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Decision-Making in Ryan White Care Act Planning Bodies: An Analysis of the Decision-Making Process of the Joint Committee of the Jacksonville HIV/AIDS Planning Council and Consortium

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DECISION-MAKING IN RYAN WHITE CARE ACT PLANNING BODIES: AN ANALYSIS OF THE DECISION-MAKING PROCESS OF THE JOINT COMMITTEE OF THE JACKSONVILLE HIV/AIDS PLANNING COUNCIL AND CONSORTIUM

by

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Maher's Ode on Bales's Law of Invariant Variability

There was a professor who lived on a hill
And I know for a fact that he's living there still
On human behavior for years he had mused
He went into it clear but came out confused.

For the books that he read and the lectures he heard
Stated findings quite dull or extremely absurd
And the more that he looked the less that he saw
'Til one day he thought, "I've discovered a law!"

In any experiment people confront
There are some who do one thing and others who don't
There are some who turn left and some who turn right
Some sit in the center quite frozen with fright.

Some turn up on time while others delay
There are some who refuse while others obey
Some press the wrong button and some press them all
Some prefer honey, some prefer gall.

So when findings appear, pray don't celebrate
It's twenty to one they won't replicate
In the next group of subjects the difference is hid
When it came to the crunch, some didn't, some did.

In Physics, proud wearer of Science's crown,
We can safely predict what goes up must come down
In Psychology, sadly, it's not the same case
The rockets we launch collapse on their base.

Here is my law, for woman and man,
In any assessment some can't and some can
Some couldn't, some could, some wouldn't, some would
The way the twigs are bent doesn't bias the bud.

Turn away from the mean, and examine the spread
Dim down the computer and switch on your head
Were it not for the variance where would we be?
If you can't make a t-test, you can't take a p.

Now this is a comfort, not grounds for complaint
Thank God for the fact that some are and some ain't.
From the data of variance pleasure derive
It's one of the things that helps us survive.

From Social Interaction Systems: Theory and Measurement (p. vii-viii) by R. F. Bales, 1999, New Brunswick, N. J.: Transaction Publishers, Copyright 1997 by Brendan A. Maher (Used by permission).

CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

The purpose of this study was to determine which factors and the degree to which these factors influenced the Joint Committee when deciding how much money should be allocated to the different services funded by the Ryan White CARE Act. This study focused on the possible explicit and implicit factors influencing the decision-making process and interactions of the members of the HIV/AIDS Joint Prioritization & Allocation Committee in the decisions that were being made on behalf of the people who are infected and affected by this disease.

The methodology included a combination of quantitative and qualitative data, utilizing surveys, coding of communicative behavior, one-on-one interviews and researcher observations. The surveys and interviews were the primary sources of data.

The findings indicated that both explicit and implicit factors influenced decisions. A significant difference was found to exist between clients and committee members for the priority ranking of services. A significant difference also existed between the committee's perception and staff's perception of which factors were most important. The influence that the committee members may have had with one another during discussions was not enough to cause any significant changes in the way they weighed the importance of the factors. The majority of the committee members reported that they relied on recorded data sources such as the needs assessment, epidemiological data, and client utilization of services, rather than their personal experience or HIV status, however this was not totally substantiated by the interviews. Persons living with HIV admitted that their HIV status was a strong factor influencing their decisions. Most participants reported feeling respected and empowered in the surveys, however during the interviews some felt that they were not being listened to adequately. This finding was supported by the interaction analysis.

The results indicated that there is a need for more training and mentoring, particularly for those who are new to the process. Some participants reported there is a need to conduct more business on a joint basis to reduce redundancy and duplication of effort. There is also a need to recognize the importance of the influence of the staff members who provide the committee with the information that is used to make the decisions.

CHAPTER 1

Zimbabwe, the African country where I grew up, is one of the hardest hit countries in the world for infections and related deaths from Acquired Immune Deficiency Syndrome (AIDS), which is caused by the human immunodeficiency virus (HIV). It is estimated that one out of every three people in that country is infected with HIV, and there are so many deaths that the morgues now stay open twenty-four hours a day. Malawi, a tiny neighboring country, is losing three school teachers every day due to deaths from AIDS (Piot, 1999). In the U.S., AIDS has become the leading cause of death among all Americans aged 25-44. In 1999, more than 47,000 new cases of HIV/AIDS were diagnosed, bringing the total since the first two cases were diagnosed in California in 1981 to an estimated 800,000 to 900,000 cases. Of those, 410,800 have died (Centers for Disease Control and Prevention, 1999). AIDS is currently considered to be a fatal, chronic disease, which, for the most part, can be managed in the home and outpatient clinics. AIDS is not only a medical problem, but also involves social, economic and political issues. Homophobia, irrational fears, and racial stereotyping have led to misunderstanding and discrimination. HIV-infection is associated with pre-existing economic problems as minorities and poor populations are disproportionately affected. Lack of access to medical and non-medical services due to socioeconomic problems affects progression of the disease (Loustaunau & Sobo, 1997; Quimby, 1993).

Since 1990, the Federal government has been involved in both HIV prevention and the care of HIV/AIDS patients (Holtgrave & Valdeserri, 1996). The U.S. Department of Health and Human Services (DHHS) administers programs and funds for HIV prevention and patient care. DHHS distributes federal funds for HIV prevention services to the Centers for Disease Control and Prevention (CDC). Funds for patient care are distributed to the Health Services and Resources Administration (HRSA); they are then allocated through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The distribution of funding is represented in Figure 1.

Figure. 1. Allocation of Federal Funding for HIV Prevention and Patient Care.

U.S. Department of Health & Human Services (DHHS)
↙ ↘

Centers for Disease Control & Prevention (CDC)
↓
HIV Prevention

Health Services & Resources Administration (HRSA)
(Ryan White CARE Act)
↓
HIV Patient Care

The CARE Act was signed into law on August 18, 1990, to improve the quality and availability of care for American people with HIV/AIDS and their families. Amended and reauthorized in May 1996, the CARE Act is named after the Indiana teenager Ryan White, who became an active public educator on HIV/AIDS after he contracted the disease through a blood transfusion. He died the same year the legislation was passed. The HIV/AIDS Bureau, a division of HRSA, administers HIV/AIDS patient care programs under four Titles and Part F of the CARE Act. The CARE Act mandates that community planning bodies coordinate patient care activities and service delivery. The intent is for grantees to develop community partnerships between private practitioners and public sector programs leading to improved access and quality of care for people with HIV who have no other source of funds for HIV-related medical treatment (Holtgrave & Valdiserri, 1996; Kieler, Rundall & Saporta, 1996; Myers, Pfeiffle & Hinsdale, 1994; Penner, 1995; Rizakou, Rosenhead & Reddington, 1991).

In 1993, CDC issued its "Supplemental Guidance on HIV Prevention Community Planning" which outlined a substantially revised planning process for the allocation and management of federal funds. In addition, it promoted greater representative community input and the application of scientific principals in decision making (CDC, 1993). Likewise, HRSA published guidance manuals to aid grantees in the planning and administration of patient care funding. While there is some general guidance from the federal government on what information sources should be used for the prioritization and allocation process, each community has the freedom to implement the process according to the local structure of the planning committee and the needs of the community (U. S. Department of Health & Human Services, 1999). No standard method exists and many HIV planning bodies are still in the process of trying to determine what works best. Kahn and Washington in Brandeau (1994) describe creative and determined, yet haphazard, efforts to control the AIDS epidemic that have been "driven less by reasoned analysis than by advocacy on the part of program beneficiaries and managers...reflecting shifting political priorities rather than epidemiologically based estimates of effectiveness" (p. 217).

The Jacksonville area receives CARE Act funding from Title I, II, III and IV of the CARE Act. A brief explanation of the four Ryan White-funded titles in Jacksonville follows. A more detailed description can be found in the literature review in Chapter 2.

The greatest amount of funding comes through Title I, which provides formula and supplemental grants to Eligible Metropolitan Areas (EMAs) that are disproportionately affected by the HIV epidemic. These EMAs are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding five years and if they have a population of at least 500,000 (U. S. Department of Health & Human Services, 1999). Jacksonville became eligible for Ryan White Title I funding in 1994 and received its first grant in 1995. Submission of a new grant application is required every year in order to continue receiving funds. Ryan White Title I funding awarded to the Jacksonville EMA totaled $4.17 million for the 2000-2001 Fiscal Year. Grants are awarded to the chief elected official (usually the mayor) of the city or county that administers the health agency providing services to the greatest number of people living with HIV in the EMA. As a requirement of the Title I grant, the mayor must establish an HIV Health Services Planning Council that sets priorities for the allocation of funds within the EMA, develops a comprehensive plan, and assesses the grantee's administrative mechanism in allocating funds. Community-based providers usually form partnerships funded under Title I to provide services to HIV-infected clients (U. S. Department of Health & Human Services, 1999).

Title II funding is provided to 65 states and U.S. territories based on the number of AIDS cases in each. The State of Florida's Department of Health (DOH) established

Title II Consortia to plan and coordinate a comprehensive continuum of care within 14 different regions of the state. Under the direction of the Consortium, the State contracts with a lead or fiscal agent, usually the local Health Department. The lead agent then contracts for services with community-based organizations and providers for direct services to the patients (U. S. Department of Health & Human Services, 1999).

Title III supports comprehensive primary health care and other services for individuals who have been diagnosed with HIV disease with an emphasis on providing early intervention services. Jacksonville was awarded a one-year Title III planning grant in 1999 in order to plan and develop a program to provide early intervention services. Title IV focuses on providing comprehensive, community-based, and family centered services to children, youth, and women living with HIV and their families. Title IV program services include primary and specialty medical care, psychosocial services, and logistical support, as well as outreach and prevention to provide a continuum of care for at-risk populations. Title IV systems of care enhance access to and linkage with clinical research supported by the National Institutes of Health and other organizations for their client populations (U.S. Department of Health & Human Services, 1999).

In an effort to manage complex health problems and fulfill required mandates, many communities, including Jacksonville, have formed partnerships that are considered to be more effective than the efforts of individual agencies. Partnerships have been formed between various agencies, including public health departments, hospitals, and community service agencies. Health care reform has been aimed at providing health care that is accessible, affordable, coordinated and appropriately delivered (Baker et al.,1994).

Incorporated in the idea of community partnerships is the inclusion of stakeholders in the decision making process. Experience has confirmed the importance of the participation of HIV-infected individuals in local decision making in order to ensure that the services are responsive to the real needs of those with HIV disease (Academy for Educational Development, 1994).

Because the provision of services in Jacksonville overlaps between Title I and Title II, the decision was made to form a Joint Coordination Committee that included representatives of both Ryan White titles for the purpose of prioritizing and allocating funding. Membership on the Title I Planning Council or the Title II Consortium's Planning and Linkage Committee is required in order to be a member of the Joint Committee. Consortium and Planning Council members were encouraged to serve on the Joint Committee through announcements made at the regular Title I and II monthly meetings prior to the prioritization and allocation process. Under guidelines outlined by HRSA (U. S. Department of Health & Human Services, 1999), information from various sources was provided by the administrative staff to the Joint Committee to enable these committee members to prioritize services and make allocation decisions based on the documentation provided. The information provided to them included an assessment of need of the consumers, epidemiological trends of the disease, utilization of services by the clients, the Title I Comprehensive Plan, the Statewide Coordinated Statement of Need, and other funding streams available for some of the services.

The researcher's interest in conducting this study grew from her involvement in coordinating a comprehensive needs assessment of the HIV-infected people who access the services funded by the Ryan White CARE Act. The process of gathering information through the needs assessment, which included surveys, focus groups and public hearings, is very time consuming and expensive compared to gathering the other information that was also provided to the committee. This led to the question of how much weight the committee members placed on the various pieces of information as they made the prioritization and allocation decisions. How much attention did they pay to the information they were given, compared to how much they listened to and influenced one another to make decisions that more closely correspond to their own values?

This study attempted to answer some of these questions, and in doing so it will hopefully allow both the staff and the committee members to better understand one another and the factors that influence the decisions they make. As a non-voting staff member providing some of the information to decision makers, the researcher played the role of participant-observer in this study which was conducted in a naturalistic field setting.

Research Objectives and Hypotheses

The objective of this study was to determine which factors and the degree to which these factors influenced the Joint Committee when deciding how much money should be allocated to the different services funded by the Ryan White CARE Act. This study focused on the possible explicit and implicit factors influencing the decision-making process and interactions of the members of the HIV/AIDS Joint Prioritization and Allocation Committee in the decisions that were being made on behalf of the people who are infected and affected by this disease. Other objectives of the study included an attempt to determine (1) whether there were any additional implicit factors involved in the decision-making process, such as personal influence and HIV status, and (2) whether the committee members perceived that they were adequately trained and mentored in order to engage in the task effectively.

Many groups prohibit actual field research. We are legally prohibited from observing some groups, such as a jury, in action and many other work groups are hesitant to allow outside observers. Because of the difficulty in conducting research on actual groups, much group research has been conducted with mathematical models and computer simulations of groups (Parks & Sanna, 1999). Therefore, a limited amount of information based on actual group observations and interactions is available. Due to the sensitive nature of the AIDS epidemic, and the shorter period of time that AIDS planning groups have existed compared to other health-related groups, even less information is available about AIDS-related decision-making groups. Little is known about how a diverse group of people, from highly educated physicians and health professionals to less-educated, infected and poor individuals, make decisions about funding allocations, and what factors come into play when the group comes together to discuss the issues.

Juries are often presented with large amounts of information concerning a case, and the jurors have to sift through it all and determine which factors should be used as a basis to make a decision. Studies of juries indicate that jurors will sometimes give more weight to implicit factors, such as the clothing worn by the defendant, when determining the guilt or innocence of a defendant and ignore the information that is presented to them (Parks & Sanna,1999). Other studies indicate that a juror may change his or her mind during deliberation as he or she is influenced by other members of the jury (Davis, Stasser, Spitzer, & Holt, 1976). In civil cases, juries are not only concerned with the guilt or innocence of a party, but whether damages should be awarded and, if so, how much. The process of determining how much money a jury should award to a plaintiff in a civil suit is conceivably very similar to the process of prioritization and allocation of funding for the Joint Committee in the Ryan White program.

Research Questions

It was conjectured in this study that, in addition to the information provided to the Joint Committee, other factors might have influenced committee members' decisions. With this in mind, the following research questions were investigated:

1. Did changes occur in individual committee member prioritization of services at the beginning of the process as compared to the priorities the committee actually made at the end of the process?
2. What differences existed between the priority ranking of services given by consumers compared to the priority ranking given by the committee?
3. How much weight was given by the Joint Committee members to the various sources of information that were provided to the committee?
4. What factors influenced the members of the Joint Committee as they went through the decision-making process?
5. What implicit factors affected their decisions, such as their personal experiences, HIV status, and influence on one another?
6. Did the members of the committee influence each other during the deliberation to

the point where individual preferences changed, and if so, to what degree?

7. Did the staff provide appropriate and sufficient information in order for the Committee to make decisions effectively, as perceived by the committee?
8. Did Committee members believe they received adequate training and mentoring in order to participate effectively in the decision process?

Hypotheses

The following hypotheses were tested for the quantitative component of this study:

1. A difference exists between the consumer's ranking of priorities, as measured in the needs assessment, and the Joint Committee's ranking of priorities, which was derived during the decision-making process.
2. A difference exists between the average of the individual Joint Committee members' ranking of priorities and the overall group ranking.
3. A difference exists between the weight that the committee members gave to the various decision-making factors before the decisions were made and after the decisions were made.
4. A difference exists between members of the Joint Committee who are people living with HIV and those who are not, concerning the weight they placed on potential factors that influenced their decisions.
5. A difference exists between the perception of the Joint Committee and the perception of the staff concerning the weight of factors that influenced the committee's decisions.

Millions of dollars are spent every year in states, cities and local communities for patient care related to HIV and AIDS. Using the findings of this study to develop a more effective planning process will help to assure that the funding is efficiently distributed and accounted for appropriately and that quality care is accessible to all those who are eligible to receive it. With so many lives affected and so many dollars spent on this disease, which at the present time has no cure in sight, there is a need to take a closer look at the community-based partnerships and planning bodies that have formed in order to deal with the epidemic.

CHAPTER 2

Literature Review

A review of the literature was conducted in order to provide further background information, identify key research, and to identify conceptual and theoretical frames related to the purpose of this study. The following literature review is organized into six sections. This study focused on the activities of a Joint Committee made up of representatives from the various Ryan White Titles that are funded in Jacksonville, therefore the first section gives a description of the Ryan White Care Act of 1990, and the various titles included in it. The second section provides some background to community participation in the health field. The third section discusses planning and decision-making in the context of community health partnerships. The fourth section is an overview of the psychological and sociological theories related to the proposed study, including collaboration theory and empowerment. The fifth section contains an overview of theories and research that have been conducted in the area of group decision making and the factors that affect it, and the concluding section describes some priority setting tools that are commonly used by decision-making groups.

The Ryan White Care Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of1990 provides funding to States and other public or private nonprofit entities to develop, organize, coordinate and operate more effective and cost-efficient systems for the delivery of essential health care and support services to medically underserved individuals and families affected by HIV disease. The CARE Act was reauthorized in 1996 (Health Resources and Services Administration, 1999).

Title I

Title I funds may be used to provide a wide range of community-based services, including the following:

- Outpatient health care, including medical and dental care and developmental and rehabilitative services;
- Support services such as case management, home health and hospice care, housing and transportation assistance, nutrition services, and day /respite care; and
- Inpatient case management services that expedite discharge and prevent unnecessary hospitalization.

Providers may include public or nonprofit entities; private for-profit entities are eligible only if they are the only available provider of quality HIV care in the area. In 1995, an estimated 300,000 people received services from Title I providers nationwide. Title I provides emergency assistance to eligible metropolitan areas (EMAs) most severely affected by the HIV/AIDS epidemic. To be eligible, an area must have more than 2,000 cumulative AIDS cases reported during the past 5 years; and have a population of at least 500,000. In FY 1999, there were 51 EMAs in 21 states, Puerto Rico, and the District of Columbia (Health Resources and Services Administration, 1999).

Grants are awarded to the Chief Elected Official (CEO) of the city or county that administers the health agency providing services to the greatest number of people living with HIV in the EMA. The CEO usually designates an administrative agent (most often the local health department) to select service providers and administer contracts. The CEO or grantee establishes intergovernmental agreements with other political subdivisions within the EMA that provide HIV services and include 10 percent or more of the EMA's total AIDS cases. The CEO must establish an HIV Health Services Planning Council. The planning council sets service priorities for the allocation of funds within the EMA, develops a comprehensive plan, and assesses the efficiency of the grantee's administrative mechanism for rapidly allocating funds. Planning councils also work in partnership with the grantee to assess service needs within the EMA and develop a continuum of care for people living with HIV disease and their families. Planning councils may also assess the effectiveness of services in meeting identified needs, and they must participate in the development of each state's Statewide Coordinated Statement of Need. Planning councils may not become involved in the selection of particular agencies to receive Title I funding or in the administration of contracts with providers; these are grantee responsibilities. Planning council membership must be reflective of the local epidemic and include representatives from a variety of specific groups, such as health care agencies and community-based providers. At least 25 percent of voting members must be people living with HIV disease. Planning councils must have an open nominations process and grievance procedures (Health Resources and Services Administration, 1999).

Since FY 1991, close to $2.9 billion have been appropriated to the Title I program; in FY 1999, EMAs were awarded $485.8 million in formula and supplemental funds. Jacksonville became eligible for Ryan White Title I funding in 1994 and received its first grant in 1995. Title I funding for the Jacksonville EMA for the year 2000 was $4.17 million. Submission of a new grant application is required every year in order to continue receiving funds.

Title II

Title II grants are awarded on a formula basis to states, the District of Columbia, Puerto Rico, and eligible U.S. territories to provide health care and support services for people living with HIV disease. Grants are awarded to the state agency designated by the governor to administer Title II, usually the health department. States with more than one percent of the total AIDS cases reported nationally during the previous 2 years must contribute their own resources to match the federal grant, based on a yearly formula. Under Title II, in addition to a base award, states receive earmarked funds to support AIDS Drug Assistance Programs which provides medications to treat HIV disease, including drugs for the prevention and treatment of opportunistic infections (Health Resources and Services Administration, 1999).

Title II funds may be used to support a wide range of services including:

- Home and community-based health care and support services;
- Continuum of health insurance coverage through either a Health Insurance Continuation Program (HICP), or provision of medical benefits under a health insurance program including high risk pools;
- Pharmaceutical treatments, through the ADAP Program;
- HIV care consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and

- Direct health and support services.

Most states provide some services directly and others through subcontracts with Title II HIV care consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease. Since FY 1991, more than $2.65 billion in Title II funding has been appropriated (Health Resources and Services Adminstration, 1999).

Title III

Title III supports comprehensive primary health care and other services for individuals who have been diagnosed with HIV disease. Currently, 181 Title III programs are funded to provide early intervention services through federally-qualified Community Health Centers and Migrant Health Centers; hospital or university-based medical centers; city and county health departments; and community based health centers that are not federally-funded. Additionally, 2 percent of Title III programs are funded through providers of health care for the homeless, family planning clinics, and comprehensive hemophilia diagnostic and treatment centers. Since FY 1991, more than $540 million have been appropriated for Title III programs; the FY 1999 appropriation is $94.3 million (Health Resources and Services Administration, 1999).

In 1997, Title III also provided counseling and testing to over 300,000 people, outreach services to more than 700,000, and case management and eligibility assistance to 70,000 people. Title III services include:

- Risk-reduction counseling, partner involvement in risk reduction, education to prevent transmission, antibody testing, medical evaluation, and clinical care;
- Antiretroviral therapies, protection against opportunistic infections, ongoing medical, oral health, nutritional, psychosocial, and other care for HIV infected clients;
- Case management to assure access to services and continuity of care for HIV infected clients; and
- Addressing "co-epidemics" that occur frequently in association with HIV infection, including tuberculosis and substance abuse.

Title IV

Title IV focuses on providing comprehensive, community-based, and family centered services to children, youth, and women living with HIV and their families. Title IV program services include primary and specialty medical care, psychosocial services, and logistical support, as well as outreach and prevention to provide a continuum of care for at-risk populations. Title IV systems of care enhance access to and linkage with clinical research supported by the National Institutes of Health and other organizations for their client populations. In 1997, 15 percent of clients were infants, 31 percent were children, 18 percent were adolescents and young adults, 24 percent were adult women, 5 percent were pregnant women, and 7 percent were adult men. The vast majority of Title IV clients are members of racial and ethnic minorities; 58 percent of enrolled clients in 1997 were Black and 23 percent were Hispanic (Health Resources and Services Administration, 1999).

Since 1988, the Title IV program, and its forerunner, the Pediatric AIDS Demonstration Program, have provided more than $287.5 million to states and communities. For fiscal year 1999, $46 million have been appropriated for the Title IV program. The Title IV program has been in the forefront of many activities to reduce perinatal HIV transmission and to promote healthier outcomes for women with HIV and their children (Health Resources and Services Administration, 1999).

The Ryan White Program in Jacksonville

The Jacksonville area receives CARE Act funding from Title I, II, III and IV of the CARE Act. Ryan White Title I funding awarded to the Jacksonville EMA totaled $4.17 million for the 2000-2001 Fiscal Year. The City of Jacksonville's Mental Health and Welfare Division is the local government agency responsible for administration of Title I funds. The Mental Health and Welfare Division utilizes the purchasing policies of the City of Jacksonville in procuring and contracting HIV/AIDS services in the EMA. Title I staff, employed by the Mental Health and Welfare Division, prepare a Request for Proposals (RFP). The RFP is formally advertised in the EMA's four major newspapers and one business journal for a period of 30 days. Prospective bidders are required to submit a sealed proposal to the City's Procurement and Supply Division by the advertised day and time. The Title I staff assemble evaluation committees made up of people living with HIV (PLWH), planning council members, providers, and community leaders who evaluate and assign points to each bid. Award recommendations are forwarded to the City's General Government Awards Committee for final approval, at which time contracts are initiated (City of Jacksonville, 1999).

Of the total number of persons living with AIDS in the Jacksonville EMA as of September 30, 1999, 38% are white, 59% are black, 3% are Hispanic, and less than 1% are other races. The majority of living cases reported are among men (69.91%). The largest percentage of cases is in the 20 to 44 years of age category (69.76%). The second largest age category is 45+ (27.93%) (City of Jacksonville, 1999).

The most frequent exposure categories are men who have sex with men (40.27%), followed by heterosexual contact (31.32%), and injecting drug use (21.34%). While the incidence of exposure through men having sex with men has declined, transmission has increased in the category of heterosexual contact. Pediatric transmission has been most frequently reported in the category of mother with/at risk for HIV infection (100%) with 38 cases.

A comparison of the demographics of the local HIV/AIDS epidemic to the total population of the EMA reveals an uneven distribution of the disease among specific populations. The population of the EMA is approximately one million. Duval County accounts for nearly 75% of the EMA's total population and 5.1% of the state's. Duval is the seventh most populous county in Florida and is predominantly urban and white (73%). The remaining population is 23% black, 3% Hispanic, and 1% other races. The demographic composition of the EMA is 81.6% white, 13.6% black, 2.1% Hispanic, and 2.7% other races (City Of Jacksonville, 1999).

The percentage of living AIDS cases in the EMA indicates a disproportional impact of HIV/AIDS on the African American community. Fifty-eight and eight tenths percent (58.8%) of cases are among blacks while the black race only represents 13.6% of the EMA's population. For AIDS cases reported in the EMA between October 1, 1997 and September 30, 1999, the percentage increased to 66.61% black and decreased to 29.84% white. The percentage of Hispanics infected is proportionate to the EMA's Hispanic population (City of Jacksonville, 1999).

Background to Community Participation in Public Health

Community participation in health care decisions is an idea which can be found in almost all contemporary major national or international declarations on health and development. The origins of the idea are not known, however, during the decades after World War II community participation became a common feature of international agricultural development programs and work with the urban poor. In the 1960s there was a growing awareness among people involved in health and development in developing countries that there was a need for health care to be delivered and organized in a different way. By the early 1970's, large international organizations such as UNICEF, the World Health Organization (WHO) and the World Bank, and smaller influential national organizations were beginning to solidify their ideas about primary health care and community participation (Bracht, 1990).

In 1977, member states of the World Health Organization at the meeting of the World Health Assembly adopted "Health For All By The Year 2000" as the main social goal of governments (Kickbush, 1987). The following year a policy framework which would guide achievement of the target was established at an international conference on primary health care (Primary Health Care, 1978) held in Alma-Ata in the then USSR. The conference declaration established that primary health care should be the basis of the "health for all" strategy and described what was entailed in the concept (Mahler, 1981).

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process (Dever, 1991). During the 1980's the idea of community participation became a basic principle in community health promotion as a means to foster the process of enabling and empowering people, and helping them to take control over factors which are important for their own health (Nilson & Kraft, 1997).

In 1981, Halfdan Mahler, former Director-General of the World Health Organization, observed that "health services are failing to reach those who do not have access to them" and that there had been a failure to control "diseases of poverty." He identified four problems of health systems in most developing countries: too few resources were invested in health; those resources available were usually spent on a very small sector of the population; richer countries were attracting doctors from the poorer ones; and ordinary people had little control over their health care. The new strategy of "health for all" was intended to address these problems by employing multisectoral efforts to remove the obstacles to health and making health services accessible to all through primary health care. He described the latter as having three prerequisites: community participation, multisectoral action and appropriate technology (Mahler, 1981).

While partnerships, coalitions, and collaborations have been a strategy for promoting health and for delivering social services since the early decades of this century, professional interest in cooperative approaches increased in the 1960s because of decentralization, specialization, and categorization of services and growing acknowledgment of the complexity of the social and economic conditions that these services attempt to alleviate. Shrinking resources, increasing competition, and administrative and technical innovations also contributed to interest in collaboration (Gray, 1989). Many government and private funders interested in eliminating duplication, increasing cooperation and leveraging resources have mandated collaborative approaches to programs in health and human services, housing, justice, and the environment. Somewhat later, the for-profit sector moved in this direction as well. The forces favoring partnerships intensified in the 1980s, spurred by federal policies that reduced traditional sources of funding for local programs. Approaches have included comprehensive community planning, functional specialization among organizations, joint programs, and task integration. Since the 1980s, inter-organizational collaborations have rapidly become a common method of producing goods and services (Alter & Hage, 1993).

Most investigators concerned with sexual health problems including teen pregnancy, sexually transmitted diseases and AIDS have concluded that broad-based, comprehensive prevention efforts are the best approach to intervention in this complex problem (Brindis,1991; Carnegie Corporation, 1989; Dryfoos, 1990; Santelli & Beilenson, 1992). Increasingly, programs serving People Living with HIV (PLWH's) recognize that meaningful strategies require community-wide, coherent, and comprehensive intervention strategies in order to be effective. Community partnerships are most appropriate when they address social problems that have multi-faceted causes, and when the most promising strategies require influence and resources beyond the scope of any single organization or sector. AIDS is such a complex phenomenon, with so many varied factors underlying it and an array of risky behaviors associated with it, that only a concerted effort on behalf of entire communities is likely to have a significant impact. Because the problem is so complex and no one intervention or sector can solve this problem alone, strategic alliances and/or partnerships among multiple sectors are seen by many as essential (Alter & Hage, 1993; Valdiserri, Aultman, & Curran, 1995). Beyond HIV, those working on other complex social problems with multiple, interrelated causes - teen pregnancy, violence, alcohol and other drug use, youth development - have come to the conclusion that individual, single-shot solutions are inadequate. As a result, efforts to address all of these problems have increasingly focused on the need to involve a variety of community institutions and mobilize resources community-wide through creative partnerships (Brindis, 1991; Chavis, 1995).

A review of literature on partnerships suggest that these associations have some significant advantages over individual organizations or agencies (Abramson & Rosenthal,1995; Butterfoss, et al. 1993; Chavis, 1995; Mattessich & Monsey, 1992 ;

Rabin, 1992). Federal and state funding directives have created complex and fragmented systems that are frequently difficult to access, as well as inflexible and redundant. By coordinating service providers, partnerships can develop comprehensive plans, eliminate duplication, allow members to specialize in their functions, link and integrate partners' activities, and ensure consistency. These benefits improve efficiency, making better use of more limited resources, increase flexibility, and enhance the ability to leverage resources. In partnerships the expertise of different individuals, professions, and groups can be pooled, allowing a more complete understanding of issues, needs, and resources, improving the capacity to plan and evaluate, and allowing for the development of more comprehensive strategies. Further, division of responsibility allows each partner to specialize, doing what it does best. Because partners share responsibility and risk, they are more willing and likely to be creative, becoming involved in new and broader issues. Partnerships, through efficiencies of scale and elimination of duplication, allow maximum use of resources (Baker, et al. 1994). They also provide access to and permit development of more talents, resources, and approaches than any single organization could. Partnerships bring together larger and more diverse constituencies than single organizations. By including diverse perspectives, partnerships can develop a more comprehensive vision, increase accountability, and achieve a wider base of support for their efforts. By demonstrating widespread support and taking joint action, partnerships can maximize their members' power and increase access to policy makers, the media and the public (Gray, 1989).

Many chronic health conditions, such as violence, alcohol and other drug use, heart disease, and adolescent pregnancy, stem from larger social, cultural, political and economic foundations (Butterfoss, et al. 1993). The social ecological approach to health promotion maintains that prevention efforts must affect both environmental and personal factors because of the interactive and transactional nature of behavior-environment relationships (Paine-Andrews & Vincent, 1996). Bracht (1995) claims a strong relationship between health, life style and social norms within the context of the environment. Environmental factors are viewed as crucial in supporting or preventing individual health promoting behavior while individuals are still considered to have a role and some responsibility. Organized community support programs and environmental changes can reinforce individual life style changes. By strengthening the environment, community partnerships can affect these chronic health conditions.

Community partnerships seem to reflect the motivations and purposes of those individuals who are involved, and they are greatly affected by the availability of financial resources, commitment of the members, and the host of social, economic, political, and cultural factors that influence change (Gray, 1989). In spite of this ambiguity, there seems to be some agreement that community partnerships, although difficult, can be invaluable components of a community's attempt to effect change (Baker, 1994).

While considerable advantages to community partnerships are noted, difficulty occurs in forming and sustaining such arrangements (Annie Casey Foundation, 1993). Individuals and organizations with experience in complex, multi-year partnership enterprises frequently note that partnerships take a long time to establish and considerable energy to maintain. Skilled staffing and support are frequently needed to manage a successful partnership. It is difficult and time-consuming to establish true community consensus on controversial issues. Collaboration is particularly challenging when the partners come from different racial, ethnic, linguistic, class and/or educational backgrounds; yet it is exactly this cross-sector involvement that is seen as most desirable. Projects built on complex partnership structure will rarely have a short term impact on the problems they seek to address. Instead, most energy in the early stages of the partnership will be devoted to building the partnership itself. Therefore, employing partnerships should be reserved for projects and initiatives with the intention and the resources to exist over an extended period of time (Baker et al., 1994; Dever, 1991).

Community involvement is another essential, and particularly challenging, part of the process. Several studies of partnerships noted that skills in community organizing and development are essential, especially among the conveners of the partnership (Abramson, 1995; Mattessich & Monsey, 1992; Nezlek & Galano, 1993). Most emphasize inclusion of those most affected by the problem, including sexual partners, family, and traditionally disenfranchised groups. Regardless, involving and sustaining residents' involvement are among the greatest challenges, requiring expertise, resources, time and energy (Cohen, 1990; Gambone, 1997; Harrison, 1996; Kotloff, Roaf & Gambone, 1995; Mattessich & Monsey, 1992; Rabin, 1992).

Involving all participants, particularly health care providers, from the beginning in the creation of a partnership is also noted as important. Many benefits can be gained by including prominent citizens and political leaders, representatives of business, education, health and human services sectors, faith communities, youth-serving organizations, the media, professional organizations and service organizations, with a balance between public and private sectors. Including potential opponents in planning is also advocated (Aber, 1996; Butterfoss et al., 1993).

Diversity of membership is considered essential in partnership success (Butterfoss et al., 1993; Centers for Disease Control & Prevention, 1998; Goodman & Wandersman, 1994; Kotloff et al., 1995; Mattessich & Monsey, 1992). Because partnerships involve members from different disciplines, of different races, genders, and cultures, and with different levels of status or position within their own organizational hierarchy, creating equality and satisfactory working relationships among them is often difficult. Partners need to develop mutual respect, understanding, and trust in order for the association to develop (Abramson, 1995). Allowing time at the start for members to learn about each other, including cultural and communication differences and agendas, to test boundaries, to evaluate others, to develop relationships, and to forge new alliances is helpful (Butterfoss et al., 1993). Cultivating patience and a willingness to learn and compromise are also important (Bailey & McNally, 1995). In partnerships involving governmental and non-governmental agencies, differences in the complexity of organizational structure and the timing of decision-making can create problems in collaboration (U. S. Department of Health & Human Services, 1999).

Creating relationships of equality between the community and professionals is particularly challenging. Inexperience of community residents may make them reluctant to assume leadership roles (Kotloff et al., 1995). In other cases, the disparity between individuals members of partnerships and those who are representatives of organizations creates problems (Bailey & McNally, 1995a). Residents need opportunities for authentic input (Nadel & Spellman, 1996). Establishing separate resident groups, conducting training workshops, and providing on-going mentoring and support to residents have been found to be helpful in building their capacity to plan and govern (Butterfoss et al., 1993). Over time in many partnerships, professionals shift from a leadership to a support role in relation to residents. This shift is seldom fully realized and appears to be facilitated by extensive community development efforts in the neighborhood (Kotloff et al., 1995). However, this shift - viewing residents as potential partners with assets and expertise rather than as clients with problems to be solved - is the essence of community empowerment and a goal in many partnerships (Fawcett et al., 1995). Established procedures for communication among members and between members and staff are also essential. Communication has to be open and frequent and both formal - through established protocols and well-developed systems - and informal or personal (Butterfoss et al., 1993). As the frequency and intensity of communication increases, the level of cooperation tends to increase (Alter & Hage, 1993). Butterfoss (1993) concluded that communication might be the most important ingredient in creating a positive climate within the partnership.

Both providers and users need an environment conducive to participation, which may have political, bureaucratic, social and cultural constraints. The ecological approach to studying organizations addresses the effects of social, political and cultural factors on effectiveness and efficiency. "Environmental linkages," relationships between members of the partnership and organizations and individuals in the environment outside the partnership, are important. Emery and Trist (1975) use the term "social ecology" to refer to cultural factors and links that can affect organizations. These links, especially those to elected officials, government agencies, religious and civic groups, and community development associations, are often a vital source of resources (Bailey & McNally, 1995).

Planning and Decision-Making in the Context of Community Partnerships

Understanding the culture of the HIV/AIDS Joint Committee in the context of a community partnership is important because the Joint Committee has the responsibility of planning for and allocating resources for the infected and affected population within the community. Community partnerships have unique personalities, based on such factors as local traditions, customs, individual values, political structure and economics. Individuals within a community planning group interact and affect other individuals or organizations (Black, 1997; Komorita, 1995; Wagerman, 1995). The nature of a community planning partnership is a complex one, therefore a need exists for an understanding of the community environment and the forces that influence it. A review of the literature concerning decision-making in the context of a community partnership identifies several important characteristics that should be included when developing and maintaining a community partnership.

The literature supports the need to create a formal statement of the partnership's mission and its goals and objectives. Butterfoss (1993) sees this as the most important element in organizing a partnership. Failure to clearly define the mission, goals and objectives is among the most commonly reported obstacles to partnership development among substance abuse prevention groups. These formal documents not only clarify the purpose of the partnership and provide guidelines against which to measure success, they also provide a mechanism for the individual members to come to a common mission and shared view of the group's role (Abramson, 1995). The importance of citizen participation in defining the problem, establishing priorities, and shaping the mission, as well as implementing activities and retaining control over what happens in the community, is emphasized by many (Bailey & McNally, 1995; Baker et al., 1994). Crucial to the adoption of a shared mission and common goals and objectives is the process of building consensus, an on-going challenge in developing and sustaining partnerships (Kotloff et al., 1995). The more diverse the group, the greater the challenge (Alter & Hage, 1993).

Community mapping is identified in many studies as a crucial process of community partnerships (Cohen, 1990; Mulroy, 1997; Nadel, 1996; Nezlek & Galano, 1993) . Three major elements constitute community mapping. The first is defining the community in terms of its location, general characteristics, and relevant demographic features of residents (Annie Casey Foundation, 1993). The second major element is gathering data on the incidence and prevalence of health concerns and risk factors. Three components that must be considered when gathering data include (1) epidemiology - the extent, distribution, and nature of the problem; (2) etiology - the origins of the problem; and (3) assessment - the effectiveness of various solutions. The third element to community mapping includes surveying the attitudes, beliefs, and behaviors of various sectors of the community and partnership members relevant to the group's mission (Nezlek & Galano, 1993).

Awareness of community politics is also important (Nadel, 1996). This process includes documenting community resources and services currently available; inventorying assets and resources that might be useful; and documenting needs, barriers and alternatives. The perspective of community residents on service delivery, barriers to service, community resources and needs is important. Once all of this information is gathered, it is essential to disseminate it to community planners and leaders. Community mapping has obvious value in establishing a base of information for creating and adjusting implementation strategies and for measuring success. In addition, the process has other important effects: it can provide information that mobilizes residents and agencies; and it can provide a place to test and refine delivery strategies. Several sources noted the difficulty and complexity of this information-gathering effort (Kotloff et al., 1995; Nezlek & Galano, 1993).

The creation of a satisfactory action plan (also known as a strategic plan or comprehensive plan) is essential to partnership development and effectiveness (Cohen, 1990). In the model developed by the Work Group on Health Promotion and Community Development at the University of Kansas, the plan included specific objectives for community changes to be sought in achieving the group's mission, the action steps that will affect these changes, and evidence that members support the plan. Focusing on specific community changes in the action plan leads to greater success than identifying issues and clarifying the mission (Francisco & Fawcett, 1996). Priorities should be established by members and should fit the unique needs of the community (Cohen, 1990). Elements of plans originate in individual committees, but the whole membership should review and approve the plan. This approach maximizes ownership at the committee level with buy-in and coordination at the larger level (Nilson & Kraft, 1997).

Organizational processes must be formally developed and clearly defined. To be effective, decisions in a community partnership should be made in a nonhierarchical and participatory manner, in which no one group or member dominates (Abramson, 1995; Butterfoss et al., 1993; Francisco & Fawcett, 1996). Non-hierarchical decision-making and problem solving are defining elements of inter- organizational networks (Alter & Hage, 1993). Smaller and single issue coalitions tend to have more consensual decision-making; larger, multi-issue groups tend to use a working consensus method, such as a two-thirds majority (Butterfoss et al., 1993). By distributing decision-making equally among members, members develop ownership of the process and its outcomes (Mattessich & Monsey, 1992). Member-led decision-making reduces obstacles and facilitates agreement in some partnerships (ISA Associates, 1994).

Several studies have been conducted to evaluate the first five years of community planning for HIV prevention groups (Holtgrave & Valdiserri, 1996) and the findings indicate that the prioritization process varied widely across the country. Prioritizing unmet needs was perceived to be one of the most difficult aspects of community planning. The most common difficulties reported included (1) making choices among facts and value judgements; (2) identifying and agreeing on key terms, such as “need”; (3) choosing an applicable decision-making tool, particularly one that includes a quantitative component; and (4) obtaining and incorporating epidemiological data (U.S. Conference of Mayors, 1995). In an effort to guide community leaders in the development of effective and efficient community partnerships, the Health Services and Resources Administration (HRSA) has published guidance manuals intended to aid communities in the development of community partnerships when they become eligible for Ryan White funding. These manuals contain specific guidance and information of interest to the various Ryan White Titles. Due to the local differences between grantees across the country, however, there is enough flexibility for the planning body within each Eligible Metropolitan Area to use any number of decision-making techniques available to them.

Because of the complex nature of community partnerships, it is important to consider several characteristics when developing and maintaining a partnership. These include an understanding of the attitudes, values, political structure, culture and behavior of the members of the community. The goals and mission of the partnership need to be clearly defined and formulated into a formal statement to clarify its purpose and provide guidelines to measure success. Other essential ingredients include gathering data to identify the prevalence and distribution of the health concerns being addressed by the partnership, an inventory of resources available, identifying needs and the creation of an action plan to address those needs. Barriers to addressing those needs should be identified and priorities should be established. Inclusion of members of the community in this process is necessary in order for them to develop ownership of the situation and feel that they are part of the solution.

Psychological and Sociological Theories

There are several theories that provided a framework for this study, including the collaborative empowerment theory (Himmelman, 1995) and the participation theory (Arnstein, 1969). In addition, many studies have been conducted to test theories that relate to decision-making in small groups. A description of the major theories related to this study follows.

Collaborative Empowerment Theory

Embedded within the collaborative empowerment theory is the collaboration theory (Wood & Gray, 1991), which emphasizes solving organizational and societal problems in a cooperative and collaborative manner. While the concept of working together on complex issues is not new, an escalation has occurred in the formation of partnerships in the public health arena in recent years (Andranovich, 1995; Bazzoli et al., 1997; Dukay, 1995; Fawcett et al., 1995). Barbara Gray (1989), with reference to the collaboration theory, states that the process of collaborating creates changes in the patterns of interaction among the parties. Coalitions of stakeholders are formed and changed amid a dynamic interorganizational field; diverse interests are forged into collective action and interorganizational alliances. Studies of collaboration offer a window to these processes, thereby contributing to the development of a more dynamic, process-oriented theory of interorganizational relations (Gray, 1989). Andranovich (1995) mentions that collaboration is another way of referring to decision-making and Gray (1989) defines collaboration as a process of joint decision-making among key stakeholders of a problem element about the future of that element.

Collaboration is conceptualized as a mechanism by which a new negotiated order emerges among a set of stakeholders. A negotiated order refers to a social context in which relationships are negotiated and renegotiated. The social order is shaped through the self-conscious interactions of participants. Negotiated order theorists (Day & Day, 1977; Goffman, 1983; Strauss, 1978) focus on social processes by which interorganizational order is negotiated. The negotiated order theory emphasizes the fluid, continuously emerging qualities of organizations, the changing web of interactions woven among its members, and it suggests that order is something the members of the organization must constantly work on. Organizations are therefore viewed as complex and highly fragile social constructions of reality which are subject to the numerous temporal, spatial, and situational events occurring both internally and externally (Gray, 1989).

The negotiated order evolves through the process that Trist (1983) refers to as joint appreciation. Appreciation involves assessing a current course of activity in light of current norms and beliefs about what is possible and desirable for the future. Building a joint appreciation means sharing individual and collective perceptions of what is and what is not possible. Thus, appreciating involves making judgments of fact as well as value judgments about how things should be (Vickers, 1965). Based on this joint appreciation, stakeholders craft agreements by which to regulate their future interactions. These agreements may include rules governing future interactions among stakeholders and redesign of roles and responsibilities among the stakeholders. These agreements constitute a normative framework through which members correlate their activities with respect to the problem (Gray, 1989).

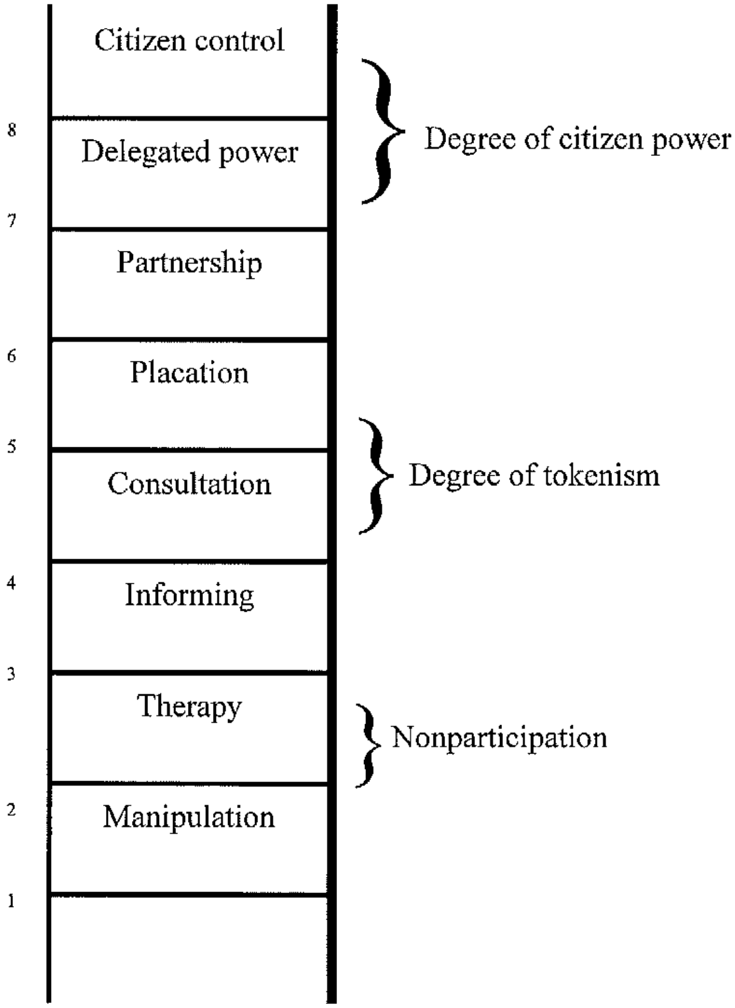
Collaborative empowerment, as described by Himmelman (1995), begins within the community and is brought to public, private or nonprofit institutions. An empowerment strategy includes two basic activities: (a) organizing a community in support of a collaborative purpose determined by the community, and (b) facilitating a process for integrating outside institutions in support of this community purpose. The empowerment approach can produce policy changes and improvements in program delivery and services. It is also more likely to produce long-term ownership of the collaborative's purpose, processes, and products in communities and to enhance communities capacity for self-determination. Some of the factors that contribute to the effectiveness of a group's activities are related to empowerment. Building up strengths and competencies of individual members within groups leads to improved decision-making and shared leadership which then enhances the possibility for people to gain control over their own lives within their own community (Rappaport, 1981).

When it comes to decision-making in community planning groups, such as the prioritization process and allocation of funding, the issue of resources can be dominant. Individuals within the group may be primarily concerned with protecting or obtaining resources which are linked to their own health or livelihood. Because of the personal interests at stake, the issues of power and influence can be major sources of conflict. In order to empower individuals and the partnership, steps should be taken to teach members how to improve their empowerment capacity (Fawcett et al., 1995).

Participation Theory

Arnstein (1969) presents a relationship between the perceived power of citizens and their level of participation through the Ladder of Citizen Participation (see Figure 2). Each rung on the ladder matches the extent of citizen's power in determining the end product. This power is the lowest on the first rung (manipulation) and increases with each move towards the highest rung (citizen control).

Figure 2. Ladder of Citizen Participation (Arnstein, 1969).



The rungs in-between, from lowest power to highest include: manipulation, therapy, informing, consultation, placation, partnership, delegated power, and citizen control. In addition to empowerment, the level of participation is also influenced by the amount of resources at the citizen's disposal and the mechanisms of their accountability to their community (Arnstein, 1969).

Decision-Making Research and Theories

Studies indicate that there are many factors that affect decision making in groups and many theories have been developed to describe them. People have a tendency to compare themselves to others, particularly when no objective standards exist (Festinger, 1954). Comparisons with others can lead to one or more persons in a group influencing the attitudes and behaviors of others in the group.

Social Impact Theory

One model of group influence is the Social Impact Theory, which has been studied in light of persuasion (Williams & Williams, 1989) and social performance (Beatty & Payne, 1983). According to the social impact theory, social forces, such as other people, affect a person in a manner similar to physical forces, such as light and sound. Latane (1981) proposes that the amount of social impact felt by a person is assumed to be a function of the strength, immediacy and number of people in the group. These factors can be expressed in a mathematical equation in which the amount of social impact is hypothesized to be multiplicatively related to these three factors. The greater the strength, immediacy and number of sources, the more influence is predicted to be felt, which can lead to a greater amount of persuasion, or have a divisive effect.

Self-Awareness Theory

Another theory relating to group performance is the Self-Awareness theory (Duval & Wicklund, 1972) which assumes that the presence of other people makes a performer self-aware of meeting standards. Increased self-attention is presumed to make performers more aware of any discrepancies between their current performance level and some idealized standard, which leads to either improved performance or impaired performance. Janis (1982) suggests that at times people in groups make decisions badly because a group has a tendency to seek concurrence. From a perspective of social comparison, concurrence-seeking reflects a tendency toward uniformity, stifling the expression of dissenting views. Pressure to self-validate or self-assess may drive a group to concurrence and disregard risk, a phenomenon known as "groupthink," leading to poor decisions.

Information Integration Theory

The Information Integration theory was originally used to describe how people use information to form impressions of others (Anderson, 1968), although this theory has been applied to the decisions made by juries. The logic is that each juror forms a judgement based on the information presented during the trial. However, during deliberation Kaplan (1987) suggests that additional facts are presented from other jurors resulting in choice shifts, and the group verdict is determined by the direction in which most jurors are shifting (Boster & Hale, 1991).

Social Decision Scheme

The oldest model used to describe jury decision making is the Social Decision Scheme (SDS) developed by James Davis (1973). This scheme is a mathematical model that uses the distribution of individual preferences and the group's decision to infer what decision rule was most likely being applied within the group (for example, simple majority, 2/3-majority). The SDS approach was originally applied to criminal trials in which the jury has a discrete number of options, but it has been extended to organizational contexts (Davis & Kerr, 1986). Davis has spent most of his career researching the question of how individual-level characteristics combine to create group-level products.

SDS researchers have considered a wide range of variables that can affect the process and outcome of group interaction, such as whether there are gender preferences for specific decision alternatives (Nagao & Davis, 1980) and whether the effect of group members' relative status affects their ability to exert influence during group discussion (Kirchler & Davis, 1986). Other factors that have been studied include group size, procedural factors, agendas, and multiple decisions (Levine, 1999).

In more recent years, researchers have attempted to develop a model for continuous-choice cases, such as civil cases, in which the jury decides on the amount of damages awarded. Gigone and Hastie (1997) suggest that discrete responses involve choices whereas quantitative responses involve judgements. Hinsz (1990) and Hinsz, et al. (1997) propose that in conditions where group decisions are categorical, the group decision is reached through a consensus process. If the group decision is dichotomous, however, then the processes leading to a single group decision involves members of one faction moving to the position held by another faction. When the responses involve nominal categories, no compromise position can be considered, resulting in a search for consensus in the group decision process. An important strength of the SDS model is that the predicted social decision scheme can be tested by comparing the observed group distribution of decision responses to the distribution predicted by the proposed social decision scheme, and then a goodness-of-fit statistic is used to indicate whether the social decision scheme is an adequate description of the group decision-making process.

Social Decision Scheme of Quantities

SDS cannot be easily used to address group decisions with large numbers of response alternatives, however. SDS was therefore modified, resulting in the Social Decision Scheme of Quantities (SDS-Q), which emphasizes the prediction of the decisions of single groups. The members of a group select their most preferred alternative from the available set of alternatives prior to reaching a decision as a group. The SDS-Q model can predict a group decision based on a function of individual member preferences on the decision task (Hinsz, 1999).

Social Judgement Scheme

Another approach is the Social Judgement Scheme (Davis, 1996), in which each member's preference is weighted by his or her "centrality" or the extent to which his or her preference is close to the preference of others. The logic is that a person whose preference is centralized will be able to exert more influence on the others than will a person whose preference is extreme.

A pervasive finding in psychological studies of decision-making is that people have a limited capacity for processing information and that because of this, they cope poorly with complex decision problems (Slovic & Lichtenstein, 1971). The most common way of dealing with this is described in the Social Judgement Theory paradigm (Brehmer, 1984), where complex decision problems are assigned to a staff of experts, which then divides the decision problem into a number of subproblems, each of which is overseen by an expert. Each expert has the task of producing the best possible judgement which is then provided to the decision maker.

One major task of a decision-maker is learning how much weight should be given to each expert. The ability of leaders to appropriately discriminate among staff members when differential weighting is appropriate (due to differences in ability or the validity of the information available to each staff member) can be crucial to decision accuracy and ultimately team performance. In general, leaders tend to utilize an equal weighting strategy in the absence of information that helps them to discriminate among their staff members (Phillips, 1999).

Other Factors Affecting Decision-Making

Another factor that could affect decision-making includes the amount of time that the group has been together, which leads to familiarity and the formation of a cohesive group. Research supports the theory that group productivity increases as group members become more familiar with one another. Cultural differences and social stratification have been found to be a barrier to group performance (Song & Parry, 1997). However, leaving certain people out of the decision-making process has been connected to poor group performance (Abramson, 1995). Hollenbeck (1995) studied decision performance in teams incorporating distributed expertise, in which team members had unequal knowledge and information about a decision problem. Results indicated that on the decision level, it was critical for teams to collect and distribute as much information as they could for each of the decision articles they considered.

Communication networks are regular patterns of person-to-person contact, typically for the exchange of information (Monge, 1987). By observing who talks to whom, and what information is connected to which people, it is possible to infer a communication network. Organizations try to develop work networks that make for efficient communication. This is not always achieved, however, which interferes with the efficiency and effectiveness of the group. When an organization reorganizes and changes group structure, it essentially redefines the established networks (Ellis & Fisher, 1994).

There are several approaches to studying communication networks. The most common network measurements are size, reachability, density, and centrality (Tichy, 1981). Size refers to the number of people to which a person is linked. Reachability refers to the number of links it takes to connect one individual to another. Density is the number of linkages that exist in proportion to the number that would exist if everyone were linked directly. The most central person is the one with the fewest links between himself and everyone else. Centralized networks solve simple problems most accurately, while decentralized groups are more accurate at solving more complex problems. Members of decentralized groups tend to have more satisfaction than members of centralized groups. The most central position of a group is usually associated with leadership and greater status in the group's hierarchy (Ellis & Fisher, 1994).

Another aspect of group communication patterns is that of gatekeeping. Some members of a network do not communicate directly with every other member of the group. Instead, information comes through a more central person in the group, who serves as a gatekeeper of the information. The gatekeeper receives more messages from more different sources than members who are in less central positions in the group. As a result, the gatekeeper occupies a position of considerable potential influence and often becomes the group leader. Gatekeepers have to exercise selective processes. They must recognize, interpret and retransmit information. Therefore gatekeepers have an awesome responsibility. They must make many crucial decisions before relaying the information, such as who should receive it and how much. People in such positions are often criticized because they have to select what information must be transmitted to others, which is filtered through their biases (Ellis & Fisher, 1994).

Extending the gatekeeping role a step further is the concept of "boundary spanning." A boundary spanner is one who communicates and processes information between networks. An important part of this job is to influence the flow of information from the organization to the environment, or community, and back. Boundary spanners are very important people in organizations. Because they have access to many types of data, they are the ones that the organization turns to when it needs influence with some component of the environment (Ellis & Fisher, 1994).

There are many factors that have the potential to influence the decision-making process. Most people would agree that clear communication is essential, but the influence of the person through whom the communication is channeled can be even more important. The information being communicated is often filtered or changed during the communication process, even without the communicator being aware of it.

Priority Setting Tools

Several methods have been utilized by federal agencies over recent years in an effort to make priority-setting decisions a little easier. Community Planning Groups, which are involved in setting priorities for HIV prevention activities, utilize three models more often than other methods - the nominal group method, the rating (or ranking) method, and the Delphi technique (Johnson-Masotti, Pinkerton, Holtgrave, Valdeserri, & Willingham, 2000). In the nominal group method, small group discussions are conducted by a skilled facilitator who poses thought-provoking questions to help guide the planning group through the decision-making process. Disadvantages of this method include the lack of precision and a lack of formal assortment of ideas (Academy for Educational Development & Centers for Disease Control, 1994).

The rating method requires that decision makers rank proposed services or interventions based on one or more preselected criteria. The first step is to decide on the set of criteria. Next each decision maker is asked to assign a score to each of the criteria and a total score is calculated. Finally the service/intervention is divided into one of three groups - high, medium, or low priority based on the total score assigned. Ideally, the prioritization criteria are established before the rating process begins (Centers for Disease Control and Prevention, 1991). Closely related to the rating method is the ranking method, which follows a similar procedure, except that services or interventions that receive a lower score are given the highest priority. For example, a service that is ranked number 1 will receive a lower score, but is considered to be more important than one that is ranked second. An advantage to using the ranking or rating method is that it forces committee members to compare services and interventions and therefore makes the prioritization more explicit. As the number of possible services increase, the more complex the comparisons become. Therefore this method is more appropriate when the number of choices is relatively small (Johnson-Masotti et al., 2000).

The Delphi method involves the use of a facilitator who solicits informed opinions from a panel of experts who provide their responses on a self-administered questionnaire. The facilitator then provides feedback on all the experts' responses to all the experts and provides them with an opportunity to review and possibly change their answers. The process is repeated in an iterative manner until the experts no longer make changes to their answers. The rankings are aggregated and a final ranking is determined. The Delphi method is time-consuming and labor-intensive, but it allows varied viewpoints to be expressed without animosity and helps to achieve consensus even though the experts also have biases (Johnson-Masotti et al., 2000).

Summary

Decision-making procedures in groups are vitally important. Organizations rely on groups to make decisions that are critical to the functioning and future of the organization. This literature review has provided background information concerning the complex nature of community partnerships and many factors that are known to enhance effective partnerships and the decisions that they make. Because of the emphasis of health-care partnerships to include members of the community who are affected by a particular health problem, most partnerships are made up of many diverse individuals, with varying levels of education, interests and abilities. These differences have the potential to affect the decision-making process of the HIV/AIDS planning partnerships. Many psychological and social factors come into play, such as status differences and perception of empowerment. The Ryan White CARE Act has only been in existence for ten years and many changes have occurred, both within individuals who are infected, and within agencies who are providing services. At the present time, little is known about how a diverse group of people, from highly educated physicians to little-educated, infected and poor individuals, make decisions about funding allocations, and what factors come into play when the group comes together to discuss the issues.

Many questions are still unanswered. This study attempted to answer some of them, and in doing so it will hopefully allow both the staff and the committee members to understand one another and the factors that influence the decisions they make. The allocation of funding for services is an important process. Many lives depend on the availability of medical care and services and it is important that the limited amount of funding be allocated to the services where it is needed the most and where the most benefit can be gained from it. It is expected and hoped that this study will contribute to better understanding and knowledge by providing the leaders in this process with information that they can translate into action in their future planning activities.

CHAPTER 3

Methodology

This section provides an overview of the procedures and methodology utilized in this study. Included in this section are descriptions of how the population was selected, the procedure undertaken to obtain consent, development and pilot testing of the instruments, study design, and how the data were collected and analyzed. Also included are delimitations, limitations and a statement for managing bias.

Selection of Site

Six cities in Florida qualify for Ryan White Title I funding. Some of these have a combined planning partnership that addresses all Title I and Title II planning and coordination activities at the same time. Like other cities that conduct Title I and II activities separately, Jacksonville conducts all activities separately, with the exception of the prioritization and allocation process of the Joint Committee. The Jacksonville EMA Joint Committee was chosen for this study for the sake of convenience and also to work within the legal constraints of confidentiality. The researcher is under contract to serve as a health planner/evaluator for the Title I Planning Council. As such, she is considered to be a staff member to the Planning Council and its committees, providing them with information, but is not directly involved in making any of decisions.

Study Approval and Informed Consent

A proposed plan of the study was submitted to the International Review Board (IRB) at the University of North Florida in order to receive approval. Under the guidelines required by the IRB, the proposed study was then presented to members of the

Title I Planning Council's Technical Committee on May 4, 2000, requesting their permission to conduct the study. They were provided with information regarding how the researcher planned to maintain confidentiality and their participation was encouraged. The committee voted unanimously to approve the study, and the plan was presented to, and approved by, the full Planning Council on May 25, 2000. The plan was presented to the Title II Consortium on May 17 and permission for the study was also granted. Informed consent forms were distributed to, and signed by, members of the Joint Committee on their first meeting day, June 1, 2000. Of the 18 total people serving on this committee, 12 members (66%) were present on the first day. At that time, these members received a packet of information that was to be reviewed prior to the next meeting.

A copy of the information packet was mailed out to the members who were absent from this meeting, along with a consent form and description of the purpose of this study. The members who were not at the first meeting were contacted by telephone and given an opportunity to ask questions regarding the study, then requested to bring the signed consent form to the next meeting. A total of 16 consent forms were signed for a participation rate of 88%. Representatives from the Title I & II planning bodies serving on the Joint Committee included 15 individuals who work full time for the Health Department or other provider agencies. There were 10 males and 8 females, 14 whites, 3 African-Americans and 1 Hispanic. Five members (28%) were people living with HIV/AIDS (PLWHs). In addition to the researcher and the two assistants helping with the study, five non-voting, full-time staff members were in attendance to provide information, record the meetings, or take minutes. Due to the resignation and replacement of one staff member, one member of the Joint Committee was a service provider at the beginning of the process, but became a non-voting staff member before the decision-making process was completed.

Instrument Development and Pilot Test

In preparation for this study, a review of historical documents pertaining to the prioritization and allocation process from previous years was conducted to learn more about the structure and background of the Joint Committee's activities. These documents included meeting agendas and minutes, bylaws and policies, annual application for funding, the comprehensive plan, membership rosters, attendance records, evaluation and monitoring reports.

The initial phase of the study included the development of survey instruments, interview questions and a coding system to allow for interaction analysis. The instruments and interview questions were developed based on the questions under study, and were pilot-tested with a similar HIV planning body in the Daytona area on May 11, 2000. Also, a former member of Jacksonville's Joint Committee was asked to provide input on the instruments. Based on feedback from the pilot test, the instruments and questions were modified. The finalized instrument used in the study can be found in Appendix A.

The method of observation most pertinent to group process and communication is interaction analysis, which breaks down the whole of the interaction into its component acts. Various methods of content analysis and systematic observation are described by Weick (1985), and criteria for the reliability and validity of creating category systems are specified by Herbert and Attridge (1975). Researchers interested in decision-making often use the *decision proposal* as a unit of analysis (Fisher, 1970), but the most common unit of analysis of communication is an *act*. Ellis and Fisher (1994) describe a system of categorizing and coding verbal interaction in decision-making groups in terms of how statements function to influence the opinions of other group members towards a specific issue being discussed. Central to this system is the concept of the decision proposal. Once a decision proposal has been identified by a member of the group, subsequent discussion statements from group members can be categorized in terms of how they function in relation to the decision proposal. The categories shown in Figure 3, were used to record committee members' communication as they engaged in making decisions. Each member's uninterrupted comment was considered to be a unit of communication. If an uninterrupted comment contained two functions it was considered to be two units.

Using the number and letters for each of the above categories, a code was developed for recording interaction during meetings. (For example 3q indicated that a committee member asked a question requesting clarification of the previous speaker's statement). Two assistants were selected and trained to observe committee meetings and record codes for the discussions. Recording of the codes was practiced and pilot tested prior to the study period by observing other Ryan White meetings during the month of May. After the first practice run the codes recorded by the researcher and the two assistants were compared and were initially found to have low interobserver reliability. The need for more practice and discussion relating to assigning the comments into categories was recognized. A second practice run was repeated during a second meeting

Figure 3. Communication Categories for Decision-Making Groups (adapted from Ellis & Fisher, 1994, p. 98)

O_n	Introduction of a new proposal (where *n* is the number of the proposal. O_1 would be the 1st new proposal, O_2 would be the 2nd new proposal, etc).	
D_n	Reintroduces a proposal for group discussion, identified by original subscript number	
M	Motion made to accept proposal	
C	Acknowledgment of acceptance of proposal by consensus	
P	Procedural - indicates acts that do not actually discuss a group decision proposal, such as instructions or information from staff. (These were excluded from the interaction analysis.)	
1.	Interpretation	
	f.	favorable toward decision proposal
	u.	unfavorable toward the decision proposal
	ab.	Ambiguous toward the decision proposal - contains both favorable and unfavorable evaluation
	an.	Ambiguous toward the decision proposal - contains neutral evaluation
2.	Substantiation	
	f.	favorable toward decision proposal
	u.	unfavorable toward the decision proposal
	ab.	Ambiguous toward the decision proposal - contains both favorable and unfavorable evaluation
	an.	Ambiguous toward the decision proposal - contains neutral evaluation
3.	Clarification	
	s.	statement intended to clarify
	q.	question requesting clarification
4.	Modification	
5.	Agreement	
6.	Disagreement	

and the data were compared and discussed immediately after the meeting. Use of an audio recording of the meeting in conjunction with discussion of the recorded codes resulted in a much higher agreement between observers' data after the second meeting. Several additional practice recordings were held during the month of May to gain more experience with this method of data collection. It was determined that listening to an audio tape recording of the proceedings in conjunction with a discussion of each observer's recorded code of the interaction as soon as possible after a meeting enabled the researchers to achieve full agreement on the coding of the data. It was also decided that, for the purposes of this study, sufficient information was being collected by using "O" and "D" without the subscripts.

Study Design

In order to gain a more complete picture, Stufflebeam (1991) recommended that multiple methods be employed in research studies. With this in mind, both quantitative and qualitative methods, were utilized for this research. Robert Stake (1978) encouraged researchers to direct their energies toward practical program concerns of stakeholders in the immediate context (i.e., a case study) because, by doing so, researchers could construct rich experiential understandings of that case. Such understandings, in turn, can provide powerful information for program improvement and also constitute a basis for naturalistic generalizations (Denzin, 1994).

This research was a case study of the Ryan White Joint Coordination Committee in Jacksonville, Florida, which is composed of representatives of the Ryan White Tile I and II planning bodies. A quantitative approach, in the form of surveys, was utilized in order to increase objectivity and decrease observer bias. A quantitative analysis of the codes of the interaction between committee members was also conducted.

A review of the literature indicates that qualitative methods involve a natural setting, an attempt to understand the participant's point of view, an attempt to understand the meaning of interactions and a small sample such as an individual, group or a community planning partnership (Bogdan & Biklen, 1992; LeCompte, 1993; Merriam, 1998). Wood and Gray (1991) indicate the importance of the contributions that case study research has made on collaborative partnerships. Action learning, as found in a case study approach, offers a means to better understand community planning partnerships. Therefore a qualitative approach was also considered to be an appropriate method for this study. The qualitative component in this study was in the form of face-to-face interviews and observation of committee meetings.

Quantitative components

1. <u>Surveys</u>:

   (A) Members of the committee were asked to individually rank their priorities of the Ryan White funded services at the beginning of the decision-making process. Their individual ranking of priorities was matched up to the final group ranking at the end of the process and also to the ranking of priorities of the clients, as determined by the needs assessment, to determine whether there were differences between them. The purpose of this component was to determine whether there were any major differences between the priorities of individuals on the Joint Committee, and the group as a whole. It was also intended to determine whether there were any differences between the Joint Committee's overall priorities and those of the PLWHs -- the people who were going to be affected by these decisions. The instrument used in this study can be found in Appendix A.

(B) Individual committee members were asked to fill out a survey on the first day of the Joint Committee meeting to determine their perception of how much weight they anticipated they would give to the factors that might affect their decision before the process began. Since the process of developing priorities is considered to be a separate function from the allocation of funds, separate questions specifically related to these two procedures were included. Committee members were then given a similar instrument at the end of the prioritization process and the allocation process to determine whether there were any differences between the anticipated weight and the actual weight they gave to the factors under study. These factors included the information they were provided with, such as the needs assessment, epidemiological trends of the disease, utilization of services, and other funding streams. The instrument also included proposed implicit factors that might have affected their decisions, such as their professional position, race, HIV status, relationships with each other, amount of time allowed for the process, and perceived influence of one or more members over one another. The purpose of this component was to determine what types of information they considered to be important as they made their decisions. The purpose of giving them the survey before and after the decision-making process was to determine whether individual members changed their minds about the importance of any of these factors during their deliberations. In addition to determining the weight they placed on these factors, they were also asked to rank the factors in the order of their perceived importance. The instrument for this component can be seen in Appendix A.

2. Interaction Analysis

Interaction analysis is a general method for analyzing communicative behaviors by breaking down the whole interaction into its component parts, which are then classified into categories (Bakeman & Vicenc, 1995; Ellis & Fisher, 1994). Categories should be exhaustive, mutually exclusive and sensitive to context. There is no standard unit of measurement, but a unit should be inclusive enough to render the object of interest available to the researcher, and it should be of manageable size. Bakeman and Quera (1995) developed a computer program known as Sequential Data Interchange Standard (SDIS) which reads sequential categorical data and creates a modified version of the data that can then be analyzed using another program known as Generalized Sequential Querier (GSEQ). GSEQ is a powerful descriptive tool that can produce two-dimensional tables which can be subjected to various cell and table statistics. The codes that were recorded during observations of the Joint Committee's interaction during the decision-making process (described previously beginning on page 50) were analyzed in an effort to determine whether there was a pattern to the interactions of the committee members and to determine whether other factors not previously identified through the surveys or interviews were involved. The major purpose behind the interaction analysis of the behavior codes was to determine whether there were any implicit factors influencing the decision-making process. (See Appendix B for the data collected for this component of the study.)

Qualitative Components

1. Interviews An in-depth interview questionnaire was used to ask some of the committee members who participated in the surveys about their perceptions of the decision-making activities of the planning committee. (See Appendix C for a list of the interview questions.) The purpose of the open-ended interview questions was to gain a greater understanding of the perspectives of members of the planning committee. The interviews allowed the participants to express their feelings and perspectives on their role on the committee and identify possible factors that influenced their decisions. The interviews generated specific themes that supported or contradicted the quantitative data gained through the surveys. A purposeful sample of five members (28%) of the committee was selected in an effort to include greater diversity. Factors that were considered in the selection of committee members to be interviewed included HIV status, meeting attendance, provider/consumer status, previous experience in serving on this committee, race and gender. In addition to the five committee members, two members of staff were asked to fill out surveys and were interviewed in an effort to determine

whether the staff's perception of factors influencing the committee differed from those of the committee's. The interviews provided a secondary source of data, allowing for more in-depth information and understanding. The major purpose behind the interviews with staff was to determine whether there were any implicit factors influencing members of the Joint Committee during the decision- making process. Prior to asking the specific interview questions, the research objectives were reviewed and the participant was provided with a list of questions they were going to be asked. The participant was reassured that the information would be presented in such a way as to protect his/her identity. Once completed, the interviews were recorded on audio tape, transcribed and analyzed. The analysis involved reading through the transcripts to identify common patterns and themes that supported or contradicted the other data collected.

2. Researcher Observation Notes

During the decision-making process, field notes were recorded by the researcher in an effort to capture any additional information that might be useful for the analysis of the other data sets.

Analysis and Interpretation of Data

Because this was a case study, triangulation was employed to produce a clearer picture of the factors involved in the decision-making process. Triangulation is the act of bringing more than one source of data to bear on a single point (Marshall & Rossman, 1995). The primary source of data concerning explicit factors were the surveys since they provided objective measures of the participants' perception. Interviews with Joint

Committee members provided a secondary source of data, allowing for more in-depth information and understanding. The major purpose behind the interviews with staff and the interaction analysis of the behavior codes was to serve as a primary data source to determine whether there were any implicit factors influencing the decision-making process.

1. Surveys - the surveys were analyzed using SPSS for non-parametric data, including paired t-tests, t-tests for independent samples, Chi-square, factorial analyses and Spearman's and Friedman's statistical tests. To ensure greater accuracy, Dr. William Wilson, of the Department of Mathematics and Statistics, University of North Florida, was consulted for assistance. It was decided that an alpha of .05 would be used to determine the statistical significance of the findings. See Appendix D for the statistical tables that were generated from the surveys.
2. Interviews - the interviews were transcribed and analyzed for patterns and themes. Highlights from the transcription appear in Chapter 4, and a discussion of the findings can be found in Chapter 5.
3. Interaction Analysis - the codes developed and recorded to observe the interaction of planning committee members during meetings were analyzed using SIDS-GSEQ, which permitted the sequential analysis and cross-tabulation of the data. Data generated from this component can be seen in Appendix B.

Limitations and Delimitations

Due to the potential difficulty of gaining access to AIDS planning committees in other locations, this study was delimited to a case study of the Joint Committee of the

Ryan White program in Jacksonville, Florida. Since the study only involved a small group of people in one location, the major limitation is that the results are not generalizable to other locations. Qualitative studies, by their nature, cannot be replicated, because in the real world each location has its own unique characteristics. Therefore the findings of this study may contribute to a deeper understanding of the Joint Committee in Jacksonville area, but may not be applicable to another location.

Reliability and Validity

Due to the lack of previous studies conducted on this topic, it was not possible to take a survey instrument that has already been used and tested for reliability and validity. In an effort to increase validity and reliability, several measures were taken. A pilot test of the instruments and coding system, described earlier in this chapter, were conducted prior to beginning the study to detect and correct problems associated with data collection. Three people were involved in observing and recording the same behavior for the interaction analysis and a comparison was made among the coded data. Also, multiple sources of data were included in the design of the study in order to allow for triangulation.

Managing Personal Bias

An additional limitation to this study was researcher bias. Although the researcher provided the Joint Committee with some of the information for the decision-making process, she was not directly involved in the decision-making process, which allowed for a degree of objectivity of the proceedings. However, two additional steps were taken to reduce researcher bias. First, surveys to obtain quantitative data were used to maintain objectivity. Second, two assistants simultaneously observed and recorded the meetings in order to verify the findings.

Ethical Considerations

One potential limitation is the fact that people have the tendency to hide their true feelings if they fear retribution or discrimination. Due to the fact that some members of the Joint Committee are infected with HIV it was essential to maintain confidentiality throughout the study. The nature of the study required that an individual's response be compared to his/her previous response, therefore the participants were asked to develop a numerical ID code that allowed each person's responses to be anonymous, yet enabled tracking of the same individual's response throughout the study. Even though precautions were taken to conceal the identities of each participant, and each participant expressed that s/he was not concerned with being identified, the ethical treatment of these participants was still a major consideration. In an effort to further protect confidentiality, the term "s/he" is used to disguise the gender of the committee members and answers to the interviews are presented in such a way as to protect the identity of the speaker.

This section provided an overview of the procedures and methodology utilized in this study, which included descriptions of how the population was selected, the procedure undertaken to obtain consent, development and pilot testing of the instruments, study design, and how the data were collected and analyzed. Also included are delimitations, limitations and a statement concerning ethical considerations. The findings from this study can be found in Chapter Four and are discussed in Chapter Five.

CHAPTER 4

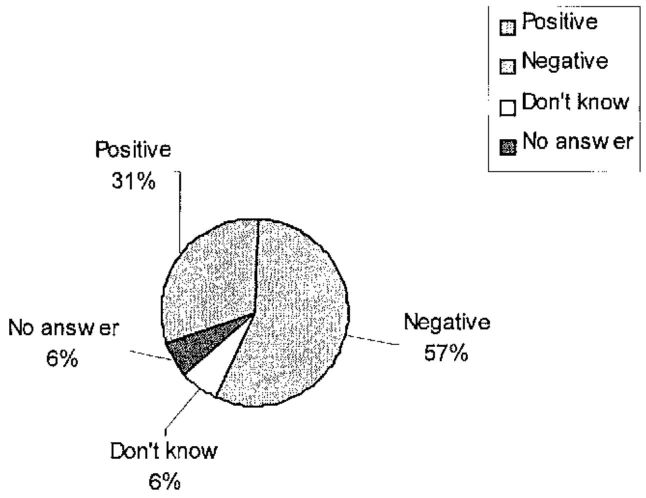
Findings

In an effort to provide a contextual setting for the findings, a demographic description of the Joint Committee members is provided first, followed by a brief summary of each decision-making meeting. Next the findings of the surveys and the responses for the interviews are given, followed by the findings from the interaction analysis.

The Joint Committee Members

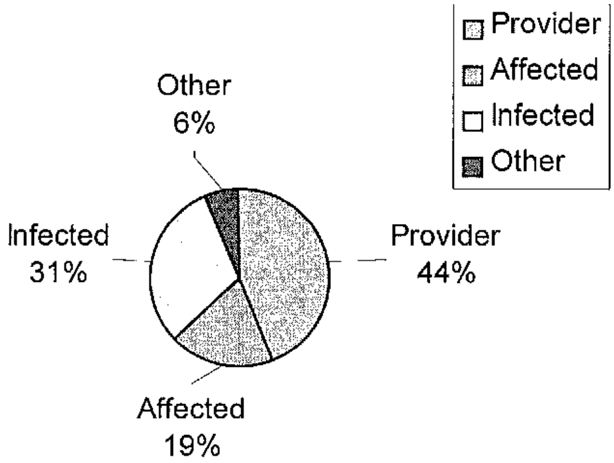
Out of a total of 18 people who served on this committee, 16 responded to the surveys. The demographic description which follows is based on these 16. Half (50%) of committee members were men and half were women. They ranged in age from 32 to 70 years old, with an average age of 48. Twelve members (75%) were white, three (19%) were African-American and one member (6%) was Hispanic.

Figure 4. HIV Status of Joint Committee Participants



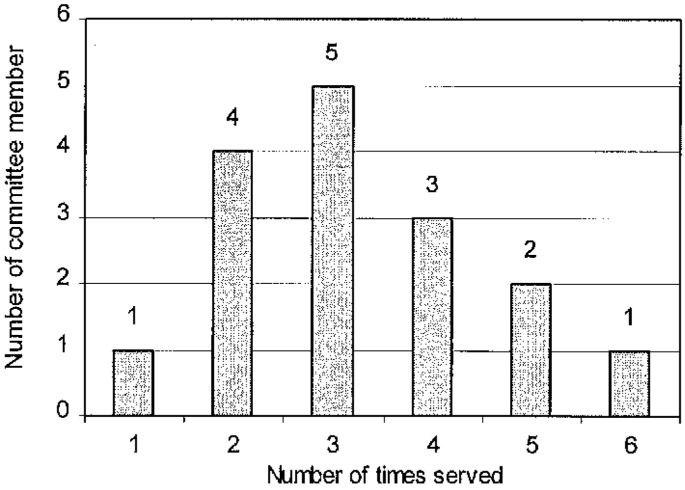
As depicted in Figure 4, 57% responded that they were HIV negative, 31% were HIV positive, 6% did not know and 6% did not answer.

Figure 5. Category of Joint Committee Members



When asked in which category they were serving on the committee (see Figure 5) 44% responded they were representing a service provider agency, 31% were infected, 44% were affected (having a close relationship with someone who is infected), and 6% responded "other."

Figure 6. Number of Times Serving on this Committee



When asked how many times they had served on this committee (counting the current membership as one), five of the members stated they had served three times, four members had served twice, three members had served four times, two members had served five times, one member had served six times, and one member had only served once, indicting this was his/her first time.

Ten members (63%) responded they had received training to serve on this committee and six members (37%) responded that they had not. Twelve members (75%) agreed with the statement that they knew what was expected of them, three members (19%) responded "somewhat" and one (6%) did not feel like s/he knew what was expected of him/her. These responses were given after the first prioritization meeting, at which time they received all the information on which to base their decisions, but prior to the second meeting during which the prioritization decisions were to be made.

Attendance was taken at each meeting. A member of the Joint Committee was expected to call in ahead of time to be excused if attendance was not possible. Table 1 shows the attendance record of all 18 Committee members for the four meetings.

Table 1

Attendance Record of Committee Members

Member Attendance	Number of Members Present	%
Attended all 4 meetings	8	44
Attended 3 meetings	4	22
Attended 2 meetings	4	22
Attended 1 meeting	2	11

As indicated in Table 1, only eight out of a total of 18 members (44%) attended all four meetings, four members (22%) attended three meetings, four members (22%) attended two meetings and two members (11%) only attended one meeting.

In addition to the Joint Committee members, the meetings were attended on a regular basis by several other people. Besides the researcher and two research assistants, the meetings were attended by two secretarial staff members, one from each Title. An administrative staff member from each Title attended regularly and an additional staff member attended one or two of the meetings, but did not stay for the entire meeting. Prior to the last meeting, one of the administrative staff members terminated employment and was replaced. The replacement was originally serving on the Joint Committee as a provider, and the switch to a staff position resulted in a change from being a voting member of the committee to a non-voting member of the staff. The meetings were open to the public, although only one additional person attended one of the meetings. While his/her presence was welcomed and included in the discussions, s/he was not included in voting.

Joint Committee Meetings

A total of four meetings, which the Joint Committee members were expected to attend, were held beginning on June1, 2000. The other meetings were held on June 13, June 29, and July 11. Before the first Joint Committee meeting, the Planning Council met for its regular monthly meeting on May 31 and voted to approve the process of prioritizing services and allocation of funding. Announcements were made at the Title I

Planning Council meeting and the Title II Consortium meeting in May that the process was about to begin and anyone interested in participating on the Joint Committee should attend the June 1 meeting. A week before the June 1 meeting, the staff from Title I and Title II met to go over the data that had been collected for the Prioritization and Allocation process in order to check the accuracy of the information and determine whether any additional information would need to be collected. A few minor errors were found in some of the reports which were corrected by June 1. At the end of the prioritization and allocation process, Title I & II staff met with members of the Title I Technical Committee in order to come to an agreement on dividing the responsibilities and financial obligations between Titles I & II.

It is customary for all Ryan White committee meetings to be called to order by the committee chair and a moment of silence observed in honor of those infected and affected by AIDS. Attendance was taken each time and members were given an opportunity to make any brief announcements. An agenda was provided to each member at the beginning of each meeting. After each meeting, secretarial staff typed up minutes and included them in a mail-out packet to the Title I Planning Council members and Title II Consortium members for approval at the regularly scheduled monthly meetings.

Meeting #1, June 1, 2000: Distribution of Information Needed for the Prioritization of Services

As is the usual practice, the tables in the conference room were arranged in a circle so that members could face each other as they talked. Prior to the meeting time, documents pertaining to the prioritization process had been prepared, copied and placed in a folder, which was then placed on the table in front of each chair so that as each member sat down a folder of information was readily available.

Three posters listing the CARE Act purpose and values, guidelines for priority setting and principles for decision-making, extracted from HRSA's CARE Act guidelines, had been hung on the walls. Since all public meetings of the Planning Council and its committees are required to be recorded, a tape recorder had been set up.

When the Joint Committee members came in they sat around the table and began looking through the folders. The Committee Chair called the meeting to order, observed a moment of silence then called roll. Immediately after roll was called, one member picked up the packet of information and left. S/he did not return to this meeting but was present for subsequent meetings.

Most of the discussion during this first meeting pertained to procedural matters. Discussion revolved around the following topics:

1. The need for members to call staff ahead of time to be excused for any absences.
2. Voting privileges for those who do not attend meetings.
3. Rules concerning a proxy for PWLHs who could not attend -- the proxy needed to be a voting member of the Joint Committee, only one proxy per voting member. The member may call Title I or II for list of proxies to assign proxy vote. Motions were made to agree on these decisions and a vote was taken. The Joint Committee voted and unanimously accepted each of the above items.
4. Staff announced that representatives of Title I need to be regular members of the Technical Committee and Title II need to be members of the Planning & Linkage

committee in order to be a member of Joint Committee. Forms were provided for people to sign up for membership on the Planning & Linkage committee if they wished to participate.

5. A staff member explained the information in the folder which contained summaries of data that were to be considered during the prioritization process during the next meeting. The Committee members were instructed to take the information home and study it so they could be informed and ready to prioritize services at the next meeting.
6. Staff discussed the importance of confidentiality and "government in the sunshine."
7. Staff discussed procedures concerning conflict of interest.
8. An Informed Consent form was provided for this study, questions were answered, and members were asked to sign it if they agreed to participate in the study.
9. The Needs assessment document was presented to the Committee by the researcher, and questions pertaining to it were answered.
10. Dates for the next meeting were announced and the meeting was adjourned.

For the benefit of Joint Committee members who were unable to come to this meeting, the information packets and minutes of the meeting were mailed out a few days later.

Meeting #2, June 13, 2000: Process of Prioritization of Services

Before the meeting began, three posters had been prepared and hung on the wall. One poster contained a list of services that were established a year ago for the current fiscal year listed in priority order. A second poster listed the priorities based on the consumer surveys that had been recently completed for the needs assessment. The third poster listed priorities based on consumer focus groups for the needs assessment. A survey had been mailed ahead of time to Joint Committee members participating in this study, and these were collected at this time. If they did not bring it with them, they were provided another copy and asked to complete it.

The meeting began with a review by staff concerning the need to consider the Statewide Coordinated Statement of Need which recommends that certain services be included in the top five priorities. They were advised that if they did not include one or more of those services in the top five, they needed to have a reasonable explanation for not doing so. They were also instructed not to consider dollar amounts at this time, since the allocation of funding is considered to be an independent process. They were asked to go around the room and count off from one to three, then instructed to separate into three groups based on the number they called. They were then asked to move into three different rooms and each group was to come to a consensus of priorities based on the information they were given at the previous meeting. They were asked to write their list of services down, in priority order, on poster sized-paper They were instructed to come back into the conference room in 30 minutes. An observer went with each group to take notes and record the codes for group interactions.

After about 30 minutes of meeting separately, the three groups reconvened and placed their list of priorities on the wall for all to see. Using this as a basis for discussion, a final group priority listing for all the services was developed and agreed on by consensus by all members present. This list of priorities was later presented to the Planning Council and Consortium for final approval when they met for their regular monthly meetings.

Meeting #3, June 29, 2000: Distribution of Information Needed for the Allocation of Funding.

Staff presented the Joint Committee members with materials that were to be used in the allocation of funding that was to take place at the next meeting. Included in this information was (1) a list of priorities accepted by the Planning Council; (2) a Service Utilization and Expenditure report for the current fiscal year; (3) an Allocations Matrix which predicted unmet need based on estimations of new HIV infections; (4) an Allocations Worksheet; and (5) the latest HRSA Housing Policy, which provided an update of guidelines concerning the use of Ryan White funding for housing.

The committee members were told that funding decisions at the next meeting were to be made on the assumption that 2498 infected clients will require services for FY 2001, and it was anticipated that $5.3 million in Title I & II and State General Revenue funds will be available for funding these services. They were instructed that the allocations were for service categories, not specific providers, and that the amounts were to be in percentages, rather than dollar amounts, since the exact amount would not be known until after the funding was awarded. After an opportunity to ask questions, the committee members were instructed to take the materials home to review and be prepared to make decisions on the funding allocations at the next meeting.

Meeting #4, July 11, 2000: Process of Allocating Funding.

Before beginning the allocation process, the staff briefly reviewed some of the materials that were provided to the Joint Committee at the previous meeting, including the following:

1. The number of clients to be served in FY 2001/2002 was estimated at 2498, based on epidemiological data.
2. The Service Expenditure Report from Fiscal Year 1999/2000 showed how much services cost, the total average per client and the total average for cost per unit. A factor they were asked to keep in mind was that the method of reimbursement was changed from reimbursement of salaries and expenditures to a method of unit cost reimbursement. While the cost per client should stay the same, the number of clients was expected to increase.
3. The Allocations Matrix contained a list of each service category, what the funding would be used for in each category, what sources of funding were available and in what amount. One category in particular that was expected to decrease its need for funding was medications since the state's AIDS Drug Assistance Program was increasing its allocation for this purpose.
4. The Allocation Worksheet contained the percentage of unmet need for each service category, which was based on the number of expected clients and sources of funding available to meet the needs of those clients. It was pointed out that the cost of medical care was expected to increase due to an increase in demand and cost of medical diagnostic tests.

The list of services that had been prioritized in the previous meeting were listed on a board. The Joint Committee was asked to begin with the top five prioritized service categories and allocate a percentage to each, then continue with each additional five categories until all categories had been allocated a percentage. After each category had received an allocation percentage, adjustments could be made based on their discussions. At the very beginning of the process, one member of the committee made a motion to accept the percentages of unmet need that was recorded on the Allocation Worksheet as the percentage of funding allocation. After discussion this motion was modified and accepted as a starting point for the decisions. The process of allocating percentages to the various categories moved fairly quickly to begin with until all categories had been assigned. At this point, the group entered into discussions concerning the appropriateness of the percentages listed for each category. Each service category was revisited and revised if the group reached a consensus on a change to the amount.

On July 27, members of the Title I Planning Council met and, among other items, voted to accept the allocations recommended by the Joint Committee. On August 16, the Title II Consortium met and voted to approve the same allocation recommendations.

On August 3, the Title I Technical Committee met. The stated purpose of the meeting was to discuss actions to be taken by the Planning Council in preparation for the Title I grant application. Due to the absence of a staff member during the prioritization meeting on June 13, the Joint Committee inadvertently failed to make recommendations on the following issues: (1) prioritization and allocation of Congressional Black Caucus funds and (2) prioritization of funding for Planning Council support. In addition, it was decided that in order to avoid confusion, a recommendation should be made to the Planning Council to rename a number of the service priorities to conform to new definitions issued by HRSA When the Planning Council met on August 24, these recommendations were approved.

Survey Responses

Data were gathered from the Joint Committee members in several different ways and at different times during the decision-making process. Before any discussions began, Joint Committee members were given the first survey on June 1 and asked to complete it before the next meeting (see Appendix A) in order to determine what factors they thought would be considered during the prioritization and allocation process. They were given a survey after they had completed the prioritization process and another one after the allocation process to determine whether those factors were, in fact, important, or whether there were other factors that became important during the discussions.

Ranking of Priorities

Page 1 of the survey asked the committee to individually priority-rank the services according their own individual preferences of priority. After deliberations, the group came to a consensus on an overall group priority ranking. The results of these two rankings were compared to determine whether there were any apparent changes in the individual rankings during the deliberations. The overall group ranking was also compared to that of the clients, based on the needs assessment. The rankings for each of these are shown in Table 2. Column 1 shows the averaged priority-rank of client priorities, Column 2 shows the averaged priority-rank of the individual committee members, Column 3 shows the priority-rank of the overall group, Column 4 shows the numerical difference between ranking of the client and that of the overall group, and Column 5 shows the difference between the average of the individual committee members and the overall group ranking. The only service category that held the same priority for all three groups was primary medical care, which was ranked as the highest priority. There are several service categories that were ranked very differently by the three groups, particularly between the client ranking and the overall group ranking.

Comparison between client ranking and overall group ranking

Service categories that had the greatest difference between the clients and the Joint Committee overall group priority ranking (Column 4) include: (1) services ranked higher by providers – female medical care, substance abuse treatment, child care and mental health therapy and specialty care; and (2) services ranked higher by clients – health education and risk reduction, insurance assistance, buddy services and counseling. The reason why there is a greater difference with female medical care and specialty care is that in the list of services for the clients to prioritize, these two categories were listed as separate service categories. However, the committee decided that they all fell under the general category of primary medical care and gave them all the same priority -- highest.

Table 2

Comparison of Average of Ranking Between Clients, Individual Committee Members and Overall Group.

Service	Column 1 Client Rank Averaged (from needs assessment)	Column 2 Individual Committee Member's Rank Averaged	Column 3 Overall Group Rank for Committee	Column 4 Client-Group Rank Difference	Column 5 Individual-Group Rank Difference
Primary Medical Care	1	1	1	0	0
Pharmaceuticals	2	2	4	-2	-2
Case Management	3	3	5	-2	-2
Dental Care	4	5	6	-2	-1
Specialty Care	5	13	1	4	12
Housing Assistance	6	12	10	-4	2
Transportation	7	8	8	-1	0
Counseling	8	14	15	-7	-1
Alternative Therapy	9	7	12	-3	-5
Legal Assistance	10	10	11	-1	-1
Food Bank	11	15	13	–2	2
Health Education	12	18	23	-11	-5
Mental Health Therapy	13	6	9	4	-3
Insurance Assistance	14	17	25	-11	-8
Substance Abuse Trtmnt	15	4	7	8	-3
Home Health Care	16	16	18	-2	-2
Buddy Services	17	23	27	-10	-4
Consum. Med. Supp	18	17	18	0	-1
Durable Med Supplies	19	21	18	1	3
Hospice Care	20	20	24	-4	-4
Female Medical Care	21	9	1	20	8
Child Care	22	19	17	5	2
Day Respite	23	22	22	1	0
Adoption/Foster Care	24	24	26	-2	-2
Outreach	nr	nr	13		
Emergency Assistance	nr	nr	15		
Capacity Building	nr	nr	18		

Note. nr = not ranked

Comparison between the average of the individual ranking and overall group ranking

Service categories that had the greatest difference in priority ranking between the average of the individual Committee members and the overall group include specialty care, female medical care, for the same reason stated above, plus alternative therapy, health education and risk reduction, and private insurance assistance.

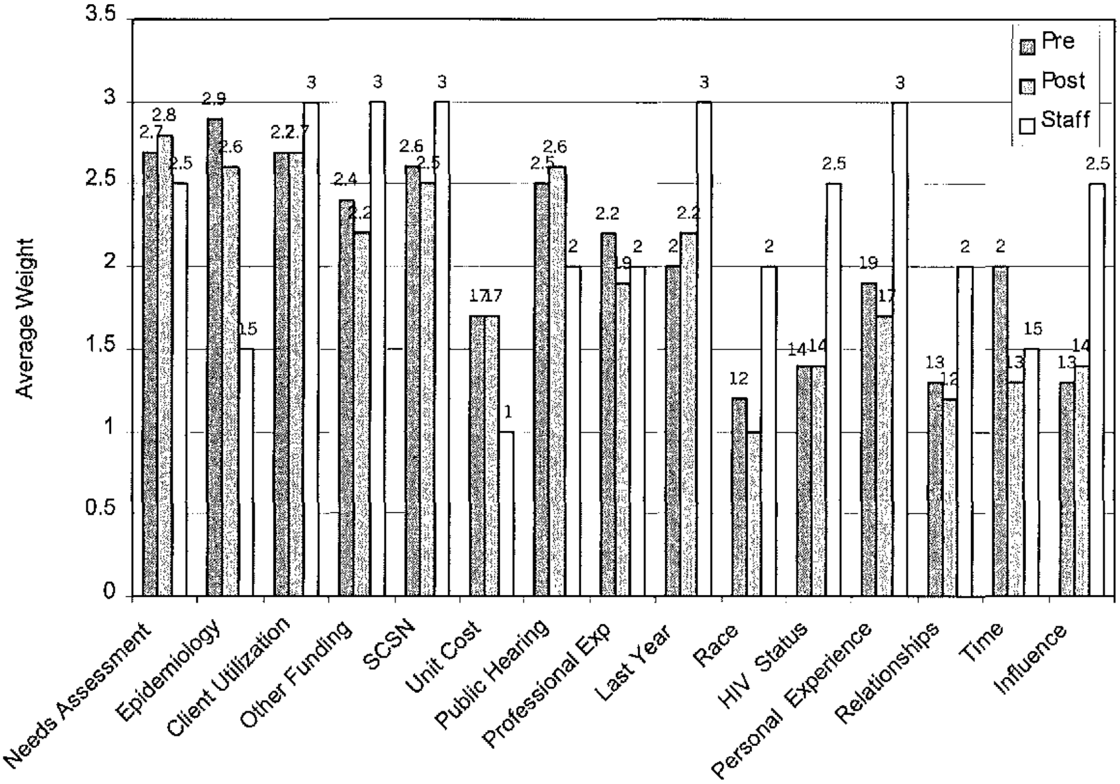
Statistical Analysis for Ranking of Priorities

The data that are summarized in Table 2 were analyzed using several non-parametric statistical tests in the SPSS 10.0 computer program. The Friedman test, a non-parametric extension of the paired t-test (SPSS Inc., 1999), showed a significant difference between the average ranking of services between the clients and the overall group, $\chi^2(1, \underline{N} = 24) = 5.261$, $\underline{p} = .022$, but not between the individual committee members and the group. A Spearman's Correlation showed that 79% ($r = .887$, $\underline{N} = 24$) $\underline{p} = .01$, of the variation in the group ranking can be explained by the averaged individual ranking, and 44% ($r = .660$, $\underline{N} = 24$) $\underline{p} = .01$ of the variation in the group ranking can be explained by the averaged client ranking.

Weight of Factors Affecting Decision-Making

A comparison of the average weight that committee members gave to the various factors before and after the decision-making process is shown in Figure 7. Also shown in Figure 7 is the average weight that staff members gave when asked how much weight they thought the committee members had placed on the various factors.

Figure 7. Comparison of Average Weight of Factors Affecting Decision-Making Committee Pre-Decision vs. Post-Decision vs. Staff



Statistically significant differences existed in the following categories:

1. Committee pre-decision vs. post-decision: time (p = .01)
2. Committee post-decision vs. Staff: other funding (p = .005), unit cost (p = .001), public hearings (p = .002), last year (p = .001) and personal experience (p = .000).

For tables listing additional statistical information, see Appendix D.

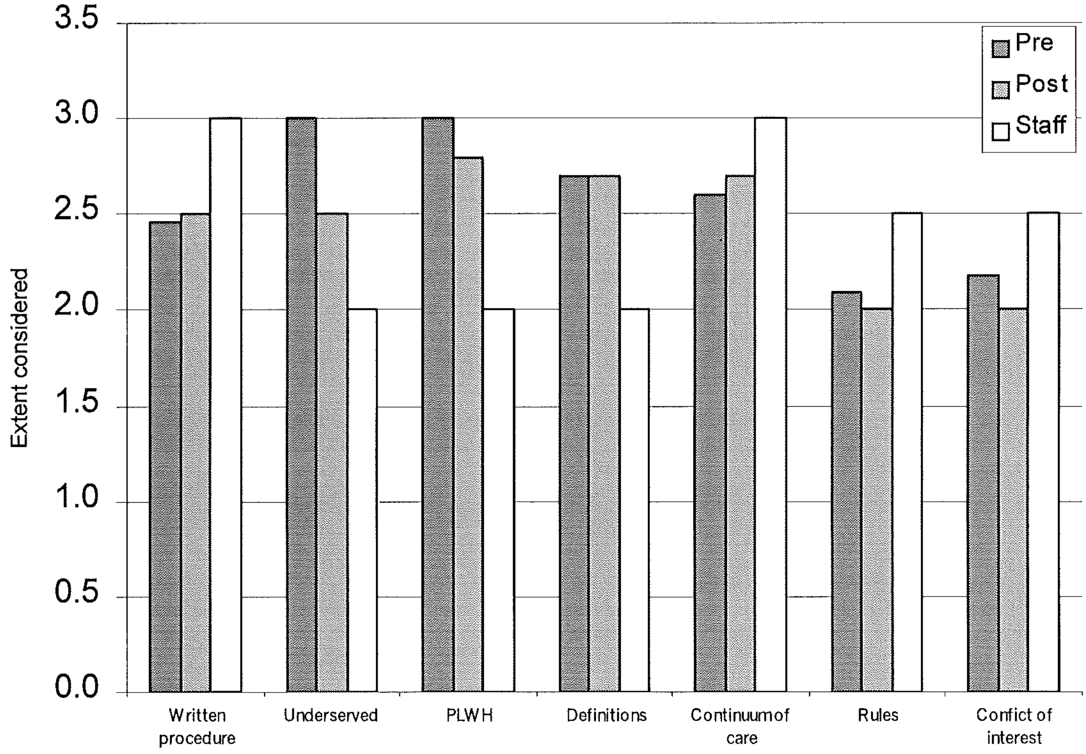
The factor that was perceived to carry the most weight by the committee after the process had been completed was the needs assessment. Other factors that carried greater weight included the epidemiological evidence provided to them, client utilization of services, public hearings and their professional experience. Factors that were reported to carry less weight included their race, their HIV status, their relationship with other committee members and the amount of time permitted for the process.

For the most part, there was not a great difference between the average weight anticipated by committee members before the decision making process and the weight they reported after the process was completed. A paired t-test (see tables in Appendix D) indicated that the only factor that had a statistically significant difference was the amount of time allowed for the process, which was perceived to carry less weight than anticipated.

A greater difference was perceived between the staff members and the committee members concerning the amount of weight the committee members placed on the various factors. The staff believed the committee placed greater weight on client utilization, other funding sources, the statewide coordinated statement of need, their HIV status, personal experience, what was done last year and the influence of others, than did the committee members. An independent samples t-test indicates several factors showed a statistically significant difference between committee perception and staff perception, as noted in Figure 7.

Figure 8 compares the pre-decision committee weight of several additional factors to their post-decision weight, and also the staff's perception of the committee's weight. As with the previous factors, the committee made no significant changes overall between their pre-decision and post-decision responses. The factors that carried less weight than anticipated were representation of the underserved population and people living with HIV. A paired samples t-test (see Appendix D) indicated that these differences were not statistically significant, however.

Figure 8. Extent to Which Factors Were Included Pre-Decision vs. Post-Decision vs. Staff.

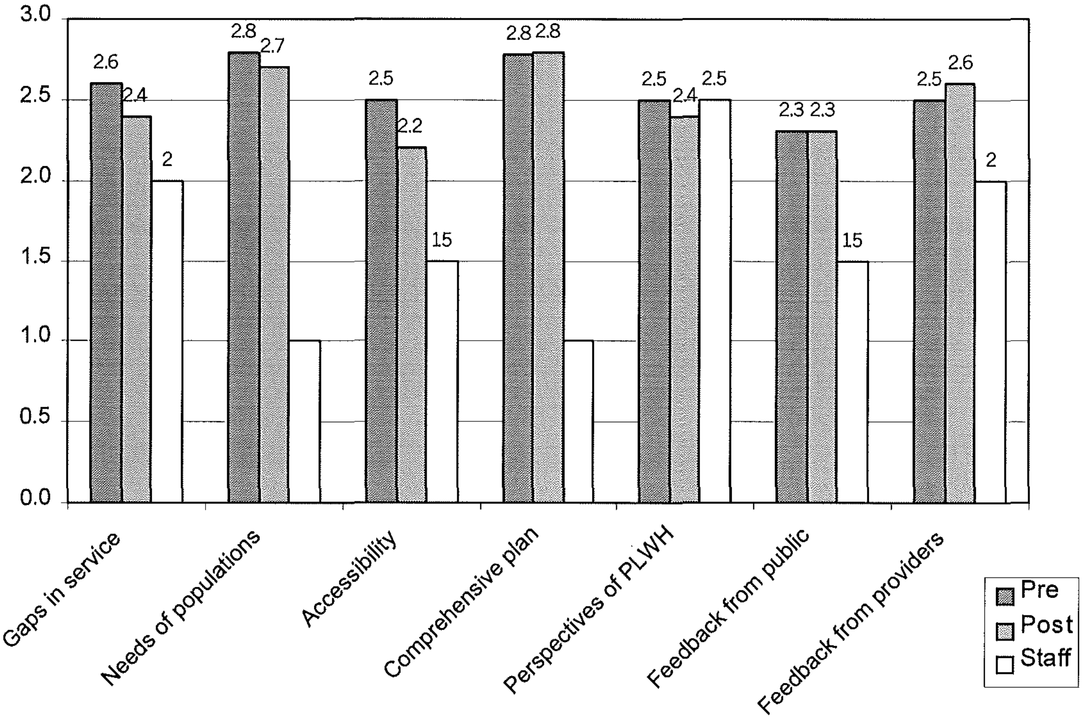


Factors having a statistically significant difference between committee perception and staff perception include: use of a written procedure (p = .025), including representatives of the underserved population (p = .025) and core continuum of care (p = .038).

Factors that carried the most weight, according to the committee, included people living with HIV, definitions of services and a core continuum of care. Factors that carried the least amount of weight were the use of rules regarding the level of agreement, and the management of conflict of interest. A comparison between the committee's responses and those of the staff indicated that the staff perceived the committee to place more weight on a written procedure and a core continuum of care than the committee claimed. The staff also believed the committee placed less weight on the underserved population, PLWH and definitions than the committee claimed. Those having a statistically significant difference are noted in Figure 8. For tables listing additional statistical information, see Appendix D.

When asked to ascertain the extent to which the following information was included in determining priorities, the committee responded as shown in Figure 9. The information that was considered to the greatest extent, as perceived by the committee, was the comprehensive plan, followed by the need of the population affected by HIV and feedback from providers. The factor that showed the greatest difference between pre-and post-decision was the accessibility of services; however, this difference is not significant. It was the perception of the staff that the committee placed less weight on the information than the committee perceived they had. Statistically significant differences between committee perception and staff perception are noted in Figure 9.

Figure 9. Extent To Which Information Was Included Pre-Decision vs. Post-Decision vs. Staff.



Statistically significant differences between committee post-decision perception and staff perception include: gaps in service (p = .016), needs of the population (p = .000), the comprehensive plan (p = .000) and feedback from providers (p = .002).

Rank of Factors Affecting Decision-Making

In addition to placing a weight on the factors that could possibly have influenced their decisions, the Joint Committee members were asked to rank these factors, both before and after the decisions were completed. A factorial analysis of their responses was conducted to determine whether there was a significant change in their answers before and after decision-making and to determine whether their HIV status had any significant effect on their responses. Tests of between-subjects effects (for non-parametric ANOVA) were conducted to determine whether there was any interaction between their HIV status and their pre-post decision answers. The only factors that showed a statistically significant difference in pre-post decisions were their ranking of epidemiological trends and what was done last year. No significant differences existed in the HIV status of the committee members as to how they ranked the importance of the factors, and there was no significant interaction between their HIV status and their pre/post decision ranking of the factors (see Appendix D for statistical tables).

Table 3.

Comparison of Pre-Decision and Post-Decision Committee Ranking of Possible Factors Influencing Decisions

Possible Factor Influencing Decisions	Pre-Decision Rank	Post-Decision Rank
Needs assessment	2.6	1.6
Utilization of services by clients	4.1	3.8
Epidemiological trends of the disease	3.0	4.5*
Statewide Coordinated Statement of Need	5.6	4.6
Public Hearings	6.1	5.4
What was done last year	8.0	6.4*
Other funding available	6.0	6.7
Your professional experience	6.1	7.1
Your personal experience	9.3	8.7
Unit cost by service category	9.5	9.7
Influence of one or more members on you	13.1	10.2
Your relationships with other members	12.4	10.5
Your HIV status	11.2	10.6
Amount of time allowed for the process	11.7	11.2
Race	12.3	11.7

* Factors showing a statistically significant difference at the p = .05 level.

A test of between-subjects effects was conducted on the ranking of the committee members versus the staff to determine whether there were any differences between the rank assigned by the committee and the perception of the staff of how the committee ranked the factors.

Table 4.

Comparison of Post-Decision Committee Ranking and Staff Ranking of Possible Factors Influencing Decisions

Possible Factor Influencing Decisions	Committee Post-Decision Rank	Staff Rank
Needs assessment	1.6	4*
Utilization of services by clients	3.8	2.5
Epidemiological trends of the disease	4.5	12.0*
Statewide Coordinated Statement of Need	4.6	2.5
Public Hearings	5.4	10.5*
What was done last year	6.4	1.0*
Other funding available	6.7	6.0
Your professional experience	7.1	12.0
Your personal experience	8.7	8.0
Unit cost by service category	9.7	14.0
Influence of one or more members on you	10.2	6.5
Your relationships with other members	10.5	10.5
Your HIV status	10.6	10.0
Amount of time allowed for the process	11.2	12.5
Race	11.7	11.0

* Factors showing a statistically significant difference at the $p = .05$ level include the needs assessment, epidemiological trends, the public hearing responses and what was done last year.

Additional Survey Questions

The last pages of the survey asked the committee members questions regarding their perception of how they were treated by other members of the committee and whether they thought the information provided was adequate. The questions that were asked are given in Table 5, with the percentage of responses on the right. As can be seen, 100% of committee members and staff felt that the committee members were given adequate opportunity to voice their opinions and that they were treated equally. They also considered the information provided to them for the prioritization and allocation process to be adequate. Twenty seven percent of the committee members responding to the survey after the process was over, however, stated that they perceived one or more members of the committee attempted to unduly influence them.

Table 5.

Responses to Additional Questions on Survey.

Question	Responses
Do you feel that you were given an adequate opportunity to voice your opinion?	Yes (100%)
Do you feel you were treated equally while serving on this committee?	Yes (100%)
Regarding the information you were provided in order to make decisions concerning the *prioritization* of funding, do you feel the information was adequate and appropriate?	Yes (100%)
Regarding the information you were provided in order to make decisions concerning the *allocation* of funding, do you feel the information was adequate and appropriate?	Yes (100%)
Do you think one or more members of this committee attempted to unduly influence you in the decision-making process?	Yes (27%) No (71%)

Interviews

As mentioned previously, a purposeful sample of the Joint Committee was selected to be interviewed. Three PLWHs, one of whom was new to the process, and two non-PLWHs were interviewed. In addition, two staff members were asked to answer the questions based on their perception of what the committee members did. In the following section, the interview questions are given in bold letters followed by the main themes of the responses, along with supporting quotations in italics. Due to the importance of maintaining the confidentiality of the individuals being interviewed, comments from several participants have been combined.

Do you think that the information provided to you by the staff was adequate for you to make decisions concerning the prioritization and allocation?

Most of the respondents indicated that the information provided was adequate to make the decisions. The staff *"provided great information," "explained the process," "the estimates that they gave as far as the calculated unmet need made sense." "I think the staff always does a real good job of keeping track of all that stuff. It makes our job a lot easier because if we've got good information to go on then all we have to do is to focus on what our job is -- to prioritize and allocate funds." "They've gotten much better at the information that they now give us."*

Some people thought too much information was provided: *"sometimes I think it's overload...there's so much that you have to consider." "I don't think you really need any more information than you're given. When you're new, you really think the specific details are important. You want to get all this information and you don't feel like you've* *got it all. The bottom line is you don't need all that information to make the decisions for the funding cycle because it can all change."* *"I think the way information is presented, especially to some of the newer members, could be a little easier to understand."*

What did you find most useful and why?

There were several factors mentioned, however most participants indicated that they placed a lot of weight on *"What we did last year"* and the information concerning *"what the estimated unmet need was...I think those two things were the most critical."* Additional information believed to be useful included: *"Knowing how many clients access particular service categories," "The amount of funds that we expended last year," "alternate billing sources," "What the community still feels are the unmet needs," "where there are still gaps in service."* One participant stated, *"I believe the needs assessment and the statewide coordinated statement of needs because basically those are the two bibles that we need to follow."*

With regard to the way the information was formatted, one participant liked the *"binder so that we could go back and review...they added to it as the meetings progressed." "The binder helped to prevent the information from getting lost....The fact that it was all there."* Also useful were *"the opportunities to request additional information from the staff if we felt that it was needed."*

Perceptions of the staff indicated that the committee members gave most of the weight to previous years' services and funding levels. They "*gave a lot more weight than they want to admit to the statewide statement of need*" and while they were interested in the needs assessment data staff members perceived that they *"looked at the needs assessment data as an affirmation of what they'd already been told."*

Is there anything you would change about what they [the staff] did to provide information?

Most respondents agreed that there was a need for more training for people who are new to the process, and the information needs to be simplified. *"A lot of people don't know what Epi data is...what a statewide coordination statement of need is....what a needs assessment is."* There should be a *"training for the process before we begin,"* an "*orientation or a training to walk people through some of it.*" One participant said, *"By throwing so much information at people without a way of filtering it down to them can cause people to get lost and we can actually lose them from the process."* Another participant stated they need, *"more time to ask questions about it or talk about it or absorb it."* New people, *"PLWHs and non-PLWH who are providers, need a little bit more time in order to digest the information. More time to study it and perhaps get help."*

In a previous year "*we prioritized things into three different categories*" and *"developed kind of like a green light, yellow light, red light system ... medical care, obviously is something that someone with HIV has to have in order to live... when it came to the allocation process allocations ...that made it a little easier to do."* One committee member stated, *"I think I would like to use the same format two years in a row,"* however a staff member stated that we need to *"make changes to make the process better."*

How much confidence do you have in the information you were provided by the staff?

Most participants indicated *"complete confidence."* They have *"a reputation for honesty and attention to detail,"* and if there *"is a question the staff is very willing to go take a look and research it and see if there are any adjustments that need to be made. If there are any, those are brought up pretty quickly and things are rectified."*

While the majority of the participants had the utmost confidence in the information provided by the staff, one person commented that *"it seems to be swayed...to make you feel that there are no new services, no change in the services, the providers are doing an adequate amount... we're not looking at more creative resources."*

Another comment concerning the structure of the Joint Committee, was *"I've noticed that kind of bias exists...that it seems the chair in charge is always a Planning Council rather than a Consortium member...almost, without exception, the chair will defer to Title I staff, even if there is a need for [Title II] staff to provide the information."*

How much weight, in your decision-making process, do you think you placed on the information that you were given compared to how much you were influenced by other factors, such as other members?

Some of the participants stated that they based their decisions on facts. *"My job was to take the information and make the best judgment that I thought I could make...I tried as much as possible to set aside those things* [position, experience with clients, personal HIV status] *because I only see a very small snapshot of the total picture...*

there's always exceptions and you can't base decisions like this on exceptions or case examples. You have to base it on something a lot more concrete. That's why I give a lot of weight to how many clients are utilizing services." One person said s/he, for the most part, was *"looking at the needs assessment, the information from the focus groups, the PLWHs versus the information provided ... listen[ing] to everything that people say, looking at the information and listening to the discussions at the table and filtering through things."* Another participant said s/he tried to *"listen to the PLWH's because they are the ones living with this, not me. I'm really there to provide that service for them. I realize that what I'm hearing from the PLWH's is their real personal experience."*

Concerning PLWHs, one person commented that *"sometimes they don't stand up for the total population. They are more tunnel-visioned than say a lot of providers or staff, which to me, has always seemed unfortunate since they should be representative of the total population."* Some participants admitted to having difficulty being objective, *"You try to detach yourself and that's a hard thing to do. You try not to think about yourself, or think about your experience, or think about other people and their experiences, but sometimes that does creep in....[Doing this process is] kind of a hard thing to do when you're living with the disease because you know you are affecting a lot of people by what you're doing."*

Another stated that s/he placed more weight on his/her *"personal experiences... what I hear from other people living with the disease - that outweighed it just a little* *bit....my HIV status, personal experiences throughout the year. A lot of people think you're just hot on this one issue right now....no, throughout the year what I've heard is a trend among people living with the disease. That was a greater factor than the information that we were given."*

Members of the staff thought *"they were equally influenced,"* the committee was *"very open to comments made, particularly by PLWHs," " they're very, very easily swayed." "If you take them as a whole I think it's pretty well-balanced. I think that's appropriate. People who have been exposed to this either as part of the profession, or they're very experienced, or they are PLWH's themselves are intrinsically involved in the service system and are going to be less influenced by the information given them as part of this process. The newer members, the ones that don't do this for a living, or aren't PLWH's, those people are going to be more influenced by the ones that are a part of this process and I think that's appropriate."*

One person stated that there will be disagreement in a group like this, and *"ultimately, that's why you have lots of people on the committee. Hopefully, the majority decision is the right one."*

Were your decisions influenced by another person's professional position or power? In other words, do you feel like some members of the committee were trying to influence the direction or the way the decisions were made?

The responses indicated that most people believed others were trying to influence them, but not everyone perceived this as unusual or negative: *" I think everybody has an* *agenda of some form or another...we also know what each other's agenda is... at the same time, I don't think anybody actually tried to use their position...to unduly influence anyone. I think everybody came to the table, explained how they saw things in their particular field and where they thought there was going to be a need and what kind of need would have to be met." "I think it does have an effect on certain people but we have enough people with enough experience and knowledge that it doesn't really sway the process very much. I think somebody tries every year but they're not very successful."*

"I think there are people in the room who have certain positions or certain histories within the group of people who have a little more credibility or a little bit more unofficial authority. It's not necessarily how I influence my decisions, but just kind of the perception of the atmosphere of the room. But, for the most part, I still go with what I felt was the appropriate priority or appropriate allocation. What I felt was right vs. what someone else was telling me that they thought should be and I was willing to weigh things. There are a couple of people who have been in this community longer than most people at the table and so people will give them a little bit more credence."

"I can remember back when a particular service got some money but not a lot, and then the people providing that service got involved in the allocation process and the money went real high, went ballistic. So I think the committee can be influenced, very much so, and I think there are people who come to that committee to try to influence others."

One member believed that other members of the committee did try influence him/her, but at the same time saw some compromise. *"Being that there were only 3 PLWHs and the rest providers, I would have to say, yes. It was a provider-driven process." "Some of them have strong personalities and they try to brow-beat you, but I'm not really intimidated easily anymore. I think a lot of compromise goes on. I think you saw that when we were in there that somebody would have a priority that was higher up than somebody else's and they'd say, well OK, I'll go this much if you'll go that much. So there was some give and take."*

One person did not see this as a problem for her/himself, however it was perceived as a problem for newer members: *"Not for me. I don't depend on anyone else for what they can do for me -- none of the agencies...so I feel like I can say anything that I want to say. There are some people on the committee who feel that because of who they are, how long they've been involved in the fight, that they have all the information and they know all the facts and we should be voting that way...You have to have those personalities and that information. It's just that those people who are new to the process...they have to go on their instincts. They have to speak up. I wonder about the personalities of providers who are new to the process. They can't say too much because they don't know just how things are."*

In previous years, personal influence was considered to be a major factor, but the process has since been restructured, *"dividing them up into 3 groups to prioritize"* in an effort to filter out this influence. A staff member described the process: *"In the past,* *before we started breaking them up into 3 groups, one or two people would totally dominate the conversation and would talk until everybody either gave up or agreed. By dividing them up into 3 groups, what you've done is you've separated the dominant personalities in the groups so that they only have a portion of the people that they can dominate. The reason we did that, was to factor out that problem."*

To what degree did you consider the needs assessment and feedback from PLWHs and members of the community compared to other sources of information?

The majority of the committee said they paid more attention to the needs assessment, *"because the numbers were better. In previous years, needs assessments and the focus groups and stuff, they were the same people going over and over and there were like 5 people saying the same things. I tried not to put very much emphasis on that because it was wasn't fair. This year, you had like a hundred or two hundred, I felt like we should listen to it. I'm not real sure that we put a lot of weight in the final decision on it but I think it definitely made me stop and think about it more than I had in previous years."*

"I took it pretty seriously. This year was the first year where as much effort was put into doing the needs assessment, to try and make sure that it reflected the needs of the community with the linking with different community groups, churches, agencies around the EMA to bring in people's input ... I think that was really effective ... and that made it a lot more viable than going back for resources and for information. I think those are the

people who can identify the gaps for you most readily because they are the ones who are always running into them."

"When I went through it, I tried to find areas of consensus between the interviews, the statistics that we were given and the focus groups that met. And if there was consistency among those then that obviously made a strong case for where that particular service category should fall and what kind of funds we should allocate to each of them. Where there was large disagreements, then that's where you have to make a personal decision as to which factors were most important. In my particular situation I gave the greatest weight to the figures given that were estimated on that need. I gave the second weight to the individual surveys and I gave the least weight to the focus groups. The reason I gave less weight to the focus groups was because anytime you have people in the same room there is always a chance that one or a couple of people are going to dominate the discussion. The facts and figures, I tried to match those as much as I could with the surveys and the results of the surveys. If there was still some doubt between those two then I would go to the focus groups as a tie breaker.

"I would say I gave it like an 80-85% as the PLWHs (the community perspective), vs. other sources of information. I would say that overall the consumer or community feedback was, by the whole committee, considered maybe 60%, maybe even 50/50, but not a lot. I think that persons living with the disease or the consumers receiving the service are not always the best judge...of what services should be provided. They feel like they have more experience because they deal with a great number of consumers vs. one consumer.

The needs assessment is *" what we're supposed to go by. That's like the unbiased facts from the community. But, it's hard not to take your own situation and other people's situation into account. Sometimes it seems that the needs assessments are at odds with what the providers think. It's just like things are totally different. In the needs assessment the priorities that the PLWHs come up with are...at odds with the priorities that the providers [have]."*

"I think they were looking at the needs assessment as an affirmation of what they were already going to do anyway. But unfortunately I don't think the majority of them read the needs assessment." "I think they look for differences from the previous year. I think that's the core part of the needs assessment that most people look at. They want to know what changed. You're essentially getting the same results for the last 5 years and they want to see where the differences are between last year and this year." "In terms of public hearings, I don't think people pay much attention to that. But I personally don't think it's a very good tool either. I think you hear from people who have an ax to grind or who have a very specialized circumstances and that kind of feedback generally isn't very useful. I think the people who understand the processes and have done this 2, 3, 4, 5 years understand how it works and generally people are turning to them to see what they think as to how they make their decisions. So, you kind of get back to that through the influence of people who are influential. There are certain people who kind of swallow all the other people. I don't necessarily think that's bad. I think it's like that anywhere."

Do you think the committee members and members from the community (specifically PLWHs), who are not working with health related organizations, received sufficient training and mentoring in order to be effectively involved in the process?

Everyone agreed that people who are new to this process, whether they were PLWHs or not, need more training in order to be effective. *"That's the one area that could use some improvement because you have a lot of people who care about the process and who would like to be able to help. I think they need help to the extent of giving information so that they have an understanding of the process and where we are going, but not so much that they become yet another one of the bureaucrats sitting at the table. I think we should provide an orientation to help them learn what the process is going to be."*

"Most of the people who come to these meetings have been there for a while. I think if you asked the ones that come they're going to tell you that PLWHs don't feel educated enough and don't have enough information in all of those things to even feel comfortable coming to a meeting. Maybe if somebody sat down with the new people and went through the entire process, what Title I and Title II and all the titles were, what the process is and what it means. Because we really don't do that. You sort of figure it out if you've been involved for a while. I think it really would help if you've never been involved before and we never do that. Maybe we could set up a mentor with somebody new so they can spend some time with them before, during and after all this process.

"I've been on the Council for several years. The first year I can say that I was totally in the dark. So it's kind of become more streamlined and easier for me to understand. But for somebody who's brand new it would be a daunting task. I think there needs to be training for prioritization and allocations specifically. Then maybe people wouldn't be intimidated by it. I don't know if the poor turnout was because of apathy or because people were just like, I can't deal with this, I don't understand it, so I'm just not going to do it. I don't know why but there were only 3 PLWHs that came on a consistent basis. That was disheartening to me as a PLWH."

"They need more verbal communication, more trainings. Perhaps 2 months before prioritization and allocation, you solicit people who want to participate in the process. So we're going to have to see many training classes. You explain this is what we did last year. This is the information. This is to explain how it's done. That might help the people so that they will have a chance, when they get to the real prioritization and allocation, they'll feel more on board."

"I consider the training that they get to be essential because otherwise they are just shooting in the dark or completely at the whim of staff. Everybody seems to know what they are supposed to be doing. I think there is a learning curve for those who've done it more than once. That's another thing you can institute, is to say that you want people that have been to previous meetings to really try and do a second year if possible. Because there are always going to be people who are half experienced, so you can take advantage of the more experienced people that understand the process."

"I think there's the potential for them to receive effective training but that would involve their commitment to becoming active members in the consortium, of going through the whole process from start to finish and understanding the way the process moves through the different steps. There weren't but 3 PLWHs that were consistently involved in either the Consortia or the Planning Council. I'm consistently disappointed that more PLWHs don't get involved. One of the things that bothered me was the fact that there were some issues that came up, there were discussions where we had some conflict and it would have added to the discussion to be able to turn to a larger number of PLWHs and asked them to give us some input while we were discussing the issue and tell us how they saw things. I think we need to do a better job of getting people involved in the process. Ninety percent of the committee are all members of service agencies, I personally would like to see the ratio reversed. I'd like to see a lot more individuals who are not connected with service agencies who are HIV positive being the dominant force in the prioritization and allocation process rather than the service providers and people who work for service agencies."

The need for more training for this process was evidenced by the following comment: *"Sometimes it was hard to figure out who was Title I and who was Title II, so I didn't even know who I was representing. I knew I was representing PLWHs."*

Do you think that individual committee members feel empowered, equal, and respected enough to participate full in the discussion of the group as decisions are made? First answer for yourself then what you think other people would think.

All of the participants said they believed the committee members felt empowered, but there were differences of opinion on the degree. *"I think so. That's why people come to that table, to be able to speak up and be able to represent people who may not be interested and/or willing to represent themselves at the table. I think that's a fairly vocal group but it's a respectable group."*

"Yes, I feel that I am. I feel that I'm respected enough, and listened to and empowered enough....At the meetings of prioritization and allocation I had my opportunity as well as anyone else."

"I think for myself, I do, but then I'm a fairly strong-willed person who believes that if you ask me for my opinion then I'm going to give it to you. I don't feel intimidated by anyone. For other people, I think that new people may in fact feel intimidated. You have doctors and lawyers and health department officials and some people give great deference to authority, whatever it's form. Especially if you don't have a personal relationship with any of those people ... I think it becomes a lot easier to see them more as a participant in the system where everyone is equal. I think a lot of that just comes with experience and time. The longer you're with them and the longer you serve, the less intimidated you become."

"I think there are some people on the committee who don't feel like they're respected or empowered to say what they believe. There are other people that don't have any issues with it and use that committee to get what they want from their own personal jobs and those sorts of things. Then I think there are other people who really are just

trying to do a really good job and don't mind speaking out. But I think they've been around for a while. I think somebody new coming in would have to establish their power base in what they think and what they do."

"I think in general our members do, but I have a feeling that our PLWHs still don't. I got the feeling that with the newer ones, they didn't know enough about what was going on to feel empowered."

"I feel like I was empowered. Whether my opinion was valued or not may be another story. I'm sure the providers were totally confident, but sometimes I still feel like we're just there for window dressing."

" I think the ones who are willing to participate become chairpersons. I mean, anyone who wants to become chair of a committee could have done that. I think you really need to get PLWH's to commit to say we want this to be, don't just say you want new people, you have to be the ones to make the commitment because you're going to be the ones who are going to have to put up with people who don't know what they're talking about, that don't know what they're doing. To get down from the point where they're at that place to being comfortable to taking over the ropes that you're in and realize that that's not fun, that's hard work. That means that you can't just sit around at the meetings and hang out with your buddies that you've known for the last 3 years. It means that you have to take the initiative, go forward, and make those people feel welcome. It's not going to take the non-PLWH staff, the non-PLWH participants that are like community providers to make those people feel comfortable. You can't say it's your

education, recruitment or PR committee's job to do that, either. It has to be the PLWH's responsibility."

"I know that even among our community, the consumer community, we have different opinions. We look at things differently. But my hope would be that by changing the makeup of the committee, it may be the same outcome but I would feel more secure."

Are there any other comments or suggestions for change?

"The titles of the categories and the definitions of the categories really need to be standardized so....that we're all on the same page."

"I would love to see and solicit on this particular committee in particular that the infected/affected community be better represented. I don't know how you'd drag those persons in but this is one of the most important times and important decisions that have been made. It should be more balanced." "There just needed to be more PLWH participation."

"I would like to see the Title I and Title II planning bodies merged so that when we do this process we don't have to wait. We come together as a joint committee and then have to present it to Consortium and then have to present it to the Planning Council and have one or both groups veto and then send it back. It just creates a lot of machinations that don't need to occur and it's a lot of redundancy. That's the one frustration because when you attend consortia and you go to a planning council you see many of the members are one and the same. There are a lot of other EMAs around the country that have consolidated their planning processes and I think that it would be nice

to see us be able to devote more time and energy or focus more attentive time and energy to these things instead of worrying about going to X amount of meetings. That would be my main thing that I would like to see changed. Then that way more money could go to services than to the administrative costs and overhead."

"The prioritization, I don't understand why we do that at all. I'm not sure it makes any sense any more. It may have at one point in time when the disease was a whole lot different, but the process has not changed but the disease has. Even though you do percentages of funding, when they say don't deal with money, everybody deals with money in their mind. That is the absolute only way you can figure out ... if you don't put dollars in your head about how many clients and how much it costs to provide this service, then you don't have a clue as to what percentage you put in that."

"I think the places where we need to make improvements are, one, we need to do a better job of coordinating, between Title I and Title II; more integration. The more we can be a joint process the better. So that's number one. Integrate the two bodies together so we can eliminate some of this redundancy and duplication of effort. You need to look at it from a joint effort. Two, make sure that the PLWH's that are participating are given those resources, are given the encouragement and given what they need to see that it happens, but also to then basically be made responsible for recruitment efforts. Give them the tools they need to get there and make sure they understand that it's their job if they want to see PLWH's in a leadership role in the planning groups then they're the ones who are going to have to do it, because they're the only ones who can do it."

"I would like to see more commitment to the process, prior to and follow up. We see a lot of people that won't show up for prioritization and allocation which is the most responsible and influential part of being a member of the planning council/ consortium. They only show up to do that so that their voice can be heard mainly from a provider's standpoint because they want to get their money, then they disappear. I hate to see that. I really think that we ought to have a smaller group that's willing to make a year-long commitment to be in that process. If they're on Title I then they agree that they will be a member of the Technical Committee and only if you are a member of the Technical Committee can you then participate on the Prioritization and Allocation Committee. I think that the best way to get the knowledge isn't necessarily to have stuff presented specifically as pre-prioritization allocation. They need to be included in your decision-making committees -- the people who are most involved are most influential in the planning body. They see the consequences of their actions. If you're reviewing the budget monthly then you see that we don't have the money in this, then we have the tough decision to make to either shut off services or allocate more money in there. That's going to have real life experience for the next time around. That's going to influence how you do your decision making on a real basis. I think that will be useful. I think that the consortium's already moved to that place but I think the planning council ought to look at that as well. To make more of a commitment than just being on that committee. They need to be in the decision-making committee on a long-term basis."

Other Miscellaneous Comments

"I think the next step is to really be looking at getting everybody equipped with software that helps them manage their reporting and that we ought to be capturing that on a network basis ... We need software that's capturing outcome information as a byproduct of the output information, that comes directly out of reporting of the service itself so that it's useful from a client management standpoint and also as it's capturing that kind of data, for producing reporting and stuff like that, so you're not sucking up their time producing reports and outcomes instead of doing their service." "If you're not talking about software or hardware and how those things are going to meet your needs, you're wasting time and money. You're penny wise and pound foolish."

"We need to be looking at infrastructures for our allocation process. We need to look at what is it going to cost us to actually pay for the service but also what are the expanding needs for space, what are the expanding needs for equipment? We need to include that as part of our discussion for allocations. Unless you include that as part of training process, I think part of the problem is that the people in the process now are used to not having that be part of the plan and so they continue not to include it."

"A cost per unit system that has real life consequences if your staff aren't being efficient. It encourages people to be more efficient and effective in what they're doing because that's how they're going to make more money. It gives them more buying power for justifying additional increases in funding for those service providers who legitimately use up the money. It can be a litmus test of where you're at with a service category as to whether you meeting needs or not."

"Three things you can do to improve the services and improve the planning process. One, better integration of planning groups; raising the consortium as a partner in this and not as poor cousins. Two, encouraging and demanding that peer education resources come into the community and educating the PLWH's on why that's important and what steps they need....They need somebody that can put that across in terms that they can understand so they don't feel threatened or offended by it. Three, integration of the infrastructure both physical infrastructure in terms of actual office space and desks and all that kind of stuff in the allocation process and also software and hardware and information services into the allocation process as well. Looking at that from a realistic standpoint as to what we need to grow, in which service categories really need that the most, and having that in part of the Comprehensive Plan. Where was that as part of the Comp Plan?"

"We're in a real space bind right now. We need to plan for that. It might not be critical right now but why wait until it is critical? We should act proactively but nobody seems to be talking about it for some reason."

Interview Summary

In summary, the prevailing themes revealed through the interviews indicated that all of the interview participants said they had the utmost confidence in the staff to provide them with accurate information. The amount of information provided by the staff was thought to be adequate but some of the PLWHs thought it was slightly biased. Some participants stated that they thought there was too much information or it was too complicated, and they needed more time to review the data. When looking at HIV status and the experience level of the members, the data seem to indicate that the committee members with less experience were the ones who felt like the information was overwhelming.

Most of the people interviewed, both HIV-positive and HIV-negative individuals, said they placed the greatest weight on the facts and figures they were given rather than other factors such as their HIV status. PLWHs, however, indicated on the survey that his/her HIV status was an important factor saying they had a great deal of difficulty separating themselves from their personal experiences and feelings. It was the opinion of the staff that the committee members were easily swayed by one another and that they placed equal importance on both sources of information.

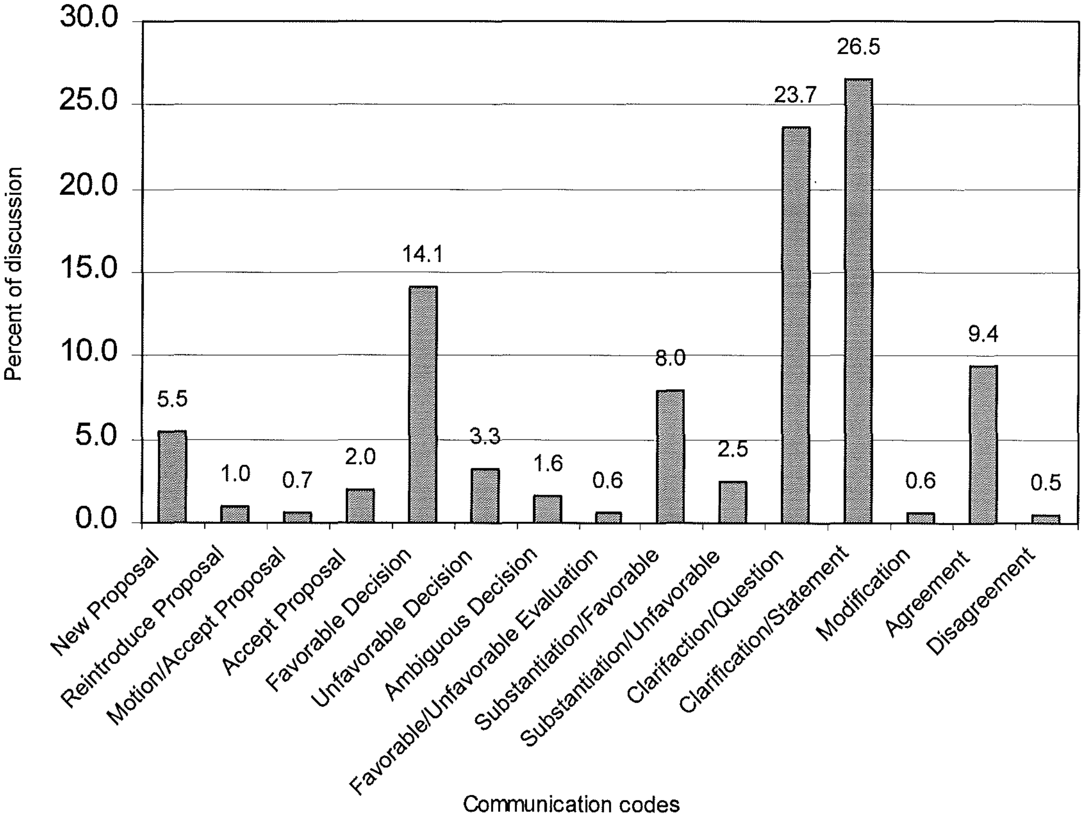
The participants stated that they believed they were empowered, treated equally, and given adequate opportunity to voice their opinions, yet, at the same time, they said they felt that some individuals who have been around a while or who work for provider agencies tend to influence others. It was the perception of most PLWHs that this was a provider-driven process, even though the non-PLWHs believed they were considering the needs of the clients as their number one priority.

One of the major issues was the lack of commitment and participation on the part of the PLWH's. Although there were five PLWHs on the committee (31%), it was perceived by the PLWHs that there were only three. Some participants stated that poor attendance issues need to be addressed and that all members of the Joint Committee and the PLWH community need to understand the importance of this process.

Interaction Analysis

After recording the codes for the communication during the meetings, the data were entered into the SDIS/GSEQ program to be analyzed (see Appendix B for a summary of the data). The type of communication that was used most frequently by the committee can be seen in Figure 10. As can be seen in Figure 10, the majority (50.2%) of the communication revolved around asking questions and making statements for the purpose of answering questions or clarification. The next most common types of communication (31.5%) were those related to agreement, followed by the introduction or

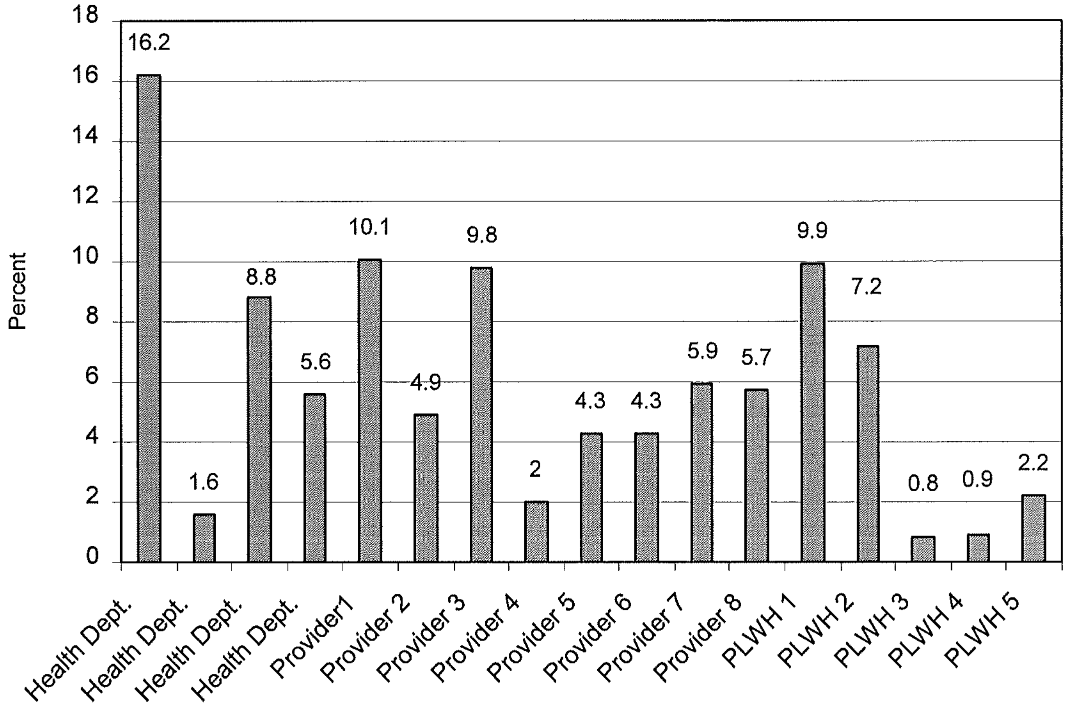
Figure 10. Percent of Communication by Type



re-introduction of a decision proposal. Very little communication was disagreement (0.5% and a minor portion of the communication (0.6%) was involved in modification of a proposal. The majority of the decisions were made by consensus.

Figure 11 shows who was involved in most of the communication over all four sessions, broken down by representation. The majority of the overall communication (34%) came from the staff and Joint Committee chair and dealt with procedural issues and instructions. This communication was excluded from Figure 11.

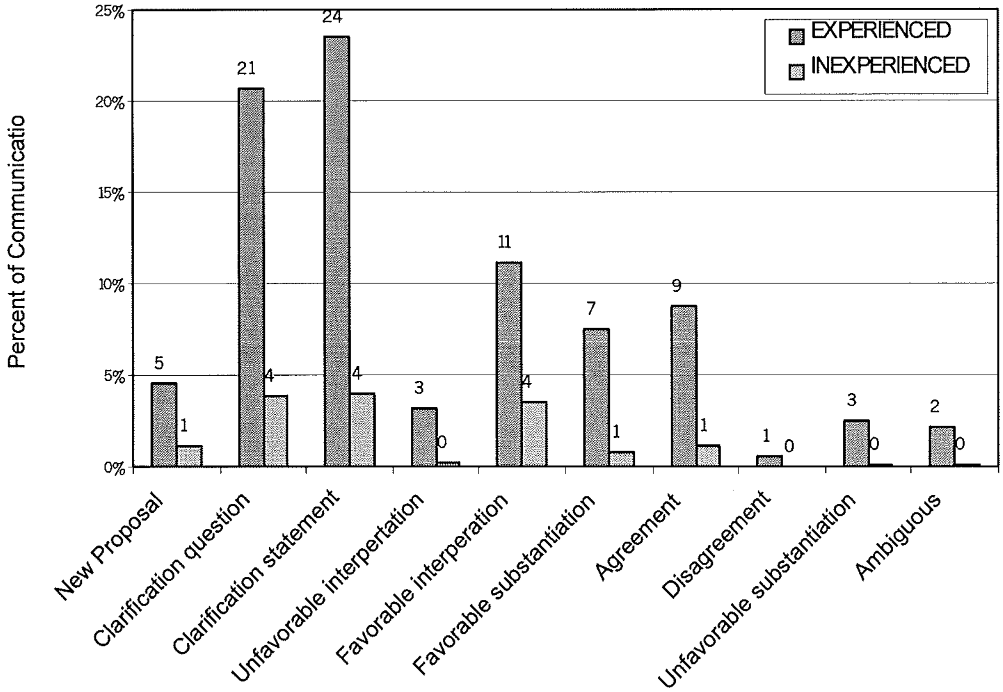
Figure 11. Percent of Communication by Member Representation.



The person who talked the most (taking up 16.2% of the discussion) during the four meetings was the committee chair, an employee of the Health Department. The other categories represented (providers and PLWHs) had a fairly even distribution of people who talked more or less than others. Considering the Health Department representatives as providers, it can be seen that the voice of the PLWHs were underrepresented on this committee, with the providers engaging in more than 80% of the discussion.

Figure 12 shows a comparison of the amount of communication between those members who have previous experience (more than two years) serving on the committee versus those who have less experience (less than two years).

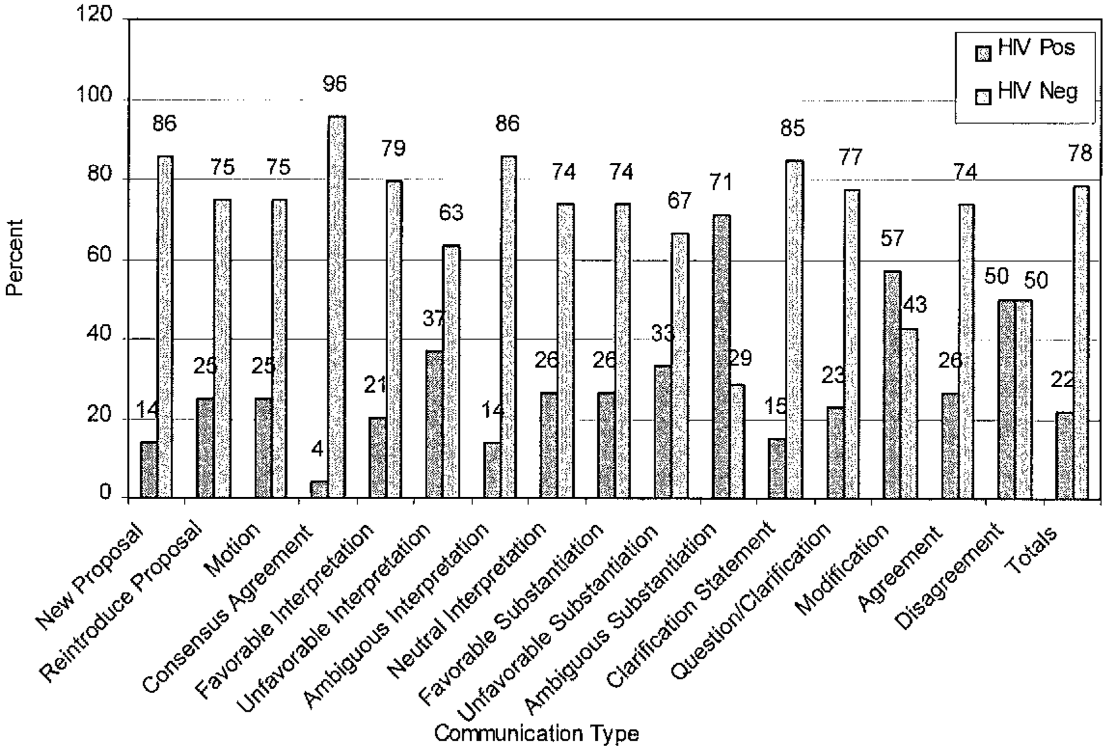
Figure 12. Comparison of Communication Interaction Experienced vs. Inexperienced Members.



It can be seen that those with more experience communicated more frequently than the less experienced members, particularly as the communication related to *clarification* issues. Following statements of clarification, the next most frequent type of communication used was *favorable responses* to members of the committee.

People living with HIV made up 31% of the Joint Committee, yet, as shown in Figure 13, their membership on the committee was not represented by their level of communication, which totaled only 22% overall. Areas that showed a higher level of communication for PLWHs were ambiguous statements and modification statements.

Figure 13. Percent of Communication by Category HIV Positive vs. HIV Negative.



Researcher Observations

Throughout all four of the meetings the Joint Committee attended, the researcher observed that, despite the cultural, professional and educational differences in the participants, a collegial atmosphere prevailed. The committee members treated each other with dignity and respect, even when they disagreed with one another. Most of the members have served on many other committees, representing their various agencies for several years and therefore have had time to develop a working relationship with one another. While all committee members were heard, it appeared that a greater deference was given to two groups of people -- the members who have been involved for several years and the PLWHs. For the most part, the newer members were much quieter than those who have been around for several years.

Of the four meetings, the second meeting was apparently the most significant. The purpose of the first meeting was to receive the information for the prioritization process prepared by the staff and set the ground rules for the process of the decision-making. The second meeting, discussed below, was for prioritizing the various services. The third meeting, which did not last very long, was to receive information regarding the upcoming allocation process, which was accomplished during the fourth meeting. The allocation of funding during the fourth meeting was based on the percentages of funding from the current fiscal year and on the priorities established during the second meeting.

The group began the process of prioritization in the second meeting by convening together briefly while the staff and committee chair went over last minute instructions. They were then separated into three different groups to develop a group-level list of priorities. The selection of who was to be in each group was determined by counting off around the room, consequently each member had an equal chance of being in any one of the three groups. As it happened, many of the most experienced and more vocal committee members ended up in one group, most of the least experienced, less vocal members ended up in another group, and the third group was a mixture of providers and PLWHs, who were both new and experienced in the process.

They met separately for approximately 45 minutes, during which time they were given a list of the services they had to prioritize, along with the priority list they had prioritized the previous year, and two lists of priorities from the needs assessment of the clients, one based on the focus groups, and one based on the surveys. The group with the most experience (Group A) moved very rapidly through the process, and was the only group to prioritize all service categories in the time allotted. There were some disagreements among the members, but they were able to talk through them and come to a consensus concerning the order of priorities in a short amount of time.

The group with the least experience (Group B) constantly requested a member of the staff to answer questions, clarify information and provide definitions. They spent time looking at and discussing epidemiological data and appeared to have difficulty knowing what information should be considered. In the absence of the more experienced people who were now in a separate group, a leader emerged in Group B. This person had been involved in the process several times, and had the respect of the Joint Committee members, but did not normally take on a leadership role in the overall group.

Group C was composed of a mixture of people. After spending about half of the allotted time chatting with each other and telling stories, they decided to get down to business. A more experienced provider attempted to place a more experienced PLWH in charge, but the PLWH claimed that s/he did not know what to do (even though this person has served on this committee before). There were two other PLWHs in this group, but neither wanted to take control. As a result, the provider took charge, and constantly asked the first PLWH what s/he would put next on the list of priorities. When an opinion was given, the group discussed it and came to a consensus. After doing this for the first five categories, they decided it would be more time efficient to have everyone write down what they would put for the next five, then they looked at the level of agreement between them. Those that had the most votes were written down as the next priority. If there were any disagreements, the category was discussed until they came to a consensus. During a later interview, the first PLWH said s/he felt empowered during the decision-making process, but did not feel that people listened.

After the allotted time was over, the three groups rejoined and determined a final priority list based on each group's individual lists. This was accomplished by taping the three lists on the wall for all to see. The committee went down the list and prioritized the categories based on the level of agreement for all three groups. Using the priority number from each list as a score, the committee was able to come to consensus fairly quickly. On categories that had a tied score, the group looked at the priorities from the needs assessment and current fiscal year as a basis for discussion.

An interesting finding during this process was that the PLWHs referred to the list of priorities that had been decided on last year for the current fiscal year as the "Providers List," and the list of priorities from needs assessment was referred to as the "Clients' List." Most providers, when looking at the needs assessment list, looked at the priorities derived from the surveys, while the PLWHs usually looked at the list derived from the focus groups.

Another interesting finding from the meetings was that the PLWHs had a tendency to want to prioritize service categories higher when they perceived a greater difficulty accessing that service. For example, one PLWH wanted to place transportation as the number one priority because "*we know they are going to give us medical care regardless, and we really need transportation.*"

During the fourth meeting, the committee was given a list of services in the priority order that had been established during the second meeting, along with the percentage of funding for the current fiscal year. Immediately after the meeting began, a motion was made to adopt those percentages for the upcoming fiscal year. After some discussion, it was decided to use the percentages as a base, from which further discussion would arise. Using the information regarding the utilization of services, anticipated cost increases and unmet need, the committee made some adjustments to the recorded percentages and came to a consensus relatively quickly.

Summary

In summary, the major findings from this study indicate that the participants use information provided to them as the most important sources of information on which they base their decisions. The information ranked the highest by committee members include the needs assessment, utilization of services by clients, epidemiological trends and the statewide coordinated statement of need. The surveys indicated that intrinsic factors, such as HIV status and the influence of other committee members were considered to be less influential. Findings from the interviews indicated that HIV status and the influence of others were more important factors than reported in the surveys, particularly among PLWHs. The influence of others, however, did not result in any significant differences between the average weight before the decision-making process and the weight after the process was completed, as reported on the surveys.

A greater difference was perceived between the staff members and the committee members concerning the amount of weight the committee members placed on the various factors. Those that were statistically different included other funding sources, unit cost, public hearings, what was done last year and personal experience. Statistical differences also existed between staff and the committee in their ranking of the needs assessment, epidemiological trends, public hearing responses and what was done last year.

Findings from the interviews indicate that the committee members had complete confidence in the staff to provide them with accurate and reliable information. Newer members of the committee felt that they needed more training in order to be adequately prepared for the decision-making process since it was perceived to be an overwhelming task to those unfamiliar with it. While PLWHs feel respected while serving on the committee, many feel that they are there as tokens, that it is a provider-driven process, and they do not feel completely empowered because they are not being listened to.

Findings from the interaction analysis component of the study indicate that the majority of the communication involved clarification, however, most of the communication was conducted by members who were providers. Most of the communication was also conducted by members with previous experience serving on the committee.

The researcher noted that the meetings were conducted in an atmosphere of congeniality, even when disagreements occurred. When separated into groups for the prioritization process, the group with the more experienced members was able to complete the task, while the group with the least experienced members floundered and were not able to complete the task in the allotted time. A difference existed between the perceptions of the PLWHs and the providers concerning the two needs assessment lists. The list generated through the focus groups appeared to be the one accepted by the PLWHs, while the list generated through the surveys appeared to be the one accepted by the providers.

CHAPTER 5

Conclusion

Some decisions are relatively easy to make, especially when it could be a matter of choosing between right or wrong, or between an item that costs more versus one that costs less. In a situation such as the Joint Committee prioritization and allocation process, however, the decisions are not always simple. There are multiple factors to consider, from the various needs of the clients to the diverse viewpoints of the different providers. The process of prioritization of services and allocation of funding to the service categories can make the difference in quality of life, or even between life and death for many individuals. When more money is allocated into one service category, it could mean that another category will have to make do with less. As the committee members come to the table to discuss the issues, they all have their own perspectives on what should be done to best serve the needs of the infected population.

The quantitative data and the qualitative data gathered in this study suggest that some significant differences existed between client priorities and Joint Committee priorities, and that some explicit and implicit factors came into play during the decision making process. This chapter discusses the findings in relation to the research questions that were mentioned in Chapter 1.

Question 1: Did changes occur in individual committee member prioritization of services at the beginning of the process as compared to the priorities the committee actually made at the end of the process?

While there were some differences between the average rank given by the individual members before the prioritization process began and the overall group rank after the process had been completed, the differences were not statistically significant. Therefore the hypothesis that a difference exists was not supported. This is further substantiated by a test for correlation between individual and group rankings, which indicate that 79% of the variation in group ranking can be explained by the variation in the average of the individual ranking. This is an indication that, for the most part, the Joint Committee members were rather knowledgeable before-hand as to what services were important to the clients, and this opinion did not change much during the discussion. The services that received a higher ranking after the process was over, alternative therapy, health education and risk reduction and private insurance assistance, were all categories that had been rated higher by clients in the recent needs assessment.

Question 2: What differences existed between the priority ranking of services given by consumers compared to the priority ranking given by the committee?

Since the committee decided that female medical care and specialty care belonged in the same category as primary medical care, the differences in ranking between these services will not be considered in this discussion. A significant difference existed between the ranking of the services by the clients, compared to the overall committee ranking. This difference was evidenced in the priority ranking lists and was also supported during the interviews. The clients were more concerned with services that were difficult to obtain (transportation), or those that made them feel better (alternative therapy) while the providers were more concerned with medical treatment. Another important difference between the priorities of providers and clients was that the providers recognized a greater need for mental health therapy and substance abuse treatment, both of which clients did not readily acknowledge a need for. The clients ranked health education and risk reduction much higher than the providers did, most likely because this category provides them with information regarding how to access services, which they feel is lacking in the current system. The hypothesis that a difference exists between client priorities and provider priorities was supported by the data. This difference was further substantiated by a test for correlation between client and group rankings, which indicated that only 44% of the variation in group ranking can be explained by the average of the client ranking.

Question 3: How much weight was given by the Joint Committee members to the various sources of information that were provided to the committee?

Both the surveys and the interviews indicated that the committee members placed greater weight on the facts and figures provided to them by the staff. The source of information that carried the most weight, according to the surveys, was the needs assessment, followed by the epidemiological data, client utilization of services, public hearings and their professional experience. This finding was supported during the interviews. Several participants mentioned the importance of the needs of the clients, client utilization of services and other data they were provided. Factors that were reported to carry less weight in the surveys included their race, their HIV status, their relationships with other committee members and the amount of time permitted for the process.

Concerning the question of which factors influenced the committee, there was a statistically significant difference in perceptions of the staff compared to the perceptions of the committee. The factors that the staff thought were important to the committee included client utilization of services, other funding sources, the statewide coordinated statement of need, their HIV status, what was done last year and the influence of others. A similar difference between staff and committee perceptions was present for other sources of information that were provided to the committee during the decision-making process. The committee claimed to place most of the weight on the inclusion of PLWH, definitions of services and a core continuum of care, whereas the staff believed the committee placed more weight on the inclusion of written procedures. The committee also claimed to place greater weight on gaps in service, needs in populations, the comprehensive plan and feedback from the providers, but the staff believed they placed significantly less weight on those factors. The hypothesis that a difference exists between the perceptions of the staff and those of the committee was supported.

For the most part, there is agreement between the staff and the committee on the most important pieces of information. Based on researcher observations, it appears that some factors, such as the inclusion of written procedures, were perceived by the staff to be important because the staff had spent a good deal of time preparing these materials, but they did not play a major part in the actual decision-making and, therefore, the committee did not weigh these as heavily as the staff did.

Question 4: What factors influenced the members of the Joint Committee as they went through the decision-making process?

Most of the people interviewed, both HIV-positive and HIV-negative individuals, initially said they placed the greatest weight on the facts and figures they were given rather than other factors such as their HIV status. This finding was supported by the survey responses. However, when given the opportunity to further discuss the influence of their HIV status on their decisions, PLWHs stated that their HIV status was a major influencing factor, while non-PLWHs said it was not. These findings, therefore, support the hypothesis that a difference exists between people living with HIV and those who are not.

In addition, as a result of engaging in the decision-making process, the committee changed the initial rank of some of the factors that they considered. Use of epidemiological data and what was done last year were thought to be significantly more important to the committee than they had originally anticipated.

Question 5: What implicit factors affected their decisions, such as their personal experiences, HIV status, and influence on one another?

Most of the people interviewed, both HIV-positive and HIV-negative individuals, said they placed the greatest weight on the facts and figures they were given rather than other factors such as their HIV status. These statements were supported to some degree by the survey responses. The test of between subject effects to determine whether there were any interactions between their HIV status and their pre-/post- decision responses on the survey indicated no statistically significant differences. One member, however, indicated on the survey that his/her HIV status was a very important factor and another member stated the same opinion during the interview. Kirchler and Davis (1986) researched whether the effect of group members' relative status affects their ability to exert group influence during group discussions. One PLWH's HIV status clearly became a factor during the second meeting when the committee broke into separate groups. In an effort to empower a PLWH, a provider attempted to give control to him/her. Those who are HIV-infected said they had a great deal of difficulty separating themselves from their personal experiences and feelings. The manner in which the participants said this implied that they thought there were something wrong with considering their personal feelings during this process, even though this is one of the reasons they were involved. PLWHs recognized that they have strong feelings based on their personal experiences, but they did not acknowledge that these feelings played an important part in this decision process.

Question 6: Did the members of the committee influence each other during the deliberation to the point where individual preferences changed, and if so, to what degree?

The data provided conflicting information regarding the committee members' influence over one another. All of the participants indicated that they felt they were treated equally and given adequate opportunity to voice their opinions. During an interview, one person stated that all the members come to the table to represent their own agency, and influence over one another is a normal process. Since they all have different perspectives, the influence they have over each other results in better decisions.

The participants stated that they believed they were empowered, treated equally, and given adequate opportunity to voice their opinions, yet, at the same time, they said they felt like some people tried to browbeat them. Some people thought that individuals who have been involved in the process longer or who work for provider agencies tended to influence others. An “us” versus “them” feeling seemed to exist. Twenty-seven percent felt that one or more members attempted to unduly influence them. It was the perception of most PLWHs that this was a provider-driven process, even though the non-PLWHs believed they were considering the needs of the clients as their number one priority.

It was hypothesized that the members of the Joint Committee would influence one another during the discussions to the extent that there would be a difference in the weight they anticipated they would give to the various factors (pre-decision) and the weight they gave after the decisions. The only decision-influencing factor that showed a significant difference before and after the process was the amount of time allowed for the process. Since this was independent of any influence from other members in the group, the hypothesis that the members influenced one another enough to change the weight they placed on the factors was not supported.

The original plan for the interaction analysis portion of the study included keeping track of the way committee members treated each other -- dominance, submission or equality. While observing the meetings, however, it was determined that despite the great differences between them, the members of the committee viewed and treated one another with respect and the recording of this behavior was discontinued. One possible explanation for this could be the amount of time that most of the committee members have been together. Cultural differences and social stratification have been found to be a barrier to group performance (Song & Parry, 1997), however, because many members have been associated with one another for a relatively long period of time, it appears that they have overcome the differences between them and are able to work well together. Most of them have developed a level of respect for one another to the point that their differences were not a major factor affecting their decision-making.

According to the Information Integration Theory groups have a tendency to make choice shifts as additional facts are presented to them (Kaplan, 1987). A choice shift did occur in some instances during the Joint Committee discussions, but not as frequently as might have been initially expected. One possible reason for this relates to the type of choices that the committee had to make. As previously mentioned, Gigone and Hastie (1997) suggest that discrete responses involve choices, whereas quantitative responses involve judgements. Categorical group decisions have a tendency to be made by consensus (Hinsz, 1990; Hinsz, et al., 1997), which was the case with the decisions conducted by the Joint Committee.

Question 7: Did the staff provide appropriate and sufficient information in order for the Committee to make decisions effectively, as perceived by the committee?

Regarding the information provided by the staff, 100% of the committee reported in the surveys that they felt that the information was adequate and appropriate. Some of these responses from the surveys were substantiated through interviews with the committee members and staff, but others also provided contradictory information. For example, a general theme from the interviews indicated that the amount of information provided by the staff was adequate. Some participants, however, stated that they thought there was too much information or it was too complicated. Several people said in the interviews that they thought the information needed to be simplified because it was overwhelming, and not all of it was needed. Several people said they needed more time to review the data, indicating that there was too much information to absorb for the amount of time allowed. Studies of decision-making (Slovic & Lichentein, 1971) contend that people have a limited capacity for processing information and, as a result, cope poorly with complex decision problems. When looking at the experience level of the members, the data seemed to indicate that the committee members with less experience were the ones who felt like the information was overwhelming. In light of this, a need to break the information down into simpler, more manageable components is indicated.

One factor that was not asked directly on the surveys, but was discussed during the interviews by some participants, was the influence of the staff. Staff members do not get directly involved in the decisions of the committee, however there are key staff members for Title I and Title II who provide all of the information on which the committee bases its decisions. The staff, therefore, serve as gatekeepers of the information. The committee relies heavily on the staff to provide accurate, up-to-date information. All of the interview participants said they had the utmost confidence in the staff to provide them with accurate information. In addition to serving as a gatekeeper, the same staff serve as boundary spanners. Information flows between the administrative agency and the agencies providing services by way of the key staff. It would be very difficult to determine whether the information provided to the committee or service provider agencies was biased in any way, missing or inaccurate. It is imperative to the success of the overall program, therefore, that the administrative staff be trustworthy and competent.

Question 8: Did Committee members believe they received adequate training and mentoring in order to participate effectively in the decision process?

Overall, more providers were represented on the committee than PLWHs, leading to the perception that this was a provider-driven process. People Living With HIV made up 31% of the Joint Committee, but their membership on the committee was not represented by their level of communication. Areas that showed a higher level of communication for PLWHs were ambiguous statements and modification statements. When analyzing the amount of communication, two members from the Health Department, two from provider agencies and two PLWHs engaged in most of the discussion throughout the process. These six more vocal members had been serving on the committee for a longer period of time than the other less talkative members, which supports the idea that experience and training serve to empower the committee members, facilitating participation in the communication process. One PLWH said during the interview that s/he usually did not say much in the meetings and remained quiet most of the time. When analyzing the amount of time this individual spoke, it was interesting to discover that s/he actually talked more than most people on the committee. While this person did feel like s/he was given an adequate opportunity to talk, s/he did not necessarily feel empowered. The same person indicated that others did not listen to him/her. When making suggestions during the discussion, the people in the group listened to him/her, but did not always vote in the same way. Part of the reason for this occurrence may be explained by the Social Judgement Scheme (Davis, 1996), which indicates that if a person's preference is centralized s/he will be able to exert more influence on the others than will a person who has an extreme preference. In this case, the PLWH's preferences tended to be more extreme than the those of the group.

The chairman of the committee and the staff talked the most during the whole process, and the major purpose of these interactions was for providing information or instructions, or to answer questions in order to make clarifications, re-emphasizing the need to maintain trustworthy administrative staff to provide the information. These results indicate a need for greater involvement of PLWHs who are committed, trained and empowered. One of the major issues that was brought up, particularly in the interviews, was the lack of commitment and participation on the part of the PLWH's. Although there were five PLWHs on the committee (31%), it was perceived by the PLWHs that there was only three. One reason for this is that they had irregular attendance, but this was true for PLWHs as much as it was true for the non-PLWHs. As a general rule attendance was a problem, with only 44% of the members attending all four meetings. As has already been mentioned, the Ladder of Participation as described by Arnstein (1969), indicates that when citizens perceive that they are being manipulated by others, or feel a lack of control in the process, it leads to a lack of participation. They need to feel that they are an intricate part of the process and what they say does make a difference. Without this feeling of empowerment, it is likely that they will participate even less in the future than they do now.

Practical Applications

Using both qualitative and quantitative methods of data collection enabled the researcher to gain insights that would not have been revealed using only one method. In many instances, the data obtained from the surveys conflicted with the interviews, and the interaction analysis revealed additional insights that would not have been possible otherwise. One of the unforseen findings exposed during this study was the efficiency of the group and expedience with which they came to consensus. During the interviews the participants indicated a high level of satisfaction concerning the outcome of the decision-making process. A possible reason for this was that most of the members have been involved in this process previously and have developed congenial relationships with each other. All members had access to the same information, potentially putting them on an equitable status, as far as knowledge level was concerned. The committee finished the decision-making process within the time constraints, without the need to call for additional meetings and without the need to request additional information.

Another unforseen finding was the claim by both PLWHs and non-PLWHs that their HIV status was not a major factor that influenced their decisions. Every respondent to the surveys, except one, said HIV status carried little weight. In contrast, the findings of the interviews indicated that HIV status was very important. One person began saying that HIV status was not a major factor, but changed this view as s/he answered the question. The findings from the interaction analysis demonstrated that the PLWHs were underrepresented in the frequency of their communication as compared to non-PLWHs, which could possibly indicate that the PLWHs feel less empowered.

In light of the findings, the following recommendations are suggested:

1. A greater effort needs to go into recruiting more PLWHs for this process so that their viewpoints will be heard and the representation more balanced. Everyone needs to be made more aware of the importance of the difference in perception among PLWHs and non-PLWHs. While the non-PLWHs perceive that the PLWHs are empowered, the PLWHs do not have this same perception. The mere presence of a person on a committee does not necessarily lead him/her to feel empowered.
2. A greater effort needs to go into training and mentoring the new people, whether they are PLWHs or not, since it is the newer members who feel less comfortable with the process and do not feel that they know what is expected of them. PLWHs are not getting paid to be a part of this process, unlike the providers, so unless they are motivated to help other PLWHs, they have no incentive to participate. The training process needs to address the importance of commitment to participation, and the benefits that can be gained, both to the committee and the PLWHs as individuals. The training should also be focused on empowering PLWHs and people who are new to the process.
3. The Planning Council and Consortium should consider conducting more business on a joint basis. Several comments referred to the fact that the same people are going to several meetings to discuss the same things, and they are getting tired of the redundancy. It will be difficult to recruit and keep PLWHs committed to the planning process if they are burned out. The likelihood of burnout increases

when participants are dealing with an illness, and this burden could possibly be eased by having fewer meeting responsibilities.

4. The importance of the influence of the staff needs to be recognized. Staff members serve as gatekeepers of the information provided to the decision-makers and therefore have the potential to influence the decisions. The success of the Ryan White program depends largely on retaining competent staff members who are trustworthy and reliable.

Suggestions for Further Research

Because this study was conducted as a case study of the Jacksonville EMA, and only a small number of participants were included, it would be advisable to conduct the study in other cities to determine whether similar findings can be found in other locations. It was recommended that PLWHs receive training before they begin the prioritization and allocation process. A study should be conducted to determine what their training needs are in order to develop a curriculum that is culturally sensitive and informationally sound, and to determine the best way to meet those needs.

There is a nationwide wide trend, encouraged by HRSA, to combine HIV planning bodies. Cities that have combined planning bodies claim that they have done so in an effort to reduce duplication and redundancy, and to prevent some of the burnout that has occurred in many places. The suggestion that this be done in Jacksonville was brought up by at least three different people during the interviews, because it was viewed as a way to bring about improvements in the system. It is recommended that research be conducted in the cities who have already implemented a joint planning process to determine whether this change has improved the efficiency of the decision process and the participation of PLWHs.

Keeping record of the interaction codes turned out to be one of the more difficult tasks in the study. Attempting to decipher an utterance, classify it according to the coding system and write it down, while at the same time trying to listen to the next speaker was sometimes a very challenging task, particularly when a lively discussion occurred with several people talking at the same time. Even with a tape recorder, coding responses accurately was very time consuming. Despite the initial difficulties encountered with the interaction analysis process, additional quantitative data were produced that supported and strengthened the data obtained from the other methods. Additional research on group decisions may benefit from the use of the interaction analysis methodology, however, it is recommended that the use of this method be limited to smaller groups.

Implications

The findings from this study have important implications to the Jacksonville EMA because they suggest areas that need improvement in the prioritization and allocation process. These findings also have application to all other health planning bodies who are involved in collaborative community planning. With the number of HIV/AIDS infections continuing to increase, the cost of treatment will continue to escalate, and more lives will be affected by this disease. To assure that Ryan White CARE Act funding is efficiently distributed and that quality care is accessible, greater emphasis should be placed on the inclusion and training of People Living With HIV in the decisions affecting them. There is a continuing need to research ways to improve the processes and policies to keep up with the changes associated with HIV/AIDS in order to improve the lives of those affected by this disease.

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APPENDIX A

COVER LETTERS AND SURVEY

1. Cover letters which accompanied the survey

2. The attached survey was filled out by each committee member. Before the decision making process, the survey was worded in the future tense, and after the decision-making process it was in the past tense.

Appendix A 1. Cover letters which accompanied the survey

TO: All Joint Prioritization and Allocation Committee Members

FROM: Andrea Davis

SUBJECT: Survey

DATE: June 5, 2000

As mentioned in the first Joint Committee meeting on June 1st, I am asking all members who are participating in the decision-making study to fill out a survey. In an effort to avoid taking up extra meeting time for you to fill out the survey I am mailing it to you ahead of time. I would appreciate it if you would take a few minutes to fill out the enclosed survey and bring it with you to the next meeting on June 13th. If for some reason you cannot come to the next meeting, I would appreciate it if you would mail it back to me by June 13th to: Andrea Davis, Suite 400 A, 900 University Blvd. N., Jacksonville, Fl 32211. To avoid someone else opening the envelope please mark "Confidential" on the envelope.

If you have questions regarding the survey, please feel free to call me at 743-0740.

I *really* appreciate your participation!

TO: All Joint Prioritization and Allocation Committee Members

FROM: Andrea Davis

SUBJECT: Survey

DATE: June 23, 2000

Now that the prioritization process is over I would like to ask you to fill out the enclosed survey. The purpose of this survey is to determine whether there are any differences in the factors you anticipated would influence you and those that actually influenced you. Again, I am mailing it to you ahead of time in an effort to avoid taking up extra meeting time. I would appreciate it if you would bring it with you to the next meeting on June 29th. If for some reason you cannot come to the next meeting, I would appreciate it if you would mail it back to me by June 29th to: Andrea Davis, Suite 400A, 900 University Blvd. N., Jacksonville, Fl 32211. To avoid someone else opening the envelope please mark "Confidential" on the envelope.

It is very important that all of you who agreed to participate will respond to this. If I only get half of the surveys back, my data will be incomplete and lose its validity, therefore I *really* appreciate your participation - I will provide more cookies if that will encourage you to fill it out. (After this survey, I will only have one more for you to fill out, after the allocation process).

If you have questions regarding the survey, please feel free to call me at 743-0740.

Thank you so much!

Appendix A 2.

SURVEY INSTRUMENT

The attached survey was filled out by each committee member. Before the decision making process, the survey was worded in the future tense, and after the decision-making process it was in the past tense.

To maintain confidentiality your name will not be used. Please select any 4-digit number that you will remember and write it on the line to serve as your ID code:_______________

PRIORITIZATION/RANKING OF SERVICES: Listed below are the services that the Ryan White program funds. As a member of the Joint Committee, you will be asked to rank these during the decision-making process. Please rank them in the order which you, as an individual, consider the clients? greatest needs are, with #1 being the greatest need (therefore having the greatest priority) and 24 as the lowest priority.

Service	**Rank**
Primary Medical Care from a Doctor or Nurse	
Dental Care	
Case Management (Someone who helps you get services)	
Prescription medicines/pharmaceuticals	
Treatment for Drug/Alcohol use	
Consumable Medical Supplies (Bandages, syringes)	
Alternative Therapies (Massage, acupuncture, pain management)	
Counseling (Other than mental health)	
Specialty Care (care for skin, female care, hearing and/or eye care)	
Private Health Insurance Payment Assistance	
Adoption/Foster Care Planning	
Day Respite (Adult Day Care)	
Child Care	
Food Bank/Home Delivered Meals	
Buddy/Home Companion Services	
Advocacy – Legal Assistance	
Hospice (Doctor or nursing care for terminally ill patient)	
Assistance with Transportation to HIV related services	
Assistance with Housing	
Durable Medical Supplies (crutches, wheel chair, etc.)	
Home Health Care	
Mental Health Therapy/Counseling	
Medical care for Female conditions (Prenatal/Pregnancy, Pap)	
Information & Referral	

POSSIBLE FACTORS INFLUENCING YOUR DECISIONS :The list in the middle of the page below, contains several factors that might influence you as you make your decisions on the prioritization and allocation of resources. Please weight and rank them according to the following instructions:

Weight:
On a scale of 1-3, with 1 being little or none, 2 being somewhat and 3 being a significant amount, please circle how much weight you think you will place on the following possible factors as you make your decisions.

Rank
Rank the factors listed below in order (1-15) compared to the other factors listed, with 1 being the most important factor and 15 being the least important factor. Place your answer on the line below.

Weight (Circle your answer below)			**Possible factor**	**Rank (1-15) below:**
None/Little	**Somewhat**	**Significant**		
1	2	3	Needs assessment	
1	2	3	Epidemiological trends of the disease	
1	2	3	Utilization of services by clients	
1	2	3	Other funding streams	
1	2	3	Statewide coordinated statement of need	
1	2	3	Unit cost by service category	
1	2	3	Public hearing responses	
1	2	3	Your professional experience	
1	2	3	What was done last year	
1	2	3	Your race	
1	2	3	Your HIV status	
1	2	3	Your personal experience	
1	2	3	Your relationships with other committee members	
1	2	3	Amount of time allowed for the process	
1	2	3	Influence of one or more members on you	
			Additional factors not listed above: (specify)	
1	2	3		

The list below contains several factors that might be considered as you make your decisions on the prioritization and allocation of resources. Please circle the extent to which you think you will include the following:

	None /Little	Somewhat	Significant	Comments
A clearly written procedure for the decision process	1	2	3	
Representatives of the underserved population	1	2	3	
People Living With HIV/AIDS	1	2	3	
Proposed list of service categories, including definitions	1	2	3	
Core continuum of care	1	2	3	
Rules regarding level of agreement required	1	2	3	
(Consensus, majority, 2/3 majority)				
Management of conflict of interest	1	2	3	

To what extent do you think the priorities committee will use the following information:

	None /Little	Somewhat	Significant	Comments
Gaps in availability of service	1	2	3	
Needs of populations/sub-populations	1	2	3	
Accessibility of services within geographic areas	1	2	3	
Comprehensive plan	1	2	3	
Perspectives of PLWH	1	2	3	
Feedback from public	1	2	3	
Feedback from providers	1	2	3	

To what extent do you think the allocation committee will use the following information:

	None /Little	Somewhat	Significant	Comments
Other sources of funding	1	2	3	
Whether identified needs will be met	1	2	3	
The CARE Act is considered the payer of last resort	1	2	3	
Zero-based budgeting approach	1	2	3	
(not based on last year?s allocations)				
Review of allocations from previous years	1	2	3	
Percentage of infants, children and women in the EMA	1	2	3	
Information regarding cost effectiveness	1	2	3	
Information regarding outcome effectiveness	1	2	3	

What other factors, not listed above, should be considered when making your decisions concerning the prioritization of services and allocation of funding?

Please circle the appropriate answers to the following questions and feel free to make additional comments below or on the back of this page.

Do you feel that you will be given an adequate opportunity to voice your opinion? Yes No

Do you feel you will be treated equally while serving on this committee? Yes No

Do you think one or more members of this committee will attempt to unduly influence you in the decision-making process? Yes No

Comments:

The following information is being collected for demographic purposes only, and will be aggregated. Information that might cause you to be identified will be coded to protect your identity.

Please circle/fill in the appropriate response:

1. **Sex:** _____Male _____Female

2. **Age** _____

3. Race/Ethnic background ______________________

4. **HIV status** _____Positive _____Negative _____Don't know

5. Which of the following categories would apply to you:

   a. Provider b. Affected c. Infected (PLWH) d. Staff e. Other (specify)

6. In what capacity do you serve on this committee (Check all that apply):

Member of:	For how long:
Title I Planning Council _____	_____
Title II Consortium _____	_____
Title III Representative _____	_____
Title V Representative _____	_____
Other (specify) _______________	_____

7. How many times have you served on the Joint Prioritization & Allocation Committee?

8. Have you received any training to serve on this committee? Yes No

9. Do you consider such training to be:

Not necessary Somewhat helpful Very helpful Essential

10. I feel like I know what I am supposed to be doing and what is expected of me as I serve on this committee. ______Agree _______Somewhat ______Disagree

Once the decision-making process was completed, the following questions were added to the survey:

Regarding the information you were provided in order to make decisions concerning the **prioritization** of services, do you feel the information was

(A) adequate (B) inadequate

(A) appropriate (B) inappropriate

What would you like to change to improve the process ?

Regarding the information you were provided in order to make decisions concerning the **allocation** of funding, do you feel the information was

(A) adequate (B) inadequate

(A) appropriate (B) inappropriate

What would you like to change to improve the process ?

APPENDIX B

Summary of Data Collected

for Interaction Analysis

Interaction Analysis Summary of Data

Session 1 Pre-Prioritization Information

Code	O	D	P	M	C	1F	1U	1AB	1N	2F	2U	2AB	3	3S	3Q	4	5	6	Total
1	2	0	8	0	0	3	0	0	0	7	0	1	0	21	4	0	5	0	51
S1	1	2	2	0	0	3	0	0	0	5	0	0	1	16	3	0	7	0	40
14	0	0	0	0	0	2	0	0	1	6	2	0	0	5	13	1	3	0	33
3	0	0	0	1	0	7	1	0	0	8	0	0	0	5	4	1	5	0	32
10	1	0	0	1	0	1	0	0	1	3	1	0	0	1	0	0	3	0	12
7	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	0	0	0	3
16	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	1	0	4
11	0	0	0	0	0	0	0	0	1	4	0	0	0	9	9	0	5	0	28
5	0	0	0	0	0	1	1	0	0	2	0	0	0	0	0	0	1	0	5
4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	2
8	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	2
S2	0	0	0	0	0	1	2	0	0	1	1	0	0	14	5	1	0	0	25
15	0	0	0	0	0	1	0	0	0	4	0	0	0	3	0	0	0	0	8
13	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	4	2	12	2	0	20	4	0	3	42	4	1	1	76	43	3	30	0	247

Session 2 Prioritization Process Group A

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
1	8	0	17	2	13	10	2	2	1	2	1	0	0	24	37	0	6	0	125
10	5	0	0	0	0	10	7	0	0	13	1	5	0	14	9	0	8	0	72
8	4	0	0	0	0	10	2	0	0	5	0	1	0	9	9	0	6	0	46
13	8	0	0	0	1	12	6	1	1	6	3	0	0	8	7	0	15	0	68
17	2	0	0	1	2	13	5	1	0	6	11	0	0	32	9	0	10	1	93
Total	27	0	17	3	16	55	22	4	2	32	16	6	0	90	71	0	45	1	407

Session 2 Prioritization Process Group B

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
7	5	2	1	0	0	12	0	0	0	3	0	0	0	6	18	0	1	0	48
5	2	2	0	0	0	3	0	0	0	3	0	0	0	4	11	0	4	0	29
4	0	0	0	0	0	6	0	0	0	0	0	0	0	2	2	0	1	0	11
S2	0	0	0	0	0	1	0	0	0	0	0	0	0	3	1	0	0	0	5
13	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	2
2	0	1	0	0	0	3	0	0	0	1	0	0	0	1	2	0	1	0	9
12	2	2	0	0	0	4	0	0	0	0	1	0	0	5	4	0	3	0	21
Total	9	7	1	0	0	31	0	0	0	7	1	0	0	23	39	0	10	0	127

Session 2 Prioritization Process Group C

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
14	1	0	2	0	0	3	7	1	3	2	5	0	0	5	21	3	8	3	64
3	2	2	3	0	0	11	1	1	3	1	1	0	0	16	18	0	3	0	62
11	3	0	1	0	0	3	1	0	0	6	1	0	0	11	7	0	3	1	37
S2	0	1	0	0	0	0	1	0	0	0	0	0	0	14	1	0	0	0	17
15	2	1	1	0	0	5	1	0	2	1	0	0	0	11	3	1	5	1	34
6	3	1	2	0	0	8	0	0	4	4	0	0	0	13	14	1	1	0	51
9	0	0	0	0	0	4	0	0	0	0	0	0	0	3	1	0	1	0	9
Total	11	5	9	0	0	34	11	2	12	14	7	0	0	74	65	5	21	5	274

Session 2 Prioritization Process Overall Group Prioritization

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
1	1	0	6	0	0	4	1	0	0	0	0	0	0	6	2	0	1	0	21
S1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	4	0	0	0	0	0	0	0	2	2	0	0	0	8
3	0	0	0	0	2	3	0	0	1	1	1	0	0	6	1	0	0	0	15
10	0	0	0	1	1	1	0	0	0	0	0	0	0	1	1	0	1	0	6
7	1	0	1	0	0	3	0	0	0	0	0	0	0	2	1	0	0	0	8
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	10	0	0	0	2	5	2	1	0	1	1	0	0	5	7	0	6	0	40
5	1	1	0	0	1	2	1	0	1	0	1	0	0	2	4	0	0	0	14
4	1	0	0	0	0	5	1	0	0	0	0	0	0	2	1	0	1	0	11
8	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
S2	5	0	2	0	2	3	1	0	0	3	1	0	0	21	7	0	2	0	47
15	0	0	0	0	1	2	0	0	0	1	0	0	0	1	0	0	0	0	5
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	3	0	0	0	1	0	0	0	6	0	0	0	0	10
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	1	0	0	0	0	2	0	0	0	4	4	0	0	0	11
2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	19	1	9	1	10	35	6	1	2	9	4	0	0	60	30	0	11	0	198

Pre-Allocation Information

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
1	0	0	5	0	0	0	0	0	0	0	0	0	0	4	4	0	0	0	13
S1	0	0	14	0	0	1	0	0	0	1	0	0	0	16	6	0	1	0	39
14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
3	0	0	0	0	0	1	0	0	0	0	0	0	0	3	4	0	0	0	8
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	1	0	0	0	0	0	0	0	10	1	0	0	0	12
11	0	0	0	0	0	0	0	0	0	0	0	0	0	2	4	0	0	0	6
5	0	0	0	0	0	0	0	0	0	0	0	0	0	5	6	0	0	0	11
4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3
S2	0	0	0	0	0	0	0	0	0	1	0	0	0	13	1	0	2	0	17
15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	19	0	0	3	0	0	0	2	0	0	0	53	31	0	3	0	111

Pre-Allocation Information

Code	O	D	P	M	C	1F	1U	1AB	1AN	2F	2U	2AB	3	3S	3Q	4	5	6	Total
1	0	0	4	0	0	0	0	0	0	0	0	0	0	12	5	0	2	0	23
S1	0	0	1	0	1	0	0	0	0	0	0	0	0	11	8	0	2	0	23

14	0	0	0	0	0	0	0	0	0	0	0	0	0	4	8	0	1	0	13
3	0	0	0	1	0	0	0	0	0	0	0	0	0	4	1	0	0	0	6
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
16	0	0	1	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	4
11	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
5	1	0	0	1	0	0	0	0	0	0	0	0	0	3	0	0	1	0	6
4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	1	0	8
15	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	0	0	5
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Total	1	0	6	2	1	0	0	0	0	0	0	0	0	58	34	0	7	0	109

Allocation Process

Code	**O**	**D**	**P**	**M**	**C**	**1F**	**1U**	**1AB**	**1AN**	**2F**	**2U**	**2AB**	**3**	**3S**	**3Q**	**4**	**5**	**6**	**Total**
1	0	0	4	0	0	0	0	0	0	0	0	0	0	12	5	0	2	0	23
S1	0	0	1	0	1	0	0	0	0	0	0	0	0	11	8	0	2	0	23
14	0	0	0	0	0	0	0	0	0	0	0	0	0	4	8	0	1	0	13
3	0	0	0	1	0	0	0	0	0	0	0	0	0	4	1	0	0	0	6
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
16	0	0	1	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	4
11	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
5	1	0	0	1	0	0	0	0	0	0	0	0	0	3	0	0	1	0	6
4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S2	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	1	0	8
15	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	0	0	5
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Totals	1	0	6	2	1	0	0	0	0	0	0	0	0	58	34	0	7	0	109

APPENDIX C

Interview Questions

A purposeful sample from the joint committee was asked to participate in an individual interview after the decisions were made. An effort was made to select members from the committee who represented various groups, such as PLWHs, black, white, health professional, staff, etc. The interview lasted approximately 45 minutes to an hour. The following questions were asked with reference to the decision-making process.

Interview Questions:

Was the information provided to you by the Ryan White staff adequate for you to make decisions concerning the prioritization of services and allocation of funding? What did you find the most useful? Why? Would you change anything about this? (Amount, type, format, etc)

How much confidence do you have in the information you were provided by the staff?

How much weight do you think you placed on the information you were given, compared to how much you were influenced by other factors such as other members of the committee, your personal experience, your job, your HIV status, etc?

Were your decisions influenced by another person's professional position or power (personality)? If so, how?

To what degree did you consider the needs assessment/feedback from PLWHs and members of the community compared to other sources of information?

Do you think committee members from the community (specifically PLWHs), who are not working for a health related organization, felt that they were receiving sufficient training and mentoring in order to be effectively involved in the process?

Do you think that individual committee members felt empowered, equal, and respected enough to participate fully in the discussion of the group as decisions are made? (First answer for yourself, then what you think others on the committee would say).

APPENDIX D

Statistical Tables

for Survey Data

Paired Samples Test for Figure 7 on p. 77

	Committee Pre-decision vs. Post-decision	t	df	Sig. (2-tailed)
Pair 1	Needs Assessment - NEEDS2	-.361	9	.726
Pair 2	Epidemiological Trends - EPI2	1.406	9	.193
Pair 3	Utilization of services by clients - UTILIZE2	.000	9	1.000
Pair 4	Other Funding streams - OTHER2	1.000	9	.343
Pair 5	Statewide Coordinated Statement of Need - STATEWI2	.361	9	.726
Pair 6	Unit Cost by Service Category - UNITCOS2	.000	9	1.000
Pair 7	Public Hearing Responses - PUBLIC2	-.361	9	.726
Pair 8	Your Professional Experience - PROFESS2	.818	9	.434
Pair 9	What was done Last Year - LASTYER2	-.688	9	.509
Pair 10	Your Race - RACE2	1.000	9	.343
Pair 12	Your Personal Experience - PERSONA2	1.000	9	.343
Pair 13	Your Relationships with other Committee Members - RELAT2	.557	9	.591
Pair 14	Amount of Time allowed for the Process - AMOUNT2	3.280	9	.010*
Pair 15	Influence of one or more members on you - INFLUEN2	-.557	9	.591

* Indicates significance at the $p = 0.05$ level.

Independent Samples Test for Figure 7 on p. 77

	Committee Post-decision vs. Staff	F	Sig.	t	df	Sig. (2-tailed)
NEEDS2	Equal variances assumed	.441	.520	.599	11	.561
	Equal variances not assumed			.438	1.164	.729
EPI2	Equal variances assumed	.110	.747	1.973	11	.074
	Equal variances not assumed			1.931	1.369	.248
UTILIZE2	Equal variances assumed	1.862	.200	-.575	11	.577
	Equal variances not assumed			-1.399	10.000	.192
OTHER2	Equal variances assumed	3.785	.078	-1.487	11	.165
	Equal variances not assumed			-3.614	10.000	.005
STATEWI2	Equal variances assumed	5.104	.047	-.801	10	.442
	Equal variances not assumed			-1.861	9.000	.096
UNITCOS2	Equal variances assumed	7.211	.021	1.288	11	.224
	Equal variances not assumed			3.130	10.000	.011
PUBLIC2	Equal variances assumed	21.060	.001	1.721	11	.113
	Equal variances not assumed			4.183	10.000	.002
PROFESS2	Equal variances assumed	2.031	.182	.000	11	1.000
	Equal variances not assumed			.000	10.000	1.000
LASTYER2	Equal variances assumed	2.565	.138	-1.851	11	.091
	Equal variances not assumed			-4.500	10.000	.001
RACE2	Equal variances assumed	.	.	-3.051	11	.011
	Equal variances not assumed			-1.000	1.000	.500
HIVSTAT2	Equal variances assumed	.252	.626	-1.678	11	.122
	Equal variances not assumed			-1.874	1.540	.238
PERSONA2	Equal variances assumed	5.925	.033	-2.209	11	.049
	Equal variances not assumed			-5.369	10.000	.000
RELAT2	Equal variances assumed	15.031	.003	-1.534	11	.153
	Equal variances not assumed			-.720	1.040	.599
AMOUNT2	Equal variances assumed	.136	.719	-.337	11	.742
	Equal variances not assumed			-.261	1.193	.832
INFLUEN2	Equal variances assumed	.011	.920	-2.183	11	.052
	Equal variances not assumed			-2.105	1.354	.227

Paired Samples Test for Figure 8 on p. 79

	Committee Pre-decision vs. Post-decision	t	df	Sig. (2-tailed)
Pair 1	Written procedure - VAR00001	.000	10	1.000
Pair 2	Reps from underserved - VAR00003	2.236	9	.052
Pair 3	PLWA - VAR00004	1.491	10	.167
Pair 4	Definitions - VAR00005	.000	9	1.000
Pair 5	Continuum of care - VAR00006	-.429	9	.678
Pair 6	Rules - VAR00007	.363	10	.724
Pair 7	Conflict of interest - VAR00008	.559	10	.588

Independent Samples Test for Figure 8 on p. 79

	Committee Post-decision vs. Staff	F	Sig	t	df	Sig.(2-tailed)
WRITTEN2	Equal variances assumed	7.918	.017	-1.082	11	.302
	Equal variances not assumed			-2.631	10.000	.025
UNDER2	Equal variances assumed	5.957	.033	1.082	11	.302
	Equal variances not assumed			2.631	10.000	.025
PLWA2	Equal variances assumed	2.487	.143	2.760	11	.019
	Equal variances not assumed			6.708	10.000	.000
DEFINI2	Equal variances assumed	15.031	.003	1.534	11	.153
	Equal variances not assumed			.720	1.040	.599
CONTINU2	Equal variances assumed	21.060	.001	-.983	11	.347
	Equal variances not assumed			-2.390	10.000	.038
RULES2	Equal variances assumed	.014	.908	-.846	11	.415
	Equal variances not assumed			-.906	1.477	.488
CONFLIC2	Equal variances assumed	.014	.908	-.846	11	.415
	Equal variances not assumed			-.906	1.477	.488

Paired Samples Test for Figure 9 on p. 81

	Committee Pre-decision vs. Post-decision	t	df	Sig. (2-tailed)
Pair 8	Gaps in service - VAR00009	1.000	9	.343
Pair 9	Needs of populations - VAR00010	1.000	9	.343
Pair 10	Accessibility - VAR00011	1.152	9	.279
Pair 11	Comprehensive plan - VAR00012	.426	8	.681
Pair 12	Perspectives of plwa - VAR00013	.557	9	.591
Pair 13	Feedback from public - VAR00014	.000	9	1.000
Pair 14	Feedback from providers - VAR00015	-.802	9	.443

Independent Samples Test for Figure 9 on p. 81

	Committee Post-decision vs. Staff	F	Sig	t	df	Sig.(2-tailed)
GAPS2	Equal variances assumed	203.077	.000	1.188	11	.260
	Equal variances not assumed			2.887	10.000	.016
POP2	Equal variances assumed	1.862	.200	3.644	11	.004
	Equal variances not assumed			8.859	10.000	.000
ACCES2	Equal variances assumed	1.274	.283	1.132	11	.282
	Equal variances not assumed			1.357	1.669	.329
PLAN2	Equal variances assumed	2.138	.174	3.428	10	.006
	Equal variances not assumed			7.965	9.000	.000
PERSPE2	Equal variances assumed	.202	.662	-.086	11	.933
	Equal variances not assumed			-.084	1.369	.944
FEED2	Equal variances assumed	.352	.565	1.290	11	.224
	Equal variances not assumed			1.396	1.493	.334
PROVID2	Equal variances assumed	21.060	.001	1.721	11	.113
	Equal variances not assumed			4.183	10.000	.002

Tests of Between-Subjects Effects and Interaction for Table 3

Dependent Variable: NA1

Source	df	F	Sig.
POSNEG	1	.000	.989
PREPOST	1	.563	.461
POSNEG * PREPOST	1	.291	.595

a R Squared = .075 (Adjusted R Squared = -.051)

Tests of Between-Subjects Effects

Dependent Variable: EPI1

Source	df	F	Sig.
POSNEG	1	.413	.527
PREPOST	1	5.181	.033
POSNEG * PREPOST	1	.586	.452

a R Squared = .199 (Adjusted R Squared = .090)

Tests of Between-Subjects Effects

Dependent Variable: UTIL1

Source	df	F	Sig.
POSNEG	1	3.807	.064
PREPOST	1	.119	.733
POSNEG * PREPOST	1	.882	.358

a R Squared = .155 (Adjusted R Squared = .039)

Tests of Between-Subjects Effects

Dependent Variable: OTHER1

Source	df	F	Sig.
POSNEG	1	1.270	.273
PREPOST	1	.601	.447
POSNEG * PREPOST	1	.047	.830

a R Squared = .074 (Adjusted R Squared = -.058)

Tests of Between-Subjects Effects

Dependent Variable: SCSN1

Source	df	F	Sig.
POSNEG	1	.218	.645
PREPOST	1	.120	.733
POSNEG * PREPOST	1	.345	.563

a R Squared = .048 (Adjusted R Squared = -.088)

Tests of Between-Subjects Effects

Dependent Variable: UNIT1

Source	df	F	Sig.
POSNEG	1	1.539	.229
PREPOST	1	.001	.974
POSNEG * PREPOST	1	.241	.629

a R Squared = .110 (Adjusted R Squared = -.024)

Tests of Between-Subjects Effects

Dependent Variable: PH1

Source	df	F	Sig.
POSNEG	1	4.095	.055
PREPOST	1	.094	.762
POSNEG * PREPOST	1	1.807	.193

a R Squared = .185 (Adjusted R Squared = .074)

Tests of Between-Subjects Effects
Dependent Variable: PROF1

Source	df	F	Sig.
POSNEG	1	.061	.807
PREPOST	1	.043	.839
POSNEG * PREPOST	1	1.430	.246

a R Squared = .101 (Adjusted R Squared = -.033)

Tests of Between-Subjects Effects
Dependent Variable: LAST1

Source	df	F	Sig.
POSNEG	1	.177	.678
PREPOST	1	4.603	.044
POSNEG * PREPOST	1	1.934	.179

a R Squared = .229 (Adjusted R Squared = .118)

Tests of Between-Subjects Effects
Dependent Variable: RACE1

Source	df	F	Sig.
POSNEG	1	1.576	.224
PREPOST	1	1.461	.241
POSNEG * PREPOST	1	2.470	.132

a R Squared = .252 (Adjusted R Squared = .140)

Tests of Between-Subjects Effects
Dependent Variable: HIV1

Source	df	F	Sig.
POSNEG	1	4.098	.057
PREPOST	1	.076	.786
POSNEG * PREPOST	1	.438	.516

a R Squared = .226 (Adjusted R Squared = .104)

Tests of Between-Subjects Effects
Dependent Variable: PERS1

Source	df	F	Sig.
POSNEG	1	1.171	.291
PREPOST	1	.267	.611
POSNEG * PREPOST	1	.014	.905

a R Squared = .085 (Adjusted R Squared = -.045)

Tests of Between-Subjects Effects
Dependent Variable: RELAT1

Source	df	F	Sig.
POSNEG	1	3.372	.081
PREPOST	1	.055	.816
POSNEG * PREPOST	1	.268	.610

a R Squared = .142 (Adjusted R Squared = .020)

Tests of Between-Subjects Effects
Dependent Variable: TIME1

Source	df	F	Sig.
POSNEG	1	3.961	.060
PREPOST	1	1.106	.306
POSNEG * PREPOST	1	1.296	.268

a R Squared = .176 (Adjusted R Squared = .053)

Tests of Between-Subjects Effects
Dependent Variable: INFLU1

Source	df	F	Sig.
POSNEG	1	.010	.920
PREPOST	1	1.875	.186
POSNEG * PREPOST	1	.294	.594

a R Squared = .091 (Adjusted R Squared = -.046)

Tests of Between-Subjects Effects and Interaction for Table 4

Dependent Variable: NA2

Source	df	F	Sig.
COMSTAFF	1	9.231	.013

a R Squared = .480 (Adjusted R Squared = .428)

Tests of Between-Subjects Effects
Dependent Variable: EPI2

Source	df	F	Sig.
COMSTAFF	1	20.161	.001

a R Squared = .668 (Adjusted R Squared = .635)

Tests of Between-Subjects Effects
Dependent Variable: UTIL2

Source	df	F	Sig.
COMSTAFF	1	.502	.495

a R Squared = .048 (Adjusted R Squared = -.047)

Tests of Between-Subjects Effects
Dependent Variable: OTHER2

Source	df	F	Sig.
COMSTAFF	1	.185	.676

a R Squared = .018 (Adjusted R Squared = -.080)

Tests of Between-Subjects Effects
Dependent Variable: SCSN2

Source	df	F	Sig.
COMSTAFF	1	1.133	.312

a R Squared = .102 (Adjusted R Squared = .012)

Tests of Between-Subjects Effects
Dependent Variable: UNIT2

Source	df	F	Sig.
COMSTAFF	1	.327	.580

a R Squared = .032 (Adjusted R Squared = -.065)

Tests of Between-Subjects Effects
Dependent Variable: PH2

Source	df	F	Sig.
COMSTAFF	1	6.292	.031

a R Squared = .386 (Adjusted R Squared = .325)

Tests of Between-Subjects Effects
Dependent Variable: PROF2

Source	df	F	Sig.
COMSTAFF	1	2.649	.138

a R Squared = .227 (Adjusted R Squared = .142)

Tests of Between-Subjects Effects
Dependent Variable: LAST2

Source	df	F	Sig.
COMSTAFF	1	11.462	.007

a R Squared = .534 (Adjusted R Squared = .487)

Tests of Between-Subjects Effects
Dependent Variable: RACE2

Source	df	F	Sig.
COMSTAFF	1	.048	.831

a R Squared = .005 (Adjusted R Squared = -.095)

Tests of Between-Subjects Effects
Dependent Variable: HIV2

Source	df	F	Sig.
COMSTAFF	1	.022	.886

a R Squared = .002 (Adjusted R Squared = -.098)

Tests of Between-Subjects Effects
Dependent Variable: PERS2

Source	df	F	Sig.
COMSTAFF	1	.043	.840

a R Squared = .004 (Adjusted R Squared = -.095)

Tests of Between-Subjects Effects
Dependent Variable: RELAT2

Source	df	F	Sig.
COMSTAFF	1	.000	1.000

a R Squared = .000 (Adjusted R Squared = -.100)

Tests of Between-Subjects Effects
Dependent Variable: TIME2

Source	df	F	Sig.
COMSTAFF	1	.247	.630

a R Squared = .024 (Adjusted R Squared = -.073)

Tests of Between-Subjects Effects
Dependent Variable: INFLU2

Source	df	F	Sig.
COMSTAFF	1	1.176	.304

a R Squared = .105 (Adjusted R Squared = .016)

VITA

Andrea Davis was born in Loughborough, England, At nine months old, her parents moved to Africa. She grew up in Kenya, Tanzania, Yemen, South Africa and Zimbabwe. At 18 years old, she was awarded a foreign student scholarship and came to the United States, where she received her B. S. in Biology and an M. S. in Biology with an emphasis in Health Science. She married her husband, Mick Davis, in 1977. Mick was an Air Force pilot, and they have been stationed in many places during his Air Force career, including Hawaii and Germany. Andrea taught Biology and Health classes on the high school and college level until Mick retired from the Air Force, at which time they moved to Jacksonville, Florida with their two sons, Clark and Scott.

Andrea began teaching for the College of Health at the University of North Florida in 1993, and also worked as assistant to the Associate Dean. During this time, she was involved in a federal grant (CSAT/NIH) to evaluate the effectiveness of two substance abuse treatment programs for pregnant and postpartum women and teenagers, and a substance abuse mediation program for high risk youth. In 1999, she became the Health Services Planner & Evaluator for the College of Health, under contract to work full-time for the City of Jacksonville's HIV/AIDS Planning Council. She currently serves on a statewide advisory council for the development of an HIV prevention evaluation plan, funded by Centers for Disease Control and Prevention and the Florida Department of Health. She also serves on the Advisory Council for Jacksonville's HIV Early Intervention Title III grant and participates on the Florida Community Planning Group. She received training from John Snow, Inc. to be a peer consultant on outcomes evaluation.

Andrea was selected for "Who's Who Among America's Teachers" in 2000.