professionals.

Subject 30:

11. More participation from dentists. More time spent teaching us how to teach, e.g., the death and dying section was great on a personal level - I'm not sure how to assimilate that knowledge to return to my colleagues.
13. Small group discussion. Biomedical update. Super location for retreat.

Subject 31:

11. Take into consideration that many of the attendees do have a lot of experience and knowledge in all aspects of AIDS care i.e. increase the sophistication of the didactic and groups.
13. Death and Dying session. The opportunity to see old friends and talk about the new developments in their programs.

Subject 32:

11. Need more small group discussions and also need time to 'digest'.
12. IVDU's, Women, Children
13. Very enjoyable and greatly needed-thanks!

Subject 33:

11. Thursday was a bit long perhaps have only experiential type groups in the last group sessions.
12. Biomedical aspects. Psychosocial aspects. Research in progress on women or children. Neuropsychological issues-children.
13. Sharing experience with colleagues.

Subject 34:

11. No sharing of rooms. Information about the area of the conference for time off activities.
12. More on Methadone-how do patients get into programs-what is the rational behind methadone maintenance. Tx options for IVDU's.
13. Interaction with faculty and participants. Not starting too early - 9AM is much better than 7 or 8 which most conferences start.
BACK: Food-yuck!

Subject 35:

11. Need more on teaching methods rather than just content.
13. Networking.

Subject 36:

12. Women
13. All2

Subject **39:**
11. Be much more **clear in the conferences goals. Most importantly: are you, or aren't you trying to** raise feelings and allowing for processing? If yes, warn people up front, provide more 1:1 counseling, encourage people to monitor their own safety issues (personally that is why I skipped

workshops). If no, tell people up front. Steer clear of talks like Sandra Benman's, encourage discussions more about the experience, rather than encouraging the re-living of the experience.
12. The topic of IVDU's concerns me deeply. The subtopics are all very important as evidenced by their high visibility in this last conference. But, I am aware of my fear (perhaps entirely unjustified) that to focus on the '2nd Epidemic' is (in part) a homophobic move to avoid the still very unresolved attitudes we all have about the 'first epidemic' = gay men. As it was, this last conference dealt with the issue of homosexuality directly in one workshop and in no talks. You now wish to exclude it entirely in the next conference, thus my fears.
13. Meeting people formally, and getting away for peaceful walks on the beach and at Pt. Libos. These were wonderfully important for my mental health as it relates to work in the epidemic and the avoidance of bum-out.

APPENDIX XI

Evaluation of the Effectiveness of the Arizona AA ETC's Training Efforts

CHANGE ON INDIVIDUAL ITEMS

I would feel comfortable working with a colleague with AIDS.	147	19	276	0.464
I think pre-marital blood testing should include testing for HIV.	138	28	271	0.406
Even with precautions, I am at increased risk of getting AIDS if I care for AIDS patients.	141	40	272	0.371
I think pre-hospital admission testing should include HIV testing.	137	39	270	0.363
I am at high risk for contracting the AIDS virus if I care for people with AIDS.	137	46	277	0.329
I would prefer not to care for AIDS patients.	122	34	275	0.32
Insurance companies should be able to test people for HIV before writing new policies.	105	27	262	0.298
HIV+ health care providers should find work in non-health care fields.	122	43	271	0.292
It is important that new cases of AIDS be reported to the Health Department so sexual partners can be located.	115	41	268	0.276
I would hire a person with AIDS as a babysitter for my children.	114	42	272	0.265
I would not mind if my child had a close friend with AIDS.	124	53	274	0.259
I would be suddenly uncomfortable if I found the patient I was working with had AIDS.	118	53	276	0.236
If I were hiring personnel for a medical office, I would hire an otherwise qualified HIV+ nurse.	116	53	273	0.231
Homosexuals are anxious to bring young teens into their lifestyle.	84	23	271	0.225
Lesbians become so because they hate men.	64	13	273	0.187
I feel OK about broaching the topic of homosexual activity with persons I care for professionally.	96	52	263	0.167
I would be afraid for a child of mine to have a person with AIDS for a school teacher.	82	37	274	0.164
If I were hiring personnel for a medical office, I would hire an otherwise qualified HIV+ receptionist.	101	58	271	0.159
The gay male is unassertive, and usually a passive person.	76	34	274	0.153
Patients with AIDS would get better caare if there were specific hospital wards set aside for them.	105	64	270	0.152

It is not fair for the general public to bear the cost of medical treatment for AIDS patients.	86	46	268	0.149
I would choose not to be a member of any organiation which had any homosexuals in its membership.	71	33	278	0.13
I would be afraid for a child of mine to have a gay or lesbian school teacher.	79	43	273	0.132
I find the thought of gay or lesbian sexual acts disgusting.	75	42	274	0.12
Nearly all homosexuals are promiscuous.	72	40	271	0.118
Health care professionals should be able to choose whether or not to care for a person with AIDS.	115	83	275	0.116
I would not send my child to school with children who have AIDS.	65	36	273	0.106
It is a waste of time to teach AIDS precautions to homosexuals and IV drug users since many of them won't bother with precautions.	57	28	273	0.106
I would be upset to find I was alone with a homosexual of my same sex.	62	36	273	0.095
Most patients with AIDS deserve the disease because of their own behavior.	53	27	277	0.094
Gay men become gay because they hate women.	43	20	271	0.08
Homosexuals should not be allowed to hold government positions that have access to classified information.	50	29	278	0.076
I can tell who is at high risk for AIDS by the way they look.	40	23	275	0.062
I would feel comfortable in bringing up the topic of IV drug use with persons I care for professionally.	74	66	273	0.029

PRE-TEST ROTATED FACTORS

FACTOR 1

.729	I WOULD BE UPSET TO FIND I WAS ALONE WITH A HOMOSEXUAL OF MY SAME SEX.
.718	MOST PATIENTS WITH AIDS DESERVE THE DISEASE BECAUSE OF THEIR OWN BEHAVIOR.
.681	I WOULD CHOOSE NOT TO BE A MEMBER OF ANY ORGANIATION WHICH HAD ANY HOMOSEXUALS IN ITS MEMBERSHIP.
,638	I WOULD BE AFRAID FOR A CHILD OF MINE TO HAVE A GAY OR LESBIAN SCHOOL TEACHER.
.580	HOMOSEXUALS SHOULD NOT BE ALLOWED TO HOLD GOERNMENT POSITIONS THAT HAVE ACCESS TO CLASSIFIED INFORMATION.
.579	HOMOSEXUALS ARE ANXIOUS TO BRING YOUNG TEENS INTO THEIR LIFESTYLE.
.534	NEARLY ALL HOMOSEXUALS ARE PROMISCUOUS.
.517	I FIND THE THOUGHT OF GAY OR LESBIAN SEXUAL ACTS DISGUSTING.
-.428	I WOULD FEEL COMFORTABLE WORKING WITH A COLLEAGUE WITH AIDS.

FACTOR 2 → Personal Concerns

-.705	I WOULD NOT MIND IF MY CHILD HAD A CLOSE FRIEND WITH AIDS.
.670	I WOULD NOT SEND MY CHILD TO SCHOOL WITH CHILDREN WHO HAVE AIDS.
.628	I WOULD BE AFRAID FOR A CHILD OF MINE TO HAVE A PERSON WITH AIDS FOR A SCHOOL TEACHER.
.576	I WOULD BE SUDDENLY UNCOMFORTABLE IF I FOUND THE PATIENT I WAS WORKING WITH HAD AIDS.
-.555	I WOULD HIRE A PERSON WITH AIDS AS A BABYSITTER FOR MY CHILDREN.
.518	I WOULD PREFER NOT TO CARE FOR AIDS PATIENTS.
,397	HIV+ HEALTH CARE PROVIDERS SHOULD FIND WORK IN NON-HEALTH CARE FIELDS.

FACTOR 3 Testing

.761	I THINK PRE-HOSPITAL ADMISSION TESTING SHOULD INCLUDE HIV TESTING
.743	I THINK PREMARITAL BLOOD TESTING SHOULD INCLUDE TESTING FOR HIV.
.530	IT IS IMPORTANT THAT NEW CASES OF AIDS BE REPORTED TO THE HEALTH DEPARTMENT SO SEXUAL PARTNERS CAN BE LOCATED.
.338	INSURANCE COMPANIES SHOULD BE ABLE TO TEST PEOPLE FOR HIV BEFORE WRITING NEW POLICIES.

FACTOR 4 extreme homophob

.848	LESBIANS BECOME SO BECAUSE THEY HATE MEN.
.833	GAY MEN BECOME GAY BECAUSE THEY HATE WOMEN
.546	THE GAY MALE IS UNASSERTIVE, AND USUALLY A PASSIVE PERSON.

FACTOR 5

-.874	IF I WERE HIRING PERSONNEL FOR A MEDICAL OFFICE, I WOULD HIRE AN OTHERWISE QUALIFIED HIV+ RECEPTIONIST.
-.831	IF I WERE HIRING PERSONNEL FOR A MEDICAL OFFICE, I WOULD HIRE AN OTHERWISE QUALIFIED HIV+ NURSE.

FACTOR 6

.749 HEALTH CARE PROFESSIONALS SHOULD BE ABLE TO CHOOSE WHETHER OR NOT TO CARE FOR A PERSON WITH AIDS.

.564 EVEN WITH PRECAUTIONS, I AM AT INCREASED RISK OF GETTING AIDS IF I CARE FOR AIDS PATIENTS.

,494 I **AM** AT HIGH RISK FOR CONTRACTING THE AIDS VIRUS IF I CARE FOR PEOPLE WITH AIDS.

FACTOR 7

,841 I WOULD FEEL COMFORTABLE IN BRINGING UP THE TOPIC OF IV DRUG USE WITH PERSONS I CARE FOR PROFESSIONALLY.

.791 I FEEL OK ABOUT BROACHING THE TOPIC OF HOMOSEXUAL ACTIVITY WITH PERSONS I CARE FOR PROFESSIONALLY.

POST-TEST ROTATED FACTORS

FACTOR 1

.725	P-I WOULD BE AFRAID FOR A CHILD OF MINE TO HAVE A GAY OR LESBIAN SCHOOL TEACHER.
,718	P-I WOULD BE UPSET TO FIND I WAS ALONE WITH A HOMOSEXUAL OF MY SAME SEX.
.656	P-I WOULD CHOOSE NOT TO BE A MEMBER OF ANY ORGANIATION WHICH HAD ANY HOMOSEXUALS IN ITS MEMBERSHIP.
.612	P-HOMOSEXUALS ARE ANXIOUS TO BRING YOUNG TEENS INTO THEIR LIFESTYLE.
.601	P-I WOULD BE AFRAID FOR A CHILD OF MINE TO HAVE A PERSON WITH AIDS FOR A SCHOOL TEACHER.
.596	P-I FIND THE THOUGHT OF GAY OR LESBIAN SEXUAL ACTS DISGUSTING.
.523	P-NEARLY ALL HOMOSEXUALS ARE PROMISCUOUS.
.521	P-HOMOSEXUALS SHOULD NOT BE ALLOWED TO HOLD GOERNMENT POSITIONS THAT HAVE ACCESS TO CLASSIFIED INFORMATION.
.513	P-MOST PATIENTS WITH AIDS DESERVE THE DISEASE BECAUSE OF THEIR OWN BEHAVIOR.

FACTOR 2

.669	P-I AM AT HIGH RISK FOR CONTRACTING THE AIDS VIRUS IF I CARE FOR PEOPLE WITH AIDS.
.657	P-I WOULD PREFER NOT TO CARE FOR AIDS PATIENTS.
.624	P-I WOULD BE SUDDENLY UNCOMFORTABLE IF I FOUND THE PATIENT I WAS WORKING WITH HAD AIDS.
.596	P-I WOULD NOT SEND MY CHILD TO SCHOOL WITH CHILDREN WHO HAVE AIDS.
.582	P-EVEN WITH PRECAUTIONS, I AM AT INCREASED RISK OF GETTING AIDS IF I CARE FOR AIDS PATIENTS:
-.529	P-I WOULD NOT MIND IF MY CHILD HAD A CLOSE FRIEND WITH AIDS.
-.528	P-I WOULD HIRE A PERSON WITH AIDS AS A BABYSITTER FOR MY CHILDREN.
.517	P-HEALTH CARE PROFESSIONALS SHOULD BE ABLE TO CHOOSE WHETHER OR NOT TO CARE FOR A PERSON WITH AIDS.
-.480	P-I WOULD FEEL COMFORTABLE WORKING WITH A COLLEAGUE WITH AIDS.
.430	P-HIV+ HEALTH CARE PROVIDERS SHOULD FIND WORK IN NON-HEALTH CARE FIELDS.

FACTOR 3

.910	P-GAY MEN BECOME GAY BECAUSE THEY HATE WOMEN
.907	P-LESBIANS BECOME SO BECAUSE THEY HATE MEN.
.526	P-THE GAY MALE IS UNASSERTIVE, AND USUALLY A PASSIVE PERSON.

FACTOR 4

.765	P-I THINK PRE-HOSPITAL ADMISSION TESTING SHOULD INCLUDE HIV TESTING
,733	P-I THINK PREMARITAL BLOOD TESTING SHOULD INCLUDE TESTING FOR HIV.
.602	P-IT IS IMPORTANT THAT NEW CASES OF AIDS BE REPORTED TO THE HEALTH DEPARTMENT SO SEXUAL PARTNERS CAN BE LOCATED.
.484	P-INSURANCE COMPANIES SHOULD BE ABLE TO TEST PEOPLE FOR HIV BEFORE WRITING NEW POLICIES.

FACTOR 5

.932 P-IF I WERE HIRING PERSONNEL FOR A MEDICAL OFFICE, I WOULD HIRE AN OTHERWISE QUALIFIED HIV+ RECEPTIONIST.

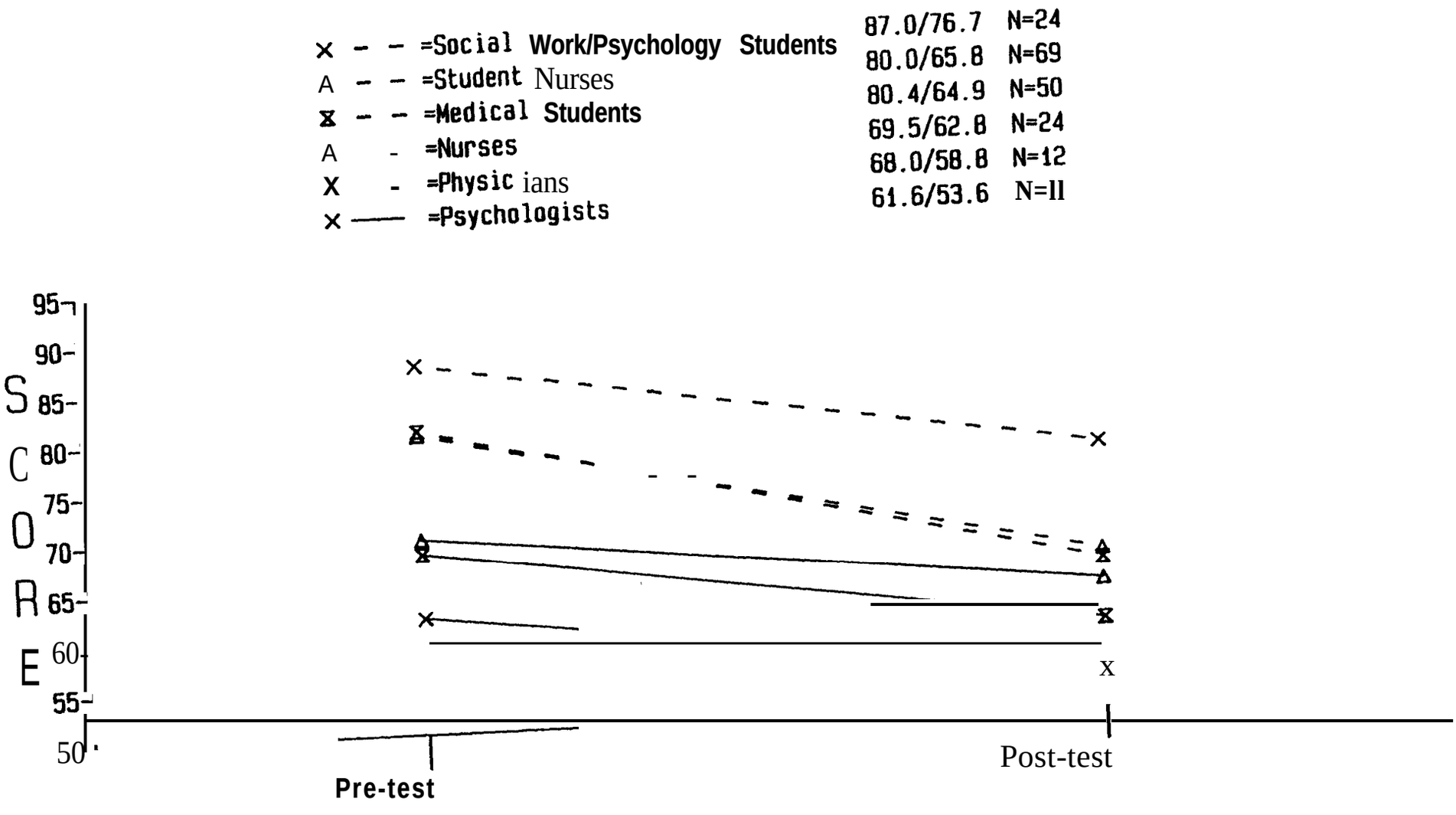
.920 P-IF I WERE HIRING PERSONNEL FOR A MEDICAL OFFICE, I WOULD HIRE AN OTHERWISE QUALIFIED HIV+ NURSE.

FACTOR 6

.837 P-I FEEL OK ABOUT BROACHING THE TOPIC OF HOMOSEXUAL ACTIVITY WITH PERSONS I CARE FOR PROFESSIONALLY.

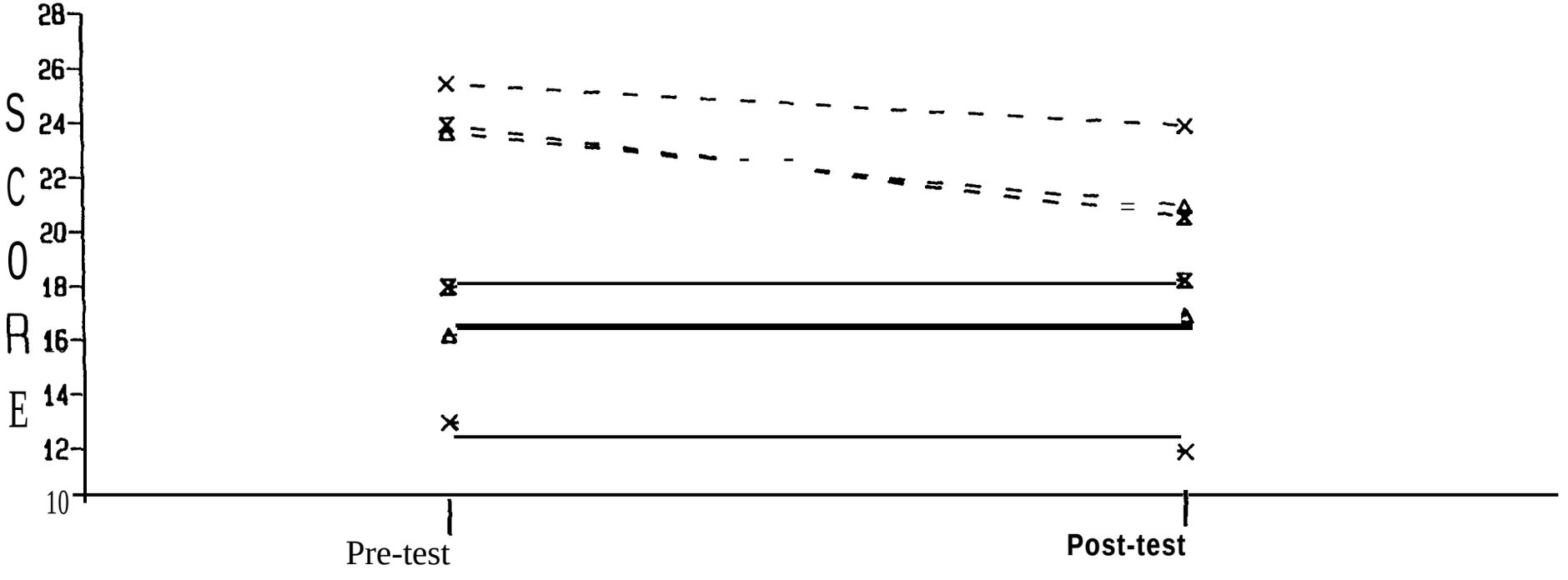
.816 P-I WOULD FEEL COMFORTABLE IN BRINGING UP THE TOPIC OF IV DRUG USE WITH PERSONS I CARE FOR PROFESSIONALLY.

CHANGE IN FEAR-OF-AIDS BY OCCUPATION

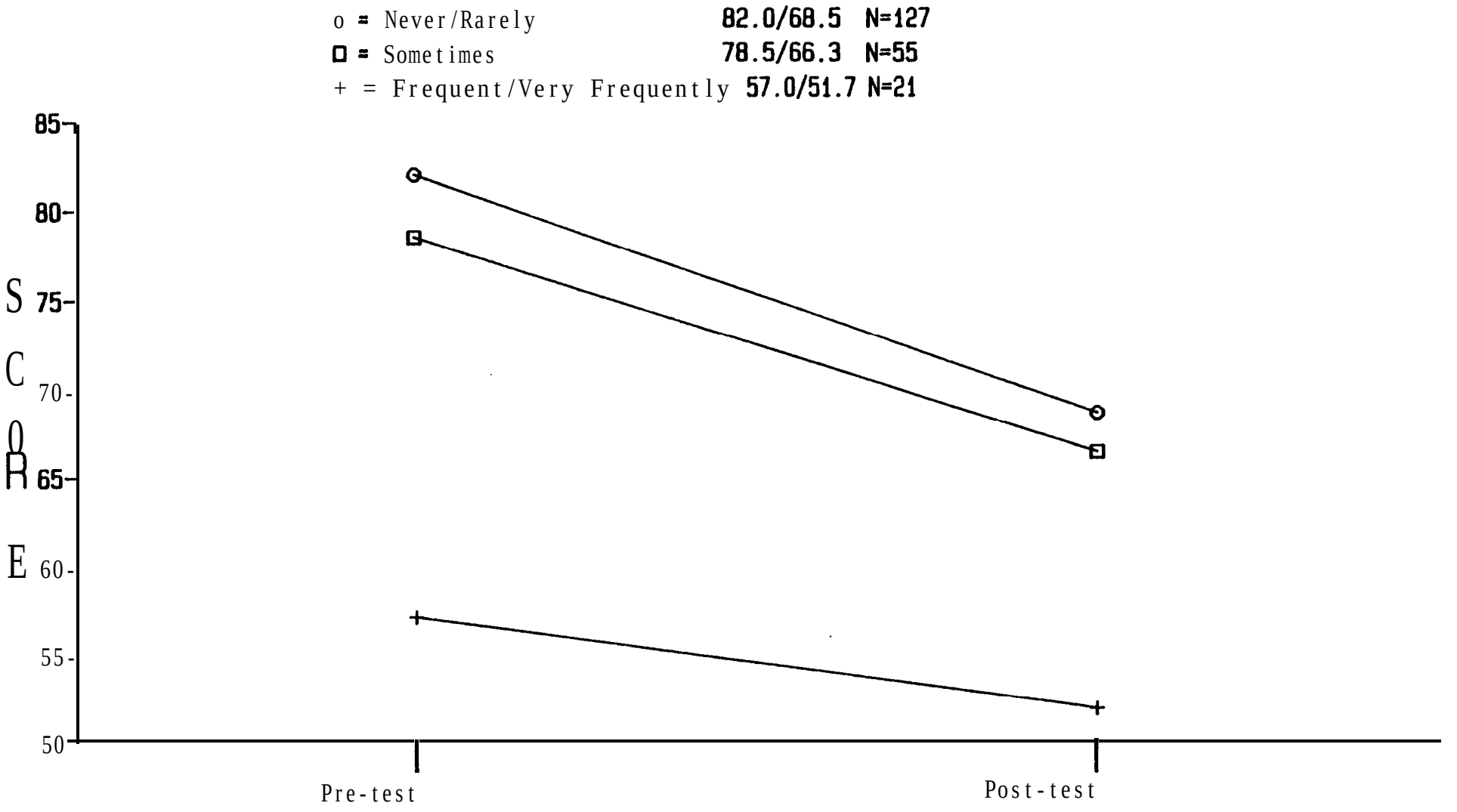


CHANGE IN HOMOPHOBIA BY OCCUPATION

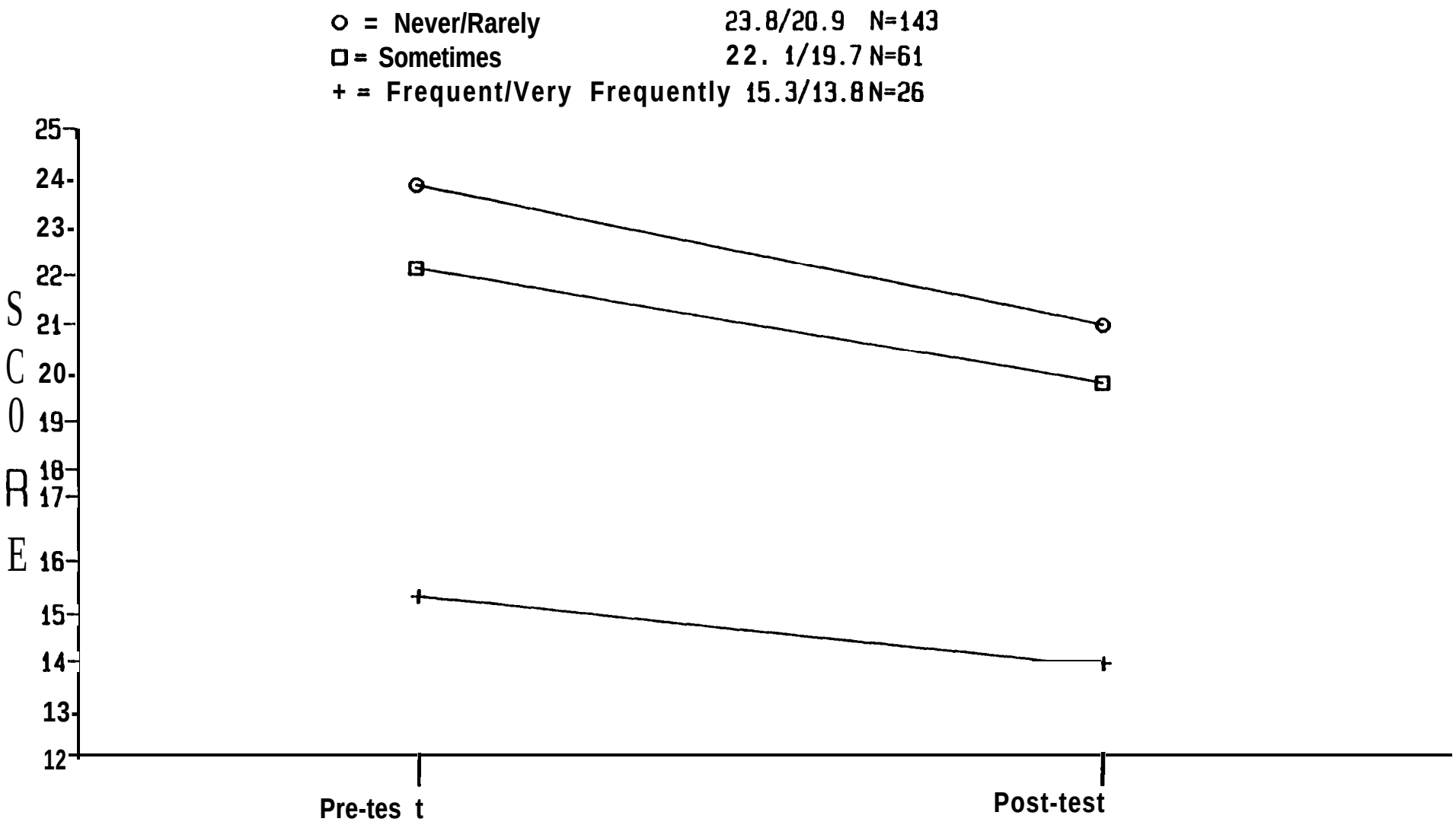
× – – =Social Work/Psychology Students	25.3/23.5	N=29
Δ – – =Student Nurses	23.5/20.4	N=73
⧗ – – =Medical Students	23.8/20.0	N=59
⧗ —— =Physicians	17.8/17.0	N=15
A - =Nurses	16.0/16.4	N=31
X - =Psychologists	12.8/11.4	N=11



CHANGE IN FEAR-OF-AIDS BY CONTACT WITH PEOPLE WITH AIDS

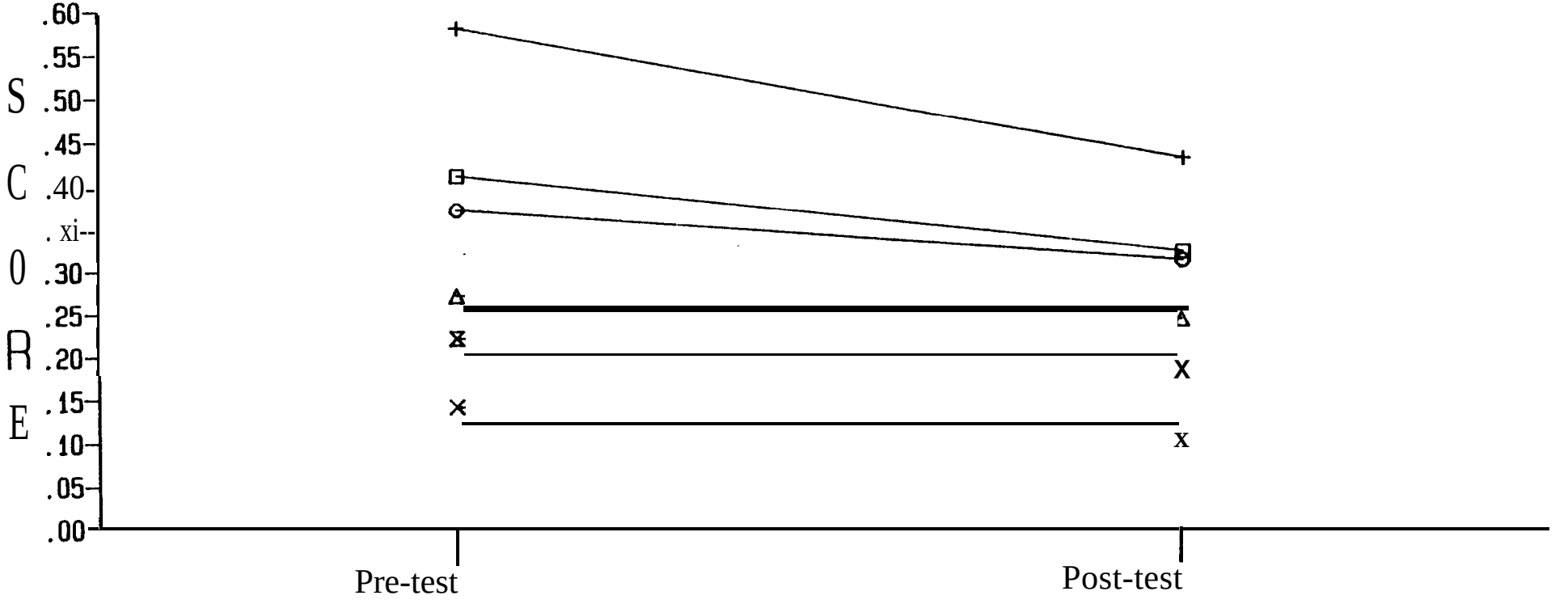


CHANGE IN HOMOPHOBIA BY CONTACT WITH PEOPLE WITH AIDS



CHANGE IN FACTOR SCORES PRE-TEST TO POST-TEST

+ =	Need to Know Who has AIDS	.56/.43
□ =	Concern about Contact with AIDS Patients	.41/.32
O =	Would Not Hire HIV+	.37/.31
A =	Inability to Discuss Sensitive Topics	.27/.24
⧖ =	Homophobia 1	.22/.18
× =	Homophobia 2	.14/.10



APPENDIX XII

Evaluation Report for the Hawaii AA **ETC's** 1989 Conference

1989 Maui Conference

Evaluation Summary

1. Each presentation was evaluated by all participants using learning objectives. Each presentation had one or more learning objective. Each objective was rated on a 1-4 point scale on how well the objective was met. (1 = not at all, 2 = somewhat, 3 = good, 4 = excellent). Over 94% of all responses were "3" or "4" across all presentations. This is an extremely high rate of success. Indeed over 64% of all responses were rated "4". Clearly, the objectives were clear and were addressed in the presentations overall.

2. In part because CERP credits were earned, a modified evaluation based on CERP requirements was included for each presentation. This evaluation asks participants to rate on a 5-point scale a series of statements (1 = strongly disagree, 5 = strongly agree). Each presentation was rated on 5 separate statements. Across the thirteen (13) presentations 52 of the 65 evaluative statements (or 80 %) produced mean scores 4.0 or above. No statement received a rating below 3.6. Again this indicates a very high level of satisfaction with the presentations.

3. Given the difficulties organizing a confernece on a neighbor island, it is noteworthy that the facilities were rated fairly high. Although ratings of the physical facilites were generally slightly lower than the other ratings, they remained above 4.0 overall.

4. Nearly all the presentations received very high ratings. Lenore Peterson's presentation receives the award for the highest ratings. (should we be suspicious?) Anita's and Jane's presentations were also rated extremely well. Only one presentation was rated noticably below the others and this still received generally favorable ratings (This presentation was by a local speaker.)

5. Respondents were voluminous in their opened-ended feedback. Each speaker can peruse the available summaries for these verbatim statements.

6. When asked how a presentation will change job performance the most common responses were about increasing sensitivity (both awareness and compassion). However, a significant minority stated that there would be no change (and cited some statement about the nature of their job). It is difficult to know whether this is a resistence, a statement of powerlessness, or a simple reality.

7. [illegible]

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Alan Katz, M.D., M.P.H. / Update on the Epidemic:
The latest on HIV Treatment and Transmission

1.) How well each of these objectives were met was rated using the foliowing scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 41

Be able to identify two reasons for uncertainty when interpreting HIV antibody test results.

na=6	5	10	20	3.4
1	2	3	4	$\bar{x}$

Be able to identify-two new strategies in the treatment of HIV disease.

na=6	4	9	22	3.5
1	2	3	4	$\bar{x}$

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		10	13	**15**	4.1

(na=3)

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
		3	13	23	4.5

(na=2)

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
	6	**1**	**17**	15	4.1

(na=2)

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
	1	10	15	13	4.0

(na=2)

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
1	2	5	14	17	4.1

(na=2)

MOST USEFUL:

1 A view of HIV as a chronic illness.

Great statistics.

Medication protocol.

All updates.

1 New strategies.

1 Updated material.

2 Basic info.

4 Update of the tx modalities.

HOPE

Information- More aware of physician's expanded role in treatment.

HOW TO IMPROVE:

Handouts! Handouts! Slides! Pictures!

Supply handout with preprinted stats and real data.

More on current drug TX's Especially specifics..

Less time on AIDS 101.

Possibly have slides made to project.

Too technical with all his DNA, and alphabet soup.

Mini workshop on the medications as PDR info. is often limited.

Somehow not focused.

Less technical jargon.

Better sound system.

Couldn't.

1/2 the content, 1/2 the speed given.

stay around for post conference.

Better handouts with speaker's info.

HOW WILL CHANGE THE WAY WILL PERFORM JOB:

1 Yes - more hopeful.

More awareness.

Just reinforces the importance of maintaining universal precautions on my unit.

Precautions with blood contact.

Motivating - Will try to keep abreast of the information on AIDS.

Probably.

Improved TX modalities.

Encouragement and practice of protective measures of health care workers.

None.

No.

Reinforce CDC Blood Universal Body Fluid Precautions.

More relaxed when working with PWA.

Consider the need for patient and M.D. to get together. Now M.D.'s are usually a part of a busy, busy schedule. These patients need psychological understanding which means "time" spent with them.

Maui conference / 11-3-89 / Building Skills, Building Knowledge
Rev. Morley **Fretch** / Meeting the Challenges of Quality Care
For the HIV Infected Person: A Maui Panel

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 33

Describe the local needs of community in providing care and treatment for people with HIV infection.

1	2	3	4	$\bar{x}$
	4	17	7	3.1

(na = 5)

Identify Maui care providers doing work with HIV infection.

1	2	3	4	$\bar{x}$
	4	16	**a**	3.1

(na = 5)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

	5	**7**	13	**6**	3.7
1					

(na=2)

2) I found the content of the session relevant to the objectives:

	1	**10**	13	7	3.8
1	2	3	4	5	$\bar{x}$

(na=2)

3) I found the content of the session clear and easy to understand:

	3	8	14	6	3.7
1	2	3	4	5	$\bar{X}$

(na=2)

4) The physical facilities were appropriate. for the session:

1	3	11	9	7	3.6
1	2	3	4	5	$\bar{x}$

(na=2)

5) My personal objectives for this workshop were met:

	4	11	11	5	3.6
1	2	3	4	5	$\bar{x}$

(na=2)

MOST USEFUL:

Charlotte Slavin can learn to project her voice.

Info on TX resources.

Hearing about concerns.

Some knowledge on roles.

Dr. Kwon's opinions and the groups questions.

Progress is slow in AIDS TX.

Info. on Hospice Program.

Identified what organizations were avaiiable.

Clarified what currently is available / needs.

Panel discussion format.

Aware of the confusion re. services on maui. Decision making.

HOW TO IMPROVE:

Monitor function of microphone / speakers & make adjustments as needed.

Charlotte Flavin can learn to project her voice.

Improve P.A. system.

Microphone functional.

Better microphone.

They have much to offer.

More distinctive forum leader.

Setting better for interaction.

State's position on treating people with AIDS.

Give suggestions as how public can help.

Increase volume of sound.

Having more guest panelists.

Participation by interested people.

HOW HAS CHANGED WAY WILL PERFORM JOB:

Dr. Kwon and Charlotte Kuwanoe were the most effective speakers and I can understand the frustrations they experience.

More effective techniques.

No.

Yes, may give us more energy to demand safer needle disposal at MMH.

None - My work is done by following federal and state laws that cannot be changed just because 1 doctor disagrees with the rules.

Volunteer in our area.

Maui conference / 11-3-89 / Building Skills, Building Knowledge
Alfred **J. Fortin /** Living with HIV Infection: People with HIV,
Family Members Speak to Health Providers

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 41

To identify common feelings and reactions of those infected with HI".

1	2	3	4	$\bar{X}$
	3	11	19	3.5

(na=8)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	3	11	12	13	3.8
1	2	3	4	5	$\bar{x}$

(na=1)

2) I found the content of the session relevant to the objectives:

1	2	4	15	19	4.2
1	2	3	4	5	$\bar{x}$

3) I found the content of the session clear and easy to understand:

1	2	4	15	19	4.2

4) The physical facilities were appropriate for the session:

1	5	9	11	15	3.8
1	2	3	4	5	$\bar{x}$

5) My personal objectives for this workshop were met:

1	4	6	17	13	3.9
1	2	3	4	5	$\bar{x}$

MOST USEFUL:

candid sharing of experiences.

Bill ? and Herb's honestv with their speaking of their experience and feelings.

To realize how volatile these people are - their needs are so great.

Putting a "face" on AIDS.

Infected people sharing.

One to one exchange.

Not personally.

1 PWAs and family presenting.

All three speakers were brave to come forth with their experiences and I thank them and empathize with them.

Choice of the panelists.

All.

Very effective to have HIV infected persons on a panel, brings AIDS issue to reality.

The candid sharing of their feelings.

HOW TO IMPROVE:

It should be stressed that welfare workers and social workers (there is a difference) can only go by rules and regulations that are set by the state, legislature and congress. Therefore, the only way DHS workers would be able to help is to have a change in the laws and regulations; talk to your representatives. The workers' hands are tied in these cases.

*Don't let Rae speak again - (offending) as she seems to be very angry with everyone.

More psychosocial help.

Facilitate more open dialogue with persons attending session.

One speaker was too hostile: She still has to work through her

anger and grief.

Less "lover" talk.

Rae Greco was too emotionally involved and shouldn't have spoke.

Ray needs help in giving a less "emotional" presentation. It alienated the audience.

Too much Doctor bashing - AIDS pts. aren't the only sick people in the island and the Doctors need to take care of them too.

Have someone in the spiritual area on panel.

Fine as is.

A couple more presenters.

HOW WILL CHANGE WAY WILL PERFORM JOB:

No change - job will not be affected personally. I have a better understanding of persons with HIV. Kudos to Bill and Herb. Was Rae referring to social worker or welfare worker? She put the Dept. of Human Services down because she did not get her way? She seems very irate at everyone in the community here and in S.F. She should move if she hates everyone. DHS is for people at poverty level. Just because her son had AIDS does not make her more, needy than others (like others with cancer or other illnesses). All persons applying for assistance must meet all conditions of eligibility regardless of situation. There is no exception to this rule as DHS follows rules given by Federal and State Govt.

Try to be sympathetic with client, but if my hands are tied by regs, what else can I do?

I will continue to be as sensitive and supportive as possible.

Yes - With more sensitivity.

More broad minded and careful.

No.

Wear gloves during direct contact with pt. while drawing blood and also, encourage employer to allow for HIV testing.

Not sure as we are just preparing to deal with this population in our services.

Not at all.

Rae seemed to be too angry to be effective and put me off, although I feel for her experiences. Herb is a good speaker and seems approachable (as Bill also is) and Bill's personality is the type of patient I would like to see more of in those people who are hospitalized.

* The two people on the panel came on strong and very angry. I understand their feelings and frustrations --- but putting down the medical staff as a whole was not appropriate. There are a lot of caring doctors on Maui and because they did not attend today's services does not mean they don't care. The panel was biased to begin with and the presentation would have been presented in a more appropriate manner --- in this way you may get more support.

More sensitive to emotional needs of PWAs/ families.

I strongly resent the expression of anger by Herb. - I house a family member with an incurable disease and no one is giving him $ 50.00 a day for his needs - he buys his own. A lot has and is being done for AIDS - granted there are more needs but money is needed for lots of things and one illness can't expect it all.

Very moving - very objective.

Become more empathetic and understand some of their feelings.

Somewhat.

Maui Conference / 11-3-39 / Building Skills, Building Knowledge
Sena Gates, DOH / New Perspectives on Substance Use and **HIV** Disease

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 14

To understand the relationship between IV drug use and HIV.

1	2	3	4	$\bar{x}$
	3	2	7	3.3

(na = 2)

To identify attitudes and behaviors of IV drug users and sexual partners in Hawaii.

1	2	3	4	$\bar{x}$
	4	3	5	3.1

(na = 2)

To identify other forms of substance use that put persons at risk for HIV infection.

1	2	3	4	$\bar{x}$
	4	3	5	3.1

(na = 2)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
	3	3	2	6	3.8

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
		4	2	8	4.3

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
	3		4	7	4.1

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
		3	6	5	4.1

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
	2	3	4	5	3.9

HOST USEFUL:

Current info on HI.

Maui information.

The outcomes of studies.

Correlation between sex and drug use.

All good.

HOW TO IMPROVE:

A pointer for the slides. Leave them up a bit longer to allow for copying.

Better AV.

Less reading. More slides. Less statistics.

Was really clear, good speaker, informative.

HOW WILL CHANGE WAY PERFORM JOB:

Good information.

N.A.

Not.

Yes.

Try not to be judgmental.

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Jane A. **Waldron,** Ph.D. / Women and HIV Infection

1.) How well each of these objectives were met was rated using the foilowing scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = **39**

Understand that women are at risk for HIV Infection.

1	2	3	4	$\bar{x}$
		6	30	3. a

(na=3)

Understand risk impact of HIV infection of fetus during pregnancy.

1	2	3	4	x
		17	19	3.5

(na=3)

Understand components of HIV risk assessment, and safe sex, and counseling for women.

1	2	3	4	$\bar{x}$
		15	21	3.6

(na=3)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
1		1	**16**	22	**4.5**

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
1		**1**	13	25	4.6

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
1		1	10	28	4.7

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
1	3	9	14	12	3.9

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
		4	13	22	4.5

MOST USEFUL: .

The speaker's knowledge, humanity and compassion.

All.

Audio visual breakup between delivery of stats.

Content.

1 Dental dam.

Talking to your prospective sex partner about safety.

Info in presentation.

The word lesbian was not used although articles were displayed for their exclusive use.

More awareness of how many women are infected.

Toys.

Liked the dammit.

To know there is a support group on Oahu.

Question and answer period.

Printed information.

2 Videos.

Everything.

The video and discussion was excellent.

New condoms.

HOW TO IMPROVE:

In general stats are variable, there must be other social factors that contribute to AIDS.

More copies of handouts.

Just more and more details.

Some dialogue.

It was fine as it was.

More data.

Longer and more handouts.

Enough.

HOW PRESENTATION HAS CHANGED WAY WILL PERFORM JOB:

More sensitive to doing risk assessments.

To be more "suspicious" as well as "nonjudgmental".

Exposure to another group at risk. Literature.

More sensitivity to HIV and women.

Be more aware of their needs. Be more aggressive in teaching.

Yes.

More awareness.

Be more sensitive to patient's perspective.

Personally not.

Yes - to know there is a support group.

More awareness and hopefully compassion.

More informed.

Broader awareness of moral/ethical issues.

Knowledgeable regarding protection.

This presentation provided me with current info. for me to be able to counsel mothers and women more effectively.

More sensitivity especially while waiting for test results. (Hospice helped me understand much about waiting for death in various positive/neg. manner.

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Anita **Gerhard, M.D. /** **HIV,** the Homeless **and** the Chronically Mentally Ill

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 17

Increased awareness of the need for outreach on HIV issues to special populations such as the homeless and the chronically mentally ill.

1	2	3	4	$\bar{x}$
	2	**5**	9	3.4

(na=1)

Increased awareness of special educational needs of the chronically mentally ill and techniques for meeting those needs.

1	2	3	4	$\bar{x}$
	1	6	10	3.5

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		4	7	6	4.1

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
		3	7	7	4.2

3) I round the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
		2	10	5	4.2

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
	1	4	4	8	4.1

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
		5	7	5	4.0

MOST USEFUL:

Excellent examples.

Description, and curricula.

The speaker's dedication and compassion and sense of humor.

How important it was to reach this population group.

1 Handout.

HOW TO IMPROVE:

We need a better microphone.

Info. on how to handle homeless person who is already HIV+.

Application to Maui.

HOW HAS CHANGED WAY WILL PERFORM JOB:

No.

DNA.

Exposure to a different targeted group to work on.

Undetermined.

Urge Mental Health Service to consider implementation.

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Lenore Peterson, A.C.S.W. / Counseling Persons at Risk *for* HIV Infection

1.) How well each.of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 18

Describe three questions you would want to ask clients in order to assess risk for HIV Infection.

1	2	3	4	$\bar{x}$
			15	4 . 0

Identify four unsafe sexual behaviors.

1	2	3	4	$\bar{x}$
			15	4.0

Cite three safe sex practices.

1	2	3	4	$\bar{x}$
			15	4.0

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
				18	5.0

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
			1	17	4.9

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
			1	17	4.9

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
		1	4	13	4.5

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
			4	14	4.7

MOST USEFUL:

Her energy.

Speaker's candor.

Interviewer to use terms.

All.

Group discussions.

Informal dialogue. Presenter very comfortable with topic. Excellent presentation.

Candor and humor.

Finding out how unaware and hou tc improve.

Listing of safe and unsafe sex.

Open-ness.

The ease with which you present a very charged subject lightly and with humor.

Very good.

The informal manner in which seminar was conducted.

Use of words accepted and not by whom.

HOW TO IMPROVE:

How would you present later counseling.

Visual Aids.

Man its good now.

HOW HAS CHANGED THE WAY WILL PERFORM **JOB**:

Many insights into people's thinking.

More informed, hopefully able to take a sex HX.

Be more specific.

Yes.

More awareness of patient's sexual behavior.

Great job! Very powerful, effective speaker.

-Will attempt taking sexual history.
-Will take info back to other staff.

ask patients - when appropriate.

Better sex HX intake re. habits of partners.

The point about providing the word for the client to use. Thanks. Aloha.

More sensitive to how the questions are asked to get the histories in short order and easier for patients.

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Anita **Gerhard, M.D. / Neuropsychiatric Issues with** HIV Infection

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 9

Increased awareness of variety of manifestations of HIV disease on the nervous system.

1	2	3	8	4.0
			4	$\bar{x}$

(na=1)

Increased knowledge of management of AIDS Dementia Complex.

1	2	1	**7**	3.9
		3	4	$\bar{x}$

(na=1)

Increased knowledge of psychopharmacology in the treatment of HIV.

1	2	3	8	4.0
			4	$\bar{x}$

(na=1)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The sneaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		3	6		4.7

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
			2	7	4.8

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
			3	6	4.7

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
			5	4	4.5

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
		1	1	7	4.7

MOST **USEFUL:**

The speaker's presentational skills.

Broad review.

Portion on care of AIDS dementia patient.

Opened the whole new insight into new-present use of drugs alone and in combination.

Anti-depressant meds and side effects of common HIV meds.

Knowledge of current drug therapy and the continued importance of personal interaction from the professional.

HOW TO IMPROVE:

- **Use** same approach - it's good.

Room too cold.

it's good.

Hope talk repeated for group who couldn't attend.

HOW HAS **CHANGED WAY WILL PERFORM JOB:**

I am not into medical or pharmacological stuff at present, but I have a limited knowledge of same medical terms and vocabulary - However, you know your stuff and I'm impressed with your whole package!

Unsure - better evaluation.

Awareness.

Increased info. on psychopharmacology will enhance the total case given to patients.

With caution and awareness of any side effects - both individually and in combination.

More knowledgeable.

I'll question prescribed RX more closely - observe closer for **side** effects and be more aware **that symptoms may be** due to HIV!? And as ever continue with universal precaution.

Maui Conference / 11-4-89 / Building Skills, Building Knowledge
Alfred J. Fortin, Ph.D. / Ethics, AIDS and Professional Practice

1.) How well each of these objectives were net was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

Increased awareness of issues involved in ethical dilemmas related to the care of persons with HIV infection. N = 16

1	2	3	4	$\bar{x}$
		3	12	3.8

(na=1)

Identify five values in health care that frame ethical decisions about persons with HIV infection.

1	2	3	4	$\bar{x}$
		3	11	3.8

(na=2)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		2	6	8	4.4

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
		1	4	11	4.6

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
		2	8	6	4.3

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
	2	1	4	9	4.3

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
		2	6	8	4.4

MOST USEFUL:

Vignettes, discussion.

Listening for loaded words.

Student involvement, periodic summarization.

Tapes and p discussion.

The two videos and discussion following them.

Care study.

The discussion of care vignettes.

Examples.

HOW TO IMPROVE:

Longer session.

It was okay.

More video episodes, less of the basic ethics/value lecture as they are generally understood.

Voice trailed off at times.

Participatory workshop.

HOW HAS CHANGED WAY WILL PERFORM JOB:

Realization how complex ethical dilemmas are.

I will try to be more aware and alert to words.

More sensitivity and broader outlook.

Very helpful in anticipating client reaction as well as your own behavior.

Yes.

More empathy for diverse social attitude.

No.

1.) How well these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 14

Increased awareness of needs of children infected with HIV, as well as needs of their birth, foster or adoptive parents:

		6	8	3.6

Understand infection control guidelines for children with HIV:

		6	7	3.5
1	2	3	4	X

na = 1

Increased awareness for HIV education in children and adolescents:

	2	5	6	3.3
1	2	3	4	X

na = 1

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{X}$
		5	4	5	4.0

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{X}$
		2	5	7	4.4

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{X}$
		2	5	7	4.4

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{X}$
	1	2	3	8	4.2

5) My personal objectives for this workshop were met:

1	2	3	3	5	$\bar{X}$
	1	3	6	4	3.9

MOST USEFUL:

Tape and p discussion.

Hand outs.

Opened up what is known today.

Discussions.

Vignettes, discussion.

Discussion re. adolescent issues.

HOW TO IMPROVE:

Speaker using mike.

More info. on efficiency of treatment, longevity, etc.

Updating constantly.

Could not hear what people in audience was saying.

More vignettes, more discussions.

More time: could be a whole workshop by itself.

HOW HAS CHANGED WAY WILL PERFORM JOB:

Uncertain.

To educate children where possible.

To listen actively. It was an inspiration to be more aware of and open to children's problems of the day.

More aware of some of people's reaction to HIV infants. Also more able to anticipate what problems may be encountered with infected babies as well as adolescents.

Found problem very complex. Much to learn yet.

Do presentation to staff and promote discussion of agency policy.

Yes indeed.

Maui Conference / 11-4-89 / Building Skills, Building Knowledge
Angela Kelly, R.N., C.N.A.A. /
Counseling Persons with HIV Infection

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 23

After this presentation the participant should be able to list Hawaii laws for informed consent and pre and post test counseling.

1	2	3	4	$\bar{x}$
	3	3	**7**	3.0

(na=8)

Be able to identify essential components of counseling for the HIV infected client.

1	2	3	4	$\bar{x}$
		4	**13**	3.8

(na=6)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		1	9	13	3.7

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
			6	17	4.7

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
		1	4	18	4.7

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
	1	2	8	12	4.4

5) My personal objectives for this workshop were met:

1	2	3	4	5	$\bar{x}$
		1	8	14	4.6

MOST USEFUL:

Case histories.

All.

Lists of things to cover.

Well organized.

Comments that simple, everyday health-oriented approaches are 90% of the battle.

Personal experience, total objectivity of speaker.

Compassion.

Specific recommendations for treatment requirements - and good health planning.

Attitude.

Well organized - slide outline.

Method of counseling.

HOW TO IMPROVE:

How do you counsel those who plan or wish to end their life?

I see no way!

HOW HAS CHANGED THE WAY WILL PERFORM JOB:

Will help me to be more competent.

Much improved.

More informed.

Excellent speaker - really knew her info, very positive -

Hopefully I know a bit more about specific questions and recommendations.

Helpful.

Excellent presentation - what a sensitive, lovely person.

DNA.

Maui Conference / 11-4-89 / Building Skills, Building Knowledge
Angela Kelly, R.N., C.N.A.A. / **Building a Community Case Management System**

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 20

Be able to define case management:

1	2	3	4	$\bar{x}$
		2	**16**	**3.9**

(na=2)

Be able to identify implementation process for case management for Hawaii:

1	2	3	4	$\bar{x}$
		5	**13**	**3.7**

(na=2)

Be **able** to identify current and future plans for case management development.

1	2	3	4	$\bar{x}$
		4	**14**	**3.8**

(na=2)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

1	2	3	4	5	$\bar{x}$
		1	5	14	4.7

2) I found the content of the session relevant to the objectives:

1	2	3	4	5	$\bar{x}$
			3	17	4.9

3) I found the content of the session clear and easy to understand:

1	2	3	4	5	$\bar{x}$
			3	17	4.9

4) The physical facilities were appropriate for the session:

1	2	3	4	5	$\bar{x}$
	1		7	12	4.4

5) My personal objectives for this workshop were net:

1	2	3	4	5	$\bar{x}$
	2		3	14	4.3

(na=1)

MOST USEFUL:

1 Clarity in description.

Review, already doing case management.

Organized, simplified presentation.

Personal experiences and knowledge.

Explanation of process of planning.

Saw the need for C.M. locally.

HOW TO IMPROVE:

- Don't know.

N.A.

Utilize local staff doing C.M.

It was okay - if overhead info is in the handout - too fast to take notes.

? Soft voice.

HOW HAS CHANGED WAY WILL PERFORM JOB:

As usual, Angela was excellent!

1. Great ideas. Who implements a HI State case management system?

2. We need uniform plans in 50 states.

Clarify.

Attitude changes and awareness improved.

Emphasized importance of C.M.

No - I do no case management;

Yes!!

Assisting with developing case management locally.

It scared me at the responsibility of case management.

Yes. As a volunteer. Maui.

Maui Conference / 11-3-89 / Building Skills, Building Knowledge
Alfred J. Fortin, Ph.D. / Legal Issues and HIV Disease

1.) How well each of these objectives were met was rated using the following scale:

1 = not at all
2 = somewhat
3 = good
4 = excellent

N = 25

Understand legal obligations regarding confidentiality of HIV related information.

1	2	3	4	$\bar{x}$
		6	16	**3.7**

(na=3)

Understand legal obligations regarding HIV testing.

1	2	3	4	$\bar{x}$
		8	14	3.6

(na=3)

Understand legal duty to warn.

1	2	3	4	$\bar{x}$
		8	14	**3.6**

(na=3)

-- Understand legal basis for HIV as a handicapping condition.

1	2	3	4	$\bar{x}$
1	1	12	8	3.2

(na=3)

For the following statements: 1 = strongly disagree
5 = strongly agree

1) The speaker demonstrated an effective teaching style that facilitated my learning at this session:

		5	10	9	4.2
1	2	3	4	5	$\bar{x}$

(na=1)

2) I found the content of the session relevant to the objectives:

		1	9	15	4.6
1	2	3	4	5	$\bar{x}$

3) I found the content of the session clear and easy to understand:

	1	4	10	**10**	4.2
1	2	3	4	5	$\bar{x}$

4) The physical facilities were appropriate for the session:

	1	6	6	**12**	**4.2**
1	**2**	**3**	4	**5**	$\bar{x}$

5) My personal objectives for this workshop were met:

	1	**3**	**11**	**9**	**4.2**
1	2	3	4	5	$\bar{x}$

(na=1)

MOST USEFUL:

Content, speaker's knowledge.

All.

More aware of new laws.

Just reviewing the laws themselves.

Transparencies presentation with excellent clarification.

All.

To know the laws and to keep observing.

HOW TO **IMPROVE:**

Have session in AM.

Video, drama, breaks.

More of it.

Too fast.

Good material but fast, voice drops.

Should have used mike as voice dropped at times.

An attorney should handle part of this.

HOW HAS CHANGED **WAY WILL PERFORM JOB:**

Keeping a tight lid on confidentiality.

DNA.

Stress confidentiality.

1 More awareness of legal issues.

No.

Reread material.

Just re-reminded of confidentiality need. It's a complicated part of the whole program. I'm not taking anything away from the speaker.

Isolate the HIV info. in the patient charts.

JSI

210 LINCOLN STREET
BOSTON. MASSACHUSETTS 02111