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Evaluation



Chapter 5

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Introduction

PURPOSE OF CHAPTER

The purpose of this chapter is to provide an overview of San Francisco's approach to evaluation of HIV prevention efforts and to outline future plans for evaluation. This chapter is intended to help all who are involved in HIV prevention – consumers, providers, the San Francisco Department of Public Health (SFDPH), researchers, and others – to understand the perspective of the HPPC on the role of evaluation in combating HIV. The HPPC supports evaluation that is community-oriented, community-driven, collaborative, and inclusive. The HPPC also supports putting in place methods to assess program effectiveness that are useful, rigorous, and practical.

The HPPC envisions an evaluation approach that is meaningful to San Francisco. To be meaningful, evaluation must effectively document our successes and help us improve our programs to better meet the needs of our affected communities and eliminate new HIV infections.

HOW TO READ THIS CHAPTER

Those interested in an overview of San Francisco's approach to HIV prevention evaluation should focus on Section I. Those interested in the specifics of San Francisco's evaluation model should also read Sections II and III. HIV prevention providers are invited to read the chapter in its entirety to understand how their current and future data collection and evaluation efforts fit into the overall picture of evaluation, but specific attention should be paid to Exhibit 9 on p. 299, which outlines evaluation priorities for HPS-funded programs. The appendices provide additional context, as well as resources for those wanting to design and implement evaluations.

TERMS & DEFINITIONS

CQI Continuous Quality Improvement. An approach to quality management that emphasizes organizations and systems, with an emphasis on ongoing improvement and collaboration.

CTL Counseling, Testing, and Linkages

HERR Health Education/Risk Reduction

IMPACT EVALUATION Focuses on the broader, longer-term results of a program or set of programs. It reaches beyond immediate individual attitude and behavior change (outcome evaluation) to look at bigger picture changes.

NEEDS/STRENGTHS ASSESSMENT The process of regularly and systematically collecting, assembling, analyzing, and making available information on the health of a community and the health systems and social structures affecting it, including strengths as well as deficits.

OUTCOME EVALUATION Answers the question: "What changed?" It looks at the impacts, benefits, and/or changes among participants/clients or in the environment that happened during or after program implementation, and tries to establish whether the changes resulted from the program and/or other factors.

PROCESS EVALUATION Assesses the extent to which a program (or set of programs) was implemented as planned and identifies ways for improving program implementation. In short, process evaluation answers the questions: who, how many, what, why, and how.

STOREE San Francisco Tells Our Real Experience Through Evaluation, San Francisco's evaluation approach is called Project STOREE.

HIV Prevention Evaluation in San Francisco

SECTION I

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A driver of a car is continuously making decisions, such as to go slower or faster, based on personal or subjective perceptions of what is safe, required or, for some, exciting. ...[F]rom time to time, even the most experienced driver needs to refer to the dashboard of the car to get evidence that complements her own perceptions. (PSI Research Division 2005).

WHAT IS EVALUATION

Evaluation is like the dashboard of a car, providing objective information to complement our lived experience, so that we can make informed decisions. There are many different gauges on the dashboard that tell us a variety of things. For example, the speedometer tells us how fast we are going, the temperature gauge tells us how hot or cold the car engine is, and the oil light illuminates when the car needs oil. Likewise, in reflecting on HIV prevention efforts, a number of evaluation tools are used to gauge how things are going. For example, epidemiologic data can show whether new infections are increasing or decreasing, and outcome evaluation can show how HIV prevention programs affect individuals and communities.

Definition of HIV Prevention Evaluation

HIV prevention evaluation is a set of systematically planned and executed activities, which can include both quantitative and qualitative approaches, designed to assess one or more of the following: (1) what a program is doing, (2) who it is reaching, (3) whether it is working (and why or why not), and/or (4) how it could be improved.

Evaluation is often discussed in the context of program effectiveness. But what does that mean? For a program to be considered effective, it must contribute either directly or indirectly to the prevention of new HIV infections. While it is often unrealistic to expect that an individual program could measure a reduction in new HIV infections, programs should, whenever possible, adopt approaches that increase the chances of success, including: (1) using theory-based or evidence-based prevention models (The logic model is a program planning tool providers can use to develop an effective program. Tools for developing a logic model can be found in Appendix 3), (2) designing clear and measurable benchmarks or objectives (both process and outcome) that are logically linked to reducing new HIV infections, and (3) periodically assessing the program to see if it has met the benchmarks or objectives, and if not, adapting the program as necessary.

A program may be very successful at meeting its process objectives – in other words, all activities were done according to plan. However, this program would not be considered effective on that basis alone, because it has not shown a link to reducing new HIV infections. For example, this program may have met its objective of perfect attendance at a four-session workshop, but this indicates little about the effect of the workshop on HIV transmission; this program would also need to establish and achieve an objective related to behavior change, knowledge of HIV status, or other factors more closely linked to reducing new HIV infections.

Program evaluation is a serious inquiry into whether and how HIV prevention is achieving its goals. Even though it requires extensive time and resources, conducting program evaluation can be extremely meaningful and illuminating. The HPPC and the HIV prevention community in San Francisco highly value rigorous program evaluation because it documents and adds to the lived experience of providers and communities, honors our successes, supports us in acknowledging and owning our failures, and gives us a foundation for taking HIV prevention to the next level – reaching our ultimate HIV prevention goal of ending HIV.

San Francisco's HIV prevention evaluation effort is called Project STOREE (San Francisco Tells Our Real Experience Through Evaluation). Our story has many chapters – the citywide chapter, the agency chapter, the staff and volunteer chapter, the participant/client chapter, and others. We want all these stories to be told.

History and Background

Project STOREE was inspired by a series of events and decisions that occurred between 1997 and 2004, both in San Francisco as well as statewide and nationally. In summary, in the mid-1990s, the HPPC and HIV prevention providers began on a path to conducting effective process and outcome evaluation. The Centers for Disease Control and Prevention (CDC) and the State of California Office of AIDS later wanted to take evaluation in a different direction, with a focus on in-depth process evaluation. In our attempt to meet CDC and State needs, San Francisco discovered that evaluation was no longer meeting local needs as well as it could. By 2004, San Francisco had in many ways ceased to benefit from the data being collected, completely contrary to San Francisco's philosophy about evaluation and the HPPC's 1997 strategic plan.

Recognizing this dilemma, the HPPC formed an Evaluation Committee in 2004. This committee planted the seeds for Project STOREE with its strategic evaluation plan entitled "Changing the Culture of Evaluation in San Francisco HIV Prevention," which the HPPC adopted. This plan set the stage for a new approach to evaluation that was more in line with San Francisco's values, beliefs, and needs. The Plan's intent was "to change the culture of evaluation to reflect a dynamic informative process of information gathering where results are synthesized in order to see the overall picture of San Francisco's prevention efforts."

In 2006, the HPS launched Project STOREE, which represents a synthesis of the HPPC's 2004 Strategic Evaluation Plan and input from San Francisco's HIV prevention providers, researchers, and other stakeholders. Much of the content of this chapter was initially developed by the Project STOREE Working Group, a collaboration between HPS staff, representatives from HIV prevention providers, and the HPPC. This group considered the input of all stakeholders in developing the chapter (see Appendix I).

Goals

The overall goals of Project STOREE, from the HPPC's 2004 Strategic Evaluation Plan, are provided below. Exhibit 1 shows the overarching HIV prevention evaluation questions for San Francisco and how answering them will help us achieve the goals.

Goal 1. Gathering the stories. Evaluation reflects how San Francisco HIV prevention efforts promote the mental, physical, emotional, and structural health and well-being of people in San Francisco.

Goal 2. Creating information bridges. Evaluation creates a bridge between the providers, participants/clients, planners, funders, and policy makers (collectively, stakeholders) of San Francisco HIV prevention programs to: 1) voice expertise and share experiences; 2) share results of HIV prevention efforts in San Francisco; and 3) improve programs.

Goal 3. Using the stories to create change. Evaluation creates the foundation for change in San Francisco HIV prevention efforts.

In order to create the change described in Goal 3, evaluation efforts should seek to answer the following overarching questions. The answers to these questions will help identify new directions for HIV prevention.

EXHIBIT 1 Using Evaluation to Create Change



Overarching Evaluation Questions

- Are our HIV prevention efforts working to reduce new HIV infections?
- Are our HIV prevention efforts meeting client and community needs?
- How could we improve our efforts?

a) **Gather the stories** that will help answer these questions

b) **Create information bridges** to share the stories

c) **Use the lessons learned to create change** and improve prevention

Core Beliefs and Guiding Principles

Core Beliefs

The HPPC holds the following core beliefs that form the rationale for Project STOREE:

- 1. Evaluation helps reduce the transmission of HIV by generating information that can be used to improve HIV prevention programs.** Evaluation is used to (1) determine whether individual HIV prevention programs are working; (2) improve the design and implementation of programs; (3) inform front-line workers and managers how to improve their work and how to better meet the needs of clients and communities; (4) ascertain which interventions reduce different risk behaviors in different populations; (5) identify gaps in services. These benefits of evaluation all facilitate the ultimate goal of eliminating the transmission of HIV in San Francisco.
- 2. Evaluation is critical for ensuring that prevention efforts meet the changing needs of affected groups.** Evaluation activities can (1) determine whether prevention programs are responding to consumer perceptions about current HIV-related issues; (2) demonstrate whether prevention efforts are keeping pace with the most up-to-date epidemiologic distribution of HIV infection and risk behaviors in the city; and (3) show whether new, creative, and innovative programs are effective in the context of current HIV epidemiology, leading to the establishment of new best practices for HIV prevention.

3. Evaluation data can improve prevention planning and resource allocation.

Evaluation can help HIV prevention planners make informed decisions about the most effective and efficient use of scarce funding and technical assistance resources. Evaluation results (1) demonstrate whether individual programs are reaching their priority populations, meeting client needs, and are effective at reducing risk behaviors; (2) show which interventions work best in which populations; and (3) indicate trends in HIV infection and risk behavior over time at the citywide level.

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4. Evaluation gives a voice to consumers of HIV prevention services.

Collecting information from those using services allows their perceptions and experiences to be heard by prevention providers, researchers, policy makers, and funders. Good evaluation (1) continually integrates the consumer voice into design, implementation, and analysis; and (2) considers consumer needs and perspectives when conducting evaluation research.

5. Evaluation gives credibility to the local HIV prevention strategy.

Evaluation offers an important opportunity for the city to (1) define what is working from a local perspective; (2) showcase and promote its innovative community-based HIV prevention model using scientific methods designed to truly capture the essence of the local work; and (3) acknowledge and own our failures so that we can learn from them as part of a continuous improvement process.

6. Evaluation is most effective and useful when it is driven by local stakeholder needs.

Because HIV and approaches to addressing it differ by locality, evaluation plans should be designed and implemented at the local level, with input from clients and communities, HIV prevention providers, the community planning group, local researchers, health department staff, and other local stakeholders. State and federal government evaluation mandates can create enormous data collection burdens for providers without generating data that is useful locally. Localities are in a better position to design evaluation efforts that highlight local successes and provide data that can be used to improve HIV prevention programs. Localities with similar epidemiologic profiles and services can then share evaluation best practices with each other.

Guiding Principles

The HPPC supports the following principles to guide the implementation of Project STOREE:

- 1. Collect only data that will be used.** The HPS should not require the collection of any piece of data that will not be used to answer, directly or indirectly, one of the three overarching evaluation questions (Exhibit 1).
- 2. Incorporate a “feedback loop” into evaluation.** When data is analyzed or studies are conducted, the findings should be presented to stakeholders, including communities, providers, the HPPC, and the HPS. This honors the effort that was put into collecting the data, builds support for data collection because people can see the results, and opens up opportunities to discuss ways to improve HIV prevention.
- 3. Limit provider and client burden.** Program and service delivery should always be providers' primary focus, with evaluation and data collection playing a supportive role. However, in order to meet San Francisco's evaluation needs, as well as those of external stakeholders, there will always be some required data collection and evaluation. The goal is to keep the requirements limited to minimize the burden for providers and clients in terms of time and effort. This will ideally free providers to implement additional evaluation that is meaningful for them as needed and as capacity allows.
- 4. Provide options for data collection and reporting.** Just as with prevention programs, evaluation and data collection must be appropriate for the client and the setting. To this end, providers should have flexibility in how they collect and report data. For example, paper and pencil might be an appropriate data collection method in some settings, whereas personal digital assistants (PDAs) might work better in others. Providers also

need flexibility in how and when they collect data. For example, with some programs and interventions it might make the most sense for clients to complete written surveys, whereas with others it might be more appropriate for providers to ask clients the questions in an interview format.

- 5. Provide training and technical assistance (TA).** The HPS should not require any data collection, evaluation, or reporting without providing the appropriate training or TA. This training and TA should be available to support providers in meeting the minimum evaluation requirements, and ideally, it would also support providers to conduct expanded evaluation at their discretion. There are a number of free and low-cost resources to draw on for this (e.g., Center for AIDS Prevention Studies Technology & Information Exchange Core Program, CDC's Capacity Building Assistance program), in addition to resources that could be allocated toward training and TA efforts.
- 6. Usefulness of evaluation findings, scientific rigor, and practical considerations are all important and must be balanced.** In San Francisco, the data needs of the users (in this case, affected communities, the HPPC, the HPS, providers, CDC, etc.) are paramount – they drive the evaluation plan. Scientific rigor, while important, needs to be balanced with the practical aspects of addressing the HIV prevention needs of San Franciscans. Nevertheless, evaluation findings cannot be trusted unless the methodology and implementation are sound, so scientific rigor cannot be ignored. Ultimately, when appropriate evaluation methods are applied to ascertain the effectiveness of programs, we can learn what is working, how programs can be improved, and how we can hold ourselves accountable. Thus, the HPPC strongly supports putting in place methods to assess program effectiveness that are useful, rigorous, and practical.
- 7. The HPS and providers should dedicate money and staff for evaluation.** Evaluation costs money. All steps involved in evaluation should be accompanied by a cost assessment (including one-time and ongoing costs) and a plan for how it will be supported. Evaluation also requires staffing and leadership, including full- and part-time positions dedicated to evaluation.
- 8. HPS-funded providers should be compensated fairly for the costs of implementing evaluation requirements.** All too often evaluation is an unfunded mandate, despite the fact that evaluation always takes time and costs money. Providers should receive adequate reimbursement for fulfilling evaluation requirements, commensurate with the amount of staff time spent on evaluation activities and the amount spent on evaluation materials and supplies (e.g., computers, software). In difficult financial times, evaluation may seem the easiest thing to cut back on, but in fact it becomes even more critical, because the need to show that limited funds are being spent on programs that work is more pressing.
- 9. Qualitative data should be an integral part of the evaluation effort.** Qualitative data – data represented in words (not numbers) that explores meaning, context, and nuance – is often overlooked as a legitimate way to evaluate HIV prevention. Qualitative data is not the same as anecdotal data or isolated stories; rather, it is collected systematically and with a particular purpose. Provider experience shows that some of the most important prevention successes and failures can only be illuminated through qualitative approaches to evaluation. Qualitative data is the key link to explaining the “why and how” behind the numbers, and it can show the impact of prevention on people's lives in a way that quantitative data does not capture. San Francisco believes in a holistic approach to HIV prevention, thus we should implement a holistic approach to evaluation that includes qualitative data. Combining the numbers and the stories can paint a fuller picture and provide greater insight.
- 10. Evaluation is a collaborative effort.** There will always be evaluation and data collection requirements that providers must embrace as a condition of their funding. However, the development and implementation of an evaluation plan for the city and for individual providers is an ongoing collaborative effort, where input and feedback from key stakeholders are always included. Stakeholders include clients, community members, HIV

prevention providers, the HPS, CDC, the State Office of AIDS, TA and capacity building assistance providers, researchers, and many others. The goal is for all the stakeholders, especially the HPPC, the HPS and providers, to see each other as partners and resources in the evaluation effort, and to engage in the partnership because it is mutually beneficial.

Lessons Learned

As Project STOREE unfolds, we must take into account lessons from the past. The San Francisco HIV prevention community has developed a wealth of practical knowledge about evaluation that should be incorporated into future evaluation plans:

- **Community members, including HPPC, program participants, and the larger HIV community, are the primary stakeholders in evaluation.** Evaluation should be inclusive and responsive to community needs. Evaluation findings should be presented back to community stakeholders. Programs and program evaluators have a responsibility to ensure that evaluation findings are used to improve community programs. Ultimately, evaluation is conducted so that we can better serve communities and clients in our pursuit of reducing new HIV infections.
- **Evaluation in the real world may look very different than evaluation in an ideal world.** HIV risk is complex, and contextual factors can be difficult to measure. Defining culturally appropriate markers of effectiveness is challenging. Even coming up with a very general definition of what constitutes “success” that all stakeholders can agree to can sometimes feel like an impossible task. In short, in the real world, evaluation is not clean and simple.
- **Perfection is the enemy of good.** Programs never have enough time or money to do everything they want to do with regards to evaluation, but just because it can't be perfect isn't a reason to do nothing. Evaluation can be something very simple – see Appendix 2 at the end of this chapter for some suggestions.
- **There is a need to move beyond “bean counting.”** Sometimes just collecting basic information on participants can take so much energy – between designing forms, training staff on how to collect the data, entering it, and checking it for quality – that programs are not able to get to the actual evaluation part, where data is analyzed and fed back into the program. This phenomenon can make data collection feel pointless and burdensome. Agencies and funders need to find ways to ensure that data gets analyzed and used. Some successful strategies that can be implemented include: (1) limiting the amount of data collected because then there is more time to analyze it, and a lot can be learned from a small amount of good-quality data, (2) integrate easy evaluation activities into the day-to-day work (see Appendix 2 for some suggestions), and (3) consider dedicating all or part of a staff position to evaluation (not just data collection).
- **Programs can reduce the need for outcome evaluation by replicating or adapting programs that have already been shown to be effective.** If a program has been shown to be effective, as long as it is implemented as intended, there is less need for outcome evaluation. The focus can then be placed on process evaluation, to ensure adherence to the program plan. CDC's Prevention Research Synthesis (PRS) Project (<http://www.cdc.gov/hiv/topics/research/prs/index.htm>) is one place to go to find such programs. Literature searches are another tool.
- **Logic models are a helpful tool for program planning and evaluation.** See chapter Appendix 3 for some resources on logic modeling.
- **Front-line staff are important stakeholders in evaluation.** Their expertise and buy-in is needed at all stages of evaluation. Without their participation, evaluation will not work.
- **New evaluation tools are needed to keep pace with new trends, such as the increased emphasis on structural approaches.** While methods for evaluating individual and group level behavioral interventions are well-developed, tools and models for evaluating HIV prevention structural change initiatives are not and are sorely needed.

The HIV Prevention Evaluation Cycle

OVERVIEW OF THE CYCLE

Evaluation is an ongoing and dynamic process. The cycle of HIV prevention evaluation in San Francisco is composed of five elements as depicted in Exhibit 2. (This visual framework is useful for understanding the evaluation process, but in reality the process is more complex and nuanced.) This cycle happens at multiple levels: (1) the individual level, where a person's individual needs are assessed and progress is measured, (2) the program level, where a particular program is evaluated, (3) the citywide programs level, where the collective effect of funded programs is assessed, and (4) the population level, where what is happening in the city as a whole is monitored.

EXHIBIT 2 The HIV Prevention Evaluation Cycle in San Francisco



Each type of evaluation is linked to the next to form an ongoing cycle. For example, needs assessment generates information that is used to develop a program, and process evaluation assesses the extent to which a program is addressing the need. Process evaluation also reveals areas in which a program could be improved, and the improvement is implemented in order to enhance the chance that outcomes will be realized, and so forth.

The centerpiece of the process – accountability – reminds us why San Francisco prioritizes evaluation in the first place. It's not about accountability to funders, although that is certainly one use for evaluation data. It's about accountability to the San Francisco community. The HPPC, the HPS, and service providers owe it to the city and to the clients to do the best job we can to prevent new HIV infections, and evaluation is one important tool for keeping us accountable.

Accountability can be defined in several ways. Program monitoring is one form of accountability – an agency/program that enters into a contractual agreement to perform a service will be expected to perform according to agreed-on terms, within a specified time period, and with a stipulated use of resources and performance standards.

Accountability in the context of program evaluation has a broader definition. It means that the HPPC, agencies/programs, as well as the HPS, must be responsive to client and community needs, must make good faith efforts to implement services that lead to a reduction in new HIV infections, and must document the ways in which they do this. This means moving through the evaluation cycle and creating a continuous feedback loop so that findings can be used to improve programs (i.e., continuous quality improvement, or CQI).

Steps 1-4

Needs/Strengths Assessment, Process Evaluation, Outcome Evaluation, and Impact Evaluation

Exhibits 3-6 define the first four steps in the cycle, present the rationale for why each step is important, and highlight factors that need to be taken into account when implementing each step. The fifth step – accountability – is discussed after the exhibits. This is an overall picture of the evaluation cycle, and it is not expected that every program or the HPS will perform every step.

EXHIBIT 3 Needs/Strengths Assessment

DEFINITION	Needs/strengths assessment, commonly referred to as needs assessment, is the process of regularly and systematically collecting, assembling, analyzing, and making available information on the health of a community and the health systems and social structures affecting it, including strengths as well as deficits. This can include information and statistics on health status, community health needs, and epidemiologic and other studies of health problems. A needs assessment identifies both met and unmet needs, possible approaches to addressing unmet needs, and highlights community assets and strengths.*
RATIONALE	Needs assessment: <ul style="list-style-type: none">• Is a critical tool for informing us about the problem at hand.• Can identify multiple aspects of need, including need as clients and community members perceive it, as well as need from an epidemiologic perspective.• Can help to quantify or shed more light on issues we already know exist. For example, it is well known that there is a lack of affordable housing in San Francisco and that homelessness can be a cofactor for HIV risk. Needs assessment could help illuminate the extent of the problem, who is most affected by lack of housing, barriers to solving the problem, and other details that we might not otherwise know.
ADDITIONAL CONSIDERATIONS	Assessment activities must extend beyond just those individuals already being reached with prevention messages and services. Needs assessment must include the broader community, not just HIV prevention participants. Specifically, it is important for improving our prevention efforts to understand which at-risk populations are not being reached and why.
GUIDING QUESTIONS	Needs assessments can help answer questions such as: <ul style="list-style-type: none">• What is the epidemiology of HIV in San Francisco?• What are the HIV prevention needs, both met and unmet, from the client and community perspective?• What are the prevention needs of people living with HIV?• What are community strengths and unmet needs regarding HIV status awareness?• What behaviors are contributing to HIV risk?• What drivers and cofactors are contributing to HIV risk?• What are the barriers to accessing services?• What are effective approaches for meeting the range of client and community needs?• What are San Francisco's HIV prevention-related structural change needs (e.g., service integration and coordination) and how can they be addressed?

*Adapted from Petersen DJ, Alexander GR: *Needs Assessment in Public Health: A Practical Guide for Students and Professionals*. Kluwer Academic/Pluwer Publishers, 2001.

EXHIBIT 4 Process Evaluation

DEFINITION	Process evaluation assesses the extent to which a program (or set of programs) was implemented as planned and identifies ways for improving program implementation. The goals of process evaluation are to: (1) ensure fidelity to the program plan, and (2) find ways to improve the program content and delivery so that it better meets client and community needs and can be more effective at achieving the specified program outcomes. In short, process evaluation answers the questions: who, how many, what, why, and how.
RATIONALE	Process evaluation: <ul style="list-style-type: none">• Can help to eliminate unwanted deviation from the program plan, in order to maximize the likelihood of achieving the desired behavioral or other outcomes.• Is a critical accountability tool. Data can demonstrate to funders that funds are being used as intended and that high-risk populations are being reached with appropriate interventions.
ADDITIONAL CONSIDERATIONS	<p>Most agencies in San Francisco conduct their own process evaluation, as opposed to contracting with an outside evaluator. This approach is very practical from a logistical and financial perspective, and in many ways the "insider" perspective can be a benefit in terms of identifying the "how" and "why" behind the numbers. There are also benefits to having an outside evaluator who is neutral and does not have any preconceived notions about the program. Either approach can be valid, depending on the circumstances.</p> <p>In order to get an accurate picture of who is being reached, certain process evaluation-related data, such as client demographics, must be collected on all clients (not just a sample).</p>
GUIDING QUESTIONS	Process evaluation can help answer questions such as: <ul style="list-style-type: none">• How many people are being reached, with how many contacts per person?• What are the demographics, cofactors, and behavioral risk populations of those being reached?• Who is not being reached?• Is there alignment between who the program was contracted to reach and who is actually reached?• Is there alignment between the epidemiologic profile, the programs funded, and who is actually reached?• Are programs being implemented as planned? If not, why not?• Are programs working to: 1) reach high-risk (or other appropriate) populations, and 2) to recruit, engage, and retain clients? Why or why not?• Are programs cost-efficient (i.e., productive relative to the cost) and cost-effective (i.e., cost per HIV infection averted is less than the lifetime cost of providing HIV/AIDS treatment and care)?

<p>DEFINITION</p>	<p>Outcome evaluation answers the question: "What changed?" It looks at the impacts, benefits, and/or changes among clients/ consumers or in the environment that happened during or after program implementation, and tries to establish whether the changes resulted from the program and/or other factors. Outcome evaluation can measure short-term, intermediate-term, or long-term changes.</p>
<p>RATIONALE</p>	<p>Outcome evaluation:</p> <ul style="list-style-type: none"> • Tells us whether a program or set of programs is actually working to change behaviors and other factors that lead to new HIV infections. • Is what shows the world that HIV prevention is worth the investment, which is critically important in this era of dwindling funds for health and social services.
<p>ADDITIONAL CONSIDERATIONS</p>	<p>Conducting outcome evaluation in a service environment is different than academic outcome research. Both are valuable and useful approaches to evaluation, each with their benefits and drawbacks. The HPPC supports an approach to outcome evaluation that maximizes scientific rigor without substantially increasing the burden (time, logistical, or financial) on programs and their clients.</p> <p>Unlike process evaluation data, outcome data can be collected and analyzed using a sample of clients, if the sample is selected using appropriate criteria, or for a limited time period instead of ongoing.</p>
<p>GUIDING QUESTIONS</p>	<p>Outcome evaluation can help answer questions such as:</p> <ul style="list-style-type: none"> • In the immediate term: Are referrals and linkages made and followed up on successfully? • In the intermediate term: Are the cofactors that affect HIV risk decreasing at the individual level? • In the intermediate to long-term: Are HIV risk behaviors decreasing? Are sexual health-promoting behaviors increasing?

DEFINITION	Impact evaluation focuses on the broader, longer-term results of a program or set of programs. It reaches beyond immediate individual attitude and behavior change (outcome evaluation) to look at bigger picture changes, such as whether healthful behaviors are sustained over many years, or whether population-level trends in disease are affected.
RATIONALE	Impact evaluation for HIV prevention: <ul style="list-style-type: none"> • Speaks directly to San Francisco's overall goal: to reduce new HIV infections by 50% by 2015. • Represents the ultimate marker of whether our efforts are pointed in the right direction.
ADDITIONAL CONSIDERATIONS	<p>Impact evaluation for HIV prevention has two significant limitations – (1) new HIV infections cannot be measured directly, and (2) it is difficult to link estimated reductions in new HIV infections to a particular program, set of programs, or specific strategies.</p> <p>To address the first limitation, San Francisco reviews a set of indicators. Indicators are conditions or diseases that are known to follow or precede the pattern of HIV transmission, such as sexually transmitted infections. A wide range of studies that examine prevalence, incidence, and cofactors are also reviewed periodically to paint a picture of the epidemiology of HIV. Finally, approximately every 5 years, San Francisco has engaged in a consensus process, in which all the available data is systematically reviewed, HIV incidence estimates are developed, researchers and community members review the estimates, and adjustments to the estimates are made as necessary. In 2008, San Francisco started to use a new methodology developed by the CDC for estimating HIV incidence.</p> <p>To address the second limitation, San Francisco must continue to emphasize and strengthen its process and outcome evaluation efforts. If these evaluations demonstrate that HIV prevention is working, impact evaluation shows a decrease in new infections, and the timing of the decrease coincides with the implementation of new or improved programs, then a stronger (but not conclusive) argument can be made that the reduction in new infections is a result of HIV prevention programs.</p>
GUIDING QUESTION	Are new HIV infections decreasing?

Step 5 **Accountability: The Feedback Loop and Continuous Quality Improvement**

San Francisco has always been a leader in HIV prevention evaluation and data collection. The HPPC, HIV prevention providers, and the HPS have united to prioritize evaluation because of its potential to provide information that will launch us to the next level – ending HIV.

In order to take that leap, a critical piece of the evaluation cycle must be in place and functioning effectively – accountability. Accountability goes beyond just showing that we did what we said we would do. It means taking what we've learned from evaluation, disseminating

it to the stakeholders that have the power to use it to create change (the feedback loop), and actually using it to make concrete improvements to programs and processes (continuous quality improvement, or CQI).

The Feedback Loop

The feedback loop operates both within agencies (e.g., between managers and line staff) and between and among institutions (e.g., between researchers and HIV prevention programs). The HPPC and the HPS are especially committed to ensuring that findings from evaluation and research are accessible to HIV prevention programs. A strong feedback loop also ensures overall coordination of services and programs and helps avoid duplication of efforts and reinventing the wheel.

Continuous Quality Improvement

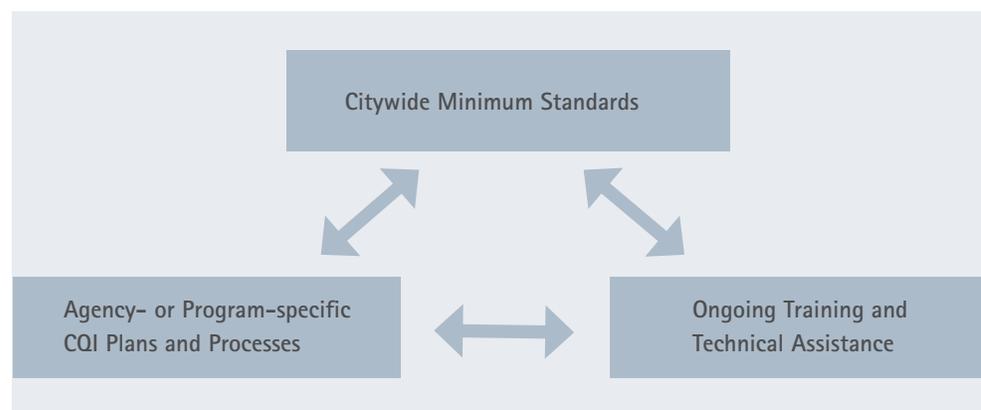
Continuous quality improvement (CQI) is an approach to quality management that emphasizes organizations and systems:¹ In the context of CQI, the term quality is defined as meeting and/or exceeding the needs and expectations of stakeholders – including clients, communities, staff, Boards of Directors, funders, etc. CQI is similar to quality assurance or QA, but it has a greater emphasis on ongoing improvement and collaboration. Specifically, CQI:

- Focuses on “process” rather than the individual;
- Recognizes both internal and external stakeholders;
- Promotes the need for objective data to analyze and improve processes;
- Relies on active participation of all involved, from front-line staff to directors of organizations;
- Is most effective when it becomes a natural part of the way everyday work is done; and
- Requires a commitment to explore, utilize, and reward new approaches in pursuit of ever-increasing quality.

The HPPC supports a CQI framework for HIV prevention in San Francisco that has three components (Exhibit 7):

- Citywide minimum standards that providers will be required to follow (e.g., required harm reduction elements in programs, staff training requirements). These standards should be developed collaboratively with providers.
- Provider CQI plans that reflect the minimum standards and also address issues specific to the agency or program. The HPS should provide training for HIV prevention providers on designing and implementing a CQI plan.
- Ongoing training and TA for providers designed to strengthen program capacity and effectiveness (e.g., training on science-based interventions, TA for improving linkage and referral processes).

EXHIBIT 7 CQI Framework



1 Adapted from: <http://heapro.oxfordjournals.org/cgi/content/full/14/1/83> and <http://www.fpm.iastate.edu/worldclass/cqi.asp>.

The Evaluation Cycle in Action: A Hypothetical Example

The fictional case study below is used to illustrate each type of evaluation, and how collaboration among different stakeholders can lead to the full use of the evaluation cycle. In the real world, the cycle is rarely as streamlined as this; thus, a real example of one step in the cycle – process evaluation – is presented in the next section to illustrate how evaluation, while incredibly useful, can also be very complex.

Needs/Strengths Assessment. HPPC members had been hearing a lot of anecdotal information from the community about the high rates of African American MSM testing HIV-positive. The HPPC voted to prioritize a needs assessment among this group to answer the following questions: (1) What is the HIV prevalence and incidence among African American MSM? (2) What cofactors and behaviors might explain the high incidence? (3) What are the supports and barriers that affect HIV testing rates among this group? and (4) What types of HIV prevention services would be of interest to this group? The needs assessment was conducted using both quantitative (surveys) and qualitative (focus groups) methods. Participants were recruited using a snowball sampling method, whereby each participant was asked to refer eligible partners, friends, or acquaintances. In addition, the HIV Epidemiology Unit provided the most current data on prevalence and incidence for this group. The results were presented back to the HPPC, with several recommendations about how to make HIV testing programs more accessible for African American MSM.

Process Evaluation. The HPPC adopted the recommendations from the needs assessment for improving HIV testing programs. The HPS also asked programs to collect data on gender, race/ethnicity, and behavior from all testers in order to conduct process evaluation. The HPS analyzed this data to determine if programs were meeting their goals in terms of numbers of African American MSM tested. HPS staff met with each agency on a quarterly basis to share and discuss the process evaluation data, and to identify program adjustments needed in order to stay on track to meet the goal. At the end of the year, the HPS presented the data on African American MSM testers back to the HPPC.

Outcome Evaluation. The HPPC also asked the HPS to evaluate two outcomes: (1) the rate of successful linkage to care among this group, and (2) any behavior change among testers three months after their HIV test counseling session. The HPS collaborated with providers and developed standards for linking people living with HIV to care and for tracking these linkages; three testing sites volunteered to conduct three-month follow up surveys with their testers. After one year, the HPS analyzed the data by comparing linkage to care rates for African American MSM versus other MSM. The HPS also assessed whether behavior changed by comparing the risk behaviors reported when people got tested to the risk behaviors they reported at three-month follow-up. Data was presented back to the providers and the HPPC.

Impact Evaluation. The HPS worked with the HIV Epidemiology Section to develop and track over time several indicators for African American MSM, including rates of unprotected anal sex, rates of methamphetamine use, and number of newly diagnosed HIV infections. After collecting and tracking these data for three years, the HIV Epidemiology Section Co-Director brought the data to the HPPC to illustrate the extent to which risk and new infections appeared to be changing among African American MSM.

Accountability: The Feedback Loop and CQI. The feedback loop and CQI were woven throughout the process, from the needs assessment to the impact evaluation phase. To support the feedback loop, findings were presented to the HPPC at each stage. CQI was implemented at both the process and outcome evaluation stages, where providers reviewed and discussed the data and made changes to improve their programs. Providers also assessed their adherence to the linkages standards on an ongoing basis, and identified ways to change their organizational systems and processes to make linkages happen more smoothly.

Process Evaluation and Continuous Quality Improvement in Action: A Real Example

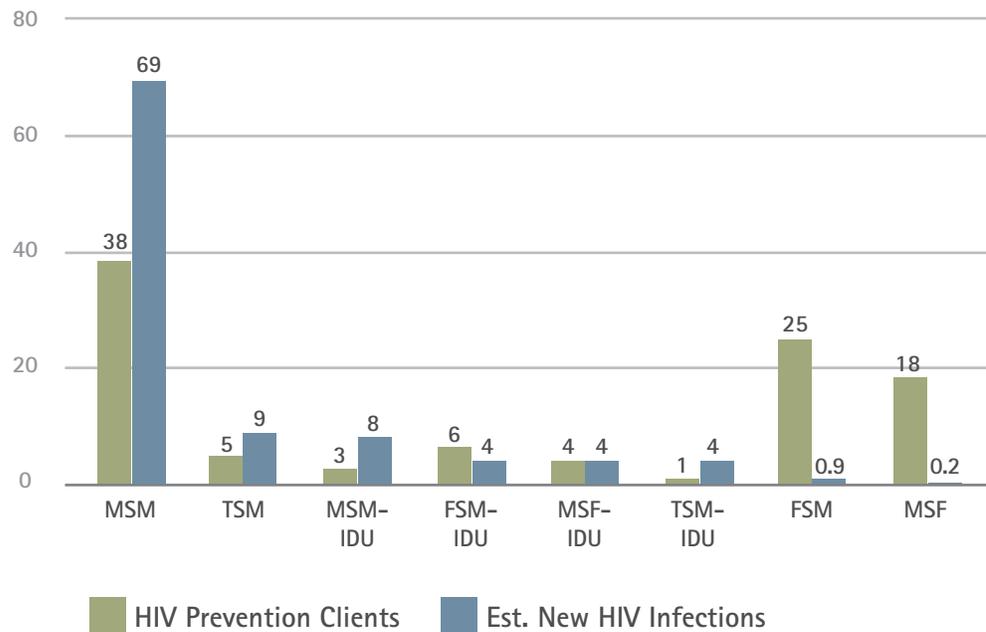
In 2007, San Francisco’s Health Education and Risk Reduction (HERR) and Prevention With Positives (PWP) providers began a new system for collecting process data on all clients. This data is called Core Variables, and it consists of 16 pieces of data related to demographics, behavioral risk population, and services accessed. The Core Variables were designed to be a tool for process evaluation. The goal is to use the data to paint a citywide picture of who is being reached with what services, and to assess whether this picture is consistent with the priorities set by the HPPC.

In 2008, the data was analyzed and compared with the prioritized populations from the HPPC’s 2004 HIV Prevention Plan. This information was presented to HIV prevention providers in June 2008 and to the HPPC in July 2008.

Core variables data has many limitations, including high rates of missing data for some variables, a tendency to over-count the number of unique clients, and the fact that this was the first year of data collection under a new system and therefore data quality assurance processes were not fully developed. In addition, core variables document the numbers of clients and contacts, whereas the HPPC sets priorities based on new infections and offers resource allocation recommendations. Finding a way to compare these different types of information was challenging and required making some assumptions.

Despite these limitations, the findings were striking. The data strongly suggested that, collectively, PWP providers were reaching populations as intended by the HPPC but HERR providers were not (Exhibit 8). In particular, it appeared that MSM were being reached at a lower rate than planned, and FSM and MSF were being reached at a higher rate. In the Exhibit, the green bar represents actual clients reached by BRP, and the blue bar represents estimated new HIV infections, on which the HPPC priorities were based.

EXHIBIT 8 HERR HIV Prevention Clients Reached (4/1/07–3/31/08) Compared with Estimated New HIV Infections from the HPPC 2004 Priority Setting Model



The next step in the process evaluation was to try to understand why this was the case. Providers, HPPC, and the HPS all suggested many hypotheses. For example, it was suggested that perhaps the HPS did not fund providers in accordance with the HPPC priorities, and therefore the problem was with the funding process and not the programs. This hypothesis was explored and rejected as the main cause of the discrepancy; while the HPS did fund MSM at the lower end of the recommended range and FSM and MSF were slightly higher than recommended, this could not explain the stark contrast between the priorities and who was actually reached.

A number of other hypotheses were offered, including:

- Many MSF reached were actually having sex with men but not disclosing it, and thus the core variables data under-represents MSM clients.
- MSM clients were seen in more intensive interventions, more frequently, and over a longer period of time compared with FSM and MSF. Therefore, even though the actual number of MSM reached was lower than intended, the appropriate level of effort and resources were spent on this population because of the intensity of the service.
- Providers actually reached their contract goals with respect to the number of MSM reached, and the FSM and MSF participants were above and beyond the expectations.

All of these hypotheses and others were investigated, and while none could be completely proved or disproved, many had merit. Ultimately, the HPS decided to focus on where it could have influence – CQI, in the form of working with HERR providers who were not reaching the priority populations they were contracted to reach. Core variables data was re-analyzed for each funded HERR program and compared with contract goals. In 2008-2009, HPS staff met with providers whose core variables data showed they were not reaching the populations as outlined in their contracts. Together, HPS and program staff developed plans for improved targeting of programs. Progress will be measured by analyzing core variables data collected in 2009 and 2010.

SECTION III Roles and Responsibilities

In order to tell all the chapters of San Francisco's HIV prevention story, all of the partners must contribute to the evaluation effort. The following sections outline the roles and responsibilities of the different stakeholders that, if fulfilled, will result in a rich and multidimensional picture of HIV prevention in San Francisco and creative ideas about strengthening our approaches.

HIV Prevention Providers

The primary role of HIV prevention providers is to contribute to the goal of reducing new HIV infections by delivering prevention that is effective and meets community needs. With respect to evaluation, providers are responsible for documenting all aspects of their efforts to ensure accountability. The proposed evaluation requirements for HPS-funded providers, both existing and those recommended for implementation in the future, are summarized in Exhibit 9.

EXHIBIT 9 Evaluation Requirements for HIV Prevention Providers

TYPE OF EVALUATION	REQUIREMENT	DESCRIPTION	Already in place	Prioritize for the future, if funding is available
PROCESS EVALUATION	Program plans	Complete and submit a program plan for each funded program. The program plan is a quantitative and qualitative description of who the program intends to reach.		X
PROCESS EVALUATION	Core variables (HERR and PWP programs only)	Collect and report on the core variables as outlined in the Core Variables Instruction Manual (http://www.sfhiv.org/provider_eval_data_collection.php).	X	
	HIV testing variables	Collect data and maintain documentation in accordance with HPS policies (http://sfhiv.org/testing_coordinator_resources.php).		
PROCESS EVALUATION	Client satisfaction survey	Conduct a client satisfaction survey once annually and report data to the HPS. Providers may design their own client satisfaction instrument and process.	X	
OUTCOME EVALUATION	Outcome objective	Conduct outcome evaluation of the program. This must include, at a minimum, the measurement of one quantitative outcome objective. All other aspects of the outcome evaluation (defining the objective, sampling, method and frequency of measurement, qualitative component) are optional, can be specific to the provider, and should be developed in collaboration with the HPS.	X	
CQI	CQI plan	Develop and implement a CQI plan and processes that incorporate the citywide standards/requirements.	X (for HIV testing)	X (for HERR and PWP)
FEEDBACK LOOP	STOREE report	Write and submit to the HPS a brief annual summary of evaluation findings, including qualitative and quantitative data. What did you learn about the program or clients? How did you use that information to improve the program? Did the data collected reveal any new trends or issues that providers across the city should be aware of? What were the program successes? The failures? The challenges?		X
FEEDBACK LOOP	Trainings and meetings	Attend all required trainings and meetings related to evaluation and data. Examples of types of meetings include: <ul style="list-style-type: none"> • Providers giving input into the evaluation requirements and overall plan; • Training on evaluation or data collection; • Sharing research findings, evaluation data, or best practices; and • Reflection and discussion about evaluation findings, and how prevention should evolve as a result. 	X	
ALL	Participation in citywide evaluation projects	Providers are strongly encouraged to participate in projects as requested if the project is relevant to them, logistically feasible, and would not create undue burden for staff or clients in terms of time or cost.	X	
ALL	Evaluation plan	Develop and implement a program evaluation plan that incorporates (but is not necessarily limited to) the minimum HPS requirements described here. The plan should address staffing, activities and timeline, and evaluation tools to be used (such as surveys).		X

HIV Prevention Section

Overall, the role of the HPS is to support HIV prevention by making information and resources accessible. The HPS does this in four main ways:

- **Collect, assemble, and analyze data.** The HPS assembles and analyzes data from providers, the literature, surveillance, and other sources. The HPS also initiates research studies on specific issues or populations as needed and as funding permits. The goal is to synthesize and summarize the data so that key stakeholders, such as the HPPC, providers, and the HPS can use it to (1) tell San Francisco's HIV prevention story, and (2) improve HIV prevention efforts.
- **Provide evaluation training, TA, and capacity building assistance (CBA).** Training is an event dedicated to transferring knowledge about a specific topic. TA is time-limited assistance provided to an agency in order to meet a specific, short-term goal. CBA may be short- or long-term, but it differs from TA in that its purpose is to increase an agency's ability to meet its longer-term goals through strengthening the organizational infrastructure. The HPS will ensure that providers have access to the training, TA, and CBA they need to meet the minimum evaluation requirements, as well as to implement additional evaluation strategies.
- **Facilitate the feedback loop and implement CQI.** The HPS is responsible for dissemination – implementing creative ways to frame and distribute evaluation and research findings – so that they can be applied to programs. The HPS is also responsible for facilitating the overall CQI process, such that prevention is continually improving. Impacted communities should always be included in the feedback loop process.
- **Encourage collaboration.** The HPS is responsible for identifying areas for collaboration among various stakeholders (e.g., researchers, providers, funders) and facilitating such collaboration, with the ultimate goal of opening channels for information exchange.

HIV Prevention Planning Council

In general, the HPPC plays three main roles:

- **Set priorities based on data.** The HPPC will review the data assembled by the HPS and set priorities for HIV prevention based on the data. Priorities might relate to populations, interventions, strategies, or research.
- **Facilitate the feedback loop.** The HPPC will work closely with the HPS to ensure that the impacted communities, providers, and other stakeholders have access to the latest research and data. The HPPC does this primarily through the San Francisco HIV Prevention Plan, which is published approximately every five years and updated annually. Please see the Epidemiology chapter (pp. 10-57) for the latest data on HIV in San Francisco, the Community Assessment chapter (pp. 60-147) for the latest research on populations and cofactors/drivers, and the Strategies and Interventions chapter (pp. 170-279) for the most up-to-date information on evidence-based interventions.
- **Encourage collaboration.** The HPPC works closely with the HPS to encourage collaboration among various stakeholders (e.g., communities, researchers, providers, funders), with the ultimate goal of opening channels for information exchange.

Researchers

The HPPC considers researchers to be our partners in HIV prevention and evaluation. In order to facilitate the use of research findings to improve HIV prevention, the HPPC offers the following guiding principles for research (first adopted by the HPPC in 2002; Exhibit 10) and requirements for researchers seeking letters of support from the HPPC (first adopted by the HPPC in 2000; Exhibit 11). All researchers conducting HIV prevention-related studies are strongly encouraged to share results with the larger San Francisco community. If a research study is providing a needed service, researchers are strongly encouraged to explore avenues for continuing the service after the study ends.

Guiding Principles for Research*

GUIDING PRINCIPLE	DESCRIPTION
COMMUNITY BENEFIT	Community-based research is research conducted by and for communities. Its purpose is to build community capacities that will provide knowledge with which to improve community conditions.
CAPACITY BUILDING	In its conduct, community-based research promotes and develops the inquiry skills of all participants. The aim of community-based research is to build sustainable capacities within communities for self-informed, self-inspired transformation.
COLLABORATION	A community's experience is a resource that belongs to the community. As such, research initiatives should invite community participation as early as possible in their formation, to shape cooperative agreements about ethical issues, the treatment of data, and the dissemination of findings.

*From "Communities Creating Knowledge – A Consensus Statement on Community-based Research" from the International Network for Community-based Research on HIV/AIDS.

Requirements for Researchers Seeking a Letter of Support from HPPC*

REQUIREMENT*	DESCRIPTION
HOLD A COMMUNITY FORUM	Convene at least one community forum and at least one provider forum (they may be done jointly as one forum) that allow a diversity of viewpoints regarding the study and its results to be shared. The forum(s) shall be appropriately publicized and advertised.
PREPARE A WRITTEN REPORT FOR A COMMUNITY AUDIENCE	Disseminate a final written community report to all appropriate stakeholders (e.g., providers, SFDPH, community members, other researchers) and anyone requesting a report.
PRESENT RESULTS TO THE HPPC	Request to present results at an HPPC meeting.
MAKE RESULTS AVAILABLE ON THE INTERNET	Post results on the Internet and inform community members about the site.

*It is recommended that all researchers conducting HIV prevention research with San Francisco populations follow these guidelines. Researchers receiving a letter of support from the HPPC are required to complete these tasks within six months of the conclusion of data analysis. If researchers who receive a letter of support from the HPPC do not fulfill the above requirements within this time frame, the HPPC will write a letter of concern stating such, indicating that the researchers' failure to fulfill the requirements will be considered should they request letters of support in the future.

Achievements to Date and Future Objectives

The following section describes San Francisco's evaluation achievements to date as well as objectives and activities to be implemented in the next phase of Project STOREE (Exhibit 12). There are many unknown factors that could affect the rollout of this plan, such as changes in HIV prevention funding levels, changes in State or CDC requirements, or changes in HPPC priorities. Nevertheless, this plan is designed to be a roadmap for HIV prevention evaluation, with the goal of continuous improvement of San Francisco's prevention efforts.

EXHIBIT 12 Evaluation Achievements to Date and Future Objectives

STEP IN THE EVALUATION CYCLE	ACHIEVEMENTS 2004–2008	CURRENT AND FUTURE OBJECTIVES
NEEDS ASSESSMENT	<ul style="list-style-type: none"> • HPPC-prioritized needs assessments: <ul style="list-style-type: none"> • <i>People who test late for HIV</i> • <i>Transmales</i> • <i>Native Americans</i> • African American Action Plan • Latino Action Plan • Many programs conduct their own needs assessments and risk assessments (ongoing) • Community assessment and gap analysis (ongoing) 	<ul style="list-style-type: none"> • By 2010, the HPPC will prioritize at least one community needs assessment for a population that is potentially high risk, but for whom there are few data.
PROCESS EVALUATION	<ul style="list-style-type: none"> • Implementation of core variables data collection requirement that will tell us who is being reached with what services • Implementation of new client-level data collection form for HIV counseling and testing • Implementation of PalMIT – the use of hand-held personal digital assistants to collect data • Program-based process evaluations, both one-time and ongoing • Qualitative evaluation of four HPS-funded HIV prevention programs • Assessment of the alignment between the HPPC priorities and who prevention is reaching citywide 	<ul style="list-style-type: none"> • By 2009, the HPS will begin issuing quarterly reports on core variables and counseling and testing data. • By 2011, HPS-funded providers will begin to submit program plans. • Annually, the HPS and HPPC will compare core variables/ HIV testing data with the epidemiologic profile to answer the question: Is there alignment between the HPPC priorities and who prevention is reaching?

<p>OUTCOME</p>	<ul style="list-style-type: none"> • Analysis of HIV testing data in terms of trends in partner counseling and referral services/disclosure assistance services and new HIV positivity rates • Provider-based one-time evaluations focusing on behavioral outcomes of program participants (e.g., Latino MSM) • Assessment of HIV prevention provider capacity and TA needs regarding outcome evaluation • Publication of data from the HOPE Study (a study of an intervention for incarcerated individuals living with HIV prioritized by the HPPC) 	<ul style="list-style-type: none"> • By 2010, the HPS will lead an effort to develop outcome evaluation guidelines for HPS-funded HIV prevention programs, with provider and HPPC input. • By 2011, prevention providers, in collaboration with the HPS, will have the tools to measure one outcome objective. • By 2011, the HPS will develop a sustainable system for ensuring that rigorous outcome evaluation is conducted with funded programs.
<p>IMPACT</p>	<ul style="list-style-type: none"> • 2006 consensus estimates issued on HIV incidence, prevalence, and population size for BRPs • New CDC methodology for estimating national HIV incidence used to estimate incidence in San Francisco 	<ul style="list-style-type: none"> • Annually, the CDC methodology will be used to develop HIV incidence estimates. • By 2012, the SFDPH will assess to what extent the CDC methodology provides information consistent with other data used in the consensus process. • By 2012, the SFDPH will facilitate a new consensus process. • By 2012, the SFDPH will complete an assessment of trends in HIV since 2006.
<p>CQI</p>	<ul style="list-style-type: none"> • CQI plans in place at all HIV testing providers 	<ul style="list-style-type: none"> • By 2011, the HPS will lead an effort to develop citywide minimum quality standards for HPS-funded HIV prevention programs, with provider and HPPC input. • By 2011, the HPS will provide a template and TA for programs/agencies to design their own CQI plans.
<p>FEEDBACK LOOP</p>	<ul style="list-style-type: none"> • Over 50 individuals from HPS-funded providers participated in one or more meetings to give input on HIV prevention evaluation and Project STOREE. • A working group was formed to share best practices for Internet-based interventions. • Project STOREE reports were published on the HPS website. 	<ul style="list-style-type: none"> • Annually, the HPS and HPPC will host Project STOREE meetings to review service data and research as well as discuss and reflect on its implications for prevention. HPPC members, providers, researchers, and other stakeholders will be invited.

SECTION V Conclusion

The San Francisco HIV Prevention community – the HPPC, providers, the HPS, researchers, and those living with or at risk for HIV – has developed a common vision for HIV prevention evaluation. The vision is simple:

Our vision is evaluation that is meaningful to San Francisco. To be meaningful, evaluation must effectively document our successes and help us improve our programs to better meet the needs of our affected communities and eliminate new HIV infections.

This chapter sets out the steps needed to make this vision a reality. With continued collaboration among all the partners in this effort, this vision is more than achievable.

APPENDIX 1 How Project STOREE was Developed

The impetus for Project STOREE really began many years ago, in the mid-1990s, when the HPPC identified a need to have data on who prevention was reaching. But it was in 2004 that the HPPC, in its Strategic Plan, first articulated the concept of evaluation as a way to tell the story of HIV prevention. This Strategic Plan laid the groundwork for San Francisco to refocus its evaluation efforts on what was locally meaningful and relevant.

The HPS immediately began to implement some aspects of the HPPC Strategic Plan, and simultaneously, embarked on a process to gather wider input about what evaluation should look like in San Francisco. This process unfolded and continues to unfold in four phases:

- **Phase 1: Gather input from stakeholders.** The HPS Evaluation Coordinator held individual and group meetings with multiple local stakeholders – HPPC members, HPS and AIDS Office staff, providers, researchers, and others (see Appendix 5: Acknowledgments). Particular emphasis was placed on getting provider input, as providers are greatly affected by changes in evaluation and data collection. Two input meetings were held in June 2006, one with HERR and PWP providers and the other with CTL providers. In addition, existing information and research on evaluation was collected and assembled (e.g., documents on intervention standards, the HPPC's Strategic Evaluation Plan, literature on evaluation models).
- **Phase 2: Design a long-term plan for evaluation.** The HPS convened a Project STOREE working group to review all of the input gathered from stakeholders. The group was composed of HPS staff, provider representatives, and an HPPC member. The group met seven times over nine months to develop the plan that formed the basis for this chapter.
- **Phase 3: Get feedback and finalize plan.** The HPPC 2008 Strategies and Interventions and Evaluation Committee reviewed and gave input on drafts of the chapter.
- **Phase 4: Disseminate and implement plan.** The Project STOREE plan is being disseminated through multiple channels. In addition to being a chapter in the 2010 HIV Prevention Plan, Project STOREE is discussed with providers and other stakeholders in both formal meetings and during informal discussions.

Nine Simple Evaluation or CQI Activities Programs Can Do at No or Low Cost

- 1. Surf the net.** Spend 1 hour at www.pubnet.gov or on the Internet. Search for publications, press releases, presentations, and other informational items on your population. Learn what others are saying about this group's risk factors and effective interventions.
- 2. Reflect on your work.** Put a standing item on your staff meeting agenda called "Reflection." During this time, discuss what is working and what needs to change.
- 3. Get feedback from clients.** Have a "Comments and Suggestions" box at your front desk, or pass one around at the end of a group. Encourage clients to fill out cards and place them in the box. Review the answers during "Reflection" at your staff meeting.
- 4. Set goals and track them.** Come up with goals you want to achieve in a particular time period, such as how many groups staff will conduct, how many referrals they will make, or how many clients will be linked to HIV testing. Keep it simple. Put a large tracking sheet up on the wall that all staff can see and use. Every time a group is held or a client gets linked to testing, staff can put a tick mark on the sheet. Review progress toward goals in team meetings, and talk about what factors helped or hindered staff from meeting the goals.
- 5. Host a meeting with other organizations serving your population.** Get together and share knowledge – best practices, trends you are noticing, interventions that seem to be working, and ideas for collaboration. Take what you learned and use it to improve your program.
- 6. Tell a story with pictures.** Use a camera to document what you do, write the story behind the picture, and post the pictures on the wall. Use the stories to illustrate program successes or to serve as jumping off points for what you can do better. See <http://www.photovoice.com/> for a description of this methodology.
- 7. Do a mini chart review.** For clients for whom you keep charts, randomly select some charts (e.g., between 20 and 50 charts). Develop a simple scoring system that will indicate how much progress a client is making toward healthy behavior change (or maintaining healthy behaviors) based on case notes or other chart elements, such as a 0 for no change, a 1 for some change, and a 2 for a lot of change. Determine the average score and discuss with staff.
- 8. Request data on your population from the SFPDPH HIV Section.** There is a wealth of data on HIV risk behaviors, prevalence, and incidence specific to San Francisco populations accessible by request. This data can help your program focus on the highest risk populations and subpopulations.
- 9. Debrief after counseling sessions or groups.** Have staff people spend 15 minutes to debrief after facilitating a group or meeting with a client. The debriefing could be done using a peer strategy or between supervisor and staff. What was one thing that worked well that could be used again? What was one challenge? What strategies were successful or not successful in handling the challenge?

General Evaluation Toolkits, Manuals, and Other Resources

APPENDIX 3

AMERICAN PSYCHOLOGICAL ASSOCIATION

<http://www.apa.org/pi/aids/introprogrameval.html>

THE CALIFORNIA ENDOWMENT

<http://www.calendow.org/article.aspx?id=1764&ItemID=1764>

CDC NATIONAL PREVENTION INFORMATION NETWORK

<http://www.cdcnpin.org/scripts/dhap/selection.asp>

NATIONAL MINORITY AIDS COUNCIL

<http://www.nmac.org/index/oes-english>

SOCIOMETRICS

<http://www.socio.com/evalpubs.htm#howto>

SYNERGY PROJECT

<http://www.synergyaids.com/apdime/index.htm>

UCSF CENTER FOR AIDS PREVENTION STUDIES

<http://caps.ucsf.edu/pubs/manuals/>

W.K. KELLOGG FOUNDATION

<http://www.wkkf.org/default.aspx?tabid=100&CID=278&CatID=278&NID=211&LanguageID=0>

W.K. KELLOGG FOUNDATION LOGIC MODEL DEVELOPMENT GUIDE

http://www.wkkf.org/DesktopModules/WKF00_DmaSupport/ViewDoc.aspx?LanguageID=0&CID=281&ListID=28&ItemID=2813669&fld=PDFFile

Evaluation of Structural Interventions and Approaches

APPENDIX 4

ANNIE E. CASEY FOUNDATION

A Guide to Measuring Advocacy and Policy

<http://www.aecf.org/upload/PublicationFiles/DA3622H5000.pdf>

CDC/ACADEMY FOR EDUCATIONAL DEVELOPMENT

Structural Interventions: HIV Prevention and Public Health: Descriptive summary of selected literature

<http://effectiveinterventions.org/download.cfm?DownloadFile=FA49EDB1-E04C-F06B-34673089680CF9B7>

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