

HIV Prevention Community Planning: Enhancing Data-Informed Decision-Making

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The primary purpose of this study was to test the impact of the first year of a 3-year intervention designed to enhance the use of behavioral data in the Massachusetts HIV Prevention Community Planning Group (MPPG). A one-group, pretest-posttest, nonequivalent independent variables, quasi-experimental design was used to assess changes before and after the first year of implementing strategies to enhance the use of behavioral data in decision-making. Over 90% of the CPG members completed surveys at baseline and at the end of the first year of the intervention. Consistent with the focus of the MPPG intervention in Year One, significant improvements were found from baseline to follow-up in member perceptions of decision-making structure and leadership, satisfaction with prevention planning processes, and intervention prioritization decisions. Findings provide preliminary evidence for the impact on member satisfaction of changes in CPG organizational structures and processes, including redistribution of power and broader constituent representation.

KEY WORDS: HIV prevention; community planning groups; HIV prevention community planning; decision-making.

INTRODUCTION

Over the past several decades government agencies and nonprofit funding entities have increasingly sought accountability in the planning of health and human service policies. This has usually meant emphasis both on greater empirical documentation of needs and outcomes, and mechanisms for involving community members in the planning process. One example of this two-pronged approach is HIV pre-

vention community planning, which was initiated in 1993 to increase community input into HIV prevention planning. It was implemented through guidance that was published by the Centers for Disease Control and Prevention (CDC) in 1993 (CDC, 1993; AED, 1994) with subsequent revisions (CDC, 1998, 2003). Implementation of community planning became a requirement for the funding of state and territorial HIV prevention programs in 1994 and these agencies organized community planning groups (CPGs) to provide mechanisms for community participation in the planning process.

The core principles of HIV prevention community planning recognize that it is an ongoing process that openness and diversity in the composition of CPGs are essential for this process. Particular attention is to be given to the recruitment of representatives of populations that have been particularly affected by the epidemic or who appear to be at elevated risk. Nominations for membership are expected to be conducted in an open process, with the

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roles and responsibilities of CPG members clearly defined from the outset. Policies and procedures to address disputes and avoid conflict are to be developed in a proactive way. The CDC guidance also calls for health departments to adhere to a principle of parity, providing all members opportunities for orientation and skills building to participate and have an equal voice in decision-making. The process is also meant to be evidence-driven, which means that CPG members, as well as researchers who provide data to the groups, need to understand how data relate to the core planning objectives of population and intervention prioritization. The decision-making process is recognized as one that requires give-and-take and may not always unfold in a planful, linear way (Valdiserri *et al.*, 1995). While the importance of decisional processes has been acknowledged in CDC guidance (AED, 1994; CDC, 1993), tools from CDC and its capacity-building partners have tended to focus on technical aspects of planning, such as recruitment (Valdiserri, 1996), and the construction of epidemiological profiles (a key compendium of data for prioritization of populations; Neal and McNaghten, 1998). Less attention has been given to organizational factors such as group process and participation, leadership, policies and procedure, and distribution of responsibility.

The large literature on decision-making (summarized in Jenkins *et al.*, this issue) has received rather limited attention in the planning process and guidance. This literature has rarely dealt with policy planning practice, which may explain its absence in most areas of community planning similar to the CDC-supported process. On the other hand, work in areas of community planning outside of HIV have noted the importance of leadership, organization, and procedures in permitting groups to promote equity among members and accomplish their core missions (Kreuter *et al.*, 2000; Cherniss and Deegan, 2000). The early experience of HIV prevention community planning in Michigan provided similar lessons as delegation of tasks needed to be weighed against the amount of participation and influence planning group members held (Dearing *et al.*, 1998). Another consideration is that satisfaction with decisions (i.e., “buy-in”) made in a planning group appears to be related to the amount of power members feel that they have over the decision process (Butterfoss *et al.*, 1996).

In attempting to increase the use of data and improve the quality of data use in HIV prevention community planning, it seems clear that a first step

is addressing the organization of the CPG, if in fact it is an impediment to decision-making. This study of decision-making in the Massachusetts Prevention Planning Group (MPPG) had three purposes: (a) to describe decision-making by the MPPG—in particular how data are used, and members’ satisfaction with the MPPG’s decisions and its decision-making process at two points in time, (b) to assess the impact of initial structural changes made to the MPPG makeup and decision-making procedures, and (c) to identify factors that may influence the use of data in decision-making. Three types of factors were examined: the group’s structures (e.g., decision-making rules, roles, and leadership), the data available to the group, and characteristics of MPPG members.

METHODS

Study Design

The types of research designs available to assess the impact of implementing recommended changes in the MPPG were limited for several reasons. First, there are no other decision-making bodies responsible for HIV prevention planning in the Commonwealth of Massachusetts, and therefore no comparison groups exist. Further, using another state health department or community planning group as a comparison was not feasible due to vast structural differences, lack of access for intervention, and budgetary constraints. Finally, we were not able to use a cohort group design for formal institutions with cyclical turnover (comparing pre-to-posttest changes for subsets of new and old MPPG members each year) since the size of the MPPG membership is small, and so few members were new in the first year.

Therefore, several approaches were undertaken to increase the interpretability of the findings. A one-group, pretest-posttest quasi-experimental design was used to assess changes before and after the first year of implementing strategies to improve behavioral data use in decision-making. A nonequivalent independent variables design was also considered useful because the implementation of MPPG changes were staged over time. This design enables comparison of changes in variables expected to improve as the result of a specific intervention, to changes in conceptually similar variables that the intervention did not target for improvement. We examined the extent of change from baseline to follow-up assessments in variables expected to

be associated with interventions to improve MPPG decision-making structures and processes during the first year, as well as the extent of change in variables reflecting areas that were targeted for improvement during the second and third years (e.g., data inputs and member characteristics). Changes during this interval were expected in relation to CPG structure, but not necessarily in relation to data presentations or member knowledge and skills (since these issues were not fully addressed until Years Two and Three of the project).

Procedures

Self-administered survey questionnaires were distributed to all MPPG members in attendance at regularly scheduled MPPG meetings in September, 2000 (baseline) and October, 2001 (follow-up). The meetings were closed to the public and to health department staff during data collection, which was conducted by staff from Northeastern University. Oral informed consent was provided in the meeting. No incentive was given. After the meetings survey forms were mailed to the remaining members. In October, 2001, surveys were also mailed to individuals who were no longer members, but had attended at least three meetings since September 2000, and alternates who had attended meetings without voting. The mailings included a written version of the oral consent. Responses were obtained via mail, fax, email, or telephone. The surveys were part of a multi-method observational study (described elsewhere, Amaro *et al.*, this issue; Jenkins, Robbins *et al.*, this issue) that included in-depth personal interviews, written surveys, archival review and directed observation of meetings.

Characteristics of the respondents are set forth in Table I. Ninety-four percent of the MPPG membership ($n = 31$ of 33 members) completed the survey at baseline, including all 27 of those in attendance at the September 2000 meeting. The two members who did not complete the survey at baseline were not noticeably different in background characteristics from respondents. At follow-up, respondents ($n = 35$) represented 83% of the broader group asked to participate, including 27 of the 28 members (and alternates) present at the October 2001 meeting.

Intervention

Findings from the baseline assessment led to highly specific and delimited recommendations for

changes within the MPPG process to ultimately improve behavioral data use in three core areas: improving (1) MPPG structure (e.g., decision-making rules, roles, and leadership), (2) data inputs (e.g., data availability and quality, and data presentations), and (3) MPPG member characteristics and capacities (e.g., member representation of affected communities, knowledge and skills in data use, participation and involvement in planning). These changes were implemented in a staged fashion over the ensuing 1–3 years as follows. During the first year, decision-making structures and leadership were altered to improve group climate, and new MPPG members were recruited. In the second year, tools were developed and implemented to improve data availability and quality, and to standardize data presentations. During the second and third years, technical assistance, opportunities for, and member training in data use were implemented. The complete intervention is described in detail elsewhere (Jenkins *et al.*, this issue) and focused on changes to all three factors affecting group decision-making. This paper is focused on determining whether the changes implemented during the first year had a discernable effect at the end of the first year.

In brief, many of the changes implemented during the first year following the baseline assessment involved modifications of the committee structure of the MPPG in order to delegate authority and increase opportunities for members to participate in governance and planning. Prior to these changes, considerable primary authority over nearly all aspects of MPPG functions had rested in the Steering Committee, which included co-chairs, and at-large members of the MPPG. The Steering Committee had been viewed as overly dominated by health department agendas (Amaro *et al.*, this issue). The intention of restructuring was to redefine the scope of influence and power, create new leadership and participation opportunities, and increase clarity regarding member roles and responsibilities and decision-making processes. Toward that end, a new organizational structure was recommended which redistributed power away from a single point of authority (the Steering Committee), added three new leadership groups or “ad hoc” groups each assuming some of the roles previously held by the Steering Committee, and six smaller, priority population work groups (i.e., MSM, Women, IDU’s, Youth, Immigrants/Refugees, and PWA/HIV).

The restructured Steering Committee (SC) was charged primarily with administrative tasks, and

Table I. Participant Profile

	Baseline (<i>n</i> = 31) % (<i>n</i>)	Follow-up (<i>n</i> = 35) % (<i>n</i>)	<i>p</i>
Survey participation			
Both phases:	68% (21)	60% (21)	<i>ns</i>
One phase only	32% (10)	40% (14)	
Age			
Range	19–60	17–63	<i>ns</i>
Mean (<i>SD</i>)	44.4 (8.7)	43.7 (8.8)	
Sex			
Male	50% (15)	51% (18)	<i>ns</i>
Female	50% (15)	49% (17)	
Education			
College or less	35% (11)	51% (18)	<i>ns</i>
Advanced degree	65% (20)	49% (17)	
Years on MPPG			
1 or less	13% (4)	50% (18)	
2–4 years	58% (18)	26% (9)	.002
5 or more	29% (9)	24% (7)	
Status			
Government employee	16% (5)	9% (3)	
Provider	71% (22)	71% (25)	<i>ns</i>
Consumer	13% (4)	20% (7)	
Attendance—meetings missed in past year			
0%	23% (7)	14% (5)	
0 < –25%	39% (12)	49% (17)	<i>ns</i>
25 < –50%	29% (9)	29% (10)	
>50%	10% (3)	9% (3)	
Committees served on ^a			
None	3% (1)	12% (4)	
1	29% (9)	37% (13)	.03 ^a
2	26% (8)	40% (14)	
3–4	42% (13)	11% (4)	
Participated in decision-making			
Population prioritization	93% (28)	60% (21)	
Intervention prioritization	80% (24)	89% (31)	<i>ns</i>
Concurrence	83% (24)	66% (23)	

^aThe number of committees served on reflects lifetime membership at baseline, and only the past year at follow-up.

process management of the meetings. In order to clarify decision-making procedures, the newly formed Policies and Procedures Committee reviewed and revised the Policies and Procedures Manual by reviewing archives and extensive discussion in order to formalize de facto group norms. In addition, it served as an independent entity, taking an active role to ensure that procedures and rules were followed by the SC and at each MPPG meeting, where a designated Committee spokesperson would function as a meeting “referee,” intervening periodically in the meeting process to clarify meeting procedures and promote member parity and inclusiveness.

A “Work Plan Committee” was also formed to plan the content of future meetings for 18 months in advance, thus, relieving the Steering Commit-

tee of that responsibility and allowing it to focus more specifically on MPPG meeting coordination and decision-making processes. The 18-month plan was designed to link data exposures more closely in time to MPPG decision-making (a problem identified in the baseline assessment). Another intervention goal was to create a mechanism for members to request needed data and for prioritization and responsiveness to requests for new data. Consistent with their responsibilities for planning the sequence of data exposures, the Work Plan Committee was assigned responsibility for prioritizing data requests, and the timeliness of response was monitored by the Steering Committee as a standing item on the agenda. Forms were developed for use by the “population groups” (described below) to request new

data, and MDPH gave oral and written presentations on the data request process.

“Population groups” were established and met in afternoon sessions following the MPPG plenary meeting. The small population groups were designed following the baseline assessment to give members opportunities to work together in smaller groups with other members (larger groups had been one of the complaints on the baseline assessment), and to give members time to discuss and apply data from presentations on an ongoing basis rather than waiting for periodic planning decisions (not having time to discuss or apply data was a second complaint, as was the protracted time period between data presentations and decision-making). The smaller, priority population sub-groups also gave members an opportunity to plan and advocate for their own constituencies throughout the year (another problem identified in the baseline assessment was distrust of other members to vote without regard to conflicts of interest).

The Membership Committee was reactivated and new members were selected with an intentionally broader representation of affected constituencies and educational levels. Rules governing membership attendance also were revised: members who missed three meetings in a row were deemed to have resigned, and alternate members were appointed. A general member “Community Planning 101” orientation was provided for new members in the first year. The orientation curriculum included a description of the history and intent of community planning, member roles and responsibilities, group norms, decision-making timelines, an assessment of new members’ training needs, and other introductory topics. More in-depth training and assistance followed in the second and third years of the project in response to the observation that “one-shot” capacity building efforts were not as effective as sustained technical assistance tied to the particular task at hand.

Measures

The questionnaires asked members about their personal characteristics, data-related knowledge and skills, opinions about the group structure and process, satisfaction with data and presentations, reliance on data in decision-making, and satisfaction with MPPG procedures and decisions. The MPPG annual planning cycle occurs between September 1 and August 31 in order to coincide with the yearly CDC Cooperative Agreement application (which is generally due at the beginning of September). At the

end of each planning cycle, MPPG members deliberate about the consistency between the health department’s Cooperative Agreement application and the recommendations (e.g., populations, interventions, needs, service gaps) that have been generated by the MPPG. The annual administration of the questionnaire was timed to coincide with the completion of MPPG planning cycle in order to assess the decisions that had been made by the MPPG over the course of the planning cycle. Questions on decisions and reliance on data included in the baseline survey referred to the process leading to population and intervention prioritization decisions made in the fall of 1999. Questions in the follow-up survey referred to the process of population prioritization that was finalized in the fall of 2000 and the intervention prioritization process that was completed in August 2001.

In order to construct summary indices, responses to items in each section of the questionnaire were subjected to a principal components factor analysis using SAS v8 for Windows and Win LTA version 3.0 (Collins *et al.*, 2002). Summary indices were constructed using the mean of response to items in each factor (the total of all responses divided by the number of items); scores for negatively worded items were reversed so that a higher score always reflected more favorable opinions.

Group Structure and Processes

Perceptions concerning various aspects of prevention planning were measured by having respondents respond to a series of statements indicating their opinion using a scale from 1 (“strongly disagree”) to 5 (“strongly agree”). Three factors emerged and several remaining items were dropped. The resulting *Decision-Making Structure* index measures perceptions of decision-making structure, using eight items (Cronbach’s $\alpha = .84$), such as “The concurrence process is largely driven by DPH” and “Parliamentary procedures exist and are usually followed.” The *Leadership* index measures members’ perceptions of the leaders’ leadership styles, using three items (Cronbach’s $\alpha = .66$), such as “The MPPG leaders encourage member participation in all decision-making.” The third factor was not used.

Satisfaction with Prevention Planning

Satisfaction with prevention planning was assessed with a series of 14 Likert-type items, scaled

from 1 (“not at all satisfied”) to 5 (“totally satisfied”) in response to the direction “Thinking back over the past year, how satisfied were you with the following aspects of the MPPG?” After factor analysis, the resulting indices were: *Satisfaction with Data* (described under ‘Data Inputs, four items, see Table II; Cronbach’s $\alpha = .86$); *Satisfaction with Process* (five items, see Table III; Cronbach’s $\alpha = .88$), and *Satisfaction with Decisions* (two items, see Table III; correlation = .73); two items did not load on any factor and were discarded.

Data Inputs

Assessment of presentations was measured by having respondents respond to a series of nine statements, such as “There is too little audience participation in presentations” and “The presentations are not usually boring,” indicating their opinion using a scale from 1 (“strongly disagree”) to 5 (“strongly agree”). The *Presentation* index (Cronbach’s $\alpha = .76$), measuring favorable assessment of data presentations, was constructed using the mean of the responses, with scores of negative statements reversed.

Sources of Information Used to Make Decisions. Respondents who took part in the most recent prioritization of populations and the most recent prioritization of interventions were asked to indicate for each decision which three types of information, from a list of 14 items (at baseline; 13 at follow-up; the items are listed in Table IV) had most influenced their decision-making. Based on the CDC guidance (CDC, 1998) concerning the types of information that are most scientific and most relevant, for each type of decision, the researchers assigned a rating of 0 (poor choice), 1 (acceptable choice), or 2 (good choice) to each item. A summary measure, *Reliance on Data index*, was then calculated for each decision by adding the ratings of the three items selected. The index had a possible range of 1 to 6; 0 was impossible because only two items had an expected rating of 0. Although for population prioritization decisions there was one more item at follow-up than at baseline with a rating of 2 and two fewer items with a rating of 1, and for intervention prioritizations there was one fewer item with a rating of 1, these small differences were not expected to alter significantly the average scores. This index for each decision was the primary dependent variable for multivariate analyses.

Member Characteristics

Sociodemographic Characteristics. Information on members’ gender, ethnicity, and membership status, i.e., consumer, provider, or government employee (from Massachusetts Departments of Education, Mental Health, Public Health, and Boston Public Health Commission) was obtained from MPPG records maintained by the Massachusetts Department of Public Health (MDPH). Information regarding age, educational attainment, and information about their participation on MPPG (such as length of service, number of meetings attended, committee membership) was obtained from the survey questionnaires. Because three or fewer respondents had educational attainment of high school or less, education was collapsed into two categories: advanced degree versus college or less.

Knowledge and Skills. Respondents rated their knowledge and skills in 13 areas relevant to prevention planning, using a scale from 1 to 4 (1 = “none” or “very little,” 2 = “some,” 3 = “moderate,” and 4 = “extensive”). Seven of the items pertained to interventions, such as “types of interventions” or “how to select effective interventions.” A summary index of *Intervention-Related Knowledge and Skills* was constructed using the mean of the seven items (Cronbach’s $\alpha = .72$). The other six items pertained to public health topics, such as “basic principles of public health” or “behavioral theories.” A summary index of *Public Health-Related Knowledge and Skills* was created using the mean of the six items (Cronbach’s $\alpha = .89$).

Confidence in Participation. Responses to six items measuring member confidence in their ability to participate fully in the MPPG, and without reprisal, such as “I know how to get something on the agenda,” and “I feel that I am free to vote any way I want without pressure from others” were averaged to form the *Confidence index* (Cronbach’s $\alpha = .79$).

Statistical Analyses

Bivariate analyses were conducted by calculating Student’s *t*-test or Pearson correlation to compare baseline and follow-up values of each measure. To determine whether or not observed changes were attributable to member turn-over, post-hoc sub-analyses were performed separately (a) among continuing members, using matched *t*-tests, and (b) between the two sub-groups of old and new members,

Table II. Group Structure, Data Inputs and Member Characteristics

	Baseline (<i>n</i> = 31) Mean (<i>SD</i>)	Follow-up (<i>n</i> = 35) Mean (<i>SD</i>)	<i>p</i>
<i>Group structure:</i>			
Decision-making structure index (range: 1 = “strongly disagree” to 5 = “strongly agree”)	3.19 (.72)	3.68 (.43)	.001
Populations well-defined	3.79 (1.05)	4.03 (.84)	<i>ns</i>
Parliamentary procedures exist and usually followed	3.48 (.83)	3.71 (.84)	<i>ns</i>
Structured & systematic process for decision-making	3.23 (1.01)	3.89 (.72)	.003
Plenty of time to make decisions	2.97 (1.19)	3.26 (1.02)	<i>ns</i>
Concurrence process “driven” by MPPG	2.71 (1.08)	3.49 (.98)	.005
Concurrence process “driven” by MDPH, and MPPG is a “rubber stamp” ^a	3.21 (1.25)	2.51 (.92)	.02
Members lacked sense of ownership in MPPG decisions ^a	3.07 (1.19)	2.00 (.77)	.0001
No clear mechanisms to request data ^a	2.67 (1.18)	2.43 (.98)	<i>ns</i>
Leadership index (range: 1 = “strongly disagree” to 5 = “strongly agree”)	3.23 (.86)	3.70 (.68)	.02
Leaders encourage member participation in all decision-making	3.31 (1.23)	4.15 (.86)	.001
Leaders do not state their opinions in a forceful manner	2.83 (1.04)	3.32 (1.07)	<i>ns</i>
Leaders (co-chairs and co-ordinator) do not encourage different opinions ^a	2.45 (1.12)	2.38 (1.30)	<i>ns</i>
<i>Data inputs:</i>			
Satisfaction with data index (range: 1 = “not at all” to 5 = “totally”)	3.45 (.66)	3.73 (.58)	.08
Quality of data available for decision-making	3.50 (.68)	3.86 (.65)	.03
Usefulness of data presented	3.53 (.63)	3.76 (.65)	<i>ns</i>
Amount of data available for decision-making	3.45 (.87)	3.71 (.89)	<i>ns</i>
Completeness of data available for decision-making	3.33 (.96)	3.60 (.69)	<i>ns</i>
Assessment of data presentations index (range: 1 = “strongly disagree” to 5 = “strongly agree”)	3.15 (.66)	3.33 (.69)	.30
Relevance of data to planning is clear	3.69 (.89)	3.53 (.79)	<i>ns</i>
Presentations are not usually boring	3.38 (.86)	3.47 (.93)	<i>ns</i>
Not enough time for Q&A afterwards ^a	3.34 (1.08)	3.09 (1.11)	<i>ns</i>
DPH presents what they want us to see ^a	3.00 (1.20)	2.91 (1.24)	<i>ns</i>
Too much information is presented at one time ^a	3.28 (1.10)	2.76 (1.07)	<i>ns</i>
Too little audience participation ^a	2.75 (1.08)	2.76 (1.05)	<i>ns</i>
Too many lectures ^a	2.66 (1.23)	2.52 (1.18)	<i>ns</i>
Nothing gets done with the data afterwards ^a	2.79 (1.01)	2.26 (.79)	.02
<i>Member characteristics:</i>			
Intervention-related knowledge & skills index (range: 1 = “none at all,” 2 = “some,” 3 = “moderate,” 4 = “extensive”)	2.53 (.61)	2.76 (.65)	.15
Intervention types	2.97 (.91)	3.31 (.72)	<i>ns</i>
Successful interventions	2.75 (.68)	3.03 (.79)	<i>ns</i>
How to select effective interventions	2.93 (.80)	2.91 (.78)	<i>ns</i>
Providers’ best practices	2.40 (.65)	2.80 (.90)	<i>ns</i>
Unsuccessful interventions	2.24 (.78)	2.49 (.95)	<i>ns</i>
Intervention cost-effectiveness	1.96 (.62)	2.17 (.79)	<i>ns</i>
Judge evaluation findings	2.40 (.96)	2.60 (.85)	<i>ns</i>
Public health knowledge & skills index (range: 1 = “none at all,” 2 = “some,” 3 = “moderate,” 4 = “extensive”)	2.87 (.73)	2.98 (.64)	.53
Specific knowledge, attitudes and behaviors that may lead to risk-taking in each population	3.16 (.69)	3.49 (.66)	<i>ns</i>
Basic principles of public health	2.96 (1.00)	3.14 (.73)	<i>ns</i>
Poverty and racism in different communities	3.00 (.72)	3.06 (.91)	<i>ns</i>
Behavioral theories	3.04 (.84)	2.91 (1.07)	<i>ns</i>
Use scientific data	2.90 (.94)	2.71 (.89)	<i>ns</i>
Current statewide allocation of resources	2.48 (.65)	2.54 (.70)	<i>ns</i>
Confidence index (range: 1 = “strongly disagree” to 5 = “strongly agree”)	3.54 (.77)	3.83 (.44)	.08
Understand parliamentary procedures enough to actively participate	3.77 (1.04)	3.91 (.87)	<i>ns</i>
Know how to put things on the agenda	3.50 (1.11)	3.71 (.89)	<i>ns</i>
Free to vote without pressure from others	3.97 (1.24)	4.40 (.77)	<i>ns</i>
Vote will not have negative consequences to agency (<i>n</i> = 25)	3.52 (1.23)	4.04 (.93)	<i>ns</i>
Vote will not have negative consequences for me	3.63 (1.07)	4.06 (.89)	<i>ns</i>
Trust colleagues will vote without regard to conflicts of interest	2.83 (1.14)	2.79 (.77)	<i>ns</i>

^aReversed in index.

Table III. Satisfaction with Prevention Planning

How satisfied with...?	Baseline (<i>n</i> = 31)	Follow-up (<i>n</i> = 35)	<i>p</i>
	Mean (<i>SD</i>)	Mean (<i>SD</i>)	
Satisfaction with decision-making process index (range: 1 = "not at all" to 5 = "totally")	2.78 (.75)	3.35 (.78)	.003
Overall work of MPPG	3.34 (.86)	3.62 (.89)	<i>ns</i>
Decision-making process	2.52 (1.09)	3.41 (1.02)	.001
Efficiency of full group	2.87 (1.04)	3.34 (1.00)	<i>ns</i>
Amount of time spent on intervention prioritization	2.80 (1.03)	3.31 (1.16)	.05
Amount of time spent on prevention planning	2.37 (1.07)	3.11 (1.11)	.007
Satisfaction with decisions index (range: 1 = "not at all" to 5 = "totally")	3.40 (.93)	3.74 (.68)	0.09
Population prioritization	3.52 (1.12) (<i>n</i> = 28)	3.77 (.81) (<i>n</i> = 25)	<i>ns</i>
Intervention prioritization	3.22 (.97) (<i>n</i> = 22)	3.71 (.79) (<i>n</i> = 32)	.03

to see whether the results were different in either sub-analysis.

To determine what combinations of variables in each of three categories—member characteristics,

group structure, and data inputs—might best predict each of two outcomes—reliance on data in population prioritization, and reliance on data in intervention prioritization decisions each year—multivariate

Table IV. Most Influential Bases of Decisions

	Population prioritization			Intervention prioritization		
	Assigned rating	Baseline 1999 (<i>n</i> = 28)	Follow-up 2000 (<i>n</i> = 22)	Assigned rating	Baseline 1999 (<i>n</i> = 25)	Follow-up 2001 (<i>n</i> = 32)
Reliance on data index (range: 1 = relied on low rated items to 6 = relied on high rated items)	<i>p</i> = 0.45	3.93 (1.41)	4.27 (1.78)	<i>ns</i>	4.36 (1.38)	3.66 (1.45)
		% (<i>n</i>)	% (<i>n</i>)		% (<i>n</i>)	% (<i>n</i>)
Needs assessment data	2	32.1% (9)	13.6% (3)	2	24.0% (6)	18.8% (6)
Behavioral risk data (prevalence of risk behaviors)	2	42.9% (12)	31.8% (7)	2	36.0% (9)	25.0% (8)
AIDS surveillance (incidence & prevalence) data	2	35.7% (10)	27.3% (6)	1	16.0% (4)	18.8% (6)
HIV surveillance (incidence & prevalence) data	2	25.0% (7)	50.0% (11)	1	12.0% (3)	18.8% (6)
STD surveillance (incidence & prevalence) data	2	17.9% (5)	13.6% (3)	1	12.0% (3)	6.3% (2)
Census data	1	0.0% (0)	<i>NA</i>	1	0.0% (0)	<i>NA</i>
Epi profile	2	<i>NA</i>	54.5% (12)	1	<i>NA</i>	18.8% (6)
Current DPH funding and resource allocation by population and funding	1	17.9% (5)	13.6% (3)	2	20.0% (5)	9.4% (3)
Gap analysis (gaps in allocation of resources for various populations)	1	35.7% (10)	4.5% (1)	2	12.0% (3)	18.8% (6)
Evaluation data on program/service effectiveness	1	7.1% (2)	0.0% (0)	2	48.0% (12)	25.0% (8)
Theory and published research on effective interventions	1	14.3% (4)	18.2% (4)	2	48.0% (12)	50.0% (16)
Cost effectiveness data on program/services	1	3.6% (1)	<i>NA</i>	1	12.0% (3)	<i>NA</i>
Program and service delivery data from providers	1	7.1% (2)	9.1% (2)	1	8.0% (2)	6.3% (2)
My own experience and knowledge of needs of the communities I work with	0	50.0% (14)	36.4% (8)	0	40.0% (10)	53.1% (17)
Personal testimony from people who are part of affected communities	0	10.7% (3)	27.3% (6)	0	12.0% (3)	21.9% (7)
Other (model to prioritize)	<i>NA</i>	<i>NA</i>	<i>NA</i>	1	<i>NA</i>	3.1% (1)

linear regression was used. The small number of respondents limits the number of variables that may be analyzed reliably in a single regression. Therefore, in order to limit the number of variables without discarding any that might attain significance in the multivariate analysis, initially, only variables with a bivariate (*t*-test or Pearson correlation coefficient) association with the outcome having a *p*-value less than 0.30 were included in the original model. In addition, because results might be sensitive to the selection method, initially, both backward and stepwise selection methods were used to fit the regression model. Results from these two different selection methods were compared. Based on the goodness of fit index (the correlation coefficient: R-square), the backward selection method provided more consistent results in this sample, so the analysis results reported in this paper were from the backward selection method. Although an alpha of .05 was used to determine statistical significance in all analyses, variables with $p(F) < 0.20$ were retained in the final multivariate model because they may suggest trends. Because of the association between education and length of membership (new members on the MPPG for less than 1 year had less education), whenever education was in the model, length of membership was forced into the equation.

RESULTS

Study Participants

Between baseline and follow-up there was very high turnover in the MPPG membership resulting from the decision to recruit new members during the interval (Table I). Of the 33 members at baseline, 15 had left and 20 new members joined by the time of the follow-up survey. However, 21 of the survey participants participated on both the baseline and the follow-up survey, enabling post-hoc comparisons to determine whether changes found among the entire MPPG membership were evident among those participants who completed surveys at both time points. A further discussion of differences between MPPG members at baseline and follow-up is presented in the section on Member Characteristics.

Group Structure and Process

Consistent with the focus of MPPG changes during the study interval, a number of statistically significant

differences in member perceptions of the group structure and process were identified.

Decision-Making Structure

There was a significant improvement from baseline to follow-up in how favorably members perceived the decision-making structure (Table II). This was largely attributable to greater agreement with the statements: "There is a structured and systematic process for decision-making" and (in reverse direction) "The concurrence process is driven by MDPH, and MPPG is a 'rubber stamp'" and "Members lack a sense of ownership in MPPG decisions."

Leadership

There was also a significantly more favorable assessment of leaders at follow-up than at baseline (Table II). This is largely attributable to dramatic improvement in the item, "Leaders encourage member participation in all decision-making."

Satisfaction with Prevention Planning

There was a significant increase in the satisfaction with decision-making index from baseline to follow-up (Table III), in particular with the items "the decision-making process" and "the amount of time spent on prevention planning" (although the latter retained its ranking as the lowest satisfaction rating).

With regard to the decisions reached (Table III), there was a significant improvement comparing member satisfaction with the *intervention prioritization* in 1999 to the decisions made in 2001, but no significant changes when comparing satisfaction with the *population prioritization* in 1999 to satisfaction with the decision in 2000.

Data Inputs

Consistent with the lack of focus on improving data inputs and presentations until Year Two, other than having established a formal mechanism for members to request data and having established small work groups for discussion and application of data during the study interval, few statistically significant changes in MPPG member attitudes toward the

availability, quality or utility of data and data presentations were found.

Satisfaction with Data

There was no significant change in satisfaction with the amount, quality, and utility of the data inputs (Table II). However, there was a trend suggesting greater satisfaction at follow-up, in particular with the quality of the data available for decision-making.

Assessment of Data Presentations

Also consistent with the focus of changes made to the MPPG during the first year, there was no significant overall change in the assessment of data presentations from baseline to follow-up (Table II). However, there was a tendency for members to be less likely to state that “nothing gets done with the data afterwards.”

Member Characteristics

New MPPG members were recruited and the membership changed during the study interval, but efforts to provide training in behavioral data use were not extensive until Year Three.

Sociodemographics

Efforts to recruit more consumers and members with a wider range of educational attainment were somewhat successful, although most differences between baseline and follow-up were not statistically significant. The turnover in membership is reflected in the number of years respondents had been a member of the MPPG: At follow-up, half of the members had 1 year or less experience with the group, compared to 13% at baseline. Changes in MPPG membership resulted in fewer government employees (from 16% to 9%) accompanied by an increase in consumers (from 13% to 20%), and fewer members with advanced degrees (from 65% to 49%) at follow-up. Although both changes fell short of statistical significance, at follow-up fewer of the newer members had advanced degrees ($\chi^2 = 4.80, p = .03$). The age and gender composition remained essentially the same, as did meeting attendance; most respondents missed 25% or fewer of the meetings both at baseline and at follow-up. In the second year, min-

utes revealed five members (one of whom resigned) with three or more unexcused absences in a row.

Knowledge and Skills

Consistent with the lack of focus on training and technical assistance in use of behavioral data during the first year, there were no significant changes from baseline to follow-up in members' self-reported level of knowledge and skills in various arenas relevant to prevention planning (Table II). Average ratings remained high for intervention types, basic principles of public health, poverty and racism, behavioral theories, and risk taking, and low for intervention cost-effectiveness, knowledge of unsuccessful interventions, and knowledge of current statewide allocation of resources.

Member Confidence in Participation

There was a trend toward improvement in the confidence index in the expected direction (Table II), but no change in any specific item contributing to the index was statistically significant.

Reliance on Data

Since the majority of the changes recommended to improve MPPG structure, data inputs, and member characteristics were ultimately designed to facilitate member use of behavioral data in CPG decision-making, a discussion of changes in, and factors associated with, reliance on data is presented separately. Assuming all of the recommended changes are implemented and successful, greater reliance on data is the primary outcome anticipated at the end of the 3-year evaluation period.

Table IV displays how many members listed each source of information among the top three most influential in their prioritization decisions. On average, there were no statistically significant overall changes from baseline to follow-up in members' reliance on data in their population or intervention prioritization decisions (Table IV). Ranks of various data sources for the intervention prioritizations followed similar, but not identical, patterns at both times; for example, “theory and published research on effective interventions” was highly ranked in both the baseline and follow-up intervention prioritization decisions. Sources used for making population prioritization decisions were less consistent

between the baseline and follow-up than sources used for making intervention prioritization decisions. Behavioral risk data ranked high across all decisions made.

Factors Associated with Reliance on Data

Table V presents the results of multivariate analyses of the factors associated with reliance on data using variables to reflect the three major categories of influence—group structure, data inputs, and member characteristics. Independent associations with two primary outcomes were of interest: reliance on data in population prioritization, and reliance on data in intervention prioritization.

In the baseline multivariate regression analysis, reliance on data for population prioritization was associated with a more favorable assessment of data presentations. Together with education and length

of membership, these variables accounted for 44% of the variance. At follow-up, men and those who reported greater satisfaction with data inputs were more likely to rely on data. The model accounted for 67% of the variance.

In the baseline multivariate regression analysis of reliance on data for intervention prioritization, there were only weak associations with several variables, and the model accounted for only 28% of the variance. However, at follow-up, members with more years of MPPG experience, and those with a more favorable assessment of the decision-making structure reported greater reliance on data. The model accounted for 29% of the variance.

DISCUSSION

This study was conducted as part of a larger, 3-year CDC-funded effort to improve behavioral

Table V. Association of Group Structure, Data Inputs and Member Characteristics with Reliance on Data in Prioritization Decisions at Baseline and Follow-Up

Predictor variable	Reliance on data in population prioritization		Reliance on data in intervention prioritization	
	Baseline 1999 (n = 27)	Follow-up 2000 (n = 22)	Baseline 1999 (n = 25)	Follow-up 2001 (n = 32)
<i>Group structure:</i>				
Decision-making structure index (perception of decision-making structure)		— ^b	— ^b	1.21 (0.03)
Leadership index (favorable assessment of leaders)		— ^b	— ^b	
Satisfaction with process (satisfaction with decision-making process)	— ^b	— ^b	— ^b	
<i>Data inputs:</i>				
Assessment of data presentation index (favorable assessment of data presentation)	0.97 (p = 0.01)	— ^b	0.80 (p = 0.06)	
Satisfaction with data index		1.18 (p = 0.04)		— ^b
<i>Member characteristics:</i>				
Gender (female vs. male)	— ^b	-1.96 (p = 0.002)	-0.79 (p = 0.14)	— ^b
Ethnicity (of color vs. white)	— ^b	— ^b	— ^b	— ^b
Education (advanced degree vs. no advanced degree)	0.84 (p = 0.14)	0.91 (p = 0.13)		
Member category (consumer vs. provider or government employee)	— ^b	— ^b	— ^b	— ^b
Age	— ^b	— ^b	— ^b	
Length of membership (years in MPPG)	0.08 ^a (p = 0.64)	0.18 ^a (p = 0.35)		0.32 (0.03)
Attendance (% meetings attended)	— ^b	— ^b	-2.41 (p=0.13)	— ^b
Knowledge of intervention index (self-reported intervention-related knowledge)		— ^b	— ^b	— ^b
Knowledge of public health index (self-reported public health-related knowledge)		— ^b	— ^b	
Confidence index (confidence in participation)	— ^b		— ^b	— ^b
R ²	0.44	0.67	0.28	0.29

Note. Variables left in the model are significant at the 0.20 level.

^aForced in the model because of its bivariate association with education.

^bIncluded initially, but not retained in the final model selections.

data availability, quality and use within selected HIV/AIDS community planning groups (CPGs). The first year of this study of the Massachusetts CPG (MPPG) was spent collecting data to identify how MPPG members perceived, and whether they used, behavioral data in decision-making. Potential barriers and facilitators of data use were identified in the literature on decision-making, and were assessed throughout the first year through interviews, observations, archival reviews, and a full membership survey in the fall of 2000 (Amaro *et al.*, this issue). Findings from this baseline assessment led to the development of a 3 year plan to change three core factors identified as influencing use of behavioral data in CPG decision-making; decision-making structure, data inputs and member characteristics. During Year One (following the baseline assessment), changes in MPPG decision-making structures and membership representation were implemented. In Year Two, changes in the quality of data available and in data presentations were targeted, and in Year Three, changes to improve member capacities (e.g., training and technical assistance) were proposed and implemented.

The purpose of this study was to evaluate the impact of the first year of MPPG change efforts. Therefore, we were interested in determining how primarily organizational structure and procedural changes to the MPPG would affect members' assessments of the group's decisions and processes, satisfaction with data inputs, as well as participation and use of data. Because the MPPG is a single entity, we used a one-group, pretest-posttest, quasi-experimental design to assess changes before and after the first year of intervention implementation; nonequivalent independent variables considered likely to change as a result of strategies implemented in the first year (e.g., in group structure, member participation, satisfaction with decisions) were examined separately from variables where changes were not expected (e.g., in perceptions of data availability and presentations, and in member knowledge and skills).

The preponderance of evidence regarding Year One changes, collected on surveys at two points in time, was quite positive, and suggests that the structural and membership changes that were implemented did in fact have an impact on MPPG members' attitudes and practices. Consistent with our expectations, significant differences between baseline and follow-up assessments were found primarily on those variables reflecting changes implemented during Year One, and not on variables where changes

had yet to occur but were planned for implementation in Years Two or Three.

Members had significantly more favorable assessments of the MPPG's group decision-making structure and leadership, and were more satisfied with the decision-making process at the follow-up assessment. The lack of improvement in areas that were not foci of the Year One intervention, such as member knowledge and skills, or assessments of the quality of data and presentations, combined with demonstrated improvements in areas where changes were made, suggests these efforts were highly successful, and highlights the need for continued implementation of the 3-year change plan for future interventions. Specific findings and conclusions are summarized below.

Group Structure

Changes made in MPPG structure, leadership and processes appear to have had a significant impact on member perceptions as well as on the climate of trust. Perceptions of the decision-making structure and the leadership improved from baseline to follow-up, and there was a concomitant improvement in satisfaction with the decision-making process, as well as with the intervention prioritization decisions that were made at follow-up.

Efforts to establish clearer decision-making guidelines could account for the increased perception of the structured and systematic process for decision-making. Members expressed greater ownership over decisions, and confidence that they are "driving" the concurrence process, and their greater satisfaction with decision-making process may indicate collective recovery from some of the conflicts engendered by the contentious 1999 population prioritization and concurrence process described in an earlier manuscript (Amaro *et al.*, this issue). At follow-up, perception of decision-making structure had a strong influence on reliance on data in intervention prioritization decisions, although those improvements did not apparently translate directly into a significant increase in reliance on data.

Perceptions of the MPPG leadership also improved from baseline to follow-up, particularly with regard to encouraging member participation in decision-making. The initial study had identified the leaders' forceful opinions as problematic, primarily due to the absence of leadership neutrality (Amaro *et al.*, this issue). Consistent with the CDC guidance

on inclusion (AED, 1994; CDC, 1998), and in order to reach sound group decisions, it is important to promote an atmosphere that constructively encourages dissent and the full participation of all members. Reducing the number of MDPH-funded staff in positions of leadership may have helped—for example, perhaps by enhancing members' sense that their views were being elicited and heard following the baseline assessment. Furthermore, shifting the power base away from a central Steering Committee toward other operational groups, thereby creating essentially a means for checks and balances between groups, also may have helped.

Data Inputs

Consistent with the focus of the MPPG changes that were implemented in Year One, no significant differences were found from baseline to follow-up in member satisfaction with the amount, quality, and utility of data inputs, nor were there any changes found in member assessments of the quality of data presentations. Two findings related to data presentations were significant. Members reported improved perceptions that something gets done with data following presentations, which we attributed primarily to the creation of small, population working groups where members have the opportunity to discuss and apply data to their own constituencies. The second significant improvement was that members were more satisfied with the quality of data available for decision-making, which we attributed to the addition of a new Work Plan Committee, designed to improve data discussion and application following data presentations, and the potential for members to request data of interest.

Presentations are the primary vehicle for exposure to data. In the absence of data, or in the absence of comprehension of a presentation, members may substitute values and experience, and thus thwart the goal of the data or message being presented (McGuire, 1981; Bennett, 1998). At baseline, MPPG members already relied on data to a fair extent—somewhat more so in decisions about populations at risk than in decisions about interventions (possibly due to the paucity of intervention data available for presentation). However, MPPG members were quite clear at baseline about the need to improve data presentations, particularly to ensure that data are available for hard-to-reach populations. Members further expressed preferences that the amount of

information presented at one time be limited, that members have time to discuss the data presentations afterwards, as well as having more opportunities to integrate and apply the findings to decision-making.

The baseline finding that more favorable assessments of data presentations were associated with greater reliance on data for decisions suggests that the improvements proposed for data presentations and implemented in Years Two and Three might hold potential to improve the quality of decisions made by the membership. Recommendations were further made to provide guidelines to presenters to potentially address the above identified data presentation deficiencies. In planning subsequent intervention phases, it was anticipated that creating a structured and consistent presentation format would also help to assure members of the completeness of data (a concern raised in the formative study), and allow them to detect important group differences in risk or disease. Follow-up studies of changes in Years Two and Three will be necessary in order to determine whether these interventions ultimately had an effect.

Member Characteristics

Findings presented in relation to member characteristics were also consistent with the focus of the Year One interventions. Recruitment of new members during Year One resulted in a slight, although not statistically significant, shift in member representation; slightly more members were consumers of HIV prevention services and fewer had an advanced degree. Furthermore, members' confidence in their ability to participate, and to do so without reprisal, improved slightly during the study interval. However, they did not report being more knowledgeable or skilled at behavioral data use—again consistent with the fact that only a brief member orientation was provided in Year One.

The MPPG's increased representation from consumers and members with lower educational attainment conforms to a tenet that community members can better represent poorer communities and those affected by HIV/AIDS (Schietinger *et al.*, 1995; Holtgrave, 1994). At baseline and follow-up, members with an advanced degree more often reported relying on data for population prioritization decisions. Since no specific training or technical assistance was scheduled during the study interval to improve reliance on data for decision-making for members with more limited education, or less

experience in data use, these findings are not altogether unexpected. However, in light of these findings and the shift toward broadening affected constituency representation, greater effort needs to go into making sure that data presentations are easily understood by members with more limited education, by simultaneously increasing the data-related skills of all CPG members. It is anticipated that the comprehensive training and technical assistance efforts proposed in Years Two and Three, along with structured opportunities to apply data throughout the project period, may be necessary for all members to equally report reliance on objective data over experiential factors in CPG decision-making. If successful, these efforts could prove especially important to narrow the education gap in use of data.

While overall self-reported skill and knowledge levels were fairly high, members did identify areas of perceived weakness, and there did not appear to be any increase in self-reported levels of knowledge and skills across the study interval. We conclude that a general and brief orientation of new members does not appear to address the knowledge and skills needs of members. The findings were, however, consistent with our expectations, since more in-depth training and technical assistance for MPPG membership was not scheduled to occur until Years Two and Three of the project. Nevertheless, deficits remain in areas related to data use and selecting interventions: how to use scientific data, how to judge evaluation findings, knowledge about intervention cost-effectiveness, and knowledge about unsuccessful interventions that need to be addressed. In spite of the limited technical assistance and training, it does seem that experience, *per se*, increased reliance on data for the follow-up intervention prioritization decision.

The weak baseline finding that members who attended more meetings relied more on experiential sources of information for decisions was unanticipated. Considering what members said about their roles in the earlier qualitative interviews, however, it is likely that members who feel that their main responsibility is to advocate on behalf of their “constituent” populations—and, therefore, rely more heavily on experiential sources in their decision-making—make a special effort to attend more regularly than other members.

Strengths & Limitations

The primary limitation in this study was the lack of an experimental design, and associated control or

comparison group against which changes made in MPPG organizational structure and processes might have been measured. The limited size of the MPPG membership (less than 40 members per year) naturally yielded a smaller sample size than would have been desired for the analysis of survey data, and thereby limited the analytic strategies available to test assumptions as well as relationships in the data. It also lowered the power of statistical tests, reducing the probability of that test reporting a statistically significant effect for a real effect of a given magnitude. In light of the exploratory nature of the study and our objective to attain the best predictive model by maximizing the goodness of fit, multivariate analysis was still used. To further compensate for this limitation, only variables with a bivariate association with the outcome with a p value less than 0.30 were included in multivariate analysis. Comparisons of baseline and follow-up data were further limited because some of the members at follow-up had participated in the baseline assessment, and some had not. We were able to overcome this limitation of the bivariate comparisons by conducting the post-hoc analyses described above, but this was not possible statistically for the multivariate models. However, we did force the length of membership back into the multivariate model equation and, consequently, the significance of education was diminished, thus, essentially controlling for whether they participated earlier.

Much of the subject-matter investigated here has not been studied previously, so self-report survey instruments were devised specifically for use in this study. The items and scales that were developed demonstrated strong internal consistency at baseline. And, while we do not anticipate any problems with data related to self-reported attitudes and perceptions of the MPPG, reliance primarily on self-reports of data-related knowledge and skills may pose a more significant problem in terms of validity. Rather than reflecting true knowledge or skills in data use, these particular items may reflect members’ confidence in their ability to use data, which is likely to be related to scientific training or experience in data use (Weiss, 1980).

Finally, the fact that we focused on a single CPG that may be unique in its membership and organizational structures may limit the generalizability of these findings to other jurisdictions. Because these findings are based upon the Massachusetts CPG, they will be most generalizable to CPGs with a similar member composition and organizational structure.

During the evaluation study period, community planning nationally maintained a relatively stable character. The only significant shift in community planning processes nationally occurred at the end of the study timeframe, when a preliminary draft of a revised Community Planning Guidance was released at the 2003 Community Planning Leadership Summit (CPLS) in New York City. Given that the MPPG was already operating by most of the new concepts (e.g., increased focus on data-based decision-making) included in the draft Guidance, this event had little impact on local processes. Meanwhile, however, MPPG representatives at annual CPLS events had interacted with colleagues in jurisdictions that had much greater access to budgetary information from health department contracted agencies. This exposure prompted the MPPG leadership to advocate locally for the provision of more financial data for use in decision-making. The MDPH had long considered review of specific fiscal details to be beyond the purview of the MPPG because of the potential for conflict of interest when agency employees glean financial data about other agencies that compete for Health Department funding. Instead, regionally-based fiscal data were provided during the 2002–2003 gap analysis. This seemed sufficient to inform the particular decision, while simultaneously protecting the confidentiality of individual service providers and avoiding possible conflict of interest.

IMPLICATIONS

The findings presented in this paper provide preliminary evidence for the kinds of impacts that changes in organizational structure and processes in CPG planning groups, including the redistribution of power, can have on member satisfaction with decision-making processes, leadership, as well as the decisions that are ultimately made. The intervention that was implemented, and included numerous structural changes to the CPG, appears to have been successful in a number of ways. However, while the results were promising, several limitations in the research design, sample size, and shifting membership during the study interval suggest caution in interpretation of the findings. And, there are still some obvious gaps, particularly in the dimensions of data inputs and data-related knowledge and skill, which remain to be addressed in subsequent interventions. The success and impact of the planned focus on those areas during Years Two and Three will be further evaluated, as will the extent to which these

combined efforts cumulatively contribute to changes in member reliance on behavioral data. Despite the unique characteristics of the MPPG, the results and lessons learned from this intervention and evaluation study have obvious relevance to other CPGs, and provide insights into the ways in which issues such as group climate and trust can both affect community decision-making and be addressed.

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