

Julie Hook:

Great, thank you. Good afternoon, everyone, and welcome to this webinar entitled "Strategies and Lessons Learned for Consumer and Stakeholder Engagement in Integrated HIV Prevention and Care Planning Implementation." My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistance Center, and I want to thank everyone for taking the time to be on today's call.

Our goal of this webinar is to provide information on key strategies for ongoing consumer and stakeholder engagement in integrated prevention and care planning, implementation, and monitoring processes. We hope that after today you'll be able to discuss the importance and benefits of broad consumer and stakeholder engagement for integrated HIV prevention and care plan development, implementation, and monitoring, identify strategies and methodologies from effective engagement processes for consumer involvement in integrated HIV prevention and care planning, to take home some lessons learned about consumer and stakeholder engagement from several jurisdictions, including Washington D.C. and the state of Pennsylvania.

We'll be answering questions at the end of the call. We'll answer as many as we can, as time permits. Questions, including those that we don't address during the call, will be included in a Q&A document and posted along with the transcription supplied on our IHAP TAC [inaudible 00:01:17] page on the target website. If you have any questions during the call, please chat them. Please use the chat feature to chat them in. Just a reminder the IHAP TAC is a three year cooperative agreement to support jurisdictions and their planning bodies with implementation of the integrated HIV Prevention and Care Plan, including both national and targeted TA strategies.

Now I'd like to introduce our speakers. Marissa Tonelli is a Senior Capacity Building Manager for Health HIV. She leads their 3D HIV Prevention Program, a technical assistance program that enhances the ability of health departments, aid service organizations, CBO's, and health organizations to conduct enhanced data collection and analysis to make better informed programmatic decisions that impact delivery and sustainability of HIV prevention services. She's also part of the Help HIV team who is one of our partners on the IHAP TAC.

David Gibbons is a PHD candidate and the director of the HIV Prevention and Care Project and the Graduate School of Public Health at the University of Pittsburgh. This project has been contracted with the Pennsylvania Department of Health Division of HIV Disease since 1994 to facilitate HIV prevention planning and now integrated planning for the Pennsylvania jurisdiction. David has been active in the field for 7 years and worked closely with the state in developing several components of its integrated HIV Prevention and Care plan including the areas of consumer and stakeholder engagement.

Leah Varga is the HIV service planner at the HIV/AIDS Hepatitis STD and Tuberculosis administration at the District of Columbia Department of Health. Drawing upon 20 years of experience and health research with minority populations, she participates in developing and implementing plans to improve HIV

services in underserved populations and conducts needs assessments to identify gaps and determine funding priorities for HIV services.

Now I'd like to introduce Steven Young, the Director of the Division of Metropolitan HIV/AIDS programs, would like to say a few words. Steven.

Steven Young: Yes, thank you Julie and welcome from the HIV/AIDS Bureau here at HERSA. I'd like to thank JSI and the IHAPTAC for hosting this webinar. Just a minute or two of some background. As I think about the subject today, comprehensive community health planning really has a rich history. While it really never realized it's full goals in terms of decreasing and controlling health care costs and maximizing health outcomes. It did serve as a framework for a number of federal initiatives and unique among all is the Ryan White HIV/AIDS program, especially in terms of comprehensive planning requirements and involvement. Really across all our programs, certainly our state level Part B Programs but particularly the program that I administered in Part A, which has legislatively required planning councils. Two key pieces of that are unaligned consumers who must make up 33% of the membership as well as a diverse group of stakeholders such as health care providers, community based organizations, social service providers, community leaders, and affected communities.

This webinar is really timely today. You probably all are aware of our integrated plan approach and feedback is coming to all the jurisdictions shortly, but we really have been and will continue to be in a capacity building and TA mode. This is certainly part of that. As we look at the integration of prevention and care, this really is absolutely necessary as we strive to improve health outcomes for people living with HIV and prevent new infections. A little bit of a focus from the program that I run in Part A. Our Part A jurisdiction are submitted integrated plans and 24 of them actually submitted integrated plans that were jurisdictional specific. That is, they did not integrate with the state. They submitted their own plan and four of those are also directly funded with prevention dollars from CDC. All the others submitted integrated plans in conjunction with the state. What we've seen is that the value for some of them is it really represented a high level effort to get to zero and end the epidemic within their jurisdiction. If some jurisdictions didn't quite strive for that yet, it certainly is serving as a roadmap and living document for their programming efforts.

Even the Part A metropolitan areas who don't receive direct CDC prevention funding, most of them are actually local administrators of prevention funds through their state and all of them are aware of the funded prevention efforts in their jurisdiction. Representing the HIV/AIDS Bureau today, I really want to emphasize the value of engaging stakeholders and particularly consumers who all bring a very unique and representative perspective regarding how best to work with marginalized populations and reach out beyond what many of us are comfortable with, and that that compliments the use of existing quantified and objective data. Let me close by reinforcing the commitment we have here within our Part A program and overall in the bureau to the integration of prevention and care efforts by our recipients. I look forward to the presentation and the discussion that I hope

it stimulates. I'm going to turn it over to Marissa to get us started.

Marissa Tonelli: Hi, good afternoon. This is Marissa Tonelli with Health HIV. Thank you so much for that great setup and introduction. I much appreciate it. I just want to quickly thank JSI, your team, and also HERSA and your team, for inviting me to speak and engage a couple of great jurisdictions that we have following me around this conversation on stakeholder and community engagement. Thank you all also for joining the call. Please engage with us in the chat box. We're willing to answer your questions at the end so if you have any ideas or questions, please chat them to our teams.

I wanted to start just by briefly posing the question of, who really is a stakeholder in the HIV planning process. Specifically in the integrated HIV planning process. I wanted to keep in mind that many jurisdictions now are being advised by different definitions or similar but different definitions for more than one of their funders and both HERSA and CDC reference stakeholders as essential partners in the planning process. I just wanted to put on a slide for you. The HERSA language that highlights that the foundation for planning is key players or stakeholders, patient funders, patient advocates. CDC uses the definition of a person or representative who has personal or professional experience, skills, or expertise in HIV, but both point out that an essential stakeholder group in HIV planning is consumers or people living with HIV. We will also kind of highlight that as an important engagement piece.

Defining the consumer, again, I think we mentioned before that, that there's a specific reference in Part A planning to unaligned consumers, which I have here, but consumers generally are people living with HIV who receive Ryan White funding, whether it's core or support services, or their caretakers. And specific to unaligned consumers, those who are receiving the services but do not specifically have a financial or governance interest. They're not members of boards, employees, or consultants to a Part A funded organization. Again, wanted to point that out. Also, point out that we might kind of be confused at this time with the changing landscape of people living with HIV who receive most of their medical services through public or private insurance rather than through Ryan White or if Ryan White Part B is paying insurance premiums or cost sharing, so how does the definition change?

Some integrated prevention and care bodies are now looking at a variety of different definitions for this, and looking specifically at a definition for consumers of prevention services, so those not receiving Ryan White services. There are legislative requirements for consumer involvements. We know in Part A, it's specific to Ryan White Part A, not Ryan White Part B or CDC. There are no legislative requirements. For Part A the planning councils must reflect in its composition the demographics of the population of individuals with HIV in the eligible area, with particular consideration given to disproportionately affected and historically underserved groups. We also know as I defined earlier that no less than a third of this council be unaligned consumers, so they have no financial ties or interest in Ryan White specifically.

There are many benefits to consumer and stakeholder engagement. I've listed a few here, but we know that beyond the legislative requirements or funder requirements that engaging stakeholders in communities ensures the planning is ultimately providing the outcomes that meet the needs of the community, ensures that services are going to be delivered in collaboration with stakeholders, it may increase responsiveness and effectiveness of HIV service delivery, result in a streamline policy and program development, and also open and have open and transparent lines of communication between health departments and their community members. We also know and have seen that it drives innovation. Engaging community level stakeholders and consumers can drive the innovation of HIV planning efforts and HIV programs. It will result in a more integrated and comprehensive planning process and continued engagement as well. It also facilitates a bi-directional feedback between stakeholder groups, planning bodies, recipients, legislature, government agencies, and others.

I know my speakers that are to follow from DC and Pennsylvania will talk more about this specifically so you'll have some great examples, practical examples for it. I wanted to just go back quickly to consumers or people living with HIV as really essential stakeholders. We know that their involvement in the planning councils and planning bodies ensures that these effected communities are involved in determining service needs, opportunities for new services, and also new barriers and how to best address them, again essential players in this process. They should be involved at all levels of planning. Not only in engagement with planning bodies and also broader stakeholder engagement activities, but also in developing and monitoring the plan. Ensuring that there are systems and care in place that meet the needs of consumers that are culturally competent, and putting kind of a check on the health department and the planning process [inaudible 00:13:08] so actually really being engaged in that monitoring and ensuring that what was stated in the planning process and engaged in the planning process is actually happening on the ground.

When identifying stakeholders in your jurisdiction, I'm sure many of you on the line are very savvy with this. We know it's important to focus on representatives of populations with the highest prevalence of HIV so the impacted communities ... In doing this you might be looking at both geographic distribution, HIV risk categories, race ethnicity, gender, gender identity, sexual orientation, age, etc. sorry. I wanted to start by kind of seeing from your perspective who you have engaged as planners maybe or as stakeholders in this process who some of your non-traditional HIV stakeholders are. We're going to do a quick poll. Just to note that we don't have all of these categories that are listed on the slide in the poll because we could only have up to ten. Please chat in anything into the other box or the chat box, sorry, for other and I will start the poll.

Great. I think we'll just give one more minute. We have about 35 responses right now. Anyone else that wants to respond, I believe you might be able to select more than one option so please do so. Okay. I'm going to close it here. It looks like about 70% of you are engaging healthcare centers which is great, especially primary care providers in health care centers providing services an essential stakeholder in this

process. They're delivering services and many times they're delivering services to people with HIV or at risk for HIV and also are seeing and providing those services outside of kind of the Ryan White and the CDC community so it's great to engage them. It's great to see that people are always engaged in homeless shelters. I know I'm here in Chicago actually today talking about integration of housing into healthcare. We know that's essential so how does that play a role and reduce a barrier by engaging those organizations, community centers, also in primary care associations.

I don't see any chats in the chat box but great, that's great to see what you guys are doing and we'd love if you want to chat some additional stakeholders that you engage that you think other health centers or any other kind of stakeholder that you see as a key population, we'd love to hear it and try and include it in our discussion. I'm going to move on to the next piece of my presentation, which is talking about some specific model strategies in stakeholder and community engagement. We know that there's a lot of effective engagement methods out there and again I'm very excited for our presenters from DC and Pennsylvania to share their specific examples but we know Town Hall meetings, other well publicized public meetings, engaging in focus groups, focus groups meetings, survey dissemination, key informant interviews, having public comment periods for the planning process so for the plan or other documents, the use of social media is a great way to drive discussion among community members and community stakeholders using technology such as webinars or conference calls to engage stakeholders, community advisory board, many jurisdictions host ad hoc panels or ad hoc advisory groups to the HIV planning bodies. Those are all really great and effective engagement methods.

I wanted to point out again kind of where in the process community and stakeholder engagement is really essential and we know that it's not just in informing the development of the integrated HIV prevention and care plan. Many organizations go through a very rigorous process of community engagement in their plan development, but we also want to acknowledge that in the implementation and monitoring of the implementation, it's really essential to ensure that there's continuous and ongoing stakeholder engagement after the plan is developed. Some of that can be done through the development of effective feedback loops. Evaluating and demonstrating the outcomes and the value of stakeholder engagement efforts so sharing that information back to the community is really important. How you're using any sort of information gathered from the focus groups or gathered from surveys, gathered from the ad hoc meetings and how that's informing planning and implementation of the plan is really important.

Also, in order to monitor this plan implementation the community members and the stakeholders need access to timely information. They need to understand the evaluation criteria metrics, any new programs that have been implemented and their goals and measures, recent and upcoming activities. They need access to up to date epidemiological data and I wanted to point out that there is a need for more research and more development of user friendly tools that enhance this community based monitoring of plans. Rather than just posting information

epidemiological data, recent activities on a calendar, on a website, how can we really meaningfully engage the community members, consumers, and other stakeholders in the monitoring of the plan and what tools could we use, what user friendly tools can we use? This is still being explored by a lot of jurisdictions.

I just wanted to point out a couple of examples before we moved to our other speakers. We know one example in the state of Maryland. They've done a lot of work in bringing feedback from their advisory groups back to the planning body. They've had a variety of different advisory groups throughout the state, both regional and population specific. They have five regional advisory committees, Baltimore planning council, Anna Rundell Commission, and also engaged the Baltimore City Commission. One focused specifically on MSM. One on transgender. One on para-natal HIV. Their hepatitis coalition and their STI Community coalition, so all key stakeholders as they work through their plan development process in monitoring and implementation.

The state of Washington has also done great work in developing and kind of moving forward the methodology where the planning group really focuses on the framework strategies and systems, and then they also have a community engagement program, which they've termed stakeholder villages as the avenue for input and exchange. Instead of engaging everyone in the planning process at the table, at the planning group table, they take the engagement out of the planning group area and into the community so they've engaged stakeholders in barber shops with DIS staff and their clients, in a client survey, you have social media, and just going right into the communities, meeting with them where they're at and actively soliciting input on specific questions related to planning.

Fulton County, Georgia also has convened several half day and day long community engagement meetings for members, for community members, sorry, over the course of the year. Through that identifying and prioritizing innovative HIV prevention care and treatment strategies, and also eliciting feedback on HIV planning goals. Another way through in person engagements at larger scale meetings as well. We know that meaningful stakeholder and community engagement must do the following things. It must occur regularly. It must consult a wide range of impacted stakeholders. We know this is challenging and I hope my colleagues can speak to some of the challenges that they've experienced and how they've overcome really reaching those highly impacted stakeholders that might not traditionally be at the table or that are difficult to engage in these conversations.

They can share some really great strategies I'm sure that they've implemented. We also know that it has to occur in a variety of venues, in a variety of formats. Not every population or stakeholder, consumer is going to receive information or share information the same. It has to accommodate the needs. It has to accommodate the preferences of those community stakeholders. It also must encourage innovation and challenge conventional wisdom. Years ago I don't think folks would have thought to put questions on Twitter or on Facebook for their constituents to respond to. For privacy reasons and a variety of reasons. Now that's commonplace

to use social media and a variety of other technologies to do so. It might occasionally take us out of our comfort zone engaging a population that has not traditionally been engaged, that you don't have a formal or even informal relationship with. These are all things to keep in mind as you go through the stakeholder and consumer engagement process that are really key to making it a worthwhile effort.

With that, I encourage you again if you have any questions for me to chat in the chat box and we can take some questions at the end, but that will be the end of my presentation and I'm excited to turn it over to David Givens, who as Julie mentioned is the director of the HIV prevention and care project at the University of Pittsburgh and works on the Pennsylvania states integrated HIV prevention and care planning so David, turn it over to you.

David Givens:

Thank you Marissa. I'm please to be here today. CDC's integrated and HERSA's integrated guidance included several sub sections focusing on consumer and stakeholder engagement. Pennsylvania's division of HIV disease worked with our project and their HPG to develop and refine these diverse methods. This was a natural development for the HPG in our state since one of its primary roles since planning integration began in 2013, with the help connect planning efforts to as many effected communities as possible and to reflect those communities perspectives back into the process. This is what has informed those sections of Pennsylvania's integrated HIV prevention and care plan, the IHPCP, and serves as guideposts moving forward. That's what we're going to be talking about here today, what we've learned through that process.

Before we begin, I think we need to highlight a few specifics around the nature of the epidemic in our state and how that challenges our specific process. One challenge is sheer numbers. At about 12.8 million people we have the sixth largest population in the country, the fifth largest percentage of elderly residents, and the ninth most densely populated community, particularly in the southeast. Our map here shows new HIV cases 2011-2015 in each of our 67 counties. Aside from Pittsburgh and Philadelphia, which is it's on HERSA EMA jurisdiction. 47 counties are designate rural. We have both large swathes of rural and urban areas to contend with, with unique stakeholders and challenges in each.

As far as the state epidemiology, state HIV surveillance estimates that there are just about 35,000 people living with HIV in Pennsylvania for brevity, for our purposes here today, we'll say that new HIV infections are similar enough to national trends that I don't need to reiterate them here, but the one statistic I will highlight is that while infections continue to rise among young people, particularly young black GMT, it's also the case that 65% of all people living with HIV in the state are over the age of 45 and 31% are over 55. In short, our HPG must represent and gather feedback, not only from typically impacted communities but also from communities that vary widely in geography, in socioeconomic settings, and in age. Now, the foundation of Pennsylvania's consumer and stakeholder outreach originates with the HPG whose organizational chart is diagrammed here. The goal of the representative group is to include as many key stakeholders and consumers

as possible, but the division of HIV disease must also operate within state guidelines that govern advisory bodies.

One way that we've mitigated this is by creating both planning partners and community members, which you can see here. 20 community members are recruited from impacted and at risk communities across the state, filling specific gaps in representation based on the EPI. Particular weight is given to consumer representation, a third of these numbers must be consumers. Other membership categories include care and prevention providers and Ryan White Part B sub-recipients. Both community members and planning partners have robust participation in this HPG, including in all sub-committee work, but the decision has been able to dramatically expand key stakeholders around the table through recruiting planning partners. These 15 diverse non-voting partners represent instrumental and intersectional state agencies and other key partners ranging from the divisions of STD and viral hepatitis to epidemiology and drug and alcohol.

It also includes departments such as corrections and education, and key partners like the mid Atlantic AETC and Philadelphia's jurisdictional planning. Finally, intersectionality also plays a large role in our membership. Many of these numbers identify with risk groups or impacted communities and throughout the planning process we encourage members to speak from these important life experiences. One of the key plans that the HPG developed during its integration was the five year stakeholder engagement plan. On the surface it's a straight forward road map for using mixed methodologies and engagement strategies, each one taking about a year to implement. Each strategy will then continue to run in the background so to speak as we move to focus on the next one. This culminates about a year before the next IHPCP is due with a snowballing amount of stakeholder information and feedback.

One major advantage to this type of planning is that we're never going to be surprised by what activities we've got on the docket. Looking up to five years ahead ensures that we're ready for even those engagement activities that are time or resource intensive. Some of these strategies we've already heard about today but I'd like to highlight some specific aspects of them. We sometimes joke that the first step in planning is planning to plan, but having an accurate road map is an invaluable tool and we've learned that this planning time is an investment rather than a liability for consumer and stakeholder engagement specifically, for us that means taking the time both identify individuals and groups who are underrepresented in the IHPCP process and to map out likely vectors for engaging those folks.

Two obvious sources of data of course are the epi-profile and feedback from the HPG, but we also gained a great deal of useful information from other sources. Needs assessments and previous surveys for example can be valuable tools in this stage to garner deeper insight into how to best reach high priority groups or hard to reach populations. This is one of the lessons we learned when our office conducted a needs assessment around rural linkage to care for example or when we surveyed field staff and Part B clinics around how they interact with



transgender clients. The information gained for serving diffused groups across a large area was valuable not only in shaping HPG recommendations and the divisions responses to these issues but in shaping our planning for engaging these consumers as well.

The next step for us is to work with creating contact points and with gatekeepers for our highest priority groups around the state. Our goals for this stage are to open mechanisms for communication and develop working relationships with agencies, community groups, and advisory boards. One successful strategy the HPG created is inviting community members who are well known or experienced in specific issues to come and speak to the HPG and the division, often in a panel format. This creates a powerful opportunity to inform planning and it builds relationships between the HPG and the communities that those guests are a part of. One unique example of the divisions work to support underserved communities is Project SOAP, a recreation based community health and prevention model for young black MSM and trans youth

Supporting interventions like this can have many positive impacts. That includes the ability to sustain community engagement and planning, and even recruit community leaders into the process. Finally, never discount the power of networking and snowball sampling for all of these methods. It's simple but effective and by empowering HPG members to contribute or tie it into their existing work. It can be a great way for them to participate in and diversify stakeholder engagement. We've already talked about town home meetings and focus groups. One thing to keep in mind with town halls that I wanted to mention is that you're more likely to get specific kinds of feedback. What we found is that those who attend are more likely to have more time and more resources, be less affected by things like stigma, be more motivated to attend or the like.

It's not a bad format, but these are factors that might influence the feedback that one receives. Many of these issues can be counterbalanced through other methods, particularly through focus groups. This social scientific method employs smaller closed door session to bring consumers together in a safe setting for open, honest discussion. It can be built around times and locations through a convenience for specific communities and in that way often capture more diverse and detailed information. One thing to be aware of with this approach though is that not just anyone can facilitate a focus group. It's methodology requires experience and training. These can be significant investments of time and energy for participants, so poorly run focus groups, or town halls for that matter, can turn away the very people you're trying to engage if they're not done well or if they are transparent.

Once it's time to start gearing up for the next IHPCP, our process will shift again to gather specific feedback on the draft plan and the issues it addresses. Last year we conducted a major survey that garnered nearly 1,000 responses from across the state. While this is powerful data, there are also limitations to keep in mind. First the survey was primarily electronic. We included an optional paper version that could be requested with paid return envelopes, but it didn't generate much

response. While computer or smart phone use grows, electronic surveys still favor responses from people with the familiarity and the means to use them.

It's also a balancing act between limiting the number of questions, which makes it sort of more accessible, and gathering enough feedback and demographic information to see that the data is both useful and representative. Because of time limitations we had then, we had to include a lot of questions all at once. One area we plan to expand in over the next few years is supplementing that large effort with smaller more targeted surveys that could be more easily completed. The final step in our five year process is much like the first. It allows us, the HPG, and the division, not only to process the activities, data, and feedback from the last several years into the IHPCP but also to document what's worked and adjust for the next five years.

In that sense, it brings us back to the beginning of year one. I should also mention two methods for feedback loops here. One is that we report and gather feedback and direction from both the division and the HPG yearly. Second is the feedback that we provide directly to the thousands of consumers and stakeholders that we've engaged in these processes. This idea developed directly from consumer feedback in one of the regions. At the end of each planning year, we are distributing a simple summary of what feedback has been gathered and it's impact. It's proven to be a tricky document to create since planning can be complex, but we feel it's important. We want to show that we value and use stakeholders contributions. We also believe that this will help key people, especially consumers, engaged in planning over time.

We've talked about how we engage consumers and stakeholders in Pennsylvania. I'd like to conclude by discussing briefly what we engaged them about. While we gather feedback or request input on many topics, a chief goal for having access to a wide network of consumers and stakeholders is to get their impressions on the implementation of the current IHPCP. The set up of the HPG has changed over time allowing it to develop several effective configurations for addressing a variety of planning needs. Now that we have the current IHPCP, the configuration or the tool kit that you see here is specifically for monitoring and evaluation. This is divided into two main sub-committees. IHPCP assessment, which monitors that plan, and progress evaluation which evaluates it's effectiveness. Engaging the HPG in this role helps to ensure representative community participation in this crucial process.

As conditions change, the IHPCP will need to change too. The Assessment Subcommittee anticipates that inevitability and can request epi-data, needs assessments, consumer and stakeholder input, and any other type of data or information that they need to see that all the sections of the plan, and it's activities, are articulated accurately. The progress evaluation subcommittee, meanwhile, will be requesting and evaluating the progress that listed parties in the plan are making towards completing activities. Both groups will report their findings and recommendations to the division yearly.

One last point about this process is that it's evolving. While we currently have these

two main subcommittees, the division and the HPG retain the ability to shift or expand the work as necessary. While all of our members are becoming familiar with how monitoring and evaluation work now, the group may well elect to reengage some of our other successful tool kits from the past few years if they'll improve the current plan or the development of the next one. That's what the ad hoc sub-committee is for. Whether it's looking at issues related to instance, access, and disparities, as the group did in 2015-16, or shifting additional focus to stakeholder engagement or needs assessments like in 2013-14, or some other topic entirely, the HPG is well positioned with a large and diverse group of consumers and stakeholders dedicated to this process and improving HIV planning for all the people that we serve. Thank you.

Leah Varga:

Good afternoon everyone. This is Leah Varga at the DC Department of Health. Thank you so much for having us present today. I wanted to start off by giving you a description of the DC EMA. The map that you see here represents the District of Columbia's eligible metropolitan area as designated by HERSA. You'll see in the very center of the map, the darkest red spot, that is where DC is. You'll also see based on the colors the HIV burden among our EMA. DC in the center has the highest burden of HIV but our EMA spans a wide metropolitan region of roughly 7,000 square miles, comprising five counties in suburban Maryland, 11 counties and 6 independent cities in northern Virginia, and two counties in West Virginia. It's home to a little over six million people and sub recipients and providers throughout our EMA receive funding from Ryan White Part A, B, C, D, and F. While Ryan White funding covers the EMA, the center for disease control and prevention funds the regions jurisdiction separately.

The DC department of health receives center for disease control funding for HIV prevention efforts. For our integrated planning like all of the other EMAs, we structure our plan around the goal to end the epidemic and it provided the overall framework for our integrated planning approach. During the development of the integrated plan we used a multi-layer approach to consumer and community engagement. At around the same time of integrated planning DC had already begun working on developing our mayors 90-90-90-50 plan to end the epidemic in DC. In order to inform the mayors plan, this is where consumer and community engagement efforts formally began, providing initial data and framework for integrated planning and consumer engagement for integrated planning. Overall the goal to end the epidemic provided the framework for integrated planning and the structure, and was developed using the goals based on our DC Mayor's 90-90-90-50 plan.

These are the goals that frame Dcs 90-90--90-50 plan. 90% of DC residents living with HIV know their status. 90% of DC residents diagnosed with HIV are in treatment. 90% of DC residents living with HIV who are in treatment reach viral suppression and this will lead to a 50% reduction in new HIV infections in the district. In developing a realistic and responsive plan for DC, individuals and organizations in the DC community generously offered their experiences, concerns, and knowledge. This included our planning bodies so the DC HIV prevention planning group. The Metropolitan Ryan White [inaudible 00:40:25] Council, various

DC Health providers, substance abuse treatment centers, non profit community agencies, community sectors, district agencies for housing and workforce development. We partnered with DC Apple Seed Center for Law and Justice. The department of health formed a public private partnership to conduct community engagement efforts for the 90-90-90-50 plan.

With help of DC Apple Seed, qualitative and quantitative data were collected via questionnaires, town halls, focus groups, and key informant interviews. Some of these also included social media platforms. As discussed we used Twitter town halls, we had Facebook discussions as well. Really the structured session posed five questions for the groups. We wanted to know what aspects of the district government response to HIV were working. What populations are not being served sufficiently or not at all. How can the district government improve access to HIV care? How can the district government improve general outreach to increase knowledge of services available, and what community access resources or programs should the government work with or learn from. The discussions identified direct health interventions and social factors, particularly housing, that will contribute to achieving district goals and the valuable insights from these sessions were incorporated into the planning process. We took what we learned through developing Dcs plan and expanded on that approach for the EMA wide integrated planning.

We leveraged these existing relationships with providers, community agencies, and community members. The planning groups and health departments, and really tried to approach integrated planning as an EMA wide learning experience involving different states. For instance, working with health departments in other jurisdictions like Virginia and Maryland, we compared and combined planned strategies and activities when appropriate, particularly addressing needs of the differing priority populations and planning for services in the overlapping areas. This also led to our data sharing plans with other jurisdictions as well as standardizing data collection approaches and instruments in things like patient satisfaction surveys and needs assessments. Also, working with Virginia and Maryland counterparts ensure that their community engagement process and efforts were actually part of our strategies that we were developing.

For our partnership and collaborations for integrated planning came again from the mayors' office and various government agencies, local and state health departments. We had academic partnerships. We have an institutional collaboration with GW, George Washington University Department of Health Policy and management. Then as far as the community and consumer engagement portion, we kind of thought about what do we mean when we say community? Who exactly are we talking about? There's a formal definition from CDC and HERSA, but we also know that in the planning process there is an engaged community and a not engaged community. Of course the engaged community is the people that we usually see, the people that do attend their doctors appointments, the people that are linked and retained and care and many who are virally suppressed. These are the people that come to town halls, that come to focus groups, that answer our needs assessment surveys. We also though have a

population that's not engaged and a lot of times represent an underrepresented population or the people that have not been diagnosed with HIV and are newly diagnosed and just don't know where to get care. We realize that a lot of time in planning, we're representing the engaged population and we really want to make an effort in the future to make sure that we're reaching out more to those who are not engaged.

For the engaged community, we had the data already collected from the mayor's plan of community input data. We also had needs assessments, town halls, patient satisfaction surveys, and information from our planning bodies. We held specific consumer town halls in addition to those to get input on state and service provisions in the EMA, identify gaps in various Ryan White service access or availability, describe general challenges of living with HIV in the EMA, lift and prioritize service needs, and discuss services that are successful at keeping people living with HIV linked to care. The information gained from all of these sources was provided to our integrated plan work group that was flown from our two planning bodies, the HIV prevention and planning group and the Ryan White planning council.

Once we had all this data from the 90-90-90-50 plan engagement, and again the needs assessments, town halls, we developed this integrated plan work group that combined members from these two planning bodies. The HIV prevention and planning group include prevention providers and advocates that serve and represent many of the high risk populations in DC. Members from the HIV prevention planning group that consistently attended and contributed to integrated plan work group meetings represented the populations listed in the slide and for the sake of time I won't read through all of that.

Our Ryan White planning council announced the formation of our integrated plan work group and invited their members to participate in the work group as well. The integrated plan work group obtained the commitment and support from all members to contribute to making recommendations and assisting with the development of integrated plan strategies and activities. The planning body chairs, coordinators, and participators, can be meetings of integrated planned work groups on a monthly basis through the year or started off at the monthly basis to coordinate work plans, set time lines, identify goals, develop strategies, list activities, and edit any drafts that were developed. As jobs got more detailed, the work group met more often, eventually meeting weekly in addition to substantial online communication exchanging drafts that we were working on.

This work group used the data collected from previous community engagement efforts to develop specific activities and strategies in the integrated plan. We had break out groups to tackle each objective. Once there was a complete draft of the work groups feedback we took the strategies and activities they developed back to the division chief at the DC Health Department for review and tweaking where necessary to make sure goals were realistic and any actual and in the actual purview of health department activities. Ultimately the strategies and activities the integrated plan work plan was developed, were minorly adjusted and led to the

comprehensive integrated five year plan for the DC EMA. The work group input is directly reflected in the strategies and activities of the integrated plan, particularly addressing housing activities, support services, availability of community health workers, and efforts to improve the regional coordination of care for people living with HIV in the EMA.

Some of the challenges and lessons learned, I wouldn't say they were necessarily challenges but aligning the various local and regional plans is something that is just something to keep in mind rather than a challenge, to make sure that we're using the same language, the same definitions when appropriate. Standardization across a jurisdiction is just assuring all jurisdictions again are using the same data standards or definitions or measures when possible and when it makes sense. We want to keep up with the community. The community really challenges us to rethink and reframe what we know and how to respond.

For example, they really pushed our linkage to care standard to 30 days from 90 because their response goal in the community is 72 hours. Listening to what their pushing themselves to do can really inspire what we try to do here. We also need to keep in mind the emerging populations and again those who are underrepresented, what do we need to do to engage those populations who are not accessed through town halls and planning bodies like the other presenters already spoke about. Also, how do we make sure that involving community stakeholders doesn't become a burden to that community. A lot of times we have a lot of meetings to discuss work groups and discuss planning, but it's not always easy for those in the community to make it to all of those meetings and work groups.

To remain engaged we are building are building on the lessons learned in the community and we created an integration task force which is part of the integration plan work group that we had before that was a combination of the planning bodies. One of the things we're currently involved with is the integration of our prevention and care planning bodies. This is in order to design a more coordinated and effective regional response to the epidemic. Prevention and care planning bodies and providers will consult on decisions in areas of shared responsibility and prevention and care stakeholders and community representatives are participating in the merging of these bodies. The plan is for the stakeholders and community representatives to actually lead the process with DC Department of Health facilitating.

During the transition, members of the task force will report planning progress back to their respective planning bodies that are still separate as well as the provider agency. This offers the opportunity for stakeholders and community to engage in the integration process. Monitoring improvement will come from this task force process as well as our planning work groups that we've created at the Department of Health. In order to respond to our 90-90-90-50 goals and again, our integrated plan goals that are weak within those, we are having, we have four work groups at the Department of Health responding to each one of those goals. Everybody here at the Department of Health is actually assigned to one of those groups. They

currently will meet every other week and we'll have a regular milestone check in with other planning bodies as well as the community group.

We'll have ... Because again of the community burden, we want to make sure that we're involving communities and they will be invited to all of the work group meetings, however we be having quarterly community meetings to report back to the community and be able to get feedback from them on the process of the work groups. General integrated plan updates are also a standing agenda item at planning body meetings and we also are trying to expand technology to improve the participation again to minimize burden and improve participation from the community if they cannot be coming to meetings every other week at the Health Department. DCApple Seed and DUH will continue to update the plan if necessary reflecting the progress made or any changes we need to make to the plan based on what we hear back from the community stakeholders.

A big part of future planning is just thinking about again how we successfully reach out and engage with the community that is underrepresented. Above all we remain flexible and adaptable. We're thinking about doing press releases, again using social media for Twitter town halls and Facebook, perhaps even podcasts. Basically building on the expertise of peers and health impact specialists. We've expanded the use of our peer model into our use programs, our prevention programs, and our housing programs and we feel that this will be a valuable way to try to connect to some of these non engaged or underrepresented populations. We also want to encourage ethnographic work and invest the time and resources necessary to do that. In order to keep building relationships across the community, perhaps making it part of staff duties to actually have this as part of their goals for their own personal duty.

Thank you very much.

Julie Hook: Great. Thanks Marissa, David, and Leah. Do you have any questions for any of our presenters? Please chat them into the chat box. While we wait for questions to come in, please note that immediately after the webinar an evaluation will pop up on your screen so we would love for you to fill out this evaluation after the webinar, as it helps us plan and develop additional webinars and resources. A couple of questions that I think either could be for David, excuse me, for David or Leah. Are there any particular training curriculums or trainings to educate newly involved consumers as it relates to integrated planning?

David Givens: I can speak to that briefly. Our HPG does a comprehensive orientation process at the beginning of each planning year. It's something that we have standardized and we continue to develop with each new iteration as we recruit members on an ongoing basis. That kind of answers that question on our end.

Leah Varga: On our end, there is an orientation to the planning bodies so whether you want to join the HPPG or the Ryan White planing council, there is an orientation on what it means to participate and how to be involved or the integrated plan process. It's very similar.

Julie Hook: Great. Thank you. Another question that I think could either be answered by David or Leah or both of you about strategies that have been successful to keep newly engaged consumers keep coming to meetings. Any thoughts David or Leah?

David Givens: Yeah, one thing that we do, it's actually a big challenge for Pennsylvania because it is such a large state, folks driving from St. Eerie can have up to a five hour drive to get to Harrisburg just to attend these meetings, which we hold bi-monthly. We have been talking with the division of HIV Disease about how we can mitigate that, whether that's through innovative uses of technology, whether that's through actually moving the meetings, there's several processes that we're considering but what we do currently is other than kind of direct travel support that the division of HIV Disease does, is really just we have a mentoring process where existing HPG members kind of look after, take under their wing some of our new members and we've found that to be pretty successful, kind of check in on them, especially with the travel. Make sure everyone gets there okay, oh how are you doing with getting adjusted to the meetings? Everything like that. Really things to help keep members of the HPG engaged.

Leah Varga: Hi, yeah, just to add to that. In DC our planning council has been restructured as relatively new so we haven't had that challenge yet but I think as David mentioned making sure that people are feeling comfortable, that there's convenient times that those meetings are available, that it's places that are easy to get to and just making it a comfortable atmosphere that's encouraging and actually listening to feedback. I think again when people feel that they come and they feel they're listened to, that that can be a big motivation to keep coming as well.

David Givens: I would absolutely agree with that. One thing that we ... Even taking relatively small feedback really to heart. We started adding music into our meetings before the meetings get started and just those little tweaks like that. It really made a big difference with having them feel very welcoming and much more driven by our stakeholders.

Speaker 6: This is [inaudible 00:55:51] and just to add a couple more words. In terms of like the PPG for DC, essentially the body is much smaller and so one of the things that actually has sort of brought a breath of fresh air is actually this integrated plan and the ability for the bodies to participate in this joint work groups. Working with planning council is certainly new to the group and they're very excited about that. Mine show that they're also just equally committed to the full body, planning body integration so I think that the more recent activities, especially in relation to DCs 90-90-90-50 plan and looks to basically eliminate the epidemic, have kind of brought about a new form of engagement and expect continued engagement.

Julie Hook: Great, thanks Nester, Leah, and David. Another question came in that specifically asks about funding for planning bodies in terms of the planning for already stressed budgets. I think I'd like to turn that over to my colleague here at JSI, Stewart Landers.



Stewart Landers: Thanks for this question, which really sort of addresses the cost of holding so many meetings and engaging the stakeholders. I think it's true that there's cost involved and I also think it's true that jurisdictions have very different levels of resources and for some it is a burden. I would go back to the introduction by Steve Young to this webinar that stressed how central consumer and other stakeholder engagement is to the planning of Ryan White services to say that this is something that should be prioritized and then in terms of cost, I think ways to try and reduce cost potentially by allowing people to call into meetings as needed, particularly in large states with large travel distances, more greater use of more current technology like Google Hang outs, things like that, can allow for participation in new ways that could potentially be more economical. This piece of work is very important and central to planning.

Julie Hook: Great. Thanks Stewart. Maybe one final sort of comment/question before we end, sort of one listener mentioned one major concern will lead to health equity and assuring the issues of racial and social justice are effectively recognized and addressed in building and sustaining the building process. Do you have any plans to offer a more focused training on this topic, which is punting it back to Stewart?

Stewart Landers: I would say that this is a very important issue and it's really part of people's plans to address health equity so we will take that into account. I'd also like to acknowledge that HERSA and in particular Part A [inaudible 00:59:26] has also funded a technical assistance center specifically for planning bodies and planning councils and that may be another source of training on support on this issue.

Julie Hook: Great. Thanks Stewart. Please contact us at IHAPTACatJSI if you have any additional questions and to obtain more information or join our mailing list. We'd also love to hear from you about similar to the last question that just came in about are there other kinds of resources or tools or webinars that might be helpful to you and your jurisdictions as you're implementing your integrated HIV prevention and care plans. Thank you again for your participation and have a great afternoon. Thank you.