



# Section 1

## Goals & Objectives

## About the Committees

In the late summer of 2002, the RICPG restructured its committees to further develop leadership in the group, increase member participation in the planning process, and apportion the work of the group in a more logical and strategic manner. The three standing committees—Community Empowerment, Strategy Planning, and REACH/Capacity Building—created a document establishing a standing meeting time, overall goals and areas of concern, and specific issues to be addressed by the committee. Implementation of this strategy, with revisions identified during the implementation process, has been ongoing.

Each of the three committees is responsible for a portion of the RICPG's goals and objectives. Their work is discussed below.

### **Community Empowerment Committee**

The Community Empowerment Committee is responsible for Goal 1, Objectives A, B, and C, and Attributes 1–18. The Committee's ongoing efforts focus on recruitment and retention of members and improving the overall efficiency of the RICPG.

For example, the Community Empowerment Committee's work includes an ongoing discussion about preserving the confidentiality of HIV-infected members and members within other priority populations. When people are recruited because they have insights and/or experiences that other members may not have, there is a risk of breaching confidentiality in certain settings. The situation requires sensitivity around inclusion, parity, and cultural competence that may not be an issue in other community groups. The balancing of such issues is the charge of the Empowerment Committee, and it is a charge that the Committee takes very seriously.

### **Recruitment**

Recruitment is going well, with the addition of five new members since January 2004.

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### *Youth*

The Committee has further charged itself with filling the gaps of representation in the current membership, having agreed that settling for minimal compliance was not an option.

The struggle to recruit and include youth members in a meaningful way continues. The RICPG does have youth-serving agencies as members, but the Community Empowerment Committee is interested in building the capacity of the RICPG to bring youth on board as members. Issues such as RICPG and Committees and Task Force meeting times, the length of the meetings, and methods of participation make it difficult to address this issue.

Solution-oriented discussions have included: collaborating with the Youth Task Force for creative insight, creating a capacity-building training on this issue through the REACH/Capacity Building Committee, and creating incentives and/or a separate RICPG youth advisory group with representation at general RICPG meetings.

### *MSM*

While RICPG has MSM representation, it does not currently have any MSM/IDU members—and the MSM Task Force membership is low. The Task Force has done some recruitment of their own and identified two potential members.

### *Faith-Based*

Another issue being discussed is the possibility of recruiting members from faith-based organizations. Committee members discussed possible obstacles in faith-based recruitment, including how to benefit from the insights of a faith-based member without alienating members who practice high-risk behaviors and are not part of a faith community. Broad-based geographic recruitment has also been discussed but was not a primary focus while the group was in low-membership status. As membership has increased, geographic recruitment will be considered in the near future, with the committee seeking to address the unique barriers that could hinder such recruitment.

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### Efficiency

Efforts to improve the efficiency and effectiveness of RICPG documentation processes include:

- **Revising forms**—the nomination/application form has had minor content and format changes and can now be completed electronically. (It will continue to be mailed in with original signature.) A re-commitment form was developed for members to complete when they are entering their second or third terms.
- **Revised Orientation Manual and Procedure**—A new, comprehensive orientation manual has been developed and distributed to all members. Additionally, the new-member orientation has been revised and consists of a half-day program. This was a collaborative effort between the RICPG facilitator and the REACH program coordinator. The training program was offered in June 2005 to all members, and will be offered periodically to new members.
- **Recommending changes to the RICPG Charter (for consideration by the full membership)**—The specific work on the charter involves clarifying wording around the process for public comment, voting on new members, removing co-chairs, conflict management, etc. In addition, the Committee has worked on clarifying maximum and minimum membership.

After the Community Empowerment Committee accepted the resignation of a community co-chair due to workload and other obligations, the RICPG operated for much of the year with only one community co-chair. In April 2005, a second community co-chair was identified and elected. The Committee received one member resignation this year due to health concerns. Five new members, however, have been recruited, increasing RICPG membership to 17.

This Committee is highly motivated and productive. However, the Committee needs new members to assist in its charge. It is expected that when the RICPG as a whole reaches full membership capacity, this issue will be addressed.

### Strategy Planning Committee

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The Strategy Planning Committee is responsible for Goal 2, Objectives D, E, and F, and Attributes 19–48. The Committee maintains the attributes throughout the year, incorporates the attributes into written RICPG documents, and works toward accomplishing the attributes according to its preset timeline.

The Strategic Planning Committee, after much discussion, has changed its name to the Strategy Planning Committee. This was done because the committee membership felt that the name was misleading. The group felt that their real work of the committee was to plan and strategize on how to best get the work of the planning group done effectively and efficiently according to CDC guidance. The term Strategic Planning is known more as an organizational road map that is a tool associated with organizational change. The committee decided that it didn't fit, and the RICPG membership agreed.

Duties of the Strategy Planning Committee continue to include:

- Monitoring of the development of the resource inventory of HIV prevention services. An update on the Resource Directory was presented to the RICPG. The plan is to create an electronic Resource Directory that is user-friendly. Models are being looked at to facilitate this process. Updates are monitored and reported to the RICPG membership.
- Review of current epidemiologic profile and determination of trends in incidence and prevalence. As part of the review, HEALTH-RI Epidemiologist Steve Meersman offered a presentation to the entire RICPG. This also served to bring the new members up to speed on the epi profile.
- Review of “best practice” HIV prevention interventions. Best practices are reviewed included in ongoing discussions at the Committee level and documented in RICPG minutes. Updates on funded programs implementing best practices are also provided for the membership.
- Categorization of interventions by type of intervention and stage of change.
- Development of a prioritization plan for target populations and interventions.
- Facilitation of RICPG discussions related to unmet needs, priority populations, and priority interventions. This is done on an ongoing basis as part of the Strategy Planning Update item regularly scheduled on the RICPG meeting agenda.

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- Completion of a gaps analysis for three of the five priority populations.
- Evaluation of the community planning process and capacity building activities with John Snow, Inc., an agency contracted for evaluation by HEALTH-RI. This feedback is presented to the RICPG membership.
- The Strategy Planning Committee supported two forums designed to gather input from specific populations. They were held in winter and spring of 2005. One forum came about as a result of conference breakout sessions, which focused on priority populations, Feedback was videotaped and a follow-up letter sent to participants regarding how the RICPG included the input in the planning process. Another community forum was held to discuss the use of Best Practices in intervening with target populations. HEALTH-RI, community members and vendors, and RICPG members met at R.I. College to discuss HEALTH-RI funding based on Best Practice proposals. Elements of Best Practices were reviewed and discussed.
- The Strategy Planning Committee is working with John Snow, Inc., to revise the attributes so that they are more easily understood. It is expected that simplifying the CDC attributes will expedite and enhance the work of committees and task forces.

### **REACH/Capacity Building Committee**

The Project REACH/Capacity Building Committee is responsible for Goal 3, Objectives G and H, and Attributes 49–52. The Committee oversees the capacity building needs of the RICPG and advises Project REACH, the capacity-building program for the Office of HIV/AIDS & Viral Hepatitis.

Project REACH currently offers two catalogs of free trainings per year, on topics ranging from HIV 101 to motivational interviewing. REACH offer between 8 and 10 trainings per catalog that are open to the public, as well as special capacity building options for specific agencies or populations. Between January and June 2005, DATA offered 10 trainings to community organizations, with more than 100 total attendees. Forty agencies have participated in training.

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REACH also works closely with the Rhode Island Community Planning Group (RICPG), designing and delivering an orientation to all members this May. REACH works with the priority population task forces and the Empowerment Committee to ensure that CPG members are prepared to participate actively in the planning process, and to secure professional development and capacity building assistance to address areas of improvement. REACH was also involved in the planning of an RICPG conference, which presented the Comprehensive Plan to the community, and asked for feedback about serving our priority populations.

Duties of the REACH/Capacity Building Committee include:

- Advising and providing input and guidance to Project REACH.
- Participating in the identification of topics for the Fall REACH workshop series.
- Responding to ongoing requests for technical support by prevention providers.
- Assessing the capacity building needs of HIV prevention professionals.
- Identifying additional capacity building resources.
- Performing outcome monitoring and impact evaluations

The following calendar captures the anticipated activities of the RICPG in 2006.

## 2006 Rhode Island Community Planning Yearly Calendar

January 2006	February 2006	March 2006	April 2006	May 2006	June 2006
<p><b>Theme: Setting the Agenda for the Year</b></p> <p><b>Strategic Planning</b> Review the goals, objectives and attributes in the guidance and the plan. Summarize the attributes to be more user friendly.</p> <p><b>Task Forces</b> Make the workbooks interactive electronically.</p> <p><b>Empowerment</b> New Community Co-chair Orientation New Member orientation Continue to update charter</p> <p><b>REACH Steering Committee</b> Develop capacity building training and activities for summer/fall catalog; review JSI report on the RICPG survey to determine the future RICPG capacity building needs; develop certification process</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p>	<p><b>Annual Meeting Theme: Without Fear</b></p> <p><b>The RICPG Annual Meeting</b></p> <ul style="list-style-type: none"> <li>• an opportunity to review the past year and transition into the new year</li> <li>• unveiling of 2006 Plan Update</li> </ul>	<p><b>Theme: Catching Up</b></p> <p>Focus on Committee and Task Force Reports and Status. An opportunity for recommendations and guidance to task force members.</p> <p><b>Strategic Planning:</b> Continue to support the Task Forces in the use of the workbook and determine epi support needs; work with HEALTH presents the on-line resource inventory to the RICPG.</p> <p><b>Task Forces</b> Prepare presentation to the RICPG.</p> <p><b>Empowerment</b> New Community Co-chair Orientation New Member orientation Prepare charter updates for the RICPG vote</p> <p><b>REACH Steering Committee</b> Develop capacity building training and activities for summer/fall catalog;; JSI report to the RICPG identifying their capacity building needs.</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p>	<p><b>Theme: Putting It All Together</b></p> <p>Day-long, retreat style meeting/training event for team building and leadership development</p> <p><b>Capacity Building/Training</b></p> <ul style="list-style-type: none"> <li>• The epi profile-understanding prevalence, incidence etc.</li> <li>• Gaps Analysis</li> <li>• Community Service Assessment</li> </ul> <p><b>Empowerment</b> Finalize the Charter</p> <p><b>REACH Steering Committee</b> Develop capacity building training and activities for summer/fall catalog; new draft catalog is presented.</p> <p><b>RICPG Consultant Team</b> Plan the retreat activities</p> <p>JSI Update on Vendor Evaluation</p> <p>REACH Update on capacity building</p>	<p><b>Theme: Putting It All Together</b></p> <p>Work on the updates for the 2007 Plan Update.</p> <p><b>Strategic Planning</b> Guide members with recommendations to the task force members;</p> <p><b>Empowerment</b> Decisions about the annual event, RRR, and awards.</p> <p>New Member orientation</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall catalog is finalized and published</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting Clarendon <b>Communication Plan Update</b> Clarendon Group</p>	<p><b>Theme: Draft of the Plan Update Begins with Consultant</b></p> <p><b>Strategic Planning</b> Continue to guide members with recommendations to the task force members</p> <p><b>Task Forces</b> Work through workbooks and continue assessments</p> <p><b>Empowerment</b> Continue to plan the annual event, Red Ribbon Rally, and awards.</p> <p>New Member orientation</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall training begins enrollment for July. Survey of providers assess the capacity building needs of community providers</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p> <p>Plan Update deadlines and task assignments are made.</p>

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2006 Rhode Island Community Planning Yearly Calendar					
July 2006	August 2006	September 2006	October 2006	November 2006	December 2006
<p><b>Vacation Month – No RICPG Meeting</b></p>	<p><b>Theme: Plan Update Is Complete</b></p> <p>Work toward finalizing the updates for the Plan</p> <p><b>Strategic Planning</b> Guide task force with the prepare of second presentation of activities to the RICPG</p> <p><b>Task Forces</b> Prepare presentation to the RICPG.</p> <p><b>Empowerment</b> Continue to plan the annual event, RRR, and awards. New Member orientation Suggest charter updates to the RICPG to prepared</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall catalog training implemented; certification process continues</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p>	<p><b>Theme: Final Assessment</b></p> <p>The RICPG considers future activities with the task force assessment</p> <p><b>Strategic Planning</b> Recommendations to the RICPG based on the task force activities; reports on the gaps analysis and resource inventory</p> <p><b>Task Force</b> Presentation to the RICPG.</p> <p><b>Empowerment</b> New Community Co-chair nominations gathered Continue to plan the annual event, RRR, and awards</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall catalog training implemented; certification process continues; next catalog is planned.</p> <p><b>RICPG Consultant Team</b></p> <ul style="list-style-type: none"> <li>• JSI prepared the RICPG survey;</li> <li>• Clarendon provides update on the RRR and annual conference marketing plan</li> </ul>	<p><b>Theme: Preparing for the Red Ribbon/Annual Event</b></p> <p>The RICPG finalizes decisions about the marketing of the RICPG, annual meeting theme and RRR.</p> <p><b>Empowerment</b> New Community Co-chair nominations gathered New Member orientation Continue to plan the annual event, RRR, and awards.</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall catalog implemented; certification process continues; winter/spring catalog for 2006 is published</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p> <ul style="list-style-type: none"> <li>• JSI implements the RICPG survey</li> <li>• Clarendon presents RRR and annual conference updates to RICPG</li> </ul>	<p><b>Theme: Preparing for the New Year</b> <b>The election of new community co-chair</b></p> <p><b>Empowerment</b> New Community Co-chair nominations gathered Continue to plan the annual event, RRR, and awards</p> <p><b>REACH Steering Committee</b> Capacity building training and activities for summer/fall completed; enrollment for winter/spring catalog of workshops begins.</p> <p><b>RICPG Consultant Team</b> Consultants Strategy Planning Meeting</p>	<p><b>Reflections/Celebrations</b></p> <p>Red Ribbon Rally to Kick Off World AIDS Day Events</p>

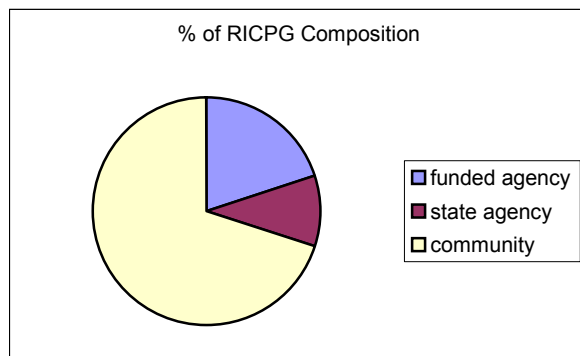
# Goal One

**Goal One: Community planning supports broad-based community participation in HIV prevention planning and evaluates the progress of this by increasing RICPG member perceptions across the five-year grant process, as well as monitoring intermediate outcomes of the process associated with this objective.**

- Indicator E.1: Proportion of population most at risk, as documented in the epidemiologic profile, has at least one RICPG member that reflects the perspective of each population.

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for RICPG membership.

Each year, the Community Empowerment Committee reviews the process of bringing new members into the fold. This year, the committee again revised the nomination form and created more objective indicators for eligibility. The group also specified membership composition percentages for individuals from funded agencies, state agencies, and the community at large (see the diagram below). The recruitment process is widespread and inclusive of the entire state and is generally achieved through extensive and focused outreach, primarily through advertisement in statewide newspapers, ethnic papers, and other broad channels of distribution (e.g., community-based agencies post recruitment flyers). This year, recruitment also included phone calls to key referral sources.



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In addition, this Committee reviews the status of existing members and is responsible for filling vacancies that occur during the year by recording and monitoring terms. An important component of this recruitment process is ensuring that priority populations continue to be adequately represented in the membership of the RICPG. This Committee is also responsible for orienting new members and assisting them in assimilating into the existing group.

### **Member Retention Plan**

Member retention provides stability to the RICPG and continuity for the planning process.

The retention plan for RICPG involves the following steps:

- Motivation: the committee creates a motivating environment and targets retention strategies for new and experienced members.
- Development: the committee creates strategies for orientation, training, coaching, capacity building and networking opportunities.
- Management of volunteer resources: the committee identifies key competencies for members, works with challenging members, and encourages members to step down when necessary.
- Member recognition.

### **Motivation**

Motivational efforts include the following activities:

- The RICPG facilitator has restructured the meeting agenda to include a warm-up activity at the beginning of each meeting and a closure activity when the meeting ends. The purpose of the meeting structure is to offer an opportunity for the members to personally connect with each other and to the mission and purpose of the RICPG.
- The RICPG's new social marketing consultant, the Clarendon Group, has created polished materials to help showcase the work of the group, including a new logo (voted on by the membership), Executive Summary of the 2004 and 2005 Plans, brochures, buttons, new stationery, and a new website, all of which are strategies to help connect

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the members with their work. The future plan is to have the members' pictures posted on the web, further associating the people with the work.

- The RICPG leadership team has developed workbooks to help clarify and guide the work of the group, and they also assist in motivating the membership to connect the goals with the planning process.
- RICPG members now provide frequent and immediate feedback on meeting objectives, which serves to motivate members by acknowledging the value of their input.

### Development

The Empowerment Committee, with support from the facilitator, has worked to change forms, including nomination forms, to be more user-friendly. The development of the Task Force workbooks has helped by offering consistency in how information is collected in the task forces and avoids duplication of effort. Also, the workbooks help to break the work down into manageable steps.

The REACH/Capacity Building Committee has involved the membership in determining training needs. The committee has developed a catalog of trainings to respond to these identified needs. Furthermore, the general planning meetings of the committee have scheduled breaks for participants to maximize the networking opportunities that come naturally with this work.

### Management

- The RICPG web site offers a calendar to assist members in accessing information on General Planning, Committee, and Task Force meetings.
- Regular communication with the co-chairs and membership is facilitated through mail, e-mail, phone, and catching up at meetings.

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- Input from the membership is requested through meeting evaluations and the JSI evaluation survey.
- An outside consultant has been used to assist in conflict management.
- The co-chairs manage the general planning meetings, and the facilitator serves to assure that the objectives are met. In Committees and Task Forces meetings, the chairs manage the meetings, and the facilitator supports the chairs as needed. Minutes are taken in all meetings to document the work.

### Recognition

Personal phone calls and e-mails are used to acknowledge the work of the membership and provide consistency in communication, which in turn serves to support the momentum and validate member contributions.

Web site postings of member accomplishments and news events are planned to assist in recognizing the work of the membership. Posting member pictures on the web, informing members of the impact of the work, and requesting input in areas of expertise are all strategies for recognition that are now and will continue to be part of the retention process. The Empowerment Committee will continually investigate options and opportunities to enhance the recognition efforts.

The committee believes that the annual review of this process by a dedicated sub-committee ensures the long-term maintenance of the open recruitment and retention process.

The long-term maintenance of Objective A is outlined in the following matrix.

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<b>Goal One: Community planning supports broad-based community participation in HIV prevention planning</b>				
<b>Objective A</b>	<b>Activities (2006)</b>	<b>Outputs</b>	<b>Immediate Outcomes (2006)</b>	<b>Intermediate Outcomes (5 year) (2009)</b>
Implement an open recruitment process (outreach, nominations, and selection) for RICPG membership.	<ul style="list-style-type: none"> <li>Empowerment Committee reviews and alters recruitment/selection process, and success is defined by maintaining at-risk population representation on RICPG</li> <li>Vacancies are quickly filled within one month to maintain representation</li> <li>Special recruitment</li> <li>Revised nomination/procedures/forms distributed</li> <li>Ads in newspaper</li> <li>Personal Call Schedule</li> <li>Distribute a RICPG brochure as a public relations/recruitment tool</li> <li>Address any gaps in membership, the nomination process, interview process and selection</li> </ul>	<p>Attribute 1 (Nominations): Presence of written procedures for nominations to the RICPG.</p> <p>Attribute 2 (Nominations): Evidence that written procedures (above) were used for nominations to the RICPG.</p> <p>Attribute 3 (Nominations): Evidence that a nominations committee has been established.</p> <p>Attribute 4 (Nominations): Evidence that nominations targeted membership gaps as identified by the RICPG.</p> <p>Attribute 5 (Selection): Evidence that membership decisions involve more than the health department staff.</p> <p>Attribute 6 (Selection): Written documentation of the process for selection of RICPG members.</p> <p>Attribute 7 (Selection): Evidence that the process (above) was used in selection of RICPG members.</p>	<ul style="list-style-type: none"> <li>Enhance Attributes 1-7 by January 2006</li> <li>Maintain attributes throughout the year</li> <li>Attributes 1-7 are incorporated and updated into written RICPG documents as an ongoing process</li> <li>100% attainment of Attributes 1-7</li> </ul>	The RICPG continues to represent the communities most affected by HIV/AIDS, and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 1-18 are in place.

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Objective B: Ensure that the RICPG’s membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in Rhode Island, and include key professionals representative of key government and non-governmental agencies.

The RICPG’s Community Empowerment Committee is responsible for the overall member recruitment and retention. A membership grid is consulted each time someone leaves the group, and a meeting of the Community Empowerment Committee is called by the chair. The membership reveals a deliberate mix of governmental and non-governmental agency representatives. The Community Empowerment Committee specified in its most recent revision of the nomination form the allowable percentages of government agency representatives, representatives of community-based and funded organizations (non-government agencies), and community representatives. The Committee’s intent was to create an equitable mix of members so as not to “tip” the scales with too many non-community representatives. In addition, the RICPG is dedicated to involving key consultants with professional expertise into the fold of the planning process. As a result, a consultant list (non-members, but active participants in the process) is attached to the membership grid. The distinction of these individuals as consultants allows the RICPG to access their expertise at any time and ensures a broader base of input.

### **Youth Involvement**

One of the RICPG’s most persistent challenges is to involve youth in a meaningful way in its membership and planning process. To address this challenge, at least two persons between the ages of 16 and 24 have been appointed to the RICPG.

### **People Living with HIV/AIDS**

To enhance communications with PLWHA, who are not RICPG members, the Office of HIV/AIDS & Viral Hepatitis will continue to present to the RICPG and the Provision of Care Committee an update on care issues (including Ryan White I and II). In addition, the Bridge Committee began work in 2005, formally linking prevention with provision of care. This group is integral to both the RICPG and the Provision of Care Committee (POC). It is

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made up of providers from prevention and care. The group meets at least quarterly to determine issues to be presented to the RICPG and the POC.

### **Outside Input**

In 2003, focus groups representative of each priority population were conducted to measure perceptions of the appropriateness, clarity, and accuracy of the RICPG's goals and objectives specific to each population; service needs and gaps for each population; and overall plan to address each population's needs. The focus groups were facilitated, and the recommended actions were documented.

### **Linkages with Other Groups**

In 2005-06, RICPG members will participate in other groups whose missions dovetail with HIV prevention, thus forging linkages among agendas. These groups include the ENCORE Steering Committee, which oversees the state's needle exchange program; HIV Minority Community Partnership; Partners in Care, which focuses on CTR issues; and the Materials Review Committee of the State Departments of Health and Education, which reviews, approves, and orders HIV prevention materials.

### ***Bridge Committee***

On May 5, 2005, the Office of HIV/AIDS & Viral Hepatitis hosted the first meeting of the Bridge Committee. The participants included both care and prevention vendors and RICPG members. The following goals and objectives were developed for the meeting:

- Goal: The goal of this meeting is to bring together HIV and Viral Hepatitis prevention and care staff from funded programs to share information, network, and identify members for the Bridge Committee, as well as to identify gaps in services. The Bridge Committee will continue to work on Care and Prevention issues identified by this larger group.
- Meeting Objectives  
By the end of the meeting the participants will be able:

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1. To identify the importance of integration of HIV and Viral Hepatitis prevention and care.
  2. To increase familiarity with at least three other programs providing services to Rhode Islanders.
  3. To identify their vendors' roles and at least one action step that they can take to increase the integration of Care and Prevention within their agency.
  4. To identify potential membership to the Bridge Committee.
  5. To set future Care and Prevention vendor meeting dates and suggested agenda items.
- Participant Objectives
- By the end of the meeting, the participants will:
1. Have an overview of a comprehensive system for HIV/VH care and prevention.
  2. Have a comprehensive system organizational chart of HIV/VH prevention and care services that includes their agency.
  3. Identify challenges in implementing a comprehensive system of care and prevention services based on their experience.
  4. Have an overview of the Bridge Committee.
  5. Identify participants interested in joining the Bridge Committee.

In 2002, the HIV Advisory Committee, which had been the group that considered treatment issues, merged with the HIV Provision of Care Committee, through which the allocation of Ryan White funds took place. A member of the RICPG is a member of this committee, and the HEALTH-RI consultant to the RICPG staffs the HIV Provision of Care Committee.

### **Community Forum**

Traditionally, each December, the Community Empowerment Committee has hosted a Community Forum to raise awareness about the efforts of the RICPG, introduce the public to the Community Plan for HIV Prevention, and obtain additional input from outside the group membership. In 2004, with the assistance of its social marketing consultant and facilitator, the RICPG restructured this event, creating the inaugural RICPG Conference in February 2005

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The conference theme was “Unsung Heroes,” and, in keeping with tradition of honoring individuals or groups that have made a significant contribution to HIV prevention in Rhode Island, the RICPG honored several individuals whose outstanding contributions have largely gone unrecognized. The conference included interactive breakout sessions, with a focus on each of our priority populations. These sessions allowed us to gather critical information from the community on service and delivery needs. The conference, which was videotaped, was evaluated very highly by participants. Follow-up letters were mailed to participants to update them on how their feedback has been incorporated into the RICPG’s work, and to act as membership recruitment tool.

The conference served as invaluable opportunity to unveil the Plan—and an attractive, professionally designed Executive Summary of the Plan—to the public and to acknowledge the good work of the RICPG. It also served as an example of the RICPG’s open, participatory philosophy of planning.

The Red Ribbon Rally (a World AIDS Day event jointly sponsored by HEALTH-RI and the RICPG for the first time in 2003), held in December 2004 with assistance of the Clarendon Group and Uptyme, was an enormous success, with a powerful impact on the community—despite inclement weather.

The long-term maintenance of this objective is outlined in the following matrix.

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<b>Goal One: Community planning supports broad-based community participation in HIV prevention planning</b>				
<b>Objective B</b>	<b>Activities (2006)</b>	<b>Outputs</b>	<b>Immediate Outcomes (2006)</b>	<b>Intermediate Outcomes (5 year) (2009)</b>
<p>Ensure that RICPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in Rhode Island, and include key professionals representative of key government and non-governmental agencies.</p>	<ul style="list-style-type: none"> <li>• Empowerment Committee reviews process monthly</li> <li>• Membership Grid is maintained as part of recruitment and selection of new members</li> <li>• Expert Consultant list maintained</li> <li>• 2004 recruitment completed and end result represents diversity of populations</li> <li>• Invite inter-state agencies to a “RICPG day” to promote benefits of RICPG involvement</li> <li>• Maintain JSI Evaluation survey each October</li> <li>• Conduct Membership Feedback Survey after each RICPG meeting</li> </ul>	<p><b>Attribute 8 (Representation):</b> RICPG includes: (a) members who represent populations most at risk for HIV infection as reflected in the current and projected epidemic, as documented in the prior year’s epidemiologic profile, and (b) persons living with HIV/AIDS</p> <p><b>Attribute 9 (Representation):</b> RICPG membership includes members who represent the affected community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution</p> <p><b>Attribute 10 (Representation):</b> RICPG membership includes, or has access to, professional expertise in behavioral/social science, epidemiology, evaluation, and service provision</p> <p><b>Attribute 11 (Representation):</b> RICPG membership includes, or has access to, key government agencies, including: health department HIV/AIDS program and the state/local health department STD program staff</p> <p><b>Attribute 12 (Representation):</b> RICPG membership includes, or has access to, key governmental and non-governmental agencies with expertise in factors and issues relative to HIV prevention</p>	<ul style="list-style-type: none"> <li>• Enhance Attributes 8-12 by January 2006</li> <li>• Maintain attributes throughout the year</li> <li>• Attributes 8-12 are incorporated into written RICPG documents by 12/05</li> <li>• 100% attainment of Attributes 8-12</li> </ul>	<p>The RICPG continues to represent the communities most affected by HIV/AIDS, and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 1-18 are in place.</p>

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

This objective is intrinsic to the RICPG's process. Since May 2004, HEALTH-RI has contracted with Uptyme to facilitate the process of community planning. The key role of the consultant is to ensure parity, representation, and inclusion at each meeting. With the facilitation of the consultant, the RICPG was able to do the following:

- distribute RICPG pins and brochures for recruitment;
- maintain a website with meetings, charter, and other RICPG information;
- sponsor Project REACH trainings, with a six-month catalog based on the RICPG input;
- prepare members to review the five-year plan in a timely fashion;
- recruit five new members and have other potential members begin the recruitment process, one being a youth leader;
- develop a new youth recruitment strategy from the substance abuse field and schools to support the youth task force.
- draft a task force workbook guide and focus task force activities. The task force efforts are a major component of the Community Service Assessment section in the plan.
- task the Empowerment Committee to make much-needed changes to the RICPG charter.
- offer the new-member orientation training curriculum throughout the year to all new members. Begin a "buddy-system" to pair veteran members with new members as part of the orientation process.
- plan to integrate local process and outcome data into decision making and priority setting.
- guide consultants (e.g. Clarendon, JSI, DATA) in assisting the RICPG to process and plan use the yearly member survey to improve the function of the group.
- demonstrate the RICPG's capacity to deal with discord and conflict in a positive manner.

### **Conflict Resolution**

Conflict is an inevitable part of the RICPG process. Where diverse cultures are joined together, conflict is expected. This year, the RICPG worked to minimize conflicts that

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impede progress by revising the group's ground rules; in addition, the facilitator reviewed the ground rules and provided them in printed format in member packets at all meetings. The Facilitator offered reminders of the role of conflict in helping or hindering the group's progress. Team-building exercises have been made a part of the opening at every meeting with the goal of building trust and connection. In addition, closing meeting objectives are reviewed for communication and goal clarity.

Although these strategies minimized conflict, an outside facilitator was also used to assist the group through a conflict resolution process. Afterward, proactive steps have been taken to build the RICPG capacity to effectively manage conflicts internally. The Empowerment Committee is currently developing a conflict management policy. Conflict management training as part of the REACH/Capacity Building efforts is also currently being considered. The facilitator will continue to monitor the communication process and provide regular feedback to the group.

The Empowerment Committee has taken on the responsibility of mediating some relationship conflicts whenever they may be needed. Peer Mediation is new to this group. Future plans will include the CDC guides as a basis for formalizing conflict management policy and protocol.

The following matrix outlines the long-term strategy to maintain parity and inclusion:

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Goal One: Community planning supports broad-based community participation in HIV prevention planning				
Objective C	Activities (2006)	Outputs	Immediate Outcomes (2006)	Intermediate Outcomes (5 year) (2009)
<p>Foster a community planning process that encourages inclusion and parity among community planning members.</p>	<ul style="list-style-type: none"> <li>• Continue to administer membership assessment after each meeting</li> <li>▪ Improve baseline of member perceptions around PIR</li> <li>▪ Tabulated assessments pertaining to inclusion/parity with timely feedback to RICPG each quarter</li> <li>• Community Empowerment Committee charged with monitoring this objective and regularly assesses PIR</li> <li>• Maintain JSI Evaluation survey each October</li> <li>• Conduct Membership Feedback Survey after each RICPG meeting</li> </ul>	<p><b>Attribute 13 (Inclusion):</b> Evidence that the RICPG convened ad hoc committees, panels, and/or focus groups to gain input from representatives of marginalized groups, who would be hard to recruit and/or retain as RICPG members.</p> <p><b>Attribute 14 (Inclusion):</b> Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g., health care or economic needs) to their continued participation in the RICPG.</p> <p><b>Attribute 15 (Inclusion):</b> Evidence of a clear decision-making process, including conflict of interest rules.</p> <p><b>Attribute 16 (Inclusion):</b> Evidence of an orientation, mentoring or training process for new RICPG members.</p> <p><b>Attribute 17 (Inclusion):</b> Evidence that RICPG meetings are open to the public and allow time for public comment.</p> <p><b>Attribute 18 (Parity):</b> Evidence of ongoing training process for all RICPG members.</p>	<ul style="list-style-type: none"> <li>• Establish Attributes 13-18 by January 2006</li> <li>• Maintain attributes throughout the year</li> <li>• Attributes 13-18 are incorporated into written RICPG documents by 12/05</li> <li>• 100% attainment of Attributes 13-18 by 12/05</li> </ul>	<p>The RICPG continues to represent the communities most affected by HIV/AIDS and each corresponding objective is reviewed by the RICPG and maintained.</p> <p>100% of the attributes 1-18 are in place.</p>

## Goal Two

**Goal Two: The Rhode Island Community Planning Group identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population).**

- Indicator E.2: Proportion of key attributes of an HIV prevention community process that RICPG membership agrees have been addressed.

The work of the RICPG is driven by the core objectives set forth by the CDC. The revised guidance has been shared with the RICPG, and members are aware that the components of community planning have been revised and that the group must continue to address the new guidelines in this phase of the process.

The RICPG has been notified and continues to discuss the expectations of CDC regarding improving HIV prevention programs by strengthening the (1) scientific basis, (2) community relevance, and (3) population-or-risk-based focus of HIV prevention interventions in each project area. The overall goals in this revised guidance have also been discussed with the RICPG, and they reflect the philosophical intent of this local planning body. This is an ongoing process.

Objective D: Carry out a logical, evidence-based process to determine the highest priority populations' specific prevention needs as well as priority interventions for the target populations in Rhode Island.

The history of this process is as follows: HEALTH-RI proposed and implemented an intensive training program for all RICPG members related to prioritization of populations and interventions. In the spring of 2003, the prioritization plan was formulated with the co-chairs, and key staff from HEALTH-RI. The plan was to reorganize the process by which RICPG prioritized populations and create a more objective process that would be viewed as such by the group. As a result, a series of small workshops were scheduled. Each RICPG member was asked to sign up for one of three identical sessions. During the workshops,

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HEALTH-RI went through a customized workbook and assisted members with completing the individual score sheets. This procedure for setting priorities was selected to give members time to review the data and materials and formulate questions.

Approximately 95% of the RICPG attended one of these workshops. The thought was to prepare the group in small sessions for the “new, improved” prioritization exercise. The small groups were facilitated by HEALTH-RI and by RICPG members who had been briefed as to the components of the new exercise. Each participant received a workbook and was asked to do a homework assignment before the actual prioritization took place in a full member RICPG meeting.

At the May 2003 meeting, RICPG members completed the population priority process that included an informational session on the draft guidelines for community planning recently issued by the Centers for Disease Control and Prevention. Members were given a packet with a copy of the draft guidance and it was discussed with an overhead presentation. The information was based on the workshop on Community Planning presented at the AIDS Summit in New York in April. Members were re-introduced to their role in priority setting and the priority setting workbook developed for this process was reviewed.

The 2003 prioritization exercise was brought forth to the 2004-05 planning year, and the RICPG agreed that the process for prioritizing in 2003 was a good one. The group continues to discuss the importance of reviewing the HIV/AIDS reporting data sets, to be certain that priorities did not change since 2003. The 2005 presentation by HEALTH-RI Epidemiologist Steve Meersman reflected no significant changes.

As indicated in the Task Force workbook, an entire section continues to be devoted to prioritization. This section illustrates that the following areas must be considered along with the HIV/AIDS incidence/prevalence data:

- Estimated Size of Target Population
- Barriers to Prevention
- Risk Behaviors/Conditions

- Risk Rating

As a result, each target population will have a priority “wheel” that the RICPG is used as the basis for planning.

The text below represents how the RICPG approaches the notion of best practices.

## Types of Interventions



- **DEBI**
- **Proven Effective Interventions**
- **Interventions for Positives**
- **Science Based/Theoretical Models**

The RICPG takes into consideration interventions for high-risk populations and people with HIV/AIDS. There are three general possibilities:

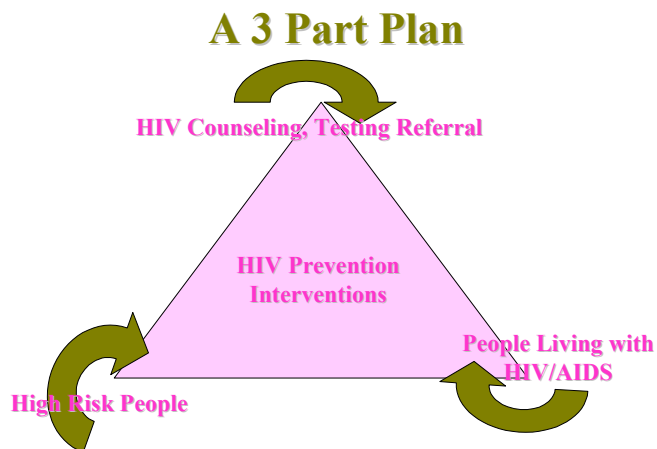
1. Interventions that have already been evaluated with outcome evaluations and have been proven to be effective with high-risk

populations. These interventions are known as DEBI and REP (Replicating Effective Programs)

2. Programs that have been proven effective with people living with HIV/AIDS.
3. Interventions sponsored by local programs that have not been proven effective. The program would need to be based on an adaptation of a DEBI or has a theoretical model. This type of program would need to have an outcome evaluation (not just outcome monitoring) in place in order to be funded. The agency would have to prove that they are implementing an effective program.

- CDC's HIV Prevention Strategy has three parts:

1. HIV Counseling and testing, especially rapid testing interventions, in proven effective settings.
2. Prevention with persons at high risk for HIV (as defined in the next slide).
3. Prevention for people living with HIV & AIDS.



There are proven, effective programs for each of these three strategies.

The CTR interventions are described in detail in the “Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions”. This has been handed out at RICPG meetings on several occasions and can be downloaded from the CDC web site:

<http://www.cdc.gov/hiv/partners/ahp.htm#journal>

## Who is High Risk for HIV?



### Within the past 6 months

#### have:

- **Unprotected sex with a person living with HIV**
  - **Unprotected sex in exchange for money or drugs**
  - **Multiple (greater than five) or anonymous unprotected sex or needle-sharing partners**
- OR**
- **Diagnosed with a sexually transmitted disease**

**This group includes those people who, within the past six months, have:**

- Had unprotected sex with a person living with HIV.
- Had unprotected sex in exchange for money or drugs.

- Had multiple (greater than five) or anonymous unprotected sex or needle-sharing partners
- Been diagnosed with a sexually transmitted disease.

Priority for Prevention Case Management (PCM) services should be given to HIV seropositive persons.

HIV seronegative persons or those of unknown HIV serostatus may be appropriate for PCM if:

- They meet the criteria of an individual at very high risk for HIV infection and
- They are experiencing competing issues that affect their ability to address HIV prevention needs.

## Prevention for High Risk People

- **DEBI**
- **Other Proven Effective Interventions**
- **Local Programs**



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Prevention programs for people at high-risk may come from three types of interventions:

1. The DEBI – a series of interventions that CDC is recommending because they are proven effective and CDC has trainings and materials (curriculum) that agencies can access without cost. There are DEBIs for high risk and PLWHA.
2. Interventions proven effective, including the DEBIs, are listed in the “Compendium of HIV Prevention Interventions with Evidence of Effectiveness”. The compendium is available at the CDC web site:  
[www.cdc.gov/hiv/partners/ahp.htm#journal](http://www.cdc.gov/hiv/partners/ahp.htm#journal).
3. Local programs can use a theoretical model such as peer counseling, natural helper, social development model, stages of change, etc. These programs must prove they are effective by doing outcome evaluation, not just outcome monitoring.

### What’s a DEBI ? A Winner

- A proven effective program for high risk and PLWHA.
- Group and community based interventions.



The **Diffusion of Effective Behavioral Interventions project (DEBI)** is a national-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD prevention interventions to state

and community HIV/STD program staff. DEBIs have an emphasis on group level and community level interventions.

The interventions have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes

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(e.g., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. With input from the researchers, the materials necessary to implement the interventions have been packaged into user-friendly kits. With the appropriate training and intervention package, service providers can increase their opportunities to conduct effective HIV/STD prevention programs in their communities.

### *Why Community and Group-Level Interventions?*

Community- and group-level interventions, compared to individual-level, have the potential to reach large numbers of the population and reach individuals at high risk who might not voluntarily seek prevention information or services. They are also more cost-effective.

### *HIV Prevention Interventions*

The interventions in the Compendium have been identified by CDC's HIV/AIDS Prevention Research Synthesis Project (PRS) as having used rigorous study methods and demonstrated evidence of effectiveness in reducing sex- and drug-related risk behaviors and/or improving health outcomes.

### *Request a Regional Training*

Agencies that are interested in and have the capacity to implement the HIV prevention interventions can schedule a training in their area on the intervention of their choice. Rhode Island could offer this regional training through REACH. For more information, visit: [www.effectiveinterventions.org](http://www.effectiveinterventions.org).

<b>Diffusion of Effective Behavioral Interventions Project (DEBI)</b>	
<b>Street Smart</b>	<b>Voices/Voces Project Respect</b>
<b>Popular Opinion Leader (POL)</b>	<b>Mpowerment</b>
<b>Real AIDS Prevention Project (RAPP)</b>	<b>Safety Counts</b>
<b>SISTA</b>	<b>Community Promise</b>

*Popular Opinion Leader:* This community-level intervention involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors in their social networks through risk-reduction conversations.

*Promise:* This community-level intervention is based on several behavior change theories. A community assessment process is conducted, peer advocates are recruited and trained from the target population, role model stories are written from interviews with the target population, and these stories are distributed along with other risk reduction materials to target audiences to help people move toward safer sex or risk reduction practices. The intervention can be adapted for various population groups (IDUs, MSM, sex workers, Native Americans, and youth at high risk).

*Voices/Voces:* A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

*SISTA:* This group-level, gender- and culturally- relevant intervention is designed to increase condom use among African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk

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reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.

*Street Smart:* A multi-session, skill building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping mechanisms using exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provides individual counseling and trips to community health care providers.

*Safety Counts:* Safety Counts is an HIV prevention intervention for active injection drug and crack cocaine users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings. This intervention works well with CDC's Advancing HIV Prevention initiative as it strongly encourages HIV testing as a precursor to program enrollment, clients can be recruited from testing programs, and sessions include a discussion of the importance of testing to the client. The intervention addresses the needs of both HIV-negative and HIV positive clients.

*Empowerment:* This community-level intervention for young men who have sex with men uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.

*Real AIDS Prevention Project (RAPP):* A community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations. There is also peer interaction with community businesses, who participate in media campaigns with distribution of role model stories and prevention and health information newsletters and brochures. RAPP is based on the transtheoretical model of behavior change.

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Following are two different types of matrices, one describing the goals and objectives over time, and the other the status (progress) of the specific attributes for each area. (See next page.)

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Objective D	Activities (2006)	Outputs	Immediate Outcomes (2006)	Intermediate Outcomes (5 year) (2009)
<p>Carry out a logical, evidence-based process to determine the highest priority populations ' specific prevention needs, as well as priority interventions for the target populations in Rhode Island.</p>	<ul style="list-style-type: none"> <li>• RICPG facilitator uses the survey findings for future leadership activities and to adjust key attributes goals and maintain them.</li> <li>• Conduct trainings using RICPG prioritization workbook for RICPG/ HEALTH-RI Staff/Consultants to increase knowledge of participants regarding key attributes 19-36 and maintenance of these.</li> <li>• Complete and annually review a priority “wheel” for each target group to augment the formal prioritization exercise.</li> </ul>	<p><b>Attribute 19 (Epidemiologic Profile):</b> The epidemiologic profile provides information about defined populations at high risk for HIV infection for the RICPG to consider in the prioritization process.</p> <p><b>Attribute 20 (Epidemiologic Profile):</b> Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues).</p> <p><b>Attribute 21 (Epidemiologic Profile):</b> Data gaps are explicitly identified in the epidemiologic profile.</p> <p><b>Attribute 22 (Epidemiologic Profile):</b> The epidemiologic profile contains a narrative interpretation of data presented.</p> <p><b>Attribute 23 (Epidemiologic Profile):</b> Evidence that the epidemiologic profile was presented to the RICPG members prior to the prioritization process.</p> <p><b>Attribute 24 (Community Services Assessment):</b> The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile.</p> <p><b>Attribute 25 (Community Services Assessment):</b> Data are gathered that define populations’ needs in terms of knowledge, skills, attitudes, and norms.</p> <p><b>Attribute 26 (Community Services Assessment):</b> Data are gathered that define populations’ needs in terms of access to services.</p> <p><b>Attribute 27 (Community Services Assessment):</b> The CSA details the target populations being served.</p> <p><b>Attribute 28 (Community Services Assessment):</b> The CSA details the interventions provided to each target population.</p> <p><b>Attribute 29 (Community Services Assessment):</b> The CSA describes the geographic coverage of interventions or programs.</p> <p><b>Attribute 30 (Community Services Assessment):</b> The CSA was utilized in demonstrating linkages between the application and funded interventions.</p> <p><b>Attribute 31 (Community Services Assessment):</b> Evidence that prior to the prioritization process, the RICPG was provided with a summary of the CSA.</p> <p><b>Attribute 32 (Gap Analysis):</b> The gap analysis includes data from the epidemiologic profile and CSA.</p> <p><b>Attribute 33 (Gap Analysis):</b> A gap analysis specifically identifies both met and unmet needs.</p> <p><b>Attribute 34 (Gap Analysis):</b> The gap analysis identifies the portion of needs being met with CDC funds.</p> <p><b>Attribute 35 (Gap Analysis):</b> Evidence that prior to the prioritization process, the RICPG was provided with a summary of the gap analysis findings.</p> <p><b>Attribute 36 (Gap Analysis):</b> The gap analysis was utilized by the RICPG in demonstrating linkages between the application and funded interventions.</p>	<ul style="list-style-type: none"> <li>• Maintain attributes throughout the year</li> <li>• Attributes 19-36 are incorporated into written RICPG documents</li> <li>• 100% attainment of Attributes 19-36 annually.</li> </ul>	<p>The RICPG continues to identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 19-36 are in place.</p>

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Attribute	Done	Not Done	Priority	Comments
<p><b>Attribute 19 (Epidemiologic Profile):</b> The epidemiologic profile provides information about defined populations at high risk for HIV infection for the RICPG to consider in the prioritization process</p>	X		1	Each year an updated EPI Profile is done for the plan as an integral part of the planning process, and a stand-alone EPI piece is then posted on HEALTH-RI's website.
<p><b>Attribute 20 (Epidemiologic Profile):</b> Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues).</p>	X		1	This has always been an integral part of the EPI Profile.
<p><b>Attribute 21 (Epidemiologic Profile):</b> Data gaps are explicitly identifies in the epidemiologic profile.</p>	X		1	Date gaps are identified in the EPI Profile, and the RICPG is trained on these gaps. This year was focused on No Identified Risk and ways to understand what that category of data meant for RI.
<p><b>Attribute 22 (Epidemiologic Profile):</b> The epidemiologic profile contains a narrative interpretation of data presented.</p>	X		1	
<p><b>Attribute 23 (Epidemiologic Profile):</b> Evidence that the epidemiologic profile was presented to the RICPG members prior to the prioritization process</p>	X		1	The HIV/AIDS Epidemiologist is a “staff” Consultant to the RICPG. A calendar of trainings by the Epidemiologist reflects the integration of this data with prioritization. The RICPG also debriefs with the Epidemiologist after the prioritization exercise to ensure accuracy and quality of interpretation of information.
<p><b>Attribute 24 (Community Services Assessment):</b> The Community Services Assessment (CSA) focuses on one or more high priority population (i.e., substantially contributing to new HIV infections in a</p>	X		1	The CSA is incorporated into both the RICPG Committee level and the TF levels. It is comprehensive in nature and does devote

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Attribute	Done	Not Done	Priority	Comments
jurisdiction) identified in the epidemiologic profile.				attention to more than one target population.
<b>Attribute 25 (Community Services Assessment):</b> Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms.	X		1	<p>Funded CBOs for the 2005-2008 funding period will be required to assess/gather data regarding the populations they work with. Our RFP, issued in 8/2004, requires CBOs to accomplish this upfront.</p> <p>In addition, the TFs will focus on target populations and be responsible for determining what assessments/surveys, etc. are needed annually. Rhode Island's HIV prevention evaluation system will be another place where the RICPG and HEALTH-RI will get their data for the CS, particularly around knowledge, attitudes, skills, and norms.</p>
<b>Attribute 26 (Community Services Assessment):</b> Data are gathered that define populations' needs in terms of access to services	X		1	This is accomplished in the TFs.
<b>Attribute 27 (Community Services Assessment):</b> The CSA details the target populations being served.	X		1	This is accomplished in the TFs.
<b>Attribute 28 (Community Services Assessment):</b> The CSA details the interventions provided to each target population.	X		1	Considerable attention has been devoted to this in both the TF workbooks and the Best Practice Workbooks
<b>Attribute 29 (Community Services Assessment):</b> The CSA describes the geographic coverage of interventions or programs.	X		1	The Resource Inventory, part of the CSA, looks at current programs by geography, and the HEALTH-RI HIV funded vendors are discussed and

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Attribute	Done	Not Done	Priority	Comments
				plotted as such.
<b>Attribute 30 (Community Services Assessment):</b> The CSA was utilized in demonstrating linkages between the application and funded interventions.	X		1	
<b>Attribute 31 (Community Services Assessment):</b> Evidence that prior to the prioritization process, the RICPG was provided with a summary of the CSA.	X		1	TF and Committees were involved in the discussion as to how to begin the CSA for 2004-2005.
<b>Attribute 32 (Gap Analysis):</b> The gap analysis includes data from the epidemiologic profile and CSA.	X		1	
<b>Attribute 33 (Gap Analysis):</b> A gap analysis specifically identifies both met and unmet needs.	X		1	
<b>Attribute 34 (Gap Analysis):</b> The gap analysis identifies the portion of needs being met with CDC funds.	X		1	
<b>Attribute 35 (Gap Analysis):</b> Evidence that prior to the prioritization process, the RICPG was provided with a summary of the gap analysis findings.	X		1	
<b>Attribute 36 (Gap Analysis):</b> The gap analysis was utilized by the RICPG in demonstrating linkages between the application and funded interventions.	X		1	

Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community service assessment.

HEALTH-RI and RICPG agree that the planning process for 2004-2005 needs to continue to be augmented with various data sets and programmatic information in addition to the Epidemiologic Profile.

*Epidemiologic Profile*

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The HEALTH-RI Epidemiologist presented current epi profile to the membership. The presentation was part of an overall member Orientation program. (See Section 2.)

### *Federal Grant from Office of Minority Health/ Report*

This report has assisted the RICPG in deliberating additional information pertaining to the disproportionate effect HIV has on communities of color. The target populations include women of color in and newly released from prison, girls in the training school setting, Native Americans, and the Southeast Asian community. The program is statewide, with the women in prison and the girls in the training school coming from all over Rhode Island. The Native American population specifically covers urban and rural youth from Providence (the capital city), Pawtucket, Central Falls, East Providence, Newport, and the rural youth come from Charlestown and Narragansett. The rationale for the populations selected is the needs assessment completed by the RICPG, which identified gaps in HIV/AIDS prevention services. This project acted as a supplemental database to obtain Rhode Island community assessment information, so as to understand the gaps and needs of these disenfranchised, high-risk populations. This project will end in September 2005.

### *RICPG Priority Population Task Force Reports*

The priority population task forces were established in 2002 to provide the RICPG with a process of “activating” the plan and as a means of organizing important community information about target populations in a more scientific manner. The task forces include MSM, IDU, High Risk Women, and High Risk Youth. Included in the work of all the task forces is how to deliver programs to “People Not in Treatment/People Who Don’t Know Their Status,” as well as communities of color. A task forces update is a regularly schedule agenda item in every RICPG full-membership meeting.

Task force work adds an additional 2 to 4 hours per month on RICPG members who are participating in these meetings. Data and information continue to be gathered using a series of various techniques including, focus groups, forums, surveys, population (research) studies and epidemiologic data, conferences. Experts and researchers from each target population participate in task force work. Task Force members continue to provide updates at all

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RICPG meetings. The long-term maintenance of this objective is indicated in the following matrices:

Goal Two: The Rhode Island Community Planning Group identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island.				
Objective E	Activities (2006)	Outputs	Immediate Outcomes (2006)	Intermediate Outcomes (5 year) (2009)
<p>Ensured that prioritized target populations are based on an epidemiologic profile and a community service assessment.</p>	<ul style="list-style-type: none"> <li>• Conduct ongoing trainings using the Office of HIV &amp; AIDS Epidemiologist for: RICPG, consultants and HEALTH-RI staff regarding community needs assessment and epidemiologic profile</li> <li>• Conduct assessments that obtain data from supplemental areas to augment epidemiologic profile through the established <u>task forces</u> of the RICPG</li> <li>• Use documented, standardized methods via workbook for prioritizing populations</li> </ul>	<p><b>Attribute 37</b> (Target Populations): Evidence that the size of at-risk populations was considered in setting priorities for target populations</p> <p><b>Attribute 38</b> (Target Populations): Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence available) was considered in setting priorities for target populations.</p> <p><b>Attribute 39</b> (Target Populations): Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.</p> <p><b>Attribute 40</b> (Target Populations): Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.</p> <p><b>Attribute 41</b> (Target Populations): Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.</p>	<ul style="list-style-type: none"> <li>• Maintain attributes throughout the year</li> <li>• Attributes 37 – 41 are incorporated into written RICPG documents</li> <li>◆ 100% attainment of Attributes 19-36 annually</li> </ul>	<p>The RICPG continues to identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island, and each corresponding objective is reviewed by the RICPG and maintained.</p> <p>100% of the attributes 37-41 are in place.</p>

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Attribute	Done	Not Done	Priority	Comments
<b>Attribute 37 (Target Populations):</b> Evidence that the size of at-risk populations was considered in setting priorities for target populations.	X		1	The Prioritization Workbook demonstrates that TFs integrated size into their planning.
<b>Attribute 38 (Target Populations):</b> Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence available) was considered in setting priorities for target populations.	X		1	Found in Prioritization Workbook.
<b>Attribute 39 (Target Populations):</b> Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.	X		1	Found in Prioritization Workbook.
<b>Attribute 40 (Target Populations)</b> Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.	X		1	Found in Prioritization Workbook.
<b>Attribute 41 (Target Populations):</b> Target populations are ranked by priority, in terms of their contribution to new HIV infections.	X		1	Found in Prioritization Workbook.

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 intended target populations for cultural appropriateness, relevance and acceptability.

The selection of prevention activities/interventions for identified target populations in Rhode Island is based on two main factors:

1. behavioral and social science—outcome-effectiveness
2. evidence that the program has been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

## Goal Three

**Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluates the progress of this by increasing RICPG member perceptions across the five year grant process as well as monitoring intermediate outcomes of the process associated with this objective.**

- Indicator E.3: Percent of prevention interventions supporting activities in the health department CDC funded application specified as a priority in the comprehensive HIV prevention plan.
- Indicator E.4: Percent of health department-funded prevention/supporting activities that correspond to priorities specified 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.

The RICPG has always built this objective into the plan process by ensuring that the RICPG has equal and timely opportunity to review the plan and the cooperative. HEALTH-RI

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involves RICPG in the review and edits of the cooperative. Furthermore, both the plan and the cooperative are matched for congruence, and each year RICPG members get to scrutinize both documents for this cohesiveness. It is estimated that the 2006 cooperative is about 90 to 95% congruent with the 2005 plan and 2006 plan update. The small difference accounts for the necessary management and fiscal goals of HEALTH-RI that are not reflected in the plan.

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<b>Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluate the progress of this by increasing RICPG member perceptions across the five year grant process, as well as monitoring intermediate outcomes of the process associated with this objective.</b>				
Objective G	Activities (2006)	Outputs	Immediate Outcomes (2006)	Intermediate Outcomes (5 year) (2009)
Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.	<ul style="list-style-type: none"> <li>• Draft Plan</li> <li>• Draft cooperative letter of concurrence                             <ul style="list-style-type: none"> <li>▪ Draft of both documents to RICPG</li> <li>▪ Both written with same priorities</li> </ul> </li> </ul>	<p><b>Attribute 49</b> (Comprehensive Plan): Explicit demonstration of linkages between the comprehensive HIV prevention plan and the health department application to CDC for federal funding.</p> <p><b>Attribute 50</b> (Comprehensive Plan): Letter of Concurrence.</p>	<ul style="list-style-type: none"> <li>• Establish Attributes 49-50 by September 2005.</li> <li>• Maintain attributes throughout the year</li> <li>• Attributes 49-50 are incorporated into written RICPG documents by 12/05</li> <li>• 100% attainment of Attributes 49-50 by 12/05</li> </ul>	<p>The RICPG continues to monitor that the RICPG priority populations and interventions are consistent with the Cooperative Agreement and funding priorities, and each corresponding objective is reviewed by the RICPG and maintained.</p> <p>100% of the attributes 49-50 are in place.</p>

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### Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

HEALTH-RI issued a Request for Proposals (RFP) for HIV Prevention services on August 13, 2004. In order to meet the needs of Rhode Islanders and the CDC guidelines, the RFP clearly links the funding of prevention services to the RICPG's priorities and *Advancing HIV Prevention* with emphasis on best practices, prevention for positives and rapid testing.

This RFP was unique because of the integration of prevention for high-risk individuals and prevention for people living with HIV/AIDS and viral hepatitis. HIV prevention services began on January 1, 2005, and replaced previous funded HIV prevention initiatives that ended December 31, 2004. Ryan White-funded interventions for people living with HIV/AIDS replace previous primary prevention activities that end March 31, 2005. The Ryan White-funded interventions began on April 1, 2005.

HEALTH-RI took a broader, more comprehensive approach to HIV prevention based on the recommendations from the Rhode Island Community Planning Group for HIV Prevention (RICPG) and the guidance from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). Funded agencies had to demonstrate their capacity to deliver on the comprehensive approach HEALTH-RI was seeking. The following categories of services were listed in the most recent request for proposals:

- Health Education/Risk Reduction
- CTR
- HIV Prevention Case Management
- Harm Reduction
- Viral Hepatitis Care Coordination
- Prevention for Positive

In, 2005 the following programs and services were funded to provide Community-Based HIV Prevention Services:

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- Prevention for Positives in a Clinical Setting (Thundermist Health Center – Ryan White Funding only)
- HIV Prevention Case Management (Sojourner House)
- Health Education/Risk reduction: Locally proven effective groups and individual interventions with women (Sojourner House) and youth (Youth In Action) were funded in 2005.
- Harm Reduction (AIDS Care Ocean State – state funding only)
- HIV Counseling, Testing and Referral (Crossroads Rhode Island, with subcontracts with Family Health Services of Cranston, AIDS Project Rhode Island, Progeso Latino and AIDS Care Ocean State).

Services for injecting drug users was left off the RFP because the Centers for Disease Prevention and Control had funded two programs in Rhode Island to provide HIV prevention services for injecting drug users: Urban Leagues of Rhode Island and MAP. The total CDC funding was more than the entire funding available for HIV prevention in Rhode Island.

While Rhode Island was able to award funding to strong program for youth, women, people living with HIV and HIV testing, no awards could be made for HIV prevention services for MSM. This is a capacity building issues, and the MSM Task Force and the CDC Project Officer and HEALTH-RI are collaborating with community partners to address the issues.

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Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluate the progress of this by increasing RICPG member perceptions across the five year grant process as well as monitoring intermediate outcomes of the process associated with this objective.				
Objective H	Activities (2006)	Outputs	Immediate Outcomes (2006)	Intermediate Outcomes (5 year) (2009)
Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.	<ul style="list-style-type: none"> <li>• Conduct vendor activities that are reflective of plan</li> <li>• RFP process is in place and reflective of plan</li> <li>• New contracts are established and are reflective of plan</li> <li>• Build into RICPG process opportunity for RICPG members to agree that recommended funded vendors and their interventions are consistent with their Plan</li> </ul>	<p><b>Attribute 51 (Comprehensive Plan):</b> Explicit demonstration of linkages between the comprehensive HIV prevention plan and funded interventions.</p> <p><b>Attribute 52 (Community Services Assessment):</b> Explicit demonstration that the RICPG has used the CSA to determine whether interventions were funded according to the comprehensive HIV prevention plan.</p>	<ul style="list-style-type: none"> <li>• Establish Attributes 51-52 by September 2005</li> <li>• Maintain attributes throughout the year</li> <li>• Attributes 51-52 are incorporated into written RICPG documents by 12/04</li> <li>• 100% attainment of Attributes 51-52 by 12/04</li> </ul>	<p>The RICPG continues to develop and monitor the fact that the RICPG priority populations and interventions are consistent with the Cooperative Agreement and funding priorities and each corresponding objective is reviewed by the RICPG and maintained.</p> <p>100% of the attributes 49-52 are in place.</p>