

# Chapter 7

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## Evaluation



## Evaluating the Community Planning Process in Connecticut

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### Introduction

The Centers for Disease Control and Prevention's (CDC) new *Guidance on HIV Prevention Community Planning* states "**the monitoring and evaluation of HIV prevention community planning is based on three goals and eight objectives for HIV Prevention Community Planning.**" According to the Guidance, monitoring and evaluation of HIV Prevention Community Planning is a shared responsibility between the health department and the CPG. In Connecticut, the DPH relies on The Parisky Group, a private consulting firm, to oversee and facilitate the community planning process and to conduct all evaluation activities related to community planning. The Parisky Group works in conjunction with members of the CPG's Membership, Parity, Inclusion, Representation and Evaluation Committee (MPIRE) to ensure that community planning members and advisors participate fully in the design of the process evaluation.

Evaluation of the August 2003 through July 2004 planning activities has been an ongoing process. The goals of the evaluation of the CPG planning process were to assess participant satisfaction with a number of elements in Connecticut's HIV prevention community planning, and to determine whether the community planning process met CDC's guidelines.

### Methodology

The CPG evaluates the community planning process by employing a number of data collection methods including monthly meeting evaluations from CPG members, advisors and members of the public, mid-year and end-of-year surveys, exit interviews and small group discussions.

- **CPG member and advisor meeting evaluations** – At the end of each CPG meeting and technical assistance session, CPG members and advisors complete and return an evaluation form, which evaluates the environment and atmosphere, the flow and organization, group interaction, presentations/group work, and committee meeting process. The form also includes a feedback section on the "best part" of the meeting, a comment section designed to solicit suggestions for improving meeting effectiveness, and "talk-back" message boxes where statements can be addressed to co-chairs, committee chairs, members, the contractor and presenters.
- **Public meeting evaluations** – Guiding Principle #6 of the CDC Guidance states that the "community planning process must actively encourage and seek out community participation." Members of the public who attend CPG meetings are also asked to submit evaluations at the end of the session. This helps gather information on several levels: (1) who attends (individuals/agencies), (2) how many times individuals have previously attended, (3) ways individuals heard about the CPG meeting, (4) reasons for attending the meeting, (5) if the meeting met the needs of the individual, and, (6) a message box section for statements to co-chairs, members, committee chairs, contractor and presenter.
- **Mid-year evaluation** – The mid-year evaluation is a self-administered survey, which evaluates parts of the planning process including the membership process, membership policies and procedures, group process, parity, inclusion, representation, as well as attendance and participation at full group CPG and committee-focused meetings. The

mid-year evaluation is designed in a way that allows the results to be compared to the end-of-year evaluation. (*see Appendix F*).

- **Exit interviews** – CPG members and advisors who left the CPG from August 2003 through July 2004 were given exit interviews. Each one was asked their reason for leaving, the effectiveness of the planning experience and leadership, and steps that would help CPG accomplish its goals.
- **Public end of the year evaluation tool** – Members of the public, attending the August 20, 2003, CPG meeting completed an evaluation designed to give them input into the planning process. Members of the public were asked to state their reasons for attending the CPG meetings, to provide suggestions for making the meetings more effective, and to provide insights regarding how the CPG could better promote community planning. A sample of the end of the year public evaluation tool is attached in **Appendix F**.
- **CDC Community Planning Evaluation Tool** – In 2003, the Connecticut CPG was one of the jurisdictions chosen by the CDC to test its draft community planning evaluation tool of CPG members and advisors. In 2004, CDC required jurisdictions to implement this community planning evaluation tool. The CPG decided to add several questions from the mid-year CPG member-advisor evaluation tool to the end of the CDC evaluation tool for an end of the year survey of community planning members and advisors. Evaluations using this revised tool were completed by members and advisors at the August 18 CPG meeting. A sample of the tool is attached in **Appendix F**.
- **Quarterly Co-Chair Letter to the AIDS and Chronic Diseases Division Director** – The Community Co-Chairs have implemented a quarterly letter to the DPH AIDS and Chronic Diseases Division Director, which outlines the progress the CPG has made and also defines its relationship to the DPH. The purpose of this letter is to ensure that communication, collaboration and cooperation remain open and active, and that any issues that arise are addressed in a timely manner. A copy of the letter is attached in **Appendix F**.

The remaining portion of this chapter describes how well the Connecticut CPG has met CDC's three goals and eight objectives of HIV Prevention Community Planning over the past year.

***Goal One: Community planning supports broad-based community participation in HIV prevention planning***

- **Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership**

The CPG has achieved Objective A. During the last planning cycle, the Membership Parity Inclusion Representation and Evaluation (MPIRE) Committee implemented several measures to recruit new members and advisors.

The committee conducted a quarterly review of the CPG's diversity chart, prepared by the CPG contractor, to help guide recruitment efforts. Information about current membership included on the diversity chart is collected from the original CPG member nomination forms and the annual CDC membership grid survey.

Using the diversity chart, the committee identified populations that needed to be represented on the CPG in order to reflect the epidemic in Connecticut. To ensure that the group's membership goals reflected the current statewide HIV/AIDS epidemic, the MPIRE committee reviewed the

best available HIV/AIDS data in the context of six of the seven CPG regions, the list of priority populations from the Comprehensive HIV Plan, and determined the additional expertise needed by the CPG to complete the community planning process. The CPG used various recruiting methods including word of mouth, media advisories, Community Days, the CPG's recruitment brochure, announcements in the monthly *News and Notes*, and the CPG website maintained by the contractor and DPH.

Members are voted on to the CPG two times annually. Prior to their official entry to the CPG, each new member class completes a comprehensive orientation process. Many new members felt a bit overwhelmed with all of the material and information presented during the orientation process. The CPG contractor implemented member suggestions that the actual orientation only be focused on the basics of community planning. CPG also has a mentoring program. Many members, however, feel that it needs strengthening and enhancement. According to the mid-year survey, members and advisors identified mentoring as a priority for the orientation session. The CPG's MPIRE Committee is currently examining the mentor program and will present recommendations to the CPG on revision of the program in the fall of 2004.

During the 2005 planning cycle, the MPIRE Committee will continue its recruitment efforts to achieve a roster of CPG members that better reflect the diversity of the epidemic in Connecticut. The committee will also refine its advisor nomination and selection process to include additional expertise in behavioral and social sciences, as well as representatives of key non-governmental and governmental organizations providing prevention and care related services.

### **CPG Structure**

Since the last planning cycle, CPG committees have been restructured down to three. The first committee restructuring occurred in November 2001, when the process streamlined the work of five committees and six workgroups into six committees. The majority of the feedback on this restructuring was positive and most members thought the CPG functioned better. However, several concerns did arise such as too few members doing all of the work, time constraints and last minute deadlines, and the need to find more effective ways of accomplishing committee tasks. The flow and organization of the meeting, and, in particular, members staying on task and completing the meeting agenda were also two items that varied widely depending on the meeting. Other comments pointed to the need for more time for committee meetings. In June 2003, the six committees were once again restructured into three, which merged together committees with overlapping commonalities and tasks. To address the concern regarding completion of work plans, CPG meetings were reorganized around two committee-focused and one full CPG meeting per quarter, thus allowing for more committee concentrated work to occur. Eighty-nine percent of the members and advisors surveyed in the mid-year evaluation of community planning indicated they were satisfied with the current meeting structure. The Executive Committee structure, which consists of the three co-chairs and two co-chairs from each committee, meets on a monthly basis to discuss business and issues around Connecticut's community planning process.

### **CPG Timeline and Work Plan**

A few obstacles were identified over the past year for the CPG to address. The general consensus was that major tasks needed to be distributed more evenly on the committee and CPG timelines in order to avoid a time-crunch as deadlines approached. One factor prompting this concern was the late start time of meetings (e.g. 20 minutes late). As a result of the late start of CPG meetings, committee meetings were shortened and important work was not being accomplished. With the restructuring of the committees into three standing committees as well

as the reorganization of monthly meetings into a more committee-oriented process, these issues hopefully were resolved during the 2004 planning cycle. Feedback from CPG members and committee chairs has been very positive and supportive about the new structures and committees. During the November 2003 CPG Retreat, the three committees discussed and refined timelines and work plans for the 2004 planning year. The review of timelines is now a standing item on the full CPG meeting and all committee meeting agendas.

### **CPG Logistics**

Behind every process, there are basic needs to be met and things that have to happen to ensure that the group can move forward. Although these are not frontline issues, they do have the potential to adversely affect the group and its progress. The CPG's satisfaction with the meeting and logistics are tracked by monthly meeting evaluations. One of the changes that have been made to make meetings more effective is having a sound system available at every meeting. Other logistical needs listed on evaluations were addressed during the 2004 planning cycle including the need for better parking, having a more stable meeting room temperature, and fewer items on agendas. Having too many agenda items has resulted in less group discussion and participation. It should be noted, however, that during the 2004 planning cycle, meeting sites were pre-screened for adequate meeting space, breakout rooms, and ample parking in order to better accommodate the physical needs of CPG members. In addition, the CPG implemented meeting structure recommendation changes in 2003-2004 planning cycle: that guest speakers present before lunch, and more interactive presentations be reserved for after lunch when member attention spans tend to shorten.

- **Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies**

The majority of CPG members interviewed agreed that CPG membership attempts to reflect the populations most affected by the HIV/AIDS epidemic in Connecticut, but that some groups were missing – e.g. transgenders, Asians, Native Hawaiians or other Pacific Islanders, American Indians/Alaskan Natives, deaf/hard of hearing, HIV-positive Latinas, injection drug users, and youth. It was also mentioned that expertise and agency representation is needed in STDs, commercial sex workers, mental/behavioral health, tuberculosis, faith community, researchers, and minority CBOs. The formation of the HIV Youth Advisory Board (YAB) has helped to fill the youth representation void; however, a youth CPG member is still considered a priority. The YAB coordinator at Wheeler Clinic in Farmington, CT updates the CPG on YAB activities quarterly. A more flexible meeting schedule, with times convenient for youth might be key to achieving this objective. Another suggestion that has been made during the 2003 was that the Executive Committee should also be more reflective of the membership of the CPG. The CPG elected all new standing committee chairs in the fall 2003 and the Executive is now more reflective of the diverse membership of the CPG. During the 2004-2005 planning cycle, the MPIRE Committee will continue to focus its recruiting efforts on addressing membership gaps.

- **Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.**

### **Member Participation**

The CPG has, in many ways achieved objective C. According to meeting evaluations, 84% to 100% (median of 88%) of the membership was in agreement that participation within the group was encouraged during meetings, that everyone's opinion was respected, and that members of the public had an opportunity to speak. Great strides have also been made in the area of

clarifying member roles. The Finance Policy and Procedure Committee (FPP) reviewed and recommended changes on the role of advisors in the community planning process. The FPP Committee recommended that the CPG narrow its definition of advisor to “a pool of experts in specific predetermined fields for use in the development of the comprehensive HIV prevention plan or community planning group process issues. CPG advisors elected under the old system were “grand fathered” for a year (ending September 2004). During the “grand fathered” year advisors under the old system were eligible for stipends/wage replacement, childcare, mileage reimbursement and conference attendance. The CPG approved the recommended changes at its September 2003 meeting. In September 2004 advisors under the old system will either apply for CPG membership or be listed in the 2005 CPG Directory of Advisors. The advisors under the old system will not be given preference for membership slots since the MPIRE Committee’s priority is to reflect the HIV epidemic in the state of Connecticut.

***Goal Two: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction***

- **Objective D: Carry out a logical, evidence-based process to determine the highest priority population, population-specific prevention needs in the jurisdiction.**

Chapter 5, Connecticut’s Priorities for 2005-2008, contains a description of the CPG’s 2003-2004 priority setting methodology. During this process, the CPG used a modified version of the Academy of Educational Development’s *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*. The co-chairs of the CPG Priority Setting Ad-hoc Committee Leif Mitchell and Brian Goodrich and DPH staff person Susan Major presented a workshop on the Connecticut CPG’s priority setting method at the 2004 HIV Prevention Leadership Summit held June 16-19 in Atlanta, GA.

- **Objective E: Ensure that the prioritized target populations are based on an epidemiological profile and community services assessment.**

In February 2004, the DPH distributed a 2004 supplement to the 2003 epidemiological profile for the state of Connecticut (updated in May 2003), which included information for the CPG Planning Group Regions as well as the Ryan White Eligible Metropolitan Areas (EMAs), sexually transmitted diseases surveillance, and viral hepatitis surveillance data. Chapter two includes the 2004 supplement and a modified version of the *Epidemiological Profile of HIV and AIDS in Connecticut for 2003*. The CPG conducted focus groups during the 2003 planning cycle for two populations identified by the former Data Assessment and Analysis Committee as emerging populations: migrant farmer workers and people over 50 (**see Chapter 3 for a description of the focus groups**). The Community Services (CSA) Committee conducted focus groups with Men who have sex with men and inmates (both male and female) of the Department of Correction. The CSA Committee also surveyed Women who have sex with women on their perceptions of HIV risk. In addition, the CSA Committee and DPH developed and implemented a resource inventory survey tool for HIV prevention contractors and non-DPH service providers for implementation in the fall/winter of 2003 and 2004. The results of the resource inventory survey were presented to the CPG by DPH staff person Susan Major at the August 18 CPG meeting (**see Chapter 3 for a description of this process**). CSA Committee is also arranging focus groups with the transgender male to female and female to male populations. These focus groups will take place in the fall of 2004.

- **Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome**

**effectiveness, and/or have been adequately tested with the intended target populations for cultural appropriateness, relevance and acceptability.**

Descriptions of the evidenced based interventions recommended by the CPG can be found in Chapter 4 – *What Works in HIV Prevention?* DPH asked that potential contractors use these evidence-based interventions in the development of their request for proposals for HIV prevention funds during 2002. In addition, DPH also sponsored several trainings for potential contractors during the winter of 2001 and spring of 2002 to better acquaint them with cognitive theories and models of health-related behaviors. During the 2004 planning cycle, presentations were provided for the CPG that addressed some of the topics listed above including a clinical intervention for HIV positive individuals, syringe exchange, migrant farm workers, injection drug users and updates on the status of current DPH HIV prevention programming.

***Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.***

- **Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.**
- **Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.**

In the spring of 2002, many CPG members and advisors participated in the request for proposals (RFP) review process of HIV prevention agencies for federal and state HIV prevention funds. The review, which was based on the information contained in Connecticut's Comprehensive HIV Prevention Plan for 2002-2004, consisted of separate review committees for each CPG region. At least one CPG member served on each committee. In addition, a committee charged to review statewide level interventions was also developed, and that group also included one CPG member. DPH is expected to ask for RFPs for prevention activities in the fall of 2004 and CPG members will again be asked to sit on review panels.

As the plan enters its update stage, CPG members review and provide feedback and comments for revisions. As this evaluation chapter is being updated (August 2004), members of the CPG reviewed individual draft chapters of the 2005-2008 Comprehensive HIV Prevention Plan. The CPG voted to approve the new plan at the July 21, 2004 meeting. CPG members will be send draft copies of the 2005 Cooperative Agreement for federal HIV prevention funding before the August 18 CPG meeting. The department will present the draft application at the August 18 and review the revised application based on feedback from CPG members and advisors at the September 1 CPG meeting. The CPG will vote on concurrence at meeting the September 1, 2004 meeting.

### **Summary and Recommendations**

Although the CPG encountered many obstacles during this year's planning process, this evaluation update has highlighted the many positive things, which are also happening within the CPG, as well as the improvements to be made during the 2005 planning cycle. While there was a wide range of opinions among the individuals who completed the mid-year, end-of-the year and CDC evaluation tools, these comments were invaluable in identifying the following recommendations to improve Connecticut's community planning process during the next planning cycle:

- **Clearer roles of CPG members and advisors:** Parity was brought up as a concern and some members felt like their voices were not equal and/or heard. Perceptions of power and influence were also seen as issues. In 2003 it was suggested that the more vocal members try to refrain from being the first to share opinions in order to allow/encourage the more quiet members to speak and provide input. The new committee structure instituted in July 2003 also appears to have addressed many of the inclusion issues addressed in last year's mid-year and end of the year surveys. The CPG will continue to focus on improvement of PIR during the upcoming planning year. Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004) compared to the Mid-Year survey (April 2004), the percentage of members and advisors who felt members and advisors didn't have equal status decreased from 43% to 38%. The percentage of members and advisors who felt there were differences in perceptions of power increased 24% from 11% from 35%) and members who were more influential stayed the same (35%) in the end-of-the year survey compared to mid-year.
  
- **Orientation:** The orientation agenda seems to be a bit overwhelming and causes participants to go into information overload. The orientation process, rather than attempting to cover every community planning issue, should instead cover more of the basics and only go into detail in those areas needing clarification and explanation. In addition, it was recommended that the mentorship program be initiated at orientation, to help assist new members to feel more welcome during their orientation period. The CPG will revisit the orientation process in the upcoming planning cycle to make it more "user friendly" for new members (e.g. mailing orientation materials to new members prior to the orientation training, focusing on roles and responsibilities and committee structure during training, highlighting the goals of community planning and editing the orientation training PowerPoint to reflect new changes to the CPG structure as well as the new CDC *Guidance on Community Planning*). Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004), members also suggested the inclusion of the following in the orientation process: mentoring of new members, increased focus on the community planning process, and more information about committees.
  
- **CPG structure:** A better distribution of work among committee members will balance the load of committee tasks and responsibilities. Rather than one or two people being solely responsible for accomplishing the work, it is the CPG's goal that all committee members will equally share tasks. With the restructuring of the CPG committees in July 2003, a better distribution of work has been and will be effected. The CPG will continue to define group and committee processes during the upcoming planning year to assure better adherence to timelines and work plans, as well as accomplishment of tasks in a timely fashion. Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004), 78% (compared to 89% mid-year) of the members and advisors indicated they were satisfied with the current meeting structure of two committee focused and one full CPG meeting per quarter.
  
- **CPG timeline and workplan:** A better distribution of work and reduction of major agenda items on committee and full CPG timelines will assist in reducing "crunch" periods in the planning process. Committees reviewed and updated respective timelines and work plans for 2004 at the annual CPG Retreat in November 2003. During the 2003-2004 planning process review of the timeline was a standing agenda item on

standing and ad-hoc committee agendas and the agenda of the full CPG meeting. The co-chairs also made efforts to start CPG meetings on time in order to allow for completion of CPG and committee tasks in a timely fashion.

**Additional End of Year (EY) Member Evaluation results compared to Mid-Year (MY)**

**Member Evaluation results:**

- **Member Understanding of Community Planning Process:** Eight-five percent (EY) of members stated they understood mostly everything or everything about the community planning process compared to 89% (MY). To further enhance their understanding of the community planning process, 35% (EY) indicated they had contacted and received feedback from other CPG members and advisors compared to 21% (MY).
  
- **Co-Chair Effectiveness:** The CPG has three co-chairs, one appointed by the DPH and two community representatives elected by the CPG. 89% of the members and advisors in the end- of the year survey felt the co-chairs run the monthly meetings smoothly and efficiently and conduct orderly meetings compared to 84% in the mid-year survey. Eighty-nine percent (EY) felt that the co-chairs provide adequate leadership compared to 84% (MY). Eighty-nine percent (EY) indicated that the co-chairs allow opportunities for group discussion (84% MY), and 89% (EY) felt that the co-chairs shared the responsibilities for facilitating the CPG meetings compared to 84% (MY).