

**Community Planning Group
Literature & Education Committee
Meeting Minutes**

Wednesday, July 22nd, 2009

12:00 - 2:00 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Yexsy Alicea (Co-Chair), Jennifer Chapman (Co-Chair), Terri Clark

Guest: Kai Chandler

Staff: Joseph Ellis, Monica Getahun, Mari Ross-Russell

Excused: Christopher Collins, Dionna Samuel

Call to Order

Y. Alicia called the meeting to order at 12:12 pm.

Approval of Agenda

Motion: T. Clark moved and Y. Alicia seconded to approve the meeting agenda after the group had reviewed the document. **Motion Passed:** All in favor.

Approval of Minutes (*May 27th, 2009*)

Motion: J. Chapman moved and Y. Alicia seconded to approve the minutes from the group's last meeting after the members of the Lit & Ed Committee had had taken some time to review the document. **Motion Passed:** All in favor.

Report of Staff

M. Ross-Russell reported that the CPG would be taking the CDC's membership survey at their next meeting. She reminded the group that the survey was used by the CDC as an indicator of the community planning being done by the CPG. She said that she would explain the survey to the CPG at the meeting, even though the Lit & Ed committee had done so in the previous year, because of time constraints. She then informed that group that the CDC had recently changed the way the survey was scored so that a response of "don't know" was now counted.

Report of Co-Chairs

Y. Alicia informed the group that she had recently changed her place of employment and that, as a result, would no longer have difficulty in attending meetings. She then introduced her new supervisor, Kai Chandler.

Discussion Items:

• **Planning for Factors Presentation**

J. Chapman directed the committee's attention to the presentation slides she had developed on the group's selected factors for reviewing interventions. She told the group that she had taken all of the procedural information for the presentation from the AED

Guidelines. She then asked whether the information in the third slide of the presentation, which concerned the committee's membership, was correct. In response, J. Ellis informed the group that Roberta Waite and Penny Killian were only on the group's mailing list and not actual members of the committee. As a result, the group decided to remove the two names from the slide.

M. Getahun directed the group's attention to the additional handout for the presentation, which listed and explained all of the committee's selected factors for reviewing interventions. As the group looked over the document, she explained the two different subsets underneath 'feasibility,' the sixth item on the list. She said that the first subset – adaptability, cost effectiveness, training, and staff – listed the feasibility factors that the committee had been able to make some reasonable assumptions about. She then reminded the group that the second set of feasibility factors – capacity, sustainability, and resources – would have to be determined by the Health Department after the committee had pared down their list of potential interventions. Additionally, she pointed out that "other," the last factor on the list, was the heading under which the committee captured any information that did not fit neatly into any of the other categories. In closing, she asked the group whether there were any elements to the document that they wanted to alter. However, no suggestions were given.

After J. Chapman had finished reviewing the slides for the presentation, Y. Alicia suggested asking the members of the CPG for any information they could give on programs operating in other cities at the end of their presentation. T. Clark proposed requesting information from the CPG on locally-developed interventions since details on them were not as readily accessible as were those concerning DEBIs and EBIS. The rest of the committee members agreed.

The group briefly discussed some of the CPG recruitment efforts after they had completed their planning for the presentation. M. Ross-Russell reported that the OHP was going to use the grantee's mailing list to disperse information about the CPG and membership applications to further the recruitment effort. T. Clark offered to forward the recruitment mailing to the AIDS Education Month mailing list when she received it.

- **Continue IDU Interventions Review**

The group continued their review of interventions using the HIV Prevention Intervention Information binders, two completed copies of worksheet 13 on Safety Counts and Project TEACH, and data on Safety Counts from the Prevention Provider Survey. M. Getahun informed the group that the two copies of worksheet 13 had been completed by Leah Hilsey, the interventions coordinator for both of the programs. T. Clark and Y. Alicia both noted that L. Hilsey had been very thorough in completing the worksheets.

Safety Counts – APPROVED

- Targets a specific population? Yes
IDUs and non-injection users who are not currently in any drug treatment programs

- Targets a specific behavior? Yes
High-risk sexual and drug use behaviors
- Effectiveness? Yes
“...1.5 times more likely to reduce drug- and sex-related risks compared with clients in the standard intervention” (Worksheet 13 – Safety Counts)
- Sound theoretical basis? Yes
Social Cognitive Model and the Theory of Reasoned Action
- Norms, Values, Consumer Preferences? Yes
Peer driven recruitment and indigenous leadership
- Intervention Feasibility?
 - Adaptability – Yes
 - Cost – currently running on \$10,000
 - Training – resources are available
 - Staff – the program works with 1 full-time coordinator and a few assistants; however, 5-6 full-time staff members are recommended.
- Ability to have the greatest impact on decreasing new infections? Yes
Clients were 1.5 more likely to reduce drug- and sex-related risks than those in standard interventions. They were also 2.5 times more likely to self-report an increase in condom use.
- Other considerations
Clients are tested for drug usage, which ensures adherence to the program. Also the intervention is already performed locally.

Sniffer – DENIED

- Targets a specific population?
Intranasal heroin users (at-risk for and/or history of IDU)
- Targets a specific behavior?
The program seeks to provide clients with safe injection procedures, self assertion and coping skills, a refusal to inject, and the ability to deal with depression.
- Effectiveness?
Patients were significantly less likely to report IDU than the control group
- Sound theoretical basis?
Social Learning Theory

The group rejected Sniffer before completely reviewing the program because of a number of issues uncovered during the discussion. Primarily, Y. Alicia noted that the targeted population, intranasal heroin users, was likely to be very small in Philadelphia.

Additionally, the group felt that powdered heroin was likely to be more expensive than the injectable variety and, thereby, more likely to be used only by wealthier individuals. They were further convinced of this idea after noting that the sample study was largely White and college educated.

BRAINE – APPROVED

- Targets a specific population? Yes
Active IDUs who are also heavy alcohol users
- Targets a specific behavior? Yes
Reduce alcohol use and injection-related risk behaviors
- Effectiveness? Unconfirmed
The study had only a small sample size, which kept it from being a DEBI.
- Sound theoretical basis? Yes
Motivational interviewing principles
- Norms, Values, Consumer Preferences?
N/A
- Intervention Feasibility?
 - Adaptability – recruitment is performed at needle exchange sites.
 - Cost – minimal – staff with motivational interviewing skills and only two sessions
 - Training – only for motivational interviewing
 - Staff – one counselor
- Ability to have the greatest impact on decreasing new infections?
Two-session ILI with a 97% retention rating after 5 months
- Other considerations
The study sample was 90% white and 62% male.

During the committee’s review of BRAINE, T. Clark stated that the program would likely be low cost despite the fact that it called for a Ph.D. level counselor. She explained that many counselors were trained in motivational interviewing through CRCS, which she felt negated the need for a Ph.D. The rest of the group agreed to approve the program based on the probability of its low cost and because its targeted population was likely very large in Philadelphia. However, J. Chapman noted that it could be worthwhile to get more information on BRAINE from other jurisdictions that were running the program.

The group moved into a discussion on Community Promise, noting that the CLI was currently being performed by GALAEI, COLOURS, and PHMC. Y. Alicia informed the group that she personally knew a few individuals who worked for Community Promise and offered to contact them to try and obtain some information about the program. M.

Ross-Russell stated that a number of providers were moving away from CLIs because of cost and the lack of control that could be maintained over such programs. K. Chandler reported that CHOP was giving a presentation on the effectiveness of Get Real, another CLI. As a result, he believed that the hospital might be able to provide some data on the program.

The Lit & Ed Committee took a moment to ascertain which IDU-targeting programs they had yet to review. As the group read over the list of programs currently funded in Philadelphia, Y. Alicia stated her belief that the committee did not need to review TIP because it was already known to work well and because it targeted Trans individuals, a highly underserved population. The rest of the group agreed. Before moving on to their next program for review, the committee requested that the OHP gather information on prison case management, CRCS, and Get Real.

M. Ross-Russell clarified that TEACH, TEACH Outside, and TEACH Spanish were all the same program. She said that, while all versions of the program targeted PLWHA, TEACH Outside targeted those with histories of incarceration while TEACH Spanish targeted those who were Spanish speakers with little or no understanding of English. Y. Alicia noted that Project TEACH had been running in Philadelphia for many years. T. Clark asked the group whether they felt it was necessary to formally review the program. J. Chapman asked whether the program had ever been evaluated, noting that DARE, a program that also had been running for many years, had recently been deemed ineffective after a thorough evaluation. Y. Alicia informed the group that many of her clients had been enrolled in TEACH and had given her great feedback about the program. M. Getahun directed the group's attention to L. Hilsey's completed worksheet 13 on TEACH, which was included in the handouts. She then suggested that the committee review the program for thoroughness and to have the process documented.

TEACH – APPROVED

- Targets a specific population?
Adult PLWHA
- Targets a specific behavior?
Prevention and treatment education, outreach, and advocacy
- Effectiveness?
Pre- and post-tests on knowledge, attitude, and behavior are given.
- Sound theoretical basis?
Health Belief Theory
- Norms, Values, Consumer Preferences?
Peers play an integral role in every session.
- Intervention Feasibility?
 - Adaptability – has been adapted for various subpopulations of PLWHA

- Cost – Under financial stress
 - Training – four sessions per year
 - Staff – one staff person
- Ability to have the greatest impact on decreasing new infections?
The program has been running for over 15 years and also provides linkage to care.
 - Other considerations
The program fulfills the prevention with positives goal of the CDC.

Old Business

J. Chapman said that she would resend assignments for the next interventions to review.

New Business

None

Review/Next Steps

- The Lit & Ed Committee planned for their presentation to the CPG on their factors for reviewing interventions.
- Afterwards, the group continued their program reviews, discussing Safety Counts, Sniffer, BRAINE, and Project Teach.
- At their next meeting, the group will continue reviewing interventions.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 1:59 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*May 27th, 2009*)
- CPG Literature & Education Update Presentation Slides
- Factors for Intervention Review Handout
- Worksheet 13 – TEACH
- Worksheet 13 – Safety Counts
- Excerpt from Prevention Provider Survey
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Literature & Education Committee

Wednesday, July 22nd, 2009

12:00 - 2:00 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Planning for Factors Presentation**
- **Continue IDU Interventions Review**

Old Business

New Business

Review/Next Steps

Announcements

Adjournment

*The next Lit. & Ed. Committee meeting will be held on **Wednesday, August 26th, 12:00 – 2:00 pm.***

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org, for updated committee meeting information.

Please contact the office at least 5 days in advance if you require special assistance

**Community Planning Group
Literature & Education Committee
Meeting Minutes**

Wednesday, May 27th, 2009

12:30 - 2:30 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Yexsy Alicea (Co-Chair), Jennifer Chapman (Co-Chair), Terri Clark, Christopher Collins, Dionna Samuel

Staff: Aneeza Agha, Joseph Ellis, Monica Getahun, Mari Ross-Russell

Call to Order

Y. Alicia called the meeting to order at 1:04 pm.

Approval of Agenda

Motion: After the group reviewed the agenda, J. Chapman moved and T. Clark seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*April 29th, 2009*)

The group took a moment to review the minutes from their last meeting. **Motion:** Afterwards, J. Chapman moved and Y. Alicia seconded to approve the document. **Motion Passed:** All in favor.

Report of Staff

• **Written Committee Reports at CPG Meetings**

M. Ross-Russell reported that, at their last meeting, the Monitoring Committee had decided that all future subcommittee reports in CPG meetings would be written instead of spoken. She said that written reports would allow for better documentation of the process and would allow more time in CPG meetings for prioritization work. She informed the group that, as part of the written report process, all subcommittees would take a moment at the end of their meetings to recount their decisions and next steps. She then pointed out the additional item at the end of the current meeting's agenda.

• **Lit & Ed Time Change**

M. Ross-Russell pointed out to the group that their current meeting time would not allow for OHP staff to write out their committee report before the start of the CPG meeting. As a result, she asked the committee whether they would be willing to start their meetings a half hour earlier to allow some time between the meetings for the report to be written. The group agreed that, moving forward, all of their meetings would be scheduled from 12:00 – 2:00 pm.

A. Agha informed the Lit & Ed Committee that she had made a few additions to the HIV Prevention Interventions Information binders. Primarily, she said that she had added CLIs to the binders because the CDC had recently endorsed them as EBIs and DEBIs. Additionally, she said that she had added two new programs to the binders. The first

program, she explained, was a CLI called the Teen Health Project, which sought to increase condom use and abstinence. The second program she had added was Focus on the Future, an ILI for Heterosexual African American men with an STD, which attempted to reduce infections through various behavior modifications. Lastly, she reported that she had made digital versions of the binders on CDs for greater portability.

Report of Co-Chairs

None

Discussion Items:

- **Process**

- **Best, Promising, and Local Interventions**

A. Agha informed the group that there were a few process-related details that the committee had to work out before continuing with their interventions review. Primarily, she said that, although the group had almost completed their review of best and promising interventions for IDUs, they had yet to investigate the locally-developed interventions for the population. Reminding the group that they had started to assign interventions for Heterosexuals, she asked them whether they first wanted to complete their review of programs for IDUs. Y. Alicia felt that it was more sensible for the committee to finish reviewing programs for IDUs primarily, since they were now familiar with the characteristics for the population. The rest of the group agreed.

A. Agha directed the group's attention to the list of locally-funded interventions in the Prevention Interventions Information binders. She said that they would have to determine which programs were not included in the compendium and, thereby, would likely require further investigation. She clarified, however, that it would not be necessary for the committee to review any case management programs. As the group compared the list of programs funded in Philadelphia to the compendium, Y. Alicia stated that she had already gathered information on Safety Counts.

- **Presentations for Information on Local Interventions**

A. Agha pointed out that, for some local interventions, program staff or administrators may have to come to a meeting to provide additional information for the committee. Therefore, she asked the group whether they would prefer such discussions take place in CPG meetings or Lit & Ed meetings. M. Ross-Russell noted that some preparation time would be required in planning such meetings, regardless of whether they occurred in CPG or Lit & Ed meetings. She said that questions would have to be developed for each of the interventions, taking into consideration that some of the programs targeted more than one population. T. Clark felt that individuals with additional information on local programs should come to Lit & Ed committee meetings. She pointed out that the group could try to coordinate such meetings so that multiple individuals with various interventions targeting the same population could come and discuss their programs together. She also suggested that the committee begin reviewing

locally-funded programs before any others since it would take some time to schedule meetings with multiple guests. The rest of the committee agreed with the suggestions; however, D. Samuel proposed requesting information from program workers before determining whether a meeting needed to be scheduled with them in order to save time. Y. Alicia agreed and noted that program staff and administrators could simply be asked to complete worksheet 13 instead of having to attend a meeting. The rest of the group supported the proposal.

- **Questions for CDC Project Officer, National CPGs, or AACO**

A. Agha reminded the group that, during their last meeting, they had discussed contacting the CDC Project Officer, other CPGs, or AACO to obtain additional information about the feasibility of some programs. She said that, in order to obtain such information, the committee would have to first agree on some specific questions to be asked. T. Clark suggested using the “questions to consider” in worksheet 13 for such purposes and the rest of the group agreed.
- **CPG Approval (Factors and Weights)**

M. Ross-Russell noted that, as part of the usual planning process, the Lit & Ed Committee would have to get approval from the CPG on some of their decisions. Specifically, she said that the factors they had selected for reviewing interventions at their last meeting and the eventual weights they would give those factors would have to be approved by the CPG. She suggested that the committee present their factors to the CPG in either June or July because by that time they would have worked with them sufficiently to be able to explain and support each. She noted that an explanation of the committee’s ongoing program review could also cause other CPG members to become more interested in the process. T. Clark agreed that having the committee explain their process would be good for all involved in the development of the next prevention plan. However, she noted that the committee would have difficulty developing the presentation before July. The rest of the group agreed and decided to wait before deciding whether to schedule the presentation for the June or July meeting of the CPG.

As the group had completed their process-related discussion, A. Agha took a moment to review their decisions. She noted that the group would review locally-developed programs for IDUs before moving on to the next population. If more information on a program was required for the group to make a decision on it, she continued, staff workers and administrators would be asked to complete Worksheet 13. She reiterated that such individuals would be asked to attend a Lit & Ed meeting for further discussion if the worksheets did not collect sufficient information from them. She also pointed out that OHP staff would contact AACO, the CDC Project Officer, or other CPGs for information on program feasibility if staff workers or administrators were unable to sufficiently respond. Lastly, she clarified that the group would present their factors for approval at the June or July CPG meeting. The group reiterated their agreement with the decisions and A. Agha said that OHP staff would develop a calendar for the group to better plan their next meetings.

- **Continue IDU Interventions Review**

The group took a moment to determine whether they would require additional information on any of the local interventions for IDUs. Y. Alicia stated that no additional information would be required on needle exchange programs because they had already been proven to work so well. However, she felt that more information would be required for Safety Counts and Project Teach. The rest of the group agreed. T. Clark clarified that, since TIP used Safety Counts, the two programs would not have to be reviewed separately. She then asked whether the committee would require more information on CRCS. A. Agha suggested that CRCS (Comprehensive Risk Counseling and Services) be reviewed separately at a later time because it targeted all populations and worked differently than the other programs. M. Ross-Russell supported the suggestion, adding that the group might want to have the grantee provide a presentation on the services.

Women's Co-Op – **ACCEPTED**

- Targets a specific population? Yes
African American women who use crack and are not in drug treatment
- Targets a specific behavior? Yes
Reduce sex risk behaviors and drug use
- Effectiveness? Yes
Since it is a DEBI, it has been proven effective. It also has a 77% retention rate
- Sound theoretical basis? Yes
African American Feminism, Empowerment Theory
- Norms, Values, Consumer Preferences? Yes
The program was specific to the targeted gender and culture.
- Intervention Feasibility? Yes
 - Adaptability – No, specific to gender and culture
 - Cost – Yes, cost effective – reasonable number of sessions; no high-paid staff; conducted for free in churches
 - Training – Yes
 - Staff – Yes, African American female living in the community
- Ability to have the greatest impact on decreasing new infections? Yes
Higher retention in the long run
- Other considerations
The targeted population is large locally; research conducted in North Carolina with a similar demography; the study was done recently ('99 – '02); addresses personal health (stress) and empowerment in addition to the behavior changes

While discussing Women's Co-Op, Y. Alicia noted that the program was both an ILI and a GLI. J. Chapman pointed out that the electronic version of Worksheet 13 would have

to be modified so that programs such as Women's Co-Op could be marked as both ILIs and GLIs.

Intensive AIDS Education – **ACCEPTED**

- Targets a specific population? Yes
Incarcerated, male adolescent drug users
- Targets a specific behavior? Yes
Eliminate or reduce HIV risk behaviors
- Effectiveness? Yes
Increased condom use over the control group
- Sound theoretical basis? No
The Problem-Solving Therapy approach is used
- Norms, Values, Consumer Preferences? No
None shown or available
- Intervention Feasibility? Yes
 - Adaptability – Yes, study conducted on mixed races but all males; similarity between NYC and Philadelphia prisons
 - Cost – Yes, cost effective – group discussions; four one-hour sessions in two weeks
 - Training – Yes
 - Staff – Yes, male counselor
- Ability to have the greatest impact on decreasing new infections? Yes
Short time frame, one counselor
- Other considerations
Possibly compare with information on AACO's Prison AIDS Project to ensure that the program would not duplicate any services.

The group debated whether or not Intensive AIDS Education would be necessary in Philadelphia because of the prison programs already in place in the city (prison case management and AACO's Prison AIDS Project). Initially, they decided not to make a decision on the program until after they got information from Philadelphia FIGHT and/or Phil DiBartolo about whether any prison programs were targeting youth. However, T. Clark felt that gathering such information about the program would go beyond the scope of the committee's duty, which she felt was only to determine whether programs were cost-effective and feasible. D. Samuel agreed and suggested that the group accept Intensive AIDS Education since youth were not being targeted in Philadelphia prisons and the program was relatively inexpensive. The rest of the group agreed.

Old Business

None

New Business

J. Ellis pointed out that the committee had to reschedule their June meeting since it was currently set for the same date as the prevention summit. The group briefly debated canceling their June meeting; however, they eventually opted to make their decision after the CPG decided whether to cancel or reschedule its own meeting.

Review/Next Steps

- The group decided that, in the event that they needed more information about a local program, they would invite individuals to their meetings to discuss the matter only if they could not get the data written
- When these questions arise, OHP staff will contact AACO, the Project Officer, or other CPGs for more information.
- OHP Staff will contact individuals with Project Teach and Safety Counts in order to have them answer the factor questions about the local programs.
- The committee will bring their factors to the CPG for approval in June or July, depending on whether or not the June meeting is canceled.
- The group spent the rest of their meeting reviewing Women's Co-op and Intensive AIDS Education, both of which they approved.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:25 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*April 29th, 2009*)
- OHP Meeting Calendar

CPG Literature & Education Update

What Does Lit & Ed Do?

- Ensuring that CPG members possess a working knowledge of the impact of HIV/AIDS in this region
- Keeping the CPG abreast of current trends, pertinent research and emerging populations
- Working with Office of HIV Planning Staff to coordinate the orientation and training of new and current members
- Other duties assigned by the CPG

Who Are We?

- Yexsy Alicea & Jennifer Chapman
(co-chairs)
- Terri Clark
- Christopher Collins
- Andrea Johnson
- Dionna Samuels
- Roberta Waite
- Penny Killian
- OHP staff: Aneeza, Monica, Mari, Joseph
- YOU !?!?!?

What is Lit & Ed Doing Now?

- **BACKGROUND**
 - Priority setting in HIV prevention community planning should lead to programs that respond to high-priority, community-validated needs within defined populations.
 - The CPG needs to develop two products that will serve as the basis for the comprehensive plan
 - Define target (or high-risk) population priorities (PP Committee)
 - Recommend interventions for each target population (Lit & Ed)

Steps in Selecting Interventions

- **Identify interventions**
- **Determine factors**
 - Weight factors
 - Rate interventions using factors
 - Score interventions using factors
 - Rank interventions
 - Review scores and select interventions

Identifying Interventions

- CDC expects CPG to identify a set of activities that we can use to prevent new HIV infections within high-risk target populations
- Our objective
 - creating a comprehensive list of proven and potentially effective HIV prevention interventions for each of the CPGs high-priority target populations

Identifying Interventions (cont)

- Consulting the CDC list of effective interventions (both best- and promising-evidence)
 - Listing (other) currently-funded HIV prevention interventions in Philadelphia
- FUTURE:
- Consulting the HIV prevention literature about effective interventions
 - If no interventions exist (in above searches) but are needed a literature search may be conducted

Determining Factors

- Factors – pieces of information to consider in decision making. By determining and then *using* factors, decisions are less likely to be based on personal – often biased – impressions rather than neutral information

Determining Factors (cont)

- The factors that we've chosen to look at:
 - Targets a specific population
 - Targets a specific behavior
 - Effectiveness
 - Sound theoretical basis
 - Norms, values, consumer preferences

Determining Factors (cont)

- The factors that we've chosen to look at (cont):
 - Intervention feasibility
 - Capacity
 - Sustainability
 - Resources
 - Ability to have the greatest impact on decreasing new infections
 - Other considerations based on state need

What's next?

- Continuing with the steps to identify effective interventions
- Recruiting CPG members to join our cause!
 - Meetings are held from 12-2:00 on the same Wednesday that the CPG general membership meeting is held.

Is this intervention specifically designed to reach a target population?
Ex: AA, Males, Incarcerated...

Is this intervention specifically designed to change the target behavior?
Ex: Needle sharing, condom use

What evidence exists to show that the intervention is effective?
Ex: Published results, reviews, evaluations

Is there a sound theoretical/behavioral/social science research theory used as a basis for the intervention design?

Is the intervention acceptable to the target population? Have members of the intended target audience either develop or provide input into the development of intervention?

OHP Staff will contact other CPGs, agencies, and CDC to find out specific information about intervention feasibility. Ex: adaptability, cost effectiveness, training, staff

Intervention

Does the capacity exist to develop the intervention. Ex: Expertise, funding, implementation time, cost

Is the intervention sustainable over time
Ex: consider funding cuts

Local resources available to assist in delivery of intervention
Ex: Current agencies

Capacity

Sustainability

Resources

Once the initial intervention list has been refined and narrowed, health department input will provide specific information about feasibility

When choosing between two interventions for the same target population, which one will reduce new infections and have the same efficacy for less resources?

Local needs, resources, literature research. Ex: Locally grown intervention, meta-analysis of interventions

Current intervention being done in jurisdictions with similar demographics to Philadelphia will be considered Ex: Baltimore

8. Other

Worksheet 13 – TEACH

Targets a specific population - Is the intervention specifically designed to reach the target population?

Project TEACH was designed to target HIV positive persons who were either recently diagnosed, expressed interest in learning more about HIV or desired to become a peer advocate for the HIV/AIDS community. Students are generally recommended by their physician, case manager, peer or activist mentors.

Targets a specific behavior - Is the intervention specifically designed to change the target behavior?

The intervention is aimed at increasing the self efficacy of consumers to communicate health concerns and needs to their physician, improve treatment adherence, examine personal strengths and challenges within treatment decision making and encourage empowerment, self advocacy and community level activism. This is just a sample of some of the desired outcomes.

Effectiveness What evidence exists to show that this intervention is effective in averting or reducing high-risk behavior?

Based on pre/post tests given for this 8 week intervention, we've found participants to be more aware and comfortable utilizing barrier protection, negotiating safer sex practices and engaging in generally high risk activities (drug use included).

Sound theoretical basis - Was behavioral and/or social science research and theory used as a basis for designing the intervention?

TEACH is based in health belief theory, examining participant's readiness for change, whether regarding medication, treatment or ability to advocate for themselves or others. We are able to meet participants 'where they are at' in order to customize each person's experience and desired outcome of the intervention. This includes assisting with written activities and providing resources for moving forward with newly acquired information (such as peer outreach, employment in human services).

Norms, values, consumer preferences - Is the intervention acceptable to the target population? Did members of the intended audience either develop the intervention themselves or provide input into its development?

Project TEACH has always been led or assisted by former graduates of the program and peers play an integral role in every session. In addition, participants inform both the intervention they are a part of and future groups of people who may benefit from it.

Intervention feasibility:

- **Capacity** Does the capacity exist to develop the interventions? Is the intervention practical, given available expertise, funding, and implementation time? Who can do this work? How much will it cost? How long will it take to be implemented?

This intervention has been running for quite a long time and has made a gigantic impact on the community of which it's a part. It's already been proven to be sustainable over time but is consistently under financial stress because of cuts in funding and misunderstandings about the benefits of education for the target population.

- **Sustainability** Is the intervention sustainable over time? If federal dollars were not available, how might this intervention be sustained?

As mentioned previously, TEACH has been a long standing intervention at FIGHT and has graduated over 2500 individuals living with HIV/AIDS. FIGHT has always managed, despite cutting corners, to maintain at least two 8 week sessions/year for more than 15 years.. We currently run 4 sessions per year and would gladly expand such a successful intervention to other areas of the city or beyond, given an increase in funding.

- **Resources** What are these resources? Are other resources available to assist delivery of the intervention?

We have built up resources for the program over the years and bring in a barrage of experts from many related fields, spanning from mental health to metabolic complications. A myriad of resources are given with the intervention binder and additional updates are made on a regular basis. Participants are encouraged to keep up with changing information and also to utilize staff members for the purpose following their graduation from the program.

- **Legality** Is this intervention legal? Do federal, state, or local laws or ordinances prohibit implementation of the intervention? If so, what are your funding sources?

The intervention is legal.

Ability to have the greatest impact on decreasing new infections - When choosing between two interventions for the same population, which one will reduce new infections for less money?

Other considerations based on state or local needs (Depends on state/local issues.)

Worksheet 13 – Safety Counts

Targets a specific population - Is the intervention specifically designed to reach the target population?

Safety Counts specifically targets persons who are actively using and are not already enrolled in a recovery program. The intervention acts as a non-judgmental, safe and informative alternative to entering a structured D&A environment, discussing the real implications of their risk behaviors but engaging participants in the principles of harm reduction. .

Targets a specific behavior - Is the intervention specifically designed to change the target behavior?

The backbone of Safety Counts is set in models of behavior theory, such as the Health Belief Model. It aims to encourage participants to utilize the stages of change to both identify their level of risk and their self efficacy towards changing or reducing those behaviors that are detrimental to their well being, create scenarios for transmission or affect treatment for HIV/HCV.

Effectiveness What evidence exists to show that this intervention is effective in averting or reducing high-risk behavior?

We keep track of goal progress and behavior change through qualitative note taking during individual sessions. In addition, we have documented changes between worksheets 1&2 for the duration of many participants' involvement in the program. These act as a pre/post example of risk behaviors indicated. When the CDC approved Safety Counts as a funded program, they indicated that 'clients who were enrolled in Safety Counts were about 1.5 times more likely to reduce their drug- and sex-related risks compared with clients in the standard intervention.' (http://www.effectiveinterventions.org/files/SF_FactSheet.pdf)

Sound theoretical basis - Was behavioral and/or social science research and theory used as a basis for designing the intervention?

As mentioned previously, much of the intervention was based on structured psycho-educational activities that focus on theories of behavior change such as the social cognitive model and theory of reasoned action. NIDA funded studies confirmed the outcomes of utilizing these models.

Norms, values, consumer preferences - Is the intervention acceptable to the target population? Did members of the intended audience either develop the intervention themselves or provide input into its development?

Safety Counts has been utilizing peer driven recruitment strategies to bring in some of the most vulnerable populations, by recognizing the importance of indigenous leadership. In agency, the intended audience became so involved with the program that boundaries had to be set in place for preventing any more influx of participants. Member became quickly comfortable with sharing information with each other and the staff about their goals and needs in terms of change.

Intervention feasibility:

- **Capacity** Does the capacity exist to develop the interventions? Is the intervention practical, given available expertise, funding, and implementation time? Who can do this work? How much will it cost? How long will it take to be implemented?

The recommendation of the CDC is for Safety Counts to support 5-6 full time staff members but has been run at FIGHT with only 1 full time coordinator and a few part time assistants. The budget for implementation covers expenses needed but would be grossly improved with the addition of qualified advocates. The sessions run for approximately 4 months at a time, consecutively, and is currently run to less than full capacity with under \$10,000.

- **Sustainability** Is the intervention sustainable over time? If federal dollars were not available, how might this intervention be sustained?

Safety Counts has been successful at FIGHT, despite the lack of staffing. This intervention can certainly be sustained but under current restrictions.

- **Resources** What are these resources? Are other resources available to assist delivery of the intervention?

All of the staff that are involved in running the program have been trained in resources available and recommended. Referrals are readily available to participants for testing, barrier protection, materials and counseling, among others.

- **Legality** Is this intervention legal? Do federal, state, or local laws or ordinances prohibit implementation of the intervention? If so, what are your funding sources?

The intervention is legal.

Ability to have the greatest impact on decreasing new infections - When choosing between two interventions for the same population, which one will reduce new infections for less money?

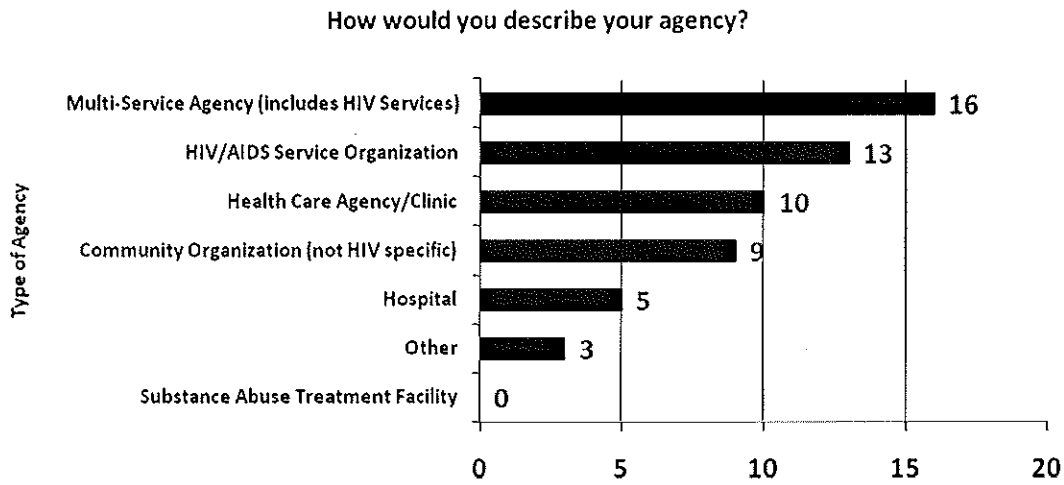
Other considerations based on state or local needs (Depends on state/local issues.)

Prevention Provider Online Survey (n=56)

Table 1. Respondent Position by Tenure in Agency

How long have you worked in the field of HIV/AIDS prevention and/or in this particular position?				
	Between 3 to 11 months	1 to 4 years	5 or more years	Total
Executive Director	0 (0%)	2 (20%)	8 (80%)	10 (100%)
Program manager/supervisor	3 (10%)	13 (42%)	15 (48%)	31 (100%)
Direct line staff	5 (50%)	4 (40%)	1 (10%)	10 (100%)
Other	0 (0%)	2 (20%)	2 (50%)	4 (100%)
Total	8 (15%)	21 (38%)	26 (47%)	55 (100%)

Figure 1. Respondents Description of Agencies



Safety Counts (n= 3). These individuals estimated serving an average 92% of African American clients and 7% who identified as Hispanic. For sex, the averaged responses reflected clients that were 70% male, 28% female, and 2% Transgender. For age, 83% were adult, while 17% were youth. Most clients HIV status was positive (72%) while 28% were negative. For special needs, 47% had mental health histories, 33% were homeless/accessing a shelter system and 13% had been incarcerated. One hundred percent of the respondents had a training on the intervention and all of them felt that it was effective in changing the client’s risk behaviors. Some noted barriers included “having narrow population categories”, “keeping retention” and “the paperwork associated with the intervention”. Some things that worked well with the intervention included: “discussion groups and information”, a respondent noted “this program works well with persons who are negative as well. We have also seen success with persons who are in the community correctional facilities”. Incentives were also something that worked well with this intervention. Overall, the respondents had a good understanding of what the intervention provided to its clients. Table 20 has the details. Finally, the respondents estimated serving an average of 92 clients the Safety Counts intervention in the last 12 months.

Table 20. What Does Safety Counts Do?

(N=3)	Yes
Increases information & skills for the client to make sound choices	3 (100%)
Reduces high risk drug use	2 (67%)
Eliminates or reduces sex risk behaviors	3 (100%)
Reaches target population in a culturally competent way	2 (67%)
Makes referrals to counseling and testing programs	1 (33%)
Helps set personal risk reduction goals	3 (100%)
Increases condom use	3 (100%)
Identifies and discusses barriers to risk reduction goals	3 (100%)
Other	0 (0.0%)