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Substance Abuse and Mental Health Services Administration

SAMHSA

Annual
AIDS Outreach Projects
National Training and Technical Assistance Meeting

**HOTEL WASHINGTON
PENNSYLVANIA AVENUE AT 15TH STREET, N.W.
WASHINGTON, D.C.**

OCTOBER 26-29, 1997



CSAT
**Center for Substance
Abuse Treatment**

"Outreach Research, Outreach Renewal"

**Annual
AIDS Outreach Projects
National Training and Technical Assistance Meeting
Full Agenda**

Sunday, October 26, 1997

5:00-7:00 Meeting Registration

WASHINGTON ROOM FOYER

7:30-9:30 Welcome Reception Buffet

SKY TERRACE

Project Display and Resource Tables

Tables for each project to assemble a display are available throughout the meeting beginning Sunday evening. Please locate your designated table, and set up your display as early as possible.

WASHINGTON ROOM

Monday, October 27, 1997

8:00-9:00 **Continental Breakfast**
WASHINGTON ROOM

9:00-10:30 **Opening And Welcome**
WASHINGTON ROOM

Master of Ceremonies: C. Godfrey Jacobs
Project Director, CSAT Outreach Technical Support Contract,
Hi-Tech International, Inc., Arlington, VA

Welcoming Remarks

David Thompson
Project Officer, Clinical Interventions Branch, CSAT

Todd Summers
White House Office of AIDS Policy

Clifton Mitchell
Chief, Clinical Interventions Branch, CSAT

Jane Taylor
Director, Division of Practice and Systems Development, CSAT

David J. Mactas
Director, Center for Substance Abuse Treatment

10:30-10:45 **BREAK**
WASHINGTON ROOM

Full Agenda

Monday, October 27, 1997

10:45-12:00

**Outreach Past, Present, and Future: A Review of
Community Health Outreach and Emerging Directions**
WASHINGTON ROOM

*Speakers share perspectives about the role and accomplishments of
outreach in addressing the HIV epidemic since the early 1980s,
exploring what we have learned and how this will shape outreach
efforts in the future.*

Moderator: ***Adolfo Mata***

Project Officer, Clinical Interventions Branch, CSAT

Diane Bonavota, C.S.W.

Senior Director, Program Planning and Development,
Project Return Foundation, Inc./Women in Crisis, New York, NY

Beri Hull

Community Training Associate,
National Association of People With AIDS, Washington, D.C.

Ruth Slaughter

Divisional Director/Project Director,
PROTOTYPES, Los Angeles, CA

12:00-1:30

LUNCH

PARKVIEW ROOM

Full Agenda

Monday, October 27, 1997

1:30-3:00

Current Trends in Outreach: Local and National Evaluator Report.

WASHINGTON ROOM

A review of results to date.

Moderator: **Karl White, Ph.D.**

Project Officer, Program Evaluation Branch, CSAT

National Cross-Site Update

Stephanie Bullman

Deputy Project Manager, National Evaluation Data and Technical Assistance Center, (NEDTAC), Caliber Associates, Fairfax, VA

Cost Data

Rick Harwood

National Evaluation Data and Technical Assistance Center, (NEDTAC), The Lewin Group, Fairfax, VA

Local Evaluation Update

Debbie Indyk, Ph.D.

Evaluator, Project Return and Project R.E.A.C.H, New York, NY

3:00-3:15

BREAK

WASHINGTON ROOM

Full Agenda**Monday, October 27, 1997****3:15-5:00 1.C Outreach, Post Traumatic Stress Disorder, and
Multiple Diagnosis Clients
ROOM 331****Moderator: *Laura Gillis*****Managing Director, Health Care for the Homeless, Baltimore,
MD*****Gustavo Martinez, Ph.D.*****Evaluator, Aliviane NO-AD, Inc., El Paso, TX*****Tessa Hill, R.N.*****HIV Programs Coordinator, Aliviane NO-AD, Inc., El Paso, TX*****Raymond Pomm, M.D.*****Medical Director, River Region Human Services, Inc., Jacksonville, FL****3:15-5:00 1.D Harm Reduction in Data Collection Strategies
COUNCIL ROOM*****Special Interest Session Recommended for All Project Directors*****Moderator: *David Thompson*****Project Officer, Clinical Interventions Branch, CSAT*****H. Richard Sampson*****Director, Division of State and Community Assistance, CSAT****5:00 Meeting Recess****EVENING ACTIVITIES AND DINNER ON YOUR OWN****EVENING MEETING ROOMS AVAILABLE UPON REQUEST**

Tuesday, October 28, 1997

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Continental Breakfast

WASHINGTON ROOM

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Federal and National Initiatives in HIV and Other Infectious Disease Prevention

WASHINGTON ROOM

Speakers will address the future of HIV prevention and treatment, including current agency initiatives, collaborative relationships, and directions for future research, programming and funding endeavors.

Moderator: Jane Taylor

Director, Division of Practice and Systems Development, CSAT

Paul Gaist, Ph.D., M.P.H.

Senior Program Analyst, Office of AIDS Research,
National Institutes of Health

Joan Holloway

Acting Director, Division of Training and Technical Assistance, Bureau of
HIV/AIDS Services,
Health Resources and Services Administration

T. Stephen Jones, M.D.

Assistant Director for Substance Abuse and HIV Prevention, Office of
HIV/AIDS,
Centers for Disease Control and Prevention

Julie Scofield

Executive Director, National Alliance of State and Territorial
AIDS Directors

Tuesday, October 28, 1997**10:15-10:45 Publicizing Your Success**
WASHINGTON ROOM

Moderator: *David Thompson*
Project Officer, Clinical Interventions Branch, CSAT

Ivette Torres
Director,
Office of Communications and External Liaison, CSAT

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SUITE 334

11:00-12:00 Data Issues and Core Variables

12:00-12:30 Taxonomy

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1:30-2:30 Publications and Other Forms of Dissemination

2:30-3:30 Developing the Monograph

Tuesday, October 28, 1997

11:00-12:30

Harm Reduction

WASHINGTON ROOM

Speakers will address the impact of a range of harm reduction strategies on community health and the provision of outreach services.

Moderator: ***Adolfo Mata***

Project Officer, Clinical Interventions Branch, CSAT

Richard H. Needle, M.P.H., Ph.D.

Chief, Community Research Branch, National Institute on Drug Abuse,
National Institutes of Health, Bethesda, MD

Pamela Lynch

Project Director,

Outreach and Pre-Treatment, Latino Family Services, Inc., Detroit, MI

Imani Woods, C.A.C.

Health Education Consultant,

President, Progressive Solutions, Seattle, WA

Dan Rawlins

State HIV Coordinator,

Texas Commission on Alcohol and Drug Abuse, Austin, TX

12:30-1:30

LUNCH

PARKVIEW ROOM

Tuesday, October 28, 1997

1:30-3:30

Concurrent Sessions

4 Concurrent Special Interest Sessions and Workshops

1:30-3:30

2.A Managing Loss and Grief

COUNCIL ROOM

Facilitator: ***Marianne Scippa, M.S., M.H.S.A.***

Training and TA Specialist, CSAT Outreach Technical Support
Contract, Hi-Tech International, Inc., Arlington, VA

1:30-3:30

2.B Outreach and Research: Seeking a Balance

SUITE 331

Moderator: ***Amy Juntunen***

Evaluation Consultant, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

Ron Coleman

Outreach Worker,

Birmingham Community Based Outreach, Birmingham, AL

Shannon Marsh, M.P.H.

Program Coordinator,

Birmingham Community Based Outreach, Birmingham, AL

Suzanne P. Murphy, Ph.D.

Evaluator, River Region Human Services, Inc., Jacksonville, FL,

Patrice Rashad

Outreach Worker,

Birmingham Community Based Outreach, Birmingham, AL

Tuesday, October 28, 1997

1:30-3:30 2.C Supervisory Skill Building
FEDERAL ROOM

Facilitator: *Ed McGowan*

**Project Director, Women's Personal Support Network,
The Village South, Inc., Miami, FL**

1:30-3:30 2.D Innovative Outreach Strategies
CAPITAL ROOM

Moderator: *Derya Williams*

**Project Coordinator, Outreach and Intervention Services,
River Region Human Services, Inc., Jacksonville, FL**

Oral Mucosal Transudate HIV Antibody Testing

Noemi Feijoo

**Outreach Specialist, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI**

Outreach in a Managed Care Environment

Nereida Diaz Rodriguez, Ph.D.

**Project Coordinator, PIASS,
Center for Addiction Studies, Bayamon, PR**

Diversity in Outreach

Gail Stern, M.S.N., R.N.C.S.

**Project Director, Accelerated Access Outreach Project,
Crozer Chester Medical Center, Chester, PA**

3:30-3:45

BREAK

IN CONCURRENT SESSION ROOMS

Tuesday, October 28, 1997

3:45-5:00

Concurrent Sessions

3 Concurrent Special Interest Sessions and Workshops

3:45-5:00

3.A Applying the *Stages of Change* Theory in Outreach Settings

FEDERAL ROOM

Moderator: ***Charles Collins, M.A.***

Project Director, Birmingham Community Based Outreach,
University of Alabama, Birmingham, AL

George Arlos

Project Coordinator, Addict Outreach and Resource Center,
Boston Public Health Commission, Boston, MA

Barbara Bush

Project Coordinator, Women's Personal Support Network, Miami, FL

Kathy Lindblad, R.N.

Project Supervisor, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

Paulette Theresa

Project Coordinator, PROTOTYPES, Los Angeles, CA

Tuesday, October 28, 1997

3:45-5:00 3.B Outreach in Correctional Settings

COUNCIL ROOM

Moderator: *Len Indyk, Ph.D.*

Evaluation/Data Consultant,

Project R.E.A.C.H. and Project Return, New York, NY

John R. Miles, M.P.A.

Special Assistant on Corrections and Substance Abuse,

National Center for HIV, STD, and TB Prevention,

Centers for Disease Control and Prevention

Joël DeWitt

Project Director, Project R.E.A.C.H.,

New York Department of Corrections, East Elmhurst, NY

**3:45-5:00 3.C The Relationship Between Outreach and Syringe
Exchange Programs**

CAPITAL ROOM

Moderator: *Tony Tommasello, Ph.D.*

Evaluator, HIV/AIDS Outreach to Homeless Substance

Abusers, Health Care for the Homeless, Baltimore, MD

Rhoda Creamer

Project Director, Addicts Outreach and Resource Center,

Boston Public Health Commission, Boston, MA

Debbie Indyk, Ph.D.

Evaluator,

Project Return and Project R.E.A.C.H., New York, New York

Pamela Lynch

Project Director, Outreach and Pre-Treatment,

Latino Family Services, Inc., Detroit, MI

5:00 Meeting Recess

6:00 Dinner and Tour of Washington, D.C. Monuments

Wednesday, October 29, 1997

8:00-9:00 **Continental Breakfast**
WASHINGTON ROOM

9:00-10:15 **Developing Collaborative Funding Strategies**
WASHINGTON ROOM

Emerging strategies for continuing to fund outreach initiatives.

Moderator: **David Thompson**
Project Officer, Clinical Interventions Branch, CSAT

Daphne Baille
Director of Communications and Marketing,
Treatment Alternatives for Safe Communities (TASC, Inc.), Chicago, IL

James Rivers, Ph.D.
Associate Professor,
University of Miami Comprehensive Drug Research Center, Miami, FL

10:15-10:45 **BREAK**
INCLUDES ADDITIONAL TIME FOR HOTEL
CHECK-OUT

10:45-12:00 **Concurrent Sessions**
4 Concurrent Special Interest Sessions and Workshops

10:45-12:00 **4.A Relapse Prevention for Outreach Professionals**
SUITE 331

Facilitator: **Michael B. Dunham**
Training and TA Coordinator,
CSAT Outreach Technical Support Contract,
Hi-Tech International, Inc., Arlington, VA

Full Agenda**Wednesday, October 29, 1997****10:45-12:00 4.B Stress Management**
CAPITAL ROOM

Facilitator: **Marianne Scippa, M.S., M.H.S.A.**
Training and TA Specialist, CSAT Outreach Technical
Support Contract, Hi-Tech International, Inc., Arlington, VA

10:45-12:00 4.C Outreach and Homelessness
COUNCIL ROOM

Moderator: **Sandra Tabron**
Project Coordinator,
Accelerated Access Outreach Project, Chester, PA

Angela Allen

Addiction Counselor, HIV/AIDS Outreach to Homeless Substance Abusers,
Health Care for the Homeless, Baltimore, MD

Joyce Black

Case Manager, PROTOTYPES, Los Angeles, CA

Laura Gillis

Managing Director, HIV/AIDS Outreach to Homeless Substance Abusers,
Health Care for the Homeless, Baltimore, MD,

Rolesia Rogers

Peer Leader, HIV/AIDS Outreach to Homeless Substance Abusers, Health
Care for the Homeless, Baltimore, MD

Tony Tommasello, Ph.D.

Evaluator, HIV/AIDS Outreach to Homeless Substance Abusers, Health Care
for the Homeless, Baltimore, MD

Louise Trehern

Project Director, HIV/AIDS Outreach to Homeless Substance Abusers,
Health Care for the Homeless, Baltimore, MD

Howard Wacker

Peer Leader, HIV/AIDS Outreach to Homeless Substance Abusers, Health
Care for the Homeless, Baltimore, MD

Wednesday, October 29, 1997

10:45-12:00

**4.D Community-Responsive Harm Reduction
Strategies**

FEDERAL ROOM

Facilitator: *Imani Woods, C.A.C.*
Health Education Consultant,
President, Progressive Solutions, Seattle, WA

12:00-1:30

Farewell Luncheon

PARKVIEW ROOM

Closing Comments

1:30

Meeting Adjourns

Substance Abuse and Mental Health Services Administration

SAMHSA

Annual
AIDS Outreach Projects
National Training and Technical Assistance Meeting

Hotel Washington
Pennsylvania Avenue at 15th Street, N.W.
Washington, D.C.

October 26-29, 1997



“Outreach Research, Outreach Renewal”

Meeting Theme And Goals

As Federal funding strategies have shifted in the last four years, both alcohol and other drug abuse and HIV prevention and treatment grant funding has been radically reduced. In the face of this dilemma, CSAT and its grantees have collaborated to refine evaluation and clinical strategies in order to demonstrate the efficacy of outreach programming. To support and advance this collaborative movement, the theme for this meeting is “*Outreach Research, Outreach Renewal...*”. This theme conveys the importance of documenting and communicating all aspects of AIDS outreach process and outcome research in order to strengthen and renew the theoretical, clinical, and financial basis on which the field rests. This meeting is designed as an interactive forum in which presenters address new and emerging technologies underscoring the need for continued funding and support in the AIDS outreach arena.

It is the goal of this meeting to help outreach professionals:

- *Explore critical research findings* which can help shape public policy and program development;
- *Review sound clinical principles* and varied applications to the operation of outreach practice; and
- *Support the growth and development of outreach professionals* to help sustain quality and innovation in the field.

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Project Evaluators' Working Session
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Agenda at a Glance

**Annual
AIDS Outreach Projects
National Training and Technical Assistance Meeting**

Agenda at a Glance

Sunday, October 26, 1997

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SKY TERRACE |
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WASHINGTON ROOM |
-

Monday, October 27, 1997

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WASHINGTON ROOM |
| 10:45-12:00 | Outreach Past, Present, and Future
WASHINGTON ROOM |

Monday, October 27, 1997, continued

12:00-1:30

**LUNCH
PARKVIEW ROOM**

1:30-3:00

**Current Trends in Outreach
WASHINGTON ROOM**

3:00-3:15

**BREAK
WASHINGTON ROOM**

3:15-5:00

Concurrent Sessions

3:15-5:00

**1.A Outreach to Women: What Makes it Special
CAPITAL ROOM**

3:15-5:00

**1.B Comprehensive Case Management: Bridging the Gap
Between Needs and Services
FEDERAL ROOM**

3:15-5:00

**1.C Outreach, Post Traumatic Stress Disorder, and
Multiple Diagnosis Clients
ROOM 331**

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**1.D Harm Reduction in Data Collection Strategies
COUNCIL ROOM**

5:00

Meeting Recess

Tuesday, October 28, 1997

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WASHINGTON ROOM |
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PARKVIEW ROOM |
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SUITE 331 |
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FEDERAL ROOM |
| 1:30-3:30 | 2.D Innovative Outreach Strategies
CAPITAL ROOM |
| 3:30-3:45 | BREAK
IN CONCURRENT SESSION ROOMS |



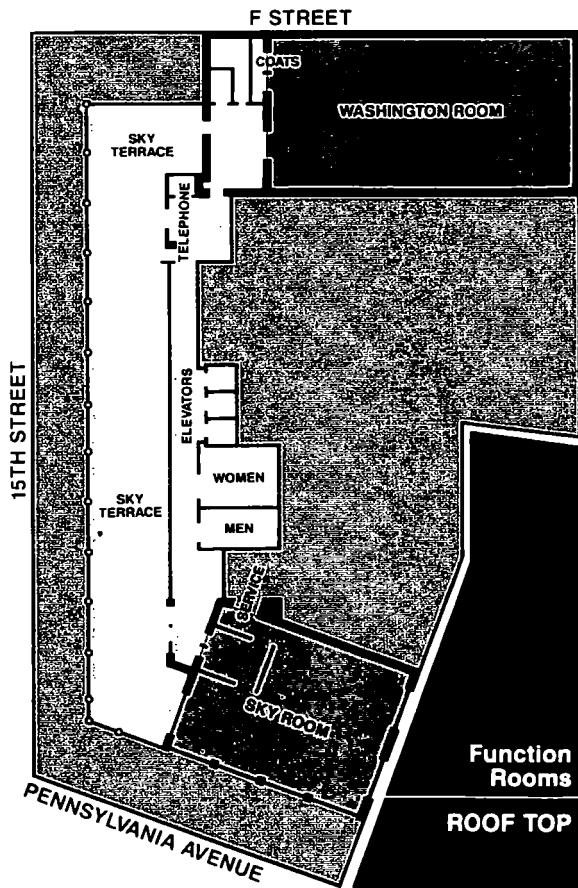
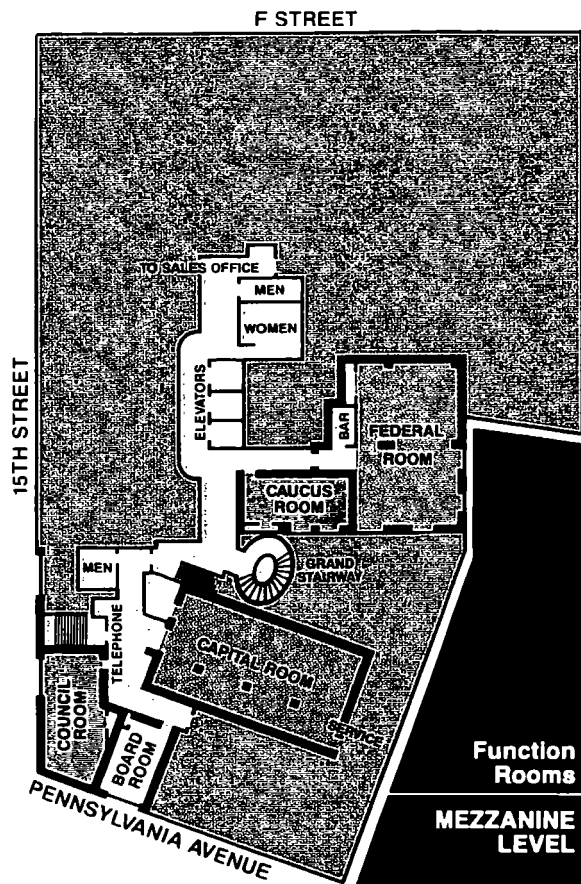
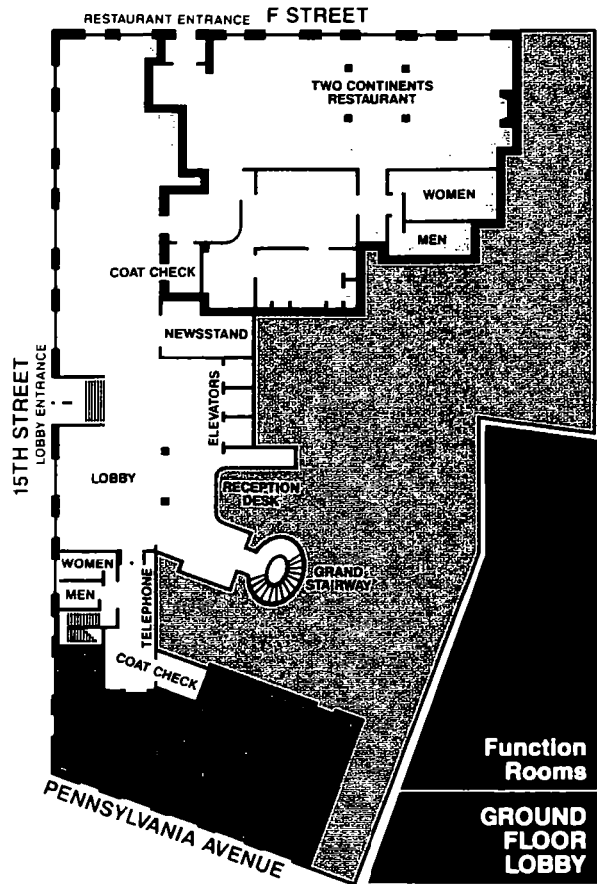
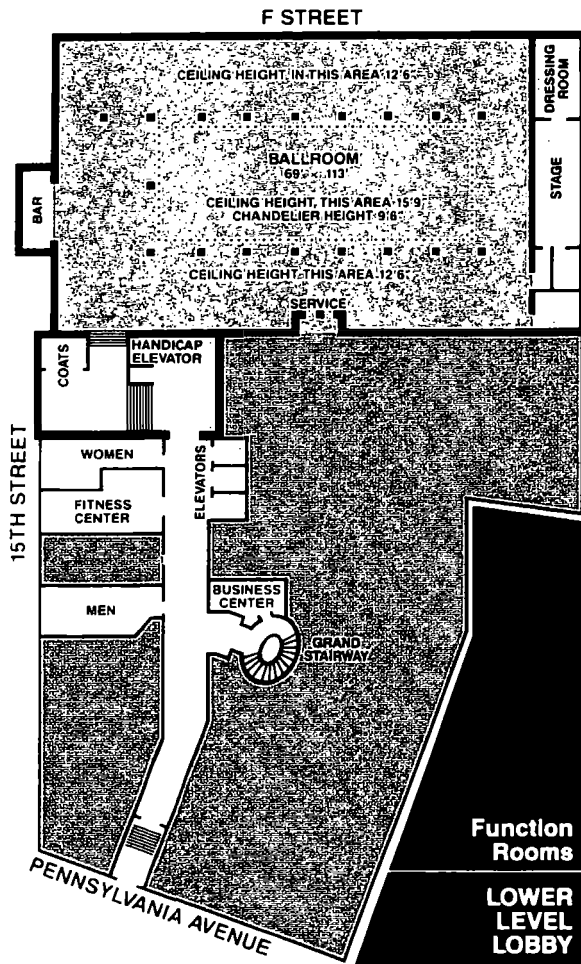
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FEDERAL ROOM |
| 12:00-1:30 | Farewell Luncheon
PARKVIEW ROOM |
| 1:30 | Meeting Adjourns |

Hotel Meeting Room Floor Plans



HOTEL WASHINGTON



Project Evaluators' Working Session

Meeting Agenda

Project Evaluators' Working Session Meeting Agenda

**Tuesday, October 28, 1997
11:00 AM - 3:30 PM**

SUITE 334

11:00-12:00 Data Issues and Core Variables

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PARKVIEW ROOM

**1:30-2:30 Publications and Other Forms of
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Facilitator: *Tony Tomasello, Ph.D.*, Evaluator, Health Care for the Homeless, Baltimore, MD

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Monday, October 27, 1997

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4 Concurrent Special Interest Sessions and Workshops

3:15-5:00 1.A Outreach to Women: What Makes It Special
CAPITAL ROOM

Moderator: *Nereida Diaz Rodriguez, Ph.D.*

Project Coordinator, PLASS, Center for Addiction Studies,
Bayamon, PR

Mari DaSilva, M.A.

Director, Women in Crisis, Project Return Foundation, Inc., New York, NY

Paulette Theresa

Project Coordinator, PROTOTYPES, Los Angeles, CA

Barbara Bush

Project Coordinator, Women's Personal Support Network, Miami, FL

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Gap Between Needs and Services
FEDERAL ROOM

Facilitator: *Kenny House*

Clinical Director, Community Outreach,
Coastal Horizons Center, Wilmington, NC

Monday, October 27, 1997

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Special Interest Session Recommended for All Project Directors

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Joan Holloway
Acting Director, Division of Training and Technical Assistance, Bureau of
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Health Resources and Services Administration

T. Stephen Jones, M.D.
Assistant Director for Substance Abuse and HIV Prevention, Office of
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Training and TA Specialist, CSAT Outreach Technical Support
Contract, Hi-Tech International, Inc., Arlington, VA

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Evaluation Consultant, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

Ron Coleman

Outreach Worker,
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Birmingham Community Based Outreach, Birmingham, AL

Suzanne P. Murphy, Ph.D.

Evaluator, River Region Human Services, Inc., Jacksonville, FL,

Patrice Rashad

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Tuesday, October 28, 1997

1:30-3:30 2.C Supervisory Skill Building

FEDERAL ROOM

Facilitator: ***Ed McGowan***

Project Director, Women's Personal Support Network,
The Village South, Inc., Miami, FL

1:30-3:30 2.D Innovative Outreach Strategies

CAPITAL ROOM

Moderator: **Derya Williams**

Project Coordinator, Outreach and Intervention Services,
River Region Human Services, Inc., Jacksonville, FL

Oral Mucosal Transudate HIV Antibody Testing

Noemi Feijoo

Outreach Specialist, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

Outreach in a Managed Care Environment

Nereida Diaz Rodriguez, Ph.D.

Project Coordinator, PIASS,
Center for Addiction Studies, Bayamon, PR

Diversity in Outreach

Gail Stern, M.S.N., R.N.C.S.

Project Director, Accelerated Access Outreach Project,
Crozer Chester Medical Center, Chester, PA

3:30-3:45

BREAK

IN CONCURRENT SESSION ROOMS

Tuesday, October 28, 1997

3:45-5:00 **Concurrent Sessions**

3 Concurrent Special Interest Sessions and Workshops

3:45-5:00 **3.A Applying the *Stages of Change* Theory in Outreach Settings**

FEDERAL ROOM

Moderator: ***Charles Collins, M.A.***

Project Director, Birmingham Community Based Outreach,
University of Alabama, Birmingham, AL

George Arlos

Project Coordinator, Addict Outreach and Resource Center,
Boston Public Health Commission, Boston, MA

Barbara Bush

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Kathy Lindblad, R.N.

Project Supervisor, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

Paulette Theresa

Project Coordinator, PROTOTYPES, Los Angeles, CA

Tuesday, October 28, 1997

3:45-5:00 3.B Outreach in Correctional Settings
COUNCIL ROOM

Moderator: ***Len Indyk, Ph.D.***
Evaluation/Data Consultant,
Project R.E.A.C.H. and Project Return, New York, NY

John R. Miles, M.P.A.
Special Assistant on Corrections and Substance Abuse,
National Center for HIV, STD, and TB Prevention,
Centers for Disease Control and Prevention

Joél DeWitt
Project Director, Project R.E.A.C.H.,
New York Department of Corrections, East Elmhurst, NY

3:45-5:00 3.C The Relationship Between Outreach and Syringe
Exchange Programs
CAPITAL ROOM

Moderator: ***Tony Tommasello, Ph.D.***
Evaluator, HIV/AIDS Outreach to Homeless Substance
Abusers, Health Care for the Homeless, Baltimore, MD

Rhoda Creamer
Project Director, Addicts Outreach and Resource Center,
Boston Public Health Commission, Boston, MA

Debbie Indyk, Ph.D.
Evaluator,
Project Return and Project R.E.A.C.H., New York, New York

Pamela Lynch
Project Director, Outreach and Pre-Treatment,
Latino Family Services, Inc., Detroit, MI

5:00 Meeting Recess

6:00 Dinner and Tour of Washington, D.C. Monuments

Wednesday, October 29, 1997

8:00-9:00 **Continental Breakfast**
WASHINGTON ROOM

9:00-10:15 **Developing Collaborative Funding Strategies**
WASHINGTON ROOM

Emerging strategies for continuing to fund outreach initiatives.

Moderator: **David Thompson**
Project Officer, Clinical Interventions Branch, CSAT

Daphne Baille
Director of Communications and Marketing,
Treatment Alternatives for Safe Communities (TASC, Inc.), Chicago, IL

James Rivers, Ph.D.
Associate Professor,
University of Miami Comprehensive Drug Research Center, Miami, FL

10:15-10:45 **BREAK**
INCLUDES ADDITIONAL TIME FOR HOTEL
CHECK-OUT

10:45-12:00 **Concurrent Sessions**
4 Concurrent Special Interest Sessions and Workshops

10:45-12:00 **4.A Relapse Prevention for Outreach Professionals**
SUITE 331

Facilitator: **Michael B. Dunham**
Training and TA Coordinator,
CSAT Outreach Technical Support Contract,
Hi-Tech International, Inc., Arlington, VA

Wednesday, October 29, 1997

10:45-12:00 4.B Stress Management
CAPITAL ROOM

Facilitator: ***Marianne Scippa, M.S., M.H.S.A.***
Training and TA Specialist, CSAT Outreach Technical
Support Contract, Hi-Tech International, Inc., Arlington, VA

10:45-12:00 4.C Outreach and Homelessness
COUNCIL ROOM

Moderator: ***Sandra Tabron***
Project Coordinator,
Accelerated Access Outreach Project, Chester, PA

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Care for the Homeless, Baltimore, MD

Wednesday, October 29, 1997

**10:45-12:00 4.D Community-Responsive Harm Reduction
Strategies**

FEDERAL ROOM

Facilitator: *Imani Woods, C.A.C.*
Health Education Consultant,
President, Progressive Solutions, Seattle, WA

12:00-1:30 Farewell Luncheon
PARKVIEW ROOM

Closing Comments

1:30 Meeting Adjourns

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DEVELOPING COLLABORATIVE FUNDING STRATEGIES
for continuation of outreach initiatives

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Transparency # 1:

**DEVELOPING COLLABORATIVE FUNDING STRATEGIES
for continuation of outreach initiatives**

Transparency # 2:

1. develop = create or improve what existed before
2. collaborate = to affiliate, cooperate and participate, to ally, band, join or unite (rather than to compete, challenge and quarrel)
3. strategy = approach, campaign, design or plan
4. The title of this panel {developing collaborative funding strategies} suggests that *past* strategies by groups {such as yours} seeking funds may typically have been independent of others and more characterized by competition and quarreling with one another for scarce resources than by cooperation and collaboration.
5. Collaborative funding strategies for continuing outreach activities = plans or approaches by two or more groups within a community that involve their united efforts to persuade one — or more likely, multiple — sources to provide funds for their coordinated outreach activities
6. In today's turbulent health care and human services environments, those who truly care about improving the human condition must 'work smarter' and more harmoniously in concert with like-minded individuals and groups.
7. This means that AIDS outreach groups — which usually target particular sub-groups, such as gay men, injection drug abusers, women in the sex-trade, jail and prison inmates, the homeless, et al. — must develop **collaborations with other groups working to serve the same subgroups or their larger inclusive populations**, not just those group or population members who are HIV+ or who have AIDS.

Transparency # 3:

8. If prospects are to improve for sustaining funding for outreach projects such as yours, your groups — and agencies which administer public health funds and those who set policy which govern the operations of these agencies — must truly embrace a conceptualization of health that includes complete *physical, mental, and social* well-being, not merely the absence of disease or infirmity.
9. All of you understand and agree, I'm sure, that individuals at-risk for HIV infection and especially PWA tend to be *unhealthy* — in the sense just noted — along several dimensions. As a practical matter, they must seek corresponding services from a diverse range of agencies and programs.
10. Consequently, successful collaborative strategies to obtain continuation funding for AIDS outreach programs may well involve two or more radically different parties combining efforts to seek funds from two or more radically different funding sources.

Transparency # 4:

11. Having just completed a report on sustaining efforts by five 1st round Target Cities sites provides me with a few observations that are worth considering by those demonstration projects assembled here today:
- Tremendous progress is possible in forging **alliances among historically competitive and/or distrusting community entities**. The respondents interviewed cited many examples of both intangible and concrete positive outcomes which they attributed to the salutary need-which-became-desire to work together that was fostered and nurtured by their demonstration projects.
 - Larger system dynamics critically affect the ability of localities to implement and sustain demonstration programs. Examples include:
 - degree of supportive involvement by the SSA and associated communicated likelihood that innovations will be continue to be funded after the demonstration period;
 - the nature and intensity of historical divisions within the community by race/ethnicity, by public-private sector ownership of services, by perspectives of the 'true nature' of the problems (moral, legal, medical, social);
 - state and local government priorities that affect resource allocations and ability of diverse agencies to shift and share costs of service delivery to common clientele;
 - the concurrent health care and welfare system reforms/revolutions.
 - Another pair of lessons learned:
 - demonstration program impacts may be **delayed** - the value of demonstration project elements may not be appreciated until some point after the project has ended.
 - important outcomes may be **conceptual** as opposed to instrumental, i.e., there may be changes in perceptions and interaction patterns that can have continuing (although sometimes time-lagged) impacts on governmental executives, policy makers, community opinion leaders and agency administrators. Evaluators can be important change-agents in this regard.

Transparency # 5:

12. Evaluation data can be — but often are not — important in persuading funding agencies to replace demonstration dollars with either *temporary sustaining* (foundations may be useful in this regard) or *continuing budgeted dollars* (almost always from governmental sources). With thanks to Shadish, Cook and Leviton (Foundations of Program Evaluation: Theories of Practice, Sage 1991) the following are some of the key questions that will determine whether program evaluations will be useful in impact continuing funding or not:

- **Are evaluators willing and able to actively assist in the use of results?**
Academically-oriented social scientists devote relatively little advance thought to how results of their investigations will be used. Their scientific peers are the primary audience or 'intended users', and journal or book publication are the primary modes of communication. This is inappropriate and insufficient as regards evaluation research. Evaluators must take active steps to increase the use of their results, including seeking answers to the following questions:
- **What kind of use, e.g., instrumental or conceptual, is desired and why?**
 - What is least known or most mis-understood about the problem and the intervention?
- **If instrumental use is the goal, have potential users been identified?**
 - Have those users been asked about the types of information they want?
 - How might they actually use the evaluation results?
 - Is the information they want readily available?
 - Is there a known deadline and can it be achieved?
- **If enlightenment is the goal, who is the target audience?**
 - How is their thinking about the problem and intervention to be affected?
 - Is the interest of this audience enduring or transient?
 - How can they be reached?
- **If both uses are desired, what is the desired balance?** (given the virtually impossibility of designing and executing an evaluation that serves multiple uses equally well)
- **What are the characteristics of the particular intervention being evaluated?**
 - Program, project or element?
 - What do the stakeholders want to know?
 - Consequently, what are the most useful questions to ask?
- **How should the results be communicated?**
 - Report interim results?
 - Action recommendations?
 - Tailored reports for various stakeholder audiences?
 - Can (should) results be disseminated through mass media outlets?

Transparency # 6:

13. Communications between evaluators and consumers of their reports has been described as "a **dialogue between the hearing and speaking impaired**". Best-intentions often fail to overcome differences in **experience, training, and vocabularies** or unspoken **divergent expectations**, unidentified **different constituencies**, unarticulated **frames of reference and world views**.

The following are some common negative perceptions and perspectives that presage evaluation reports that have virtually no chance to make an impact:

EVALUATIONS DO NOT ALWAYS PRODUCE DEFINITIVE ANSWERS. Evaluations (indeed, all scientific endeavors) involve investigator choices, e.g. methods, cutting points, analytic schemes, interpretations, recommendations. Evaluators must make assumptions which cannot always be empirically verified, and they themselves often point out imperfections and weaknesses in their methodologies. Decision makers may or may not attend to stated assumptions or recognize unstated ones, but they will often focus on the weaker aspects of evaluation reports.

Also, the more complex the evaluation, the more jargon used, the more hidden or equivocating the conclusion, the more caveats in the preamble, the thicker the report, the more obscure the evaluator, and the more controversial or sensitive the issue, the more likely the decision maker is to discard and ignore or attack the evaluation. (If the evaluation is attacked, at least it can be discussed and defended; unfortunately, ignoring evaluations is the more typical reaction which is the worst possible outcome from the perspective of evaluators.)

EVALUATIONS WHICH DON'T SUPPORT PREFERRED CONCLUSIONS ARE 'BIASED' AND IGNORED. DECISION MAKERS HAVE NEITHER THE TIME NOR INCLINATION TO ASSESS THE QUALITY OF AN EVALUATION. The skills employed, the soundness of the methodology, and the quality of thought shown in the evaluation are often either unrecognized, unappreciated, or considered irrelevant. Results which support the decision makers' personal views are trumpeted while those which do not are rejected as "biased" or serving the opposition's cause and are shelved.

EVALUATORS HAVE THE ANNOYING HABIT (TO DECISION MAKERS) OF RESTATING QUESTIONS. For example, the policymaker may have asked "how many addicts were really 'cured'?" s/he is not really interested in whether treatment improves social functioning and reduces criminal activity. The suspicion is that the evaluator restated the question simply to make the work easier rather than "operationalizing" it, i.e. making it measurable and answerable.

DECISION MAKERS ARE USUALLY ELECTED OFFICIALS WITH POLITICAL CONSTITUENCIES WHOSE PREFERENCES MAY TAKE PRECEDENCE OVER EVALUATION RESULTS. If the proposed location of a clinic raises neighborhood objections because of the fear of increased crime or lowered property values and the residents enlist the support of their legislator, the "larger political" judgement will likely prevail, regardless of any objective analysis showing that the fears are unfounded. Elected officials often assert that they are better situated and informed ("more in touch with the pulse of the public") to make judgements (which they fail to note contain well-hidden political considerations that are cloaked with purported objective analysis) than evaluators.

Transparency # 7:

14. How can the prospects for evaluation results to be used by decision makers be improved? These suggestions may prove helpful:

JOINTLY IDENTIFY THE CRITICAL QUESTIONS AND AUDIENCES. Evaluators and decision makers should agree up front about critical questions and audiences, then include these in a mission statement, a written scope of work, and a framework for presentation of results.

FORGET THE RESEARCH PAPER STYLE LEARNED IN GRADUATE SCHOOL OR USED IN PROFESSIONAL PUBLICATIONS. It turns off decision makers and leads them to suspect the evaluator's chief motivation is resume or curriculum vita enhancement.

USE APPROPRIATE UNITS OF ANALYSIS. Organize results by geographic locations (political jurisdictions, planning districts, etc.) that relate to the decisions to be made. If census areas or zip codes are used as analytic units, present results in best-approximations of generally-recognized or politically meaningful boundaries.

PRODUCE RESULTS QUICKLY, INCLUDING INTERIM REPORTS IF NECESSARY; PROGRESSIVELY REFINE ESTIMATES AS CONDITIONS ALLOW. For questions that are truly important, partial answers are useful and create momentum for increasing support. Evaluators should educate consumers that data quality, definitions and systems, levels of cooperation and skills of staff usually improve incrementally. Thus, initial imprecise estimates may have to be revised and initial questions may have to be restructured from general to more specific ones, or vice versa. Priorities may have to be drawn and the focus may have to be narrowed or broadened to respond rapidly to questions which can be answered with available data and staff.

Transparency #7 (continued):

PRESENT MULTI-LEVEL REPORTS TO SATISFY DIFFERENT LEVELS OF

INTEREST. Consumer desires for evaluation information spans a continuum from the "bottom line" to detailed explanations of methodology and citation of other relevant publications, from "reporting the time" to "explaining how to make a watch". Therefore, evaluation reports should be structured accordingly. For example, they can be divided into four parts:

- a. **Executive Summary** - a maximum of two pages in plain English, limited to critical questions and audiences. Use "bullet" format with critical points presented first; they are not buried in the middle or at the end of the document. Recommendations are included only if requested.
- b. **Body of the Report** - organized like a table of contents with summarizing headlines. If tables are included, they should be concise and understandable to a lay person; the numbers should never contradict - someone always checks closely and disagreeing numbers can (and often are used by opponents to) discredit the entire evaluation report. If data permit and it is requested, a cost-effectiveness analysis can be included.
- c. **Conclusions** - as noted in the Executive Summary, use "bullet" format, but expand to short paragraphs which can be used by decision makers in interviews, debate, and press announcements. Conclusions should be statements which stand alone and are somewhat oversimplified. If a cost effectiveness analysis has been included in the body of the report, appropriate cost-benefit conclusions can be stated here. Provide conclusions, not recommendations, unless they are specifically requested; decision makers usually don't want specific policy decisions made for them.
- d. **Appendix** - contains technical detail (material, caveats, procedures, methodology, cost-benefit calculations, etc.), complex tables, and any other supporting or explanatory notes, e.g. any material useful to other researchers, critical readers and reviewers, and as documentation needed for replications, but likely to be disconcerting "noise" to the decision makers.

FOLLOW THE THREE "P-A" RULES. In conducting evaluative studies for governmental decision makers, evaluators should strive to be:

- o **PRACTICAL**, remembering to **ANSWER** critical questions;
- o **PECUNIARY** (if requested), addressing **ACCOUNTABILITY** for public dollars;
- o **POLITICAL**, in the sense of providing direction for **ACTION** for critical

Transparency # 8:

In summary, I want to commend and encourage you to build upon your demonstration projects. They are important engines for knowledge development and models for developing and testing improvements in existing and emergent service delivery systems which are increasingly stressed to serve stigmatized vulnerable populations with their multiple problems.

These populations critically need service systems that are integrated both horizontally and vertically.

I urge you to ally yourselves with disparate groups and agencies, to form either informal or formal provider networks, alliances, etc. Increase your efforts, resources and sophistication in using evaluation data more effectively to garner needed funding.

Failure to attend to these issues and to achieve collaborations among disparate groups and agencies may well result in a dwindling number of community programs which will become increasingly overwhelmed. Critical aspects of care will be displaced onto inappropriate institutions and families with inadequate resources. The public impact will be a less healthy society with a lower quality of life.

GLOSSARY

DEVELOPING COLLABORATIVE FUNDING STRATEGIES

DEVELOP = CREATE OR IMPROVE WHAT EXISTED BEFORE

COLLABORATE = AFFILIATE, COOPERATE, PARTICIPATE
(~~compete, challenge, quarrel~~)

STRATEGY = APPROACH, CAMPAIGN, DESIGN OR PLAN

IMPLICATIONS

PAST STRATEGIES - SEPARATE, COMPETITIVE, DIVISIVE?

CURRENT/FUTURE STRATEGIES -

- ◆ **JOINT PLANNING ... TWO OR MORE GROUPS**
- ◆ **UNITED EFFORTS TO PERSUADE MULTIPLE SOURCES**
- ◆ **PLAN AND RATIONALE FOR COORDINATED EFFORTS**

FIRST PRINCIPLES

HEALTH = *PHYSICAL, MENTAL AND SOCIAL* WELL-BEING

PWA & HIGH HIV-RISK POPULATIONS:

- ◆ **MULTIPLE HEALTH PROBLEMS**
- ◆ **MULTIPLE SOURCES OF *HEALTH* SERVICES**

IMPLICATIONS

CONTINUATION STRATEGIES FOR AIDS OUTREACH:

- ◆ **COLLABORATION OF MULTIPLE DIVERSE FUND SEEKERS**
- ◆ **APPLICATIONS TO MULTIPLE DIVERSE FUNDING SOURCES**

LESSONS LEARNED FROM TARGET CITIES STUDY

- **HISTORICAL ANTAGONISTS CAN FORM ALLIANCES**
- **LARGER FORCES, POLICIES, DECISIONS**
 - **nature, intensity of historical community divisions**
 - **state support: past, present, and planned future**
 - **resource allocation, shifting & sharing policies**
 - **concurrent health care and welfare system reforms**
- **PROGRAM/PROJECT IMPACTS MAY BE DELAYED**
- **CONCEPTUAL AND INSTRUMENTAL OUTCOMES**

EVALUATION DATA:

QUESTIONS THAT MAY DETERMINE ITS USE IN CONTINUATION FUNDING EFFORTS

- **Willingness and ability to participate by evaluators?**
- **Instrumental or conceptual use desired and why?**
- **Have potential instrumental users been identified?**
- **Who is the target audience for enlightenment?**
- **Balance of instrumental and enlightenment uses?**
- **Intervention characteristics to be evaluated?**
- **How to communicate the results?**

**BE ALERT TO NEGATIVE PERSPECTIVES
RE: EVALUATION RESEARCH**

- **SELDOM PROVIDES DEFINITIVE ANSWERS**
- **RESULTS CONTRARY TO PREFERRED CONCLUSIONS
ARE 'BIASED' AND IGNORED**
- **DOES NOT ANSWER QUESTIONS AS ASKED**
- **'CONSTITUENCY PREFERENCES' TAKE PRECEDENCE**

SUGGESTIONS:

IMPROVING USE OF EVALUATION RESULTS

- **FIRST IDENTIFY CRITICAL QUESTIONS, AUDIENCES**
 - **USE APPLICABLE UNITS OF ANALYSIS**
 - **TAILOR PRESENTATION STYLE TO AUDIENCE**
 - **INTERIM REPORTS, SERIES OF IMPROVED ESTIMATES**
 - **MULTI-LEVEL REPORTS**
 - **Executive Summary**
 - **Body of the Report**
 - **Conclusions**
 - **Appendix**
-
- **USE THE THREE "P-A" RULES**
 - **be PRACTICAL, ANSWER critical questions**
 - **be PECUNIARY, address ACCOUNTABILITY**
 - **be POLITICAL, i.e. provide direction for ACTION**

SUMMARY

- **DEMONSTRATIONS ARE SOURCES OF NEW KNOWLEDGE FOR VULNERABLE STIGMATIZED MULTIPLE PROBLEM POPULATIONS WHICH CRITICALLY NEED HORIZONTALLY AND VERTICALLY INTEGRATED SERVICE SYSTEMS**

- **DISPARATE GROUPS MUST ALLY THEMSELVES AND USE EVALUATION DATA MORE EFFECTIVELY**

- **SKILLFUL USE OF DATA FROM WELL EVALUATED DEMONSTRATIONS CAN HELP PREVENT:**
 - ☐ **DWINDLING NUMBER OF INCREASINGLY OVERWHELMED COMMUNITY PROGRAMS**
 - ☐ **DISPLACEMENT OF CRITICAL ASPECTS OF CARE**
 - **INAPPROPRIATE INSTITUTIONS**
 - **FAMILIES WITH INADEQUATE RESOURCES**
 - ☐ **OVERALL IMPACT: DIMINISHED QUALITY OF LIFE**

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National Training and Technical Assistance Meeting

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