Center for Applied Social Research
All Grantees Conference Call
February 12, 2007

In attendance:

4CC
Kevin Foley
Sherrick Roanhorse
Melvin Harrison

ANTHC
Gloria Eldridge
Carol Piscoya
James Berner

Healing Lodge
Peggy Opitz
Trish Carter
Bruce Swett

NAHC
Mark Espinosa
Lorraine Martinez

SPIPA
Jutta Riediger
Raylene McCloud
Lisa Shipman

YK
Sandi Duggan
Carl Evans

Introduction of Lorraine Martinez who is an evaluator at NAHC.

Permission to record was granted.

Glenn: The purpose of this conference call is to set the direction of the presentations for the final meeting. When we talk about lessons learned we look back at our barriers that we've done and we're doing that internally here at the Center as well, the barriers. And what we proposed to do in our proposal is taking some of the things that we've done that if we had another chance we'd do it differently. But also, the things that have really worked well in the programs. Not just the things that were barriers that you couldn't overcome. And, what I'd like to do today is ask each one of you to talk about a lesson learned, and then no one else repeat that particular one.

The goal is at the end of the call for each project to have 3 lessons learned for a total of 18. We'll send a summary out to all projects with 18 bullets.

KG, do you have anything to say?
KG: No.
Sandi, do you have anything to say?
Sandi: No, I think that's good – good structure.
Nancy?
Nancy: No, I'm good to go.

Glenn: Bruce, you want to start.

Bruce/Trish/Peggy: I think some of the lessons learned is as a new organization is one putting funds in to help break the stigma and to provide education, which I think we're doing that well now. But, early in the project we didn't really do this. The lesson learned is to get in on this early.

Another lesson learned was the importance of student collaboration to help get this done and to reaching the clientele.

Glenn: Okay, so we'll put one down for you, and that's going to be what, Bruce?

Bruce/Trish/Peggy: I take the lesson learned the importance to getting to the gate keepers, collaboration, and getting the service to clients.

Jutta/Raylene/Lisa: We all agree that we will use the intergenerational approaches because they really seem to be the most culturally appropriate in our communities for dealing with issues surrounding HIV/AIDS. Also outreach, getting people to testing. That's what we'd like to focus on.

Gloria/Carol/James: One of the lessons that we learned is that we've gone through so much transition that it's been difficult to recruit, replace folks at the Doreen level and the individual people here locally. We need to review our job description and update the job description so that we can offer adequate pay to recruit more people here.

San Francisco defers until a later time because of hiring a new HIV Services Director.

Kevin/Sherrick/Melvin: The biggest one is to reiterate the primary goal of the project which is all substance abusers should know their HIV status. The lesson learned from this is that its hard to do, but that ultimately with all the interventions that were a part of this project it gives the person [client] a lot of information in that we've shown their knowledge of their AIDS risk has increased from pre to post test. With the total intervention its very rewarding.

To say this more succinctly, the outcome of the data shows that giving a HIV education session, a pre test and post test and one-on-one counseling it shows that it works.

Carl: The pre and post test counseling along with risk reduction counseling provided with the quick test was a powerful moment for the people that got it. Specifically, the quick test as opposed to other ways of finding out. The 20 minutes is the moment of teaching right then and that's very powerful.

Round 2

Bruce/Trish/Peggy: The lesson we learned in this project that developed from the ground up that it does take time to develop an infrastructure. Particularly given the problem of [HIV] and the stigma in the community. Even though you think through the process in writing the grant it still often is more complicated when you're dealing in a rural area and trying to address issues that have a lot of stigma attached to it. So, I think the lesson that we learned was that it does take time to develop an infrastructure and it does involve partnerships and collaboration in the community.

Succinctly said: In the period of time that we had it took a great deal of time to develop infrastructure. And, I think my only regret now is that the grant is coming to an end and there's an infrastructure in place and its going to be challenging to continue that on when a lot of effort has been expended to do that. But, it does take time. Sometimes more time than we think that we

will need to allocate to develop an infrastructure. And, I think that its even more so when you deal with the health problems that has a stigma that must be addressed.

Just the extra time that's needed to develop an infrastructure for a new agency. Especially for this project, the changes and other variables contributed to the increased amount of time it took to develop the infrastructure.

Paraphrasing: One lesson is to plan on staff change.

Or, to have an alternative plan. Nobody could anticipate the kind of changes that did occur on different levels, at HRSA and OU and in our own agency. It is good to try to think through that as quickly as you can have a contingency plan. In some cases we had to go back to the drawing board to rethink the grant.

Paraphrasing: Time is something all projects can relate to and staff change.

Jutta/Raylene/Lisa: A need for HIV and Hepatitis C outreach, screening, and treatment. Anecdotal feedback from the clinics directors is that about 25% of the tribal population in their tribe is Hepatitis C positive. So, having a combination of the two would have been much more productive.

Gloria/Carol/James: Our project was trying to imbed a new service into existing services. I think the lesson we learned from that you have to have the time and ability to do the upfront preparation for staff before you introduce that kind of change, otherwise you encounter a lot of resistance afterwards. So, look at the personnel and policy implications up front and then after implementation continue to attend to both of those afterwards.

Kevin/Sherrick/Melvin: From an analysis of chart abstraction data of CD4 count and viral load and correlating that with health surveys of HIV positive people we learned that there is a significant relationship between being disabled and having a high CD4 count.

Carl: It is essential to spend time in the individual communities, and travel is expensive and unpredictable and budget for projects need to reflect the high cost of air travel. [Alaska specific, no roads, travel is by air]

Clarify: The importance of spending time in village communities requires travel and travel is expensive.

Round 3

Bruce/Peggy/Trish: Dealing with recruiting and enrollment and providing services one important factor is building relationships with the community so you can build trust, and to bring education as much as possible, and collaboration and partnerships.

Clarify: Collaboration and partnerships is important.

Jutta/Raylene/Lisa: Recognize the importance of tribal protocols with SPIPA boards and local tribes. This includes offering food at the different events, honoring timelines for review, honoring elders and tribal chairs and including them in different events.

Simplify: Honoring the protocols that exist on different levels.

Recognizing protocols of tribes and communities

Recognize and Honor. We couldn't have moved forward if we not only recognize, but honored also.

Gloria/Carol/James: Not all substance abuse counselors who are intimately involved in this effort are ever going to be comfortable with sexual behavior counseling.

[**Kevin:** That's a good one.]

Kevin/Sherrick/Melvin: The sharing of data between Navajo AIDS Network and Dr. Erlu at the Gallup Medical Center that there have been some secondary gains - it has worked to increase awareness of the 4CC and it has also worked to facilitate integration of services.

Simplify: Sharing of Data

We take data sharing to the Health Advisory Board for the Navajo Area Indian Health Service and they approve it and then take it to Navajo IRB. The Hospital has an Advisory Board also that we have to go through.

Carl: Case management that is able to focus on the unique needs of the HIV positive client in the rural community is essential for providing proper medical care.

Clarify: Some training in case management up front would be called for at the beginning of the project.

Open for to anyone who would like to contribute to lessons learned personally or for the projects.

Melvin: I have a couple of things. I've been in the SPNS cycle for the last 12 years or so - the 4 SPNS cycles that I've been in. A big thing I learned is that the all the things the projects are doing do work, that they can be replicated, especially the work that we do out here on Navajo is excellent work as well as all the other projects. We do these projects for 5 years and nothing happens, we do nothing with them over the last 12 years - the mid 1990s. The federal government they don't give out any money to replicate. There is no way to replicate them after the 5 years.

That is something that we have to work on and take them to the next level. There are some of who are taking a lot of stuff to the national agenda because we have to do something about these projects. We can't just drop them. All the work that's done across the country these six projects

should be replicated somewhere. I know that HRSA does say that you go to Title I or Title II or some of the other Titles but we can't go there because our numbers are too small. Usually that's the number one barrier on these other Titles is that we're informed that our numbers are too small and we don't qualify for these funds to replicate them.

Clarify: small numbers and getting your message out better to not only the Feds but to the tribal members.

The lesson learned is that these projects do work and they should be replicated. I think the intent of these projects is to demonstrate that if they work or not work. These projects do work. For example, on Navajo - many times we talk about jurisdictional problems - but on Navajo we've had a collaborative. And, its worked somewhat. I think we've broken some barriers down. We work with Indian Health Services, we've had input from the tribal government. I think one of the big lessons is how involved the Navajo IRB was involved in really supporting this project.

Glenn: There is nothing unique in the lessons learned - every project faces the same problems because of the restraints of how the grant was written from you guys. Overcoming the barriers from the Barriers Report from 2 and a half to 3 years ago. And, the lessons learned are all positive. I don't see that any of the projects are failures.

Melvin: Which is true, and I don't think anyone's saying that. But, I think we needed someone to say that. These projects do work and we should be talking about that. And, we feel that these projects have been really successful.

Glenn: We all have high expectations, but we are limited by what's written in the proposals. It's like here at the Technical Center when the guidelines were written and got funded we could only do certain things. It's a case of the glass is half full for us here. Looking at you guys, you did a great job under a lot of different kinds of barriers. And you've overcome a lot of them. And the lessons learned is also to help you to view it as a positive experience that you've made a difference in the life of many people. A real difference. And I know you don't hear that enough. But that's how we all feel here.

Jutta: We've received about $10,000 to host talking circle sessions with the tribes. So we put on three dinners, went out, showed them what SPNS had done, told them what tribal Bear had done and then asked them to contribute what they would like to see. All of them - and 61 people at Niqually is an amazing turnout for this small tribe, and then we had 41 at Squaxin Island - all of them said continue, bring more Hepatitis C education. Adamant about bringing it to all levels of the tribal community. So, that's the intergenerational approach. Tribal council members showed up and said we need it, we'll endorse it, we'll push it forward. So, I think I hear Melvin saying it's one thing to feel good about what you've done, it's another to be able to bring that to other tribal communities to benefit from it and to find funding for the ability to do something.

Clarification - There's sustainability of your own project, but there's replicability or spreading it elsewhere.

It would be wonderful for us to go to the next level - in our case a combination of HIV and Hepatitis C - and that's nowhere to be found, no funding anywhere and that certainly would be great if other tribes could duplicate what has been done.

Berner: The comment on sustainability of the project is a generic problem. One of the lessons we learned is that if you can link the activities of your project to a reimbursable [billing] service code that's the key to sustainability. I think that's one of the breakthrough in our project. We didn't find any HIV cases, but we did find a way to sustain our project. To me that's just as important.

Bruce: We have a unique project - we took on the Spiritual Connections piece - there have been other communities wanting to model our project because its been very strong in educating the community and also help bringing people to the point of getting tested and help breaking the stigma because they know more about how to address it. Plus, our model has been adapted to other programs. I continue to get folks in adjoining counties wanting to get information and get us to do training. That has been a lesson learned for me.

How important it is to have technical assistance especially for me.

Glenn: We are going to do a lessons learned presentation at the meeting, too and we'll be doing one on providing technical assistance.

Kevin: Personally I've learned that we have a low HIV infection rate, but we have a high rate of people of getting infecting and a high death rate.

Carl: Same here - infection is low but risk factors are astronomical.

Gloria: We've noticed the same thing. We were good at getting people to get tested, and we found out the risk factors were high. It was difficult to get people to come back for test results. This is why rapid testing is good because when people are interested in getting tested they get their results.

Adan: These are important points that are potential topics for discussion when you come to the final meetings and present your evidence based findings and lessons learned. We're trying to plan for the final grantee meeting. We're listening to your comments and we'll gather them into a final presentation and you'll present them at the meeting.

Glenn: During the individual calls next week we'll go over notes from your project's lessons learned today and do some expansion in linking all these into one big lessons learned. It goes back to the projects before our final meeting.

Thank you all for being here.

Adjourned at 12:45.