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COMMISSION ON HIV

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HIV PREVENTION PLANNING WORKGROUP Virtual Meeting

Agenda and meeting packet will be available prior to the meeting at http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Wednesday, April 27, 2022

5:30PM-7:00PM (PST)

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PREVENTION PLANNING WORKGROUP

Virtual Meeting Agenda

Wednesday, April 27, 2022 @ 5:30 – 7:00pm

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AGENDA

1. **Welcome and Introductions 5:30-5:45pm**

2. **Co-Chairs' Report (5:45-5:50pm)**
   a. Highlights from March 15 Planning, Priorities and Allocations (PP&A) Committee Meeting

3. **Discussion: Survey development to assess Commissioner's understanding and capacity to engage effectively in integrated planning (5:50-6:30pm)**
   a. Articulate purpose and scope of survey
   b. Clarify audience/survey recipients
   c. Identify key questions or areas of inquiry
   d. Identify timeline for completion

4. **Comprehensive HIV Plan 2022-2026 Update 6:30-6:45PM**

5. **Commission on HV Staff Updates 6:45-6:50pm**
   a. Staff support for PPW
   b. PPW meeting time and day check
   c. Planning for in-person, virtual, and/or hybrid meeting formats

6. **Next Steps and Agenda Development for Next Meeting 6:50-6:55pm**

7. **Public Comment + Announcements 6:55-7:00pm**

8. **Adjournment 7:00pm**

SAMHSA
Substance Abuse and Mental Health Services Administration

A Guide to SAMHSA's Strategic Prevention Framework

JUNE 2019

Acknowledgments

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TABLE OF CONTENTS

INTRODUCTION

Prevention planners are pressed to put in place solutions to urgent substance misuse problems facing their communities. But research and experience have shown that prevention must begin with an understanding of these complex behavioral health problems within their complex environmental contexts; only then can communities establish and implement effective plans to address substance misuse.

To facilitate this understanding, SAMHSA developed the Strategic Prevention Framework (SPF). The five steps and two guiding principles of the SPF offer prevention planners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their states and communities.

The SPF includes these five steps:

1. **Assessment:** Identify local prevention needs based on data (e.g., What is the problem?)
2. **Capacity:** Build local resources and readiness to address prevention needs (e.g., What do you have to work with?)
3. **Planning:** Find out what works to address prevention needs and how to do it well (e.g., What should you do and how should you do it?)
4. **Implementation:** Deliver evidence-based programs and practices as intended (e.g., How can you put your plan into action?)
5. **Evaluation:** Examine the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

The SPF is also guided by two cross-cutting principles that should be integrated into each of the steps that comprise it:

- **Cultural competence.** The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.
- **Sustainability.** The process of building an adaptive and effective system that achieves and maintains desired long-term results.

The SPF has several defining characteristics that set it apart from other strategic planning processes. Most notably, it is:

- **Dynamic and iterative.** Assessment is the starting point, but planners will return to this step again and again as their community's substance misuse problems and capacities evolve. Communities may also engage in activities related to multiple steps simultaneously. For example, planners may need to find and mobilize additional capacity to support implementation once a program or practice is underway. For these reasons, the SPF is a *circular* rather than a linear model.
- **Data-driven.** The SPF is designed to help planners gather and use data to guide all prevention decisions—from identifying which substance misuse problems to address in their communities, to choosing the most appropriate ways to address these problems, to determining whether communities are making progress.
- **Reliant on and encourages a team approach.** Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners. The individuals and institutions involved in prevention efforts may change as the initiative evolves, but the need for prevention partners will remain constant.

This toolkit provides an introduction to the SPF's well-tested and user-friendly planning approach. Organized by each of the steps in the framework, the toolkit provides a snapshot of how each of the components fit together and build on one another. Used in tandem with its companion resource, *Selecting Best-Fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners*, the toolkit provides an important starting point for engaging in a thoughtful, data-driven process that supports best practices, engages critical stakeholders, and draws on evidence. Adherence to the principles in the framework increases the likelihood that prevention efforts will produce anticipated outcomes, reduce harmful behaviors, and keep communities healthy and safe.

STEP 1: ASSESSMENT

OVERVIEW

The purpose of this step is to understand local prevention needs based on a careful review of data gathered from a variety of sources. These data help planners to identify and prioritize the substance misuse problems present in their community; clarify the impact these problems have on community members; identify the specific factors that contribute to these problems; assess readiness; and determine the resources required to address those factors. Ultimately, a thorough and inclusive assessment process helps to ensure that substance misuse prevention efforts are appropriate and on target.

To conduct a comprehensive assessment of prevention needs, prevention professionals gather data about each of the following:

- The nature of the substance misuse problem in the community and related harmful behaviors
- Risk and protective factors that influence substance misuse problems, particularly those of high priority in the community
- Community capacity for prevention, including readiness and available resources

PROBLEMS AND RELATED BEHAVIORS

It is important to assess the nature and extent of both substance misuse problems *and* related harmful behaviors in the community. But what are *problems* and what are *behaviors*?

Substance misuse problems are characterized by the behavior patterns that describe how substances are misused, for example, binge drinking alcohol. In turn, substance misuse problems may lead to other harmful behaviors or adverse outcomes, such as traffic accidents and fatalities from driving under the influence of alcohol or other drugs. However, the relationship between substance misuse and other associated problems is not one-to-one. An individual's substance misuse behavior can lead to a wide range of problems, often multiple ones—including illnesses, injuries, violence to self and others, and crimes. For example, binge drinking among 12- to 17-year-olds can lead to alcohol poisoning, motor vehicle crashes, delinquent and violent acts, and other serious problems reported in this age group.

ASSESSING PROBLEMS AND RELATED HARMFUL BEHAVIORS

Prevention planners can use the following questions to guide community assessment of substance misuse problems and related harmful behaviors:

- ***What*** substance misuse problems (e.g., overdoses, alcohol poisoning) and related harmful behaviors (e.g., prescription drug misuse, underage drinking) are occurring in the community?
- ***How often*** are these substance misuse problems and related harmful behaviors occurring? Which ones are happening the most?
- ***Where*** are these substance misuse problems and related harmful behaviors occurring (e.g., at home or in vacant lots, in small groups or during big parties)?
- ***Who*** is experiencing more of these substance misuse problems and related harmful behaviors (e.g., males, females, youth, adults, members of certain cultural groups)?

The answers to these questions can help planners identify—and determine how to most effectively address—a community's priority substance misuse problem(s). To obtain these answers, planners rely on data. Data is the driving force behind the SPF planning process. Prevention efforts are more successful when planners use data to understand the substance misuse problems facing their communities.

Community practitioners and planners may begin by collecting existing state and local archival data that are readily available. In some instances, states, tribes, and jurisdictions have established epidemiological workgroups—collaborative groups of agencies and individuals focused on using data to inform and enhance prevention practice at both the state and local levels. These workgroups collect, analyze, and disseminate a wide variety of substance use and behavioral health data. These findings are often presented in epidemiological profiles—detailed reports that summarize the problems affecting a particular community or population. Hospitals, law enforcement agencies, community organizations, and state agencies can also be important sources of data.

Once the data are compiled, it is important to examine and discard what is irrelevant or not useful. It is also important to determine whether any information (e.g., about a particular problem, behavior, or population group) is missing and, if so, identify ways to fill data gaps by collecting new data. (See *Appendix A* to learn about data collection methods and their benefits and limitations.)

PRIORITIZING PROBLEMS AND RELATED HARMFUL BEHAVIORS

Data collected through the assessment process may reveal that a community has multiple areas of need that are contributing to substance misuse. Planners will want to establish criteria for analyzing assessment data in order to determine how to prioritize problem(s). These criteria may include the following:

- **Magnitude:** Describes the prevalence of a specific substance misuse problem or harmful behavior (e.g., Which problem/behavior is most widespread in your community?)
- **Severity:** Describes how large an impact a specific substance misuse problem or harmful behavior has on the people or the community (e.g., Which problem/harmful behavior is most serious?)
- **Trend:** Describes how substance misuse patterns are changing over time within a community (e.g., Which problem/harmful behavior is getting worse or better?)

- **Changeability:** Describes how likely it is that a community will be able to modify the problem or behavior (e.g., Which problem/harmful behavior are you most likely to influence with your prevention efforts?)

When setting priorities, planners should consider all four of these criteria together in order to gain a balanced view of the problem, its significance in the community, and the potential for change. Different planners or practitioners may weigh each criterion differently, depending on their unique community context and perspective. Working through these considerations is important to build support for the community prevention efforts that will be directed to the priority substance misuse problem.

ASSESSING RISK AND PROTECTIVE FACTORS

Once a community has identified one or more priority problems, it is important to look at the factors associated with those problems. Two types of factors influence the likelihood that an individual will develop a substance misuse or related mental health problem:

- ***Risk factors*** are associated with a higher likelihood of developing a problem (e.g., low impulse control, peer substance use).
- ***Protective factors*** are associated with a lower likelihood of developing a problem (e.g., academic achievement, parental bonding, and family cohesion).

Understanding risk and protective factors is essential to prevention.

Prevention planners cannot change a substance misuse problem directly. Instead, they need to work through the underlying risk and protective factors that influence the problem. A prevention program or practice can only make a difference if it's a good match for both the problem and its underlying factors.

The following are some key features of risk and protective factors:

- Risk and protective factors exist in multiple contexts (e.g., individual, family, peer, and community).
- Risk and protective factors are correlated and cumulative.
- Individual factors can be associated with multiple problems.
- Risk and protective factors are influential over time.

It is important to recognize that the underlying factors driving a substance misuse problem in one community may differ from the factors driving that same problem in a different community. Effective prevention focuses on reducing the risk factors and strengthening the protective factors specific to the priority problem in *your* community. (See *Appendix B* to learn more about risk and protective factors.)

ASSESSING CAPACITY FOR PREVENTION

Assessing a community's available resources and readiness to address substance misuse is a key part of the prevention planning process. Prevention efforts are more likely to succeed when they are informed by a complete assessment of a community's capacity to address the identified substance misuse problems. Capacity for prevention includes two main components: resources and readiness.

Resources include anything a community can use to establish and maintain a prevention effort that can respond effectively to local problems. Examples include:

- People (e.g., staff, volunteers)
- Specialized knowledge and skills (e.g., research expertise)
- Community connections (e.g., access to population groups)
- Concrete supplies (e.g., money, equipment, technology)
- Community awareness about local substance misuse problems (e.g., high rates of opioid overdose)
- Existing efforts to address those problems (e.g., policies)

A well-planned and focused resource assessment will produce far more valuable information than one that casts a wide net. To that end, it's helpful to focus capacity assessments on resources that are related to your priority problem(s). At the same time, keep in mind that useful and accessible resources may also exist beyond the boundaries of the community's substance misuse prevention effort. Many organizations, including state and government agencies, law enforcement, health care centers, and faith-based organizations are also working to reduce the impact of substance misuse and other harmful behavioral health problems.

Readiness describes the motivation and willingness of a community to commit local resources to addressing identified substance misuse problems. Factors that affect readiness include:

- Knowledge of the substance misuse problem
- Existing efforts to address the problem
- Availability of local resources
- Support of local leaders
- Community attitudes toward the problem

Readiness assessments should reflect the preparedness of the community sectors that will be involved in addressing the priority problem and/or will be affected by it. To do this, prevention planners must engage in a culturally competent assessment process that includes representatives from across community sectors. A thorough capacity assessment should include information about:

- The cultural and ethnic makeup of the community
- How problems are perceived among different sectors of the community
- Who has been engaged in previous prevention efforts
- Existing barriers to participation in prevention efforts

To assess readiness for prevention, it is often helpful to speak, one-on-one, with local decision-makers and public opinion leaders. If individuals with access to critical prevention resources are not initially supportive of or invested in prevention efforts, then it will be important to find ways early on to increase their level of readiness.

Understanding local capacity, including both resources and readiness, helps prevention planners to:

- Make realistic decisions about which substance misuse problem(s) a community is prepared to address.
- Identify resources a community may need, but doesn't currently have, for addressing identified prevention needs.
- Develop a clear plan for building and mobilizing capacity (see SPF Step 2) to address identified problems.

Assessing community readiness, in particular, helps prevention professionals determine whether there is social momentum for addressing the issue(s) they hope to tackle. Community readiness is just as important in addressing substance misuse problems as having tangible resources in place.

SHARING ASSESSMENT FINDINGS

The final step in completing a needs and capacity assessment is to communicate key findings to prevention stakeholders. There are many ways to share findings, but what is critical is that the chosen approach is the right match for the audience. Included below are some key considerations for sharing assessment findings.

- **Develop a full report.** Funders and close prevention partners (e.g., task force members) will want the whole story. It's helpful to have all of the details in one place.
- **Highlight key findings.** For stakeholders who may be interested only in assessment highlights, develop brief handouts or short slide presentations.
- **One size does not fit all.** Be prepared to tailor assessment materials by featuring those data that are most meaningful to each audience. This is particularly important when presenting assessment findings to key stakeholders (e.g., local decision-makers, public opinion leaders, and potential partners). If these individuals have specific questions or reservations, be sure to address them.
- **Solicit input from the community.** Find ways for community members and groups to provide feedback on the assessment results. Their comments can help to confirm that prevention plans are on track and/or shed light on findings that may have been confusing or surprising.

STEP 2: CAPACITY

OVERVIEW

In this step, local resources are built and mobilized and the community's readiness to address priority substance misuse problems is determined. In Step 1, planners took stock of what was available in their communities. In Step 2, they ensure the readiness of the community to buy in to the prevention effort and take stock of the resources needed to tackle the problem and produce a positive change.

A community needs both *human* and *structural* resources to establish and maintain a prevention system that can respond effectively to local problems. It also needs people who have the motivation and willingness—that is, the readiness—to commit local resources to addressing these problems.

The following are three strategies for building local capacity for prevention:

1. Engage diverse community stakeholders
2. Develop and strengthen a prevention team
3. Raise community awareness about the issue

By building and mobilizing local capacity for prevention, planners create the foundation communities will need to begin developing prevention efforts that will be effective and enduring.

ENGAGING DIVERSE STAKEHOLDERS

Substance misuse is a complex behavioral health problem, and to address it requires the energy, expertise, and experience of multiple players, working together across disciplines. Prevention planners need diverse partners—from neighborhood residents to service providers to community leaders—to share information and resources, raise awareness about critical substance misuse problems, build support for prevention, and ensure that prevention activities reach multiple populations with multiple strategies in multiple settings. By involving community members in all aspects of prevention planning, implementation, and evaluation, planners demonstrate respect for the people they serve and are more likely to develop prevention services that meet genuine needs, build on strengths, and produce positive outcomes.

Following are community sectors that planners may want to involve in prevention efforts:

- Treatment providers
- Law enforcement
- Health care providers
- Local government
- Youth-serving agencies and institutions
- Local businesses
- University and research institutions
- Neighborhood and cultural associations
- Faith communities

It is important to build relationships with stakeholders who support prevention efforts as well as with those who do not. It is also important to recognize that potential community partners will have varying levels of interest and/or availability to get involved. One person may be willing to help out with a specific task, while another may be willing to assume a leadership role. Keep in mind that as people come to understand the importance of prevention efforts, they are likely to become more engaged. (See *Appendix C* to learn more about levels of involvement.)

The following list includes some of the ways to approach people and organizations in the community with information about, and invitations to participate in, prevention efforts:

- Call known contacts, particularly those with overlapping interests
- Attend and speak up at community meetings and events
- Ask partners to contact their partners
- Keep potential partners well informed about prevention activities and progress made
- Meet with key players, including public opinion leaders and local decision-makers
- Anticipate and overcome roadblocks (e.g., address the concerns of those who might oppose or hinder prevention efforts)

Included below are different ways to encourage stakeholders who are already engaged to get *more* involved in prevention efforts:

- Meet face-to-face to discuss overlapping goals and agendas
- Extend an invitation to attend a prevention team or task force meeting
- Once prevention planning is underway, make more specific requests for involvement
- Extend invitations to attend future prevention events and activities
- Maintain relationships by keeping stakeholders informed of prevention activities and progress made

DEVELOPING AND STRENGTHENING A PREVENTION TEAM

A strong prevention team is often the guiding force behind effective prevention efforts. The prevention team, or task force, should include representatives from those community sectors that are most vital to the success of the prevention initiative. In other words, the prevention team will be a subset of the stakeholders identified above. Here are some considerations for building and/or strengthening a prevention team:

- **Be deliberate.** Establishing a representative prevention team requires deliberate and strategic planning. When inviting new members, be clear about the purpose of the collaboration, determine how goals will be attained, and establish clear roles and responsibilities for all involved.

- **Build prevention knowledge.** A truly representative prevention team means that members will bring diverse insights and experiences to the table, as well as varied knowledge and perspectives on the priority problem being addressed. Use a variety of strategies—including guest speakers and group trainings—to increase the team's understanding of the problem and effective prevention strategies.
- **Monitor and improve group structure and processes, as needed.** Even the most well-informed group won't be productive unless it functions well. To help the team work together effectively, discuss how you will share leadership, make decisions, divide tasks, resolve conflicts, and communicate with one another as well as with the broader community.

RAISING COMMUNITY AWARENESS

By raising public awareness about a community's priority substance misuse problem(s), prevention planners can help garner valuable resources and increase local readiness for prevention. The following are some strategies for raising community awareness:

- Meet one-on-one with public opinion leaders
- Ask task force members to share information in their own sectors
- Submit articles to local newspapers, church bulletins, neighborhood newsletters, etc.
- Share information on relevant websites and social media outlets
- Host community events to share information about and discuss the problem
- Convene focus groups to get input on prevention plans

It is always helpful to think "outside the box" when looking for new ways to raise community awareness. For example, the local high school may have a media club that can help to create a video about the community's priority problem and/or prevention efforts. Also, think about "ripple" potential—that is, which individuals and community groups might help to spread the word and get others involved in prevention efforts.

Finally, when building capacity, don't forget about the data. Data collected during the assessment process can help to increase general awareness about critical prevention problems and engage key stakeholders. Data can also be used to mobilize resources to support prevention efforts.

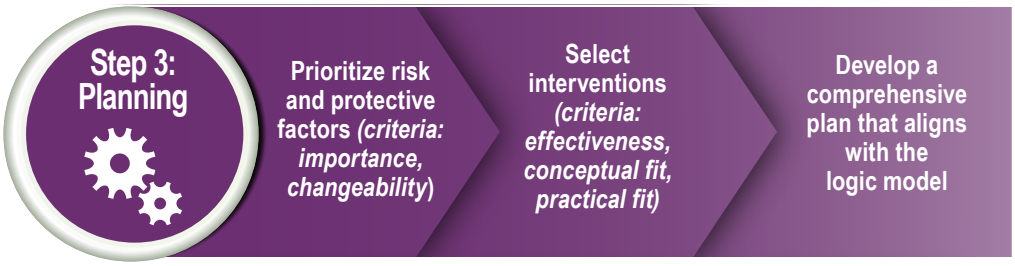
STEP 3: PLANNING

OVERVIEW

Strategic planning increases the effectiveness of prevention efforts by ensuring that prevention planners select and implement the most appropriate programs and strategies for their communities. In an effective planning process, communities involve diverse stakeholders, replace guesswork and hunches with data-driven decisions, and create comprehensive, evidence-based prevention plans to address their priority substance misuse problems.

To develop a solid prevention plan, planners need to:

- Prioritize the risk and protective factors associated with the substance misuse problems that have been identified (See *Step 1: Assessment*)
- Select appropriate programs and practices to address each priority factor
- Combine programs and practices to ensure a comprehensive approach
- Build and share a logic model with stakeholders



The flowchart included previously in *Step 1: Assessment* to illustrate the information communities must gather in order to determine their prevention needs can also guide the development of an effective prevention plan.

As noted earlier, communities can't change substance misuse problems directly. These are changed indirectly by addressing the risk and protective factors that are associated with the problem. Evidence-based programs and practices can only make a difference if they're a good match for both the substance misuse problem *and* the underlying risk and/or protective factors that drive changes in that problem.

PRIORITIZING RISK AND PROTECTIVE FACTORS

Every substance misuse problem in every community is associated with multiple risk and protective factors. No community can address all of these factors—at least not all at once. So, the first step in developing a prevention plan is to figure out which risk and protective factors are the "key drivers" of a community's priority problems. To prioritize factors, it is helpful to consider a factor's *importance* and *changeability.*

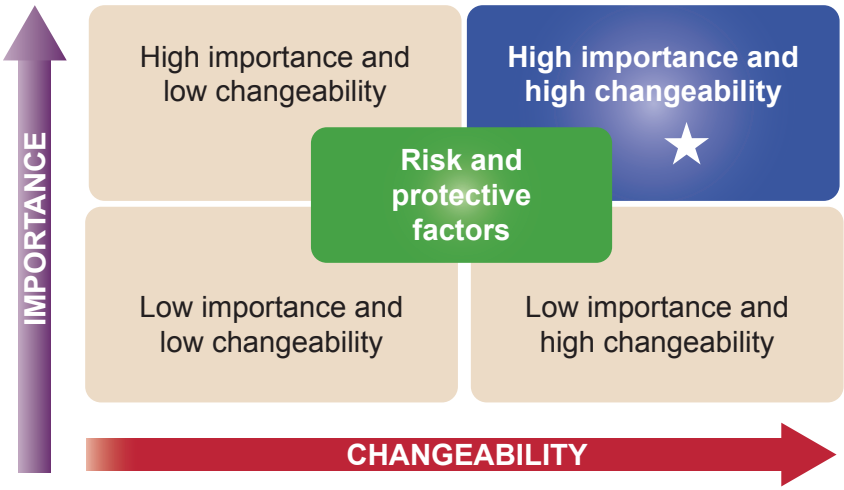
Importance describes how a specific risk or protective factor affects a problem. To determine a factor's importance, ask the following:

- How much does this factor contribute to our priority problem?
- Is this factor relevant, given the developmental stage of our focus population?
- Is this factor associated with other harmful behavioral health problems?

Changeability describes a community's capacity to influence a specific risk or protective factor. To determine a factor's changeability, ask the following:

- Do we have the resources and readiness to address this factor?
- Does a suitable program or practice exist to address this factor?
- Can we produce outcomes within a reasonable timeframe?

When developing a prevention plan, it is best to prioritize risk and protective factors that are *high for both importance and changeability.*



If no factors are high for both, the next best option is to prioritize factors with high importance and low changeability. Since factors with high importance contribute significantly to priority substance misuse problems, addressing these factors is more likely to make a difference. Also, it may be easier to increase the changeability of a factor (e.g., by building capacity) than it is to increase its importance. In some cases, however, a community may choose to address a factor with low importance and high changeability. Doing this can give the community a quick "win," help raise awareness and support for prevention, as well as increase the community's capacity to address more important factors in the future.

SELECTING APPROPRIATE PROGRAMS AND PRACTICES

Sometimes people want to select prevention programs or practices that are popular, those that worked well in a different community, or those with which they are familiar. These are not necessarily the best selection criteria. What is more important is that the program or practice can effectively address the priority substance misuse problem and associated risk and protective factors, and that it is a good fit for the specific community.

The following are three important criteria for selecting appropriate prevention programs and practices:

- **Evidence-based foundation.** Whenever possible, prevention planners should select programs or practices that are evidence-based (i.e., that have documented evidence of effectiveness). The best places to find evidence-based programs are federal registries, peer-reviewed journals, systematic reviews, and individual evaluation reports. Planners may also look to federal reports, such as *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016;* many include extensive program listings and descriptions. Since states have different guidelines for what constitutes credible evidence of effectiveness, it can also be helpful to talk to prevention experts, including state-level evidence-based workgroups.

- **Conceptual fit.** A program or practice has a good conceptual fit if it directly addresses one or more of the priority factors driving a specific substance misuse problem and has been shown to produce positive outcomes for members of the focus population. To determine a conceptual fit, ask, "Will this program or practice have an impact on at least one of the community's priority risk and protective factors?"

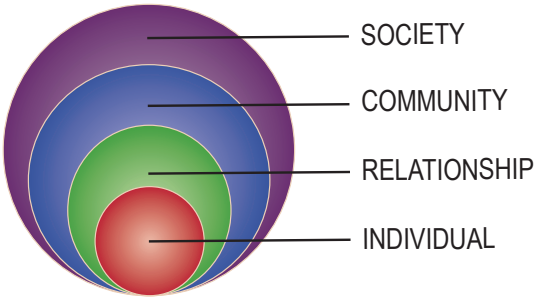
- **Practical fit.** A program or practice has a good practical fit if it is culturally relevant for the focus population, the community has the will and capacity to support it, and it enhances or reinforces existing prevention activities. To determine a practical fit, ask, "Is this program or practice appropriate for our community?"

Evidence-based programs or practices with both conceptual fit *and* practical fit will have the highest likelihood of producing positive prevention outcomes. (To learn more about each of these criteria, see SAMHSA's companion tool *Selecting Best-Fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners*.)

ENSURING A COMPREHENSIVE APPROACH

In a comprehensive approach to prevention, programs and practices combine to reach people with different levels of risk. They target multiple social contexts and ensure cultural relevance. Each of these is described below.

- **Levels of risk.** To stop the progression of substance misuse, effective prevention efforts include those programs and practices that are directed toward individuals or groups who are not yet engaging in risky behaviors (e.g., alcohol awareness programs for all 10th grade students). These efforts also include interventions for individuals or groups who have a higher likelihood of engaging in these risky behaviors or who have already begun doing so (e.g., programs for children whose parents have substance use disorders, or post-overdose interventions for individuals who have survived an opioid overdose).



- **Multiple social contexts.** The socio-ecological model shows how risk and protective factors operate across all social contexts, including individuals, friends and family, schools and other community settings as well as the broader societal context of laws and norms. A comprehensive prevention plan includes multiple programs and practices, operating in multiple settings and across multiple domains. (See *Appendix D: The Socio-Ecological Model* to learn more about this topic.)
- **Cultural relevance.** Programs and practices must be responsive to, and appropriate for, the different cultural groups that comprise a focus population. Throughout the SPF process, planners must take steps to ensure the cultural relevance of prevention efforts. For example:
  - ***During Step 1: Assessment.*** Map the cultural landscape to identify different population groups in the community as well as key leaders within each group. Analyze assessment data by group.
  - ***During Step 2: Capacity.*** Share and discuss assessment findings throughout the community. Invite interested community members and groups to participate in prevention planning. Make sure the planning team includes individuals with strong ties to groups at high risk.
  - ***During Step 3: Planning.*** Recruit focus population members to help identify appropriate programs and practices. Convene focus groups with diverse community members to obtain valuable feedback on potential interventions.

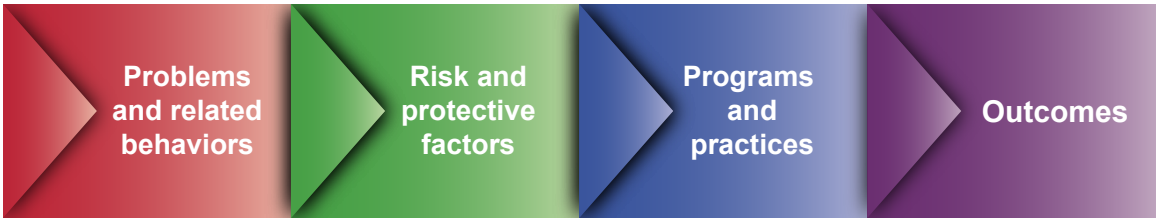
BUILDING AND SHARING A LOGIC MODEL

A logic model is a graphic planning tool, much like a roadmap, that can help prevention planners communicate where prevention efforts are headed and how goals will be reached. Logic models can help planners:

- **Explain why a program or practice will succeed.** By clearly laying out the tasks of development, implementation, and evaluation, a logic model can help planners clearly explain what will happen and why.

- **Identify the logical connections between the problem to be addressed, the associated underlying factors, and the prevention programs and practices that will effect change.** Logic models help to expose gaps in reasoning or "disconnects" between the community's problem and the actions that have been planned to address it. A logic model helps planners identify places where assumptions might be off track or may be unsupported by research or past experience. The sooner mistakes are discovered, the easier they are to correct.
- **Make evaluation and reporting easier.** Developing a logic model before implementing a program or practice makes evaluation easier since it shows clear, explicit, and measurable intended outcomes. When a prevention initiative is laid out fully and clearly in a logic model, it is much easier to identify appropriate evaluation questions and gather the data needed to answer them.

Though logic models can vary in their design, most include the following four critical components.



Outcomes are the changes communities want their prevention programs and practices to produce. Prevention outcomes can be either short-term or long-term.

- **Short-term outcomes.** Short-term outcomes are the most immediate effects of a program or practice. Short-term outcomes are closely related to how well a program or practice is implemented. These include changes in knowledge, attitudes, beliefs, and skills, and are usually connected to changes in priority risk and protective factors.
- **Long-term outcomes.** Long-term outcomes are the effects of a program or practice after it has been in place for an extended, clearly defined, period of time—usually months or years. Short-term outcomes reflect changes primarily in risk/protective factors. Long-term outcomes build on these short-term effects to produce changes in substance misuse behavior.

After completing a logic model for prevention, it is important to share it with these two important groups:

- **Prevention partners.** These include the individuals, groups, and institutions who participated in the needs assessment; were brought onboard during the capacity-building process; and will play a key role in selecting prevention programs and strategies. Make sure the logic model clearly communicates what the prevention plan hopes to accomplish and what the role of partners will be in helping everyone to get there.

- **Other prevention stakeholders.** These include funders as well as community members and groups who may not yet be actively involved in prevention efforts. A logic model can help planners build support for prevention overall, as well as to mobilize the specific capacities needed to implement specific programs and practices. Also, the more people who understand the problem and are onboard with the prevention plan, the more likely it is that selected programs and practices will be sustained over time.

STEP 4: IMPLEMENTATION

OVERVIEW

In this step, a community's prevention plan is put into action by delivering evidence-based programs and practices as intended. To accomplish this task, planners will need to balance fidelity and adaptation, and establish critical implementation supports. Each of these tasks is addressed in detail below.

BALANCE FIDELITY AND ADAPTATION

In preparing to implement selected programs and practices, it is important to consider *fidelity* and *adaptation*.

- ***Fidelity:*** The degree to which a program or practice is implemented as intended.
- ***Adaptation:*** Describes how much, and in which ways, a program or practice is changed to meet local circumstances.

Evidence-based programs and practices are defined as such because they consistently achieve positive outcomes. The greater the fidelity to the original program design, the more likely the program will be to reproduce positive results. While customizing a program to better reflect the attitudes, beliefs, experiences, and values of a focus population can increase its cultural relevance, it is important to keep in mind that such adaptations may compromise program effectiveness.

Remaining faithful to the original design of an evidence-based program or practice, while addressing the unique needs and characteristics of the target audience, requires balancing fidelity and adaptation. When we change a program, we risk compromising outcomes. However, implementing a program that requires some adaptation may be more efficient and cost-effective than designing a program from scratch.

Consider these guidelines when balancing fidelity and adaptation:

- **Retain core components.** Evidence-based programs are more likely to be effective when their core components are maintained. Core components are those parts of a program or practice that are responsible for producing positive outcomes, and thus most essential and indispensable. Core components are like the key ingredients in a cookie recipe. We might be able to take out the chocolate chips, but if we take out the flour—a core component—the recipe won't work. However, understanding and adhering to the principles underlying each core component may allow for flexibility (see *Adapt with care* on next page).

- **Build capacity before changing the program.** Rather than change a program to fit local conditions, consider ways to develop resources or to build local readiness so that it can be delivered as it was originally designed.
- **Add rather than subtract.** Doing so decreases the likelihood of important program elements (i.e., those that are critical to program effectiveness) getting lost.
- **Adapt with care.** Even when programs and practices are selected with great care, there may be ways to improve their appropriateness for a unique focus population. Cultural adaptation, for example, refers to modifications that are tailored to the beliefs and practices of a particular group and enhance the cultural relevance of an intervention. To make a program or practice more culturally appropriate, consider the language, values, attitudes, beliefs, and experiences of focus population members.
- **If adapting, get help.** Knowledge experts, such as program developers, can provide information on how a program has been adapted in the past, how well these adaptations have worked, and what core components should be retained to maintain effectiveness. Members of the focus population can also suggest ways to enhance program materials or messaging to better reflect their concerns and experiences.

Keep in mind that adaptations can be ***planned*** in order to improve a program (e.g., the case with cultural adaptation) or ***unplanned***. It's important to be aware of the potential for unplanned changes that may occur during implementation (e.g., missed sessions when schools close unexpectedly due to bad weather) and to address any changes that might compromise program effectiveness (e.g., schedule makeup sessions so students don't miss out on core program content).

ESTABLISH IMPLEMENTATION SUPPORTS

Many factors combine to influence implementation and support the success of prevention efforts. These include the following:

- **Favorable prevention history.** An individual (or organization) who has had positive experiences implementing prevention programs or practices in the past is likely to be more willing and able to support the implementation of a new intervention. If an individual (or organization) has had a negative experience implementing a program or practice—or doesn't fully understand its potential—make sure to address their concerns early in the implementation process.
- **Leadership and administrative support.** Prevention programs and practices assume many forms and are implemented in many different settings. However, in order to be effective, all of them require leadership and support from key stakeholders.
- **Provider selection.** When selecting the best candidate to deliver a prevention program, consider professional qualifications and experiences, practical skills, as well as fit with the focus population. Ask, "Who is prepared to implement the program effectively? With whom will program participants feel comfortable?" Certain provider characteristics that extend beyond academic qualifications and experience factors are difficult to teach in training sessions, so must become part of the selection criteria.

- **Provider training and support.** Pre- and in-service trainings can help providers who are responsible for implementing a program to understand how and why it works, practice new skills, and receive constructive feedback. Since most skills are learned on the job, it is also very helpful to connect these providers with a coach who can provide ongoing support. The implementation of evidence-based programs and practices requires behavior change at the provider, supervisory, and administrative support levels. Training and coaching are the principal ways in which behavior change is brought about for selected staff in the beginning stages and throughout the process of implementing evidence-based programs and practices.
- **A clear action plan.** When developed in collaboration with all key partners, these plans can help to ensure that everyone involved in implementation is on the same page and no key tasks fall through the cracks. A clear action plan includes all implementation tasks, deadlines, and person(s) responsible.
- **Implementation monitoring.** By closely monitoring and evaluating the delivery of a program or practice, planners can make sure that it is being implemented as intended and can thereby improve it as needed. By assessing program outcomes, planners can determine whether a program or practice is working as intended and is worthy of sustaining over time. Assessments of provider performance and measures of fidelity also provide useful feedback to managers and implementers regarding the progress of implementation efforts and the usefulness of training and coaching. (See *Step 5: Evaluation* to learn more about this topic.**)**

These implementation supports are interactive and can compensate for one another, so that a weakness in one can be overcome by strengths in others. Organizations are dynamic and there is an ebb and flow to the relative contribution of each support to the overall outcomes. Implementation monitoring can help to reveal where supports may need to be adjusted to improve effectiveness or efficiency.

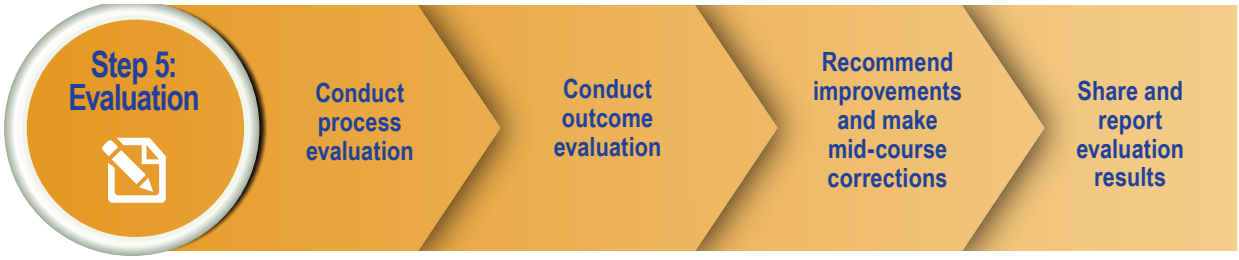
STEP 5: EVALUATION

OVERVIEW

In the SPF, evaluation is about enhancing prevention practice. It is the systematic collection and analysis of information about prevention activities to reduce uncertainty, improve effectiveness, and facilitate decision-making.

The evaluation step helps communities to:

- Systematically document and describe prevention activities.
- Meet the diverse information needs of prevention stakeholders, including funders.
- Continuously improve prevention programs and practices.
- Demonstrate the impact of a prevention program or practice on substance misuse and related behavioral health problems.
- Identify which elements of a comprehensive prevention plan are working well.
- Build credibility and support for effective prevention programming in the community.
- Advance the field of prevention by increasing the knowledge base about what works and what does not.



EVALUATION AND THE SPF

In the SPF, evaluation involves examining both the process and outcomes of prevention programs and practices. This means asking questions at three levels:

1. Since a comprehensive prevention plan includes multiple programs and practices, examine separately how each was delivered and the degree to which it produced positive outcomes.
2. Determine how well these different programs and practices work together as part of the community's comprehensive plan to address priority substance misuse problems.
3. Evaluate the implementation of the SPF process itself (e.g., "Were all step-specific tasks completed? Were cultural competence and sustainability principles and activities integrated along the way?")

Stakeholder involvement is as crucial a part of the evaluation step as it is of other SPF steps. An evaluation stakeholder is anyone who cares about, or has something to gain or lose from, a program or practice and its evaluation findings. This includes members of those populations that the prevention program or practice is intended to reach. The importance and benefits of involving diverse stakeholders

in the evaluation process cannot be overstated. By involving diverse stakeholders, prevention planners can:

- Demonstrate respect for the many individuals and groups connected to prevention efforts.
- Obtain the help and support needed to conduct a thorough evaluation.
- Enhance understanding of the evaluation process among those involved in data collection and analysis.
- Ensure the cultural relevance and appropriateness of the evaluation design, tools, and findings.
- Increase the credibility of prevention programming as well as the evaluation process and findings.
- Increase the likelihood that evaluation findings will be disseminated and used.
- Garner support for any efforts to expand and/or sustain programs and practices that have been shown to be effective.

UNDERSTANDING THE DIFFERENCE BETWEEN PROCESS AND OUTCOME EVALUATION

In the SPF, prevention planners consider two types of evaluation: *process* and *outcome.*

Process evaluation answers the question, "Did we do what we said we would do?" Prevention planners use process evaluation extensively to assess the quality of implementation, keep implementation on track, and inform adjustments that can strengthen the effectiveness of their prevention efforts. Process data help prevention planners determine the following:

- Were programs and practices implemented as planned?
- What adaptations were made?
- Were the resources sufficient?
- What obstacles were encountered?
- Who participated and for how long?

Outcome evaluation measures the direct effects of a program or practice following implementation, That is, it determines whether the program or practice made a difference and, if so, what changed. An outcome evaluation might document changes in a population group's knowledge, attitudes, skills, or behavior in both the short- and long-term. Specifically, outcome data can help planners determine:

- What changes occurred.
- How resulting changes compare to what the program or practice was expected to achieve.
- How resulting changes compare with those of individuals not exposed to the program or practice.

Both process and outcome data are important. Outcome evaluation looks at results, but results don't tell the whole story. An evaluation that focuses only on outcomes is sometimes called a "black box" evaluation because it does not take process into consideration. Case in point, examining how a program or practice was implemented, the number of clients served, dropout rates, and how clients experienced the intervention can shed light on disappointing outcome evaluation results. Similarly, examining these same factors can also explain positive evaluation results. (One can't take credit for positive results if one can't show what caused them.) An outcome evaluation alone, without a process evaluation component, won't provide information about why a program did or did not work. (To learn about some cost-effective ways to conduct both process and outcome evaluations, see *Appendix E: Making the Most of Your Evaluation Dollars*.)

ADHERING TO EVALUATION PRINCIPLES

Successful evaluations adhere to the principles of utility, feasibility, propriety, and accuracy.

- ***Utility*** is about making sure that the evaluation meets the needs of prevention stakeholders, including funders. To increase the utility of the evaluation, prevention planners may:
  - Identify the evaluation needs of all key stakeholders
  - Document findings so that they are easily understood
  - Share findings with stakeholders in a timely manner

- ***Feasibility*** is about making sure that the evaluation is realistic and doable. To ensure the feasibility of the evaluation, prevention professionals may:
  - Establish data collection procedures that are practical and minimize disruption
  - Anticipate and address potential obstacles (e.g., opposition from special interest groups)
  - Consider efficiency and cost-effectiveness

- ***Propriety*** is about making sure that the evaluation is conducted in accordance with legal and ethical guidelines and is consistent with each community's cultural context. To support the propriety of the evaluation, prevention professionals may:
  - Respect the rights and protect the well-being of all involved
  - Examine the program or practice in a thorough and impartial manner
  - Define how findings will be disclosed and who can access them

- ***Accuracy*** is about making sure that the evaluation is conducted in a precise and dependable manner. To increase the accuracy of evaluation findings, prevention professionals may:
  - Clearly describe the program or practice as well as the evaluation procedures
  - Gather and use information that is both valid and reliable
  - Systematically and appropriately analyze all information
  - Justify and fairly report all conclusions

(See *Appendix F: Evaluation Design, Reporting, and Lessons Learned* for more information on this topic.)

SPF GUIDING PRINCIPLE: CULTURAL COMPETENCE

Behavioral health disparities pose a significant threat to the most vulnerable populations in our society. Whether manifesting themselves as elevated rates of substance misuse among American Indian/Alaska Natives, high rates of suicide among LGBTQ youth, or reduced access to prevention services among people living in rural areas, these disparities threaten the health and wellness of these populations and of our society as a whole.

To overcome systemic barriers that may contribute to disparities, planners must be culturally competent. They must recognize and value cultural differences—such as those in the health beliefs, practices, and linguistic needs of diverse populations. They must develop and deliver prevention programs and practices in ways that ensure members of diverse cultural groups benefit from their efforts.

SAMHSA has identified the following cultural competence principles for prevention planners:

- Include the target population in all aspects of prevention planning
- Use a population-based definition of community (i.e., let the community define itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Employ culturally competent evaluators
- Promote cultural competence among program staff, reflecting the communities they serve

Cultural competence is one of the SPF's two guiding, cross-cutting principles and, as such, should be integrated into each step of the framework's implementation. By considering culture at each step, planners can help to ensure that members of diverse population groups can actively participate in, feel comfortable with, and benefit from prevention practices.

Included in the following table are some opportunities to integrate cultural competence throughout the SPF process.

SPF Step	Opportunities to Integrate Cultural Competence
Assessment	◆ Take steps to identify those sub-populations who are vulnerable to behavioral health disparities and the disparities that they experience. ◆ Identify data gaps and take efforts to fill them. ◆ Develop plans to share and solicit input about assessment findings with members of these sub-populations, and describe these findings using terms and phrases that are devoid of jargon.
Capacity	◆ Build the knowledge, resources, and readiness of prevention practitioners and community members to address disparities, as well as to provide culturally and linguistically appropriate services. ◆ Make sure that practitioners understand the role of cultural competence in their work, overall, and the unique needs of those sub-populations experiencing disparities. ◆ Develop new partnerships that will help engage members of these groups in prevention planning efforts.
Planning	◆ Make community representation in the planning process a priority. ◆ Involve members of the focus population as active participants and decision-makers. ◆ Identify and prioritize factors associated with disparities. ◆ Develop logic models that include a reduction in health disparities as a long-term outcome. ◆ Incorporate effective prevention programs and practices that have been developed for and evaluated with an audience similar to the focus population. ◆ If and when misunderstandings arise, be persistent in keeping communication lines open.
Implementation	◆ Implement prevention programs that target populations experiencing behavioral health disparities. ◆ Involve members of these groups in the design and delivery of those programs. ◆ Understand that people may choose to participate in different ways and that they may also have different learning styles. ◆ Adapt and/or tailor evidence-based practices to be more culturally relevant. For example, create an in-person version of a training that was originally designed to be delivered virtually so that it is accessible to audiences with limited online access.

Evaluation	◆ Conduct process and outcome evaluations to demonstrate whether selected programs and practices are having the intended impact on identified disparities. ◆ Track all adaptations. ◆ Allocate the evaluation resources needed to learn whether the interventions you selected are having the intended impact on the behavioral health disparities you are hoping to reduce. ◆ Conduct follow-up interviews with program participants to better understand program evaluation findings.
Sustainability (Guiding Principle)	◆ Engage partners who represent and work with sub-populations experiencing behavioral health disparities in your sustainability planning efforts. ◆ Sustain processes that have successfully engaged members of these populations. ◆ Sustain programs that produce positive outcomes for these populations.

SPF GUIDING PRINCIPLE: SUSTAINABILITY

In prevention, sustainability is the capacity of a community to produce and maintain positive prevention outcomes over time. To maintain positive outcomes, communities will want to sustain an effective strategic planning process as well as those programs and practices that produced positive prevention results. Accomplishing these dual tasks requires the participation, resolve, and dedication of diverse community members and a lot of careful planning.

SUSTAINING AN EFFECTIVE STRATEGIC PLANNING PROCESS

There are a number of reasons why it is important to sustain an effective strategic planning process. These are some things to keep in mind:

- ***Prevention takes time.*** While communities are likely to achieve some short-term outcomes initially, it can take many years to produce long-term results. When practitioners help the SPF process live on over time, communities are much more likely to make a significant and lasting impact on their substance misuse problems.
- ***Substance misuse problems and priorities change.*** Prevention needs and capacity are always evolving with new substance misuse issues arising that no one can anticipate right now. With a well-established strategic planning process like the SPF already in place, communities will be able to recognize—and respond effectively to—these important changes over time.
- ***Successful implementation of the SPF depends on collaboration.*** The SPF is widely recognized by many public health funders and practitioners. Adherence to a common planning process can help planners establish a shared language across health issues and build the interdisciplinary partnerships needed to make a real difference.

SUSTAINING PROGRAMS AND PRACTICES THAT WORK

A primary goal of an effective strategic planning process like the SPF is to identify the right combination of programs and practices to address local prevention priorities. Many factors contribute to effectiveness in prevention. In general, programs and practices must operate in a variety of community settings and influence local risk and protective factors at both the individual and environmental levels. Thus, a comprehensive prevention plan might include:

- A school-based youth skills promotion program
- Parent education to support children's healthy development
- Organizational/community rules and regulations that support healthy behavior
- Enforcement of rules and regulations that support healthy behavior

Some programs and practices included in a comprehensive prevention plan are likely to work better than others (e.g., they produce positive outcomes and/or receive community support). To maintain positive outcomes over time, it's important to identify and sustain those prevention programs and practices that work well for a community.

SPF Step	How the SPF Contributes to Sustainability
Assessment	◆ During assessment, practitioners begin making decisions based on a clear understanding of local prevention needs. They also begin building relationships with data keepers and stakeholders who can play important roles in supporting and sustaining local prevention efforts over time.
Capacity	◆ Intentional capacity building at all levels helps to ensure that successful programs are sustained within a larger community context, and therefore less vulnerable to local budgetary and political fluctuations. ◆ Effective capacity building increases an organization's or community's ability to respond to changing issues with innovative solutions. ◆ Building capacity also involves promoting public awareness and support for evidence-based prevention, and engaging partners and cultivating champions who will be vital to the success—and sustainability—of local prevention efforts.
Planning	◆ When developing a comprehensive approach to preventing substance misuse, communities should consider the degree to which prevention interventions fit with local needs, capacity, and culture: the better the fit, the more likely interventions are to be both successful and sustainable.
Implementation	◆ By working closely with community partners to deliver evidence-based programs and practices as intended, closely monitoring and improving their delivery, and celebrating "small wins" along the way, planners help to ensure their effectiveness and begin to weave prevention into the fabric of the community.
Evaluation	◆ Through process and outcome evaluation, communities can make important mid-course corrections to prevention efforts, identify which practices are worth expanding and/or sustaining, and examine ongoing plans for—and progress toward—sustaining those practices that work. ◆ By sharing evaluation findings, planners can also help build the support needed to expand and sustain effective interventions.
Cultural Competence (Guiding Principle)	◆ To ensure that prevention practices produce positive outcomes for members of diverse population groups, communities must engage in an inclusive and culturally appropriate approach to identifying and addressing their substance misuse problems. ◆ Culturally competent prevention is the only type of prevention worth doing—and sustaining.

PUTTING IT ALL TOGETHER: THE SPF AT-A-GLANCE

APPENDICES

APPENDIX A: PRIMARY DATA COLLECTION METHODS

Data is essential to understanding the prevention problems that may exist in our communities. It also helps us to determine which, if any, groups are experiencing poorer behavioral health outcomes, and to quantify the extent of these disparities. The more we learn about these populations, the more we can help identify those characteristics and situations that place members at higher risk for substance misuse, as well as those factors that might mitigate those risks.

Practitioners frequently engage in primary data collection efforts to better understand the needs of at-risk populations not captured in standardized surveys or surveillance systems. In the following pages, we provide a quick overview of three common data collection methods: interviews, focus groups, and surveys. When selecting a method, or combination of methods, think carefully about which to employ and understand that a one-size-fits-all approach to data collection is unlikely to reveal the critical needs of those populations most often underserved.

It is also important to involve members of these groups, from the start, in the data collection process, in making decisions about methodology, developing tools and questions, and in interpreting findings. The greater the involvement of community members, the greater the likelihood that data collection strategies and survey questions will reflect the culture and attitudes of the populations experiencing disparities.

INTERVIEWS

Interviews are structured conversations with specific individuals who have experience, knowledge, or understanding about a topic or issue about which you want to learn more. Relatively easy to prepare for and conduct, interviews offer practitioners the chance to find out how community members are thinking about an issue or situation. Interviews can be conducted in-person or by phone. The structure of the conversation is also somewhat flexible. Questions and topics can be added or omitted as needed.

Key informant interviews are conducted with select people who are in key positions and have specific areas of knowledge and experience. These can be useful for exploring specific problems and/or assessing a community's readiness to address those problems.

One-on-one community interviews, typically conducted by coalition members, tend to be less formal and offer excellent opportunities to build relationships, raise awareness, and inform community members about pressing problems and prevention efforts.

INTERVIEW PROS

- ✓ Low cost, assuming relatively few are conducted
- ✓ Respondents define what is important
- ✓ Have relatively short turnaround time
- ✓ Make it possible to explore issues in depth
- ✓ Offer opportunity to clarify responses through probes
- ✓ Can be source of leads to other data sources and key informants
- ✓ Have generally lower refusal rates
- ✓ Offer opportunity to build partnerships

INTERVIEW CONS

- × Can be time consuming to schedule
- × Require skilled and/or trained interviewers
- × Have limited generalizability
- × Produce limited quantitative data
- × Have potential for interviewer bias
- × May not be good for sensitive information unless rapport is established
- × May make it more difficult to summarize and analyze findings

FOCUS GROUPS

A focus group is a systematic way of collecting qualitative or descriptive data through small-group discussion. Focus group participants are chosen to represent a larger group of people from whom you want information. Through focus groups, practitioners can explore prevention related topics in depth and participants can share their unique perspectives.

Specifically, in focus groups prevention practitioners can ask participants questions that may be difficult for them to answer in writing and help them clarify their responses by asking follow-up questions. Focus groups create an opportunity for rich dialogue as participants build on one another's responses. They also generate narrative information that is compelling and easy to understand.

FOCUS GROUP PROS

- ✓ Relatively low cost
- ✓ Have relatively short turnaround time
- ✓ Participants define what is important
- ✓ Offer some opportunity to explore issues in depth
- ✓ Offer opportunity to clarify responses through probes

FOCUS GROUP CONS

- × Can be time consuming to assemble groups
- × Produce limited quantitative data
- × Require trained facilitators
- × Offer less control over the process as compared to key informant interviews
- × Make it difficult to collect sensitive information
- × Have limited generalizability
- × May make it more difficult to summarize and analyze findings

SURVEYS

Surveys provide standardized data that is relatively easy to manage and can be compared to other surveys that use the same questions. They are beneficial in situations where you want to collect information across a large geographic area, hear from as many people as possible, and explore sensitive topics.

Survey modes of administration can include phone, paper (mailed), and online surveys. Phone and mailed surveys can be expensive and time consuming to implement. On the other hand, respondents may be more likely to respond honestly to questions presented in an anonymous, written survey than to those posed during a one-on-one interview. Online surveys are less expensive to administer but tend to yield lower response rates.

SURVEY PROS

- ✓ Can be highly accurate
- ✓ Can be highly reliable and valid
- ✓ Allow for comparison with other/larger populations when items come from existing instruments
- ✓ Generate quantitative data
- ✓ Make it easy to summarize and analyze findings
- ✓ Make it possible to add more sensitive questions

SURVEY CONS

- × Relatively high cost
- × Take time to design, implement, clean, and analyze
- × Accuracy depends on who is surveyed and the size of the sample
- × Accuracy is limited to willing and reachable respondents
- × May have low response rates
- × Offer little opportunity to explore issues in depth
- × Questions cannot be clarified
- × Offer no opportunity to build rapport with respondents

APPENDIX B: KEY FEATURES OF RISK AND PROTECTIVE FACTORS

When identifying, assessing, and prioritizing the risk and protective factors present in their communities prevention planners should consider that:

- Risk and protective factors exist in multiple contexts.
- Risk and protective factors are correlated and cumulative.
- Risk and protective factors are influential over time.
- Not all people or populations are at the same risk.

These are described in greater detail below.

RISK AND PROTECTIVE FACTORS EXIST IN MULTIPLE CONTEXTS

All people have biological and psychological characteristics that make them vulnerable to or resilient in the face of potential behavioral health issues. Because people have relationships within their communities and the larger society, each person's biological and psychological characteristics exist in multiple contexts. A variety of risk and protective factors operate within each of these contexts. These factors also influence one another. Targeting only one context when addressing a person's risk or protective factors is unlikely to be successful because people don't exist in isolation.

RISK AND PROTECTIVE FACTORS ARE CORRELATED AND CUMULATIVE

Risk factors tend to be positively correlated to one another and negatively correlated to protective factors. In other words, people with *some* risk factors have a greater chance of experiencing even *more* risk factors and are *less likely* to have protective factors. Risk and protective factors also tend to have a cumulative effect on the development of behavioral health problems, including substance misuse. Young people with multiple risk factors have a greater likelihood of experiencing substance misuse problems or engaging in other related harmful behaviors. On the other hand, young people with multiple protective factors are at a reduced risk. These correlations underscore the importance of early intervention and programs and practices that target multiple, rather than single, factors.

INDIVIDUAL FACTORS CAN BE ASSOCIATED WITH MULTIPLE OUTCOMES

Although preventive programs and practices are often designed to produce a single outcome, both risk and protective factors can be associated with multiple outcomes. For example, negative life events are associated with substance misuse as well as with anxiety, depression, and other harmful behavioral health problems. Prevention efforts targeting a set of risk or protective factors have the potential to produce positive effects in multiple areas.

RISK AND PROTECTIVE FACTORS ARE INFLUENTIAL OVER TIME

Risk and protective factors can have influence throughout a person's entire lifespan. For example, risk factors such as poverty and family dysfunction can contribute to the development of mental and/or substance use disorders later in life. Risk and protective factors within one particular context—such as the family—may also influence or be influenced by factors in another context. Effective parenting

has been shown to mediate the effects of multiple risk factors—including poverty, divorce, parental bereavement, and parental mental illness. The more planners understand how risk and protective factors interact, the better prepared they will be to develop appropriate programs and practices.

NOT ALL PEOPLE OR POPULATIONS ARE AT THE SAME LEVEL OF RISK

Prevention programs and practices are most effective when they are matched to their target population's level of risk. Prevention programs and practices fall into three broad categories.

- ***Universal programs and practices*** take the broadest approach and are designed to reach entire groups or populations. Universal prevention programs and practices might target schools, whole communities, or workplaces.
- ***Selective programs and practices*** target individuals or groups who experience greater risk factors (and perhaps fewer protective factors) that put them at higher levels of risk for substance misuse than the broader population.
- ***Indicated programs and practices*** target individuals who show early signs of substance misuse but have not yet been diagnosed with a substance use disorder. These types of interventions include referrals to support services for young adults who violate drug policies. They also include screening and consultation for the families of older adults who are admitted to hospitals with potential alcohol-related injuries.

APPENDIX C: LEVELS OF INVOLVEMENT

Potential community partners will have varying levels of interest and/or availability to participate in prevention efforts. Some may be willing to help out with specific tasks, while others may be willing to take on leadership roles. Some participation options for prevention stakeholders are included below.

PARTICIPATION OPTIONS

- **No involvement.** Stakeholders engage in separate activities, strategies, and policies. (For example, "You do your thing, we'll do ours.")
- **Networking.** Stakeholders share what they are doing during interagency meetings. They talk about community issues in which they all have a stake or communicate about existing programs, activities, or services. (For example, "Let's talk and share information.")
- **Cooperation.** Stakeholders publicize one another's programs in agency newsletters, write letters in support of one another's grant applications, co-sponsor trainings or professional development activities, and/or exchange such resources as technology expertise or meeting space. (For example, "I'll support your program, and you'll support mine.")
- **Coordination.** Stakeholders serve together on event planning committees and community boards or implement programs and services together. (For example, "Let's partner on an event.")
- **Collaboration.** Stakeholders create formal agreements (e.g., memoranda of understanding or contracts). They develop common data collection systems; partner on joint fundraising efforts; pool fiscal or human resources; and create common workforce training systems. (For example, "Let's work together on a comprehensive plan to address the issue. After all, our missions overlap.")

APPENDIX D:
THE SOCIO-ECOLOGICAL MODEL

OVERVIEW

The socio-ecological model is a multi-level framework that allows us to consider the different contexts in which risk and protective factors exist. The model also allows us to examine how contexts interact with one another and to choose prevention strategies that operate at multiple levels in order to achieve the greatest impact.

ABOUT THE MODEL

The theory behind the socio-ecological model is that an individual does not exist in a vacuum and that her/his behavior both influences and is influenced by the surrounding environment, which consists of various levels. Each level operates within and is influenced by the next level.[1] This reciprocal relationship and dynamic interaction helps us to understand human development and behavior because different risk and protective factors operate within each level.[2] The four levels[3] are:

- **INDIVIDUAL.** Includes factors specific to the individual, such as age, education, income, health, and psychosocial problems, which may correspond with substance use. For example, undergraduate students who exhibit poor self-regulation, impaired control, and impulsiveness are more likely to binge drink.[4]
- **RELATIONSHIP.** Includes an individual's closest social circle—family members, peers, teachers, and other close relationships—that contribute to their range of experience and may influence their behavior. For example, youth who affiliate with deviant peers are more likely to use marijuana.[5]
- **COMMUNITY.** Includes the settings in which social relationships occur, such as schools, workplaces, and neighborhoods. For example, living in neighborhoods with chronically high rates of disorganization, crime, and unemployment is associated with higher risk for substance abuse.[6]
- **SOCIETY.** Includes broad societal factors, such as social and cultural norms. Other significant factors operating at this level include the health, economic, educational, and social policies that contribute to economic and/or social inequalities between populations.

[1] Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 513-531.

[2] Blum, R. W., McNeely, C., & Nonnemaker, J. (2002). Vulnerability, risk, and protection. *Journal of Adolescent Health, 31*(1 Suppl), 28-

[3] Terminology adapted from Bronfenbrenner (1977).

[4] Neal, D., & Carey, K. (2007). Association between alcohol intoxication and alcohol related problems: An event analysis. *Psychology of Addictive Behaviors, 21*(2), 194-204.

[5] Hampson, S.E., Andrews, J.A., & Barckley, M. (2008). Childhood predictors of adolescent marijuana use: Early sensation-seeking, deviant peer affiliation, and social images. *Addictive Behaviors, 33*(9) 1140-1147.

[6] Institute of Medicine, O'Connell, M. E., Boat, T. F., Warner, K. E., & National Research Council. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: National Academies Press.

APPLYING THE MODEL TO PREVENTION

The socio-ecological model highlights the importance of working across levels to address the constellation of factors that influence both individuals and populations.[7] For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults.

A more effective and comprehensive prevention approach—with the potential to impact multiple contexts—might include changes to the school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training. The table below, organized by the levels of the socio-ecological model, offers examples of relevant risk and protective factors and related prevention strategies.

Level	Risk Factor	Protective Factor	Strategy Example
Individual	Genetic predisposition to substance misuse Prenatal exposure to alcohol Poor impulse control	Positive self-image Self-regulation and control Social competence	One-on-one psycho-education therapy Social and decision-making skills training
Relationship	Parental permissiveness Peer acceptance of heavy drinking	Positive parental involvement Peer disapproval of substance use Low peer substance use	Parental training on communicating disapproval of use Peer refusal skills training
Community	Poor neighborhood safety Law enforcement permissive of underage substance use	Availability of afterschool activities Low perceptions of alcohol use among the general student population	Social marketing campaign to promote positive social norms
Societal	Laws favorable to substance use Historical trauma	Limited availability of substances	Increase price or tax of alcohol Raise minimum legal drinking age

[7] Blum, et al. (2002).

APPENDIX E: MAKING THE MOST OF YOUR EVALUATION DOLLARS

OVERVIEW

There are no two ways about it: well-designed evaluations cost money. Just how much money depends on the experience and education of your evaluator, the type of evaluation required, and the geographic location of your program or practice. But there are ways to save money without compromising the validity of your findings.

WORKING WITH AN EVALUATOR:

- **Look for a qualified yet inexpensive evaluator.** Create a practitioner-researcher partnership. Faculty at colleges and universities are a good source. They might consider making the evaluation a project for one of their classes. They may also have access to students who can act as paid research assistants, but who earn less than other evaluation staff. Make sure, however, that the faculty member will be closely supervising any students who participate in the study.
- **Look for an evaluator who may be able to get independent funding** to conduct the evaluation through a separate grant or contract. This is rare but not unheard of. The chief drawback is that you may have to wait, sometimes several months, to see if this can be done before proceeding with the study.
- **Explore other incentives.** For example, look for an evaluator who is interested in branching out and trying new things. Sometimes an evaluator will work for less in order to have an opportunity to do research on a new topic.
- **Look for an evaluator who has experience evaluating programs like yours.** Again, this will save money because the evaluator is already familiar with instruments, design issues, and other aspects of the study.
- **Use a collaborative model.** Having program staff assume some evaluation tasks (like survey monitoring or data entry) reduces costs. If your organization has the capacity, also consider using an in-house evaluator.
- **Ask the evaluator to price components of the evaluation.** This will make it easier for you to drop particular elements or make informed decisions about how to spread around the work.
- **Estimate costs before specifying an amount in your funding proposal.** If you pick a number at random—say, $30,000—you are going to get proposals for studies that cost close to that amount. There may be a chance that you could get the study done for substantially less. Your future funder may be willing to help you estimate appropriate costs. Ask them to look at what they want from the evaluation and provide a ballpark estimate of what it should cost. You can also hire an evaluator just to do a cost estimate.

SPENDING LESS ON DATA COLLECTION:

- **Start small.** Narrowing the scope of your evaluation will save costs without compromising outcomes. One way to do this is by limiting your evaluation to specific target audiences. For example, if your program aims to affect both students and parents, you might study its impact on only one group, then study the other group when you have more resources. Another way to save money is by focusing on intermediate outcomes, since long-term outcomes are usually more difficult to assess. If you are involved in a drug education program, for example, start out by focusing on whether program participants learn new information about drugs. Then, if you get positive results, you can look at long-term outcomes when more funds become available.
- **Use existing data.** Data specialists often have concerns about the quality of even the most reputable national data sources. Yet many of these data are better than what a community can collect on its own without a significant expenditure of time, money, and expertise. Most national data systems analyze their data and publish data reports (often available for no cost online). Others will supply raw data to users, do custom data runs, and/or make their data available in formats (or on the Web) that allow people to generate reports tailored to their specifications.
- **Pilot test.** Save money in the long run with pilot testing—the process of trying out your data collection instruments and procedures with a small target audience. This can reveal critical flaws like ambiguous questions or interviews that take too much time. Data collection efforts (especially those involving large numbers of people) should always be pilot tested before implementation.
- **Implement with care.** When collecting data, consistency is key. Communicate the importance of consistency to everyone involved in your effort to ensure your results are reliable. If your results are not, you may need to start the evaluation process all over again.
- **Select data collection methods wisely.** Consider the advantages and disadvantages of focus groups, surveys, and interviews. Qualitative methods tend to be less expensive than administering a survey (depending on the population you are surveying) and can produce useful information. Keep in mind that investing in evaluation can actually save you time and money over the long haul. With the information you learn from a worthwhile evaluation, you can focus your resources on the most critical problems facing your community and the most effective countermeasures. However, you are much more likely to collect this information if you partner with a knowledgeable evaluator who understands your program and with whom you can work comfortably.

APPENDIX F: EVALUATION DESIGN, REPORTING, AND LESSONS LEARNED

OVERVIEW

Evaluation results are used to improve programs and practices, sustain positive outcomes, and improve the community's overall plan for addressing substance misuse and promoting wellness. But they can be used for other reasons as well, such as to help obtain funding and to build community awareness and support for prevention. Therefore, evaluation results need to get into the hands of the people who can use them. Keep in mind that organizations don't use evaluation results, people do. The Department of Health, for example, isn't going to use the results of an evaluation, but "Cathy Smith" in the Department of Health may. So, unless you get the results of the program evaluation into her hands and explain how she can use them, they will sit on a shelf somewhere in the Department of Health.

Follow these general guidelines for reporting your results:

- **Brief stakeholders throughout the process.** Try to avoid surprising your stakeholders with the results of your evaluation. Brief them along the way, rather than waiting until the end of the project. Present a draft form of your report before it goes public.
- **Create a dissemination plan.** Identify the various audiences who need to see the results (including the population that is the focus of the program or practice). Also, identify what information would be most useful to these audiences and how to get it into their hands.
- **Select vehicle for reporting results.** Make sure you use the most appropriate vehicle (e.g., public presentation, social media post/campaign, flyers, reports) for each of the audiences you identified.
- **Help stakeholders understand the data.** Take time to review the findings with your stakeholders, discussing the ramifications of what you found. Don't shy away from negative or unexpected results. Instead, use these as an opportunity to inform future efforts.

SELECTING AN APPROPRIATE EVALUATION DESIGN

The first step in any project is to develop a plan for getting the work done. The plan for an evaluation project is called the "design." All too often, prevention planners launch into their evaluation without coming up with a plan. They start thinking about *how* to collect data before determining *what* to collect. This is usually followed by the statement, "Let's do a survey." But before choosing methods, planners need to take a step back, consider the four principles outlined above, and do the following:

- **Clarify purpose.** For example, is the purpose of the evaluation to find out if the program or practice reached the focus population or to determine how well it worked to bring about change? Purpose should be dictated by stakeholder needs, including funding requirements, and guide all decisions that follow.
- **Develop questions.** Questions should be closely tied to purpose. Some questions will provide insight into implementation and others will produce information related to outcomes. When

developing questions, make sure to avoid those you can't afford to answer. Available resources (i.e., time, money, people) can influence an evaluation plan more than any other single factor. (See *Appendix E: Making the Most of Your Evaluation Dollars* for more information on this topic.)

- **Select the right design.** There are different ways to design, or structure, an evaluation. Some questions are best answered by gathering data from program participants and practitioners throughout the implementation. Other questions are best answered by gathering data before and after the program, and/or by gathering data from non-participants as well as participants. This last approach allows for helpful comparisons and a better understanding of an intervention's effects.
- **Choose appropriate methods.** There are many different ways to gather evaluation data. Which methods you select will depend on what you want to learn, on your budget and timeline, and on what's most appropriate for your focus population.
  - ***Qualitative methods*** (e.g., key informant interviews, focus groups) produce data that are usually expressed in words. They let planners explore an issue or population in depth by having such questions as "Why or why not?" and "What does that mean?" answered.
  - ***Quantitative methods*** (e.g., surveys, checklists) produce data that are usually expressed in numbers. They allow planners to draw general conclusions about an issue or population based on answers to such questions as "How much? How many?" and "How often?"

SAMHSA

Substance Abuse and Mental Health
Services Administration

VIRTUAL MEETING—PREVENTION PLANNING WORKGROUP (PPW)
Wednesday, February 23, 2022 | 5:30-7:00PM
MEETING SUMMARY

Attendees:

AJ King	Donta Morrison	Greg Wilson
Kevin Donnelly	Miguel Martinez	Katja Nelson
Dr. William King		
Commission on HIV (COH) Staff: Cheryl Barrit, Jose Rangel-Garibay		
Division of HIV and STD Programs (DHSP) Staff: Paulina Zamudio, Pamela Ogata		

Attendees introduced themselves.

I. Welcome and introductions

a. Attendees introduced themselves and shared their agency affiliations and pronouns.

b. Co-chair nominations and elections

i. Greg Wilson self-nominated and supported the nomination for Miguel Martinez and Dr. King.

ii. Cheryl clarified that the group determines the structure for completing the work and can have three co-chairs. She also suggested that at least one of the co-chairs is a commissioner to ensure the workgroup has a tie to the full COH body.

iii. Dr. William King self-nominated and shared that although he does not have any DHSP contracts, he is private provider and will serve as co-chair without bias.

iv. Miguel Martinez, Dr. William King (WDK), and Greg Wilson were elected as co-chairs for the Prevention Planning Workgroup.

II. Discussion: Continuing our planning for the Comprehensive HIV plan (CHP)

a. CHP Updates/Define syndemics related to HIV:

i. AJ is making his rounds and visiting different stakeholder groups and has begun conversations about what the framework of syndemics will look like for the CHP. What is the statement that we (COH) want to put out there? Mental health, housing issues, what about Hep C? has this been

done historically within in the COH? Are we talking about health conditions specifically, and then folding in social determinants? Are we lifting up mental health (stigma)?

ii. Cheryl added that having a clear definition about how we (COH) see syndemic and have a clear understanding in how to determine the direction of the five-year vision we (COH) hope to set in Los Angeles County.

iii. Miguel: HIV, STD, HCV, the number of things that you can add (systemic racism, poverty, housing instability) becomes overwhelming. How do we make sure the plan speaks to (all) those in terms of activities?

iv. Paulina: If we are to address HIV without addressing these other barriers, we are not going to move the needle in HIV prevention. Just talking about changing behaviors without considering all that the client deals with is a missed opportunity. Not necessarily recognizing or identifying interventions that address these issues, but it is important to mention them. This can look like a push for people to access other resources and for service providers to begin coordinating and collaborating to meet the needs of the client. For example, HCV screening is, by CA law, part of Basic training for HIV counselors, they are trained on implementing the rapid HCV screening test. Partners at ACDC (Acute Communicable Disease Control) have received funding to increase the number of rapid HCV tests available, however, it is not currently a priority test at the express clinics, but it can be added.

v. Miguel: Asked to clarify about the meaning of syndemic: Are we talking about drivers or are we talking about defining?

vi. AJ: What is our statement about syndemic -> we are addressing the syndemic of HIV and ___? We all have the understanding that HIV is not something that can be addressed in a silo. A syndemic approach is the counter HIV exceptionalism, it helps with that regard.

vii. WDK: Through a clinician's lens, there are time constraints, however, one of my goals is for primary care clinics to see that HIV, HCV, STIs, even opiates are within the wheelhouse of primary care clinics. Clients/patients do not need to necessarily go to a specialist. The patients may be more satisfied with a one-stop shop by having the primary care clinics do the screening annually. Primary care carries more than just screening and testing, but also treating. We can expand the definition of primary care to include treatment.

viii. Greg: Need to provide training to places that are providing care for things like substance use and make sure they have the tools to help those in need of HIV services. Inviting Dr. Sharon of the leadership of DMH to help us bridge the gap as it pertains to mental health.

ix. AJ: What are some strategies for improving the areas/making the connections?
x. Miguel: Need to invest in supporting folks in impacted communities and consider para-professional models for clients that may not necessarily be dealing with acute psychosis and would benefit from trauma informed therapy. Look beyond just hiring more social workers and doing more things that are low barrier. The current system does not work and is not responsive to community needs.
xi. Pamela: hopefully DHSP's mental health assessment will identify needed connections and available tools and services. The DHSP mental health assessment is part of DHSP. DHSP's EHE work plan. I'm actually not on the work group but I/Paulina can share the findings and progress to date etc
xii. Paulina: It will take about a year to conduct the assessment.
xiii. Paulina: suggested to Greg to start the conversation with clients and partners, and let people know that the plan is happening and want to know what needs to be added to the plan.
xiv. AJ: what is working, what is not working, and what needs to be built into the plan.
xv. Kevin: looking forward to the DHSP capacity assessment, and asked if there is a need for a needs assessment to balance what we know the is the lack of capacity? Need to identify in the context of the syndemic, both how much mental health services, attitudes, substance use disorder, programs, can work as preventative measures against our physical health syndemics or HIV, STDs, HCV, -> lack of parity between mental health and physical health.
xvi. Pamela: maybe find out how/what services can address some of the directives given to DHSP (i.e., psychosocial services, MH services for specific racial/ethnic groups)
xvii. Miguel: the conversation about mental health and emotional wellness for people living with HIV can be used to document the impact of untreated mental health issues. There is literature that would support funding low barrier mental health strategies that help folks struggle with making decisions about their health, and with the barriers in the way of support their autonomy to make those decisions.

III. Review program directives from a prevention lens

a. Cheryl described the handouts in the meeting packet.
    i. Quick reference handout 5.2: Directives -> address how best to meet the priorities established by the planning council.

ii. Original set of directives that was submitted to DHSP and PPA received responses (page 25), the matrix describes/list the directive on the left and the DHSP response/status update on the right for each of the directives. This will be a useful tool to identify areas to highlight and make suggestions for looking at it through a prevention lens and send the feedback to PP&A.

b. Cheryl provided an overview of the directives pertinent to the prevention planning workgroup.
c. Miguel: recommended adding language that states "across all funding sources for prevention and care"
d. Kevin: recommended to have all the directives to call out the prevention work. When we make new directives, there is a room to call out the prevention work.
e. Paulina: how much more specific does it need to get? Adding "prevention and care" is important. Adding something about PrEP and mental health
f. Miguel: directive one focuses on the geographic approach. The directives that are there now are focused on care. The things that are missing are directives around PreP access and that focus on housing, mental health.
g. WDK: when we are talking about prioritizing populations, and targeting certain areas, and the response from DHSP -> can we see that [data]? Need (DHSP response) to be more specific and less vague with regards to prevention.
h. Kevin: clarified that the directives can be as specific as the group wants to be make them.
i. Cheryl: the most recent data received is on the care side, testing date, DHSP funded prep centers of excellence
j. Paulina: HIV surveillance report is out, 2019 data and use that, it identifies areas that people are testing positive. This information for all DHSP funded programs, not all programing that is happening in the county. Can reach out to ACDC for Hep C data.
k. Cheryl: noted that the target populations listed in the Ending the epidemics plan used surveillance data and may be helpful for this group.
l. Miguel: is there a specific lens or definition for "adherence" that can be used for different populations?
m. EHE populations: Black AA MSM, Latinx MSM, women of color, people who inject drugs, transgender, and youth under 30
n. Miguel: partner with SAPC and DMH to fund low barrier interventions for the same target groups identified with a focus on prevention.
   WDK: I like that last comment, Miguel. Our treatment adherence goals of 90+ % may be much different than patient provider collaborative treatment reflective of how people are *actually* taking the medications.
o. Cheryl: think of housing a "crisis intervention" but need to think about how to keep people housed as a prevention strategy.

p. Paulina: does not necessarily needs to be DHSP fund recipients. People that enter the housing services should also receive training that can help support people with maintaining their housing, identifying, and understanding the legal issues that can help the client.
q. Cheryl: within RW there is MCC model to support high acuity, is there a similar type of structure within LAC prevention portfolio, within MCC you are assessed for the different issues that would lead you to fall out of care.
r. Paulina: there is case management models that do include risk assessments, housing is not in all of them. Health Education and Risk Reduction -> navigation services and link them to other services that are not just HIV, they can assess housing. The issue comes with referrals and how to link people to services. It is not fair to have the workers without having a basic knowledge of the resources and services available so that staff are comfortable with doing that assessment. This is intended to be a one-time, short term, this not a long-term commitment, this is short term client they might see for 6 sessions and a 30 day follow up.
s. Kevin: shared that they attended a webinar where BSS shared their experience, how they prepared to see the client, how they followed up with the client, how they varied their question types and pattern of asking -> need to explore how much we can lean on the BSS teams. Be what the clients needs, not what the BSS thinks the client needs.
t. Paulina: clarified that under the PrEP contract, the navigators are required to provide some level of case management such as following up with the client regarding their adherence to PreP. Recommended adding the population over 50 as a target population regarding prevention, considering the status neutral approach.
u. WDK: I see hep c in my 50+ population -. Many did not know there were positive
v. Paulina: noted that the meeting attendance has decreased over the past year.
w. Cheryl: reminded the group that at some point the group will need to strategize in terms of determining the future for the group. The goal could be that the prevention conversation is on par and getting equal attention to care.
x. Miguel: Asked what is the mechanism for assessing the capacity of the commissioners for their understanding and appreciation around care and prevention?
y. Cheryl: this is something that has not been done before and could be used as a survey question for the entire body.

IV. Public comment and announcements

a. There were no public comments or announcements made.

V. Adjournment

a. The meeting adjourned at 6:58pm.